AMGA FOUNDATION

Chronic Care In Focus

A Team-Based Model for Cardiometabolic Diseases

National Habor, MD – November 12, 2025

Meeting Summary

AMGA Foundation

Chronic Care Roundtable

John W. Kennedy, MD, AMGA Foundation president and AMGA chief medical officer, welcomed participants to the fall 2025 Chronic Care Roundtable. This year's event focused on team-based strategies to manage cardiometabolic diseases, exploring how organizations can strengthen care coordination, integrate specialists, and deliver more holistic support for patients with complex chronic conditions such as diabetes, obesity, kidney disease, and cardiovascular disease.

Keynote: Bridging the Divide in Cardiometabolic Care

Juan Delgado Hurtado, MD, MPH, *Division Chief – Endocrinology, Bassett Healthcare Network*

Hurtado began his presentation with a patient story.

A 50-year-old woman arrived at the emergency department with a history of coronary artery disease, type 2 diabetes, and increased urination and thirst.

"She was recently started on long-acting insulin for a markedly elevated HbA1c of 13.5%," Hurtado shared. "She didn't take any blood pressure medication, even though her blood pressure in the clinic was 149 over 88. Her BMI was 30, consistent with Class 1 obesity. Her diet, as per the patient, was unhealthy, and she had never seen a dietitian. She smoked, and she was not on a statin.

"So, here are the things that the primary care physician recommended," Hurtado said. "They ordered a lipid panel and a urine-to-creatinine ratio. They discussed blood sugar goals and scheduled an HbA1C in three months. She was prescribed testing supplies and asked to keep a glucose log."

In keeping with the integrated approach of Bassett Healthcare Network's Preventive Cardiology Program and Lipid Clinic, these labs and conversations led to the prescription of a statin and GLP-1 to complement her insulin and referrals to a diabetes educator, dietician, and tobacco cessation program.

After just three months, the patient achieved her target level of glycemic control with a reported A1C of 6.7%.

Adiposity, blood glucose, lipids, and blood pressure are all connected, Hurtado declared. Therefore, preventing and managing these cardiometabolic conditions—obesity, diabetes, hypertension, and chronic kidney disease—needs to be interconnected as well.

Hurtado walked through evolving guidance and recommendations, the rising role of pharmacological interventions, and the obstacles standing in the way of coordinated care.

Intersecting and Evolving Guidance

With diabetes an independent artherosclerotic cardiovascular disease (ASCVD) risk factor, cardiovascular disease a major cause of morbidity and mortality, and major cardiovascular risk factors clustered and common among patients with diabetes, addressing multiple cardiovascular risk factors—such as control of glycemia, blood pressure, and lipids—simultaneously can yield big benefits.

For patients with diabetes, the American Heart Association recommends regular monitoring of blood sugar, blood pressure, blood cholesterol and weight, along with lifestyle interventions.[1]

Guidelines by the American College of Cardiology similarly recommend dietary and exercise intervention and acknowledge the interconnections across cardiometabolic conditions: "Patients with diabetes are at increased risk of developing atherosclerotic cardiovascular disease (ASCVD) with its manifestations of coronary artery disease (CAD), chronic heart failure, atrial fibrillation (AF), and stroke, aortic and peripheral artery diseases, and is a major risk factor for chronic kidney disease, which enhances risk for CV and all-cause mortality."[2]

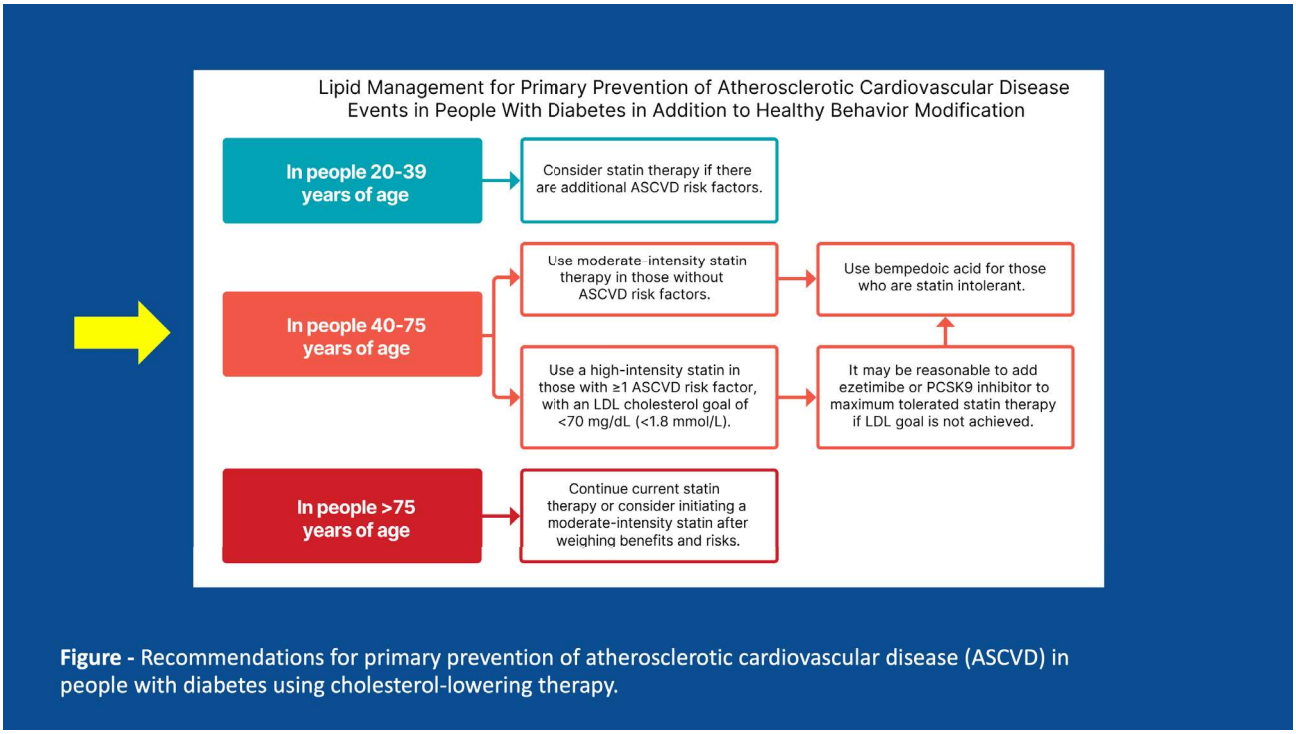


Figure - Recommendations for primary prevention of atherosclerotic cardiovascular disease (ASCVD) in people with diabetes using cholesterol-lowering therapy.

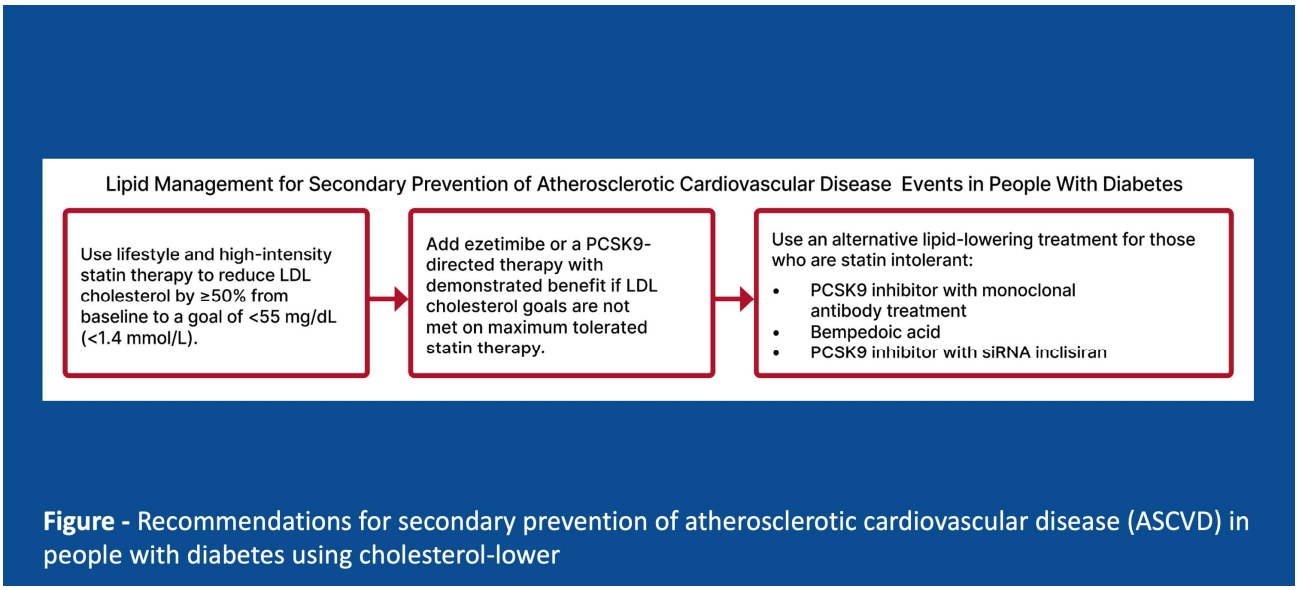


Figure - Recommendations for secondary prevention of atherosclerotic cardiovascular disease (ASCVD) in people with diabetes using cholesterol-lower

For both primary and secondary ASCVD prevention in patients with diabetes, high-intensity statins, escalated to ezetimibe or PCSK9-directed therapy as necessary, are recommended for lipid management, with alternatives for statin-resistant patients.

This guidance is still evolving.

Hurtado pointed out that the American Diabetes Association recommends screening patients for stage B and C (asymptomatic) congestive heart failure, but it does not recommend routinely screening patients for coronary artery disease unless the patients have symptoms or electrocardiogram abnormalities.

“This is important because the decision to start an SGLT2 inhibitor or a GLP1 receptor agonist are influenced by whether or not a patient has artery disease,” he said.

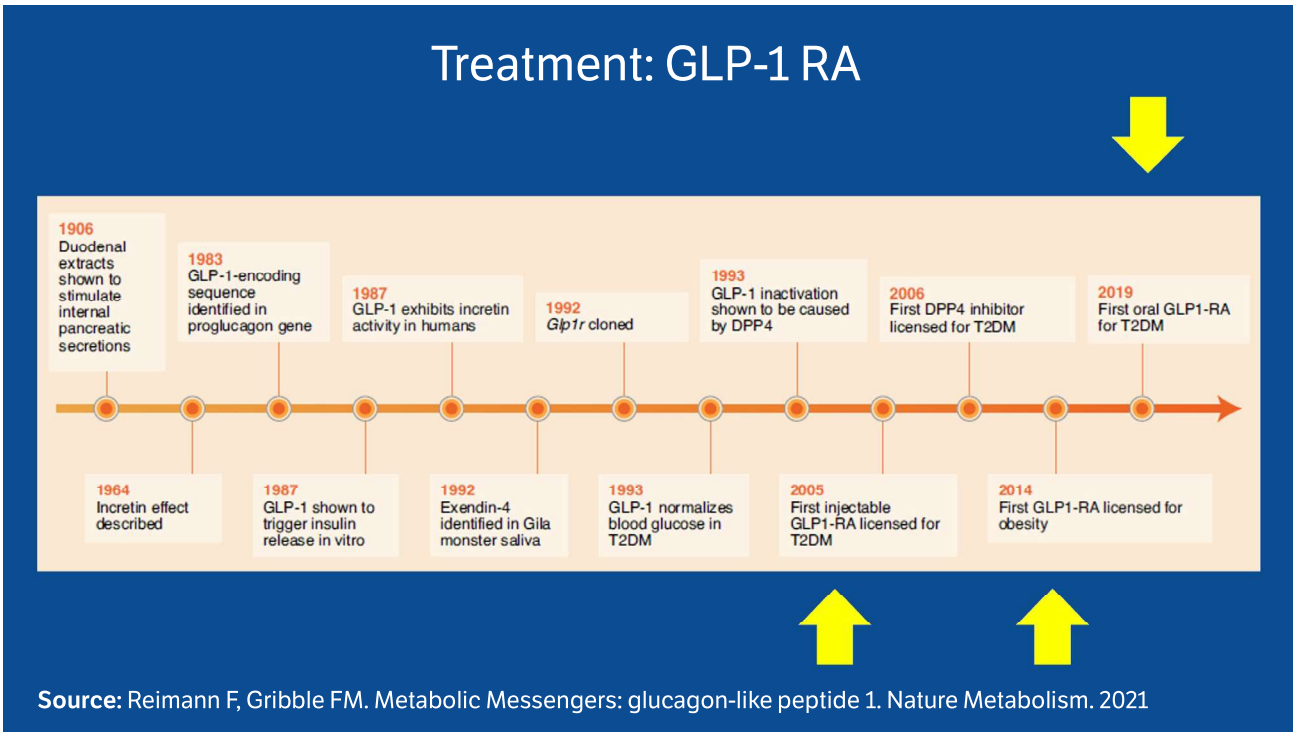
Pharmacologics Rise to the Challenge

“GLP1 receptor agonists are not a new medication,” Hurtado explained. “They have been around for the last 20 years.”

He walked through the multiple mechanisms of action for this class of medications, including how GLP-1 receptor agonists manage type 2 diabetes by mimicking a natural gut hormone to stimulate glucose-dependent insulin secretion, suppress glucagon, slow digestion, and reduce appetite for better blood sugar control and weight loss.

Cardiometabolic treatment—addressing cardiovascular disease, kidney disease, and type 2 diabetes in a holistic fashion—is the next step on this timeline.

Hurtado walked through recent research demonstrating these possibilities: a systematic review and meta-analysis of randomized, placebo-controlled trials spanning more than 71,000 patients across 10 trials and including new data from the SOUL trial evaluating semaglutide on cardiovascular outcomes and FLOW trial evaluating its effect on chronic kidney disease.



Source: Reimann F, Gribble FM. Metabolic Messengers: glucagon-like peptide 1. Nature Metabolism. 2021

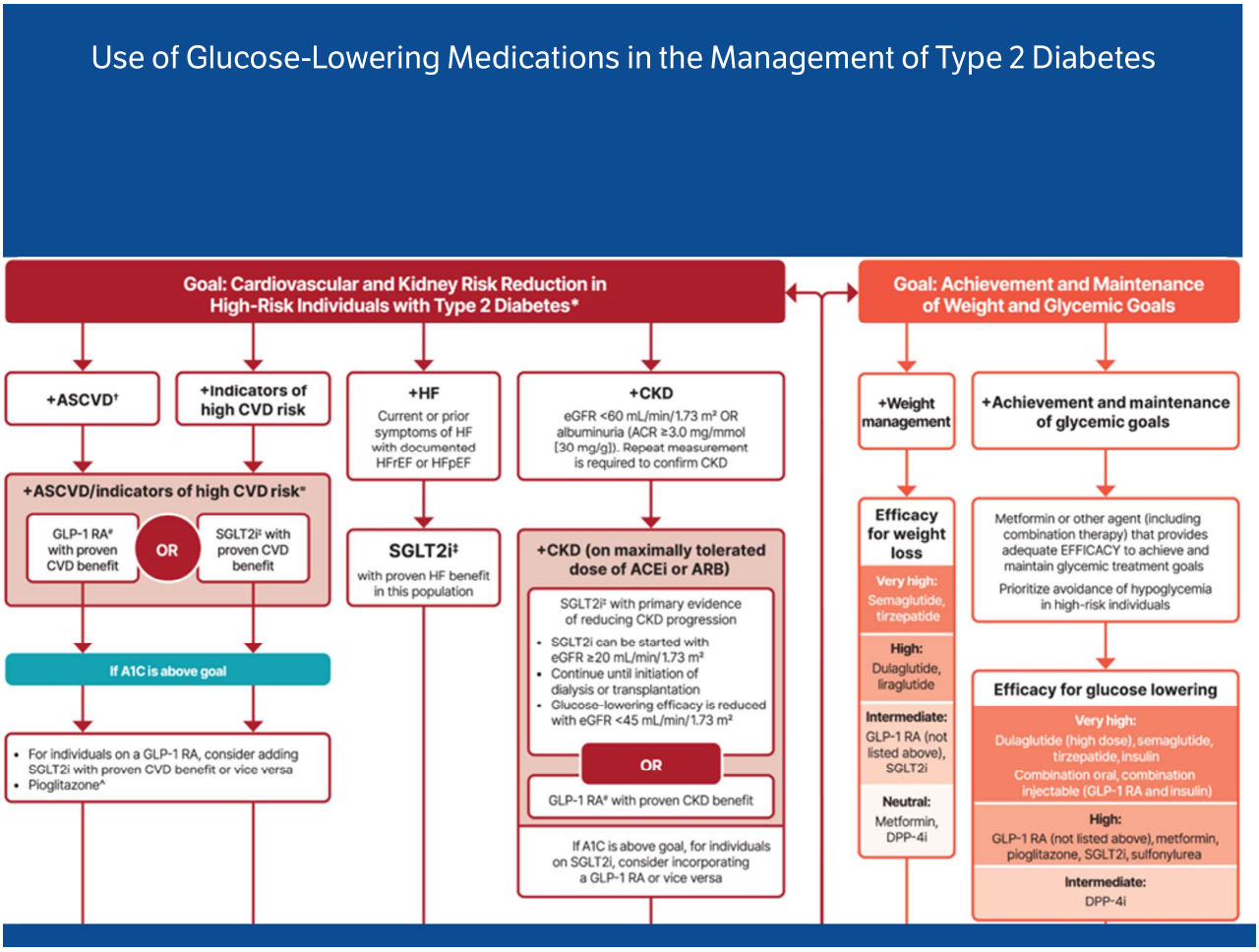
"The findings are quite impressive," Hurtado reported.[3]

- Both major adverse cardiovascular events and hospitalization for heart failure decreased by 14%
- Composite kidney outcomes improved by 17%
- All-cause mortality decreased by 12%

These intersections have been making their way into treatment guidelines. Hurtado walked through a diagram illustrating the use and efficacy of glucose-lowering medications in the management of type 2 diabetes.

- GLP-1 receptor agonists and SGLT2 inhibitors are part of the algorithm for both ASCVD and chronic kidney disease
- SGLT2 inhibitors are part of the algorithm for heart failure
- GLP-1 receptor agonists and SGLT2 inhibitors rank high in efficacy for lowering glucose
- GLP-1 receptor agonists and SGLT2 inhibitors rank intermediate, above metformin, for efficacy in weight management

The power of GLP-1s and SGLT2s to reduce cardiovascular events, liver disease, and chronic kidney disease is just the beginning. Importantly, GLP-1s have also received Food and Drug Administration approval for the treatment of obstructive sleep apnea. Beyond approved indications, research areas of interest include investigating potential impacts on substance use disorders, neurodegenerative diseases such as Parkinson's and Alzheimer's, osteoarthritis, and polycystic ovary syndrome.[4]



Multifaceted Obstacles to Medication Adoption

With more and more research shedding light on cardiometabolic medications and their benefits, what have adoption rates been like in the nation's healthcare organizations?

Hurtado walked through a study of patients with newly diagnosed ASCVD and type 2 diabetes. From 2018-2022, all prescriptions increased: GLP-1 receptor agonists only, SGLT2 inhibitors only, and various combinations.

The bad news: Despite steady increases over these four years, all percentages by 2022 remained well under 20%. More than four out of five eligible patients had missed out on potentially beneficial treatment.

Hurtado examined key reasons why.

Several barriers stand in the way of high-quality, multifaceted diabetes management, starting with fragmented care and poor coordination. Many healthcare organizations also lack information systems, like registries, which can

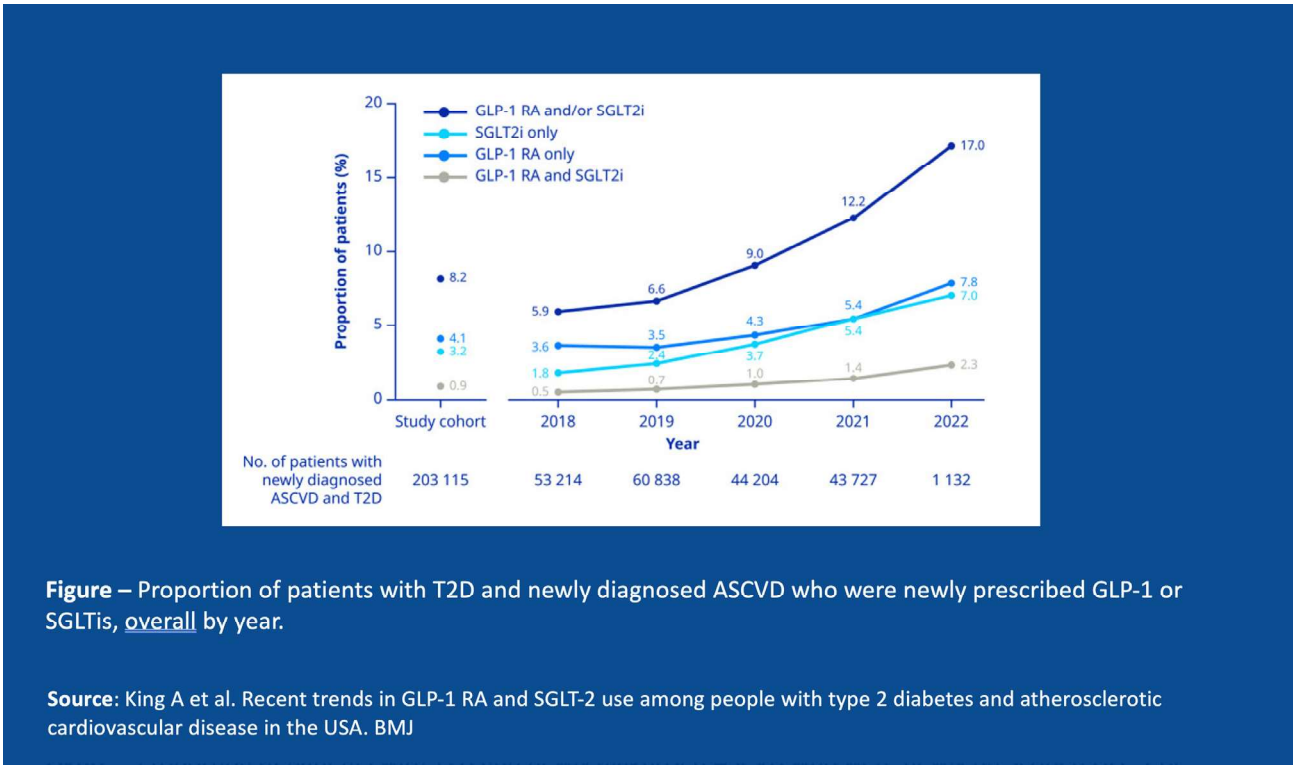


Figure – Proportion of patients with T2D and newly diagnosed ASCVD who were newly prescribed GLP-1 or SGLTis, overall by year.

Source: King A et al. Recent trends in GLP-1 RA and SGLT-2 use among people with type 2 diabetes and atherosclerotic cardiovascular disease in the USA. BMJ

provide support on an individual and population level. Finally, diabetes care may not be appropriately incentivized, funded, or supported with a quality-oriented culture.

At the same time, high costs and insufficient insurance coverage too often impedes the use of cardio-protective medications, along with patient fear of injections.

On the provider side, many providers lack familiarity and practical knowledge of these agents, leading to concerns about potential adverse effects, particularly in older patients with multiple prescriptions.[5]

Hurtado concluded with a reference to the American Diabetes Association (ADA) guidelines—and a call to action.

“Improving individual and population health for people with and at risk of diabetes requires engagement of a collaboration between people with diabetes, their caregivers, interprofessional healthcare teams, health systems, community partners, payers, policymaker, and public health agencies,” he said. “I think here in this group, we represent this.”

Roundtable Discussions

Hurtado's remarks provided a foundation for sharing on-the-ground experiences, challenges, and advice.

What barriers currently impede coordinated cardiometabolic care in your organization?

Participants talked about gaps between specialists and primary care. How do you gain timely access to endocrinologists? How do you efficiently educate the full care ecosystem on the many evolving facets of cardiometabolic medicine?

More broadly, this challenge involves "democratizing knowledge" across team members and training people to work at the tops of their licenses. At a more detailed level, teams are challenged to navigate recommendations from multiple sources, especially guidance that can be complicated for nonspecialists to interpret.

Streamline the information, was one suggestion. "I don't need 14 obesity guidelines to talk to primary care." Embed recommendations into order sets. Finally, consider interprofessional consultations—a billable opportunity for primary care providers and specialists to learn from each other.

What's most essential for optimal patient outcomes?

Education for patients and providers alike, participants responded.

They also called out the value of state and collaborative practice agreements. Such documents formally outline scope, supervision, and responsibilities for physicians and other members of the care team.

"They empower clinical pharmacists to take ownership," one participant said. "The roles are clear, and trust is there," another declared.

What structures, partnerships, and policies would promote more effective coordination?

Conversations touched on multiple areas—and the difficulty of pinning it all down.

"Just the term *cardiometabolic* is so broad," one participant remarked.

"The focus is on medications filled right now," was one observation. "GLP1s are breaking the system like the iPhone did."

Adding more prescriptions to a list that may already include statins and lipid control brings the risk of polypharmacy complications.

"You can't start with all the medications at once in case there are adverse events," one participant cautioned. Medication management needs to be easy for the patient as well.

Participants discussed the challenges of proliferating technologies, platforms, and log-ins. “You have to make it easy for the provider.”

At the same time, care teams need to keep their eyes on bigger-picture factors like social drivers of health. A patient could be mislabeled as noncompliant, one participant pointed out. “But maybe there are other things happening. You need to prioritize what is most urgent.”

Care teams need to keep an eye on the bigger picture as well. “We have a problem in Western society of focusing on treatments instead of prevention,” one participant observed.

Such a focus often means insufficient billing codes for prevention-related activities. “Hopefully value-based care can help address this in future,” one participant said.

Throughout all of these complexities, culture is key, participants agreed. “You need to have that. You need to have a champion, so this all is not just falling on deaf ears.”

Panel Discussion: Coordinated Care Solutions

John Clark, MD, PhD, *Chief Population Health Officer, Sharp Rees-Stealy Medical Group*

Matthew Malachowski, PharmD, MHA, BCPS, *System AVP for Population Health and Ambulatory Care, Ochsner Health*

Matthew R. Weir, MD, *Professor and Division Head, Nephrology, University of Maryland School of Medicine*

Moderator: **Nancy R. Beran, MD, MHCDS, FACP, CPE**, *Vice President and Chief Quality Officer for Ambulatory, Northwell Health*

A multifaceted San Diego medical group, a nonprofit healthcare organization in Louisiana, and a Mid-Atlantic academic research institution have different structures, patient populations, and strategic priorities. But they share many of the same challenges and experiences in the area of cardiometabolic care.

What does coordinated care look like in your institution?

Clark cited a variety of roles that supplement Sharp Rees-Stealy’s in-clinic teams, including RN case managers, diabetes educators, pharmacists, and community health workers.

“We’re really trying to help patients navigate to the right options or treatments,” he said. This might involve behavioral counseling or connections to a consultant like an obesity specialist.

Sharp Rees-Stealy has "a lot of tools at our disposal," including a diabetes care management program, Clark said. But primary care providers aren't always aware of all of the options for patients. Furthermore, other members of the team, like population health specialists, might be in a better position to identify what a patient needs in some situations.

Reimbursement adds even more complexities. "Seventy percent of patients taken care of by our physicians or a medical group are in a capitated program," Clark said. "We're really trying to figure out what the right resources are given the payment model."

Ochsner is focusing on building out its coordination infrastructure right now, Malachowski said, "to make care delivery as seamless as possible." One key component of this is "an easy button" at the point of care, bringing up data like a patient's A1C to set the stage for deeper conversations.

"If it's not going to be fluid and helpful and bring joy to practice, it's not going to get used, and then nobody wins."

— Matthew Malachowski, Ochsner Health

It's part of an overall prioritization of ease and experience, he said. "Are resources easy to use? Are they easy to find? Is the experience enjoyable for the physician and the patient?"

Weir shared his challenges and constraints at the University of Maryland School of Medicine in Baltimore. "We are a very large program serving a large surface area, and many of the patients are underserved, have low health literacy, and present late in the course of disease."

The many facets of cardiometabolic care strain an organization's resources. Weir shared an example: "We're scrambling for new ways to facilitate reimbursement for non-face-to-face engagement in areas like chronic immunosuppression, which is very time-intensive and needs a lot of following up."

He also called out the need for more resources upstream. University of Maryland has a large program for polycystic kidney disease, for example. "Once your kidneys fail, then here are resources," he said. "We should also have resources to prevent kidney failure."

How do you take your programs to scale?

If you want innovation to stick, Malachowski advised, hardwire it into the electronic medical record (EMR).

"Education is fluid, and organizations have practitioner turnover," Malachowski said. "If your solution involves only either 'message the doctor' or education, that is very short-sighted."

Embedding new processes into the systems teams use every day makes it easier for providers to administer care. It also enforces standardization across the organization—both important factors for adoption and growth.

"For scalability, your EMR is your best friend," he said.

Panelists also recommended using remote or digital care when possible in order to free up clinic space and time for activities that can only be performed on site.

Malachowski shared the example of Ochsner's digital diabetes program, which uses a home device to monitor glucose for much of the year. Any signs of risk are triaged to clinicians, and reports uploaded into Epic get physicians up to speed for a patient's annual wellness visit.

Diagnosing MASH (metabolic dysfunction-associated steatohepatitis)—a chronic, progressive, and potentially life-threatening disease—is another area in which Malachowski sees potential for tech-enabled efficiency and scalability. Administrative features for the initial Fibrosis-4 index or FIB 4 screening blood test to estimate the risk of liver fibrosis and subsequent ultrasound can be built into Epic, he explained, freeing up physician time and brainpower for patient conversations and decisions that need a human touch.

How do you align people and processes across your efforts?

Technology factored heavily in the panelists' responses.

Standardize the work being done within the EMR, Clark advised.

He acknowledged that this is easier said than done. "I've worked at probably four different organizations that are all Epic-based, and they all have very different Epic builds," he shared. Any adaptations or new builds take money and time.

Tech alignment gets particularly challenging when patients seek care outside of the health system, Weir added. While many EMRs that University of Maryland works with "read seamlessly" together, he said, the situation is "never the twain shall meet" for others. "They're all different."

Outside of the EMR, what care coordination activities should organizations prioritize?

"Set up a single site where all the disciplines are, where you can literally line up patient appointments," Weir suggested.

"These patients have cardiometabolic disease, right? Yet we make them see multiple specialists to address it as opposed to trying to create cardiometabolic centers," he continued. Communication gaps arise when organizations coordinate and manage care across all of these disparate systems and silos.

What best practices do you recommend to other organizations looking to strengthen care coordination?

Communicate, Malachowski advised. "I'm very blessed with some very strong physician leaders. They're comfortable having hard conversations about panel sizes, RVUs, and so forth."

Keep an eye on innovation, with a focus on early-stage treatment, he added. "The therapies we have for heart failure, chronic kidney disease, MASH—this was all just watchful waiting five, 10 years ago. If we can diagnose something early enough and if a treatment is cost-effective, we can bend the curve on disease progression," he said.

Clark suggested finding ways to connect patients to support outside the traditional patient-physician relationship.

He gave the example of a patient looking to improve their A1C. "There may be very different tools, problems, or barriers along the way, like problems with transportation, that a community health worker or RN case manager could help address."

Importantly, direct people to these resources in a centralized way. "Make it an easy button," he said.

How have you been getting medications to the patients who need them?

As Beran posed this question, she mentioned Northwell's work with New York's Coalition to End Racism in Clinical Algorithms[6] (CERCA) and the importance of "making it easy to do the right thing," in her words, "identifying those patients who may really have a clear benefit and making more obvious in the EMR that these are patients we want providers to have a conversation with."

Sometimes such efforts aren't enough, Weir reminded participants, as many other factors lie outside of the healthcare organization's control. "You can implement all the right EMR prompts and then they are either ignored by the clinician, declined by the patient, or denied by the insurer," he said.

Administrative bottlenecks further impede care. Just one prior authorization for one patient can take 30 minutes of an assistant's time, he pointed out. Furthermore, in his practice, "for certain payers, it's almost impossible for me to get SGLT2 inhibitors or GLP-1 receptor agonists for a kidney diagnosis, even though GLP-1 receptor agonists are the treatment of choice for people with chronic kidney disease."

What else should organizations think about in their approach to cardiometabolic disease?

Eliminate today's silos, panelists responded. Develop systems to support this work, like Ochsner's "super clinic", an integrated, one-stop-shop for many healthcare needs, moving beyond traditional hospital settings to provide convenient, comprehensive outpatient services, and all care team members working at the top of their license. Realize that alignment across complicated organizational structures and reimbursement models may require a total redesign.

Train providers and care teams early so they can tell patients what they're doing, why they're doing it, and why it's important to start this treatment early.

Get upstream and make it cost-effective. And keep this education going, as the data, treatment options, risks, and opportunities in cardiometabolic care are constantly changing.

As more and more medications enter the cardiometabolic care ecosystem, participants talked about the factors that would make them more likely to bring one into their system:

- "An easy button" in the EMR to facilitate administration
- The ability to keep patient care and data within the organization
- Financial viability for patients and healthcare organizations alike

Breakout Sessions

In panelist-facilitated interactive discussions, participants continued to speak candidly on a range of topics.

What They're Doing Now

Participants described redesigning care team processes, roles, and responsibilities to better distribute workload and improve care delivery. One participant shared, "We redesigned our team approach so not everything falls on the physician. Medical assistants and practice RNs all help with care gaps, along with quality and population health."

Another noted a growing role for pharmacists: "We realized there was an opportunity to embed pharmacists on the clinical side. It started with education and antibiotics stewardship. Now we're working on chronic care management and moving more into value-based care."

Technology has been a common theme. One organization reported being on track to redirect hundreds of thousands of in-basket messages, "to give physicians 30 minutes of each day back." Another is launching an e-visit designed to route patients to the most appropriate service line, whether primary care, a specialty service, or bariatric surgery, helping ensure patients get to the right care more efficiently.

The Transformative Impact of New Medications

Conversations frequently touched on GLP-1s and what one participant described as "the paradigm shift with obesity." Another noted, "I've never had a patient come in saying, 'Oh, I read about this statin and I'm interested.'" Another observed, "No one asks to be put on a statin, but it is different for GLP-1s," calling this shift "a great opportunity to have a patient-centered conversation about weight or health improvement."

At the same time, participants raised concerns about access and coverage as new treatment options introduce new complexities. One participant asked how people are dealing with access when they age into Medicare and no longer have coverage for GLP-1 medications prescribed for obesity. Another questioned, "What happens to those patients with cardiovascular risk? Does the conversation end when the GLP-1 is denied?"

Participants also discussed the rapid growth of direct-to-consumer products and services emerging to fill these gaps. One asked, "Do they wait and let things get worse, or go to a consumer option like Hims & Hers?" Another noted, "A consumer can fill in a few forms and in a matter of minutes have a GLP-1 delivered to them. That isn't 'care,' but it is reality."

GLP-1s aren't the only medications complicating the treatment landscape for patients with ASCVD. PCSK9i medications may also be utilized in combination therapy of elevated cholesterol levels, requiring the prescribing physician to obtain additional prior authorizations and provide individualized patient education on the unique timing and dosing requirements for these injectable medications.

Such developments are impacting all aspects of care. One participant predicted, "The volume of new medications coming down is going to be overwhelming." Another added, "We need a fast-track where educational material from research is getting translated to clinical practice." And for patients who wish to avoid medication altogether, one piece of advice was, "Providers should ask, 'What are your health goals this year?' instead."

Making the Workloads Work

While cardiometabolic medicine brings multiple conditions together into one patient visit—"It's a great opportunity to think about other health issues," was one observation—participants remained concerned about physician overload.

They cited the "huge issue with physician burnout, in-basket fatigue, and things done outside of visit room," along with the need to "take out the administrative stuff they never went to med school for."

It's a situation that requires education as well as bandwidth. One participant offered as an example, "Primary care sees a patient on a high-dose statin, but their LDL is not to goal. They need to escalate, but they're not sure how."

Care teams need more and better warnings in the EMR, with seamless integration into the next steps, such as testing or medication. "There has to be a response built in," one participant emphasized. "Warnings can't just be something people can click away."

"Rescue the physician and you rebuild trust. Then what else can we build together?"

Meanwhile, full expansion and integration of a multidisciplinary team isn't quite there yet. "We're still not talking a lot about bariatric surgery," was one observation. Another also mentioned, "Support systems and wraparounds are missing."

"When using pharmacists, how do you measure success? How do you know you're getting the right referrals?" one participant queried the group. "Education on how to use the pharmacist is critical." A participant remarked that not everyone knows how to optimize the use of a pharmacist in a clinic setting. The participant also said, "It is a different kind of work force that we had to create our own workflows and care paths to make such collaboration happen."

Siloed systems complicate workflows and standardization. One participant noted how their healthcare ecosystem spans multiple EMR systems, "so we can't just build one process for the entire organization. We have to build multiple processes to work with all their different systems."

Conversations touched on the opportunities tech can bring as well, like making it easier to collect data from weight loss and behavioral health programs outside of the organization.

AI-enhanced clinical decision support is another area with potential. "Hit a button and it pulls everything the patient is on and their conditions."

All of the pieces come together to serve the retired patient who is highly engaged with modern technology, said one participant. "They will prefer to go to a super clinic where all their physicians are available, and the tech can keep up with them."

The Bottom Line

One challenge that concerned participants throughout involved demonstrating return on investment in order to receive buy-in from leadership to maintain financial viability.

"You've got to be able to talk to the pharmacy benefits manager, CFO, and clinical director and pull out the right wins for each individual," one participant emphasized, cautioning that these can be "extremely different conversations."

Pick your metrics and investments with an eye for value and impact, was another recommendation. Noting that "corporate cost centers are dangerous," one participant stressed the need to marry resources and labor with benefits.

Definitions of this may vary. "The one that gives the most bang for the buck is bariatric surgery, and that has gone down dramatically with the increasing use of more effective weight loss medications," one participant observed.

"Focus the pharmacists on the highest-risk patients," was another suggestion. One participant pointed out, "Pharmacy engagement can also be a quality improvement opportunity or measure,"

Finally, consider the technology tools you'll need—and the best ways of implementing them. "For incident to coding,[7] infrastructure is needed, which sometimes wipes out the benefit of the funds received," was one piece of cautionary advice.

Collective WISDOM

To conclude the roundtable, Kennedy moderated a final group activity in which each participant shared an actionable takeaway or new idea inspired by the day's discussions. These "What I Shall Do on Monday" (WISDOM) highlights covered:

Learning from Peers

- "I took copious notes on addressing multiple cardiometabolic factors simultaneously, asking how often patients are getting their meds."
- "I'm going to put something in practice that Juan [Hurtado] taught, that the current ADA guidelines recommend screening your patients with diabetes with a B-type natriuretic peptide (BNP)[8] for ACC/AHA Stage B asymptomatic heart failure.[9] So, I'm going to start that myself and let the whole world know."

- "I am interested in exploring Ochsner's model on digital diabetes, the CGM [continuous glucose monitoring] data upload, and how you're using that data to prioritize contact with patients."
- "My goal for Monday is to learn how our practice may benefit from integrating virtual pharmacist services for our patients with cardiometabolic disease."

Listening to Their Teams

- "I'm going to be asking the physicians that I work closely with about their pain point, because we think we know a lot of them, but I've heard a lot of different perspectives that I don't think we get on a daily basis."
- "I'm going to talk to our data team to find better ways to measure success rates for the wonderful educational initiatives we have around chronic disease management."

Expanding the Care Ecosystem

- "I'm going to pull together some subject matter experts and see if we can start to create a cardiometabolic team."
- "I'm going to call our pharmacist on Monday and see how we can collaborate better."
- "How can we work collaboratively with all of our different partners and all the different healthcare practitioners?"
- "We're going to continue to figure out how to connect the dots with community-based organizations."

Optimizing Technology and Workflows

- "Of all the things we talked about in the EHR, for care, for delivery, what do we want to study?"
- "How can we put together more materials and protocols that will better help your organizations and your workflows close?"
- "We're going to continue the work with our data strategist and IT teams to make sure the right patients are getting what they need when they need them."

Maintaining Momentum

- "I'm going to look at some of our recently completed projects and think about ways we can share some of the process elements, beyond just the interim and final data."
- "There were a lot of conversations around access and partnerships with community organizations and how to integrate community health workers into your systems. I'd love to have more conversations with all of you about potential partnerships."
- "We have the science. Now let's share it through AMGA Foundation with the community."

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