Emerging Challenges In Primary Care: *2017*

Activity Evaluation Summary

CME Activity: Emerging Challenges in Primary Care: 2017
Saturday, June 3, 2017
Marriott Atlanta Century Center/ Emory Area
Atlanta, GA

Course Director: Gregg Sherman, MD

Date of Evaluation Summary: June 13, 2017

NACE NATIONAL ASSOCIATION FOR CONTINUING EDUCATION

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In June 2017, the National Association for Continuing Education (NACE) sponsored a CME program, ***Emerging Challenges in Primary Care: 2016***, in Atlanta, GA.

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 Diabetes, Pseudobulbar Affect, Lipids and Idiopathic Pulmonary Fibrosis.

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.

Four hundred and ten healthcare practitioners registered to attend ***Emerging Challenges in Primary Care: 2017*** in Atlanta, GA. Two hundred and thirty-eight 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. Two hundred and thirty 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 Credits*™. 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	85	36.17
DO	4	1.70
NP	119	50.64
PA	10	4.26
RN	12	5.11
Other	1	0.43
No Response	4	1.70

What is your specialty?

Response	Frequency	Percent
Primary Care	182	77.45
Endocrinology	2	0.85
Rheumatology	0	0.00
Pulmonology	4	1.70
Cardiology	10	4.26
Gastroenterology	2	0.85
ER	2	0.85
Hospitalist	7	2.98
Psychiatry/Neurology	9	3.83
Other	55	23.40
No Response	1	0.43

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

Response	Frequency	Percent
None	16	6.81
1-5	31	13.19
6-10	52	22.13
11-15	33	14.04
16-20	31	13.19
21-25	20	8.51
> 25	52	22.13
No Response	0	0.00

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

Response	Frequency	Percent
None	133	56.60
0-1	57	24.26
2-3	17	7.23
4-7	5	2.13
8-10	5	2.13
> 10	3	1.28
> 15	1	0.43
No Response	14	5.96

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

Response	Frequency	Percent
None	18	7.66
1-5	18	7.66
6-10	36	15.32
11-15	34	14.47
16-20	38	16.17
21-25	22	9.36
> 25	67	28.51
No Response	2	0.85

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	55	23.40
0-1	74	31.49
2-5	46	19.57
6-10	23	9.79
11-15	10	4.26
16-20	8	3.40
>20	7	2.98
No Response	12	5.11

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

Response	Frequency	Percent
None	29	12.34
1-5	55	23.40
6-10	46	19.57
11-15	32	13.62
16-20	30	12.77
21-25	17	7.23
> 25	22	9.36
No Response	4	1.70

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	184	78.30
Somewhat	46	19.57
Not at all	2	0.85
No Response	3	1.28

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	194	82.55
Somewhat	38	16.17
Not at all	1	0.43
No Response	2	0.85

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	205	87.23
Somewhat	13	5.53
Not at all	2	0.85
No Response	15	6.38

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	208	88.51
Somewhat	20	8.51
Not at all	1	0.43
No Response	6	2.55

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	50	21.28
Somewhat	1	0.43
Not at all	0	0.00
No Response	184	78.30

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	183	77.87
Somewhat	27	11.49
Not at all	1	0.43
No Response	24	10.21

Overall, this was an excellent CME activity:

Response	Frequency	Percent
Strongly Agree	180	76.60
Agree	53	22.55
Neutral	2	0.85
Disagree	0	0.00
Strongly Disagree	0	0.00
No Response	0	0.00

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

Response	Frequency	Percent
Strongly Agree	180	76.60
Agree	53	22.55
Neutral	1	0.43
Disagree	0	0.00
Strongly Disagree	0	0.00
No Response	1	0.43

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

Response	Frequency	Percent
Strongly Agree	174	74.04
Agree	50	21.28
Neutral	8	3.40
Disagree	0	0.00
Strongly Disagree	0	0.00
No Response	3	1.28

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

Response
How to diagnose and treat PBA
Apply information to daily clinical practices
Use of GLP1, SGLT, diagnosis of IPF
Interactions, side effects
Incorporating GLP1 into the management of diabetes. To recognize and treat pseudobulbar affect
Start using CNS-LS, screen COPD patients for AATD
More timely medication dose adjustments
Diagnosing early and treating appropriately
Add GLP1 to insulin with poorly controlled diabetes. Recognize PBA and utilize proper medications. Identify IPF - know which tests to order for IPF
Initiated GLP1 and SGLT2 in T2DM, recognizing PBA, recognizing patients that may have IPF and process for diagnosis
Improving lipid management. Identifying IPF
Addition of diabetic medications for better diabetic hgbA1c control. Improve control of lipids
Learned role of antibody therapy for LDL-C reduction. Use new guidelines for screening for AATD. Importance of postprandial hyperglycemia for DM complications
Aggressive therapy and implementation of and using right agents
Early consideration of SGLT2 meds alpha GLP1
Screening my COPD patients for alpha 1AT and/or IPF using PFT's and radiogram as primary screening rather than radiogram alone. Decreasing statin rather than DC in patients demonstrating statin intolerance
Using SGLT2 and GLP1 in treating diabetes mellitus. Effectively treating hyperlipidemia. Referring PBA. Being more familiar with IPF. Treating COPD and diagnosing AATP

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

Response
Identifying IPF/treatment, lipid management, successful management of DM
Rx and LDL more aggressively. Diagnosis of IPF earlier and refer to transplant facility earlier
New Rx for NIDDM, IPF, Pseudobulbar affect, dyslipidemia and COPD
Importance of looking at post prandial glucose levels. Weight issues benefit with GLP1. PBA and diagnosis criteria
Put more effort in helping patients normalize their post prandial hyperglycemia. Be more vigilant about PBA and possibly treat more
GLP1 Rx. Dextromorphan Rx. PBA diagnosis
How to diagnose and treat PBA. More knowledgeable about SGLT2 and GLP1 RA medications
Really review meds again based off of cardiovascular risk
Treatment of PAP, Hg cholesterol and DM
Educate regarding need for early intervention, healthy living, health consequences
Adding new agents and in discontinuing older agents for better control
Ezitimibe treatment first. CNS liability scale. New drug for diabetes, SGLT. PCSK9 for LDL reduction. IPF PFT/XRt. HRCT. Dextromethropan. Quinidine for PBA
Identify patients with various processes
Use of Zetia
Augmentation alpha antitrypsin Rx. LABA/LAMA for Gold C and Gold D. No steroids for mild COPD Gold A and Gold B
Consider SGLT2 use in certain patients. Diagnosis and treatment of PBA
Increase awareness of early recognition of IPF
Specific. Detailed
Use more GLP1 agents for DM. Recognize PBA more effectively
Treatment of elevated LDL. Treatment of post prandial elevated glucose. Treatment of restrictive lung disease
I don't work in Primary Care or family practice (Women's Health/Family Planning NP)
Add GLP1 RA to optimize management of T2DM. Evaluate patients for symptoms of PBA
Utilizing CNS liability scale. Add PCSK9 to prescription regimen
Screening for AATD by checking the level in appropriate patient adjusting statin therapy considering other options early as needed for individual patient. Use of SGLT2 and GLP in appropriate population. Careful screening of possible Pda
Assessing for PBA CNS liability
Consider PBA in appropriate cases such as TBI, post stroke... patients. Screening for alpha 1 deficiency - refer for testing
Use Ace/AHA ASCVD risk calculator. Using tools to assess pseudobulbar affect. Adding SGL2 or GLP1 to DM regimen
SGLT2 use, contraindications, benefits
IPF workup/treatment
More aggressive cholesterol management. IPF diagnosis earlier
PBA is not depression. If HgA1c is close to 7, then decrease basal insulin and add
Screening for PBA. Avoid use of ineffective therapies. Niacin. Fenofibrates in HN. Screening and treatment of IPF
Learned how to recognize PBA and what is the etiology
Enhance my knowledge further on the many topics that I was unfamiliar with
Suggest testing for A1AT deficiency for patients not improving with COPD. Check to make sure at risk groups on appropriate dose/type statin
Using a GLP1 and basal insulin good combo to reduce PPG and A1c. Be aware to screen for PBA
Benefits of determined history/physical taking
Increase data collection for HP; specific data guidelines for treatment
Combining basal insulin and GLP medications okay
New ways to monitor and treat hyperlipidemia, need more practice with DM medications
Start using or encouraging PCSK9 inhibitors for continual LDL post using statin and ezetimibil to gain better control prior to referral to cardiology

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

Response
Obtaining a good physical and health history to guide your differential
Treat patients with PBA in our high risk TBI population. Prescribe CHOL meds via guidelines
Appropriate pharm intervention, radiological tests to order, identifying at risk patients
Aggressive treatment using more of the newer medication
Adding GLP-RAs to insulin therapy. Screening for and treating PBA, also recognizing PBA
More utilization of GLP1 and SGLT2
Use PBA liability scale to help diagnose PBA. Need to be more aggressive in starting Statins
It will help improve my diabetes care, lipid management. I will also now be more familiar with PBA. Knowledge of COPD improved
Better cholesterol management, will recognize PBA, test for alpha IAD
Use of SGLT2 and GLT2 medicines in diabetics difficult to control
Use GLP1 receptor agonists. Clinical diagnosis of PBA. Treatment HLD with PCSK9 inhibitor
Only one approved treatment for PBA, Dextramethrapenaril. Use of GLP-1 receptor agonize when intensifying therapy for diabetes. Can be GLP and basal insulin. Always start with metformin treatment as it is free. GLP-1 RA is good for high CV risk patients. Use ezetimide if LDL high
Obtain better PMH to better diagnose PBA and integrate new medicines presented today
Use of long acting GLP1 RA in patients with gastroplasia consider using CHS-LS
Educate patient. Review side effect profile of medication
Adding GLP1 therapy earlier
Sequence of drug addition for elevated LDL. Drug management for Pseudobulbar Affect
Minimize hypoglycemia
Consider PBA as differential diagnosis
Add SGLT2 and GLP t help with A1C and increase fluid volume. These may reduce weight and blood pressure
I will try to treat patients according to the guidelines - modify my treatment
I do very little in these areas - practice is basically clinical research
Implementing SGLT2 and GLP, therapy with diabetes workup/diagnosis ILD/IPF, considering PBA with traumatic head injury and treatments
Review diabetic patients meds for hypoglycemia events and add SGL
Take a closer attention to the new drugs, lipid management
Screen, treat, and refer more efficiently
I work in pediatrics, most not applicable, except POA in teen athletes
Screen for PBA in population at risk. Consider use of GLP1 RA and/or SGLT2 to reach goal HgbA1c
Management of hyperlipidemia with PCSK9s - DOC Ezetimoula. Use of PCSK9s as monotherapy. ASCVD risk factors
Not in clinical practice
To better manage diabetic patient. Identify pseudobulbar affect patients and treat. Control of resistant hypertension
Acting early on basal insulin and GLP1. Medication readjustments
Incorporate GLP-1 to reduce post prandial hyperglycemia. Compare GLP1 RAs for glycemic efficacy. Combination strategies
Lipid management. What pseudobulbar is and treatment
Adding SGLT2 therapy in uncontrolled patients. Assessing for and identifying PBA in patients, monitoring HDL closely and adding Zetia
Use scales for measurements. Use assessment strategies for medication use
Considering cardiovascular risks when dosing medication for my patients
Updated my practice in that I will broaden treatment options, discovered some of my treatments are outdated
Specific testing for diagnoses. Guidelines for therapy
Recognition of when to use SGLT2 inhibitors when eGFR<60. A 2 mmttg reduction in BP can reduce risk of stroke by 6% and CVD by 4%. Escalate therapy at 3 months if target not achieved. Longer acting GLP1 RAs have greater impact on FBG

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

Response
Low for PBA, IPS
I have more knowledge of how I can be more effective in treating my patients
Using PCSK9 for lowering LDL. Using DM/Q for PBA
Utilize appropriate screening for AATD. Utilize new 2017 quality measures for use of statin therapy. The prevention and treatment of CVD
Be more aggressive
Role of kidney in genetic control. Use of GLP1 receptor with mention to control post prandial BS
Better selection to treatment choices with Rx
SGLT2 inhibitor for lowering CHF, lowering weight, lowering hypoglycemia risk
More frequent use of SGLT and GLP-1 agents
Identify patients and institute meds according to guidelines follow up and manage care. Start using PCSK9 if applicable
Use of GLP1, screening for PBA - med Rx, add Zetia to treat to goal, suspect IPF (cough DOE) - HRCT
Consider using SGLT2 earlier versus later/don't be scared to use GLP1 sooner! Keep PBA in differential/what to Rx first to get PCSK9 paid for/sometimes you need to consider "zebras"
Increase screening, avoid clinical inertia
Evaluation of lab results, chronic conditions and potential effects
Statin LDL>190. PCSK9 high risk patients
Careful exam of T2DM regimen and implement changes to newer agents. Consider PBA and ask about TBI. Increase education for statin use for patients
I will be questioning my father's endocrinologist about these DM meds. Definitely will be more aware of PBA
PBA, GLP1 agonists
Recommendation for screening
As a consultant to family medicine practice make recommendations
Care with hypoglycemia and CVD
More knowledgeable discussion with patient - non primary treater
Treatment of hyperlipidemia. Identification of PBA - recommendations for treatment
Start GLP1 RA and insulin
Importance of using assessment risk to help identify disease process. Clinical guidelines for statin prescriptions. Prioritizing physical assessment and social history
Refer patients with familiar hyperlipidemia for anti-PCSK9 monoclonal antibody therapy. Possibly use more SGLT2 therapy
I will ask more about hypoglycemic episodes - using the costly GLP1 RA and SGLT2 is probably not feasible because most of my patients are uninsured and homeless, but I will have it on my radar for use if possible. I will be more aware of PBA
I may consider GLP-1 before insulin. CNS - liability scale is a scale I would use
Identifying indications/contraindications for SGLT2 inhibitors. Identifying patients with PBA
Treatment with PCSK9, diagnosis of IPF
Learned to better diagnose PBA, IPF, better manage DM, HLD, PBA and IPF, COPD
Recognize IPF, test for A1AT, recognize pseudobulbar affect
Assess PBA in high risk. Check adding GLP1 RA/SGLT2 with Metformin if not controlled
More aware of hypoglycemia combination strategy. Use basal insulin, guideline directed lipid strategyegies, get CT scan if think IPF, think AATD
Use of diagnostic tools. Familiarity with - actions of diabetic add-on drugs (different classes)
Learned to recognize PBA and strategies for treatment. Earlier intervention in diabetes with GLP1 RA and SGLT2. More aggressive use of statins and earlier use
Will definitely use questionnaire for PBA. Use risk calculator for hyperlipidemia. PCSK9 inhibitors
Using PFT's, ext., high resolution CT scan, using GLP and SGLT2 medications
PBA-ask about head trauma. Screen for A1AD

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

Response
Don't be afraid patients use statins in care. The use of SGLT therapy in my diabetic patients. How to identify IPF and work up studies
Earlier use basal insulin, benefit of basal insulin
A patient with GLP1 RA with basal insulin in combination works better. PBA isn't depression. Hypertension and diabetes are high for CV disease. D. statins are highly recommended for CVD
SGLT2 and GLP-1 RA reduces cardiovascular events. GLP 1 RA plus basal insulin combination works better to reduce A1C. Recognizing symptoms of PBA
Although I do specialty tertiary care, will consider diagnostic and therapeutic identification of above discussed topics

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

Response	Frequency	Percent
Very likely	168	71.49
Somewhat likely	40	17.02
Unlikely	1	0.43
Not applicable	20	8.51
No Response	6	2.55

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

Response	Frequency	Percent
Within 1 month	154	65.53
1-3 months	41	17.45
4-6 months	7	2.98
Not applicable	23	9.79
No Response	10	4.26

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

Response	Frequency	Percent
Excellent	156	66.38
Very Good	56	23.83
Good	14	5.96
Fair	0	0.00
Unsatisfactory	0	0.00
No Response	9	3.83

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

Response	Frequency	Percent
Excellent	170	72.34
Very Good	45	19.15
Good	12	5.11
Fair	1	0.43
Unsatisfactory	0	0.00
No Response	7	2.98

In terms of delivery of the presentation, please rate the effectiveness of the speaker: Alejandro Alva, MD - PBA:

Response	Frequency	Percent
Excellent	200	85.11
Very Good	15	6.38
Good	1	0.43
Fair	0	0.00
Unsatisfactory	0	0.00
No Response	19	8.09

In terms of delivery of the presentation, please rate the effectiveness of the speaker: Keith C. Ferdinand, MD, FACC - Lipid Management:

Response	Frequency	Percent
Excellent	195	82.98
Very Good	16	6.81
Good	1	0.43
Fair	0	0.00
Unsatisfactory	0	0.00
No Response	23	9.79

In terms of delivery of the presentation, please rate the effectiveness of the speaker: Fernando J. Martinez, MD, MS - IPF:

Response	Frequency	Percent
Excellent	183	77.87
Very Good	18	7.66
Good	1	0.43
Fair	0	0.00
Unsatisfactory	0	0.00
No Response	33	14.04

In terms of delivery of the presentation, please rate the effectiveness of the speaker: Fernando J. Martinez, MD, MS - Alpha-1 and COPD:

Response	Frequency	Percent
Excellent	38	16.17
Very Good	4	1.70
Good	1	0.43
Fair	0	0.00
Unsatisfactory	0	0.00
No Response	192	81.70

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

Response	Frequency	Percent
Excellent	190	80.85
Very Good	25	10.64
Good	9	3.83
Fair	1	0.43
Unsatisfactory	0	0.00
No Response	10	4.26

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

Response	Frequency	Percent
Excellent	192	81.70
Very Good	28	11.91
Good	7	2.98
Fair	2	0.85
Unsatisfactory	0	0.00
No Response	6	2.55

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

Response	Frequency	Percent
Excellent	205	87.23
Very Good	15	6.38
Good	3	1.28
Fair	1	0.43
Unsatisfactory	0	0.00
No Response	11	4.68

To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Keith C. Ferdinand, MD, FACC - Lipid Management:

Response	Frequency	Percent
Excellent	194	82.55
Very Good	14	5.96
Good	3	1.28
Fair	0	0.00
Unsatisfactory	1	0.43
No Response	23	9.79

To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Fernando J. Martinez, MD, MS - IPF:

Response	Frequency	Percent
Excellent	189	80.43
Very Good	14	5.96
Good	3	1.28
Fair	0	0.00
Unsatisfactory	0	0.00
No Response	29	12.34

To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Fernando J. Martinez, MD, MS - Alpha-1 and COPD:

Response	Frequency	Percent
Excellent	42	17.87
Very Good	3	1.28
Good	2	0.85
Fair	0	0.00
Unsatisfactory	0	0.00
No Response	188	80.00

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

Response	Frequency	Percent
Topics covered	177	75.32
Location/ease of access	157	66.81
Faculty	33	14.04
Earn CME credits	198	84.26
No Response	4	1.70

Future CME activities concerning this subject matter are necessary:

Response	Frequency	Percent
Strongly agree	123	52.34
Agree	92	39.15
Neutral	15	6.38
Disagree	1	0.43
Strongly Disagree	0	0.00
No Response	4	1.70

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

Response
Thyroid disease management
Basic EKG
Autism, stroke (CVA), Schizophrenia, ch. liver disease, fatty liver, hepatitis
Asthma, GI diseases, renal diseases
Women's Health
Ortho
Orthopedics, dermatology, MACRA, MIPS
Dermatology. Orthopedics. Efficacy of non traditional medication (ex supplements, etc.)
Thyroid disorders
Pain management
Thyroid disorder
Cardiac arrhythmias. Obesity problem, nothing is successful so far. Depression topics, CVA, etc. Practical lectures for practitioners, shorter than your research presentations
Weight loss meds
CAD, stroke, HLP
Autoimmune diseases
Hypertension, Women's Health. Prenatal care. Endocrine disorders
Skin disease. HTN. DM complication. Strokes. Asthma. Arthritis
GI disease - IBS
Primary care hypertension
Any new advances in any field
Abdominal issues: GERD, gastritis, H. Pylori and ulcers
Cardiometabolic syndrome
Antibiotic Rx. More diabetes Rx. Hypertension Rx. CHF Rx
Immunization update, Dementia diagnosis and treatment
Asthma, hypogonadism, HTN
Prostate disease
Fibromyalgia, chronic fatigue syndrome
Cancer
Lipid management and more on newer agents for management and control
Stemi, sepsis, stroke
Psychiatry conference
Stroke, CKD
Opioid addiction, using electronic health record data to improve population health management

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

Response
Pain management. Thyroid disease
HTN
Thyroid disease, obesity, Collagen Disease, Anemia(s), joint infections
Basic diabetes/hypertension management for providers (not in primary care)
Hematology topics, GI topics, Urological topics
The discussion of advanced stage lung cancer in non-smokers
Endocrinology and GI medicine
PTSD
Repeat Diabetes - by same speaker
Managing depression/Bipolar disorder
Primary Care issues
Diagnosis and treatment of adult ADHD
Musculoskeletal disorders. Heart disease
DM. Dermatology for the Family Practice NP
Dementia - adult ADHD. Sarcoidosis
Updates in Primary Care
Dermatology in Primary Care. Abdominal pain (differential diagnoses). Ortho disorders of chronic pain syndrome
Advanced directive discussion on outpatient (Primary Care setting)
DM complication-management. Lipid management. Thyroid disease, diagnosis and management
Fatty Liver Disease
Diabetes/HTN/CVA/stroke/hypercholesterolemia
HTN, EKG skills, laboratory interpretation
Asthma, pediatric illnesses, ADD/ADHD
More DM, Gyn, other endocrine disorders
Dementia, Women's Health
Any except pediatrics and OB/Gyn
Women's Health, STDs, Cardiac
All the topics are very informative
Common skin conditions
Need for probiotic/Crohn's and Colitis, back pain/arthritis
Send outline of course in email
Obesity, therapy - neuropathy therapy
Arthritis, pain management
Rheumatic disorders with emphasis in immunology
Treatment of psych disorders including Schizophrenia and Bipolar disorders
Diabetes, HTN, Hyperlipidemia, CAD, Asthma
ADHD in adult
Treatment of Osteoporosis. Treatment of BPH
Stroke, cancer
DM. AFib. Quality measures
Treating peripheral vascular disease, treatment of Hepatitis C, new treatments of IBD
Obesity in children, ADHD in children and adults
Asthma/COPD. Hyperlipidemia
Anticoagulation therapy
DM and HTN
Nutrition - vitamin deficiencies. Chronic sinusitis. Tinea disorders autoimmune disorders

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

Response
Obesity interventions - what works? Strategies, programs, funding
Anxiety, depression, asthma, CHF
Obesity
Hypo/hyperthyroidism, irregular/dysfunctional uterine bleeding
IPF, COPD, diabetes and hyperlipidemia, oncology - lung cancer
Hypertension - depression, anxiety
STDs. Ethics
No preference
ADD, ADHD
Obesity, insomnia, GERD, PTSD, HIV, CVD, skin diseases, joint pain, low back
New drug and medications
CHF, alternative medicine, AFib
Topics that address younger (children and teens) population of FP
HCV, ALS, MS, anxiety disorder
Joint injections. Trigger point injection. Casting
BPH/SKIN
PAD in CVD
Depression, Gastrointestinal conditions
GI/GU
Convenient care-based - seasonal, acute, illnesses
Pain, thyroid disease
CAD, CHF, AFib
Viral and infectious diseases
Retail health
Hypertension, cultural competency care, obesity
Depression, anxiety, asthma, hypothyroidism/hyperthyroidism
More on diabetes, hematology! Autoimmune disorders
Heart failure, MI
HIV updates
Any
Dermatology tips and tricks for Primary Care
Pain management. Mental health problems. ADHD, Bipolar disorder. Depression
Brain injury effects
RA, OA, Psoriasis treatment
Cardiovascular diseases and infectious diseases
Osteoporosis
Pain management. Vitamin deficiency. Autoimmune disorders
Movement disorders
Depression, PTSD, more psychiatric topics
CAD, thyroid problems, COPD, pneumonia, rheumatoid arthritis
Women's Health, opioid use, HTN, DM
Any primary care topics
Effectiveness of adding non-pharmacologic treatment to pharmacological treatment in selected diseases
Trauma
More Primary Care topics
Prostate cancer. Colon cancer. ED

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

Response
Kidney disease. Overall, great review
COPD, asthma/acne Rx/Parkinson management, Lymphoma
Depression/anxiety/migraine
Hormonal/post menopausal
Hypogonadism, asthma
Pain treatment
Continued ed and review of dyslipidemia/T2DM meds and treatment
Hypertension
Sepsis new guidelines
Lupus, autoimmune disease
More Geri topics
Osteoporosis. Anemia
Heart disease in women
Treatment in Type II Psychiatric patients receiving luthure or Zypnexa
Thyroid dysfunction management. HTN - Pheochomoytoma. Kidney diseases. Congenital heart disease
CHF, HTN, HIV, breast cancer
HCV, immunomodulators (IBD, Crohn's, psoriasis, RA treatment)
CHF Angina
Workshops - joint infections, xray reading
DM, HIV, obesity, erectile dysfunction, anemia (iron-deficiency vs. anemia of chronic disease)
Doesn't matter
Psychiatric/mood disorder
Best practices: weight loss (meds, surgical), common MSK disorders/management
Better diagnose PBA. Better treatment plan for DM, HLD
Hepatitis C, non-alcoholic fatty disease, infectious disease
Atrial Fib. Acute coronary syndrome. Treatment of DVTs with Eligulis vs coumadin. Anemia workup. Vitamin D deficiency/Osteoporosis-management
Antibiotic use in various infectious diseases
Thyroid disease, anemia, urology
Asthma, HTN
Infectious Disease and appropriate antibiotic Rx
Skin conditions
Update on HTN management. CKD
Osteoporosis, Depression, Fibromyalgia, PTSD

Additional comments:

Response
Dr. Pratley slightly biased to a certain product. Dr. Alva too. Dr. Martinez is excellent
Thanks
Very good
Great program. Thanks
Excellent lecturers
Seating was limited/not enough tables in conference room. Dr. Martinez was excellent
Great presentations
PBA very interesting topic. Thank you
The lecture hall was extremely cold

Additional comments:

Response
Do 2-3 times a year in this city
Very good program
Excellent topics. Good training
Extremely cold facility. Would like to have WiFi access if possible
Very good conference. I didn't stay due to illness, but I will attend more when available
The speakers were excellent with great teaching skills
Excellent program
First session, the first speakers had a TON of information to impart. Very hard to follow. Second session better
Very good
Great lectures!
Room was a bit cold (temperature). Dr. Ferdinand was excellent
Drs. Ferdinand and Martinez are excellent speakers. Very impressive
Excellent presentations
The conference was very informative. The speakers (all) were knowledgeable and presented the information in a way that was easily understood. My interest was kept the entire time, and I'm very thankful for the continuous audience engagement
Very organized CME, great speakers. Suggestion - room temperature needs to be adjusted to be warmer
Simulcast of live conference is greatly appreciated. Traffic and parking are difficult and lack of seating is an issue, not being able to see lower portion of screen and restroom issues do not exist with simulcast! 9 hour day but only 6 CME hours
Great conference. I will come again next year
Very good conference
Excellent program! Thank you for lunch
Rooms were extremely cold! Need access to slides and internet
Well presented, great location and time of day, too early but great presentations
Great conference!
Many slides with little bitty type and you couldn't provide a conference code so we could use the WiFi to see the slides on iPads - SHAME ON YOU! The rooms were too cold (again)
Informational CME session, but need more coffee and teas out throughout the time of conference
Excellent!
N/A, thanks. Great speakers! Nice staff!
Improve hall sitting and arrangement
Great conference! Thanks for feeding us
All excellent lecturers - usually am sleepy after lunch, but this time I was fully awake
Was going to leave, but stayed until the end because lectures so entertaining
The PBA topic could have been covered in half the time
Very good presentations
Dr. Pratley was great. Screens were too low to read bottom rows
Consider separating MDs from nurses in treatment sessions and giving physicians more inplusticated breakout sessions
All the speakers were very well informed and engaging
The questions sometimes had more than 1 answer. Even the speaker acknowledged
Great learning activity!
Excellent use of my time
Great seminar!
Very good faculty
Excellent program

Additional comments:

Response
Drug companies do not belong at a conference. I came to a conference to learn general information and drug companies/reps should not be allowed to speak or if so, the conference attendees shouldn't be expected to attend
Excellent program
The room temp was too cold
Very good conference. Very educational. I learned a lot, Keep up the good work
These presentations are well done and appropriate
Excellent info. Good with lunch speaker - well done! Wish there was an afternoon coffee/tea/snack offered
Topics were very informative
Thank you - very nice program
This was very educational and will definitely enhance my practice and care of patients
Very good CME
Thanks for providing this workshop!
I have not attended any seminar in the last 3 years nor worked due to my illness. I really appreciate this conference. Today was good and made me feel good. Thank you very much
Very well organized CME. Thank you!
Very smooth, coordinated. I will return for future workshops
Great conference. STD testing and treatment
Very much enjoyed conference. Thank you!
Excellent. Recommend to everybody
Having WiFi access would be beneficial for viewing slides on devices. The room was very cold!
Excellent conference. Great presentations
Dr. Angela Brown, excellent speaker, learned a lot about resistant HTN
Very good conference
Thank you
Excellent CME, like to see more live conferences
Good CME!
Less statistics, more clinical info/too much time spent "voting" - couldn't access slides because no internet access?! Waaay too many questions!
Dr. Pratley excellent speaker. Dr. Martinez excellent with main take home points
Excellent location - easy to negotiate. Much better than Buckhead or downtown with parking restrictions, etc.
Room cold, not enough seating, all speakers were great nad had sense of humor
Really enjoyed the PBA lecture
At least one break without a presentation
This conference is so well done - thank you. I watch for emails from you to see when and where you will be. Love the pre-post test music! Keeps my brain happy and engaged!
Excellent speakers and info
Thank you
I do not typically prescribe therapy
Dr. Ferdinand was awesome. Most interesting presentation
Thank you
Great session
I really enjoyed Dr. Alva's presentation. I also enjoyed Dr. Ferdinand's lipid presentation (I'm going to start patients more aggressively on statins)
Coffee would be appreciated post lunch to increase mental alertness. I will even pay for it
Dr. Ferdinand was great!
Good conference
Conference very good. Thank you

Additional comments:

Response
None
Some of the questions for response were poorly written