KAISER PERMANENTE®

PHASE

PREVENTING HEART ATTACKS
& STROKES EVERY DAY

Welcome to the PHASE Learning Community!

May 29, 2019

Webinar Housekeeping

1. Dial in for audio: 303-248-0285, Access Code: 5617817
2. Lines are muted. You can **chat in questions** or **unmute your line** by pressing *7 to ask a question (*6 to re-mute).
3. Webinar is being recorded and will be posted on careinnovations.org/phasesupport and a link will be emailed.
4. Please fill out our **feedback survey** at the end of the webinar.

Our Speakers Today

Landis Coghlan, MD
Clinical Lead- CV Risk Reduction, Statin, Aspirin
The Permanente Medical Group

Lisa Gilliam, MD, PhD
Clinical Leader, Kaiser Northern California Diabetes Program
The Permanente Medical Group

Ronald Scott, MD
CVD Co-Lead, Integrated Cardiovascular Health Lead
Southern California Permanente Medical Group

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The Permanente Medical Group

PHASE – highlights and key updates

Landis Coghlan, MD
TPMG Clinical Lead- CV Risk Reduction, Statin, Aspirin

Lisa K. Gilliam, MD, PhD
Clinical Leader, Kaiser Northern California Diabetes Program
The Permanente Medical Group

May 30, 2019

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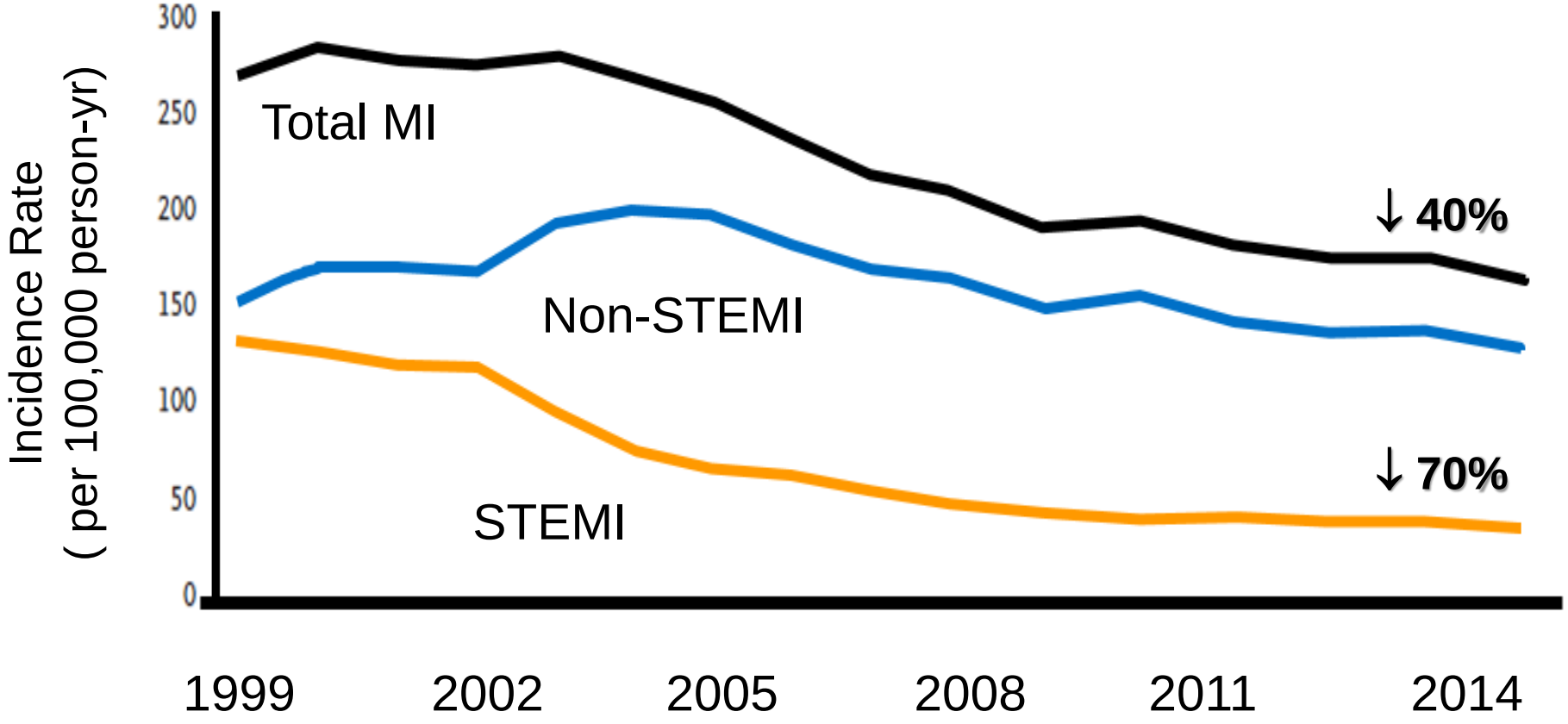
Agenda

- 2018/ 2019 Changes to PHASE on a Page
- Elements of Success with PHASE
- Operational Workflows to get value from POAP
- What's next? New areas of focus for PHASE

PHASE

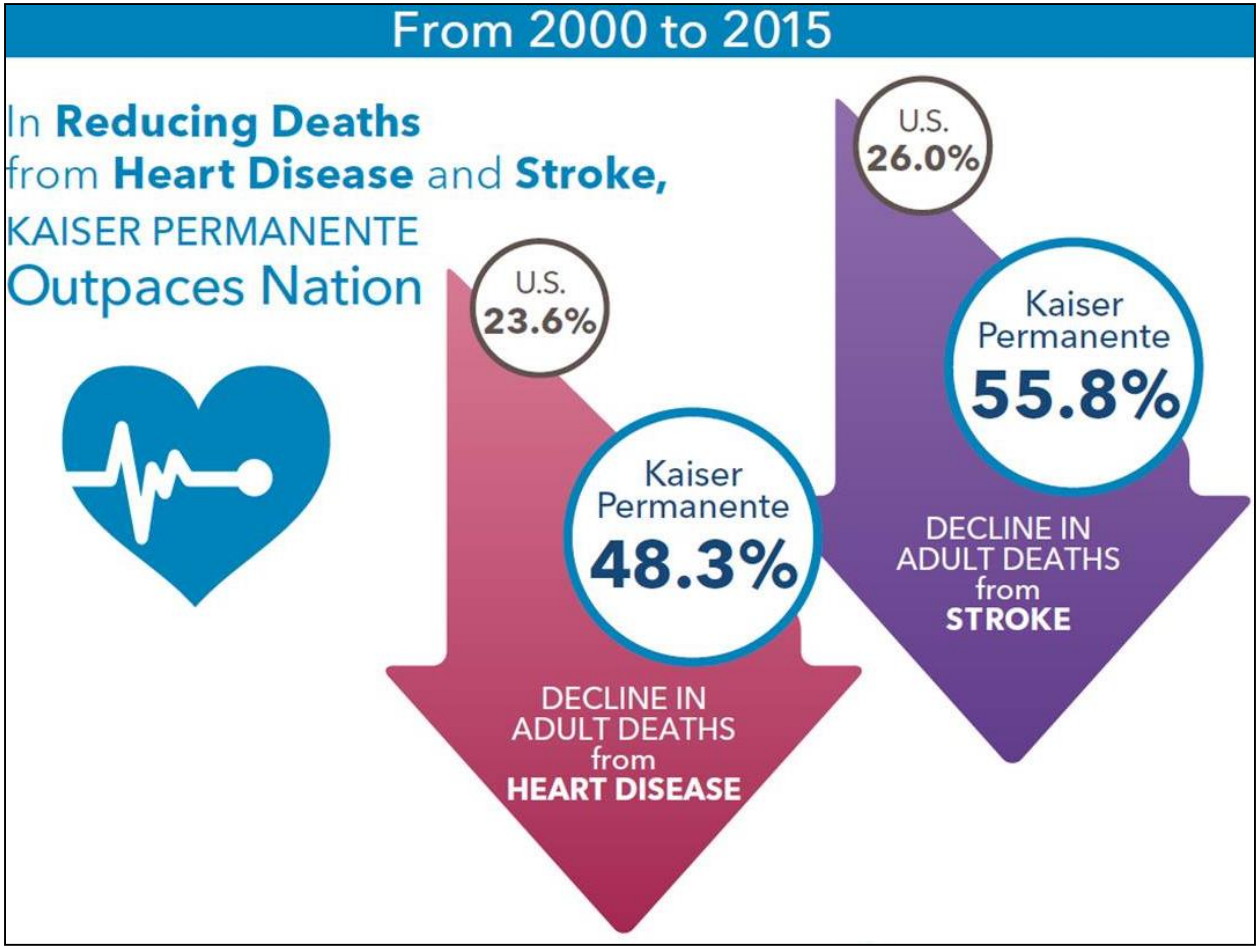
- Preventing Heart Attacks and Strokes Everyday
- Identify at risk population
- Algorithm for lifestyle and medication management of cardiovascular risk factors – diabetes, hypertension, statin, aspirin, smoking, exercise, diet
- Clear accountability for this care
- Multiple touch points with patients

PHASE: Prevent Heart Attacks and Strokes Every day
BP Control, Statins, Aspirin, A1c Control + Optimize Lifestyle



Yeh RW. Engl J Med 2010;362:2155-165.
Solomon MD. J Am Coll Cardiol. 2016;68(6):666-668.

Did Preventing ASCVD Events Save Lives? YES!



PHASE
Changes in 2018/ 2019

PHASE Updates 2018/2019

Blood pressure:

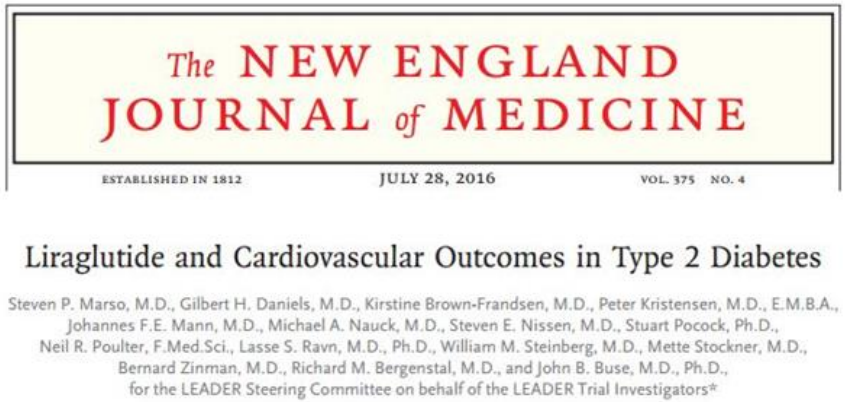
- Goal back to <140/ <90 for all
- Speed up escalation of meds in the algorithm
- Aim for point of care med changes (when patient comes in for BP check, and its high, intervention is made at that time)
- AOBP especially for white coat hypertension

PHASE Updates 2018/2019

Diabetes:

- Recognition/addition of SGLT2 and GLP1 medications
- Separate DM1/ DM2
- Attention to populations/disparities especially Latino

Trial data supporting SGLT2/GLP-1 use in special populations

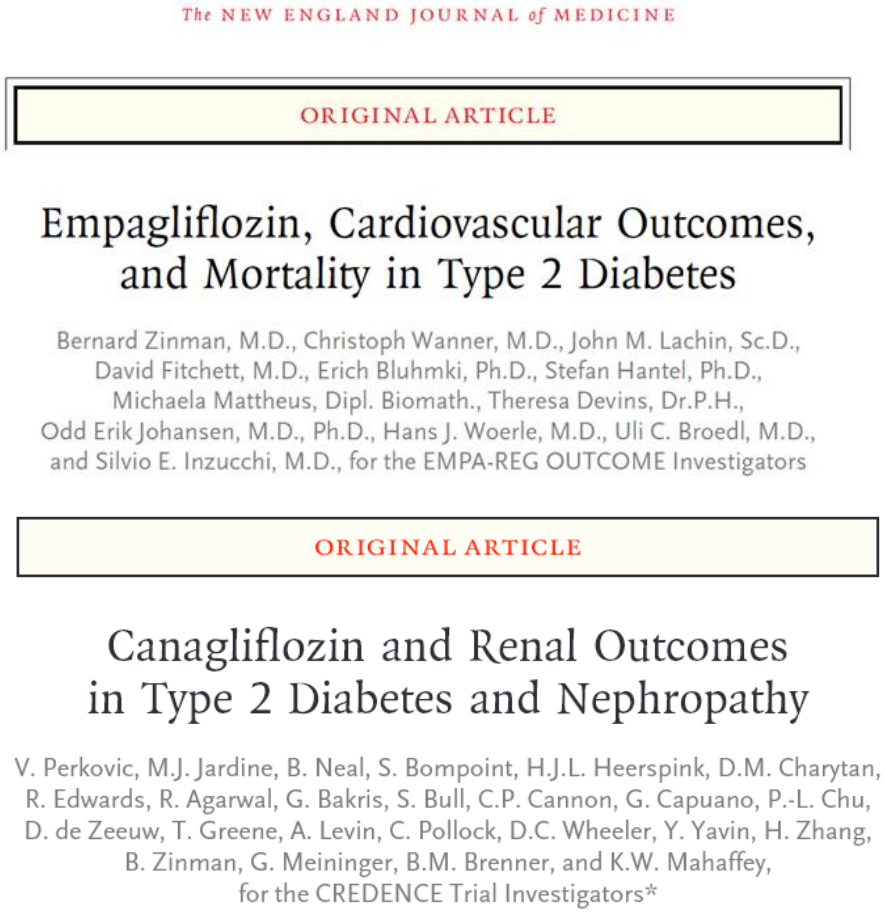


The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 JULY 28, 2016 VOL. 375 NO. 4

Liraglutide and Cardiovascular Outcomes in Type 2 Diabetes

Steven P. Marso, M.D., Gilbert H. Daniels, M.D., Kirstine Brown-Frandsen, M.D., Peter Kristensen, M.D., E.M.B.A., Johannes F.E. Mann, M.D., Michael A. Nauck, M.D., Steven E. Nissen, M.D., Stuart Pocock, Ph.D., Neil R. Poulter, F.Med.Sci., Lasse S. Ravn, M.D., Ph.D., William M. Steinberg, M.D., Mette Stockner, M.D., Bernard Zinman, M.D., Richard M. Bergenstal, M.D., and John B. Buse, M.D., Ph.D., for the LEADER Steering Committee on behalf of the LEADER Trial Investigators*



The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Empagliflozin, Cardiovascular Outcomes, and Mortality in Type 2 Diabetes

Bernard Zinman, M.D., Christoph Wanner, M.D., John M. Lachin, Sc.D., David Fitchett, M.D., Erich Bluhmki, Ph.D., Stefan Hantel, Ph.D., Michaela Mattheus, Dipl. Biomath., Theresa Devins, Dr.P.H., Odd Erik Johansen, M.D., Ph.D., Hans J. Woerle, M.D., Uli C. Broedl, M.D., and Silvio E. Inzucchi, M.D., for the EMPA-REG OUTCOME Investigators

ORIGINAL ARTICLE

Canagliflozin and Renal Outcomes in Type 2 Diabetes and Nephropathy

V. Perkovic, M.J. Jardine, B. Neal, S. Bompoint, H.J.L. Heerspink, D.M. Charytan, R. Edwards, R. Agarwal, G. Bakris, S. Bull, C.P. Cannon, G. Capuano, P.-L. Chu, D. de Zeeuw, T. Greene, A. Levin, C. Pollock, D.C. Wheeler, Y. Yavin, H. Zhang, B. Zinman, G. Meininger, B.M. Brenner, and K.W. Mahaffey, for the CREDENCE Trial Investigators*

SGLT2 inhibitors

Empagliflozin (Jardiance) NF*,

Dapagliflozin (Farxiga)$_{NF}$, Canagloflozin (Invokana)$_{NF}$, Ertugliflozin (Steglatro)$_{NF}$

Blocks renal glucose reabsorption, promotes glucosuria

A1c: ↓ 0.7 - 1.1%

Advantages

- Oral
- Modest weight loss (~2-3 kg)
- Lowers blood pressure
- CV benefit in pts w/ CVD
- Renal and CHF benefit in pts w/ clinical CVD or CVD risk factors

Disadvantages

- High copays / cost
- **GU infections (10%)**
- UTI / urosepsis, pyelonephritis
- DKA
- Polyuria / hypotension / dizziness
- Fracture risk
- Not effective in pts with renal impairment and **contraindicated for GFR<30**

If prescribing **Empagliflozin, start with ½ tabs (½ of 25 mg tab = 12.5 mg)** to reduce cost from$$$$$ to $$$$

*** Non-formulary preferred agent**

GLP-1 receptor agonists

Liraglutide (Victoza) NF*

Exenatide ER inj (Bydureon) NF*, Dulaglutide inj (Trulicity) **NF**, Semaglutide (Ozempic) **NF**, Lixisenatide (Adlyxin) **NF**

A1c: ↓ 0.7 - 1.5

Advantages

- Modest weight loss
- Once weekly dosing
- Less hypo risk
- CV benefit in pts w/ CVD (Liraglutide)

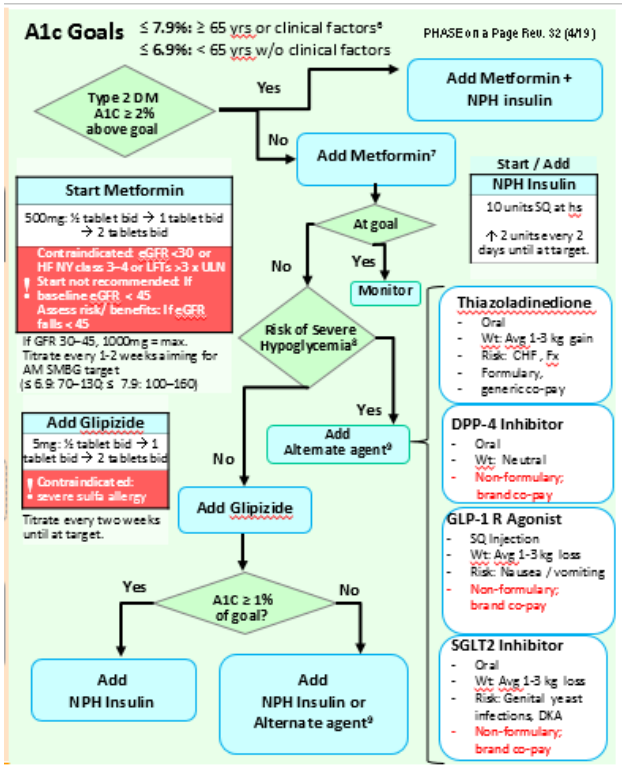
Disadvantages

- Injected
- **GI SE's** (N/V, diarrhea in 20 - 40%)
- **VERY** costly
- **Contraindicated** if FHx of MTC or MEN2 (Boxed warning)
- Acute pancreatitis

* Non-formulary preferred agent

PHASE on a Page DM Updates

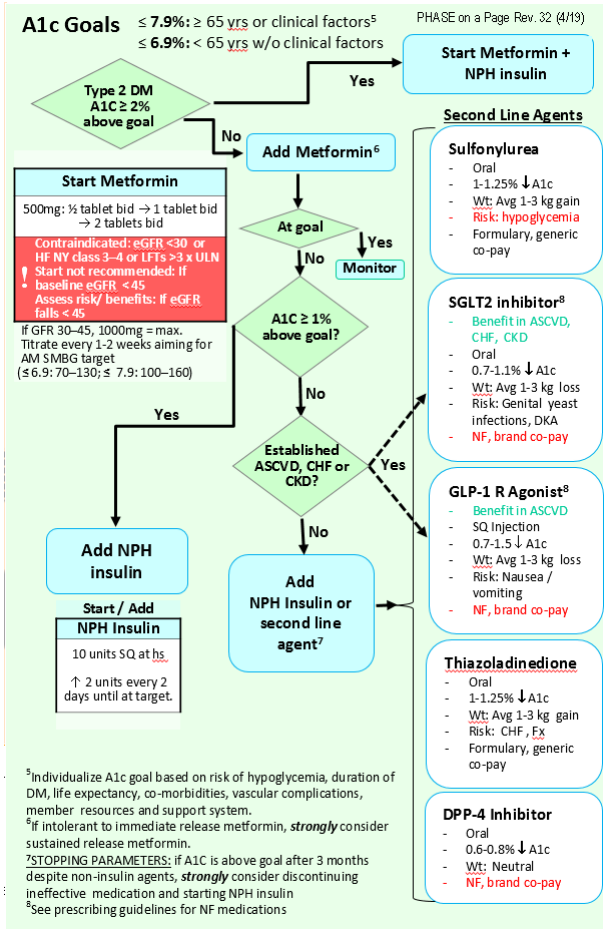
CURRENT VERSION



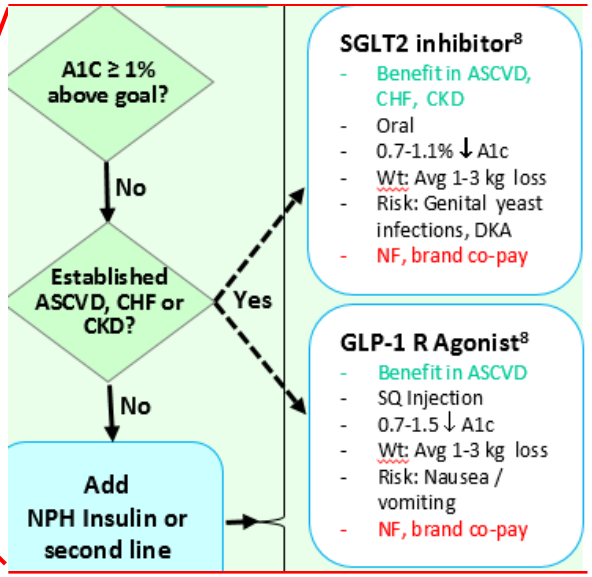
[5]Clinical Atherosclerotic Cardiovascular Disease (ASCVD), e.g. CAD, TIA/CVA, Symptomatic PAD.
[6]Individualize A1c goal based on hypoglycemia risk, duration of DM, life expectancy, co-morbidities, vascular complications, member resources and support system.
[7]If intolerant to immediate release metformin, ***strongly*** consider sustained release metformin.
[8]Severe Hypoglycemia = Hypoglycemia resulting in / likely to result in seizures, loss of consciousness, or needing help from others. Mild to moderate hypoglycemia = Symptoms of neuro-glycopenia such as hunger or sweating that the patient can effectively self-treat.
[9]A1C above goal 3+ months despite non-insulin agents, ***strongly*** consider discontinuing ineffective medications and initiating insulin + metformin.

Ed.

NEW VERSION



[5]Individualize A1c goal based on risk of hypoglycemia, duration of DM, life expectancy, co-morbidities, vascular complications, member resources and support system.
[6]If intolerant to immediate release metformin, ***strongly*** consider sustained release metformin.
[7]STOPPING PARAMETERS: if A1C is above goal after 3 months despite non-insulin agents, ***strongly*** consider discontinuing ineffective medication and starting NPH insulin
[8]See prescribing guidelines for NF medications



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PHASE Updates 2018/2019

Cholesterol/ Statins:

- Reframe as ‘to prevent heart attack and stroke” (not ‘for cholesterol’)
- NONFASTING lipid tests
- Separate ASCVD and DM populations

PHASE Updates 2018/2019

Aspirin:

- No change if ASCVD
- Primary prevention (including diabetics) - more caution overall about recommending
- Stop/don’t start for patients >70yo

BP Goals[1] (in mm/ Hg)	Conventional Office	AOBP or Avg[2] Home Reading
All Adults Strong Rec.	≤ 139 / 89	≤ 134 / 84
If: ≥ 75 yrs, eGFR 20 – 59 mL/min, ASCVD or ≥10% 10-yr ASCVD risk	Consider ≤ 129/89	Consider ≤ 129 / 84

If BP above goal

Start ACEI + Diuretic

Lisinopril - HCTZ
20 - 25mg
½ → 1 → 2 tabs daily

See CAUTION/INFO: verify contraception & eGFR.
Titrate to BP goal.

Optional: Replace ACEI w/ ARB if ACEI intolerant

Losartan
25mg daily → 25mg twice daily → 50mg twice daily
Titrate to BP goal.

Add Calcium Channel Blocker

Amlodipine
2.5 → 5 → 10mg daily
Titrate to BP goal.

Replace HCTZ w/ Chlorthalidone

Chlorthalidone
25mg daily (max rec. dose)

Add Spironolactone*

Spironolactone
12.5 → 25mg daily
*If on thiazide AND eGFR≥ 60 AND K< 4.5

If Spironolactone eligibility criteria not met:

Bisoprolol[3]
2.5 → 5 → 10 mg daily
Titrate to BP goal. **Maintain pulse of 55 or greater**

[1] BP algorithm applies if eGFR ≥ 20 and if LVEF ≥ 40%.
[2] Automated Office BP (AOBP) avg. is the avg. of 3 readings measured with the patient unobserved using an AOBP device.

Statin Goals

Atorvastatin 40-80 mg:
- Clinical ASCVD[5] Age < 75 + any LDL
- DM: Age < 75 + LDL ≥ 190

Atorvastatin 10-20 mg:
- Clinical ASCVD Age ≥ 75 + any LDL
- DM: Age ≥ 40 + LDL 70-189*

DM Age < 75 LDL ≥ 190 | **Clinical ASCVD[5]** | **DM** Age ≥ 40 LDL 70 – 189*

Age <75 | Age ≥75

Start Statin
Atorvastatin
20 mg daily
See CAUTION/INFO
Verify contraception

Start Statin
Atorvastatin
80mg daily
See CAUTION/INFO
Verify contraception

Optional: 10 yr CV risk ≥ 7.5%

If recommended dose of statin not tolerated, switch to a different statin (such as rosuvastatin). If that doesn't work, reduce to highest tolerated dose. *[update SIG w/ dosing changes]*

Optional: LDL monitoring to ensure appropriate response

* For DM w/ LDL <70, see primary prevention guidelines.

[3] Beta Blockers, independent of their mild anti-hypertensive effect, are sometimes indicated for secondary cardio-protection

Adapted from KPNC CPG for:
CAD, DM, Cholesterol, HTN, HF and Stroke
Complete guidelines, including **updated guidelines on the Dx of HTN**, can be found in the Clinical Library at http://clkp.org

***Contact*: Jonathan Lee**, Sr Consulting Assoc., Regional Health E
***Design*: Vince Rowell**, Quality and Operations Support

A1c Goals

≤ 7.9%: ≥ 65 yrs or clinical factors[5]
≤ 6.9%: < 65 yrs w/o clinical factors

PHASE on a Page Rev. 33 (5/19)

Type 2 DM A1C ≥ 2% above goal

Yes → **Start Metformin + NPH insulin**

No → **Add Metformin[6]**

Start Metformin
500mg: ½ tablet bid → 1 tablet bid → 2 tablets bid
Contraindicated: eGFR <30 or HF NY class 3–4 or LFTs >3 x ULN
Start not recommended: If baseline eGFR < 45
Assess risk/ benefits: If eGFR falls < 45
If GFR 30–45, 1000mg = max.
Titrate every 1-2 weeks aiming for AM SMBG target
(≤ 6.9: 70–130; ≤ 7.9: 100–160)

At goal
Yes → **Monitor**
No → **A1C ≥ 1% above goal?**

A1C ≥ 1% above goal?
Yes → **Add NPH insulin**
No → **Established ASCVD, CHF or CKD?**

Established ASCVD, CHF or CKD?
Yes → **Add NPH Insulin or second line agent[7]**
No → **Add NPH Insulin or second line agent[7]**

Start / Add NPH Insulin
10 units SQ at hs
↑ 2 units every 2 days until at target.

Second Line Agents

Sulfonylurea
- Oral
- 1-1.25% ↓A1c
- Wt: Avg 1-3 kg gain
- Risk: hypoglycemia
- F, Generic co-pay

SGLT2 inhibitor[8]
- Benefit in ASCVD, CHF, CKD
- Oral
- 0.7-1.1% ↓A1c
- Wt: Avg 1-3 kg loss
- Risk: Genital yeast infections, DKA
- NF, Brand co-pay

GLP-1 R Agonist[8]
- Benefit in ASCVD
- SQ Injection
- 0.7-1.5 ↓A1c
- Wt: Avg 1-3 kg loss
- Risk: Nausea / vomiting
- NF, Brand co-pay

Thiazoladinedione
- Oral
- 1-1.25% ↓A1c
- Wt: Avg 1-3 kg gain
- Risk: CHF , Fx
- F, Generic co-pay

DPP-4 Inhibitor
- Oral
- 0.6-0.8% ↓A1c
- Wt: Neutral
- NF, Brand co-pay

[5] Individualize A1c goal based on risk of hypoglycemia, duration of DM, life expectancy, co-morbidities, vascular complications, member resources and support system.
[6] If intolerant to immediate release metformin, ***strongly*** consider sustained release metformin.
[7] STOPPING PARAMETERS: if A1C is above goal after 3 months despite non-insulin agents, ***strongly*** consider discontinuing ineffective medication and starting NPH insulin
[8] See prescribing guidelines for NF medications

PHASE
PREVENT HEART ATTACKS AND STROKES EVERYDAY

Cardiovascular Risk Management Medications and Lab Chart Rev. 28 (05/19)

PHASE POPULATIONS

CAD Symptomatic **PAD**

CVA/TIA Ischemic

DM
ASA: If 10 y CV risk > 10%:
Ages 40-59: **Consider** ASA;
Ages 60-69: **No rec.** for/against ASA.
Age 70+ : **Stop / do not start** ASA.

PHASE MEDICATIONS & CAUTIONS

Established ASCVD: ASA Recommended

ASA	81mg daily

CAUTION/INFO If ASA intolerant:
Clopidogrel : CAD, Sx PAD

ACEI

Lisinopril	10mg daily

CAUTION/INFO Verify effective contraception in women of childbearing potential: Use Chlorthalidone or HCTZ.
Use ACEI with caution: eGFR <30, K >5.5
ARB may be inappropriate : Hx of Angioedema, renal failure or hyperkalemia on ACEI.

STATIN

- Clinical ASCVD[3] Age < 75 + any LDL
- DM: Age < 75 + LDL ≥ 190

Atorvastatin	40–80mg daily

- Clinical ASCVD Age ≥ 75 + any LDL
- DM: Age ≥ 40 + LDL 70-189**

Atorvastatin *OR*	10-20mg daily
Rosuvastatin	10-20mg daily

CAUTION/INFO Verify effective contraception in women of childbearing potential.

BETA BLOCKER – FOR CAD/Sx PAD

Bisoprolol	25mg daily

CAUTION / INFO Use with caution: HR <55, asthma, hypotension.

** For DM w/ LDL <70, see primary prevention guidelines.

BP	Preferred Dosage Forms	Max. Rec. Dose	Optimal Titration Interval	Baseline Labs	Titration
ACE Inhibitor - Diuretic Lisinopril - HCTZ (Prinzide®) F	Tab 20 / 25mg	40 / 50mg daily	2 weeks	K+ and SCr. < 6 months (Na+ optional)	K+ and SCr. 1 week after initiation or dosage change (Na+ optional)
Thiazide Diuretics HCTZ (Hydrodiuril®, Esidrix®) F	Tab 25mg	HCTZ 50mg daily	2 weeks	K+ and SCr. < 6 months (Na+ optional)	K+ and SCr 1 week after initiation or dosage change (Na+ optional)
Chlorthalidone (Hygroton®) F	Tab 25mg	25mg daily	2 weeks	K+ and SCr. < 6 months (Na+ optional)	K+, SCr 1 week after initiation or dosage change (Na+ optional)
ACE Inhibitor Lisinopril (Prinivil®) F	Tab 5, 10, 20mg	40mg daily	1 week	K+ and SCr. < 6 months	K+ and SCr 1 week after initiation. K+ 2 weeks after dosage change
ARB Losartan (Cozaar®) F	Tab 25, 50mg	100mg daily or 50mg BID	1 week	K+ and SCr. < 6 months	K+ and SCr 1 week after initiation. K+ 2 weeks after dosage change
Calcium Channel Blocker Amlodipine (Norvasc®) F	Tab 2.5, 5, 10mg	10mg daily	1 week	None	None
Potassium Sparing Diuretic Spironolactone (Aldactone®) F	Tab 25mg	25mg daily	1 week	K+, SCr. < 1 month	K+ and SCr 1 week after initiation & 2 weeks after dosage change
Beta 1 blocker Bisoprolol (Zebeta®) F	Tab 5, 10mg	10mg daily	1 week	None	Maintain pulse ≥ 55

DM 2 (non-insulin agents)	Preferred Dosage Forms	Max. Rec. Dose	Optimal Titration Interval	Baseline Labs	Cautions / Contraindications
Biguanide Metformin (Glucophage®) F	Tab 500, 1000mg	1000mg BID	2 weeks	SCr. (CBC optional)	Contraindicated: eGFR <30 or HF NY class 3–4 or LFTs >3 x ULN; Not recommended: baseline eGFR < 45; Assess R/B: If eGFR falls < 45
Sulfonylurea Glipizide (Glucotrol®) F	Tab 2.5, 5, 10mg	20mg BID ac	2 weeks	None	Contraindicated: severe sulfa allergy
Thiazoladinedione Pioglitazone (Actos®) F	Tab 15,30,45 mg	45 mg daily	2 months	ALT,(AlkP ,T bili optional)	Contraindicated: CHF stage III or IV
DPP-4 inhibitor Linagliptin (Tradjenta®) NF	Tab 5 mg	5 mg daily	N/A	None	N/A
SGLT2 inhibitor Empagliflozin (Jardiance®) NF	Tab 10, 25 mg	25 mg daily	2 weeks	SCr.	Contraindicated: eGFR <45
GLP-1 receptor agonists Liraglutide (Victoza®) NF	SQ Inj 0.6, 1.2 mg	1.8 mg daily	1 week	SCr.	Contraindicated: personal or FH Medullary thyroid CA or MEN2
Exenatide ER inj (Bydureon®) NF	SQ Inj 2 mg	2 mg weekly	N/A	SCr.	Contraindicated: personal or FH Medullary thyroid CA or MEN2

Statins	Preferred Dosage Forms	Max. Rec. Dose	Optimal Titration Interval	Baseline Labs*	Titration
Atorvastatin (Lipitor®) F	Tab 40, 80mg	80mg daily hs	N/A	ALT, SCr	N/A
Rosuvastatin (Crestor®) F	Tab 10, 20mg	20mg daily hs	N/A	ALT, SCr	N/A

F: Formulary NF: Non-formulary

*Do not routinely measure CK. Consider baseline CK if inc. risk for adverse muscle events (s.a. personal or family history of statin intolerance or muscle disease, clinical presentation, or concomitant drug therapy that might inc. the risk for myopathy).

Drug info site: http://pharmacy.kp.org

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Most important aspects for clinical benefit

PHASE: key aspects for benefit

- Identify patients at point of care, limit back sweep work
- Identify and standardize goals and meds across providers (POAP)
- Easy med escalation, usually generics
- Evidence based
- Enables providers at several levels (MA, nurse, PharmD, doctors) to intervene on patient's behalf

PHASE: Operational workflows

Blood pressure:

- BP measurement excellence
- AOBP
- Same day med escalation
- Identify cohort, get high BPs back in for recheck
- Outreach plan, accountability
- Reports/tracking

PHASE: Operational workflows

Diabetes:

- Identify cohort and their specific needs (updated lab vs medication escalation)
- Someone accountable
- Offer diet, exercise, education to patients
- Clear medication escalation instructions
- Start insulin early, it is not a sign of failure

PHASE: Operational workflows

Cholesterol/ Statins:

- NONFASTING labs
- The doctor voice is powerful
- Reinforce medication adherence and give positive feedback at every encounter
- Myalgia – don’t stop the statin, change to a different statin
- Emphasize lifestyle and diet changes, ongoing

PHASE
What is next area of focus?

PHASE: Next focus areas

BP, Diabetes, Statins, Aspirin- Ongoing efforts:

- new modes of measurement
- keeping up with guideline changes

In addition:

- Disparities – HTN, DM. Identify and close the gap, Culturally inclusive messaging
- Medication adherence – reinforcement across the medical center
- Motivational interviewing – key at all levels

Thank you

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Southern California
Permanente Medical Group

PHASE discussion

Ronald Scott, MD

Family Medicine, KP West LA

KPSC CVD Co-Lead

KP National Integrated Cardiovascular Health (ICVH) Clinical Lead

KP National Cholesterol and Cardiovascular Risk Clinical Lead

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Elements for Success

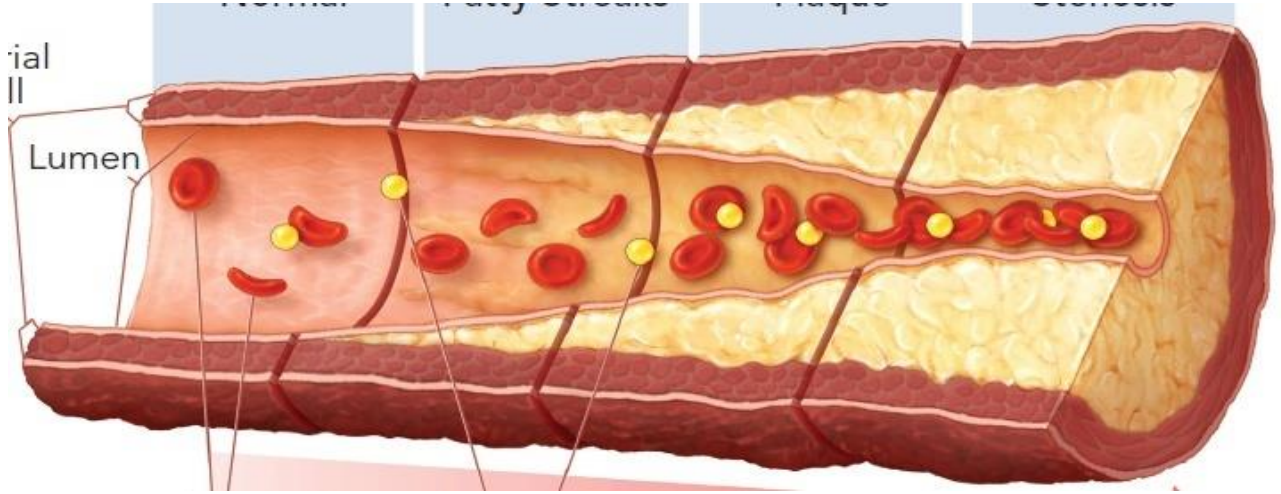
- Champion, network of champions.
- Know and try to align evidence, metrics, guideline and protocol.
- Simplified protocols. Minimize complexity and branchpoints.
- Data / feedback preferably unblinded. Sharing of best practices, performance improvement.

Key Operational Workflows:

- Hypertension – KP national to <140/90 end of 2017 (with ICVH consensus statement). Point of Care med changes, AOBP.
- DM –similar to KP Nor Cal.

Key Messages – align with Million Hearts

- Heart attacks and strokes are preventable, yet they remain leading causes of death and disability. Hits many middle age adults (age 50-64 years).
- “Screening, lifestyle, and medicines together can help you live a longer healthier life.”
- KPARE – Kaiser Permanente ASCVD Risk Estimator (ARisk) launch, Dec 2018.
- Statins – Agree with KPNC “to help prevent heart attack and stroke”, “to help keep arteries open” messages.



Statin Impact, primary prevention

Randomized Clinical Trial	ARisk	RRR	NNT
MEGA Prava 10-20 mg, **LDL -17%**	**5.1%**	24%	**82**
AFCAPS Lova 20-40 mg, **LDL -27%**	**6.9%**	26%	**56**
JUPITER Rosuva 20 mg, **LDL -50%**	**7.6%**	44%	**25**
ACC Guideline “High Intensity” **LDL -50%**	**10%**	45%	**22**

Preferred LDL lowering options

Medicine	% LDL lower	Medicine	% LDL lower
Rosuva 40 mg	63	Atorva 80 mg	53
Rosuva 20 mg	55	Atorva 40 mg	48
Rosuva 10 mg	47	Atorva 20 mg	41
Rosuva 5 mg 2x/week (Mon, Thurs) + ezetimibe			40

Rosuvastatin effective, inexpensive, great safety.

(For GFR <45, use atorvastatin)

2019 Four Cholesterol Management Groups, KPSC

Clinical ASCVD (age ≤75)

- Start rosuvastatin 20 mg daily (R20), aim for ≥50% reduction in LDL levels.
- If LDL remains ≥70 mg/dL, consider ezetimibe.

LDL >=190 (age 20-75)

- Start R20, aim for ≥50% reduction in LDL levels.
- If achieve <50% reduction, and/or LDL ≥100 mg/dL, consider ezetimibe.

As age to ≥76 years, shift to consider statin. For GFR <45 use atorvastatin.

DM (age 40-75)

- KPARE ≥7.5% and LDL ≥70, R20.
- KPARE <7.5% or LDL <70, R10.

By Risk (age 40-75, LDL 70-189)

- KPARE ≥10%, R20
- 7.5-9.9%, consider R20.
- 5-7.4%, consider discussing R10.

Over 60% increase in high-intensity statin use 2009 – 2015. Reynolds et al, ACC, March 2017

Learn / improve at multiple levels. Seek out member convenient synergy.

- Individual physician level, Module leader level, Regional level (13 medical centers KPSC), KP National Level – Learn from other KP Regions
- Working outside KP, researchers – share and learn, keep improving care.
- Seek synergy, example: 65+ yo male former smoker AAA screening → No AAA, but find aortic atherosclerosis → promote statin use and adherence.

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Questions?

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See you at the In-Person PHASE Convening!

Engaging Patients as Active Partners

Tuesday, June 11
8:30 a.m. – 4 p.m.
Hilton Oakland Airport

Agenda & Materials available here:
careinnovations.org/phase-jun-2019-convening/

Please complete the post-session feedback form!

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