Emerging Challenges In Primary Care: *2017*

Activity Evaluation Summary

CME Activity: Emerging Challenges in Primary Care: 2017
Saturday, June 10, 2017
Sheraton Raleigh Hotel
Raleigh, NC 27601

Course Director: Gregg Sherman, MD

Date of Evaluation Summary: January 2, 2018

NACE NATIONAL ASSOCIATION FOR CONTINUING EDUCATION

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In June 2017, the National Association for Continuing Education (NACE) sponsored a live CME activity, Emerging Challenges in Primary Care Update 2017, in Raleigh, NC.

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 Lipid Management, Microvascular and Microvascular Outcomes into Diabetes, Integrating Diet and Lifestyle Management into Diabetes, Idiopathic Pulmonary Fibrosis, Demystifying A1AT Deficiency and COPD

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 seventy-one healthcare practitioners registered to attend Emerging Challenges in Primary Care: 2017 in Raleigh, NC and four hundred fifteen registered to participate in the live simulcast. Four hundred fifty-two healthcare practitioners actually participated in the conference: One hundred thirty attended the conference in Raleigh, NC and three 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 2.0 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

June 10, 2017
Raleigh, NC
Live & Simulcast

What is your professional degree?

Label	Frequency	Percent
MD	80	36%
DO	5	2%
NP	114	52%
PA	21	9%
RN	1	0%
Other	2	1%
Total	223	100%

What is your specialty?

Label	Frequency	Percent
Primary Care	166	70%
Endocrinology	2	1%
Rheumatology	1	0%
Pulmonology	5	2%
Cardiology	3	1%
Hospitalist	7	3%
Psychiatry/Neurology	8	3%
ER	5	2%
Gastroenterology	1	0%
Other	42	18%
Total	240	100%

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

Label	Frequency	Percent
None	24	11%
1-5	29	13%
6-10	34	15%
11-15	31	14%
16-20	28	13%
21-25	19	8%
> 25	59	26%
Total	224	100%

Indicate the number of patients you see each week in a clinical setting regarding each therapeutic area listed: Patients at risk for, or with, IPF

Label	Frequency	Percent
None	29	31%
1-5	33	36%
6-10	16	17%
11-15	9	10%
16-20	2	2%
21-25	2	2%
> 25	2	2%
Total	93	100%

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

Label	Frequency	Percent
None	9	9%
0-1	6	6%
2-5	7	7%
6-10	6	6%
11-15	16	17%
16-20	13	14%
> 20	39	41%
Total	96	100%

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

Label	Frequency	Percent
None	11	11%
0-1	9	9%
2-5	27	28%
6-10	15	16%
11-15	12	13%
16-20	6	6%
> 20	16	17%
Total	96	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	178	81%
Somewhat	41	19%
Not at all	1	0%
Total	220	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	176	80%
Somewhat	43	20%
Not at all	1	0%
Total	220	100%

Upon completion of this activity, I can now: Understand ways to integrate lifestyle management into diabetes care; Discuss strategies to help patients improve dietary management of their diabetes; Recognize how to improve medication adherence for patients at various stages of diabetes.

Label	Frequency	Percent
Yes	197	92%
Somewhat	18	8%
Not at all	1	0%
Total	216	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	156	72%
Somewhat	58	27%
Not at all	3	1%
Total	217	100%

Upon completion of this activity, I can now: Discuss the pathophysiology of alpha1-antitrypsin deficiency (AATD); Utilize appropriate screening for AATD; Incorporate AATD testing into routine chronic obstructive pulmonary disease (COPD) management algorithms; Discuss treatment options for AATD and latest GOLD guideline recommendations.

Label	Frequency	Percent
Yes	112	65%
Somewhat	57	33%
Not at all	3	2%
Total	172	100%

Upon completion of this activity, I can now: Define Patient Experience & How to Measure it; Describe today's Healthcare World; Outline the importance of the Patient Experience; Understand & apply the H.E.L.P. communication method.risk.

Label	Frequency	Percent
Yes	172	86%
Somewhat	23	12%
Not at all	3	1%
Total	198	100%

Overall, this was an excellent CME activity:

Label	Frequency	Percent
Strongly Agree	164	73%
Agree	58	26%
Neutral	2	1%
Disagree	0	0%
Strongly Disagree	0	0%
Total	224	100%

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

Label	Frequency	Percent
Strongly Agree	166	74%
Agree	56	25%
Neutral	2	1%
Disagree	0	0%
Strongly Disagree	0	0%
Total	224	100%

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

Label	Frequency	Percent
Strongly Agree	153	69%
Agree	63	28%
Neutral	7	3%
Disagree	0	0%
Strongly Disagree	0	0%
Total	223	100%

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

Label		
Very Likely	145	66%
Somewhat likely	53	24%
Unlikely	3	1%
Not applicable	20	9%
Total	221	100%

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

Label	Frequency	Percent
Within 1 month	146	66%
1-3 months	35	16%
4-6 months	12	5%
Not applicable	29	13%
Total	222	100%

In terms of delivery of the presentation, please rate the effectiveness of the speaker:
Barbara Hutchinson, MD, PhD FACC - Lipid Managemen**t**

Label	Frequency	Percent
Excellent	162	74%
Very Good	46	21%
Good	10	5%
Fair	0	0%
Unsatisfactory	0	0%
Total		100%

In terms of delivery of the presentation, please rate the effectiveness of the speaker:
Mark Stolar, MD - Diabetes and Vascular Disease

Label	Frequency	Percent
Excellent	154	71%
Very Good	53	24%
Good	11	5%
Fair	0	0%
Unsatisfactory	0	0%
Total	218	100%

In terms of delivery of the presentation, please rate the effectiveness of the speaker:
Mark Stolar, MD - Diabetes - Diet and Lifestyle

Label	Frequency	Percent
Excellent	159	74%
Very Good	45	21%
Good	11	5%
Fair	0	0%
Unsatisfactory	0	0%
Total	215	100%

In terms of delivery of the presentation, please rate the effectiveness of the speaker:
Franck Rahaghi, MD, MHS, FCCP - Idiopathic Pulmonary Fibrosis

Label	Frequency	Percent
Excellent	156	74%
Very Good	46	22%
Good	8	4%
Fair	0	0%
Unsatisfactory	0	0%
Total	210	100%

In terms of delivery of the presentation, please rate the effectiveness of the speaker:
Franck Rahaghi, MD, MHS, FCCP - Alpha-1 and COPD

Label	Frequency	Percent
Excellent	151	75%
Very Good	42	21%
Good	9	4%
Fair	0	0%
Unsatisfactory	0	0%
Total	202	100%

In terms of delivery of the presentation, please rate the effectiveness of the speaker: Marlene R. Wolf, MD, FAAFP - Patient Experience

Label	Frequency	Percent
Excellent	122	66%
Very Good	48	26%
Good	9	5%
Fair	4	2%
Unsatisfactory	1	1%
Total	184	100%

To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Barbara Hutchinson, MD, PhD FACC - Lipid Management:

Label	Frequency	Percent
Excellent	164	77%
Very Good	43	20%
Good	7	3%
Fair	0	0%
Unsatisfactory	1	0%
Total	215	100%

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

Label	Frequency	Percent
Excellent	156	73%
Very Good	49	23%
Good	9	4%
Fair	1	0%
Unsatisfactory	0	0%
Total	215	100%

To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Mark Stolar, MD - Diabetes - Diet and Lifestyle

Label	Frequency	Percent
Excellent	166	77%
Very Good	41	19%
Good	7	3%
Fair	1	0%
Unsatisfactory	0	0%
Total	215	100%

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

Label	Frequency	Percent
Excellent	166	79%
Very Good	39	19%
Good	5	2%
Fair	0	0%
Unsatisfactory	0	0%
Total	210	100%

To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Franck Rahaghi, MD, MHS, FCCP - Alpha-1 and COPD

Label	Frequency	Percent
Excellent	158	78%
Very Good	41	20%
Good	4	2%
Fair	0	0%
Unsatisfactory	0	0%
Total	203	100%

To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Marlene R. Wolf, MD, FAAFP - Patient Experience

Label	Frequency	Percent
Excellent	137	72%
Very Good	40	21%
Good	7	4%
Fair	4	2%
Unsatisfactory	1	1%
Total	189	100%

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

Label	Frequency	Percent
Topics covered	159	30%
Location/ease of access	150	28%
Faculty	31	6%
Earn CME credits	188	36%
Total	528	100%

Future CME activities concerning this subject matter are necessary:

Label	Frequency	Percent
Strongly agree	117	53%
Agree	81	36%
Neutral	22	10%
Disagree	3	1%
Strongly Disagree	0	0%
Total	223	100%

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

Comment
Effective lipid management evolving treatment of Diabetes current guidelines in management if COPD/ alpha 1 antitrypsin
meet patient where he/she is better motivate by positive reinforcement
How to screening every potential patient with frequent coughs and production phlegm. Screen patients with smoking history, asthma and frequent bronchitis. Have a strategy for diabetic patients in monitoring dietary intake, blood glucose log and keeping appointments.
Keen consideration for patient experience Have A1C at review to drive DM management Continue to seek knowledge to improve practice
Lipid guidelines Use of statins / ezitimibe / newer medications / although cost makes it hard for current use Approach to diet and exercise in the diabetic PT Ipf / keeping in it in mind while evaluating PT with cough / sob / ? Chronic findings on Xray differential dx for copd
Lipid management, add ezetimibe 10mg after treated with statin. Still not achieved LDL-C>70, consider PCSK-9 Macrovascular and Microvascular outcomes for Diabetes Management: SGLT2 Inhibitors can be used for FPG, PPG, and A1C. Intergrating Diet and Lifestyle mgmt into Diabetes care: Obesity is a predictor for diabetes and a marker of insulin resistance.Recommend patients to exercise 30-45 minutes daily to lose 5% of weight. Recommend healthy diet. Idiopathic Pulmonary Fibrosis: High resolution CT is considered a key imaging study for diagnosis. Symptom recognition: Prolonged coughing & bibasilar crackles. A1AT Deficiency and COPD: Diagnosis of AATD requires low serum concentration of AAT
stop and put myself in pt's place to make the experience better for the pt. consider AATD in pts with pulmonary disease
Uses, contraindications, complications of SGLT2 inhibitors in diabetes; emotional component screening scale in diabetics Diagnostic tools for IPF H.E.L.P. and its goals for patients

5 to 10% weight loss is an optimal strategy to decrease live fat and enhance effectiveness of medication in obesity and the management of t2dm. High resolution ct for diagnosis of ipf.
Add Ezetimibe as necessary or PCSK9. Use combination therapy with COPD patients. Diabetics on statin therapy as necessary. Use early antibiotic therapy
Add Zetia to statin; signs and evaluation of IPF; focus on CVD risk red when choosing meds for DM; reduce focus on weight for DM patient
Adding Ezetimibe to statin therapy to decrease cardiovascular risk after maximizing statins, use of PCSK9, use of high resolution CT for diagnosis IPF
Adding lipid lowering agents - when and what, better ways to talk with patients about making changes in life/diet
Adding SGLT Ihibitors to poorly controlled DM2 patients. Consider adding PCSK9 especially for patients with high risk for CVD and mortaltity Employ life stye management of diet and excercise individualized o meet the unique needa of each patient
Adding Zetia, 7% weight loss with DM, strategies for IPF (1)
Addition Ezitimide in poorly controlled hyperlipemia patients Check Antitrypsin antibody for COPD patient.s
Adhere to guidelines
After statin therapy based on current guidelines to improve cardiovascular outcomes. Use of SGLT2 inhibitor based on mechanism that benefits CV outcomes
Algorithm for diagnosing IPF. Importance of effective communication in patient experience
Always to AATD on COPD patients. Do Menotype and Phenotype
Applying new antilipidemia guidelines. Reviewing SGLT2 needs; more PFTs and COPD analysis
Approach diagnosis and weight reduction for patient based on proven procedures, information, and maintain a strong positive relationship to my patients
Approaching lifestyle changes with DM2 by not focusing on weight loss and motivating patients in other ways.
Appropriate use of SGLT1 inhibitors. Appropriate use of PCSK9 inhibitor
Appropriately evaluation and when to refer patients out
As a retiree these lectures review my general knowledge and education
Assessment, specific questions to ask to assist with differential diagnosis
At least consider IPF
Better communication of alternative ways to communicate lifestyle changes for my diabetic patients. Assess patients to allow me to identify IPF in my patient population. Understand the importance of renal function in glucose metabolism for my diabetic patients.
Better diagnosis, awareness and choice of therapy
Better knowledge of DM, lipid, more about lifestyle exercises
Better med management and dietary encouragement. Learned of less recognized maladies
better treatment options for patients with hyperlipidemia, Diabetes, IPF, and COPD
Change discussion of weight with diabetics. Screen COPD patients for AATD. More use of PCSK9 inhibitors to treat cholesterol
Change in drug approach in pts with inadequate statin response. More compassionate diabetic conversations. Increase in ordering A1AT. More comprehensive work-ups for patients with unexplained SOB.

change screening strategy, add new treatment plans
Check Rx diabetes
Close monitoring of patients on multiple medications
Communication to diet/lifestyle. Modification to better control BQ/exercise/increase activity/improve HgA1c in diabetic patient, elective way of changing statins
Consider adding SGLT2 as second agent when single agent treatment fails. Increase awareness of IPF and knowledge to start workup with >70yo and dyspnea, crackles on exam
Consider each individual patient. Look at their disease, labs, and risk factors
Consider testing all patients with COPD for AATD Not to ignore "chronic changes" on chest X-ray
Considering AATD, identifying IPF Understanding diabetes medications better Role of kidney in glucose metabolism Quality measures for statin therapy
continue screening and as appropriate
COPD (in 70%) respond to bronchodilator - will try COPD assessment questionnaire (CAT) for staging COPD - very useful. Screen all COPD patients with LgAT test
COPD management Communication role. Diet and life style modification.
Currently retired but I occasionally do volunteer work doing medical missions in a third world country
Diagnostic and therapeutic tools
Diet n exercise
Diet, lifestyle, medication
Different approach to diabetic exercise activity, weight loss
different approaches to lipid management approaches to DM management
Discussion of cholesterol and new medications. Support for sgl2s.
Early referral to Pulmonology (1)
educating patient about diet exercise and habit that effect disease and medications
Education, EBP
Encouraging patients to improve health in a positive manor. Understanding medications being used in these areas.
Evaluation of 1 episode of hypoglycemia. Implementation and evaluation of spirometer for lung function Cognizant of the patient experience within the practice
Evidence based protocols
Ezetimide is good option. Feel confident with SGLT2 use. Diabetes is heart disease
Frequent monitoring of patients when on SGLT2 inhibitor
Get PFT Get High resolution CT Lung scan for low volume PFT Replace b glyburide with newer sglt2 inhibitors

Gfr Parameters for using sgl2 inhibitors Avoid them in PVD, foot ulcer risk. Importance of office spirometry screening.
Guideline-directed strategies
HELP
how to integrate small changes for diabetics. when to order AATD. Recognizing IPF
I am an ophthalmologist with strong interest in internal medicine,use information dealing with geriatric population
I can make better recommendations to my patients for them to discuss with their PCP, to optimize their care
I do not treat chronic disease
I feel more confident with lipid management. Testing Alpha-1 antitrypsin deficiency in my COPD patients
I have learned how to teach patients what to do regarding lifestyle management and how to focus on the patient experience.
I learned a lot from your program but my current job has no patient contact. The knowledge I gained from attending your CME programs has help me to do my job better.
I learned new strategies in diabetes and lipid management that I can incorporate in my practice
I may try new agent for lipid. Try to d/c statin for pt > 80 yrs unless there is indication
I now have updated information to treat my patients and was provided answers to questions I have had for a while
I will be better able to choose appropriate lipid management, treatment
I will use spirometry more often and refer more to pull. I will be aware of the PT experience.
Implement resources
improve communication with patient.
Improve management DM II and control glucose Improve diagnosis of IPD and correct treatment
Improved discussion for glycemic control, and to be more suspect with alpha 1 anti-trypsin disorder.
improved overall management
Improving patient experience through communication and building rapport by using H.E.L.P.
Increase patient experience by engaging with patient; testing for A1AT deficiency (1)
Increase use of spirometry and pulse Ox. Plan is to have diabetic patient education classes
Increase, consider testing for Alpha. Manage hypoglycemia tighter. Give more hope for IPF
Instructing patients to check blood sugar post prandial Integrating diet, exercise and weight reduction into diabetic management. Diagnostic studies to evaluate pulmonary fibrosis Using HELP strategies for communication.
Knowing meds and guidelines
Learned PCSK9 inhibitors, COPD, and Pulmonary Fibrosis Rx
Learned standard of care for lipid management
lifestyle management for diabetics and pts with hyperlipidemia. different medication regimes for lipid management.
Lifestyle management in setting of DM. IPF diagnosis and treatment
Likely increased use of Zetia to improve LDL levels. Work up bibasilar crackles

Lipid management DM management with Sglp2 COPD and PF early detection and management How to provide better care to patient
lipid management and DM management and their influence on vascular diseases.
Lipid management, diabetic management
Lipid meds
Listen to patients
Listen to patients, lifestyle changes, quality care
Look at research and new developments for better options for treatment. Keep learning and working for patient improvement
Management of DM with SGLT-2 therapy, and lifestyle coaching strategies for these patients. Use of statins, non-statins and PSK-9 inhibitor medications. Greater awareness of presenting symptoms / etiology for patients with IPF Consideration of AADT for patients with COPD
Management of hyperlipidemia, diabetes, improvement of A1C with medication and lifestyle management, COPD and AADT diagnosis and treatment, IPF diagnosis and treatment
Management of hyperlipidemia. DM use of new meds, lifestyle, IPF, AATD, plan of tests and treatment, COPD management for Primary Care
Max out Lipitor then add Zetia in order to hopefully let insurance pay for PCSK9 inhibitors, reiteration that Lipitor is best option for treatment
Maximizing treatments in patients with hyperlipemia, Know when to integrate pcks9 inhibitors
Menopause & autoimmune disease.
Modify how I discuss weight management with my patients
monitor pt for dyslipedemias more closely
Monitoring labs, high A1c, patient home glucose
More aggressive lipid management. Individualized dietary recommendations. Increased surveillance
More attention to statin treatment for appropriate patients
More aware of IPF and its treatment. Will be more effective in addressing diabetic patients regarding lifestyle changes - more aware of how wording affects patients
More familiar with new drugs
More frequent spirometry. More productive lifestyle discussions
More intensive medication management and monitoring
more reassurance in eval and mgmt. of T2 DM, IPF and AATD.updated information.
More use of Ezetimibe
Move from statin to PCSK9 The role of the kidneys and diet to control diabetes, spirometer for early detection on COPD as well as IPF, improve on patient experience etc
Need A1C at the office not later from the lab. 10,000 steps per day recommended; use of physically active instead of exercise
New medication options, guidelines keep on cell phone
new treatment algorithms, new diagnostic tools
Not applicable

Not discussing exercising - physical activity - more actively use Zetia
Patient centered approach. Change one med at a time.
Patient experience, Integration of lifestyle management in DM care
Plan and make decision with the patient Look, and listen, and pay attention to the patient Elicit and engage with empathy Say hello with a smile
Rationale/usage of newer diabetic and cholesterol treatment
Remember patient with statin intolerance have higher CVS event rule. Remember benefit of SGLT2 and weight reduction with low BP. Use of spirometry, MMRC to diagnose COPD
Risk with using Psychotropic medication
Routine spirometry - currently just using with lung symptoms; consider PCSK9, use of statins in lower risk CVD
Screen for AATD. Regular reminder of office staff of patient communications. Ensure meds used properly
Screen for COPD. Use more PCSK9 and SGLT2
Screen patients for Alpha 1.
Selection of statins appropriately, best choice options for DM Rx, workup for CLD
SGLT2 safe use in ARF/AKI can be safe - work with patient on lifestyle changes on what is sustainable; work to get LDH-C to <70 and lower better
Start ezetimide for first statin. Diet and education of exercise for DM every visit. Pay attention to basilar crackles. Test for AATD
Strategies for prevention of CVD. Evidence-based data for DM treatment eg SGLT2 usage and proper diets
Strategies on patient communication example: use physically active instead of exercise, better DM management, charts to measure DDE
Strategies to keep in mind with patient care. I work retail health so no diagnosis tools
suspect and test for IPF with cough and basilar crackles Screen for A1at def. with COPD Dx.
Take strategies and utilize them
Talking to patient and their family members.
Testing for AATD more often
Testing for differential diagnosis of AATD in COPD, recognizing presenting factors for IPF
The criteria and step approach to the hyperlipidemia diagnosis and treatment.
The HELP-I will communicate differently with patients. I will check COPD pt for AATD . I will stop talking about weight loss and start talking about controlling the disease with diet/nutrition. Very helpful.
The patients I see daily fit most of these areas
The slides were outstanding
The use of SLGT2 The use of PSK9s
To be more aggressive in treatment
to better anticipate patients need and to implement new treatment modalities To keep current with medical trends

To incorporate the quality patient service to every patient and remember that when patients come to us it's because they trust us due to our education and w was chief patient care Officiers we MUST GIVE THEM THE BEST ! Encourage patients to create more physical activity into their lives, open the lines of communication and help them achieve their long term goals . Make the right diagnostic protocols for patients with COPD, DM II
Treat DM aggressively as well as lipids
Treat lipids more aggressively. Choose appropriate agents for my T2DM patients. Think of IPF and AATD during Dx presentations (
Use new theories in Typ2 DM, including SGL, DP2, etc. Use PCSK9 when appropriate and affordable. Diagnosis and treatment of COPD, us of AATD screening and Rx
Use of new medications
Use of PCSK9
Use of PCSK9 inhibitors
Use of SGLT's more often in type 2 DM patients. Dietary counseling
Use of spirometry, use of Alpha 1 antitrypsin deficiency
Use of statin and ezetimibe, new non-statin meds, prefer oral meds for DM2, diagnosis and Rx for IPF
Use Zetia second line therapy after statin. Use PCSK9 inhibitors third line. SGLT-2 use for uncontrolled diabetics
Using clinical guidelines for cholesterol management Utilizing SLGT2 meds more knowledgeably in my DM patients Assessing for AATD in at risk patients; identifying at risk patients Auscultations for bilateral lung crackles and ordering tests Applying the HELP technique to the patient experience
Utilization of PCSK9 and AAT and SGLT2 meds
Very helpful
very useful
Ways to approach patients more effectively
When and how to add lipid lowering agents to further lower LDL-C in high risk patients. Rational use of newer DM agents and how to employ them. Lifestyle management/adherence
When to use add on lipid therapy, use of SGLT-2 therapy and cautions, lower carb diet in DM and engaging the patient, early signs to consider IPF, testing for AATD. Using the H.E.L.P communication method
Will be more aggressive with statin therapy. Try to get BW done prior to appointment. Will screen for AATD
Will never let bibasilar crackles go without workup. Will screen all COPD patients for A1AT deficiency. Will be more effective in managing lipid abnormalities
Will review with colleagues
Work up elderly with dyspnea and crackles; avoid word "exercise" when counseling diabetics, get a PFT machine, screen for A1AT deficiency

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

Comment
ADHD
AIC and patient quality care
Alzheimers, Hospice & Palliative Care; Pain relief/management
Anything pulmonary related
Arthritis management, diagnosis
autoimmune disease.
business ownership for NPs
cardiovascular, diabetes treatments
Cardiovascular, EKG
CHF , Neurology, Cardio
CHF Dementia care Multiple sclerosis
CHF management
CHF, Antibiotics use,HTN, PVD
CHF, New diabetes treatments.
CHF; GI-UC, IBS, Celiac
COPD, weight loss
Coumadin titration
dealing with insurance challenges
dementing syndromes; end of life care
Dermatology
dermatology, rheumatology
DM / asthma / Tb
EM boot camps
ethics in medical care
Fatigue
gastroenterology topics
geriatric care in primary care setting
Geriatric diseases and management
GLP, DPP, SGL inhibitors and demystifying them
Headache in Pediatrics
Hormone management
Hospice and Workers comp
HTN ,DM, Heart DZ
hyperlipidermia
Hypetension/brief updates in different specialties
Hypothyroidism, HTN, Arthritis
I always appreciate ur choices
IBS management,physician burnout management
Insulin pump therapy for people with uncontrolled diabetes
interpretation of insulin pump and CGM downloads
Lipids Mgmt/ diabetes mgmt
Mental health issues
Obesity meds
obesity; holistic medicine

opiods,dermatalogy
Pain Managment
Palliative care
Pediatrics primary care
Perhaps some common pt visits like recurrent UTI and rhinosinusitis.
Pre-op clearance in primary care
prostate cancer and gyn cancer
provider role difficulties
Psychiatric disorders, orthopedic problems, hypertension
Psychiatry in primary care
rashes, suspicious moles, atrial fib, CVA
Review on Pharmacology pertaining to primary care
SKIN
Skin and chronic wound care strategies, Womens' health issues, geriatric considerations
sleep apnea; neuropathy
STD testing, antibiotic resistance, prep
Stem cell use
stem cells
stroke
The misunderstood topic of Natural thyroid replacement and the bioidentical approach to better health. More functional medicine. My patients are asking for more a more natural approach to health care and all the CME is devoted to the next pharmacological answer.
Treating patients with multimorbidities
Treatment of COPD
UTI review, URI review
Vascular disorders. Musculoskeletal disorder and women and Men's health
Women's health

Additional Comments

Change topics from 1 conference to others
Convenient webinar format that was interactive and valuable information overall.
Excellent
Excellent lectures
excellent program
Excellent program!
Give us more credits for free
good session!
Great
Great web conference!
I am actually retired from active practice
I thank you NACE for having this webinar available, remotly.
I totally enjoy and love the presentations. I truly look forward to them and i tell everyone to join in.
It was hard to hear
It's time for the faculty to be able to answer questions on Niacin, REd Yeast Rice, Black Cohosh, Estradiol vs Estrogen synthetic, progesterone vs progestin.

My sound didn't work throughout the whole presentation even though other sites on my computer had sound
None
On west coast, but I got up at 5 am
Online broadcast is very convenient
Online connectivity was not always speeding. was disconnected several times. unsure if this was on my side or yours
Poor audio initially and lack of slides with questions to answer that I noted x 3 during the presentations.
Thank You
Thank you.
Thanks for a great program!
Thanks for the learning experience
Thanks for the outstanding,well coordinated CME meeting and very helpful logistical staff members.
Thanks. I love NACE!
These conferences r greatnr
This program was outstanding!
Very disappointed with the webinar. Information regarding what internet software is supported. This would have avoided a lot of stress ahead of time.
Well presented
Wish I could hear the presentation again.