NATIONAL ASSOCIATION FOR CONTINUING EDUCATION

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Join us... Emerging Challenges in Primary Care: 2010

May 8, 2010
Raleigh, NC
Raleigh Marriott City Center

Course Director
Gregg Sherman, MD

Activity Director
Michelle Frisch, MPH, CCMEP

Program Evaluation
May 24, 2010

In May 2010, the National Association for Continuing Education (NACE) sponsored a CME program, ***Emerging Challenges in Primary Care: 2010***, in Raleigh, NC.

This educational activity was designed to provide primary care physicians, nurse practitioners, physician assistants and other primary care providers the opportunity to learn about Diabetes, Hypertension, Female Sexual Dysfunction, Male Hypogonadism, Psoriasis, Osteoporosis and Rheumatoid Arthritis.

In planning this CME activity, the NACE performed a needs assessment. A literature search was conducted, national guidelines were reviewed, survey data was analyzed, and experts in each therapeutic area were consulted to determine gaps in practitioner knowledge, competence or performance.

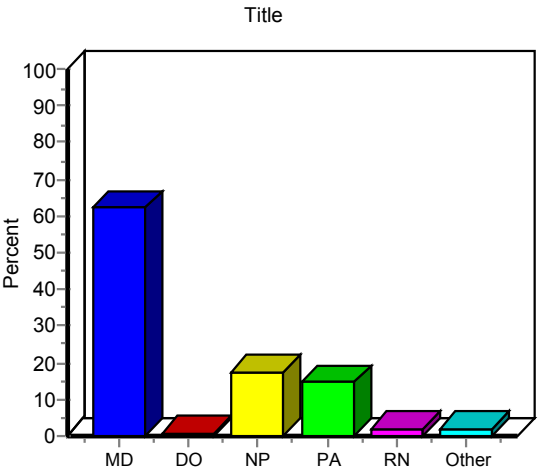
Two hundred ninety three healthcare practitioners registered to attend ***Emerging Challenges in Primary Care: 2010*** in St. Louis, MO. Two hundred seven healthcare practitioners actually attended this conference. Each attendee was asked to complete and return an activity evaluation form prior to the end of the conference. Two hundred four completed forms were received. The data collected is displayed in this report.

CME ACCREDITATION

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 educational activity for a maximum of 7.25 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

What is your professional degree?

Label	Frequency	Percent	Valid Percent
MD	127	62.3	63.2
DO	1	0.5	0.5
NP	36	17.6	17.9
PA	30	14.7	14.9
RN	4	2.0	2.0
Other	3	1.5	1.5
Total Valid	201	98.5	100.0
Total Missing	3	1.5	
Total	204	100.0	



What is your specialty?

Label	Frequency	Percent	Valid Percent
Primary Care	153	75.0	75.7
Endocrinology	6	2.9	3.0
Rheumatology	0	0.0	0.0
Pulmonology	0	0.0	0.0
Cardiology	2	1.0	1.0
Gastroenterology	5	2.5	2.5
OB/GYN	7	3.4	3.5
Other	29	14.2	14.4
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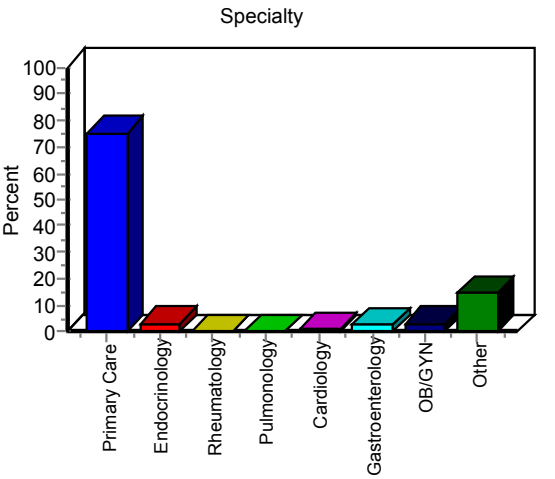
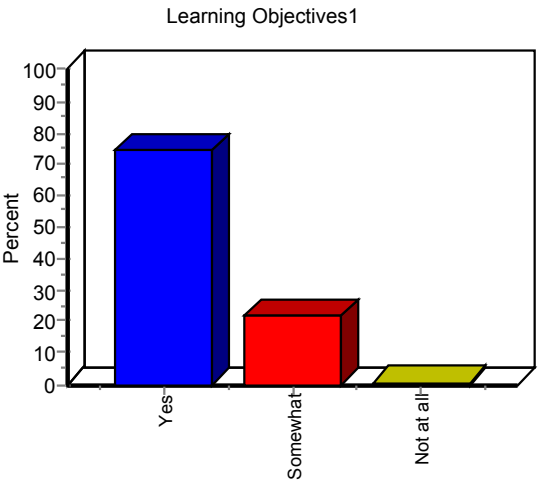


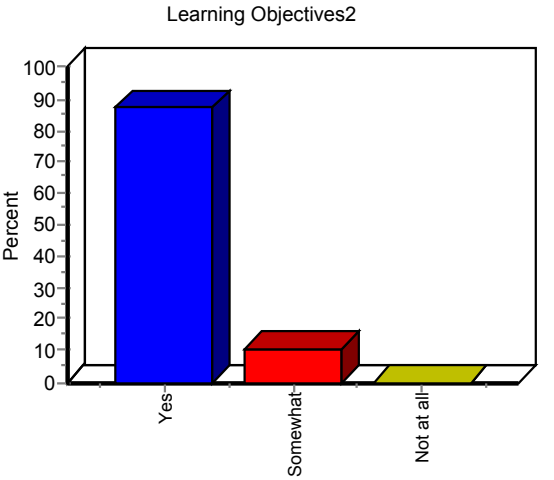
Upon completion of this activity, I can now - Discuss the pathogenesis of hyperglycemia; Make more effective decisions towards optimizing therapy; Explain the effectiveness of diet and exercise in treatment of diabetes at each stage of disease; Recognize the impact of treatment on cardiovascular disease risk; Explain the role of newer therapies in diabetes management:

Label	Frequency	Percent	Valid Percent
Yes	151	74.0	77.0
Somewhat	44	21.6	22.4
Not at all	1	0.5	0.5
Total Valid	196	96.1	100.0
Total Missing	8	3.9	
Total	204	100.0	



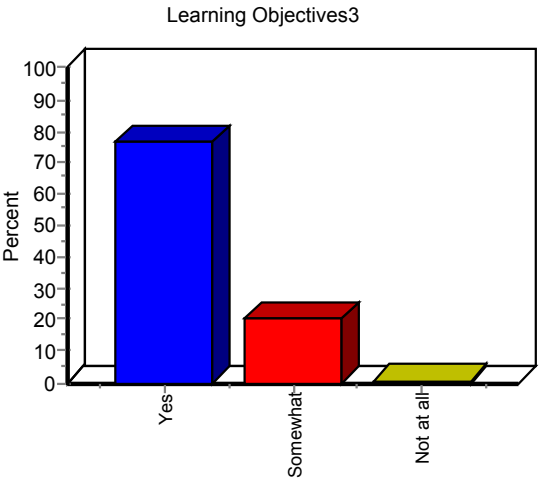
Upon completion of this activity, I can now - Explain the importance of the RANK/RANKL/OPG system in bone health and disease; Describe strategies to identify candidates for pharmacologic treatment; List available therapies for osteoporosis; Identify and overcome barriers to compliance and persistence with therapy:

Label	Frequency	Percent	Valid Percent
Yes	178	87.3	89.0
Somewhat	22	10.8	11.0
Not at all	0	0.0	0.0
Total Valid	200	98.0	100.0
Total Missing	4	2.0	
Total	204	100.0	



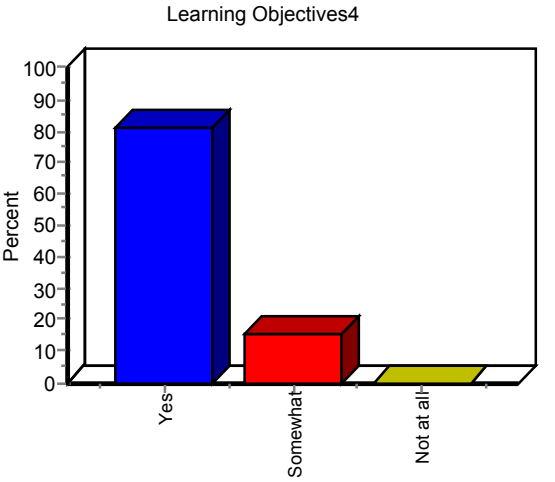
Upon completion of this activity, I can now - Discuss the various etiologies of female sexual dysfunction; Share current epidemiologic information describing the prevalence, incidence, societal burden and personal impact of female sexual dysfunction and its desire disorder of HSDD (hypoactive sexual desire disorder); Address conditions contributing to sexual dysfunction, e.g., depression, anxiety, diabetes, cardiovascular and neurological diseases, pelvic or abdominal surgery, and cancer; Engage in respectful, productive conversation with women regarding the role of sexual health in their overall well-being:

Label	Frequency	Percent	Valid Percent
Yes	156	76.5	78.4
Somewhat	41	20.1	20.6
Not at all	2	1.0	1.0
Total Valid	199	97.5	100.0
Total Missing	5	2.5	
Total	204	100.0	



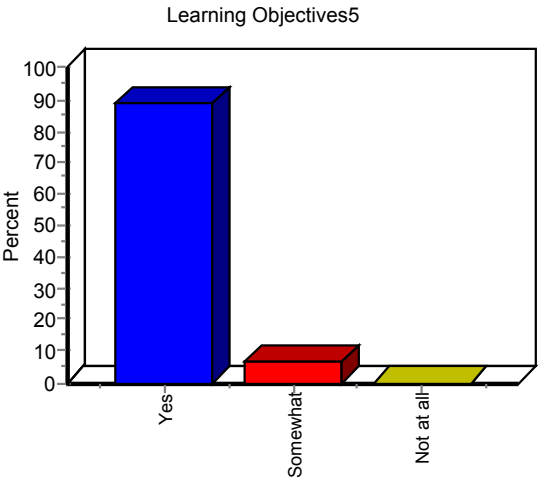
Upon completion of this activity, I can now - Discuss the prevalence of male hypogonadism; Order appropriate lab tests to make a diagnosis and understand the full scope of the problem; identify appropriate management strategies, utilizing traditional testosterone replacement therapies and newer modalities such as transdermal patches, gels and buccal tablets; monitor ongoing therapy more confidently to optimize outcomes and minimize morbidity:

Label	Frequency	Percent	Valid Percent
Yes	166	81.4	83.8
Somewhat	32	15.7	16.2
Not at all	0	0.0	0.0
Total Valid	198	97.1	100.0
Total Missing	6	2.9	
Total	204	100.0	



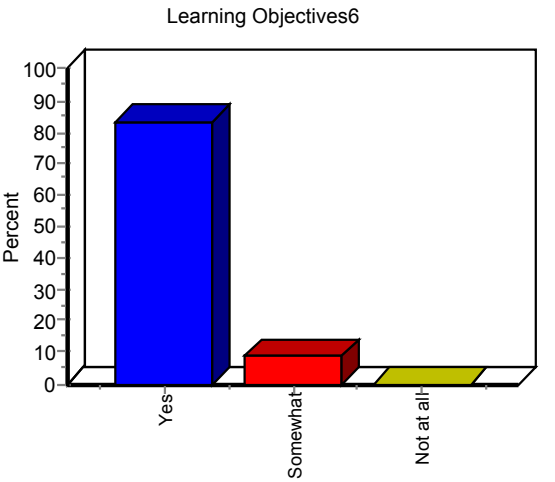
Upon completion of this activity, I can now - Discuss the prevalence of patients not achieving targeted blood pressure goals and the importance of Clinical or Therapeutic Inertia; Understand the role of combination therapy in management of Hypertension and current treatment guidelines; Recognize the impact of Renin-Angiotensin-Aldosterone system manipulation on global cardiovascular risk reduction; Discuss the role of newer agents in achieving blood pressure targets:

Label	Frequency	Percent	Valid Percent
Yes	180	88.2	92.8
Somewhat	14	6.9	7.2
Not at all	0	0.0	0.0
Total Valid	194	95.1	100.0
Total Missing	10	4.9	
Total	204	100.0	



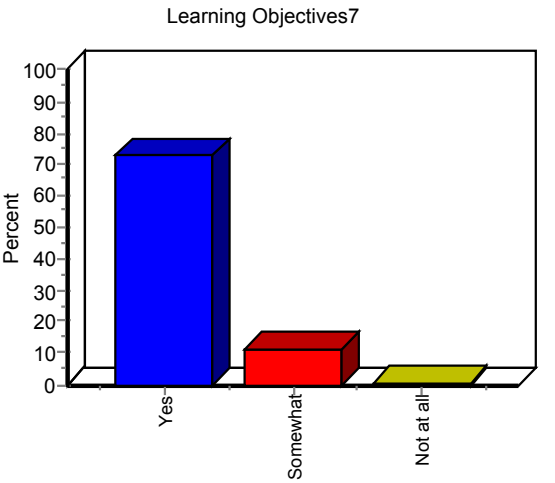
Upon completion of this activity, I can now - Define criteria for diagnosis of RA; Outline potential benefits of early RA diagnosis and aggressive management; Describe the clinical rationale for why the tumor necrosis factor inhibitors and the newer biologics have the potential to improve outcomes; Summarize the efficacy and safety of the available biologics; Utilize referrals to arthritis specialists when necessary, and initiate prompt treatment if a specialist appointment is not readily available; Examine appropriate RA patient management through a collaborative approach with arthritis specialists, physical therapists, and occupational therapists:

Label	Frequency	Percent	Valid Percent
Yes	169	82.8	90.4
Somewhat	18	8.8	9.6
Not at all	0	0.0	0.0
Total Valid	187	91.7	100.0
Total Missing	17	8.3	
Total	204	100.0	



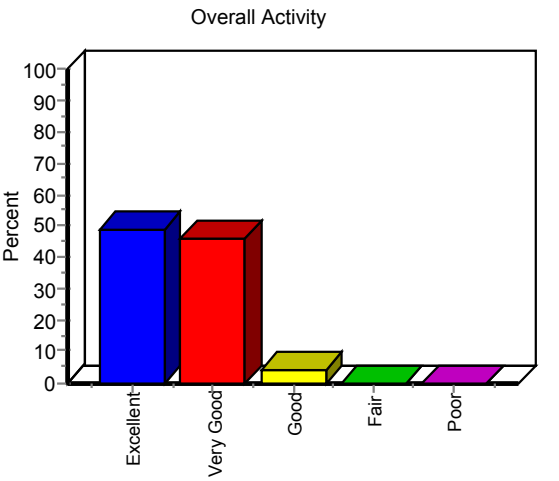
Upon completion of this activity, I can now - Recognize and diagnose Psoriasis and Psoriatic Arthritis (PsA) earlier, and institute appropriate initial treatment options; Discuss the burden and impact of Psoriasis and PsA; Recognize the systemic impact of Psoriasis and the relationship to the metabolic syndrome; Evaluate various management options for Psoriasis ad PsA and recognize which patients are candidates for systemic and biologic therapy; Understand novel therapeutic options in the management of Psoriasis:

Label	Frequency	Percent	Valid Percent
Yes	149	73.0	85.6
Somewhat	24	11.8	13.8
Not at all	1	0.5	0.6
Total Valid	174	85.3	100.0
Total Missing	30	14.7	
Total	204	100.0	



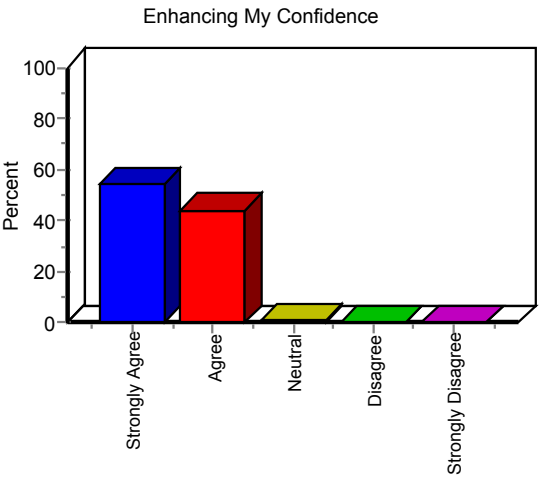
Overall, I would rate this activity as:

Label	Frequency	Percent	Valid Percent
Excellent	100	49.0	49.5
Very Good	94	46.1	46.5
Good	8	3.9	4.0
Fair	0	0.0	0.0
Poor	0	0.0	0.0
Total Valid	202	99.0	100.0
Total Missing	2	1.0	
Total	204	100.0	



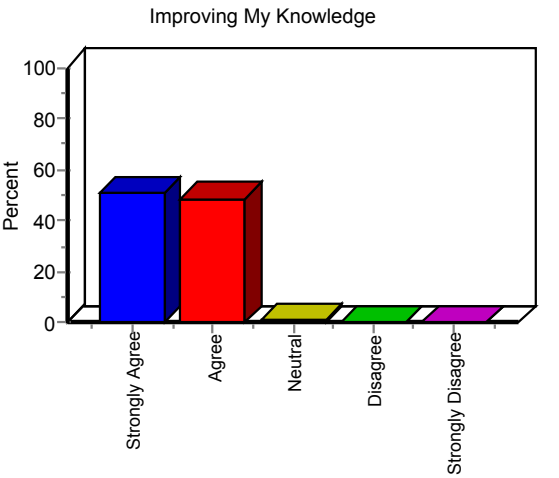
Overall, this activity was effective in enhancing my confidence in caring for patients with the condition(s) presented?

Label	Frequency	Percent	Valid Percent
Strongly Agree	110	53.9	54.5
Agree	90	44.1	44.6
Neutral	2	1.0	1.0
Disagree	0	0.0	0.0
Strongly Disagree	0	0.0	0.0
Total Valid	202	99.0	100.0
Total Missing	2	1.0	
Total	204	100.0	



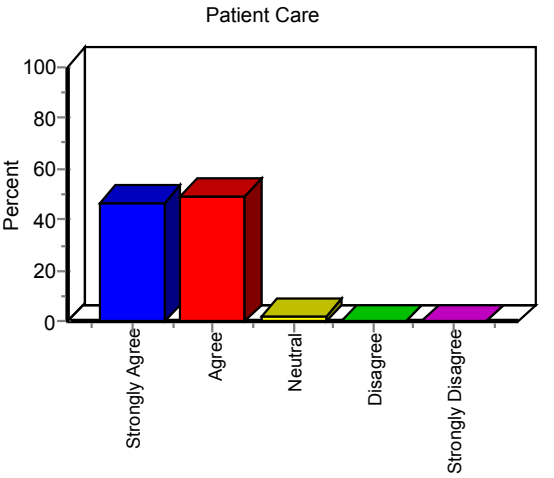
Overall, this activity was effective in improving my knowledge in the content areas presented:

Label	Frequency	Percent	Valid Percent
Strongly Agree	103	50.5	51.0
Agree	98	48.0	48.5
Neutral	1	0.5	0.5
Disagree	0	0.0	0.0
Strongly Disagree	0	0.0	0.0
Total Valid	202	99.0	100.0
Total Missing	2	1.0	
Total	204	100.0	



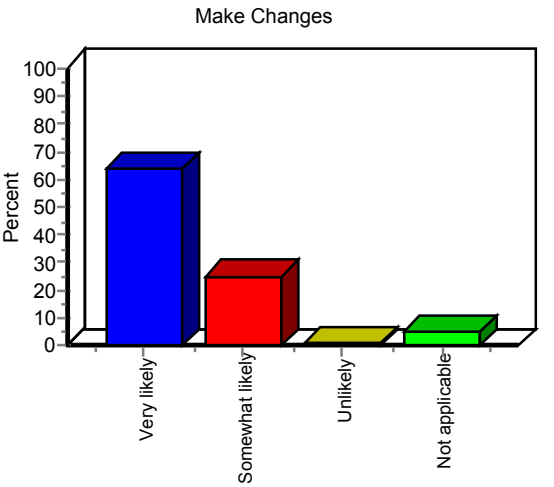
As a result of this activity, I have learned new strategies for patient care:

Label	Frequency	Percent	Valid Percent
Strongly Agree	95	46.6	47.3
Agree	101	49.5	50.2
Neutral	5	2.5	2.5
Disagree	0	0.0	0.0
Strongly Disagree	0	0.0	0.0
Total Valid	201	98.5	100.0
Total Missing	3	1.5	
Total	204	100.0	



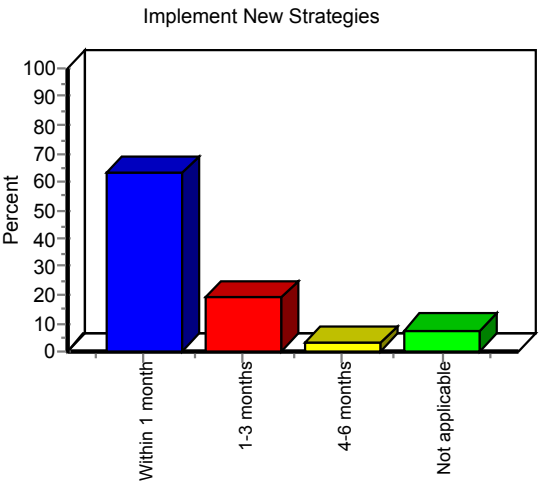
How likely are you to implement these new strategies in your practice?

Label	Frequency	Percent	Valid Percent
Very likely	131	64.2	67.5
Somewhat likely	51	25.0	26.3
Unlikely	2	1.0	1.0
Not applicable	10	4.9	5.2
Total Valid	194	95.1	100.0
Total Missing	10	4.9	
Total	204	100.0	



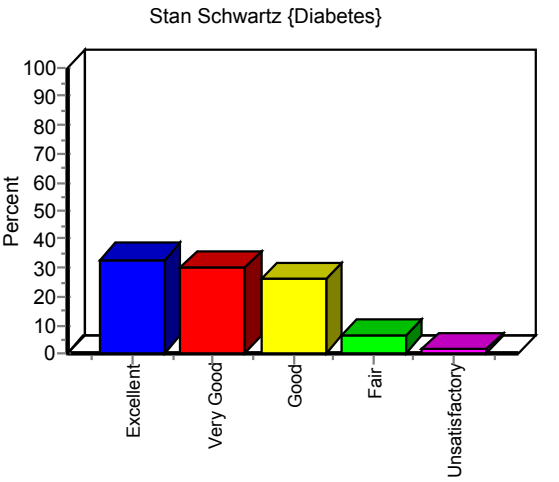
When do you intend to implement these new strategies into your practice?

Label	Frequency	Percent	Valid Percent
Within 1 month	129	63.2	67.9
1-3 months	39	19.1	20.5
4-6 months	6	2.9	3.2
Not applicable	16	7.8	8.4
Total Valid	190	93.1	100.0
Total Missing	14	6.9	
Total	204	100.0	



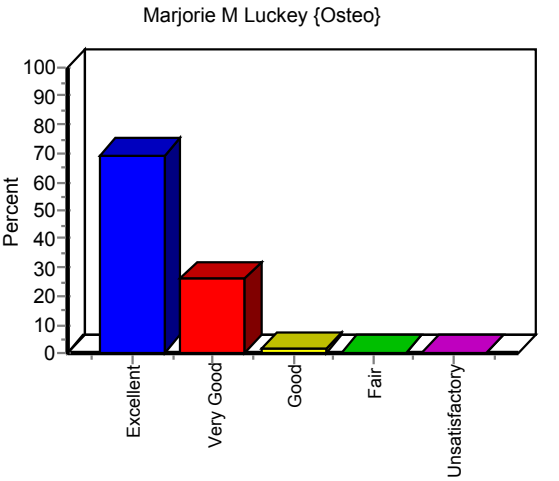
In terms of delivery of the presentation, please rate the effectiveness of the speaker: Stan Schwartz, MD (Diabetes):

Label	Frequency	Percent	Valid Percent
Excellent	67	32.8	34.2
Very Good	61	29.9	31.1
Good	53	26.0	27.0
Fair	12	5.9	6.1
Unsatisfactory	3	1.5	1.5
Total Valid	196	96.1	100.0
Total Missing	8	3.9	
Total	204	100.0	



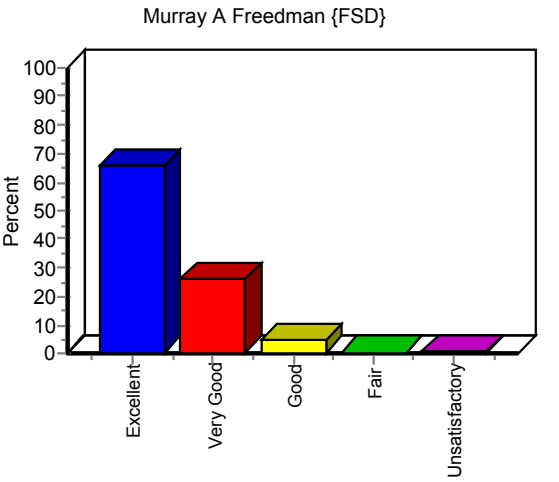
In terms of delivery of the presentation, please rate the effectiveness of the speaker: Marjorie M. Luckey, MD (Osteo):

Label	Frequency	Percent	Valid Percent
Excellent	142	69.6	71.7
Very Good	53	26.0	26.8
Good	3	1.5	1.5
Fair	0	0.0	0.0
Unsatisfactory	0	0.0	0.0
Total Valid	198	97.1	100.0
Total Missing	6	2.9	
Total	204	100.0	



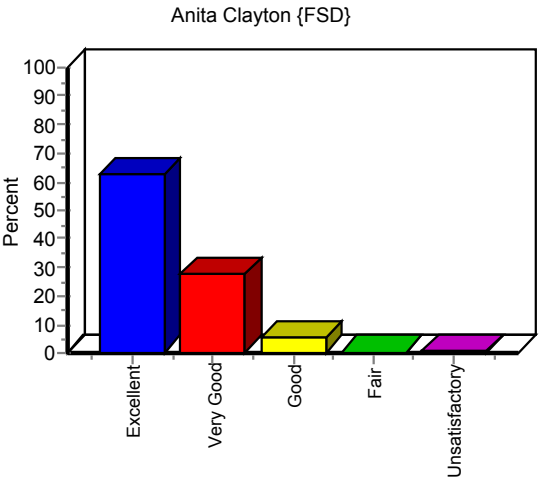
In terms of delivery of the presentation, please rate the effectiveness of the speaker: Murray A. Freedman, MD (FSD):

Label	Frequency	Percent	Valid Percent
Excellent	134	65.7	68.0
Very Good	53	26.0	26.9
Good	9	4.4	4.6
Fair	0	0.0	0.0
Unsatisfactory	1	0.5	0.5
Total Valid	197	96.6	100.0
Total Missing	7	3.4	
Total	204	100.0	



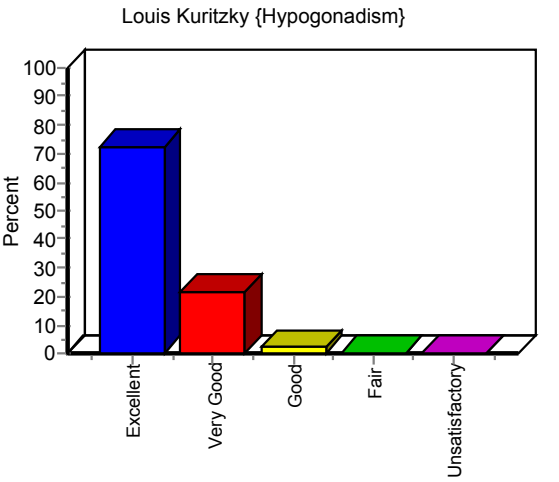
In terms of delivery of the presentation, please rate the effectiveness of the speaker: Anita Clayton, MD (FSD):

Label	Frequency	Percent	Valid Percent
Excellent	128	62.7	65.0
Very Good	57	27.9	28.9
Good	11	5.4	5.6
Fair	0	0.0	0.0
Unsatisfactory	1	0.5	0.5
Total Valid	197	96.6	100.0
Total Missing	7	3.4	
Total	204	100.0	



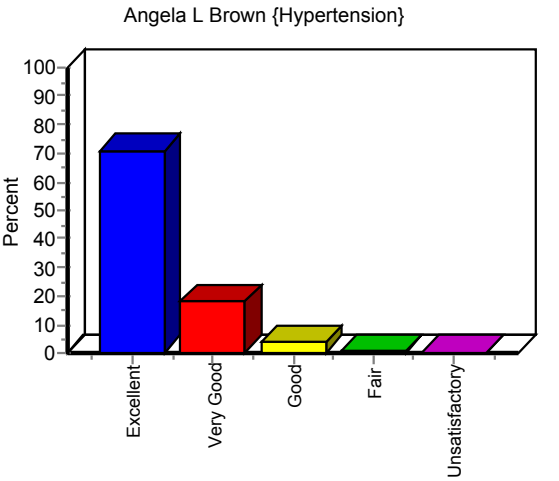
In terms of delivery of the presentation, please rate the effectiveness of the speaker: Louis Kuritzky, MD (Hypogonadism):

Label	Frequency	Percent	Valid Percent
Excellent	147	72.1	75.0
Very Good	44	21.6	22.4
Good	5	2.5	2.6
Fair	0	0.0	0.0
Unsatisfactory	0	0.0	0.0
Total Valid	196	96.1	100.0
Total Missing	8	3.9	
Total	204	100.0	



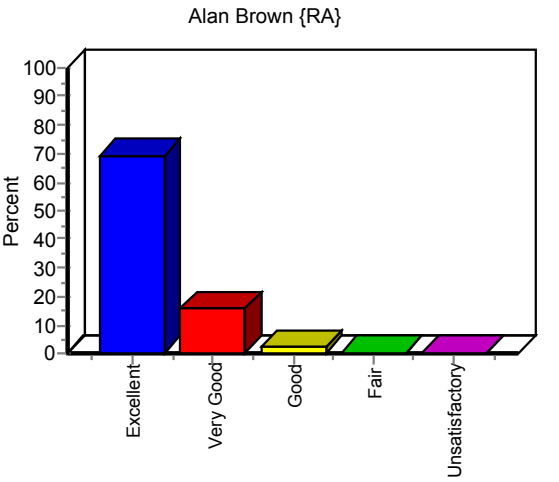
In terms of delivery of the presentation, please rate the effectiveness of the speaker: Angela L. Brown, MD (Hypertension):

Label	Frequency	Percent	Valid Percent
Excellent	145	71.1	76.3
Very Good	36	17.6	18.9
Good	7	3.4	3.7
Fair	2	1.0	1.1
Unsatisfactory	0	0.0	0.0
Total Valid	190	93.1	100.0
Total Missing	14	6.9	
Total	204	100.0	



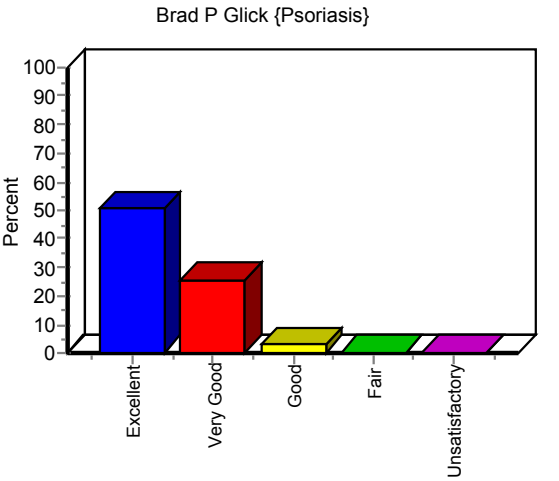
In terms of delivery of the presentation, please rate the effectiveness of the speaker: Alan Brown, MD (RA):

Label	Frequency	Percent	Valid Percent
Excellent	141	69.1	79.2
Very Good	32	15.7	18.0
Good	5	2.5	2.8
Fair	0	0.0	0.0
Unsatisfactory	0	0.0	0.0
Total Valid	178	87.3	100.0
Total Missing	26	12.7	
Total	204	100.0	



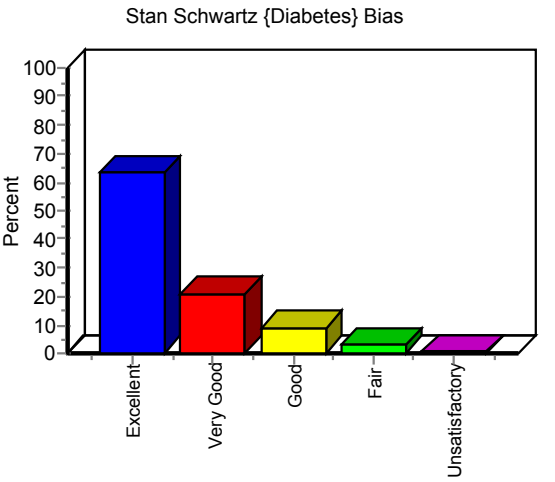
In terms of delivery of the presentation, please rate the effectiveness of the speaker: Brad P. Glick, DO (Psoriasis):

Label	Frequency	Percent	Valid Percent
Excellent	103	50.5	64.4
Very Good	51	25.0	31.9
Good	6	2.9	3.8
Fair	0	0.0	0.0
Unsatisfactory	0	0.0	0.0
Total Valid	160	78.4	100.0
Total Missing	44	21.6	
Total	204	100.0	



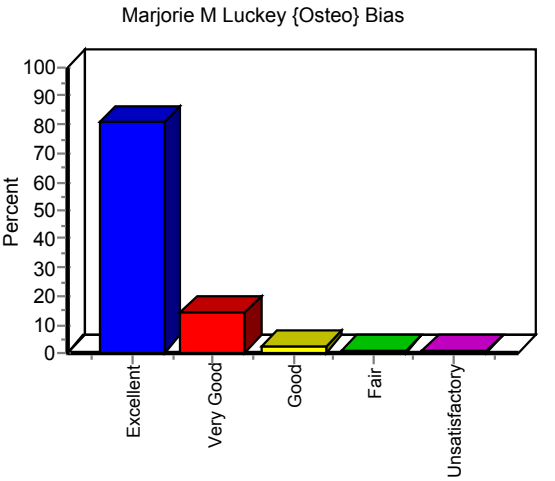
To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Stan Schwartz, MD (Diabetes):

Label	Frequency	Percent	Valid Percent
Excellent	129	63.2	65.5
Very Good	42	20.6	21.3
Good	19	9.3	9.6
Fair	6	2.9	3.0
Unsatisfactory	1	0.5	0.5
Total Valid	197	96.6	100.0
Total Missing	7	3.4	
Total	204	100.0	



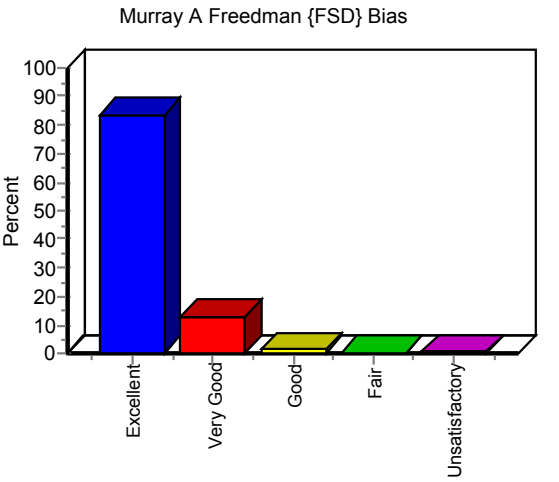
To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Marjorie M. Luckey, MD (Osteo):

Label	Frequency	Percent	Valid Percent
Excellent	164	80.4	82.0
Very Good	29	14.2	14.5
Good	4	2.0	2.0
Fair	2	1.0	1.0
Unsatisfactory	1	0.5	0.5
Total Valid	200	98.0	100.0
Total Missing	4	2.0	
Total	204	100.0	



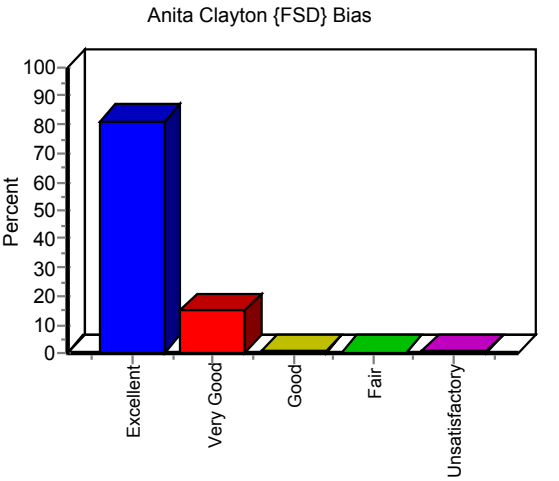
To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Murray A. Freedman, MD (FSD):

Label	Frequency	Percent	Valid Percent
Excellent	170	83.3	85.0
Very Good	26	12.7	13.0
Good	3	1.5	1.5
Fair	0	0.0	0.0
Unsatisfactory	1	0.5	0.5
Total Valid	200	98.0	100.0
Total Missing	4	2.0	
Total	204	100.0	



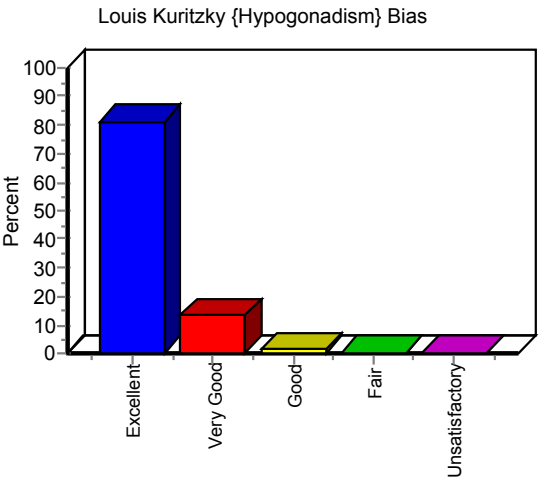
To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Anita Clayton, MD (FSD):

Label	Frequency	Percent	Valid Percent
Excellent	166	81.4	83.0
Very Good	31	15.2	15.5
Good	2	1.0	1.0
Fair	0	0.0	0.0
Unsatisfactory	1	0.5	0.5
Total Valid	200	98.0	100.0
Total Missing	4	2.0	
Total	204	100.0	



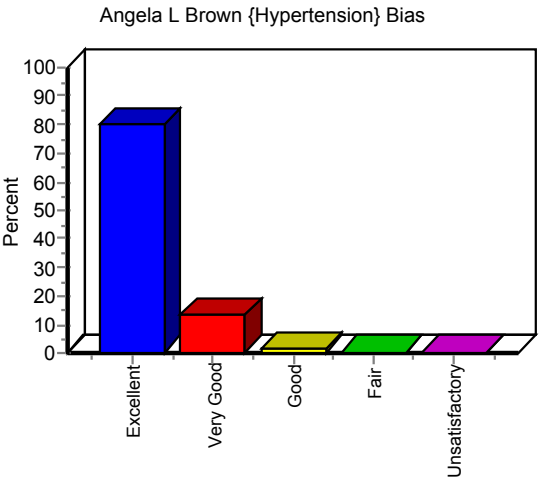
To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Louis Kuritzky, MD (Hypogonadism):

Label	Frequency	Percent	Valid Percent
Excellent	166	81.4	84.3
Very Good	28	13.7	14.2
Good	3	1.5	1.5
Fair	0	0.0	0.0
Unsatisfactory	0	0.0	0.0
Total Valid	197	96.6	100.0
Total Missing	7	3.4	
Total	204	100.0	



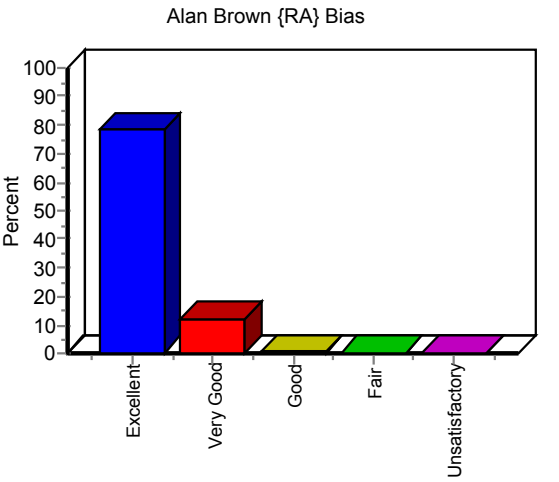
To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Angela L. Brown, MD (Hypertension):

Label	Frequency	Percent	Valid Percent
Excellent	163	79.9	84.0
Very Good	28	13.7	14.4
Good	3	1.5	1.5
Fair	0	0.0	0.0
Unsatisfactory	0	0.0	0.0
Total Valid	194	95.1	100.0
Total Missing	10	4.9	
Total	204	100.0	



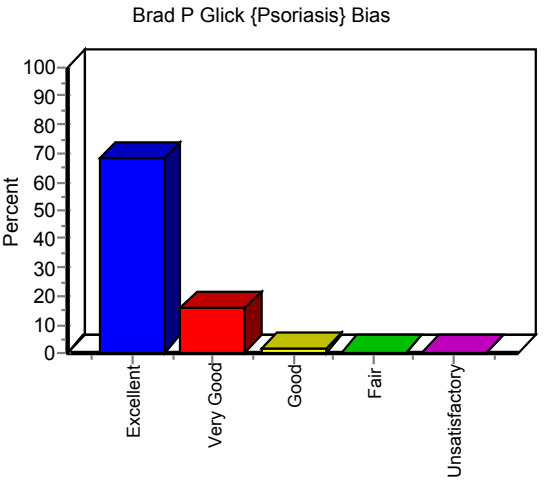
To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Alan Brown, MD (RA):

Label	Frequency	Percent	Valid Percent
Excellent	160	78.4	85.6
Very Good	25	12.3	13.4
Good	2	1.0	1.1
Fair	0	0.0	0.0
Unsatisfactory	0	0.0	0.0
Total Valid	187	91.7	100.0
Total Missing	17	8.3	
Total	204	100.0	



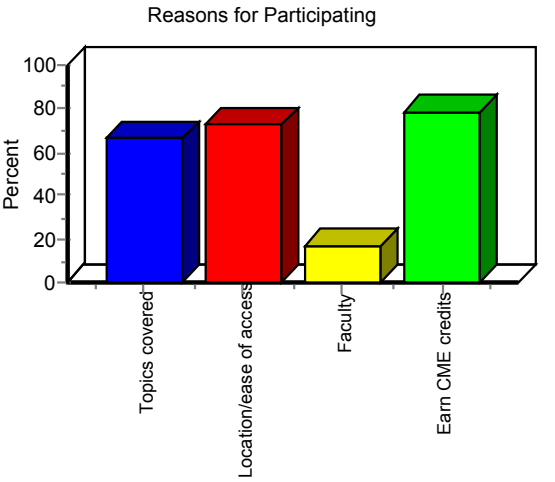
To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Brad P. Glick, DO (Psoriasis):

Label	Frequency	Percent	Valid Percent
Excellent	138	67.6	79.8
Very Good	32	15.7	18.5
Good	3	1.5	1.7
Fair	0	0.0	0.0
Unsatisfactory	0	0.0	0.0
Total Valid	173	84.8	100.0
Total Missing	31	15.2	
Total	204	100.0	



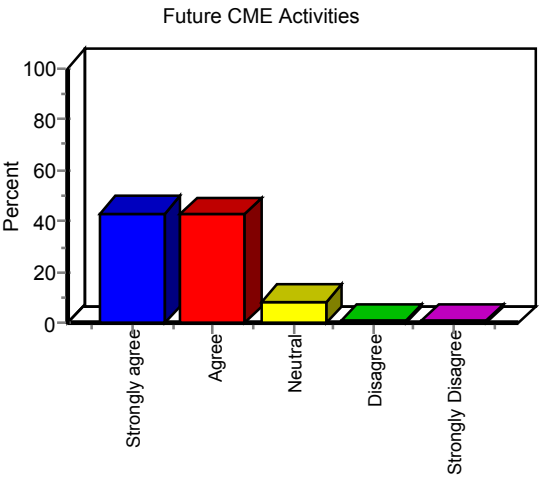
Which statement(s) best reflects your reasons for participating in this activity:

Label	Frequency	Percent	Valid Percent
Topics covered	136	66.7	68.0
Location/ease of access	147	72.1	73.5
Faculty	33	16.2	16.5
Earn CME credits	161	78.9	80.5
Total Valid	200	98.0	100.0
Total Missing	4	2.0	
Total	204	100.0	



Future CME activities concerning this subject matter are necessary:

Label	Frequency	Percent	Valid Percent
Strongly agree	88	43.1	45.4
Agree	86	42.2	44.3
Neutral	17	8.3	8.8
Disagree	2	1.0	1.0
Strongly Disagree	1	0.5	0.5
Total Valid	194	95.1	100.0
Total Missing	10	4.9	
Total	204	100.0	



What is your professional degree?

Comment
Student
RD
PharmD

What is your specialty?

Comment
Hospitalist x2
Oncology
Neurology x2
Family Medicine x4
Emergency
Urgent Care
Pediatrics
Infectious Disease
Psychiatry
Geriatrics x2
Diabetes x3
Drug Safety
Pain Management
Nephrology
Aesthetics
Dermatology x2
College Health
Urology

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

Comment
Choosing anti diabetic agents to avoid hypoglycemia and treating osteoporosis and assessing risk of osteoporosis
This activity really very effective in improving my practice
Early use of combination anti-hypertensives and not "waste time" titratiny single agent to maximum dose; early referral of RA patients-early aggressive therapy; psoriasis treatment
More use of combination anti hypertensives
Address female sexual dysfunction with use of lifestyle vital signs and reference the PLISSIT model. Assessing hypogonadism, be attentive to S/S-treatment appropriately and follow up. Appropriate test to order for treatment of RA; be aggressive and refer to Rheumatologist. All information for psoriasis-appropriate medications especially BSA>60-treatment systemic medications vs. topicals.
Use testosterone replacement more aggressively. Manage osteoporosis more effectively. Use GLP/GIP agonists more often to control diabetics better. Use better techniques in sexual interviewing
Treatment of hypogonadism and use of FRAX in osteoporosis
Cantine education
The introduction of new medicine-H management of DM and measurement treatment of hypogonadism
Improved drug choice for blood pressure and ask more about female sexual dysfunction
Learned about new JNC8 guidelines and also as to how to deal with sexual problem issues
Increase awareness of osteoporosis in my patient population
Use slide about osteonecron's to calm patients about biophosphonatis and diet tips simply used in diabetes

Comment
FDC for initial treatment of HTN; awareness for testosterone and vitamin D deficiency in my patients; use of FRAX for osteoporosis risk stratification; early referral for suspected RA
Encourage proper diet with DM, then maybe adjust medications. Encourage patient to talk by using the PLISSIT model. Use the DX scan or FRAX tool to help diagnose OP and consider testing younger postmenopausal females who had treatment after age 50
How to avoid hypoglycemia
Multidrug regimens
More evidence based DM and HTN treatment modalities
Use T2DS over SU, use pioglit vs. rosight, go to GLP-1 early, screen my patients for osteoporosis at younger age, treatment 5-10 years with bisphosph before "holiday", ask my DM patients regarding FSD, screen for hypogonadism much more often, rev testosterone therapy earlier
Basal over other insulin strategies, eliminate NPH, awareness of rank treatment in osteoporosis
ARB/CCB combination in treatment of HTN better than ACE inh/HCT2; discussing and treating sexual dysfunction will improve mental well-being; vitamin use in preventing diabetic retinopathy; using FRAX as a tool in determining indications for treating osteopenia
HTN-starting with combination instead of mono therapy; Rheum-earlier use of biologic-treat toward remission
More frequent testing of testosterone
Using FRAX; empathetically discussing female sexual dysfunction; managing HTN >20 and >10 with combination therapy
How to begin discussion about sexual dysfunction
Interview techniques for sexual dysfunction and monitoring of testosterone
New, appropriate therapies and new questions and techniques to talk at diseases
Focused and simple dietary changes which yield significance over time. Favor diabetic meds which reduce hypoglycemic phenomena. Consider increasing vitamin D level testing. Consider expanded testing when RA is in the differential, e.g. Hep C. Discuss with colleagues expanded screening for FSD and hypogonadism. Review with colleagues latest data on renin inhibition and also nebivolol. Share with colleagues latest data on biologics in treatment of psoriasis and psoriatic arthritis
Use FRAX screening tool to decide on who to start on osteoporosis treatment. Ask about sexual dysfunction. Evaluate for signs of hypogonadism. Use HCT2 in combination with ACE or CeCh blocker more for improved BB control. Avoid combination of ACE/ARB especially in patients with heart failure
Increased awareness of the problems and issues
Use of DPP and GLD-1 agonists in treatment of type 2 diabetes inhibitors; interview/screening of patients for female/male sexual dysfunction; more use of combination anti hypertensive drugs
Use FRAX tool and initiate some of the tests
Will implement treatment strategies regarding FSD, BP treatment and osteoporosis treatment. Increased awareness in diagnosing and treating RA/psoriasis and other presented conditions
Better able to assess sexual dysfunction and hypogonadism in patients. It would be good to comment on cost when talking about the BP and DM meds
Effective use of FRAX to determine which patients to treat and strategies for bringing up female sexual problems
Screen more consistently for osteoporosis and try newer diabetic drugs in spite of cost
Change in diabetes management or modalities; PLISSIT model; FRAX; HTN therapeutic modalities; aggressive treatment of RA as a systemic disease
Primary goal to avoid hypoglycemia in treatment of DM. Using FRAX for patients with osteopenia. Consider combo drugs sooner for treatment of HTN. Squeeze test for RA, what to look for in diagnosis and refer early
Using FRAX to help guide management of osteoporosis
Testing for hypogonadism more, then follow up broad less if abnormal; HTN treatment; check Hep B, Hep C, HIV for inflammatory arthritis

Comment
Incorporation of FRANK score in the decision of treatment for osteopenia. To start with combination antihypertemine therapy for better BP control. Rule of ten application in blood pressure management
Very good topics and good material, updated materials
Hypertension use of consitors early in treatment
Implementing lifestyle vital such as sexual health to my follow up discussions
FRAX testing
Got better knowledge of osteoporosis and female sexual function
I learned better strategies to broach female sexual dysfunction. The osteoporosis lecture was particularly helpful for answering recent patient questions regarding benefits of bisphosphonate treatment
Increase use of FRAX and more aggressive in opening SFD issues
Start new drug for every 10 mmHg over target BP. Do this instead of simply titrafling dose
Bringing sexuality to a point where it is comfortable to bring up
Avoid Avandila, combo or NPH insulin. Use more spirono lecture in treatment resistance HTN with patients on combination therapy. Use of FRAX in clinical practice. Hold CCP testing for RA. Co- morbidities in RA and psoriasis
Actually do much do mention in this short time; DM with treatment; female sexual dysfunction; male hypogonit. All excellent presentations with much to learn and very helpful for my patients
More aggressive in diagnosing and treatment of osteoporosis
Diabetes control and new strategies for decreasing fracture risk
Examining for and treating vitamin D and testosterone deficiency
Excellent speakers
Using FRAX, increase use of Byetta, proper screening for decrease testosterone
HTN and diabetes treatments have been strengthened and updated. Recognize hypogonadism and evaluate it. Document RA and refer for it
Take hypoglycemia seriously and avoid at all costs
Combination treatments of HTN; new Beta blocker; take good sexual history; DM treatments; review of hypogonastic
Female sexual dysfunction was great topic but a very weak lecture-need more science and modeling but less "empathy tracking" and no role playing
FRAX tool for fracture risk; better ways to approach sexual dysfunction PLISSIT and lifestyle vs; simple screening for RA
Aggressive treatment of DM, HTN, hypogonadism
Proper timing of testing and incorporating PLISSIT into my practice
Osteo Rx; sexual dysfunction techniques; testosterone use; RA treatments
Decrease use of sulforylorea T2DM and use FRAX
Latest recommendations on treated wide variety of problems. New problems to consider more in routine screenings
Approaches to interview regarding female sexual dysfunction
Consider early use of incretions in diabetic patients. More screening of osteoporosis and start using FRAX in osteopenic patients. Proper monitoring for testosterone therapy in hypogonadism
Evidence based practice
Order CCP in all suspect RA patients; use BP treatments more accurately; consider many men with of low testosterone
New techniques on counseling FSD; means of assessing osteoporosis; new combination of anti hypertensives
DM/HBP management; management RA/PsA-need for early and aggressive treatments to decrease risk of co-morbidities
Better management of andrology and osteoporosis. Better ways to explore female sexual dysfunction
Use of Byetta or Victoza; use of FRAX; routinization of lifestyle vital signs; use of SHBG testing; use of ABB and CCB therapy; use of anticcp with RF testing; early systemic treatment of psoriasis
Screenings for osteoporosis and treatment choice; hypertension treatment combinations
Shift in treatment of DM and osteoporosis and awareness of FSD
Considering Actos and Byetta for patients with diabetes; using PLISSIT model to elicit problems with FSD; use FRAX assessment for decisions on osteoporosis treatment

Comment
FRAX; 3/0/3 basal insulin; OPP4 inhibitor; combination therapy for HTN; monitoring total T to diagnose hypogonadism
I will do combination treatment in my HTN from the start. I will refer my psoriasis patient early on for biologic treatment. I will consider hypogonadism as a diagnosis
Discussing sexual concerns; treating osteopenia; approaches to hypertension; screening for RA
FRAX; more confident regarding my choices in HTN; PLISSIT; refer some for RA
Treatment decisions for women with osteopenia and use of FRAX guidelines
I will not dilly dally in bringing down HTN
Screen for RA more aggressively; rule out TB, HCV, HBV, and HIV; on presentation for HTN consider add on of speranolactine 25mg if combined ACG/CCB and HCTZ not effective so long at renal function and Kt; use FRAX tool in osteoporosis; use exantinide instead of insulin NPH and regular insulin to avoid hyperglycemia
Enhanced communication skills
Check more vitamin D; better first choices of treatment in DM when insurance allows; check more men for osteoporosis; FRAX; STITCH; check Hep C in new RA patients
Improve selection of drug therapy
Know better when to refer to PCP or specialist; awareness of S/S of discusses and prevalence-more apt to be able to alert doctor
Better treatment plans
More open discussion of sexual dysfunction; consider RA diagnosis; RA patient with red eye-immediate ophth. Referral; earlier recommendations for combination treatment in HTN
Most likely implement incretine as second therapy after metformin
Improved compliance and better monitoring
I will be more aggressive in the treatment of HTN, RA and psoriasis
I will be testing testosterone levels more commonly with chronic narcotic therapy patients
Aggressive treatment of RA
Ask lifestyle Vital signs, including sex. Management of flyroforadism; check SHB4 and monitor test level; not to use sulfomylureal as second agent instead use Exevertide or OPP-4, EL8-1; aggressive with RA
Diagnosis and aggressive management for RA; diagnosis and management of hypogonadism
Osteoporosis; DM; HTN; RA
HTN; DM, especially osteoarthritis; treatment regimens; sexual problems/dysfunction; good updates; HTN management
Wait to add insulin-use pre med treatments first; use FRAX for patients in "grey area" risk for osteoporosis; new strategies for initiating discussion of sexual dysfunction; initial therapy for hypertension in select patients will start with combination therapy; earlier referrals for psoriasis to dermatologist
Adoption of new approaches to each of these topics
Order testosterone levels and sexual history
Combine risk factors with T-score and introduce FSD as part of social history
Plan to check for testosterone in older males
More aware of hypogonadism
Osteoporosis and management of RA and HTN
Discussion of sexual dysfunction with female patients
Early detection and utilizing specific labs for diseases presented today
Lifestyle Vital signs; prevention of hip fractures with certain bisphosphonates; proper tests for diagnosis of hypogonadism; early combination treatments for HTN, ACE, and CCB better than ACE and HCTZ for outcomes
See learning objectives prior page
Starting with at least 2 drug combinations in HTN when BP >20/10>above normal; accept need for 4-5 days in some hypertensives order anti CCP older in all patients with RA; remember gone H zoster vaccination before starting a biologic in patients >65 ERA
Combination therapy for hypertension; biologic treatment for psoriasis; diagnosis of RA-use anti-CCP lab

Comment
The initial treatment of HTN with combination treatment vs. mono therapy; re-emphasize the role of diet in DM; being more aggressive in treatment of DM earlier control; earlier referral for RA for aggressive treatment
Recommend to patient when to see their primary physician when appropriate referral to other disciplines as therapist or specialist
When to check for hypogonadism
Discuss female sexual dysfunction
Early referral/treatment and diagnosis of RA and psoriasis
Use of FRAX tool; use of PLISSIT model; start single dose therapy as initial therapy in treatment of HTN
Use of FRAX, screening guidelines for osteoporosis; routinely asking about sexual function at annual visits; start combination BP meds if SBPS>20 or DBP>10 above goal
Integrating sexual history in practice and new approaches on hypertension medications
Better able to approach the subject of female sexual dysfunction
Titrating of medications for Bcell failure patients; using PLISST and continuing to discuss sexual disorders with patients; testing and treating hypogonadism and using the "problems" acronym for approaching
Emphasis of osteoporosis on medical/nature; management of sexual dysfunction and bone loss; monitoring of BP with new meds and management of HTN
PLISSIT; screening and treatment of hypogonadism algorithm; new AACE guidelines; early diagnosis and referral of RA
Better questioning in FSD; quicker response and what to use while waiting for patient to go to rheum for RA/psoriasis
Hypogonadism-checking testosterone and SHBG, when and how to treat; learned about blood pressure treatment use of combination agent early on
Learned about FRAX calculator and this helps to decide who needs treatment medications
Use of FRAX for determining OP treatment appropriateness; incorporate lifestyle VS and sexual health issues into history routine of OV; consider treatment of male hypogonatism
Correct labs to order for male sexual dysfunction; use Fosomax reg for osteoporosis but more importantly how/when to for osteoporosis; talks with sexual functional patients
P2 communication and new therapies for medical problems
Assessment of and dysfunction; consideration of male hypogonadism and testosterone deficiency; treatment and diagnosis of osteoporosis; starting 2 hypertensive agents in combination in appropriate patients; RA diagnosis tips-hand/foot squeeze-refer early
Test male patients more frequently for testosterone; be more proactive to initiate questions about female sexual dysfunction; importance of early systemic therapy for patients with psoriasis
Decrease smoking/quit to prevent OP
Pain management; legal issues; malpractice
Early aggression RA treatments and biologic agents as first line treatment
Sexual history
Approaching sexual dysfunction issues during patient interactions and incorporating newer diagnosis guidelines for RA
Talking with patient about female sexual dysfunction and using the new clinical guidelines

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

Comment
Hepatitis and aging
GYN/OB topics
Obesity (childhood to adult)
More common dermatology conditions, common neurologic conditions, common foot problems
SKE connective tissue diseases and early onset multiple sclerosis diagnosis and anemia review
Hepatitis, cardiac arrythmia, and strokes
Obesity, colon cancer, breast cancer, and screening controversy

Comment
More on cost containment in delivery of care and end of life care
Nutrition
Review of hormonal replacement therapy
More about diabetes management
Continued developments in diabetes, lipids, CAD, EP, OCPs
DJD and surgery; chest pain treatment
Treatment and management of musculo-skeletal problems
Diagnosis/management of mental health conditions in primary care
Lipid management and depression management
Updates-hematologic disorders, infectious disease, cancer diagnosis and follow up
ICD-a and CPT coding/improving reimbursement
Oncology
More specific about DM treatment and insulin therapy
Vitamin D and managing mild proteinuria and elevated creatinine
ADHD and treatment for female gynecologic problems
Pain management, hyperlipidemia, ADHD, depression
Sarcoidosis, atrial fib/cardiac arrhythmias, CVA, CHF, asthma/allergies
Chronic pain and different patients and family members
Examination and diagnosis of common orthopedic conditions by primary care providers (ie meniscul tear) and diagnosis/treatment of dermatitices by primary care providers
Dermatology and immunization
Emphasize more on treatment regarding female sexual dysfunction, ADHD. Depression
More on DM, depression, mental health issues, data regarding PSA screening
Once available, obesity treatments (new ones) and how to select right drug to treat depression
Polypharmacy
Strategies and obstacles to optimal health care-cost and non-compliance
Cardiovascular and pulmonary disease and infectious disease
Depression/anxiety, PCOS, OB issues
Asthma, autism, developmental disorders
CAD, hyperlipidemia, COPD
Mental health
Ethics
Depression after SSRI and TCA. Renal insufficiency before ESRD. When to call the medical geneticist
Sinusitis management and depression
Geriatric care
COPD, live disease, NASH
Thyroid disorders and treatment
Immunization, GI disorders, and asthma
Lipid management, bipolar and ADD
Pain management (fibromyalgia and back pain)
Herbal medicines
Migraine and irritable bowel
GI
HCVD and gastrointestinal diseases
Infectious disease-rashes; more dermatology; depression
APHD in the adult patient; hepatitis-A,B,C; NASH; Dyspepsia; GERD; travel medicine
SLE; gout; HIV; MRSA; TB; fibromyalgia; PVD; RSD; chronic pain syndrome
Chronic kidney disease; importance of HER; IBD; IBS

Comment
CVD and osteoporosis
DM-pumps and conversion evals to insulins
Electronic medical records and keep the psoriasis talk following the RA talk
Hypothroidism; hyperlipidemia; CAD; MI
Hepatitis; common skin conditions; travel medicine
Wound management in primary care and patient compliance issues
Ethics and healthcare
Integrative medicine
Asthma; COPD; AR; pediatrics
Asthma; cancers-lung, breast, colon, prostate; BPH; genetic screening
GI disorders
Stroke; coronary artery disease; more diabetes
Always diabetes; HTN-anything new; treatment of female sexual dysfunction; antibiotics and resistancy; OA
Pediatric asthma
Any topic relevant to nursing care patients
Chronic pain treatment
CHF; DM2; drug abuse (Coke, MJ, etc); chest pain; GI issues Crohn's/UC
Behavior change strategies
Medical ethics
Joint injections and dizziness
Cardiac murmurs; CHF; Afib; treatment of GERD
Hyperlipidemia; hepatitis; fibromyalgia
Lipid management and thyroid for paralyzed
Wound care
Chronic pain
Weight loss; effects of gastric bypass; beriatric medicine
Neurology and sleep medicine
Hyperlipidemia and urinary incontinence
Chronic pain management
CKD and CAD
Dermatology other than psoriasis; COPD; asthma; sexual traumatic dysfunction; CHF
Vitamin D deficiency (multi system discussion) and pain management in primary care
Dementia
HIV; dermatology; stroke
NRT/ERT and breast and colon cancer
Diagnosis and treatment of COPD and CVA
Renal failure; anemia; osteoarthritis
Sports medicine
CAD; colon cancer; renal failure
HTN; DM; dyslipidemia
Women's health updates
Vitamin D deficiency
Skin cancer
When, why, how to study
ADHD and fibromyalgia
Anemia and renal disease
Treatment community acquired pneumonia; MRSA; evaluation of chest pain; ambulatory orthopaedics
More dermatology

Comment
Any primary care topics
Contraception in women over 40
Anxiety; depression; weight loss
Hypothyroidism and renal failure
HIV; pharmacology; diabetes; infectious disease; HTN
Thyroid disorder
ADHD; HSDD treatment; continued updates in HTN treatment
Thyroid disease; atherosclerosis/heart disease; and Rh disease
Cancer screening; acute coronary syndrome; update on HIV
CHF and procedures- aspirations/injections/sutures
Cardiac care for primary care
Asthma/allergies; anxiety disorders; VHD; COPD; OSA
NAFLD; chronic pain management; adult ADD; bipolar disorder; sympathetic parasympathetic neurosystem RSD
Cholesterol diagnosis/treatment and STDs
Current advances in primary care
Orthopedics-shoulder, knee, hip evaluation, referral indications
Orthopedic and hormone replacement therapy
DM/screening tools
Malpractice
Evidence based treatment for CAD
Bipolar disorder; PTSD; narcotic abuse
Prostate cancer; urinary incontinence; breast cancer; fibromyalgia
MRSA infections
Systemic manifestations of GI disorder
Open to any topic

Additional comments:

Comment
Please schedule CME events in Raleigh every year
Thanks for your hard work-excellent speakers and presentations-FREE! I would have rather had 2 hours of DM-2 management than female sexual dysfunction because no actual treatment was discussed, other than to encourage the patient to talk to partner/referral. What about testosterone/wellbutrin/other treatments
Very informative information. Excellent speakers
Always a pleasure to hear Dr. Kuritzky
Very good CME
Thank you
Nice conference
Overall very good seminar
Great and knowledgeable speakers and useful information
Excellent primary care topics-can't believe it was free
Thank you
When given questions explain when the wrong answers are correct
Great talks and lectures
Dr. Glick was knowledgeable. Case studies were helpful. Thank you for this excellent conference and the free CME credits
Excellent CME meeting! Thank you for coming to Raleigh
Overall good conference.

Comment
Osteoporosis and RA were superior to the others
Overall, I greatly appreciate all who made this educational activity possible, speakers, coordinators and sponsors. Thank you
Excellent
Lectures need to indicate which number is the correct answer to the questions
Good talks
Schwartz was knowledgeable
Thank you for the food!
Very well done
Very good program
Very poor acoustics
It could be nice to have snacks in between lectures
Thanks
Very good conference
I would have liked to hear more about treatment options for female sexual dysfunction instead of role play. I have no problem discussing the issue
Nice facility.
Thanks for breakfast and lunch
Thank you. This was a great CME activity, Very informative and excellent speakers. Please make sure your come back to Raleigh again next year.
Good lectures, long day
Well prepared and excellent speakers
Great meeting
Thank you-overall excellent
Great CME. Would have liked more information on bone health.
Dr. Schwartz was very informative
DM lecture was good
Thank you
Vignette videos were interesting
Good meeting
Very educational. Thank you
Thank you
I am glad I came to this event
Hypertension lecture excellent
Haven't been to NACE before but I will again. Thanks
Excellent presentation, free meal, free CME
Excellent
Keep on coming to Raleigh! More food and full breakfast
Great Day! Thanks
Thanks
Good info
Excellent CME. Thanks
Thanks for everything
Thank you very much. I have to participate in your future offerings
A small snack available at the first break would be great

Comment
Excellent conference and good topics
Thanks
I usually attend all these. They are great
A very well organized activity
Good setup-conducive to learning. Good program and faculty with current knowledge
Would have liked to address problems with diabetes as a result of steroid use. Maybe add some time to this lecture. RA lecture also good.
I plan to attend future programs
Good program. Keep on time. Well organized
Thank you
Some of slides hard to read due to color choices
Excellent CME, definitely attend more
Excellent set of presentations. Thank you very much
Thank you for putting this meeting together (excellent meeting) and for inviting me to attend. Location was great too
Thank you. Excellent topics and speakers. Dermatology issues and treatment should be increased so there is more time to discuss.
Program well done
Excellent speakers and presentation; clear and clinically relevant; good balance of basic science, research, and clinical guidelines
Dr. Luckey was excellent. Please bring her back for more lectures. Afternoon snacks; FSD lecture only needs 1 hour ; good slides on RA lecture
Good job
A snack in the afternoon would be nice; during lectures including brand name would be helpful along with generic names or have a brand/generic list reference
Good CME event
Thank you
Thanks for the free CME