# Emerging Challenges In Primary Care: 2016

## Activity Evaluation Summary

**CME Activity:** Emerging Challenges in Primary Care: 2016
Saturday, August 27, 2016
Detroit Marriott Troy
Troy, Michigan

**Course Director:** Gregg Sherman, MD

**Date of Evaluation Summary:** September 14, 2016

NACE NATIONAL ASSOCIATION FOR CONTINUING EDUCATION

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

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, ADHD in adults, pulmonary arterial hypertension, 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 fourty seven healthcare practitioners registered to attend ***Emerging Challenges in Primary Care: 2016*** in Troy, MI and four hundred eighty eight registered to participate in the live **s**imulcast. Four hundred fifty healthcare practitioners actually participated in the conference: two hundred twenty three attended the conference in Denver, CO and two hundred twenty seven participated via the live simulcast. Each attendee was asked to complete and return an activity evaluation form prior to the end of the conference. Four hundred thirteen 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 3.50 *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 3.25 *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 6.75 contact hours of continuing education (which includes 3.0 pharmacology hours).

Maintenance of Certification: Successful completion of this activity, which includes participation in the evaluation component, enables the participant to earn up to 6.75 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.

## What is your professional degree?

| Label | Frequency | Percent |
|---|---|---|
| MD | 207 | 47% |
| DO | 13 | 3% |
| NP | 172 | 39% |
| PA | 18 | 4% |
| RN | 26 | 6% |
| Other | 7 | 2% |
| Total | 443 | 100% |

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

| Label | Frequency | Percent |
|---|---|---|
| None | 88 | 20% |
| 1-5 | 168 | 39% |
| 6-10 | 67 | 15% |
| 11-15 | 40 | 9% |
| 16-20 | 26 | 6% |
| 21-25 | 14 | 3% |
| > 25 | 30 | 7% |
| Total | 433 | 100% |

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

| Label | Frequency | Percent |
|---|---|---|
| None | 45 | 10% |
| 1-5 | 66 | 15% |
| 6-10 | 57 | 13% |
| 11-15 | 55 | 13% |
| 16-20 | 73 | 17% |
| 21-25 | 36 | 8% |
| > 25 | 99 | 23% |
| Total | 431 | 100% |

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

| Label | Frequency | Percent |
|---|---|---|
| None | 120 | 28% |
| 1-5 | 197 | 46% |
| 6-10 | 51 | 12% |
| 11-15 | 26 | 6% |
| 16-20 | 18 | 4% |
| 21-25 | 7 | 2% |
| > 25 | 9 | 2% |
| Total | 428 | 100% |

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

| Label | Frequency | Percent |
|---|---|---|
| None | 177 | 43% |
| 1-5 | 153 | 37% |
| 6-10 | 39 | 9% |
| 11-15 | 24 | 6% |
| 16-20 | 8 | 2% |
| 21-25 | 6 | 1% |
| > 25 | 9 | 2% |
| Total | 416 | 100% |

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

| Label | Frequency | Percent |
|---|---|---|
| None | 45 | 11% |
| 1-5 | 55 | 13% |
| 6-10 | -54 | 13% |
| 11-15 | 54 | 13% |
| 16-20 | 64 | 15% |
| 21-25 | 47 | 11% |
| > 25 | 109 | 25% |
| Total | 428 | 100% |

**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.

| Label | Frequency | Percent |
|---|---|---|
| Yes | 352 | 81% |
| Somewhat | 82 | 19% |
| Not at all | 0 | 0% |
| Total | 434 | 100% |

**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.

| Label | Frequency | Percent |
|---|---|---|
| Yes | 382 | 87% |
| Somewhat | 55 | 13% |
| Not at all | 1 | 0% |
| Total | 438 | 100% |

**Upon completion of this activity, I can now:** Describe ADHD symptom profiles and common presentations in a primary care setting; Identify risks for coexisting disorders in adult patients with ADHD with emphasis on anxiety disorders, mood disorders, and substance use/abuse disorders; Implement appropriate pharmacologic treatment for adults diagnosed with ADHD designed to improve compliance, minimize side effects and maximize outcomes in a busy primary care setting; Use adult ADHD assessment and treatment tools for assessment, treatment and follow-up monitoring.

| Label | Frequency | Percent |
|---|---|---|
| Yes | 319 | 75% |
| Somewhat | 103 | 24% |
| Not at all | 2 | 0% |
| Total | 424 | 100% |

**Upon completion of this activity, I can now:** Explain the pathophysiology of pulmonary arterial hypertension (PAH); Determine when PAH should be suspected and how to determine the specific etiology including the importance of right heart catheterization and ventilation-perfusion (V/Q) scan; Define parameters that determine the severity of PAH; Review of treatments and how to appropriately refer and follow patients receiving treatment for PAH.

| Label | Frequency | Percent |
|---|---|---|
| Yes | 270 | 68% |
| Somewhat | 123 | 31% |
| Not at all | 6 | 2% |
| Total | 399 | 100% |

**Upon completion of this activity, I can now:** Describe the role of the kidney in glycemic control; Review emerging data surrounding the effects of SGLT2 inhibitor therapy; Recognize the incidence and risk of hypoglycemia in managing patients with diabetes; Discuss approaches to individualizing the treatment of T2DM.

| Label | Frequency | Percent |
|---|---|---|
| Yes | 336 | 85% |
| Somewhat | 57 | 14% |
| Not at all | 3 | 1% |
| Total | 396 | 100% |

**Overall, this was an excellent CME activity:**

| Label | Frequency | Percent |
|---|---|---|
| Strongly Agree | 325 | 73% |
| Agree | 113 | 25% |
| Neutral | 4 | 1% |
| Disagree | 1 | 0% |
| Strongly Disagree | 1 | 0% |
| Total | 444 | 100% |

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

| Label | Frequency | Percent |
|---|---|---|
| Strongly Agree | 312 | 70% |
| Agree | 126 | 28% |
| Neutral | 5 | 1% |
| Disagree | 0 | 0% |
| Strongly Disagree | 1 | 0% |
| Total | 444 | 100% |

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

| Label | Frequency | Percent |
|---|---|---|
| Strongly Agree | 265 | 60% |
| Agree | 152 | 34% |
| Neutral | 22 | 5% |
| Disagree | 1 | 0% |
| Strongly Disagree | 1 | 0% |
| Total | 441 | 100% |

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

| Label | Frequency | Percent |
|---|---|---|
| Very Likely | 269 | 62% |
| Somewhat likely | 113 | 26% |
| Unlikely | 9 | 2% |
| Not applicable | 45 | 10% |
| Total | 436 | 100% |

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

| Label | Frequency | Percent |
|---|---|---|
| Within 1 month | 268 | 62% |
| 1-3 months | 83 | 19% |
| 4-6 months | 16 | 4% |
| Not applicable | 65 | 15% |
| Total | 432 | 100% |

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

| Label | Frequency | Percent |
|---|---|---|
| Excellent | 275 | 63% |
| Very Good | 134 | 31% |
| Good | 22 | 5% |
| Fair | 4 | 1% |
| Unsatisfactory | 0 | 0% |
| Total | 435 | 100% |

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

| Label | Frequency | Percent |
|---|---|---|
| Excellent | 280 | 65% |
| Very Good | 133 | 31% |
| Good | 19 | 4% |
| Fair | 2 | 0% |
| Unsatisfactory | 0 | 0% |
| Total | 434 | 100% |

**In terms of delivery of the presentation, please rate the effectiveness of the speaker:**
Priscilla Pemu, MD, MSCR, FACP – Heart Failure Part II**:**

| Label | Frequency | Percent |
|---|---|---|
| Excellent | 303 | 70% |
| Very Good | 116 | 27% |
| Good | 13 | 3% |
| Fair | 2 | 0% |
| Unsatisfactory | 0 | 0% |
| Total | 434 | 100% |

**In terms of delivery of the presentation, please rate the effectiveness of the speaker:**
Priscilla Pemu, MD, MSCR, FACP – Hypercholesterolemia**:**

| Label | Frequency | Percent |
|---|---|---|
| Excellent | 310 | 72% |
| Very Good | 107 | 25% |
| Good | 11 | 3% |
| Fair | 1 | 0% |
| Unsatisfactory | 0 | 0% |
| Total | 429 | 100% |

**In terms of delivery of the presentation, please rate the effectiveness of the speaker:**
Birgit Amann, MD– ADHD**:**

| Label | Frequency | Percent |
|---|---|---|
| Excellent | 295 | 71% |
| Very Good | 102 | 25% |
| Good | 17 | 4% |
| Fair | 0 | 0% |
| Unsatisfactory | 0 | 0% |
| Total | 414 | 100% |

**In terms of delivery of the presentation, please rate the effectiveness of the speaker:**
Alexander Duarte, MD– PAH**:**

| Label | Frequency | Percent |
|---|---|---|
| Excellent | 265 | 66% |
| Very Good | 122 | 30% |
| Good | 15 | 4% |
| Fair | 0 | 0% |
| Unsatisfactory | 0 | 0% |
| Total | 402 | 100% |

**In terms of delivery of the presentation, please rate the effectiveness of the speaker:**
Louis Kuritzsky, MD– Diabetes**:**

| Label | Frequency | Percent |
|---|---|---|
| Excellent | 287 | 74% |
| Very Good | 89 | 23% |
| Good | 10 | 3% |
| Fair | 1 | 0% |
| Unsatisfactory | 0 | 0% |
| Total | 387 | 100% |

**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**:**

| Label | Frequency | Percent |
|---|---|---|
| Excellent | 305 | 71% |
| Very Good | 106 | 25% |
| Good | 17 | 4% |
| Fair | 2 | 0% |
| Unsatisfactory | 0 | 0% |
| Total | 430 | 100% |

**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**:**

| Label | Frequency | Percent |
|---|---|---|
| Excellent | 312 | 73% |
| Very Good | 100 | 23% |
| Good | 16 | 4% |
| Fair | 2 | 0% |
| Unsatisfactory | 0 | 0% |
| Total | 430 | 100% |

**To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias?** Priscilla Pemu, MD, MSCR, FACP – Heart Failure Part II**:**

| Label | Frequency | Percent |
|---|---|---|
| Excellent | 324 | 75% |
| Very Good | 93 | 22% |
| Good | 13 | 3% |
| Fair | 1 | 0% |
| Unsatisfactory | 0 | 0% |
| Total | 431 | 100% |

**To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias?** Priscilla Pemu, MD, MSCR, FACP – Hypercholesterolemia**:**

| Label | Frequency | Percent |
|---|---|---|
| Excellent | 324 | 75% |
| Very Good | 95 | 22% |
| Good | 13 | 3% |
| Fair | 1 | 0% |
| Unsatisfactory | 0 | 0% |
| Total | 433 | 100% |

**To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias?** Birgit Amann, MD– ADHD**:**

| Label | Frequency | Percent |
|---|---|---|
| Excellent | 300 | 74% |
| Very Good | 91 | 22% |
| Good | 15 | 4% |
| Fair | 1 | 0% |
| Unsatisfactory | 0 | 0% |
| Total | 407 | 100% |

**To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias?** Alexander Duarte, MD– PAH**:**

| Label | Frequency | Percent |
|---|---|---|
| Excellent | 295 | 74% |
| Very Good | 90 | 23% |
| Good | 13 | 3% |
| Fair | 0 | 0% |
| Unsatisfactory | 0 | 0% |
| Total | 398 | 100% |

**To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias?** Louis Kuritzky, MD– Diabetes**:**

| Label | Frequency | Percent |
|---|---|---|
| Excellent | 298 | 76% |
| Very Good | 83 | 21% |
| Good | 12 | 3% |
| Fair | 0 | 0% |
| Unsatisfactory | 0 | 0% |
| Total | 393 | 100% |

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

| Label | Frequency | Percent |
|---|---|---|
| Topics covered | 344 | 34% |
| Location/ease of access | 307 | 30% |
| Faculty | 67 | 7% |
| Earn CME credits | 308 | 30% |
| Total | 1026 | 100% |

**Future CME activities concerning this subject matter are necessary:**

| Label | Frequency | Percent |
|---|---|---|
| Strongly agree | 258 | 59% |
| Agree | 158 | 36% |
| Neutral | 18 | 4% |
| Disagree | 2 | 0% |
| Strongly Disagree | 0 | 0% |
| Total | 436 | 100% |

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

| Comment |
|---|
| Early implementation of sglt2 |
| I will be better prepared to identify CHF, DM2, hyperlipidemia, PA and ADHD and the |

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| treatments offered and the pharmacogenomics of their plans. I will refer when necessary |
| Can better counsel pts. w/ heart failure as to options.<br>Can better discuss cholesterol management and options for treatment.<br>Can better assess and treat ADHD in adults.<br>Better appreciation of new diabetes meds. |
| -Determining appropriate patients who will benefit from Sacubitril/Valsartan as well as other medical therapies per evidence based recommendations.<br>Familiarizing and applying recommended update on lipid, diabetes, ADHD and PAH medication therapies. |
| 1. Addition of SGLT2 inhibitor promotes glucose control, weight loss, and BP reduction.<br>2. Ivabradine helps reduce heart rate.<br>3. Muscle cramps secondary to statin can be treated by holding statin until symptoms resolve and reveal restarting the statin. |
| 1. How to effectively manage a patient with heart failure<br>2. How to treat, according to guideline, hyperlipidemia<br>3. Manage patients with ADHD. |
| 1. Remember to control patients A1C, blood pressure, and cholesterol<br>2. Will try to use sumatriptan Iontophoretictransdermal patch for patients with migraine.<br>3. Use non-invasive markers to diagnose NASH/inflammation to avoid for liver biopsies. |
| 1. Screen always for modifiable CAD risk.. Will continue to stees healthy lifestyles to client<br>2. Use of the guidelines to help guide treatment and when to implement new drug for treatment |
| 6-minute walk to assess severity of PAH |
| Able to differentiate PAH from other forms of heart disease diagnosed<br>Utilize new strategies for treating and managing adults with ADHD other than Strattera<br>Know limits in treatment and refer for best outcomes |
| Able to discuss with patients easier and with confidence |
| Add additional labs to help with diagnoses, pay more attention to heart rate in regards to HF, remember to use zeta, 'use risk as barometer' more often, remember many hypoglycemic episodes not noticed, remember PAH and hereditary lipidemia as differential diagnoses and pertinent labs |
| ADHD treatment |
| Advise latest advances. Use new strategies for diagnostics |
| African American HF patient consider hydralazine/isosorbide nitro. Consider Ivabradine if HR>70 beats/minute in patient not responding to treatment |
| Although I see patients with these listed diagnoses currently in my practice, I do not manage them. My strategy would be to determine if these issues are being addressed with the health history and encourage patient to follow up or refer. |
| Always screen for ADHD. PSCK9 inhibitor in familial hypercholesterolemia. High blood pressure and heart rate are importance factors for HF modification |
| Application of guidelines and evidence-based medicine. |
| Application of the knowledge I ve learned from theses lectures |
| Apply strategies to risk management/treatment of primary care patients |
| Better knowledge and use of glucagon-like peptide (GLP)-1 receptor agonist (GLP-1 RA) therapy to address post-prandial hyperglycemia. The benefits of LDL-C lowering with pharmacologic therapies that improve cardiovascular outcomes |
| Aware of new meds, adding and adjusting these new meds |
| Be alert for more of the PAH symptoms in my patients |

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| Be more aggressive to improve heart rates in HF to improve outcomes. When statin Rx IR LDL-C remains >70 add PSCK-9 inhibitor to decrease CV risk. HFpEF 2HRT-use Ivabradine-decrease heart rate. Six minute walk to assess range |
| Behavior medicine to address biopsychosocial aspects to health/ mind body connectoin |
| Better awareness and screening for ADHD; My practice is with a generally healthy young adult population, and so I was particularly interested in the discussion of comorbidities associated with ADHD. The cardiovascular content was both an excellent review as well as a good update. |
| Better focused Assessment<br>Alternate treatment therapies<br>Deliver care with focus on multiple comorbidities |
| Better knowledge and increase use of newer medications presented for CHF and diabetes. Increased screening for ADHD. |
| Better knowledge on practical applications for newer therapies |
| Better management of DMII. More comfortable to treat ADHD |
| Better management of HF/CVD and HLD with evidence based med. Clearer understanding of med approach to PAH |
| Better management of hyperlipidemic patient and patients with heart failure |
| Better understanding about treatment of disorders discussed |
| better understanding of how to approach and treat adult ADHD |
| Better understanding, assessment & treatment |
| Blood sugar control |
| BP control, desirable lipid profile |
| Bring up to date education to my patients |
| By increase knowledge |
| Can still use statins, even with muscle adverse events if no significant incidence of CK, screening for ADHD, how to diagnose PAH |
| Consider post-prandial BS as important as FBS<br>Initiating Beta blockers in HF patients<br>Importance of considering Ezitimibe addition to Statin for benefits of LDL-reduction |
| Considering use of meds |
| CHF treatment. Pulse over 70 in CHF |
| chf, adhd |
| Clinical assessment, screening, diagnostics and interventions related to enhanced client outcomes. |
| Communication skills; more comfortable with SGLT2 inhibitor therapy; treatment options for elevated LDL; more knowledge of heart failure and treatment |
| Comorbidities of Adhd in consideration in treating patienst with this condition. |
| Comprehensive assessment, in depth history taking and collaboration with other specialties |
| Congestive Heart Failure carries high risk to end in Heart Transplant, and for that possibility it should be preventive. It should be evaluated carefully, to know if it is with preserved Eject fraction or it is with reduced EF, to know the correct drug therapy and to know the prognosis. HFrEF with heart rate greater than 70 despite maximally tolerated beta blocker therapy is associated with poor outcome. Those pts benefit from Ivabradine, especially for those pts with EF less of 35%. Sacubitril/valsartan may be appropriate to pts with HFrEF. |
| Consider different agents based on evidence based practice guidelines |
| Discerning<br>Early approach<br>Proper testing |

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| Proper m edication |
| Discuss more with patient |
| Do screening tests before initiating trial treatment e.g. ADHD |
| Document monitoring parameters<br>Education regarding medications<br>Nonpharmacologic plans |
| Each patient is different<br>case by case |
| Early diagnosis<br>Better management |
| Early diagnosis of pulmonary hypertension<br>Using bio markers to help diagnose heart failure<br>Effectively treating hyperlipidemia to reduce cardiac risk |
| Ethnic specific e.g. Hydralazine for AA regarding BP, HF. Ivabradine to decrease heart rate; dual strategy of sacubalal/valsartan in HF, ADHD screens, PAH-complex-refer; use SGLT-I prefer over sulfaneurics safe and effective |
| Evaluating ADHD, evidence based treatment of heart failure and PAH |
| Evaluating patients more extensively to prescribe. Awareness of studies to base sound interventions |
| Evidence based trials were helpful, examining cost helpful |
| Evidence-based implementation of medicine |
| Explaining to pta the role Of the kidneys in glucosa control. |
| Facilitating the new concepts in my daily practice. Applying varied approaches and screening techniques to identify underlying issues. |
| Familiarity with ivabradine.<br>Screening for CHF.<br>ADHD screening in adults. |
| Follow suggestions made throughout lectures |
| Following guidelines |
| Following up to date published guidelines for treatments |
| Full and complete hx prognosis, rx |
| Future drug Rx of CHF and high cholesterol |
| Good |
| Good information on managing heart failure, etc., and better strategies for medication use. It was truly eye opening to learn about the differences between managing African Americans, etc., and how the use of medication to magnify beta blocker effectiveness is critically important. |
| Guidelines |
| Guidelines for adjusting Caridine Rx in HF |
| Heart failure guidelines and management |
| Heart Failure is was difficult for me to manage in primary care. I am now able to take each case individually and discern what medication should be added or taken away.<br>I feel more comfortable treating Adult ADD patients and treating with the long acting medications as well as the use of the assessment tool. |
| HLD management, DM strategies |
| How to approach the discussion with the patient. How to work with the different types of medications to get the full benefits |
| How to better care for my patients |
| How to screen high risks patients for Heart failure, DM, and PAH |

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| How to educate my patients and incorporate the latest evidence based drugs for better patient outcomes |
| How to treat and diagnose CHF |
| HTN and HF management |
| HTN is the most important thing to manage to prevent CHF.<br>When to use Ivabradine.<br>Use Isosorbide/Hydralazine with africian americans with CHF. |
| I am a fairly new practitioner -some of the medications discussed I was unfamiliar with - I currently work in an emergency room and interventions used are basically on an emergent basis |
| I am able to discuss/ be more aware of patients with ADHD. Excellent speaker.<br>Understand better the new many medicines for diabetes, hypercholesterolemia, ADHD, etc |
| I am more aware for my patients. |
| I do not recall I do plan to listen to the cme again |
| I have a better understanding of adjusting cholesterol treatments with other options. I work in minor acute care so do not adjust many long term medications |
| I have learned more about each topic |
| I intend to at least try to identify heart failure patients and consider the medications presented during the conference. I do not believe that I will use any sglt2 I'm not convinced of the long-term safety. |
| I learned a good deal about new medications and about the assessment and evaluation of patients with the different disorders. I'm currently practicing on a limited basis, but the information will prove helpful when I increase my practice hours. |
| I learned more about diagnosing and monitoring heart failure. I agree with hypercholesterolemia presentations and ADHD. Diagnosing and managing hypertension, PAH |
| I learned other options for treating cholesterol and diabetes |
| I will be adjusting how I prescribe medications in my next position. Presently, I am not employed in a prescribing role. |
| I will keep referring my HF patients to Cardiology until I feel more comfortable. I will start using SGLT2 inhibitors with confidence. I will only use extended release stimulants in adults with ADHD. |
| I will use what I learned |
| I've acquired information on new medications to add to my tool kit in treatment of CHF, T2DM, and hypercholesterolemia. |
| Identify and treat risk factors, monitor at risk patients, treat the appropriate patient based on the appropriate clinical trial |
| Identify coexisting disorders in adult patient with ADHD. Recognize to incidence and risk of hypoglycemia in managing patients with diabetes |
| If heart rate is greater than 75 beats per minute, Ivabradine in African Americans, heart rate reduction leads to best prognosis |
| Implementing current guidelines through assessment, diagnostic tests and evaluation of medications to ensure quality care based on EBP. |
| Improving outcomes in heart failure, PAH, and Hypercholesterolemia |
| Incorporate what I learned in Heart Failure, PAH, Diabetes, ADHD and Cardiovascular Risk into Pain Management guidelines |
| Increased my knowledge base on ADD and pulmonary hypertension. |
| Individualizing treatments and appropriate referral |
| INVABRADIN IMPROVES CARDIOVASCULAR OUTCOME,BENIFITS MAXIMUM |

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| DECRESASE IN HT RATE.WITHOUT AFFECTING HT RATE.<br>USE OF PCSK9 INHIBITORS TO REDUCE LDL. |
| Keep heart rates down in heart failure. Consider newer agents for lipid lowering |
| Keep in mind African Americans have different response to certain meds |
| Keeping abreast to current evidence based practices<br>Improved knowledge of treatment options improves patient options<br><br>Working in retail clinic, with acute illnesses limits exposure to disease management, however conference reinforced how crucial it is to look beyond the immediate care and refer patients to the appropriate care for improved outcomes. Also improved comfort level in discussions with patients, strategies with help patient with comfort level of making care decisions. |
| Learning when to use PCSK9 Inhibitors and data behind Statin and Zetia treatment<br>Also familiarizing with new medication options for heart failure and heart rate lowering.<br>I will use BNP and pro-BNP more often to follow status of CHF |
| Learnt how to treat ADHD, first treatment for HF |
| Like the Screener for adult ADHD  Need to develop referrals for this as more patients than I thought are likely to have this<br>Thank you for the JNC 8 algorithm page useful in considerations of choices for patients in specific demographic<br>We do much screening in the practice I am in, More intensive considerations for lipids and appropriate tx or referral |
| listen<br>assess<br>evaluate<br>use evidenced based practice |
| Mainly ADHD treatment strategies which I used to refer before |
| Manage the diseases<br>Know the different therapies<br>Know their side effects<br>Understand the pathophysiology of the diseases |
| Management of HF, DM, and high cholesterol. With the use of new pharm knowledge |
| Management of HT total HT, EF. Screen ADHD - adults over 60 |
| Medication treatment modalities |
| Medication. Regular visits. Follow up |
| Monitor and evaluate lipid levels. Understand altering of meds in CHF |
| MONITORING FOR HYPOGLYCEMIA MORE CAREFULLY |
| More extensive history taking and use of teaching tools |
| More knowledge of testing & interpretation of testing to make diagnosis |
| More medical knowledge |
| Much better understanding of CHF treatments, esp in AA<br>Better comprehension of SGLT2 inhibitor therapy<br>More awareness of ADHD symptoms in adults |
| Much more aggressively work on comorbidities in patients with HFpEF. Use Ibrane in HFrEF with heart rate over 70 |
| New approach to manage hypercholesterolemia, PAH, and DM2 |
| New medical knowledge |
| New Medical therapy |
| New medications for heart failure |

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| How those medical therspy will affect the patient thier lab values |
| New medications that I was not previously using |
| New treatment for heart failure |
| Monitoring post prandial sugar |
| new treatment in lipid<br>pul hypertension |
| New updated standards of care for the cardiac, diabetic and ADHD patients. |
| Obtaining right heart cath for PAT, adding non statin meds with statin if needed |
| Optimal management of Heart Failure, with fixed dose therapy. Additional medication for Diabetes such as SGLT2 inhibitor therapy. Use of PCSK9 in the management of Hyperlipidemia. Diagnosis and appropriate referral of PAH. Use of assessment tools for ADHD during follow up to guide medication treatment, adjustments and to lessen potential side effects from it. |
| Organization |
| Patient education |
| Patient education approach. Focus more on LDL. When to order anti PCSK-9. Clearer picture of mechanisms of action of drugs |
| Physiology of disease process<br>Risk factors and co-morbidity<br>Appropriate treatment management |
| PLAN TREATMENT OPTION<br>USE INVESTIGATION PROPERLY<br>PATIENT SHARING DECISION |
| Primary care coordinates the management of their patients with the specialists |
| Proper diagnosis and treatment and evidence based information |
| Rate control for CHF,<br>ADD / ADHD history taking techniques<br>confirmed how I treat dm-2 |
| Rational approach to use of newly approved drugs for heart failure. Valsartan/Sacubutine and Ivabradine |
| Recognition of disease |
| Recognizing CHF based on risk factors<br>Utilizing SGLT-2 in the appropriate patient |
| Recognizing the signs and symptoms of each disease and apply evidence based practice guidelines to plan of care |
| Reminding patients why & not just how to follow best practice medical protocols. |
| Retired since 2000 |
| Review med list in all patients. Be more aggressive with statins, lower heart rate |
| Risk assessment |
| Screening for ADHD Better.<br>Managing HLD with more treatment options.<br>Treating Pulm. HTN Better |
| Screening for ADHD. Applying new medications/combinations |
| Started to use SGLT2 meds |
| Statin use |
| Stratify patients appropriately<br>Initiate and evaluate necessary therapy |
| To not wait too long before starting a SGLT2<br>If a patient is not responding well with glycemic control, to add SGLT2 to therapy |

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| Treat all conditions much more aggressively |
| Treating elevated LDL levels and evaluating treatment options |
| Treating HF with more options and newer agents, using different agents for treating CV disease, DM, ADHD and pulmonary hypertension |
| Treatment of ADD, diabetes, hypertension |
| Updated Diabetes Care<br>Updated Heart Failure<br>Updated Pulmonary care |
| Updated medical treatment regimens, diagnosing patients, proper referral avenues based upon symptomology |
| Use of previously unknown/unused drug treatments |
| Use screeners for ADHD<br>Use Hydalzine/nitroglycerine combination in blacks with heart failure |
| Use screening tools to assist the diagnosis of ADHD |
| Using ADHD adult diagnosis. Strep in pulmonary hypertension evaluation |
| Using appropriate screening tools for ADD, proper screening and more effective treatment for PAH and HF, and tighter, more effective glycerin control with my diabetic patients. |
| Will consider the new HF meds presented at the meeting.<br>Will screen for adult ADHD more readily.<br>Ready to try SGLT2 inhibitor |
| Will use SGLT2 inhibitors on diabetic patients<br>Will be more likely to recognize and screen patients for ADHD<br>Will be able to be more active in monitoring patients with CHF/CMO |
| Zetia and PCSK inhibitor use and guidelines |

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

| Comment |
|---|
| -Obesity pharmacological and surgical treatment |
| ACS, MI, DM, Dementia, Alzheimer's |
| Add - pediatric topics |
| Additional lipid management, especially with statin intolerance<br>Vit D deficiencies and management |
| ADHD<br>Cardiomyopathy<br>Stroke<br>Atrial fibrillation<br>Backpain |
| Any subjects that help to keep Primary Care up to date in all specialties- Neurology, Endocrinology, Psychiatry, etc. |
| Any topic related to internal medicine |
| Any topics cardiac or DM, herbal interactions with meds, bone health |
| Anything on latest psychiatric pharmacological and nonpharm approaches- |
| Arrhythmia management |
| Auto- immune diseases |
| Autoimmune, Depression |
| BPH. Ovarian cancer. Indications for cataract surgery. Diagnosis and treatment of Schizophrenia |
| CAD, metabolic syndrome, obesity. GI problems, ED |

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| Cancer and behavioral together |
| Cancer screening, adult immunization, skin rashes, associated autoimmune disease |
| Cancers treatment, leukemias and lymphomas |
| Chest Xray difference in the patient with COPD<br>Understanding heart sounds |
| Chronic disease mgmt strategies related to long term achievement of outcomes. |
| Chronic kidney disease and future treatments that may be coming |
| Chronic pain<br>Fibromyalgia<br>HRT |
| Cirrhosis, transaminitis, encephalopathy, dementia |
| Continue with diabetes |
| COPD<br>AFib<br>Ckd |
| COPD, Asthma, PNA, Bipap benefits |
| CVA Update, treatment strategies.<br>Mote HTN,DM and HLD Updates as new guidelines evolve. |
| Degenerative/demyaling (MS, ALS, Parkinson's), Diabetes treatment |
| Dementia, Parkinson's Disease, MS |
| Depression and bipolar |
| Depression and Diabetes |
| Dermatological treatment options, latest COPD treatment options |
| Dermatology<br>Common eye problem in primary care |
| Dermatology-skin rashes and treatment |
| Dermatology/infectious diseasde |
| Diabetes<br>erectile Dysfunction or Hypogonadism<br>Glaucoma  Cataract<br>Alzhimers |
| Diabetes |
| Diabetes management in pediatric/adolescent/adult transition |
| Diabetes, chronic pain management, COPD |
| Diabetes, psychiatry in Primary Care |
| Diagnostic challenges in clinical medicine |
| ED, Hypogonadism |
| EHR How to survive it<br>New CMs regulation<br>Antibiotics?  when where and not to |
| Endocrine topics<br>rheumatology |
| Eosinophilic Esophagitis |
| Fibrotic atrial cardiomyopathy and AFib risk. Genetic issues with loss of miricoxide in african americans |
| Further discussion and treatment of heart failure, DM. Have topics on sports medicine for the weekend, high school, college and semi-professional athletes. |
| Gastroenterology and ophthalmology health issues |

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| Genetic contribution in medical diseases |
| Gynecology, adolescent, neurology |
| Hematological, renal, dermatological disorders |
| HIV, Nutrition, pneumonia, hypertension, Vitamin Deficiency |
| HIV, prep treatment/prophylaxis and treatment |
| How to complete thorough orthopedic exams. Chronic pain management. |
| HTN, Geriatrics, Asthma, Pain Management |
| Hypertension urgency<br>Inflammatory bowel disease |
| Hypertension.<br>Syncope and Orthostatic Hypotension.<br>Cardiac Arrhythmias.<br>Acute Coronary Syndromes.<br>Valvular Heart Disease.<br>Heart Transplant and Cardiac Support Devices. |
| I would appreciate more information on renal disease, as well as autoimmune disorders. |
| Infectious disease, sepsis, Pneumonia |
| Infectious disease, sports medicine, hypotension |
| INFECTIOUS DISEASES AND HIV |
| Insomnia Rx; spirometry interpretation and accuracy; lymphocytic colitis/colitis/malabsorption and renal stone Rx/prevention |
| Insurance coding/billing<br>Methods to effectively bill |
| IPF, obesity as relates to cancer development, and other disorders, Death & bereavment, lobbying for ARNP issues |
| Lifestyle, nutrition, ortho, derm, procedures, microbiome |
| Lines failure/ETOH. HTN/TIA/CVA. Anticoagulopathy Rx. MOF/SiRS/sepsis. Trauma |
| Lymphedema. PVD |
| Management of CKD |
| Menopause |
| More diabetes management |
| More focus on primary health concerns of different cultural groups i.e. middle east, native americans, etc. (more than what we have seen in past years) |
| More of gynecological subjects |
| More of the same, plus infectious antibiotic resistance and new strategies for fighting infections and immunology vaccination updates recommendations for travel |
| More on diabetes; hypertension; asthma; pretty much any topic related to primary care. Also related to pediatric primary care. |
| More primary care |
| More specific and advanced trt of complex diabetic patients |
| More women's medical issues |
| Neurology in primary practice |
| new guideline in paediatry pneumonia |
| New trends in osteoporosis.<br>New recommendations in mammograms.<br>Common meds ok with pregnancy without going or consulting with OB MD |

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| Not sure |
| Nutrition helping adults lose weight with family/ support |
| Obesity - Pharmacologic therapies in patients with multiple medical problems, especially in patients with CAD, CHF/stroke |
| Obesity and nutrition. Migraine. O.A. |
| Obesity evaluation, treatment |
| Obesity, diabetes, hypertension |
| Obesity, HPV vaccinations, opioid induced constipation |
| Obesity, HTN in children |
| PAD and propesia management, STI in adolescents |
| Pain management/EKG's/imaging protocol |
| Pain medicine |
| Pain mgt and multiple comorbidities |
| Palliative Care<br>Pain Management |
| Parathyroid disorders |
| PCOS<br>hyperthyroidism<br>Bipolar Disorder |
| Pediatric and adult asthma<br>Dermatology - psoriasis, eczema<br>migraine/headache<br>concussion management |
| Pediatrics and Dermatology in primary care |
| Problems in aspiration - how to control it |
| Psychiatric topics |
| PSYCHIATRY |
| Psychiatry in primary care physician adult immunization |
| Renal disease. Musculoskeletal diseases |
| Renal failure |
| Resistant antibiotics, dermatology for Primary Care, Hepatitis C treatment |
| Review of treatment for obesity |
| Rheumatology- New therapies<br>Dermatology |
| Seizure disorders, Rheumatoid disorders, Hepatitis C treatment/managment |
| Seizure, Depression |
| Similar clinically relevant topics on diabetes, lipid management, hypertension, CHF |
| Similar topics for everyday primary care |
| Sleep apnea eval and management<br>More type 2 DM management |
| Sleep Medicine |
| Sports injuries, cancer screening |
| Stem cell therapy |
| Suboxone,<br>Addiction |
| Substance abuse<br>Alzheimer |
| Substance abuse & dependence; renal disease; liver disease; depression |

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| Sudeen cardiac death |
| Surgical topics |
| Syncope, chronic pain management, medical billing |
| Theyroid and liver diseases |
| Thyroid disease<br>dermatology for the non dermatologist |
| Trauma care in the elderly<br>HTN Management<br>Stroke |
| Treating obesity. Pain management guidelines |
| Unstable angina, hospital acquired pneumonia |
| Urgent care CE |
| Use of newre insulins in T2DM<br>inflammatory bowel disease |
| Vascular complications of diabetes, dermatology, managing patients with depression in the primary care setting. |
| Vascular diseases (venous and arterial diseases) and treatments<br>Orthopedic diseases and treatments<br>Nonconventional methods of treating pain, musculoskeletal disorders etc |
| Vitamin D |
| Women's Health |
| Wound care. Pain management |
| X-rays<br>Usg<br>Afib |
| You do very well with all your presentations and look forward to their presentation. I can't offer any suggestion only welcome the opportunity |

**Additional comments:**

| Comment |
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| ALWAYS excellent, fully knowledgeable, friendly speakers. Some exhibit a refreshing sense of humor. Tho packed full of info, I always learn some pearls to use in patient care!<br>THANK YOU! |
| Always very informative |
| As an OB-Gyn when I see above indicated conditions, they are medically managed by other colleagues |
| Chairs/seats too close to each other - overcrowded. People sitting too close to each other, elbow to elbow, very uncomfortable with spacing! |
| Communicable disease please |
| Conference topics were well covered. Initially difficulty focusing on speaker, dialect was a little difficult to hear clearly, background lighting was dark even with conference adjustment. No complaint though, great presentation. Wish I had read material before conference. |
| Definitely an excellent CME program |
| Dr. Anekwe used too many gap fillers which made his presentation very difficult to understand because I kept waiting for the next gap filler and that led to the message being lost.<br>Other than that, the entire day presentation was very informative. |

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| Dr. Onwuanyi - difficult to understand - voice drops to inaudibility, doesn't comment on the choices that are wrong, or the correct ones for that matter |
| Dr. Onwuanyi - would've been helpful to see answers to questions right away. Would like to know cost of drugs for patients. Dr. Kuritzky was a great speaker |
| Enjoyed the topics, thank you! |
| Environment too cold |
| Excellant speakers, learnig new treatments |
| Excellent |
| Excellent meeting, convenient CME on line, expect more CMEs |
| Excellent - was also wonderful that it was free - nice room, video, comfortable seats - also kept to times, allowed questions - thank you! |
| Excellent CME |
| Excellent conference |
| Excellent conference! |
| Excellent conference. Very organized speakers presented good reviews of relevant topics |
| Excellent event |
| Felt that each lecture was targeted to a specific drug, almost like drug rep lecture/meeting and felt bias with the lecture targeting a single class/medication to prescribe |
| For Primary Care - studies and details on these studies are not useful in clinical practice |
| Glad was able to attend, will surely attend more so in future, thanks for making it available |
| good conference |
| Good conference. Heart failure was too long |
| Good location and CME credits. Very good topics |
| Good presentations during this conference. I was about 30 minutes late in case you need to deduct that on my hours. Thanks for offering this webinar. You make it easy to obtain much needed "LIVE CME" hours. See you in San Antonio |
| Good presentations, nice location, good speakers |
| Good Simulcast except few tech glitches! |
| Good to have Wifi! Thanks |
| Good topics and well presented |
| Great location. Good topics |
| Great presnetation |
| Great program, thank you all for bring quality ce programs to my home office!!! |
| Great topics and great speakers |
| Great! Well organized! Impressive staff |
| Heart failure treatment. |
| How to get copies of slide program/lecture for each subject. References often from 2003, 2004. Need copies of assessment tools (i.e. ADHD). Too much information to write down without handouts and support so missing a lot of information. Too busy trying to write. Information was good, more than I knew before, wanted to re-read |
| I always have to thank you for these excellent conferences. I wish all conferences could be webinars! And yours is still always free!! thank you so much |
| I am impressed with content and lectures |

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| I was up at 5:00 AM in the PNW for the conference. The conference was interrupted during the second heart failure presentation, and I was unable to get back into the conference for the lipid/reduction of cardiac risk factors. Later in the day I was able to rejoin the conference. I was disappointed to miss the presentation of cardiac risk factors. |
| I work primarily in women's health so I am not charged with managing these items on a daily basis but am required to have the ability to at least manage some first line and make appropriate referrals I appreciate the knowledge |
| It is excellent to learn and refresh our medical activities |
| It was a good CME |
| It was informative |
| Keep the location: Troy Marriott is great. Kindly choose speakers without accent - who speak clearly with good diction |
| Missed first lecture due to inability to access - technical issues. |
| More case studies would be helpful. |
| N/A - handouts will be helpful |
| None as it was excellent |
| Not enough time for PAH - meds sheet reviewed in 10 seconds |
| Over all, great topics. |
| Overall good |
| Overall good educational experiences |
| Pens should have been available |
| Please provide a selection option of "did not attend" to allow participants to accurately reflect attendance and feedback for the sections they did not attend. Thank you. |
| Please tell speakers to define all acronyms |
| Pre-test questions should have had option of 'I really don't know' instead of having to guess. I was an only participator and especially on test questions, the slides didn't keep up with the presenter a few times |
| Presentation outstanding |
| Program moved quickly and was very well done.<br>I appreciate the ability to earn CEUs on a Saturday, from home, and at no cost. |
| Room was too crowded/seats too close together for comfort. I found Dr. Onwuanyi's presentation confusing. Slides were projected too low - couldn't see bottom over people's heads |
| Seating was close together |
| Subjects on psychiatry/psych therapy |
| Thanks a lot |
| Thanks! |
| The ADD lecture was full of energy and was a great topic to have after lunch. I was thoroughly engaged. |
| The course was very utilitarian, as have been almost all of the NACE courses that I have attended over the years.<br>Thank you,<br>Stan Frankowitz, D.O. |
| The speakers made it easy to listen |
| There were some technical problems but I utilized your online contact to address them which proved very helpful. The first speakers accent occasionally made it hard to follow his lecture,especially when he spoke softly or rapidly...but perhaps |

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| that was just me!<br>I am not currently practicing, thus the 0 pt count for your queries. |
| This conference provides an excellent review<br>I learnt a lot |
| Very useful presentation. Good/excellent topics and speakers/presenters |
| Very well done. Thank you! |
| Very well presented. I will come again |
| Wifi access should have been provided. Venue wasn't pre-tested for functionality, slides didn't always work correctly, no power sources near seats, no break at 3:20 so I missed some of the lecture at 3:25! |
| Would like updates on similar presentations. |
| You should have some syllabus and the PowerPoint/lecture notes available for purchase |