Emerging Challenges In Primary Care: 2016

Activity Evaluation Summary

CME Activity:	Emerging Challenges in Primary Care: 2016 Saturday, June 4, 2016 The Sheraton Birmingham Hotel Birmingham, AL
Course Director:	Gregg Sherman, MD
Date of Evaluation Summary:	June 20, 2016

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

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

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

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 ninety one healthcare practitioners registered to attend ***Emerging Challenges in Primary Care: 2016*** in Birmingham, AL. Two hundred 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 ninety eight 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 3.5 *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 2.5 *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).

Maintenance of Certification: Successful completion of this activity, which includes participation in the evaluation component, enables the participant to earn up to 6 MOC points in the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program. It is the CME activity providers' responsibility to submit participant completion information to ACCME for the purpose of granting ABIM MOC credit.

Through the American Board of Medical Specialties ("ABMS") and Association of American Medical Colleges' ("AAMC") joint initiative (ABMS MOC Directory) to create a wide array of Maintenance of Certification ("MOC") Activities, Emerging Challenges in Primary Care has met the MOC requirements as a MOC Part II CME Activity by the following ABMS Member Boards: American Board of Family Medicine and American Board of Preventive Medicine.

Integrated Item Analysis Report

What is your professional degree?

Response	Frequency	Percent	Mean: -
MD	73	36.87	
DO	1	0.51	
NP	106	53.54	
PA	2	1.01	
RN	12	6.06	
Other	4	2.02	
No Response	5	2.53	

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

Response	Frequency	Percent	Mean: 3.03
None	24	12.12	
1-5	73	36.87	
6-10	43	21.72	
11-15	15	7.58	
16-20	18	9.09	
21-25	8	4.04	
> 25	13	6.57	
No Response	4	2.02	

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

Response	Frequency	Percent	Mean: 4.75
None	14	7.07	
1-5	20	10.10	
6-10	22	11.11	
11-15	31	15.66	
16-20	26	13.13	
21-25	20	10.10	
> 25	61	30.81	
No Response	4	2.02	

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

Response	Frequency	Percent	Mean: 4.80
None	13	6.57	
1-5	17	8.59	
6-10	26	13.13	
11-15	27	13.64	
16-20	28	14.14	
21-25	23	11.62	
> 25	60	30.30	
No Response	4	2.02	

Upon completion of this activity, I can now: Know the risk factors for heart failure and the role of biomarkers in diagnosis and treatment; Recognize the importance of heart rate in cardiovascular risk of heart failure; Utilize the most recent clinical evidence to inform their decisions for the management of heart failure; Identify approaches to facilitate early recognition and optimization of heart failure management?; Describe pathophysiologic factors contributing to increased risk of heart failure among African Americans and other ethnic minorities.

Response	Frequency	Percent	Mean: 1.11
Yes	176	88.89	
Somewhat	22	11.11	
Not at all	0	0.00	
No Response	0	0.00	

Upon completion of this activity, I can now: Discuss the benefits of LDL-C lowering with pharmacologic therapies that improve cardiovascular outcomes; Define the appropriate use of non-statin medications in addition to statin therapy; Discuss the role of anti-PCSK9 monoclonal antibody therapy in LDL-C reduction to achieve cardiovascular risk reduction; Recognize and develop appropriate treatment strategies for special populations (women, elderly, ethnic minorities) that would benefit from lipid lowering therapy.

Response	Frequency	Percent	Mean: 1.07
Yes	184	92.93	
Somewhat	13	6.57	
Not at all	0	0.00	
No Response	1	0.51	

Upon completion of this activity, I can now: Recognize the role of postprandial hyperglycemia in type 2 diabetes (T2DM) patients not at target and examine its role in the pathogenesis of diabetic complications; Utilize glucagon-like peptide (GLP)-1 receptor agonist (GLP-1 RA) therapy to address post-prandial hyperglycemia in ways current fixed dose strategies do not; Compare GLP-1 RAs for glycemic efficacy and differential impact on postprandial glycemic control; Discuss various GLP-1 RA combination strategies to effectively control fasting and post-prandial hyperglycemia.

Response	Frequency	Percent	Mean: 1.07
Yes	179	90.40	
Somewhat	14	7.07	
Not at all	0	0.00	
No Response	5	2.53	

Upon completion of this activity, I can now: Summarize the natural progression of type 2 diabetes and how that is reflected in signs such as the glycemic monitoring patterns and other key clinical manifestations; Describe the current and newer insulins, and how they may be utilized in the design of an insulin replacement program; Provide educational support for individualized insulin regimens to achieve targeted levels of glycemic control for people diabetes; List common obstacles to insulin initiation, treatment, and adherence stemming from patient, provider, and office-systems based issues, and methods to address them.

Response	Frequency	Percent	Mean: 1.06
Yes	176	88.89	
Somewhat	12	6.06	
Not at all	0	0.00	
No Response	10	5.05	

Overall, this was an excellent CME activity:

Response	Frequency	Percent	Mean: 1.23
Strongly Agree	153	77.27	
Agree	43	21.72	
Neutral	1	0.51	
Disagree	0	0.00	
Strongly Disagree	0	0.00	
No Response	1	0.51	

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

Response	Frequency	Percent	Mean: 1.22
Strongly Agree	154	77.78	
Agree	42	21.21	
Neutral	1	0.51	
Disagree	0	0.00	
Strongly Disagree	0	0.00	
No Response	1	0.51	

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

Response	Frequency	Percent	Mean: 1.25
Strongly Agree	148	74.75	
Agree	48	24.24	
Neutral	1	0.51	
Disagree	0	0.00	
Strongly Disagree	0	0.00	
No Response	1	0.51	

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

Response	Frequency	Percent	Mean: 1.47
Very likely	141	71.21	
Somewhat likely	36	18.18	
Unlikely	1	0.51	
Not applicable	18	9.09	
No Response	2	1.01	

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

Response
Fair review of old and new data. Presentations of questions somewhat confusing
Optimize HF management for black patients/medication choices/early recognition. Appropriate treatment - lipids; GLP-1 usage
Better care for patients knowing how to apply the information helps me feel more confident in making changes or starting therapy
Use of GLP-1, insulin usage
I have learned that you have a better change of having a compliant patient (with meds) if you can get them to take pills that are in phases of color and are in a colorful bottle
Diabetes management - very informative
Use of Ivabradine

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

Response
New medications and new treatment for different patient population
New medications usage. Interval at stage I for heart failure
Identifying high risk patients to maximize therapy in hyperlipidemia and heart failure - adding insulin to oral therapy
New drugs available
Titration of basal insulin, algorithm for treating hyperlipidemia and Diabetes II. Use of new Bidil, Entresta, and Corlamor
Four groups to focus on for statin therapy. When to use DOP4 and GLP-1
Evaluate patients for newer HF therapies. Make more use of BNP. Use updated lipid guidelines. Evaluate patients for GLP-1RA. Better use basal insulin
Benefits of Ivabradine, management of HF, more efficiently manage HA1C
Stepwise process for implementing GLP-IRA and insulin therapy
Better able to work with internist since I am a psychiatrist
Excellent
Utilize PCSK9 to lower LDL. Consider statin therapy with Entresto
Use of new treatment options for HF
More aggressive Rx for CHF and hyperlipidemia
Use Ivabridine in heart failure patients when HR>70. Consider ethnicity when prescribing meds for heart failure patients
Disregard HDL levels; use Zetia where appropriate
Treat heart rate in HF patient; consider post-prandial BG in patients with DM
Newer treatment for CHF - Entresto. Use more Bioil
The main strategy is patient education and other propels medication, lifestyle
Will utilize Ivabradine when appropriate for patient. Incorporate the newer Diabetic medications to improve patients' glucose HbA1c
Better patient care
Able to use GLP's more frequently
The use of Sacubitril/Valsartan, Ivabradine, and dinitrate/hydralazine in HF and use of different GLP-1RA
Adding GLP-1 for diabetic patients. Use Ivabradine in HF tachy patients. Aggressively treating newly diagnosed diabetics. Using statins
Treatment of HF. Use of GLP-1 more in diabetics
The use of niacin in hypertensive patient. The use of Omaims outlet in glycemic control. The correlation of genetic disposition in African American patients to heart failure treatment
Tailoring heart failure therapies based on ethnic origin. Targeting post prandial glucose levels in DM management
More attention to HR in CHF, less use of Niacin and fenofibrate, more attention to PPBS, increase use of GLP-1
Treat ASD patients with high dose potency statins, add what is needed to reach goal
Newer therapies regarding CHF and HLP Rx
Observe AA patients and in choosing appropriate medication, Iso/Hydra; keep patient on statin drug. Using GLP-1 RA more frequently
GLP-1 and thinking of post prandial glucose. Better care of heart failure in African Americans - consider IP/H
Treat African American with Isosorbide/Hydralazine combination
Inform patient of importance of adhering to healthy diet, exercise, compliant with meds
Niacin does not show effect/benefit. High HDL level does not protect
Better evaluation of CHF patients
Follow guidelines of CHF carefully when trying to add on D/C drug. Prevention versus treatment steps in CHF. Do not D/C oral hypoglycemic when start insulin treatment. Post-prandial glucose control deteriorate fast that fasting glucose level, treatment of post-prandial is very important
New pharmacology meds. Continually fasting and post-prandial treatment/glucose
I have learned the new medications on the market that have not been taught in school and how to put these medications into practice when I graduate NP school in December 2016

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

Response
Sacubitrital/Valsartan treatment for CHF. Ivabradine treatment for CHF. The efficacy and post prandial effects of GLP-1's
Use of Ivabradine. Add GLP to basal insulin is better than adding rapid acting insulin
Better understanding of treatment for HF in AA to CA. Better understanding of the effect of new drugs on the biomarkers
IDN/Hydralazine use in CHF. GLP-1 RA use/mech
Treat post prandial glucose
Look at ethnic background closer. Use approved guidelines in initiating and changing treatment R/T HD/other factors
Utilization of new medications
Not only considering NXHF class but also stage of CHF
Importance of and options for reducing ppbs. Overcoming barriers to use of injectables for treatment of DM. Adding non-statins to statin therapy to decrease LDL
Focus on ethnicity in treatment as well. Go to GLP-1 before basal. Focus more on heart rate control
Why HPCEF patients decompensate. A7, Nat, HTN, DSA, Anemia, etc. 2013 AAC7/AHA guidelines for treatment of H7; do not titrate U-300
Use ISD/HDN IM AA patients CHF
Individualize CHF treatment. I thought tetia went out, but now it's back
Use of Ivabridine in optimizing patients with Ha>70 who are not well controlled on beta blockers
Adding GLP-1; treatments for HF, nonstatin therapy to reach HDL goal
Will add new drugs in CHF management now
How to effectively treat patient with HF. Different techniques in titrating and using diabetic drugs
Consider PP glucose; re-look at diabetic medication management
Look strongly at HF patients with HR>70 and make changes
Stages of CVD (stage A-D); statin therapy. New order of adding DM meds
How to utilize new agents in heart failure like Ivalmadinic
Maximizing statin therapy, adding evidence-based meds to improve HFrEF and better insulin management
Use if Ivabradine. Use of Sacubitril/Valsartan. Ezetemibe/PCSK9 use
More aggressive therapy in HF
Beta blockers for control of heart rate
More aggressive with DM management. More aggressive with lipid control
Identifying patients for HF, treatments for DM, statin therapy
Adding Zetia when maked ou statin if LDL not at goal. Check postprandial glucose at secondary, not just FBG
Adding the Isabimid/Hydralyzine therapy to increase HTN uncontrolled
Heart failure treatment in prevention stage A/B. Check PPS
Using insulin with oral meds, importance of post prandial testing
Application of evidence based practice guidelines in treatment of HF, particularly among African American population
Consider medication therapies mentioned more often
Maximize use of statins and re-challenging if patient not tolerating statins. Starting basal and bolus insulin and the use of GG early
Medication usage for more effective treatment
Screening for HF in primary care. Stricter control with other agents for high cholesterol. Utilize newer agents with DM
When LDL remains elevated on high statin will start a non-statin Ezetimibe and will also use a B1e acid if another medication needs to be added for high LDL-C
CHF therapy
Help in strategy with CHF treatment, how to use statin, use of PCSKSI
Change valsartan to sacubitril/valsartan if beneficial and consistent

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

Response
Introducing topics discussed today with my next teleconference meeting with my coworkers, especially knowing the first line of treatment with CHF, HLD, and T2D. Discussing more about findings discussed here today
Verify HR in those with HF/check for familial hypercholesterolemia/have patients monitor post prandial BG
Improved use of fixed dose ISDM/Hydralazine and use of Sacubitril/Valsortan in CHF. Increased use of egetimide, increased use of GLP-1 + basal insulin use (combo-injectable therapy)
Change treatment
Add eztimibe for inadequate statin response. Consider FH for LDL>190. Rechallenge statin intolerance
Treat LDL to goal. Initiate GLP1 more often
Guidelines updated for HF treatment
Be more aggressive with CHF treatment. Lower lipids more if medications are tolerated. Treat diabetes more aggressively
Correctly treating LDL, hypoglycemia, and HF. Excellent class
I am retired. Learning newer agents - helpful for me, intellectually. Also, I have CAD, Hyperlipidism, Diabetes. This information helps me
Ivaloradine to decrease HR in class III HF and rates >70
GLP-1 plus insulin is ideal. Byetta Bid has better effect on lowering PPG. Hypertension is a modifiable risk factor. Check BNP's, use with other clinical factors
Using Ivabradine in HR>70 in systolic dysfunction heart failure
Increase patient education to titrate to goal. Regulating blood sugar pre and post prandial. Side effects of new insulin therapies
AA treatment protocol for HF
Use of Ezetimibe in addition to high intensity statin. Use of Isosorbide DN/Hydralazine in combination with ACE/ARB in African American with HF. Use of Ivabradine in HF patients with HR>70
Limitation of BNP test. Better use of meds in heart failure. More use of GLP-1
The use of Ivabradine to control HF and the role of monitoring BNP, when to and when not to
GLP contraindications, learned about new insulins, statin intolerant patients often can be re-challenges
Use of PCSK-9 in management of dyslipidemia
I can implement the new guidelines into treatment of the patient
Recognizing and treatment options in HF
Use newer modalities for CHF. Use GLP-1 receptor agonists. Better use titrating statin. Add PCSK9 when appropriate
Understanding the medications used for HF, hyperlipidemia, and DM. First line therapy then combination therapy
Better control of CHF with new combinations. Better regulate diabetes and monitor patients
Appropriately treating dyslipidemia and heart failure. Recognizing progression of DM2 and treating
Education
Increase use Ivabradine. Increase use ISDN/Hydralazea. Continue use Sorbitol/Vaxsartin
Education is important
Use of lipid lowering medications, use of GLP-1, DDFY, basal, fast acting insulin
When introducing insulin, I will keep patients on oral agents and then think about discontinuing sulfers/when LDL does not decrease on statin, could be familiar hypocholesterolemia
Medication combinations taking into consideration, ethnic differences and treatment of CHF and mechanisms of action of different DM agents
Reevaluate statin intolerant patients
Recognize heart failure patients and treat DMII with multiple meds to goal
Adequate use of newly approved drugs and their combination as it relates to current and new drugs
Add Ezetimibe to statin, add IDN/HD to AA patient with HF who is symptomatic
Increasing use of Isosorbide/Hydralazine in AA CHF patients. Increase use of GLP-1 RA in treatment of DM type 2 patients
Classifying review for CHF and basic treatment/disparities

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

Response
Increase use with non-insulin injectables. More familiar with newer HF therapies
HF treatment guidelines
Better understanding of drugs. Better use/comfortable using meds
Comfortable in using meds
Don't forget GLP-1. Look for FH; expect need for more aggressive treatment
Pay more attention to patient population i.e. Caucasian, Asian, African American. look at complete health picture and individualize treatment accordingly
More management strategies
When to initiate Bidal, when to initiate, how to manage hyperlipidemia
ISDNT hydr for AA/Block patients. If not tolerate max dose of BB, may add Secubtrol/Velsustan to lower HR. Replace ACE/ARBc with ARN after 36 hours
I learned meds and how to treat CHF. Also learned how to mix different meds/insulins to treat DM more effectively
How to utilize CHF and DM meds more effectively
Better cholesterol management. Insulin management. BP control in African American
Risk factors and identification - early identification HF. Compliance with statins
Statins should be held for 2 months if Myalgias occur. Can then be re-challenges possibly at 9 lower dose
I've learned when to use newer CHF meds. Newer drugs to optimize treatment in DM
When to refer

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

Response	Frequency	Percent	Mean: 1.58
Within 1 month	131	66.16	
1-3 months	38	19.19	
4-6 months	3	1.52	
Not applicable	23	11.62	
No Response	3	1.52	

In terms of delivery of the presentation, please rate the effectiveness of the speaker: Anekwe Onwuanyi, MD - Heart Failure Part I:

Response	Frequency	Percent	Mean: 4.65
Excellent	140	70.71	
Very Good	47	23.74	
Good	10	5.05	
Fair	1	0.51	
Unsatisfactory	0	0.00	
No Response	0	0.00	

In terms of delivery of the presentation, please rate the effectiveness of the speaker: Anekwe Onwuanyi, MD - Heart Failure Part II:

Response	Frequency	Percent	Mean: 4.67
Excellent	141	71.21	
Very Good	48	24.24	
Good	7	3.54	
Fair	1	0.51	
Unsatisfactory	0	0.00	
No Response	1	0.51	

In terms of delivery of the presentation, please rate the effectiveness of the speaker: David N. Smith, MD - Heart Failure Part II:

Response	Frequency	Percent	Mean: 4.67
Excellent	141	71.21	
Very Good	48	24.24	
Good	7	3.54	
Fair	1	0.51	
Unsatisfactory	0	0.00	
No Response	1	0.51	

In terms of delivery of the presentation, please rate the effectiveness of the speaker: David N. Smith, MD - Beyond Statins:

Response	Frequency	Percent	Mean: 4.72
Excellent	142	71.72	
Very Good	48	24.24	
Good	3	1.52	
Fair	0	0.00	
Unsatisfactory	0	0.00	
No Response	5	2.53	

In terms of delivery of the presentation, please rate the effectiveness of the speaker: Robert S. Busch, MD, FACE - Using GLP-1 RA in Diabetes:

Response	Frequency	Percent	Mean: 4.86
Excellent	158	79.80	
Very Good	22	11.11	
Good	0	0.00	
Fair	0	0.00	
Unsatisfactory	1	0.51	
No Response	17	8.59	

In terms of delivery of the presentation, please rate the effectiveness of the speaker: Robert S. Busch, MD, FACE - Insulin Management in Diabetes:

Response	Frequency	Percent	Mean: 4.84
Excellent	151	76.26	
Very Good	21	10.61	
Good	1	0.51	
Fair	0	0.00	
Unsatisfactory	1	0.51	
No Response	24	12.12	

To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Anekwe Onwuanyi, MD - Heart Failure Part I:

Response	Frequency	Percent	Mean: 4.82
Excellent	166	83.84	
Very Good	29	14.65	
Good	2	1.01	
Fair	1	0.51	
Unsatisfactory	0	0.00	
No Response	0	0.00	

To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Anekwe Onwuanyi, MD - Heart Failure Part II:

Response	Frequency	Percent	Mean: 4.81
Excellent	164	82.83	
Very Good	31	15.66	
Good	2	1.01	
Fair	1	0.51	
Unsatisfactory	0	0.00	

To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? David N. Smith, MD - Heart Failure Part II:

Response	Frequency	Percent	Mean: 4.85
Excellent	171	86.36	
Very Good	25	12.63	
Good	1	0.51	
Fair	1	0.51	
Unsatisfactory	0	0.00	

To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? David N. Smith, MD - Beyond Statins:

Response	Frequency	Percent	Mean: 4.88
Excellent	172	86.87	
Very Good	23	11.62	
Good	0	0.00	
Fair	0	0.00	
Unsatisfactory	0	0.00	
No Response	3	1.52	

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

Response	Frequency	Percent	Mean: 4.88
Excellent	164	82.83	
Very Good	21	10.61	
Good	1	0.51	
Fair	0	0.00	
Unsatisfactory	0	0.00	
No Response	12	6.06	

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

Response	Frequency	Percent	Mean: 4.90
Excellent	166	83.84	
Very Good	19	9.60	
Good	0	0.00	
Fair	0	0.00	
Unsatisfactory	0	0.00	
No Response	13	6.57	

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

Response	Frequency	Percent	Mean: -
Topics covered	145	73.23	
Location/ease of access	127	64.14	
Faculty	31	15.66	
Earn CME credits	163	82.32	
No Response	4	2.02	

Future CME activities concerning this subject matter are necessary:

Response	Frequency	Percent	Mean: 1.53
Strongly agree	102	51.52	
Agree	88	44.44	
Neutral	7	3.54	
Disagree	1	0.51	
Strongly Disagree	0	0.00	

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

Response
Obesity updates
Diabetes management
DM, new insulin and other therapies
Bariatric surgery and Diabetes, the outcome on the disease
Dr. Smith was relegated to a straight man in heart failure presentation in other words a prop, very awkward
HTN, HF, DI, all Endo aspects, GI, ID
Diabetes. Dyslipidemia
Renal disease. Oncology. Dementia
Coronary artery disease
More on insulin, statins
HIV. Hepatology. ID for Primary Care. Dermatology for Primary Care
Thyroid management. Women's Health
"Pain" medication controlling your patient and keeping your license
Physical activity across life span
New blood thinning agents/reversal of anticoagulation
Psychiatric topics - Bipolar, ADHD, etc.
Seizure
Adherence to HTN medications with patients who have Diabetes
Psychiatry, Bipolar Disorders, developmental disabilities
Ideal diet
Cardio Renal Syndrome
Infectious disease. Treatment of chronic pain
Weight loss. Counting carbs
Osteoporosis. GI problems. Urology problems

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

Response
Pediatrics
COPD, Asthma, thyroid disorder, obesity treatment (physical/psychological)
COPD management. Parkinson's. Management of psychiatric conditions in the primary care setting
Pulmonary
How to deal with mental health problems, Bipolar, Depression, Schizophrenia
HIV
Multidrug resistant hypertension
Pharmacology update. Repeat today's subjects again
Inflammatory bowel disease. Excellent conference
COPD diagnosis and treatments. Reading EKG and when to refer to cardiology. Herbal supplements
Infectious disease
Thyroid issues
Women's health. Sexually transmitted diseases. Increased pharmacology CEU's
HTN, Thyroid Disease, concussions in athletes. Rheumatology
HPV
More emphasis on HTN, DM, weight control, HLP
Management of COPD
Wound care, COPD, abdominal pain
COPD, asthma
Occupational and urgent care
Neurodegenerative diseases
Liver disease
Update on treatment of hypertension
Uncontrolled hyperlipidemia. Rheumatoid arthritis. Gout with renal failure. CKD
Pulmonary - COPD asthma
Anemia, idiopathic dysplastic anemia
Depression and mood disorders
Diagnostic blood test, anemia management, end of life care and choices
Would like to learn more about long term effects of patients after use of newer prtoocols for Rx of T2DM
Dermatology. Orthopedics
Osteoporosis, pain management in chronic pain
Inflammatory bowel disease. Gastroenteritis
Hormone (female and male) interpretation and deficiency and adequate treatment
RA
Difficult to treat HTN
Endocrine problems (aside from DM2)
Geriatrics/Dementia. Hypertension. Renal failure
Stroke. HTN. DM
Women's Health. STD. Travel medicine
Pharmacology update - new meds for last year. Antimicrobial Rx'ing. Geriatric Cardiology - medical management in patients/conditions who are non-surgical candidates. I would have been happy to pay for a lunch to have here
Pediatric topics
Acute coronary syndromes; cardiac transplant
A lot of information in a short period... be good to hear it again! RA, OA (joint injections, TPI)
Perioperative management of patients with different comorbidities
Arrhythmias

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

Response
Osteoporosis, spine/back problems
Family Practice
Immunizations in older adults
Any, this was a great one
Dermatology
Dementia treatment. PTSD. HTN in the older adult age. Pharmacology (new medications)
Menopause complaints/treatment. CKD. Hepatitis C treatment
CV. DM. Psychology. Primary Care. HTN
More on Diabetes and problems it causes - skin/Dermatologic, including more pharmacy cause and effects - listing brand and generic names. Gastro subjects
More time on the different mechanisms of action of the different DM agents
Pediatrics. Genetics
Pharmacology update. Dyslipidemia management. Dementia treatment. Psychological update of disease treatment
Top 10 diseases seen in general office
Women's health. Dermatology
Treating patient with multiple comorbidities with infection using antibiotics
Evaluation and treatment of thyroid issues. Resistant HTN, evaluation of and treatment
Neurological disorders
Alzheimer's disease, peripheral vascular disease, mental health, pulmonary, Dementia
GI issues acute and chronic
Bipolar. Psych topics
Dermatology, renal
Pulmonary
Chronic kidney disease. Chronic back pain. Pain management. PAP smear guidelines
HTN guidelines. More diabetic education
Renal failure and RA
Topics in Neurology. Dermatology for the primary care doctor
Some pediatric CME (e.g. adolescent ADHD, Depression, anxiety, etc.); HTN in adolescents
Intensive HTN management
CAD. Discussion on all medications used for HF. Cerebrovascular disease and Dementia
Management of resistant hypertension
Orthopedics, HRT
Neurology for non-Neurologists. Chronic kidney disease management. Psychiatry in primary care
DM. HTN. Psych
Occupational health, urgent care
Treatment of colon problems. Autoimmune disease. Current treatment of cancers
Hypertension, Anemias, and weight management
Malnutrition and quickly recognizing it for treatment
Keep current topics, especially HF, Men's Health
Urology topics. GI topics. Chronic pain
Live disease. Heart disease
Dermatology, Ortho, EKG interpretation
Chronic kidney disease/dialysis
Use of GXN hormonal therapy pre and post menopause. Proficient use of psychotropic medications
Urinary symptoms
Psychiatry - Schizophrenia and bipolar treatment

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

Response
Renal topics. Tumors of brain and pediatrics
Thyroid disease
Dermatology, Ophthalmology
More on diabetes management in outpatient setting
Chronic renal insufficiency
Evaluation/treatment of GI disorders
Treatment of seizure for non neurologist. Treatment of mental disorder, depression, PTSD, anxiety
Updates on new medications
Anemia. CKD. HTN. COPD. Primary Care. Hypothyroidism. Back pain. Parkinson's. Hyponatremia. IBS. Gastroparisis. Electrolyte imbalance
Hormone supplementation in men. Treating anxiety/depression - which meds work better for which symptoms
Nutrition in weight loss
More diabetes/endocrine (thyroid, etc.). HF, HTN
Hypothyroidism
Liver/GI disorders
COPD, Anemia, Dementia
Update on outpatient, common adult lung diseases
Women's Health
Updates in women's health and men's health, vaccination pros and cons

Additional comments:

Response
Great course
This was excellent! Thank you very much for keeping it free! Buying our own lunch is okay when the conference is free. Stayed entire day
Great speakers! Dr. Busch was phenomenal! Great facility, nice BF. Glad I came
Very good speakers. Smart. Able to break information down so NP can understand
Great conference
Great faculty - well organized
Bring back Keith Ferdinand. More interaction/panel discussion - multi-specialty
I am a psychiatrist so these issues are peripheral to my primary practice
Room temperature was cold before lunch
Both topics very good. Too much insulin
Great
Great CME course
Could benefit from additional explanation on why raising HDL is not associated with lower CV risk
Great seminar, thanks
Enjoyed the program
Love the music during the pre and post tests
The seminar was well organized and informative
Really enjoyed the post and pre tests and scenarios
I favor this format of one day conference, especially in Birmingham, AL
Love Dr. Onwuanyi, but when he gets tired I can't understand him. Love the accent, but I can't understand certain words at all
Excellent activity
Add another lecture or two, tally 8 CME hours

Additional comments:

Response
Excellent topics and speakers
Very informative
Super CME lectures. Has always been very educational. I have attended 3 already
Good topics. Great speakers
Excellent
Very informative. It helped me understand why certain drugs may or may not be added for Diabetes and Heart Failure. I will also be able to educate my patients better
Appreciate the NACE conference. Dr. Busch was great
Dr. Busch needed more time, and talk slower, so we who are 'rusty' can follow. A little too deep, became overwhelming with so many details. Otherwise, great! P.S. Lots of little bugs flying around the room!
Great program
Great activity
Dr. Onwuanyi was awesome! Excellent speakers. Nice facility too
My practice is serving veterans 70-100 years of age, difficulty adding some treatment. Many problems is non-adherence to diet and ability to exercise. Great CME
Great speakers, great conference - I always enjoy attending NACE
Please provide syllabus. Notes would have very much enhanced the learning experience
Thank you
Learned a lot, very informative
It is okay to use trade/brand names - we all know them and understand your efforts to avoid this, but real clinicians use them daily and to say we are discussing 'evidence-based medicine', then use generic terms in substitution for the 'exact drugs' on which the evidence is based is a poor choice
Excellent location
Excellent activity
Thank you for program. More food at the breaks! The room temperature was perfect. First conference I have been to in which I did not freeze
Excellent presentations
Very informational. Truly enjoyed the lectures
Love these lectures! Please continue to have them. Thank you
Loved it
Excellent conference. Well organized
Enjoyed active participation
Heart failure presentation was difficult to follow - topics were likely too advanced to apply to Primary Care and more applicable in a Cardiology setting
Thank you for bringing these CME activities to Birmingham
Very practical conference for Primary Care
Very informative. Really enjoyed it. Stayed widely awake the whole time after 5 hours of sleep
Thank you
Shorten break time and get out quicker (10-12 minutes). Short lunch, shorter time to answer questions - drags out, less boring. Good faculty
Enjoyed the conference
Good
Dyslipidemia lecture very helpful
Good meeting overall
Very good material and speakers
Role of bariatric surgery in treatment of diabetes and control of HTN and Hyperlipidemia
Dr. Smith questions confusing
Excellent

Additional comments:

Response
Excellent topics
I am amazed that so many people are able to sit for more than 1 hour. Not me! Although hard of hearing, sitting in back so I can stand, stretch at will, since sitting is unhealthy, I would promote speakers encouraging everyone sitting through session for over an hour to stand/stretch at mid-session
Dr. Busch was an excellent speaker
I loved this so much. DM was covered very nicely. Great job by Dr. Busch
Great conference
Excellent! All speakers were great, especially Dr. Busch
Please don't give email address and phone number to other companies
Great conference! Speakers and topics were great
Enjoyed the presentations
This was one of the best conferences