



Emerging Challenges In Primary Care: *2017*

Activity Evaluation Summary

CME Activity: Emerging Challenges in Primary Care: 2017
Saturday, May 20, 2017
The Sheraton Birmingham Hotel
Birmingham, Al 35203

Course Director: Gregg Sherman, MD

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300 NW 70th Avenue • Plantation, Florida 33317
(954) 723-0057 Phone • (954) 723-0353 Fax
email: info@naceonline.com

In May 2017, the National Association for Continuing Education (NACE) sponsored a live CME activity, *Emerging Challenges in Primary Care Update 2017*, in Birmingham, AL.

This educational activity was designed to provide primary care physicians, nurse practitioners, physician assistants and other primary care providers the opportunity to learn about varied conditions such as Hypercholesterolemia, Diabetes, Idiopathic Pulmonary Fibrosis, Obesity

In planning this CME activity, the NACE performed a needs assessment. A literature search was conducted, national guidelines were reviewed, survey data was analyzed, and experts in each therapeutic area were consulted to determine gaps in practitioner knowledge, competence or performance.

Two hundred ninety-six healthcare practitioners registered to attend *Emerging Challenges in Primary Care: 2017* in Birmingham, AL and five hundred eighty registered to participate in the live simulcast. Three hundred seventy-two healthcare practitioners actually participated in the conference: One hundred fifty attended the conference in Birmingham, AL and two hundred twenty-two participated via the live simulcast. Each attendee was asked to complete and return an activity evaluation form prior to the end of the conference. Two hundred thirty completed forms were received. The data collected is displayed in this report

CME ACCREDITATION



The Association of Black Cardiologists, Inc. is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The Association of Black Cardiologists, Inc. designates this educational activity for a maximum of 1.0 *AMA PRA Category 1 Credit™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.



The National Association for Continuing Education is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The National Association for Continuing Education designates this live activity for a maximum of 6.0 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.



National Association for Continuing Education is approved as a provider of nurse practitioner continuing education by the American Association of Nurse Practitioners. AANP Provider Number 121222. This program has been approved for 7.0 contact hours of continuing education (which includes 2.75 pharmacology hours).

AAPA accepts certificates of participation for educational activities certified for *AMA PRA Category 1 Credit™* from organizations accredited by ACCME or a recognized state medical society. PAs may receive a maximum of 7 Category 1 credits for completing this activity.

EMERGING CHALLENGES IN PRIMARY CARE: UPDATE 2017

**MAY 20, 2017
Birmingham, AL
Live & Simulcast**

What is your professional degree?

Label	Frequency	Percent
MD	118	29%
DO	7	2%
NP	234	60%
PA	15	4%
RN	17	4%
Other	3	1%
Total	394	100%

What is your specialty?

Label	Frequency	Percent
Primary Care	146	74%
Endocrinology	7	4%
Rheumatology	1	0%
Pulmonology	2	1%
Cardiology	2	1%
Hospitalist	4	2%
Psychiatry/Neurology	4	2%
ER	4	2%
Gastroenterology	0	0%
Other	28	14%
Total	198	100%

Indicate the number of patients you see each week in a clinical setting regarding each therapeutic area listed: Diabetes on Insulin therapy

Label	Frequency	Percent
None	45	12%
1-5	58	16%
6-10	56	14%
11-15	56	14%
16-20	40	10%
21-25	39	10%
> 25	95	24%
Total	389	100%

Indicate the number of patients you see each week in a clinical setting regarding each therapeutic area listed: Hyperlipidemia

Label	Frequency	Percent
None	41	11%
1-5	52	14%
6-10	41	11%
11-15	62	16%
16-20	48	13%
21-25	34	9%
> 25	104	26%
Total	382	100%

Indicate the number of patients you see each week in a clinical setting regarding each therapeutic area listed: IPF

Label	Frequency	Percent
None	98	26%
0-1	107	27%
2-5	90	23%
6-10	41	11%
11-15	22	6%
16-20	7	2%
> 20	18	5%
Total	383	100%

Upon completion of this activity, I can now: Describe the role of the kidney in glucose metabolism in health and disease; Review the physiologic effects and clinical efficacy of SGLT-2 therapy in various patient populations; Review emerging data on possible renal and macrovascular effects of evidence-based diabetes treatment options; Integrate the impact of treatment decisions on postprandial hyperglycemia and risk of hypoglycemia.

Label	Frequency	Percent
Yes	299	77%
Somewhat	87	22%
Not at all	3	1%
Total	389	100%

Upon completion of this activity, I can now: Discuss the role of postprandial hyperglycemia in the pathogenesis of diabetic complications; Incorporate GLP-1 RA therapy into practice to reduce post-prandial hyperglycemia and decrease glycemic variability; Compare GLP-1 RAs for glycemic efficacy and differential impact on postprandial glycemic control; Discuss various GLP-1 RA combination strategies with or as a possible alternative to basal insulin in the diabetic patient not at glycemic target.

Label	Frequency	Percent
Yes	305	78%
Somewhat	82	21%
Not at all	2	1%
Total	389	100%

Upon completion of this activity, I can now: Describe the typical clinical presentation of a patient with possible idiopathic pulmonary fibrosis (IPF); Discuss the diagnostic approach to a patient with suspected IPF; Discuss and contrast the available pharmacotherapeutic options for patients with IPF; Discuss and contrast the available non-pharmacotherapeutic options for patients with IPF.

Label	Frequency	Percent
Yes	279	72%
Somewhat	102	26%
Not at all	9	2%
Total	390	100%

Upon completion of this activity, I can now: Understand the pathophysiology of Obstructive Sleep Apnea; Recognize the clinical features and presentation of Sleep Apnea; Describe comorbidities associated with Sleep Apnea; Perform an appropriate evaluation to accurately diagnose Sleep Apnea; Discuss recent advances in management of Obstructive Sleep Apnea.

Label	Frequency	Percent
Yes	327	85%
Somewhat	51	13%
Not at all	7	2%
Total	385	100%

Upon completion of this activity, I can now: List 2017 Quality Measures for the use of statin therapy for the prevention and treatment of cardiovascular disease; Explain the role of anti-PCSK9 monoclonal antibody therapy in LDL-C reduction to achieve cardiovascular risk reduction; Discuss ACC guidelines on the role of non-statin therapies in the management of atherosclerotic cardiovascular disease; Employ guideline-directed treatment strategies for primary and secondary prevention of cardiovascular disease in high-risk patient populations.

Label	Frequency	Percent
Yes	294	77%
Somewhat	82	22%
Not at all	5	1%
Total	381	100%

Upon completion of this activity, I can now: Recognize that Obesity is a disease frequently associated with expansion of the perivascular adipose tissue which is associated with increased production of atherogenic adipokines and other biologically active molecules; Understand the central role of abdominal and perivascular adipose tissue as a root cause of co-morbidities and cardiometabolic risk; Understand that excess amounts of visceral and perivascular adipocytes are associated with an impairment of insulin sensitivity and other co-morbidities; Recognize that Obesity itself, even without associated co-morbidities of hyperglycemia, hypertension and hyperlipidemia are responsible for cardiovascular disease risk.

Label	Frequency	Percent
Yes	319	87%
Somewhat	45	12%
Not at all	5	1%
Total	369	100%

Overall, this was an excellent CME activity:

Label	Frequency	Percent
Strongly Agree	298	75%
Agree	87	22%
Neutral	7	2%
Disagree	1	0%
Strongly Disagree	2	1%
Total	395	100%

Overall, this activity was effective in improving my knowledge in the content areas presented:

Label	Frequency	Percent
Strongly Agree	295	75%
Agree	92	23%
Neutral	5	1%
Disagree	1	0%
Strongly Disagree	2	1%
Total	395	100%

As a result of this activity, I have learned new and useful strategies for patient care:

Label	Frequency	Percent
Strongly Agree	281	72%
Agree	87	22%
Neutral	22	5%
Disagree	0	0%
Strongly Disagree	2	1%
Total	392	100%

How likely are you to implement these new strategies in your practice?

Label	Frequency	Percent
Very Likely	277	72%
Somewhat likely	72	18%
Unlikely	5	1%
Not applicable	36	9%
Total	390	100%

When do you intend to implement these new strategies into your practice?

Label	Frequency	Percent
Within 1 month	257	66%
1-3 months	74	19%
4-6 months	10	3%
Not applicable	48	12%
Total	389	100%

In terms of delivery of the presentation, please rate the effectiveness of the speaker:

Robert Busch, MD, FACE - Diabetes and Vascular Disease:

Label	Frequency	Percent
Excellent	285	74%
Very Good	77	20%
Good	17	4%
Fair	2	1%
Unsatisfactory	2	1%
Total	383	100%

In terms of delivery of the presentation, please rate the effectiveness of the speaker:

Robert Busch, MD, FACE - Diabetes and GLP-1 :

Label	Frequency	Percent
Excellent	289	75%
Very Good	70	18%
Good	20	5%
Fair	2	1%
Unsatisfactory	2	1%
Total	383	100%

In terms of delivery of the presentation, please rate the effectiveness of the speaker:

Arunabh Talwar, MD, FCCP - Idiopathic Pulmonary Fibrosis:

Label	Frequency	Percent
Excellent	302	80%
Very Good	57	15%
Good	15	4%
Fair	2	1%
Unsatisfactory	2	0%
Total	378	100%

In terms of delivery of the presentation, please rate the effectiveness of the speaker:

Arunabh Talwar, MD, FCCP - Sleep Apnea:

Label	Frequency	Percent
Excellent	171	73%
Very Good	53	22%
Good	10	4%
Fair	2	1%
Unsatisfactory	1	0%
Total	236	100%

In terms of delivery of the presentation, please rate the effectiveness of the speaker:

Mahfouz El Shahawy, MD, MS, FACP - Lipid Management:

Label	Frequency	Percent
Excellent	227	62%
Very Good	99	27%
Good	29	8%
Fair	5	1%
Unsatisfactory	5	1%
Total	365	100%

In terms of delivery of the presentation, please rate the effectiveness of the speaker:

Mahfouz El Shahawy, MD, MS, FACP - Obesity:

Label	Frequency	Percent
Excellent	221	64%
Very Good	93	27%
Good	25	7%
Fair	4	1%
Unsatisfactory	5	1%
Total	348	100%

To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Robert Busch, MD, FACE - Diabetes and Vascular Disease:

Label	Frequency	Percent
Excellent	306	79%
Very Good	61	16%
Good	14	4%
Fair	1	0%
Unsatisfactory	3	1%
Total	385	100%

To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Robert Busch, MD, FACE - Diabetes and GLP-1:

Label	Frequency	Percent
Excellent	307	79%
Very Good	61	16%
Good	14	4%
Fair	1	0%
Unsatisfactory	3	1%
Total	386	100%

To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Arunabh Talwar, MD, FCCP - Idiopathic Pulmonary Fibrosis:

Label	Frequency	Percent
Excellent	311	82%
Very Good	57	15%
Good	8	2%
Fair	0	0%
Unsatisfactory	2	1%
Total	378	100%

To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Arunabh Talwar, MD, FCCP - Sleep Apnea:

Label	Frequency	Percent
Excellent	311	81%
Very Good	58	15%
Good	10	3%
Fair	0	0%
Unsatisfactory	2	1%
Total	381	100%

To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Mahfouz El Shahawy, MD, MS, FACP - Lipid Management:

Label	Frequency	Percent
Excellent	267	73%
Very Good	74	20%
Good	20	5%
Fair	4	1%
Unsatisfactory	4	1%
Total	369	100%

To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Mahfouz El Shahawy, MD, MS, FACP - Obesity

Label	Frequency	Percent
Excellent	271	75%
Very Good	71	20%
Good	14	4%
Fair	3	1%
Unsatisfactory	3	1%
Total	362	100%

Which statement(s) best reflects your reasons for participating in this activity:

Label	Frequency	Percent
Topics covered	308	32%
Location/ease of access	273	28%
Faculty	57	6%
Earn CME credits	333	34%
Total	971	100%

Future CME activities concerning this subject matter are necessary:

Label	Frequency	Percent
Strongly agree	231	60%
Agree	131	33%
Neutral	23	6%
Disagree	2	1%
Strongly Disagree	0	0%
Total	387	100%

As a result of this activity, I have learned new strategies for patient care.

List these strategies:

Comment
2017 Quality measures for statin therapy
Implementing the New strategies with obesity tx plan , and aggressive tx. Diabetes management and new tx guidelines.
Lipid lowering agents for primary/ secondary prevention Appropriate evaluation for accurate diagnosis of sleep apnea Understanding if obesity as a risk for CVD Just to name a few
Vigilant monitoring of renal functions of diabetic patients... Vigilant assessment for correct diagnosing of IPF vs. other chronic pulmonary diseases... Vigilant weight monitoring & mgt. & utilization of available tools for weight mgt./ weight loss.. Utilization of OSA testing for appropriate diagnosing & treatment with recommended tx modalities e.g. CPAP... Increased utilization of GLP-1 agonists for multi drug treatment of diabetes mellitus
Additional areas of history to ascertain Additional pharmacologic treatment options Additional outcome measures
Employing GLP-1 RAs and SGLT-2 inhibitors more readily in patient care (with less hesitation, now that I better understand their mechanism of action and am reminded of the pathophysiology of DM that these medications are directed to work on. Have a more tailored approach to management of hyperlipidemia/CV disease prevention instead of simply defaulting to lifestyle then statin use without further specific consideration of each individual. Hopefully further incentivize patients presenting for help with weight loss efforts (who fit

diagnosis of obesity) by helping them understand obesity as a disease process rather than a weight label.
Recognize multiple risk factors for cardiovascular disease and focus on prevention
Keep in mind potential for hypoglycemia, be aware of patient's GFR and modify anti-diabetic medications as needed. Look for possible hypotension when SGLT-2 is used in combination with anti-HTN medications and other anti-diabetic medications. Obtain high resolution CT in patient with long smoking history, progressive dry cough, DOE, normal or reduced PFTs and non-specific x-ray findings. Consider adding a non-statin medication when LDL-C levels remain elevated despite maximum doses of anti-lipid medications.
Good history taking strategy Differential diagnosis to rule out definitive diagnosis Use gold standard diagnosis recommended by CDC
If Statin intolerance try to decrease the dose then reassess. Try another Statin Or order Statin every other day or every three days for Statin intolerance.
Include these issues by name in my ROS Now, refer to notes for memory update Keep updated on them
Select patients for SGLT-2 therapy Focus more on controlling post-prandial hyperglycemia. Have a higher index of suspicion for IPF in patients with a cough and dyspnea. Refer more patients for formal sleep studies when appropriate. Consider PCSK-9 agents when unable control lipids with statins and Zetia and lifestyle changes.
To screen my COPD patients for A1ATD To always recommend positional therapy to my patients with OSA prior to CPAP (1)
Use learned knowledge in patient care. I can prescribe SGLT-2 treatment when indicated. I canGLP-1 RAs when indicated. I am more familiar withidiopathic pulmonary fibrosis (IPF); now. I can manage sleep apnea now. I can prescribePCSK9 monoclonal antibody, when statin therapy is failed. I can manage obesity better now than before.
Increasing knowledge of the clinical presentation of idiopathic pulmonary fibrosis, it's diagnosis and treatment. Increasing awareness of the impact of sleep apnea in recovering postoperative patients.
In DM2,think of GLP_1 in case of Post prandial Hyperglycemia.(Byetta po or Bydureon inj.). Think of ILP if chronic cough, bil. basal crackles. Dx with RFT,CXR, and HR CT scan. Avoid CS, Broncodilators. O2,Lung Transplant.... Think of OSA, carry out complete appropriate evaluation for Dx of OSA & comorbidities.. in case of increase of LDL-chol, think of Ezetimibe & Evolocumab.... Obesity is a disease even if one does not find hyperlipidemia but it affects CV disease including Atherosclerosis.
A new set of things to look for when assessing my patients.
Able to discuss treatment and diagnosis of IPF
Able to discuss with patients possible treatment plans that support best practice treatments

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and tests to optimize outcomes. I feel better equipped with the knowledge and notes taken to discuss informatively with pts. Especially in the areas of diabetes, statins, kidney dz. and pulmonary ILD.
ACE guidelines over ADA guidelines
ACE guidelines. Pharmacotherapy for IPF
Adding GLP-1 after Metformin and Basal insulin for better control of diabetic patients. Performing routine pre-screening for OSA, referring patient for PSG if positive for risk factors/ comorbidities of OSA.
Adding SGLT2 and GLP1 RAs earlier in therapy strategies for DM T2. Work with patients with OSA for greater compliance with treatment. Emphasis on obesity
Address DM by focusing more on PP blood sugars instead of fasting. Be more focused on identifying Obesity as a disease process and be more proactive in screening for sleep apnea as a source for Comorbidities
Address more risk factors for hyperlipidemia, sleep apnea and obesity.
Adequately management for diabetes. Adequate management for hyperlipidemia. And how to identify IP.
Adjusting medication to assist in better patient controls
Adjusting pharmacological treatment of diabetes appropriately by targeting the contributory factors to the A1c levels.
Early evaluation and referral of patients high risk of IPF.
Address obesity and weight problems in every visit.
Early diagnosis of sleep apnea to improve quality of life.
Affects of different kinds of treatment for DM, sleep apnea
Application of best practices
Approach to Pulmonary Fibrosis. Increased use of GLP1 therapy. Add Zetia to statin to reach LDL goal
Approaches to managing my overweight and obese patients.
New treatment guidelines for managing hyperlipidemia
Appropriate use of GLP1 and SGLT2 drugs in diabetes management (type 2). Screen for OSA as it affects BP and CV system
Appropriate use of SGLT2 and diagnosing IPF earlier
As a retiree it enhanced my education
As described
As recommended by each speaker.
Asking patients about sleep habits, excessive sleepiness, proper use of CPAP, check diabetic patients for OSA. Re-evaluate DM patients to see if SGLT2 or GLP1 therapy. Anti-PCSK9 therapy for lipids
Asking patients who appear overweight about losing weight.
Assess clients with suspected AIDP by CT. Ask clients questions about exercise, daytime sleepiness
assess, lab results
Assessing for sleep apnea as a contributory factor to obesity
Educating patients on the lesser role of Niacin in the treatment of hyperlipidemia
Assessment of patients with greater than 40 BMI
Assessment recognition guidelines studies
Assessment, Diagnosis, Laboratory and imaging evaluation

Attention to patient details as needed
Awate of PdsK
Being able to identify individuals that need assistance.
Being able to identify when a patient would need to go on the SGPLT 2 meds and how obesity plays a role in the development of diabetes and sleep apnea. (1)
Being more proactive from the gate with screening Monitor labs more frequently
Better able to assess patients with diabetes, pulmonary fibrosis, obesity and sleep apnea
Better able to treat diabetes Able to treat hyperlipidemia Able to treat obesity
Better choice of medications
Better choices and management for patients with newer diabetes and hyperlipidemia medications Be able to diagnose IPF
Better diagnosis, treatment strategies
Better diagnostic skills
Better evaluation of IPF symptoms and testing; Enhanced knowledge of ACC guidelines on non-statin therapies.
better glucose mgmt, better ild screening
Better knowledge of DM treatment, will screen more patients for apnea
Better management of DM2, appropriate use of CPAP
Better observation of accompanying symptoms of sleep apnea to make referrals. Use GLP-1 therapy sooner.
better prepared to treat hyperlipidemia, statin first even at small doses a couple times weekly if that is what pt can tolerate. diagnose IPF with high resolution CT and treat and list for lung transplant. diabetes meds are better but more expensive. obesity contributes to diabetes, depression, HTN, dyslipidemia, sleep apnea (50% of pt with BMI >40) (1)
better prescribe medications for diabetic control of sugars. better prescribe lipid lowering agents.
Better prescribing for DM2 patients (1)
Better understand how and when to start GLP-2 Gain better understanding on the central role of abdominal and perivascular adipose tissue as a root cause of co-morbidities and cardiometabolic risks. Understand the diagnostic approach to a patient with suspected IPF; Discuss and contrast the available pharmacotherapeutic options for patients with IPF; Discuss and contrast the available. nonpharmacotherapeutic options for patients with IPF.
Better understanding of GLP-1, etc meds and now I know what the ENDO's use. Loved basic explanation of lung/stages/crackles by Pulmonologist
Better use of new diabetic medications; more sensitive to diagnosis of pulmonary fibrosis
Better utilize my options in the treatment of my diabetic patients. Diagnose IPF. Clarify and enforce the treatment guidelines for hyperlipidemia. To be more aggressive with preventive care with my obese patients.
By knowledge application in clinical setting
can greatly better assist my patients in effectively using CPAP therapy have option for better lipid control

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Change diabetic medications for better response
Check lab values. Early intervention with regard to risk factors
Check waist circumference. Pay attention to OSA because of its overall effects
choice of subgroups of dm meds going beyond statins physiology of sleep apnea
close monitoring of weight diet counselling exercise programme
Combining basal insulin with GLP-1 agonist
Compliance
Consider combo of Metformin SGLT2 and GLP1 to help my patients achieve glycemic control. Screen patients earlier with risk factors/symptoms of ILD
Consider pcsk 9 monoclonal an Medscape for pts with statin intolerance Incorporate Glp-1 s in diabetic patients as an alternative to basal insulin Consider IPF in pts with wheezing/ sob And making appropriate eval /tests for osa
Consider the alternative treatment strategies based on patient' condition
content of overall material presented was excellent. First time user of site, missed slide presentation of first 3 but was able to figure it out midway through. would have loved to have followed slid presentation with lecturer.
Controlling post 'radial blood sugar Monitoring hyperglycemia in osa patients Early treatment of obesity
DC Thiazide if using SGLT2 hold SGLT2 if npo, stop GLP for belly pain. For patient with SOB, fine crackles, normal xray consider IPF and order high resolution CT Scan if indicated. Screen for OSA - assess oropharyngeal, daytime drowsiness. Discuss weight loss with overweight, obese patient, associated risks
Developing differential diagnosis as it relates to IPF and diagnostic workup. Assessing patients with OSA and how it affects physically patients
Diabetes manage my with SGLT2s
Diagnosing IPF. Take good history of aches/pain before starting statin
Diagnosis of IPF
Diagnosis of IPF, understanding therapies and identifying CXR.
diagnostic approach, implementing therapeutic guidelines, and treatment strategies
Diagnostic cues for health condition especially IPF and sleep apnea
different meds; education
Discuss sleep apnea non compliance as indicated, recommend high-dose CT scan to PCP as indicated
discuss use of glp-1 with pts discuss use of sgl-2 with pts discuss dangers of obesity with pts
Discussion of weight management strategies
DM lectures were best and first time I actually understood usage of SGLT and GLP drugs!
DM management and new medications
Dyslipidemia management
Earlier use of GLP-1 RA, SGLT-2
Early addition of GLP-1/SGLT2 in DM treatment. Early diagnosis/intervention for OSA.

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Appropriate use of PCSK9 in dyslipidemia
EARLY INTEGRATION OF GLP1 WITH BASAL INSULIN.
Easy to understand analogies for understanding SGLT-2 and GLP-1 medications. (1)
EBP ways to manage these diseases
Educate more patients during visits.
Educate patient.
Stay up today about current Research
Education
Effectively care for patients with the covered conditions
Empathize and later emphasize that Life style modification will go a long way in controlling symptoms and disease stability.
Emphasize to obese patients that obesity is a disease even w/o comorbidities. Initiate GLP-1 RA therapy to reduce post-prandial hyperglycemia. Evaluation, diagnosis, and MX of OSA.
Emphasize to patients that obesity even w/o comorbidities is a disease. Utilize GLP-1 RA therapy to reduce post-prandial hyperglycemia. Institute evaluation, DX & recent advances in the MX of OSA. (1)
Employ use of SGLT2 therapy for diabetics. Treatment with SGLT2 drugs. Use GLP-1 injectables
Employing GLP agonist therapy in Diabetes management
Evaluate more aspects of clinical history; work closely with pts to find acceptable treatment modality that they can be compliant with; encourage polysomnography
Evaluating for IPF
Explaining sleep apnea to patients. Combination therapy for type 2 DM - GLP1 RA with reduced dose of basal insulin. Use of SGLT2 in type 2 DM to decrease CV risk and complications
Explaining the basic disease mechanism and medication actions to get a better patient understanding
Felt that best lectures were on diabetes.
Follow AACE guidelines, workup for conger and dyspnea
following algorithms for plan of care; diagnostic assessments
For DM, GLP-1 should be first injectable choice. Suspect IPF - 3 labs, PFT, CXR, and gold standard CTHR; GLP-1 is better than insulin without weight gain (1)
Further understanding treatment management, deeper understanding of management function.
getting better controls of DM Making all are on statins screen for sleep apena
GLP-1 benefits in reducing A1C levels IPF - CT scan diagnostic OSA - consider in patients with increased neck size and obesity with excessive daytime sedation. Forget niacin and fiber in cholesterol management. Go after LDL levels first, consider PCSK-9 treatment if not responding to statin and Zetia. Cut statin dose in half if patient is not tolerating. Can add Zetia when not responding to mono therapy with statins alone Obesity is a reconized disease with diagnostic coding and can provide reimbursement to providers treating obesity.

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GLP-1 RAs for glycemic efficacy and differential impact on postprandial glycemic control; non-statin therapies in the management of atherosclerotic cardiovascular disease; abdominal and perivascular adipose tissue as a root cause of co-morbidities and cardiometabolic risk
Go for the SGLT2 inhibitor and GLP1 agonist, spirometry/CXR for screen of dry cough, increase SOB
Going to apply in my clinical practice
How and when to use various diabetes medications, evaluation for ipf. Identifying patients with OSA.
How to diagnose idiopathic pulmonary fibrosis
How to diagnose patients and look for risk factors
How to teach pt about their disease/condition. Use the factor of 3 when considering lung diseases
I am not currently actively practicing - between jobs right now.
I am not in clinical practice. I do chart review for Social Security Disability. This seminar will help me assess the severity of the claimant's conditions with diabetic complications, morbid obesity, pulmonary fibrosis and sleep apnea to determine if they qualify for disability. (1)
I am retired
I do ortho
I feel more comfortable using GLP-1 RAs in practice and helping patients to use these meds effectively. I feel more comfortable considering IPF as a possible diagnosis
I had trouble with the audio and could only attend to the first 2 sessions, I can now change my strategies and implement the right treatment option to my pts
i have learn the necessary tepts necessary to better control diabetes and hyperlipidemia
I have updated the studies and guidelines useful in delivering the appropriate and effective treatment to my patients
i learned about the most recent diagnostic tests and treatments for these problems which i will be able to use when i return to work.
I learned more about GLP 1 drugs, IPF, obesity, and the anti PKSC 9 drugs. IPF lecture was good about not prescribing steroids.
I learned so much from the Diabetes speaker, im already adding GLP1 and SGLT2 to my insulin dependent pts who are not at goal.
I plan to consider evaluating patients for OSA prior to symptoms. I plan to investigate IPF in patients with the symptoms previously discussed
I plan to use more GLP-1 RAs on those diabetics who are non-compliant with diet and medication to help lower their blood glucose.
I will now employ more GLP-1s with my diabetics. I will also order more sleep studies to identify my patients with DM and OSA.
I will talk to every patient about their obesity, and risks; encourage them to lose weight, and explain I can offer ongoing support including dietary, physical therapy, pharmacological, and surgical support as needed. I have a better understanding of how to reduce post prandial blood sugar with GLP1s and SGLT2s; and how to reduce LDL levels with Statin, Ezeteimbe and PKS9. I also learned to screen for OSA in men receiving testosterone. I also learned how to screen for IPF.
I work part time in the community
Identification and Management of the above disease processes.
identifying at risk patients

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identifying diabetic patients that may be good candidates for GLP-1 RA therapy
Identifying patients with IPF for further evaluations
Identifying the goal of lipid mgmt Having the courage to discuss obesity with puts Screen for IPF in order with respect problems
Im an FNP student
Improve management of CV disease through management of Lipids. Improve knowledge of the mechanism of action of SGLT-2. Think of IPF as a differential diagnosis, when appropriate
Improve understanding of disease process and treatment options.
Improved diagnostic accuracy Expanded treatment options
Improved diagnostic approach New early recognition guidelines to apply Discuss and contrast the available pharmacotherapeutic options
Improved management of Diabetes Increased sensitivity re: IPF Diagnosis Management options for Hyperlipidemia not responding to Statins or to patients who are truly intolerant of statins
Improved treatment and more effective diabetes management
Improved treatment recommendations for patients in regards to DM/Asthma COPD and obesity management
Incorporate GLP-1 therapy to avoid use of basal insulin. Monitor more closely for IPF with spirometry and HRCT. In regards to statin intolerance decreasing dose or changing dosing intervals to every other day etc to help with compliance and decrease rate of MI
Incorporating the newest strategies for treatment of diabetes & hyperlipidemia
Increase use of GLP1 RA instead of relying mainly on basal bolus insulin to obtain euglycemia. Use criteria of fine crackles and al CXR to diagnose and early intervene on cases of IPF
Increase use of SGLT2 therapy and GLP1 RA therapy. Consider pulmonary fibrosis, non productive cough and dyspnea DD high resolution CT. Daytime sleepiness - sleep study - add new agents for lipid therapy - help change lifestyle obese
Increased awareness in identifying at risk patients and therapeutic treatment interventions
Increased awareness of disease processes in patients and address health care needs.
Increased knowledge in using SGLT2 and GLP1 RA meds. Screening/identifying IPF.
Individualize treatment for obesity
Influenza and more lipid management
Introducing glp-1 agonist
IPF - history taking. OSA - physical exam findings. Learning the huge risk of hypoglycemia and heart arrhythmias
Just some Knowledge Adding Anti diabetic medications canagliflozin, Dapagliflozin, Empagliflozin, Ezetimibe PCSK 9 Abdominal obesity.
Keep a tape measure handy
Keep Hba1c 7.3 and less, treat with DM using GLP-1, DPP-4, SGLT -2. It is very important

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to lower a postprandial glucose level as well. Remember about GFR and SGLT2 inhibitors. GLP1 agonists decrease death, antiatherosclerotic effect, and losing weight and BP. Combination of GLP1 and SGLT2 doesn't cause hypoglycemia. IPF Dx is high resolution of CT chest. CHF can mimic interstitial lung disease. Do spirometer in the office. Thx is Pirfenidone, nintedanib. OSA- caller size great of 17 male and 16 female is most likely OSA. I'd recurrence a. fib think about OSA. Tx is CPAP. 100% OSA has patients with DM, metabolic syndrome, diastolic dysfunction, obesity. Lipid management. If muscle pain cut dosage of statin on 1/2, or every other day, every 2 days. Doubling dosage of statin minimize LDL on. 6% but can increase muscle ache. Non statin meds : Zetia, Bile acid, PCSK9 inhibitors. Niacin and fenofibrate do not work. PCSK 9 use in high level familial hyperlipidemia. This is monoclonal Antibodies PCSK 9 inhibitors. Evolocumab, Alirocumab. It patient on atorvastatin 80mg and Zetia 10 my has recurrent TIA, NSTEMI add PCSK9 . Combination Ezetimib/Simvastatin 10/40 (Vytorin) 17% LDL lower by ezetimab. Obesity measure waist not BMI. Obesity grade 1,2,3

Kidney disease in AKF

Learnt the criteria for the initiation of PCSK9 for lipid management, Screening and recognizing clients with obstructive sleep apnea and implementing therapy that will improve their quality of life.

less use metformin and instead more newer options now that feel better informed tx dm

Lipid and diabetes management

Look more at clinical presentation and compliance.

Medications. Timing of referrals

Metformin first then any other class can be used. Test patients with insulin resistance for sleep apnea. Strategies to reduce noncompliance with sleep apnea CPAP

Metformin then add GLP-1 and/or SGLT2 for patient whose DM is controlled

Metformin, GLP1, SGLT2, order high resolution CT s/o IPF; screening sleep apnea, Afib, uncontrolled/resistant HTN, obese, max tolerated dose statin and Zetia and PCSK9 to get LDL to goal

Mixed pharmacotherapy

Monitor levels

Monitor renal function more closely

**MORE ABOUT ACC GUIDELINE, IPF & SLEEP APNEA
ROLE OF OBESITY IN CARDIOVASCULAR DISEASE
ALTERNATIVES TO INSULIN THERAPY**

More accurately identify patients who will benefit from SGLT-2, GLP-1 RA therapy; I am more aware of IPF, and exacerbation of IPF; Better equipped to evaluate Sleep Apnea; Aware of 2017 quality measures for the use of statin therapy for the prevention and treatment of CVD.

More aggressive use of GLP-1 and SGLT-2; workup for IPF, workup for OSA

More assertive with identifying A1c patients that would benefit from addition of medications and discuss sleep habits/characteristics with all patients

More choices to managing diabetes, cholesterol, diagnosing pulmonary fibrosis and obstructive sleep apnea better

More comfortable with newer DM meds

more effective diabetes management; more aware of IPF as differential diagnosis; continue current approach to obesity management

More effective DM & hyperlipidemia therapies

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More GLP1
More knowledge of current treatments
More likely to screen people for OSA
More likely to use SGLT2 and GLP1 earlier. Include IPF in TLM DDX of unexplained Dyspnea earlier; include questions and exc on all patients regarding OSA (1)
More options for glucose HbA1c control
More screening for IPF and pay attention more to PPBS
Multiple
New medication in addition to better manage my diabetic patients
New meds and devices coming on market soon
new pharmacotherapeutic options for patients with IPF
New ways to evaluate sleep apnea r/t severity. Adding or change meds for treatment of T2DM
No answer
none
not applicable
Now understand new treatment algorithms for DM2
Obesity is not measured by BMI, but waist measurement
ORDER CORRECT TESTS IPF ADD MEDICATIONS FOR LIPID CONTROL ASSESS PATIENTS IN 18 SEC EFFECTIVE E OBESITY CARE ADD MEDICATIONS FOR BLOOD GLUCOSE CONTROL (1)
Ordering SGLT-2 therapy in addition to decreasing basal insulin and discontinuing sulfonureas to treat DM II effectively. Treatment of dyslipidemia with nonstatin regime. PSck9 therapy to decrease cardiovascular risks. OSA treatment with CPAP is the universal treatment, obesity treatment is the most important I preventing CV risks, DM, and all preventable diseases.
OSA can cause other disease and is easily corrected. LDL ideally needs to be below 70 if DM2 but can be lower without cognition issues.
OSA management, diagnosis. Obesity and comorbidity (1)
Pathophysiology of disease process. Diagnosis Tests and work up analysis Treatment plans
Pathophysiology of diseas. Pharmacology and patient application of meds (1)
Patient Education Counseling
Patient education is a must in healthcare. I feel after this conference, I can better explain each of these issues/plans of care with my patients.
Perform appropriate evaluations to diagnose sleep apnea Incorporate SGLT-2 inhibitors in the treatment of patients with Diabetes New approach to treatment of patients with familial hyperlipidemia
Pre SGLT2 use advice and precautions to share with patients. Screen all patients for risk of OSA if surgery planned
Prevention and early intervention

Prior to the course I did not know much of anything about Idiopathic pulmonary fibrosis. This course has helped me to understand the patho and treatment of this disorder as well as my need for further education concerning obesity, and statin use.
Promote earlier use of GLP-1 and/or SGLT2 in lieu of insulin or sulphonyureas, emphasize early continued use of metformin. Follow persistent cough with negative CXR with PFT's early. Explain dangers of untreated OSA. Appreciate risk of obesity without diagnosed comorbidities.
Proper SGLT-2 use, GLP-1 use; evaluation for IPF
Pt.ed.re: the kidney in DM,SGLT-2 and GLP-1 RA and s/sx of hypoglycemia. Tests to diagnosis IPF and tx options. How to dx & manage sleep apnea. I have a better understanding of current statin therapy and a new awareness that obesity is a disease.
Quicker use of GLP1, recognize possible IPF patients, think more about OSA in patients with arrhythmias, start PCSK9 use in appropriate patients
Rarely seen the IPF patient
Recognition and management of IPF. DM, new Rx
Recognition and treatment of IPF
Recognize risks and benefits of covered topics to use for my pts
Recognize the clinical presentation of a patient with possible IPF. Explain SGLT-2 therapy in more detail.
Recognize the early signs of pulmonary fibrosis, sleep apnea. Start to SGLT2 inhibitors early of the treatment of diabetes
Recognize the risks of patients diagnosed with Sleep Apnea. Identification of patient in whom a monoclonal therapy can be implemented. Teach obese patients the risks of cardiovascular diseases.
Reducing hypoglycemia, reducing weight white, decreasing A1C
Refer patients early with restmotive lung function dysfunction to r/o IPF; sleep apnea has multiple QV risks which need treatment. Need aggressive treatment in patients with LDL-C about 100 and additional CV risk factors
Reinforcement diabetes care Understanding and recognizing s/s related to IPF Understanding treatment of Hyperlipidemia
Retired from clinical practice of Radiology
Revisit patient on insulin, IPF, LDL
Revewing patient data and available meds for goals
Rex diabetic with this new Rex regimen
Rx options for management of diabetes, evidence based management of hyperlipidemia, sleep apnea and diabetes Better understanding of making a diagnosis of ipf (1)
Screen all my patients Better education
Screen more often for sleep apnea
Screen patients (appropriately) for IPF Check A1C after one month Use zetia more often than I have Use more patient education in obesity
Screen patients appropriately Dx the above diseases

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Use updated diagnosis tests and labs Refer appropriately
Screening for certain risk factors. Educating patients on their disease. Knowing what tests to use to assist in risk management.
screening for IPF
Screening OSA, HLD and treatment in Primary Care
Screening OSA. DM treatment med
SGLT2 inhibitor lower Tmax allowing secretion of excess sugar
Shared decision making Self-management options Setting pt goals within preferences
Since attending the lectures, I have change my prescribing strategy for DM2 medications based on the 2 lectures and current ACE 2016 guidelines. I have also prescribed yesterday and will consider adding Repatha, the new injectable medication for familial hypercholesterolemia.
Sleep apnea evaluation
Sleep studies, better diabetic control
Spend time listening to patient rather than looking at computer. Order appropriate studies
Staying up to date with current guidelines and medications to treat osa, pif, and hyperlipidemia
Steps in managing high cholesterol and managing muscle pain associated with statins
Strategies like when to start the patient on GLP-1 and SGLT-2 therapy of type 2 DM; combining the diabetic medications to reach desirable glycemic levels for patients with DM; identify IPF patients and how to intervene, to help patients achieve comfortable health state in experiencing IPF; how to prescribe proper therapy for patients diagnosed with obstructive sleep apnea; use the algorithm of hyperlipidemia therapy; and intervene with reduction of obesity.
Strategies to more effectively evaluate patients at high risk for sleep apnea and ensure appropriate therapy is initiated.
Stress importance of wt control to minimize co morbidities
Take care patients with DM. Hyperlipidemia effectively
take more patient history
take more time getting patient history
The appropriate precautions to consider when using SGLT2
The diabetes lectures were most helpful an informative to me.
The epivascular fat that forms around the heart foreboding CV, etc issues. Multiple tips on IPF and PFT interpretation.
The patient population that I will prescribe SGLT-2 and GLP-1 to.
The role of GLP-1 in diabetes Improve management of sleep apnea patients the role of obesity in health management the guideline for hyperlipidemia management
The use of SGLP2 meds. Identifying factors indicating further workup for IPF. The role of obesity, inflammation and CVD was a surprise. Will learn more.
The use of SGLT2 and in hypoglycemia, CT lunge effective IPF, statin therapy

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think more about treating pts with something besides metformin, sulfonamides and insulin (1)
Thorough assessment of symptoms Matching patient strategies to patients Encourage sleep hygiene and weight loss in patients with OSA
thorough history taking
thorough history taking techniques as an essential component in diagnosing
To aggressively identify IPF. Utilize GLP1 and SGLT2 in treating diabetes
To be more aggressive with screenings and treating these conditions
to diagnose and treat sleep apnea to advise patients on about ways to work on their over all health to decrease obesity
Treat hyperlipidemia to decrease LDL to goal primarily with statin and ezetimibe but add PCSK9 inhibitors if necessary. Focus diabetes management to minimize hypoglycemia by avoiding use of medications that induce hypoglycemia and use the GLP1 and SGLT2 more often.
Treatment DM patients with GLP1 receptor agonists, treatment of hyperlipidemia
Treatment guidelines Risks Symptoms
Treatment in diabetes, counsel patient to use cPap in sleep apnea
Unable to as I am an occupational medicine
Under better how sleep apnea affects the whole body. Will start ordering sleep studies
Understand when to add PCSK9. Be able to explain better to patients about anatomy of OSA. Be more cognizant of using GLP1's. Consider adding SGLTs for treatment of diabetes
Understanding IPF and how to diagnose and treat
understanding pathophysiology and importance of early recognition and intervention
Update on recent guidelines to implement changes
updated evidenced based evaluation and treatment of above conditions
Updated guidelines on diagnosis, treatment and monitoring of dyslipidemia
Updates on medications and management of discussed subjects
Use ASCVD risk assessment. Always be considerate for potential hypoglycemia episodes. Efficacy of HRCT for diagnosis of IPF
Use different technique & treatment for DM
Use more Zetia. Use more GLP1. Consider CPSK9. Be more aggressive with sleep apnea. Refer Pulmonary Fibrosis to Pulmonologist. Try to be aggressive with obesity
Use of anti-PCSK9 monoclonal antibody therapy in LDL-C reduction Use of available non pharmacotherapeutic options for patients with IPF Improved appreciation of the impact of treatment decisions on postprandial hyperglycemia & hypoglycemia
Use of diff anti-diabetic drugs more effectively
Use of diff meds for lipids. Diagnosing IPF
Use of evidence-based treatments
Use of GLP1 agonists & SGT2 inhibitors for DM management Providing patients with info on potential health risks of obesity
Use of longer acting insulin to manage DM, earlier recognition of lpf

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Use of new meds
use of resources to improve care use of algorithms for statin management new resources for OSA treatment
use of sglt-2 intervention in patients in long term and home settings
Use of SGLT2 inhibitors. Parameters for obesity treatment. New knowledge about IPF. Lipid management.
Use of SLP-1, more aggressive with OSA diagnosis/management
Use of SLP2, GLP1 long versus short acting
Use physical exam to consider likelihood of sleep apnea. Talk to patients about their weight
Use SGLT2 and GLP1 and T2D medications. Try to persuade patients for sleep apnea treatment. Watch LDL more closely. See importance of obesity and reason for it
Use SGLT2 more frequently. OSA can bet treated with Primary Care. Rx GLP1 drugs - give good patient education. OSA - will be put in differential more frequently
Using combination therapy in diabetes to reduce A1C.
Using jaks and type 1 and 2 cytokines
Using newer therapeutic hyperlipidemia and diabetic agents
Using SGL2 inhibitors and GLP agonists for DM2 instead and or with basal insulin. Using Pcsk9 inhibitors third line with Persistent high LDL.
Utilize GLP-1 sooner in therapy. Overall management of T2DM using Metformin _ GLP-1, SGLT-2 and DPP-Y (1)
Utilize GLP1; look for IPF; obesity.
Very nice
Very nicely organized and explained
Waist measurements
Watch dose of Invokana with GFR <60
Ways to diagnose IPF, ways to identify sleep apnea, medications for IPF treatment
What radiologic studies to use
When to introduce SGLT2 and GLP1 therapy and to not just accept the standard practices
When to modify antidiabetic therapy and what insulin therapy is best to use. New to put GLP-1 into my practice for treating diabetics
When to use GLP'-1 RA's and SGLT-2 in the management of diabetes.
will be more aware when adjusting DM meds; learned a lot on IPF and have a pt that was dx recently ; this will help me in moving that pt thru the healthcare system (1)
Will consider SGLT2 therapies faster and with more confidence. Consider GLP's in pp hyperglycemia. Be more vigilant in bibasilar rales to have IPF as differential
Will use GLP and SGLT medications sooner in diabetes. Order appropriate labs for IPF
With new DM T2 consult endocrinologist regarding combo interventions. Add Zetia to retractable hyperchol (1)
WITH NEW INFORMATION I LEARN FROM THE CME , I CAN APPLY DIRECTLY TO PATIENT CARE.
with those at risk for IPF & OSA
Workup of IPF, using SGLT2 agents more; choosing lipid agents
Would integrate different classes of diabetic medications (GLPs) sooner than previously

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considered.

Would be more persistent in early stages of CPAP adjustment for continued success for patients.

What topics would you like to see offered as CME activities in the future?

Comment
Abg interpretation, vent values
Actual causes of obesity instead of end stage symptom drug treatment
ADHD - Mental Health
ADHD, bipolar, heart failure
Adolescent medicine, Orthopedic injuries, sickle cell disease, lab interpretation,
AKD versus CKD
Ankylosing spondylitis, psoriatic arthritis, ENT evaluations for common disorders
Anticoagulation
antihypertensive selection process
anxiety/depression
Anything in primary care that is concerning guidelines and best practice updates. (1)
asthma
Asthma immunology allergic rhinitis
Asthma, hypertension
Asthma, hypogonadism, sports physical for children
Autoimmune diseases
BPH and Diabetes
CAD, infectious disease
Cancer treatment
Cardiac arrhythmias
Cardiac arrhythmias
Cardiac, more endocrine, Dementia
cardiovascular
Cardiovascular, ACS etc
cause of heart failure
Chf
Chf treatment, Copd
Chf, ckd, hypothyroidism, chronic pain control
CHF, further review of DM, HTN
CHF, GLP-1s
CHF, Strategies and medication treatments for smoking cessation
Chronic pain, personality disorders,
clinical nutrition; ANY FUNCTIONAL MED TOPIC
Clinical practice guidelines for cancer screening.
Coding
Common skin disorders
Congestive heart failure
Congestive heart failure, acute renal failure
Critical care
dementia

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Depression in primary care
depression/anxiety in primary care
derm, psychiatry
Dermatitis
Dermatology
Dermatology issues
Dermatology topics
diabetes management
Diabetes/EKGs
diabetes/lipids
Diagnostics
DME requirements and documentation
drug addicted patients, review of spirometry measures
DVT/PE
ECG interpretation
EKG. HF.
Erectile dysfunction and Prostate diseases
Gastroenterology
Geriatric patient care
Geriatrics's population
GYN, Oncology
Heart Disease
Heart disease, migraine headache
Heart Failure, HIV/AIDS, Hypothyroidism
Heart, Endo, ID, Neuro
HIV
Hormonal therapy
Hormone replacement, rheumatoid arthritis, IBD
HTN
HTN treatment
HTN, hyperlipidemia, obesity, diabetes
Hyoer IGE Syndrome
Hypertension
Hypertension management
Hypertension, more Diabetes, Asthma, COPD, Preventative screening, Measures to increase medication compliance.
Hypertension, Office orthopedics
Hypothyroid
Hypothyroidism
IHSS
immunotherapy for cancer
infectious disease
Insomnia treatmentg
Insulin pump therapy for diabetes management
Irritable bowel
Kidney disease, anemia

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Liver diseases (fatty liver, PBC) IBD, pancreatic insuff, pseudocyst, cancer
Liver n thyroid diseases
Lung cancer
Management is GERD, Asthma, Atopic dermatitis & pediatric ADHD
Management of CHF, COPD and HTN
Management of pain without opioids
management of psych in primary care
Management of stage 3 CKD.
Management of Thyroid Problems especially where TFTs Results are confusing or inconclusive
managing chronic pain
Mental health
mental health and primary care
Mental health related topics - depression, anxiety.
Mental illness
Metabolic Syndrome
metabolic syndrome, diabetes
MI
more cardiovascular and pulmonary diseases.
More GYN issues and menopause.
More on Diabetes and narcotic weaning, alternatives to narcotics.
More on diabetes management
More on obesity. Other topics that have clouds of presumptions that are no longer applicable.
more respiratory
Most needed
Musculoskeletal conditions
n/a
NASH LIVER DISEASE
NEUROLOGY
neuropathy treatment; foot disorders in general
New innovations and what the future holds
not sure
Noval oral anticoagulants vs Coumadin
Oab, depression, substance abuse, medications to decrease cravings for substances
Obesity medicines
Obesity related
Orthopaedic's
Pain management
Pain management and opiates
pain management,Neuropathy
PCOS, asthma
Pediatric subjects
Pediatric topics
pediatrics, orthopedics, endocrinology, joint disease, geriatrics
personality disorders

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pharmacological management of obesity
Pulmonary and Sleep disorders
Radiological study use in primary care
real issues on how difficult it is to be a provider in todays horrible abusive pt care environment
Renal disease
Renal Failure
respiratory infections
Retail health care management
Rheumatoid arthritis, Ocular problems in primary care
Role of Probiotics
Roles of lifestyle in mang
Safety in Patient Medication Prescribing (
Seizure disorders
Seizure, hep c, hiv
Sexually transmitted diseases
skin disorders
Spinal stenosis interventions
STDs
Stroke prevention and treatment, blood thinners
Stroke; headache; Afib
The real story about treating hyperlipidemia and how that relates to the development of CVD.
thyroid
Thyroid and parathyroid disorders, Urgent care workshop, X-ray interpretation
Thyroid diseases, dermatology rashes
Thyroid, pancreatitis, liver disease,
To cover topics for physicians who work in urgent care and ER settings
Topic about osteoporosis, Vit D
Treating Dementia, incontinence, menopause, depression, Parkinsons
Treatment of arthritis...discussion of available therapies and the order to use thd
Treatment of hypertension
Updates in HTN management
Uterine fibroids, dementia, care of the elderly
Venous stasis; EKG reading
women's health
Women's health and pediatric care
Women's HRT, Depression/Anxiety, Alcoholism/Drug Abuse

Additional Comments:

Awesome job on this CME!!
being able to do this online was great; no 5 hours of travel and had lunch with family a win/win for this type of learning
Enjoyed the ability to attend conference on the web

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excellent
excellent cme
Excellent learning experience
Excellent presentations! I was able to read the slides from the first two presentations, but hearing the presenter's explanations. I had a hard time to access the webinar in the beginning. Something wasn't working. The questions were seen on and off. I communicated it to someone a couple of times. All of a sudden, the webinar started working after the two first presentations. Thank you. Very informative and well presented program. Great faculty. I used to attend it live in the past when done in South Florida. Unfortunately, I don't have that leisure here in Jacksonville.
Excellent presenters and presentations
Excellent programs
Excellent seminar
Excellent speakers this conference
Excellent speakers!! The pulmonologist was exceptional with his presentation as he made it so practical. I also enjoyed the diabetes discussion as there are so many new meds that trade names helped me understand better which he referred to because that is what our pts remember Too! Not always generic names! I liked that and he did not make it a commercial biased lecture! Loved it.
GI/GERD
Great Activity
Great conference!
Great lectures
Great presentations (2)
Great primary care conference overall! Thanks!
Great Program
Great topics.
Had a few sound issues during the presentation causing difficulty answering the provided questions. May be on my part. However, overall this was a great learning experience!
Had a major problem with starting program and the sound
Had trouble with the audio function during some of the lectures
I always learn something new! I love these conferences
I am a note taker some of the presenters talked too quickly for me to take notes like I normally enjoy doing
I am really appreciative of these CME courses. I currently work in research, so I don't do a lot of patient care. These courses keep me up to date on a lot of topics. Thank you.
I had difficulty getting the audio to work at the beginning. It would have been very helpful to have a pretest link for the simulcast to make sure my computer was in sync with your software. It was very frustrating to find a number to call for help! Contact information for assistance would be helpful also in the email.
I learned alot.
I really enjoyed it.
I was called away from last segment of final presentation, but would be interested to view recording when available.
I was disappointed that I was unable to make the connection to hear the audio and visual person's at the presentation. I was in touch with the IT person via email several times. I

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reconfigured my computer during one of the presentations and hopes of being able to get it . I was interested to find out when talking to a colleague that I wasn't the only one with those problems.
I was not able to establish audio, so could not hear the speaker. Very frustrating
I would like to see these conferences that were offered via online to be offered as a recorded option for future use.
Illicit drug related issues
it was great
It was very difficult to understand the last 2 speakers. Subtitles would have been great.
lets do alot more on the reality of practicing against incredible impossible odds
Lifestyle changes is the key to prevent common medical problems
Loved the variety of topics available !!!
N/A
Na
no
None
None. Thanks
not sure
Please bring in speakers from IFM (Institute for Functional Med) or A4M. THANK YOU for this program!
Practical Topics & updated Data presented reknown excellent Speakers in perfect AV settings.
Rheumatoid and osteoporosis
Thank u for the all the awesome cme
Thank you
Thank you for an excellent simulcast presentation. It's the best way to earn CME credits at home convenience.
Thank you for having this webinar available.
Thank you for providing this very important information.
Thank you so much for simulcast option.
thank you!
Thank you!!!!
Thank you. Excellent program.
thank yoyu
Thanks
The Audio was horrible. Not consistent. Unless you can fix it in the futire, pls don't offer the Webcast
The conferences keep getting better and better
The morning presentations were great. Unfortunately, I could not complete the day but will look for futher presentations.
The obesity lecture was offensive and unprofessional. If this doctor gave a presentation on any other aspect of medicine for instance cancer patients or kidney failure patients and showed mocking photos he might have his state license temporarily suspended. Also he did not appear to have any training or expertise in the causes of obesity namely genetic predisposition emotional eating disorder addiction or any training in nutrition
This is excellent program

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This presentation of material was very informative.
This was a very well designed conference program, with excellent topics & presentors/ faculties. The accessibility to the conference (virtual simulcast) was great! Thank you!
Thx to NPACE for making obtaining CEUs easily accessible! I really appreciate this.
Very good CME opportunity
Very good program
Well organized
Wondering learning experience