Emerging Challenges In Primary Care: *2017*

Activity Evaluation Summary

CME Activity: Emerging Challenges in Primary Care: 2017
Saturday, May 6, 2017
Hilton Baltimore
Baltimore, MD

Course Director: Gregg Sherman, MD

Date of Evaluation Summary: June 1, 2017

NACE NATIONAL ASSOCIATION FOR CONTINUING EDUCATION

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In May 2017, the National Association for Continuing Education (NACE) sponsored a CME program, ***Emerging Challenges in Primary Care: 2017***, in Baltimore, MD.

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 Hyperlipidemia, Pseudobulbar Affect, Diabetes, Idiopathic Pulmonary Fibrosis and Alpha-1 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.

Three hundred twenty six healthcare practitioners registered to attend ***Emerging Challenges in Primary Care: 2017*** in Baltimore, MD. One hundred eighty six healthcare practitioners actually attended this conference. Each attendee was asked to complete and return an activity evaluation form prior to the end of the conference. One hundred eighty five 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 live 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 5.0 *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 6 contact hours of continuing education (which includes 3.25 pharmacology hours).

Integrated Item Analysis Report

What is your professional degree?

Response	Frequency	Percent
MD	82	44.32
DO	1	0.54
NP	87	47.03
PA	9	4.86
RN	3	1.62
Other	3	1.62
No Response	0	0.00

What is your specialty?

Response	Frequency	Percent
Primary Care	123	66.49
Endocrinology	8	4.32
Rheumatology	1	0.54
Pulmonology	3	1.62
Cardiology	5	2.70
Hospitalist	10	5.41
Psychiatry/Neurology	5	2.70
ER	3	1.62
Gastroenterology	8	4.32
Other	48	25.95
No Response	2	1.08

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

Response	Frequency	Percent
None	21	11.35
1-5	27	14.59
6-10	21	11.35
11-15	22	11.89
16-20	28	15.14
21-25	14	7.57
> 25	47	25.41
No Response	5	2.70

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

Response	Frequency	Percent
None	21	11.35
1-5	26	14.05
6-10	27	14.59
11-15	22	11.89
16-20	23	12.43
21-25	17	9.19
> 25	45	24.32
No Response	4	2.16

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

Response	Frequency	Percent
None	99	53.51
0-1	49	26.49
2-3	8	4.32
4-7	4	2.16
8-10	3	1.62
>10	1	0.54
>15	3	1.62
No Response	18	9.73

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:

Response	Frequency	Percent
None	57	30.81
0-1	48	25.95
2-5	33	17.84
6-10	15	8.11
11-15	4	2.16
16-20	2	1.08
>20	4	2.16
No Response	22	11.89

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

Response	Frequency	Percent
None	26	14.05
1-5	51	27.57
6-10	37	20.00
11-15	19	10.27
16-20	13	7.03
21-25	16	8.65
> 25	18	9.73
No Response	5	2.70

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.

Response	Frequency	Percent
Yes	146	78.92
Somewhat	37	20.00
Not at all	0	0.00
No Response	2	1.08

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.

Response	Frequency	Percent
Yes	150	81.08
Somewhat	34	18.38
Not at all	0	0.00
No Response	1	0.54

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.

Response	Frequency	Percent
Yes	141	76.22
Somewhat	43	23.24
Not at all	0	0.00
No Response	1	0.54

Upon completion of this activity, I can now: Review the epidemiology and impact of Pseudobulbar Affect (PBA); Recognize the importance of early recognition of PBA in primary care; Describe diagnostic tools and criteria for objective diagnosis of PBA; Discuss therapeutic options for PBA.

Response	Frequency	Percent
Yes	153	82.70
Somewhat	25	13.51
Not at all	0	0.00
No Response	7	3.78

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.

Response	Frequency	Percent
Yes	134	72.43
Somewhat	27	14.59
Not at all	0	0.00
No Response	24	12.97

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.

Response	Frequency	Percent
Yes	112	60.54
Somewhat	30	16.22
Not at all	0	0.00
No Response	43	23.24

Overall, this was an excellent CME activity:

Response	Frequency	Percent
Strongly Agree	129	69.73
Agree	49	26.49
Neutral	2	1.08
Disagree	1	0.54
Strongly Disagree	1	0.54
No Response	3	1.62

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

Response	Frequency	Percent
Strongly Agree	134	72.43
Agree	47	25.41
Neutral	2	1.08
Disagree	0	0.00
Strongly Disagree	1	0.54
No Response	1	0.54

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

Response	Frequency	Percent
Strongly Agree	132	71.35
Agree	45	24.32
Neutral	4	2.16
Disagree	0	0.00
Strongly Disagree	1	0.54
No Response	3	1.62

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

Response
More comfortable with PCSK9 prescribing. Check for AIAT deficiency and COPD. Use ASCUD and DM status to be aggressive with metabolic treatment
Patient education
Using PCSK9 in practice. Hypoglycemia. Using GLP-1 in diabetes management
Re-evaluate and increase the secondary agents for DM especially SGLT-1 anti, GLP-1 RA. And awareness of Dx PBA on existing patient that Dx bipolar with depression
New medication management techniques/emerging research studies
Better patient history. Not be afraid of initiating GLP-1 RA and SGLT-1 therapy
Better evaluation of patient with COPD, IPS, review treatment of lipid management and DM
Better treatment of DMII. Testing for AATD. Diagnosing pseudobulbar affect
Better lipid control, tight glucose maintenance, introduce SGLT-2, GLP-1, screening and treating PBA
Assess for these disorders specifically. Refer patient to specialist when necessary, order appropriate test and treat
Get good history for PBA to differentiate between PBA and bipolar
Effective treatment for managing diabetic patients. Better recognition/consideration of PBA
Consider using PCSK9 inhibitor for patients with hypercholesterolemia reluctant to oral therapy
Patients that meet the criteria for use of PCSK9 inhibitors. How to diagnose or suspect PBA in patients that I encounter. How to manage DM type II patients on oral med insulin
Consider anti-emetics med. x nausea with GLP-1. Choosing long/shorter GLP-1 med based on issue of need for focus on fasting versus post-prandial BG. Awareness of PBA in my patients with neurologic insult or injury
Better understanding of SGLT
New cholesterol meds. Use SGLT-2 inhibitor
Incorporation of GLP and SGLT2 inhibitors

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

Response
Better use of statin and non-statin drugs
If CPK isn't elevated, patient probably doesn't have a statin intolerance. Do not use a SGLT2 if patient has urinary retention and refer them to urology. Diagnosing and treating patient with PBA
Information obtained at this conference will help to keep me up to date with best practices in primary health considering that I'm in specialty setting (Gastroenterology)
Treat patients with COPD for AAT
Use of CNS-LS tool. ID of chronic changes in CXR. Use of GLP-1 with basal insulin
Identifying appropriate treatment options for best patient care and outcome based on guidelines
Have been skeptical of new diabetes agents, but feel more likely to use now. This activity will improve my management of hyperlipidemia with statins
Use different dosages learned today
Using nonstatin therapy more often. Screen for PBA more often. Consider using GLP1RA + SGLT2 therapy more often
Regular adjust medications for T2D
Awareness of PBA Dx and Tx. IPF and ABTD treatment and diagnosis, apply this knowledge
YouTube video. End of presentation questions was interactive
I work in a free/low income clinic that would make it difficult to maximize most of these strategies due to cost of tests/meds
Include PBA in differential. Feel more empowered in combination therapy in T2DM, earlier recognition of IPF
Diagnosis of PBA
Verbal screening for PBA in at risk populations. Never accept basilar crackles and/or chronic changes on CXR as benign findings
Combination basal insulin and GLP-1 RA. Recognize post-bulbar affect
In patients with muscle pain - consider reducing the statin, consider adding a non statin to lifestyle changes in patients refusing a statin. Do not give SGLT2 to DM Type 1
Review material, discuss with expert, etc.
Use newer DM meds. Be more aggressive with COPD, Rx patient and increase screening for PBA
Screening for PBA. Identifying appropriate statin dosing and calculation of CV risk
Use of non-statins, identifying PBA. Use of SGLT2 inhibitors for treatment of diabetes. Better understanding of new drugs for diabetes can initiate
Diabetic management, lipid management, PBA management, IPF, AATD
Approach to insulin, GLP-1, especially with PBA now this is emphasized in my new knowledge
Implementing appropriate dose of statins and adding PCSK-9 when appropriate. Stepping up diabetic therapy appropriately; especially use of GLP-1 RA for appropriate post prandial high glucose as well as FBS
Adding Zetia to statin therapy then using a PCSK9. Checking CPK or cutting statin dose in half for muscle aches. Work with Diabetes specialist to manage patients with DM
Increased my diagnostic skills and treatment of COPD, IPF
Closely looking at postprandial glucose, using guidelines
Correct use of new drugs for Diabetes. Screen more for Alpha-1. New lipid guidelines for Rx
Asking the 2 questions to determine whether or not the patient has PBA. Do not ignore basal crackle (bilateral)
Screen more for pseudobulbar affect
Questions to ask to rule in PBA; CT findings specific to IPF; dose adjustments and c/o affect on lowering CDL
Review current use of statins
Reduce LDL-C to less than 70 for high risk patients. then SGLT-2 and GLP-1 to reduce A1C
Explaining how meds work to patients. Strategies to improve adherence
Manage hypoglycemia and recognize PDB and IPF and treatment. Test for IPF
Change of statin therapy and supplementing medications. Managing diabetes, GLP-1
Evidence based addition of non-statin for lipid management. Use of SGLT-2 inhibitors for T2DM. Ask about PBA symptoms; appropriately work up for IPF

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

Response
Better management of patients with DM using SGLT-2, GLR1 and lipid and cholesterol management using PCSK9 inhibitors, identifying and treating patients with PBA, and management of patients with IPF and COPD
More aggressively treat hyperlipidemia and employ risk stratification more often
Use of new medications for diabetes and hyperlipidemia management; improved recognition of PBA; improved understanding of pulmonary fibrosis and COPD
Managing patients with hyperlipidemia with additional therapy to achieve a goal. Management of patients with DM to prevent incidence of increased CVD
Improving diabetic care and lipid care
Improve cholesterol level. Combine meds
Recognition of PBA, IPF, and incorporating the various testing and imaging strategies, will also try to continue my efforts to purchase a PFT
Dx and Tx of topics covered
Consider nonstatin Rx of hyperglycemia. Diagnosis of IPF. Better options for DM Rx. Importance of checking for AATD in app. clinical evaluation
GLP1 RA and basal insulin
Taking seriously basilar crackle
My practice is limited to treating patients who have acute pain secondary to car accidents or work related injuries
Identify PBA. When to consider anti PCSK9 treatment in lipid management. Application of SGLT-2 vs bLPIRA treatment. IPF evaluation/treatment
SGLT-2 indication and initiation use
To consider differential diagnosis of IPF and AATD
Know that there are other options in treating DM2. Recognize PBA and IPF and be able to address/refer
Proper diagnosis and risk classification, evidence based disease management
I will ask head injury patients about crying/laughing matching mood. I will be more likely to screen COPD patients for AATD
Partner with specialists to learn more and effectively treat/support. Combination of GLP-1/basal insulin treatment with better awareness of risks, for example CV risks. Use of tools to better assess PBA. 1 in 3 patients with neurological dx (stroke, TBI, etc.) have PBA
GLP-1 additions to therapy
PBA recognition
Improve documentation to support medical decisions
Be more aware of PBA in doing histories. Be more aware of GLP-1 RA impact on post prandial control with insulin. Use of SGLT-2. Be aware of basilar crackles and assessment
Screen for Alpha-1 patients
Precautionary use of SGLT2 with Type 1 DM. Strategies in identifying PBA. Ordering HRRT to diagnose type of IPF when other workup inconclusive
Use ASCUD risk calculator/mod risk factors. Modifying Rx based on fasting. Use GLP with basal insulin in DM control
Screen COPD patients for AATD; think about anti-PCSK9 therapy in patients with unmanaged hyperglycemia. Consider GLP-1 agonist in place of raising dosages
Ask about laughing/crying c/u control. Basal insulin and GLP can be used together
Treatment of high risk ASCVD patients
Use CNS-liability scale in my practice for suspected PBA
Adding DM medications. Altering meds for HLD based on LDL
When to use PCSK9 monoclonal Ab therapy; consider role of SGLT2 and GLP1 RA therapy for better DM control
Adjustment and choice of patient. Better understanding of Rx of PBA
Add SGLT2 therapy and GLP1 RA therapy. Consider diagnosis of PBA
Treat hyperlipidemia. Treat type II DM patients with NASH/cirrhosis
Better counseling and Rx
T2DM is better with combination therapy

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

Response
Combination therapy in T2DM is better when diabetes is well controlled. Be aware of PBA and treat properly
Patient education
Use of combination therapy in management of T2DM
Diagnosing other causes of symptoms
Better understanding of screening tools for all areas discussed, enhanced understanding of treatment options for diseases discussed, better knowledge of PBA and IPF

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

Response	Frequency	Percent
Very likely	131	70.81
Somewhat likely	37	20.00
Unlikely	0	0.00
Not applicable	14	7.57
No Response	3	1.62

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

Response	Frequency	Percent
Within 1 month	112	60.54
1-3 months	41	22.16
4-6 months	7	3.78
Not applicable	19	10.27
No Response	6	3.24

In terms of delivery of the presentation, please rate the effectiveness of the speaker: Mahfouz El Shahawy, MD, MS - Lipid Management:

Response	Frequency	Percent
Excellent	90	48.65
Very Good	60	32.43
Good	23	12.43
Fair	3	1.62
Unsatisfactory	1	0.54
No Response	8	4.32

In terms of delivery of the presentation, please rate the effectiveness of the speaker: Richard S. Beaser, MD - Diabetes and Vascular Disease:

Response	Frequency	Percent
Excellent	116	62.70
Very Good	56	30.27
Good	7	3.78
Fair	0	0.00
Unsatisfactory	0	0.00
No Response	6	3.24

In terms of delivery of the presentation, please rate the effectiveness of the speaker: Richard S. Beaser, MD - Diabetes and GLP-1:

Response	Frequency	Percent
Excellent	129	69.73
Very Good	42	22.70
Good	6	3.24
Fair	0	0.00
Unsatisfactory	0	0.00
No Response	8	4.32

In terms of delivery of the presentation, please rate the effectiveness of the speaker: Gustavo Alva, MD, DFAPA - Pseudobulbar Affect:

Response	Frequency	Percent
Excellent	153	82.70
Very Good	21	11.35
Good	1	0.54
Fair	0	0.00
Unsatisfactory	0	0.00
No Response	10	5.41

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

Response	Frequency	Percent
Excellent	135	72.97
Very Good	17	9.19
Good	2	1.08
Fair	0	0.00
Unsatisfactory	0	0.00
No Response	31	16.76

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

Response	Frequency	Percent
Excellent	116	62.70
Very Good	21	11.35
Good	3	1.62
Fair	0	0.00
Unsatisfactory	0	0.00
No Response	45	24.32

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

Response	Frequency	Percent
Excellent	131	70.81
Very Good	31	16.76
Good	8	4.32
Fair	1	0.54
Unsatisfactory	0	0.00
No Response	14	7.57

To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Richard S. Beaser, MD - Diabetes and Vascular Disease:

Response	Frequency	Percent
Excellent	142	76.76
Very Good	30	16.22
Good	4	2.16
Fair	2	1.08
Unsatisfactory	0	0.00
No Response	7	3.78

To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Richard S. Beaser, MD - Diabetes and GLP-1:

Response	Frequency	Percent
Excellent	141	76.22
Very Good	29	15.68
Good	4	2.16
Fair	2	1.08
Unsatisfactory	0	0.00
No Response	9	4.86

To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Gustavo Alva, MD, DFAPA - Pseudobulbar Affect:

Response	Frequency	Percent
Excellent	145	78.38
Very Good	22	11.89
Good	5	2.70
Fair	1	0.54
Unsatisfactory	0	0.00
No Response	12	6.49

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:

Response	Frequency	Percent
Excellent	138	74.59
Very Good	21	11.35
Good	1	0.54
Fair	0	0.00
Unsatisfactory	0	0.00
No Response	25	13.51

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:

Response	Frequency	Percent
Excellent	126	68.11
Very Good	21	11.35
Good	1	0.54
Fair	0	0.00
Unsatisfactory	0	0.00
No Response	37	20.00

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

Response	Frequency	Percent
Topics covered	130	70.27
Location/ease of access	126	68.11
Faculty	35	18.92
Earn CME credits	146	78.92
No Response	7	3.78

Future CME activities concerning this subject matter are necessary:

Response	Frequency	Percent
Strongly agree	95	51.35
Agree	58	31.35
Neutral	20	10.81
Disagree	0	0.00
Strongly Disagree	0	0.00
No Response	12	6.49

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

Response
COPD. Hematology topic

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

Response
Arthritis - autoimmune and Gout. Chronic pain or short term for PCP management. Weight management or motivation for health habits
Hepatitis C. Hypertension
Arrhythmias. DM. HBP. Cardiovascular Disease
Lyme's Disease. Peripheral Neuropathy - workup. Lung cancer update managements
Hospitalist. Pre-op/post-op/intra-op concerns. Cardiology-specific conditions
Sarcoidosis, Tropical Medicines
Women's Health
Differing management for viral and bacterial URI. Management of sprains. Screening of hearing loss, what screening results mean? Treatment of acute chronic bronchitis/asthma treatment - outpatient
Hypertension. Endocrine. Fractures. Skin disorders
Include topics in Pediatrics
GI. Cancer
DVT and anticoagulant therapy. Dermatology
Hospice/Palliative Care
Women's Health (ex - uterine fibroids, menopause). Elderly health issues (ex - aging and its impact)
Heart failure. Atrial Fibrillation. Hypertension
Adolescents and Primary Care. Non-pharmacological lipid management. Spirometry values interpretations
Cardiovascular treatment, management, compliance and social economics
Menopause evaluation/management, anxiety, weight loss
Cardiovascular disease. Septic ulcers. Kidney Disease. Polycystic Kidney Disease. Renal dysfunction/failure and management
Pain management, addiction
Interpretation of CXR, extremities x-ray
Infectious Disease topics
Anything GI related and/or topics related to Type 1 Diabetes
GI diseases, pain management
Developmental disabilities. PFTS DLCO
Pediatric topics please include in the future
More psychiatric topics along with the latest update for primary care. Latest update of medical treatment for HTN - Diabetes, drug addiction/opioids
Pain both opioid and non-opioid treatments to include neuropathic meds
Stroke, Rheumatologic disorders
IBS and pain management
Alzheimer's Disease. Hypertension. PTSD. Drug abuse/management
Acute and chronic pain management. Fibromyalgia. Rheumatoid Arthritis
Thyroid disease. Rheumatology
More on COPD and Pseudobulbar. Also, prostate cancer screening guidelines
More GI topics - chronic pancreatitis, diagnosis, treatment, and management
Depression - Bipolar. Anxiety. ADD/ADHD. Abdominal pain. Dizziness
Asthma, Dermatology, current immunizations, office ortho
Gastroenterology outside IBD. Hepatic autoimmune hepatitis, IBS, GIST
COPD/Asthma, CAD
Diastolic dysfunction. Personalized treatment in Oncology. Aortic Stenosis
Dual Antiplatelet Therapy. Ticaopeler, Parrigree vs Plavix
Transgender Care
Cardiology, Endocrinology, practical skills (suturing), Emergency Medicine

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

Response
Reviewing Infectious Disease topic
Obesity management - pharm vs surgery. Thyroid disorder. CVD Dx and Rx
Heart Failure, HTN, Hep C, and HIV
Comorbidities associated with substance use disorders
HIV - comprehensive management, status in 2017
HTN. CHF. CKD. Lab interpretations
Psych meds
Traumatic brain injury. Fibromyalgia. Sickle Cell Anemia
Chronic kidney disease, Hepatitis
Psychiatry. Personality disorder. DVT. Derm
Critical Care. Acute Care. Surgery. Cardiac surgery
EKG interpretation. PFT test. Management of back pain
IBD. HPV
New oral anticoagulant drugs
Strategies for healthy lifestyle (new). Cognitive Behavioral Therapy
PCOS, asthma, STI, HTN, Vaginitis
Psoriasis. Celitis
Hypertension, cancer screening
I would like CME related to pain management; safe prescription, etc. and palliative approaches
Nutrition, IBS, dizziness/vertigo, differentiating COPD and Asthma, Pseudobulbar Affect (so sad I missed this lecture), Dementia, Menopause
PTSD; more geriatric topics; Dementia
Hypertension
Vitamin D deficiency. Dermatology
AFib
Neuropathies, movement disorders, Dementia
Opioid abuse
Geriatric-specific topics, Dementia, polypharmacy, Palliative therapies, blood dyserasias, metabolic disorder
Stroke, Syncope
Infectious Disease update on IBC review Dx options, unresponsive OP - inp and pneumonia, neuro optic anemias, short/long term effects of steroid Rx, C diff counts, past 2 presentations were better because of slides
Osteoporosis, CKD
Cardiac
New treatments for rheumatoid arthritis
Liposarcoma. Acute Erythroderma Syndrome. More on DM management. PFT evaluation. OCD
DM meds and management. End of life decisions. Palliative/hospice. Code status. Sarcoidosis
Thyroid dysfunction and treatment
Dermatology; Lab reviews; EKG interpretations; ENT; Asthma
Diabetes, liver failure, kidney disease, HTN, HLD, COPD, diverticulitis/IBS
Gastroenterology
Concussion treatment
Update DHA guidelines - CVA, MI. Pre post hospital case. Pulmonary topics
Pain management - distinguishing physical pain from psychiatric/emotional pain and how to treat effectively. More like Dr. Alva's sessions
CHF
Topics on Rheumatology, radiation/Oncology treatment, Neurosurgery - DBS, spine adjustments
Pediatric topics

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

Response
Drug addiction. Migraine. Thyroid disorders
Thyroid disease and management. Hypertension
CHF, Oncology/Hematology topics
Open
Cancer/aging/stroke
Oncology. Hematology
Orthopedics; Dermatology; Psychiatric illnesses; anxiety, Depression; pain management
Buprenorphone for opioid dependence/treatment protocols. Medical marijuana
Hep C diagnosis and treatment. Depression management
Dermatology, Psychiatry and Orthopedics in Primary Care
CHF. Treatment for Osteoporosis, pneumonia, infectious disease
Pulm HTN
Obesity - weight loss modifications
Heart disease. Arthritis
Diabetes. Gyn for PCP. Derm for PCP
Musculoskeletal/ortho issues. HTN. Migraines, GI
Epilepsy. Cardiac arrhythmias. Rheumatoid arthritis. Psoriasis. Inflammatory Bowel Disease. Bed bugs
Cardiac arrhythmias
Sleep Medicine - awareness about sleep apnea. Topics on use of PAP therapies, use of PAP in cardiovascular, weight management, diabetes, excessive daytime sleep, snoring
Hypertension, Coronary Artery Disease
Any new Rx
Increasing incidences of opioid abuse in supposedly short term use for mild to moderate pain
Treatment of PVD
Oncology please!
Cardiology, Neurology, Pulmonology
Lung cancer, cardiomyoma, Pulm HTN
Advances in the diagnosis and treatment of Alzheimers Disease
Medical marijuana, EKG review, pulmonary hypertension, new cardiovascular agents, treatments of bipolar illness

Additional comments:

Response
Lipids - too many pretest questions. DM - too many pretest questions
Thank you again for a wonderful conference. Would prefer a room with WiFi access
The location is great
Excellent conference. I enjoyed the interaction with response remotes. Really enjoyed the topics/discussion
Excellent presentations
Try Hilton in Baltimore County
Good conference and moderator!
Room got very cold. Lunch - mustard on turkey too hot. Dr. Shahawy very difficult to understand. Dr. Rahaghi was excellent
All were very informative, especially Dr. Gustavo and Dr. Rahaghi
Excellent symposium
Also suggest that vendors attend seminars to advertise products and programs that benefit the underinsured
Location - ran out of breakfast food, no internet access for downloading slides, no option obvious on website to download slides. There should be a link on the website

Additional comments:

Response
Excellent speakers
Dr. Rahaghi was excellent! Also enjoyed Dr. Gustavo
No video - please!
Speakers excellent. Topics very informative
Excellent - thank you!
Thank you!
Any chance of increasing your pool of female speakers?
Fantastic conference - keep up the great work
It's very good and helpful program. Willing to attend future CME by NACE
Slides in talk 1 to 3 were overload, with small type face and poor choice of contrast with background colors. Speakers did not have laser pointers to highlight what was important. Overall very poor. Too many drug abbreviations and "nicknames"
This year's faculties are very knowledgeable and topics are excellent
Agree that PBA is underdiagnosed! Thank you!
Excellent - my 5 hour drive was definitely worth this day
Consider engaging nurse/APN speakers
Very good program - good facility
Dr. Shahawy was difficult to understand at times. Review registration process to decrease lines. Announce that schedule changed
First speaker was difficult to understand. Audio not good. PBA speaker - great presentation!
Entertaining and informative
Excellent
Nice job. Thanks. Do not need one hour lunch break, can be half hour
Unfortunately I was only able to attend 2 lectures (schedule conflict). Thank you for your enjoyable and informative conferences
Too many pre and post test questions
Wonderful and great speakers
Would like to see technique classes on suturing, wound care, splinting, and wrapping, PFT technique and interpretation, EKG technique and interpretation, ultrasound
Please add NPs/PAs to your line-up of faculty. There are some excellent non-MD speakers out there to increase diversity of the mix
Too busy slides, questions too much data too quickly absorb. Bullet points should be put in booklet as biggest take-home points. Too many acronyms! Brooklet poorly designed
Excellent speakers
Internet access should be available in conference room. Signs to point where the conference room will be upon entering hotel facility. More space available in hallway for registration and food service (breakfast). I like these key pads better than previous. Juice with continental breakfast
Thank you all for a great presentation on my first attendance to NACE
Great learning opportunity. Thanks for providing lunch
Thanks
Speakers should have clear speech to understand lecture delivery
Spend too much time on doing pre-tests and tests in general. Need to spend more time educating and having discussions. Understand you are trying to keep participants engaged, but it is frustrating when we come to learn, not take a test. If you do the tests prior to the discussion, best to give answers/rationale right after. Will certainly keep this in mind when considering attending a NACE conference in the future. Would benefit more from being able to hear more and ask more questions after presentation in which everyone participates. Because time was limited, questions sometimes asked of speakers individually after sessions. When everyone could have benefited from discussion. This improved with progression of the day. Like case studies. Thank you!
Highly satisfactory meeting

Additional comments:

Response
Consistent CME presentations over the years which are entertaining and informative. I would like to see more offerings in Baltimore
Speakers very knowledgeable, but sometimes talked too fast, but were enjoyable and interesting
Thanks NACE! Looking forward to some conferences in "Long Island"
Good presentations
I would gladly pay for condiments for my sandwich. I found the speaker difficult to hear clearly - sometimes due to accent
Great conference. Made complex topics more clear and understandable. Thank you for providing free conferences
Thank you
It would have been nice to have condiments for the sandwich
Not enough time for questions for lipid management. Poor acoustics
Dr. Shahawy's accent made it difficult to understand everything he said
Thank you!
Thank you!
Overall the conference and the topics are very good
some questions poorly worded
Thank you!
Very good program
Dr. Alva was a fantastic speaker! Very dynamic, as was Dr. Rahaghi