

In December 2014, the National Association for Continuing Education (NACE) sponsored a live CME activity, *Clinical Updates for Nurse Practitioners and Physician Assistants: 2014*, in Dallas, TX.

This educational activity was designed to provide nurse practitioners and physician assistants the opportunity to learn about diagnosis and management of patients with varied conditions such as Diabetes, Alpha-1 Antitrypsin Deficiency, Psoriasis, and Inflammatory Bowel Disease.

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.

One hundred twenty seven healthcare practitioners registered to attend *Clinical Updates for Nurse Practitioners and Physician Assistants: 2014* in Dallas, TX and one hundred ninety five registered to participate in the live simulcast. One hundred fifty six healthcare practitioners actually participated in the conference: fifty nine attended the conference in Dallas, TX and ninety 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. One hundred eighteen completed forms were received. The data collected is displayed in this report.

CME ACCREDITATION

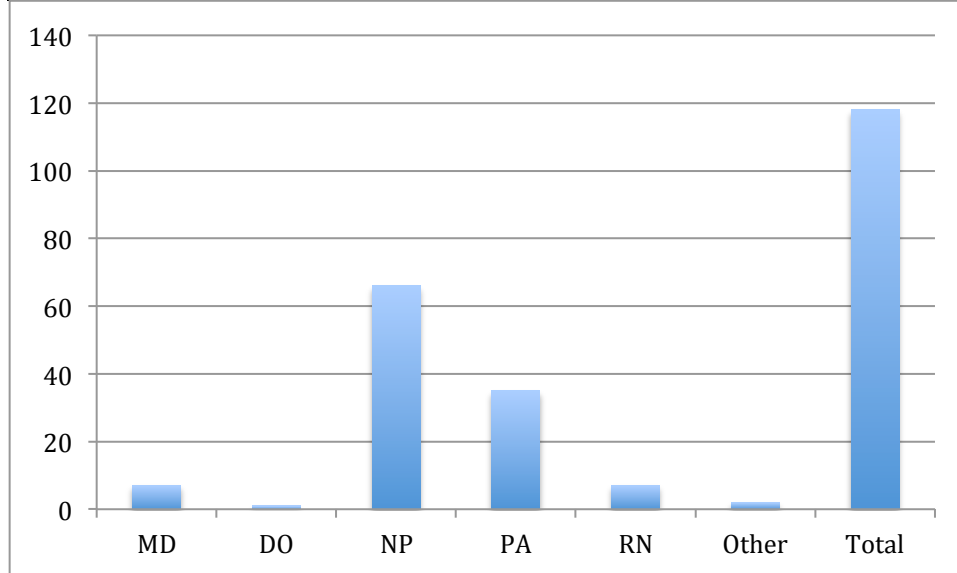
The National Association for Continuing Education is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The National Association for Continuing Education designates this live activity for a maximum of 6.0 *AMA PRA Category 1 Credits*[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

National Association for Continuing Education is approved as a provider of nurse practitioner continuing education by the American Association of Nurse Practitioners. AANP Provider Number 121222. This program has been approved for 6.0 contact hours of continuing education (which includes 3.5 pharmacology hours).

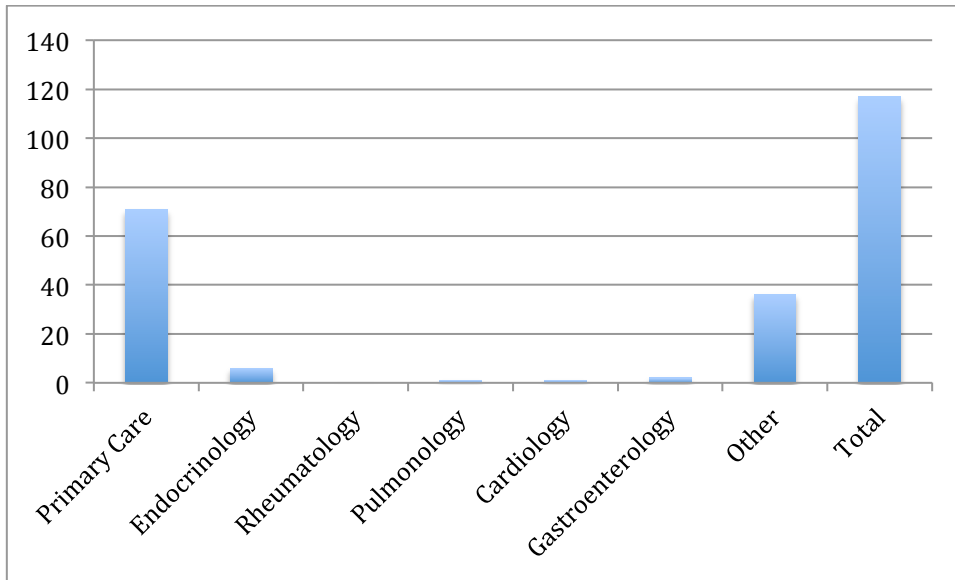
What is your professional degree?

| Label | Frequency | Percent |
|-------|-----------|---------|
| MD | 7 | 6% |
| DO | 1 | 1% |
| NP | 66 | 56% |
| PA | 35 | 30% |
| RN | 7 | 6% |
| Other | 2 | 2% |
| Total | 118 | 100% |



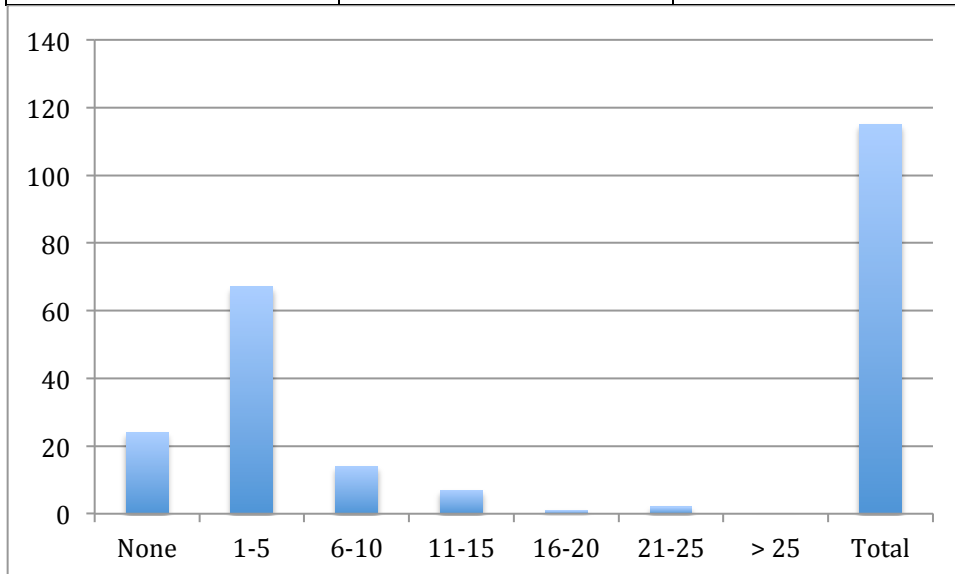
What is your specialty?

| Label | Frequency | Percent |
|------------------|-----------|---------|
| Primary Care | 71 | 61% |
| Endocrinology | 6 | 5% |
| Rheumatology | 0 | 0% |
| Pulmonology | 1 | 1% |
| Cardiology | 1 | 1% |
| Gastroenterology | 2 | 2% |
| Other | 36 | 31% |
| Total | 117 | 100% |



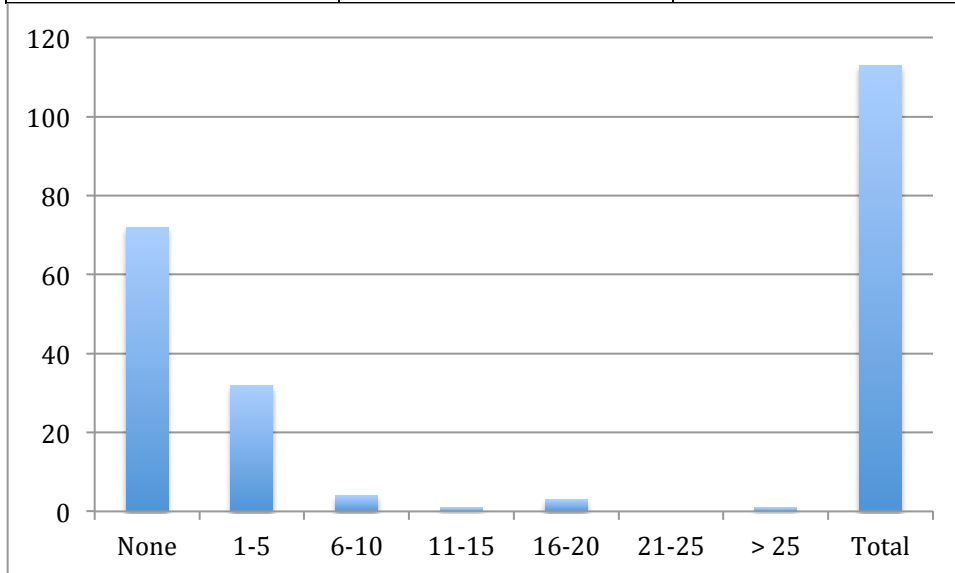
Indicate the number of patients you see each week in a clinical setting regarding each therapeutic area listed. (IBD)

| Label | Frequency | Percent |
|-------|-----------|---------|
| None | 24 | 21% |
| 1-5 | 67 | 58% |
| 6-10 | 14 | 12% |
| 11-15 | 7 | 6% |
| 16-20 | 1 | 1% |
| 21-25 | 2 | 2% |
| > 25 | 0 | 0% |
| Total | 115 | 100% |



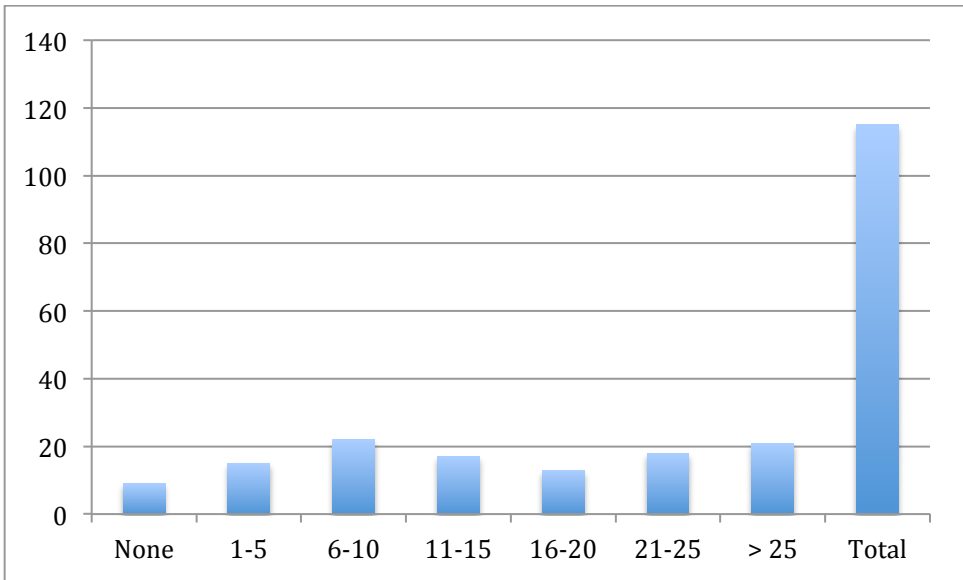
Indicate the number of patients you see each week in a clinical setting regarding each therapeutic area listed. (Alpha-1)

| Label | Frequency | Percent |
|-------|-----------|---------|
| None | 72 | 64% |
| 1-5 | 32 | 28% |
| 6-10 | 4 | 4% |
| 11-15 | 1 | 1% |
| 16-20 | 3 | 3% |
| 21-25 | 0 | 0% |
| > 25 | 1 | 1% |
| Total | 113 | 100% |



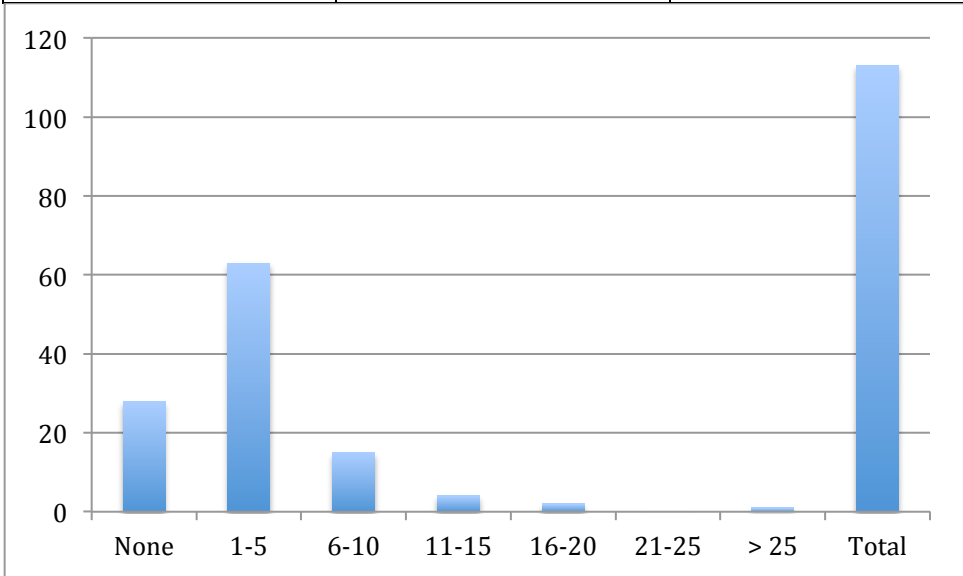
Indicate the number of patients you see each week in a clinical setting regarding each therapeutic area listed. (Diabetes)

| Label | Frequency | Percent |
|-------|-----------|---------|
| None | 9 | 8% |
| 1-5 | 15 | 13% |
| 6-10 | 22 | 19% |
| 11-15 | 17 | 15% |
| 16-20 | 13 | 11% |
| 21-25 | 18 | 16% |
| > 25 | 21 | 18% |
| Total | 115 | 100% |



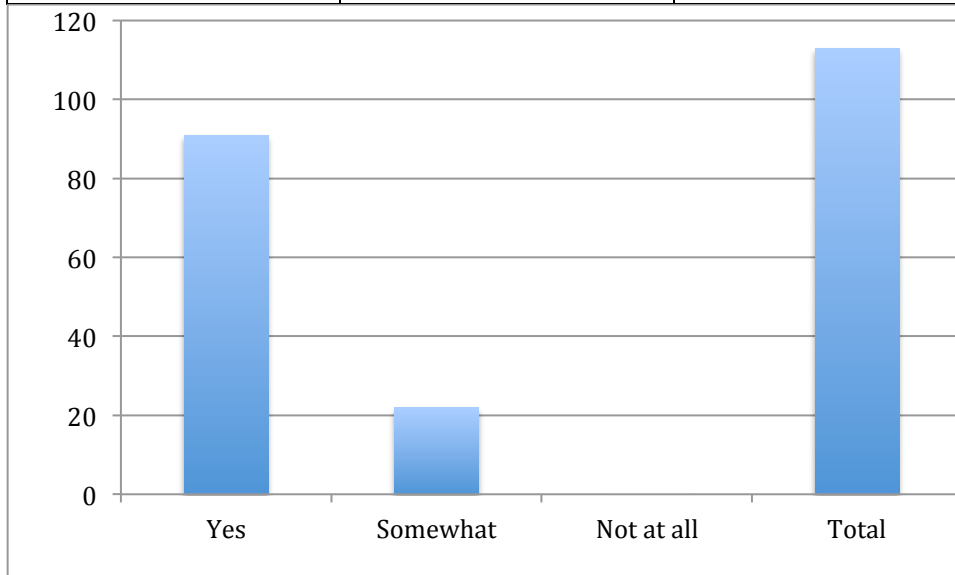
Indicate the number of patients you see each week in a clinical setting regarding each therapeutic area listed. (Psoriasis)

| Label | Frequency | Percent |
|-------|-----------|---------|
| None | 28 | 25% |
| 1-5 | 63 | 56% |
| 6-10 | 15 | 13% |
| 11-15 | 4 | 4% |
| 16-20 | 2 | 2% |
| 21-25 | 0 | 0% |
| > 25 | 1 | 1% |
| Total | 113 | 100% |



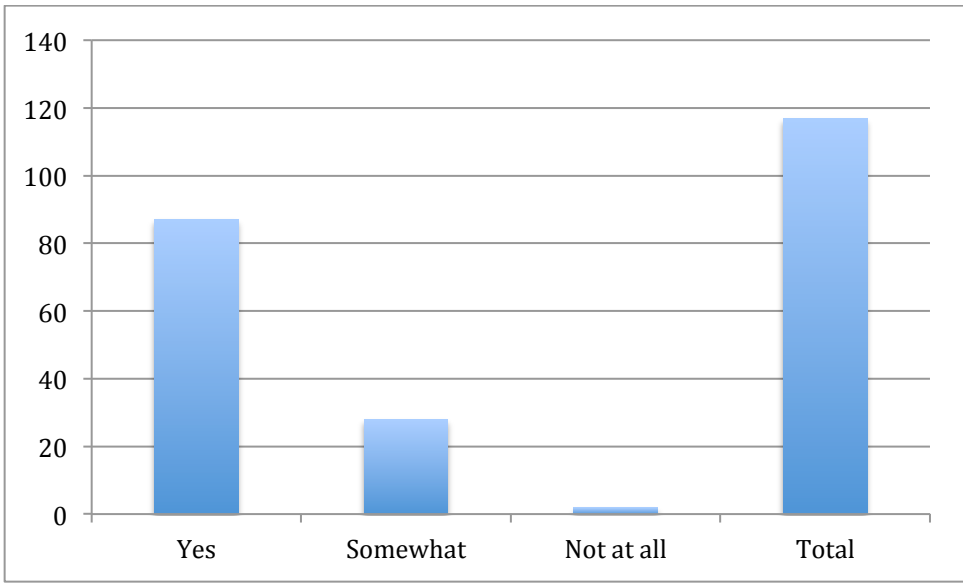
Upon completion of this activity, I can now: Identify the conditions referred to as inflammatory bowel disease (IBD), and recognize their clinical presentations and degree of severity, implement appropriate pharmacologic and nonpharmacologic therapeutic strategies for managing IBD in accordance with evidence-based guidelines; Identify patients who are at high risk of complications from IBD and who may benefit from new mechanisms of action in IBD therapy; Employ approaches for effectively communicating the risks and benefits of IBD treatment options and facilitating adherence.

| Label | Frequency | Percent |
|------------|-----------|---------|
| Yes | 91 | 81% |
| Somewhat | 22 | 19% |
| Not at all | 0 | 0% |
| Total | 113 | 100% |



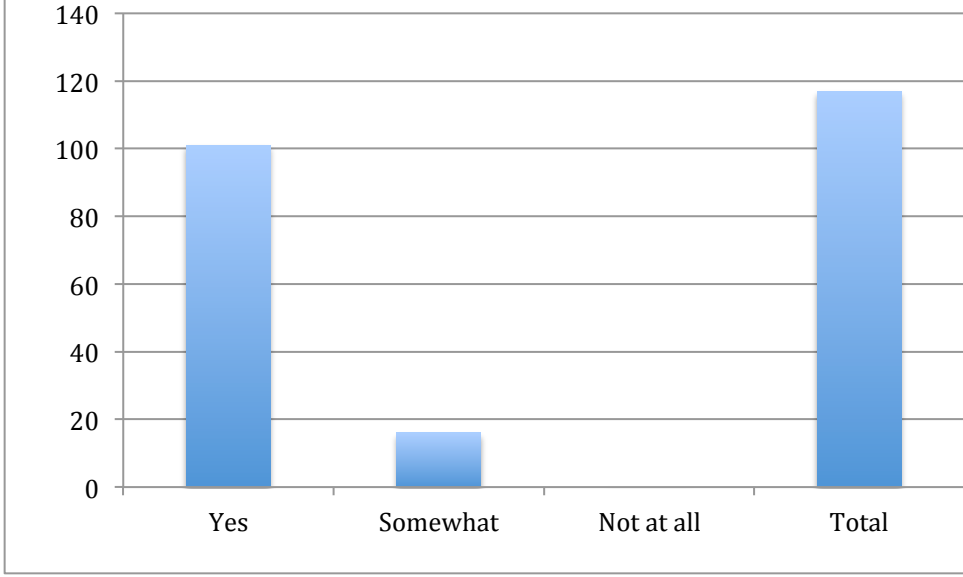
Upon completion of this activity, I can now: Identify who and when to test for AAT deficiency; Describe the 50-year history of alpha1-antitrypsin (AAT) deficiency; Discuss how to incorporate testing for AAT deficiency into everyday practice; Describe the new insights into the efficacy of treatment for AAT deficiency.

| Label | Frequency | Percent |
|------------|-----------|---------|
| Yes | 87 | 74% |
| Somewhat | 28 | 24% |
| Not at all | 2 | 2% |
| Total | 117 | 100% |



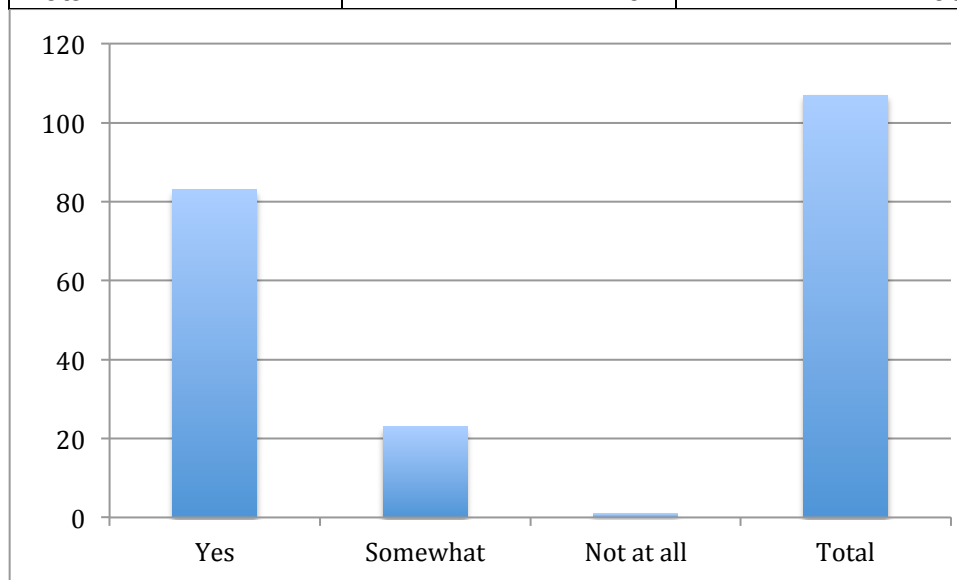
Upon completion of this activity, I can now: Identify the barriers between physicians and patients to discussing and initiating injectable treatments for diabetes; Recognize the importance of glucotoxicity in the development of beta cell failure and diabetic complications; Describe how best to initiate, utilize and intensify insulin therapy in patients with diabetes, and to recognize the role of combining GLP-1 analogues and SGLT-2 inhibitors with insulin to individualize care, achieve targets and minimize hypoglycemia.

| Label | Frequency | Percent |
|------------|-----------|---------|
| Yes | 101 | 86% |
| Somewhat | 16 | 14% |
| Not at all | 0 | 0% |
| Total | 117 | 100% |



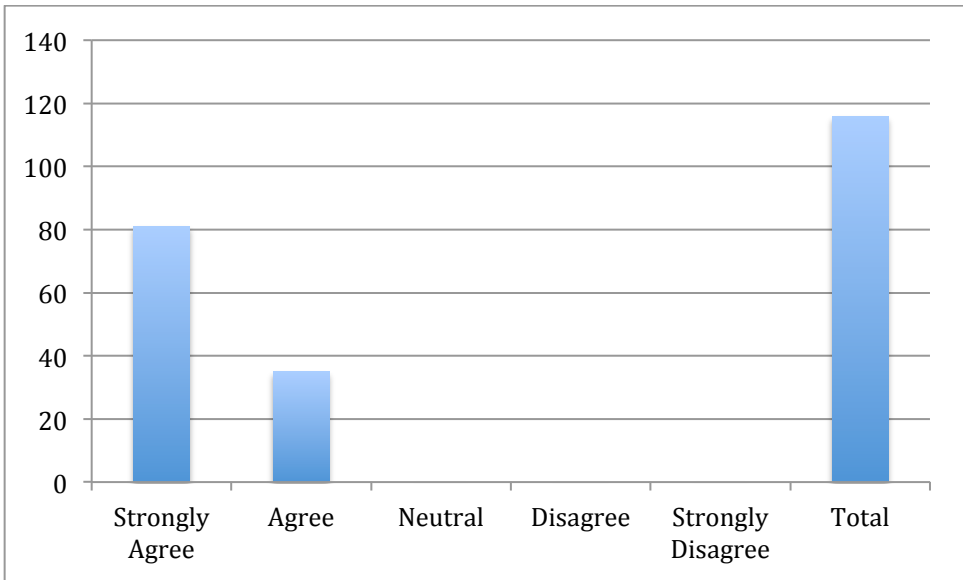
Upon completion of this activity, I can now: Discuss the most up-to-date treatment protocols based on the current understanding of psoriasis and its related disorders as T-cell mediated immune diseases; Define psoriatic disease and outline the clinical presentation and pathophysiology of psoriasis; Identify and discuss the ever-expanding numbers of co-morbid conditions associated with psoriatic disease; Interpret and apply evidence-based approaches for the treatment of patients with psoriatic conditions.

| Label | Frequency | Percent |
|------------|-----------|---------|
| Yes | 83 | 78% |
| Somewhat | 23 | 21% |
| Not at all | 1 | 1% |
| Total | 107 | 100% |



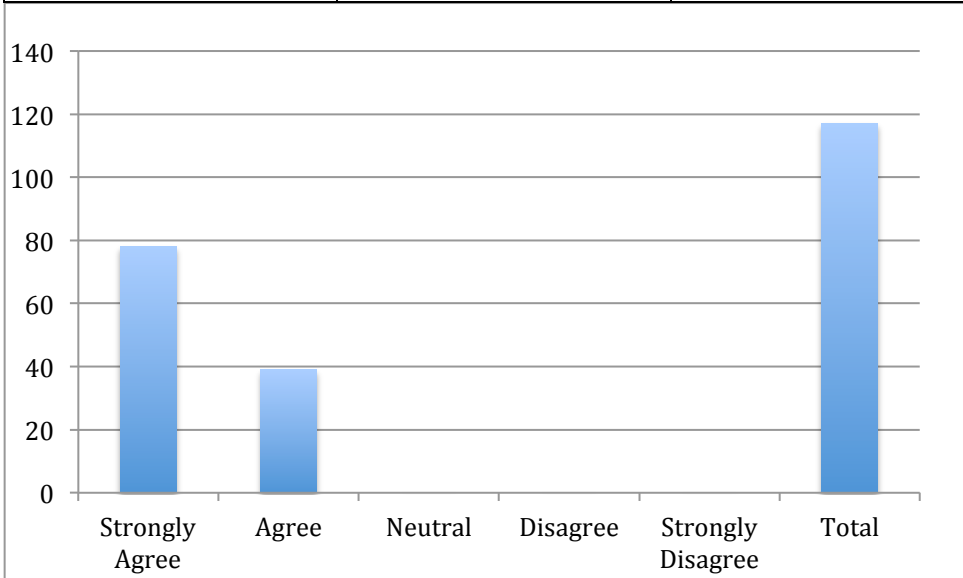
Overall, this was an excellent CME activity:

| Label | Frequency | Percent |
|-------------------|-----------|---------|
| Strongly Agree | 81 | 70% |
| Agree | 35 | 30% |
| Neutral | 0 | 0% |
| Disagree | 0 | 0% |
| Strongly Disagree | 0 | 0% |
| Total | 116 | 100% |



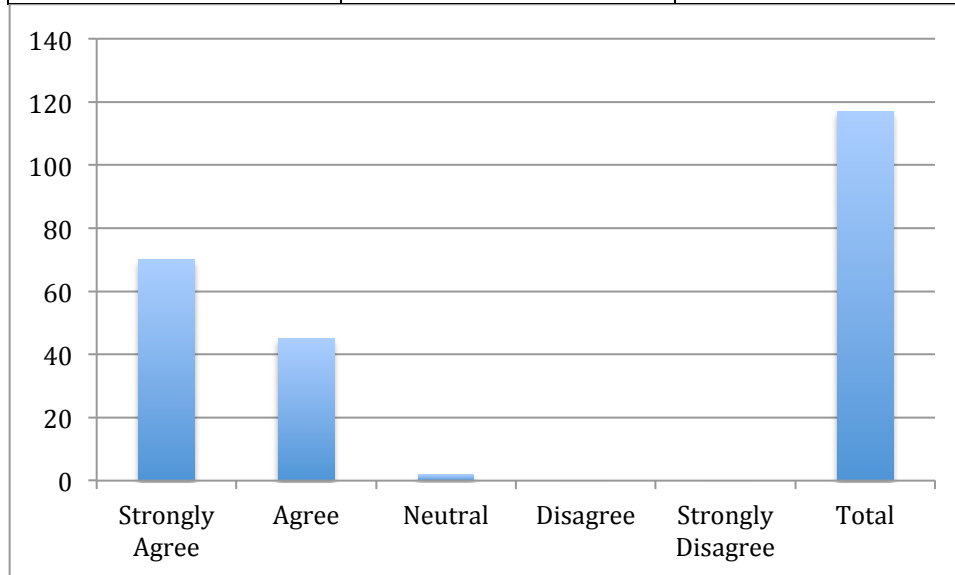
Overall, this activity was effective in improving my knowledge in the content areas presented:

| Label | Frequency | Percent |
|-------------------|-----------|---------|
| Strongly Agree | 78 | 67% |
| Agree | 39 | 33% |
| Neutral | 0 | 0% |
| Disagree | 0 | 0% |
| Strongly Disagree | 0 | 0% |
| Total | 117 | 100% |



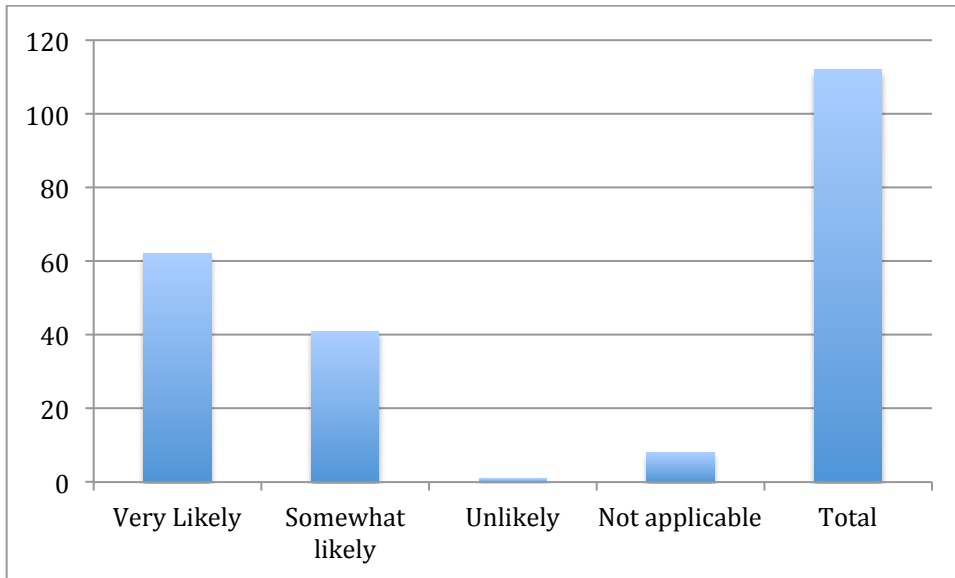
As a result of this activity, I have learned new and useful strategies for patient care:

| Label | Frequency | Percent |
|-------------------|-----------|---------|
| Strongly Agree | 70 | 60% |
| Agree | 45 | 38% |
| Neutral | 2 | 2% |
| Disagree | 0 | 0% |
| Strongly Disagree | 0 | 0% |
| Total | 117 | 100% |



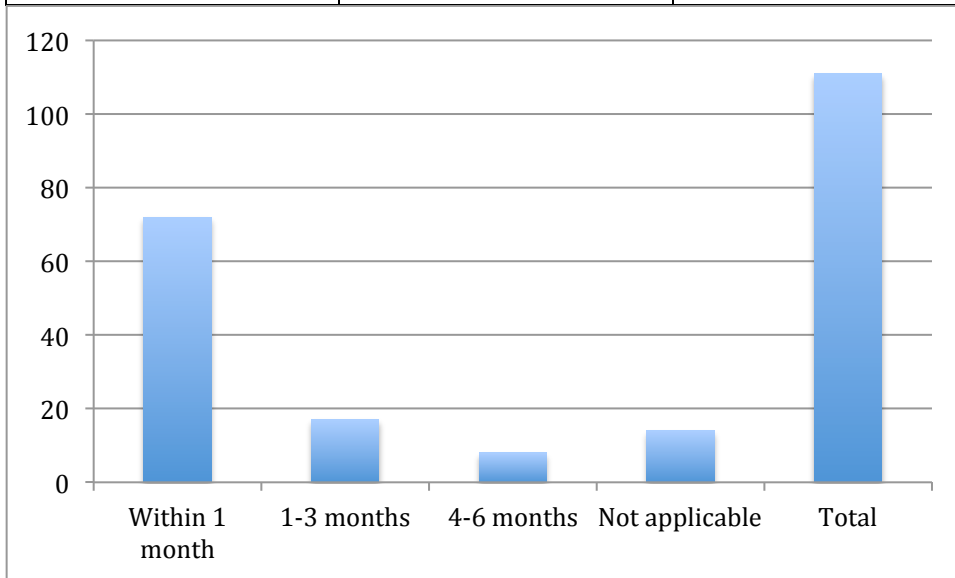
How likely are you to implement these new strategies in your practice?

| Label | Frequency | Percent |
|-----------------|-----------|---------|
| Very Likely | 62 | 55% |
| Somewhat likely | 41 | 37% |
| Unlikely | 1 | 1% |
| Not applicable | 8 | 7% |
| Total | 112 | 100% |



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

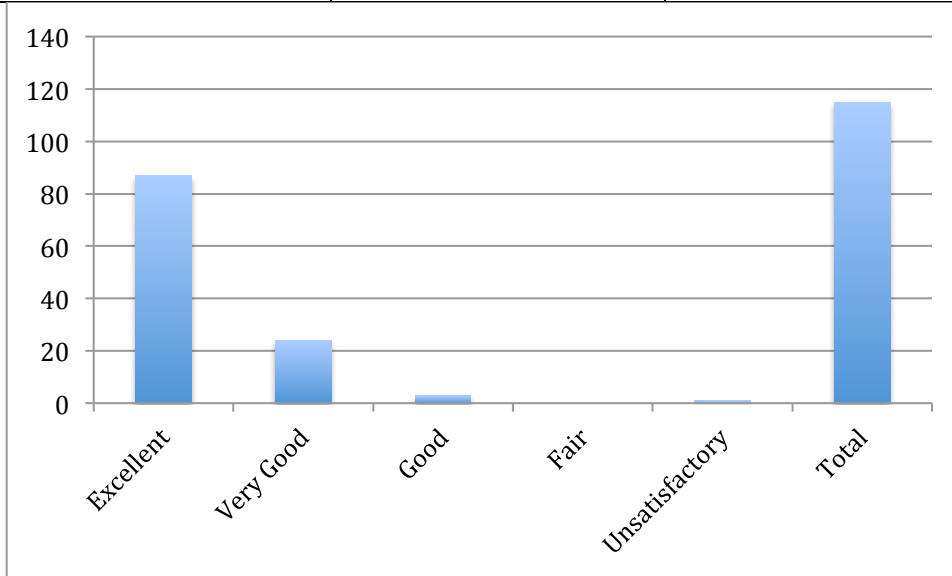
| Label | Frequency | Percent |
|----------------|-----------|---------|
| Within 1 month | 72 | 65% |
| 1-3 months | 17 | 15% |
| 4-6 months | 8 | 7% |
| Not applicable | 14 | 13% |
| Total | 111 | 100% |



In terms of delivery of the presentation, please rate the effectiveness of the speaker:
Gerald W. Dryden, MD. (IBD)

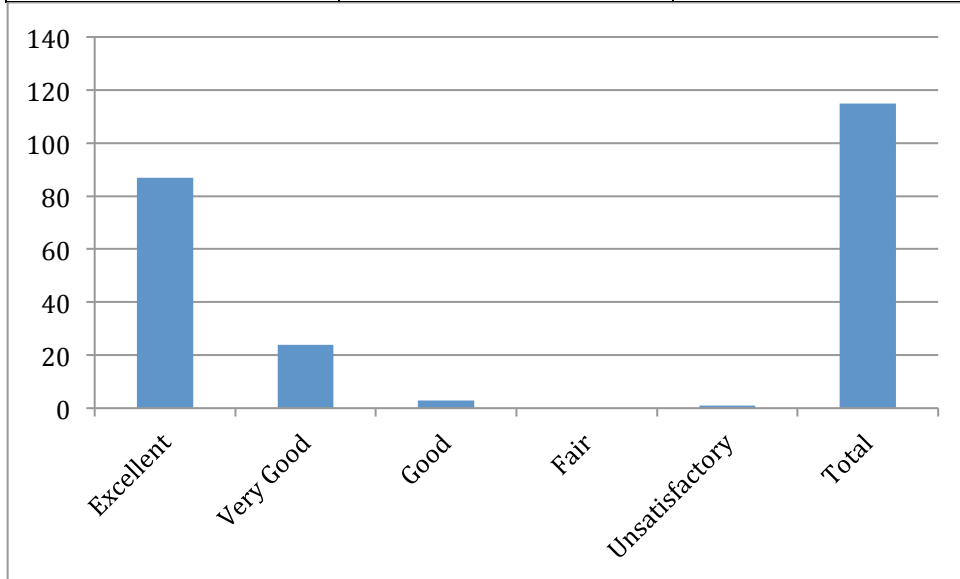
| Label | Frequency | Percent |
|-----------|-----------|---------|
| Excellent | 87 | 76% |
| Very Good | 24 | 21% |
| Good | 3 | 3% |

| | | |
|----------------|-----|------|
| Fair | 0 | 0% |
| Unsatisfactory | 1 | 1% |
| Total | 115 | 100% |



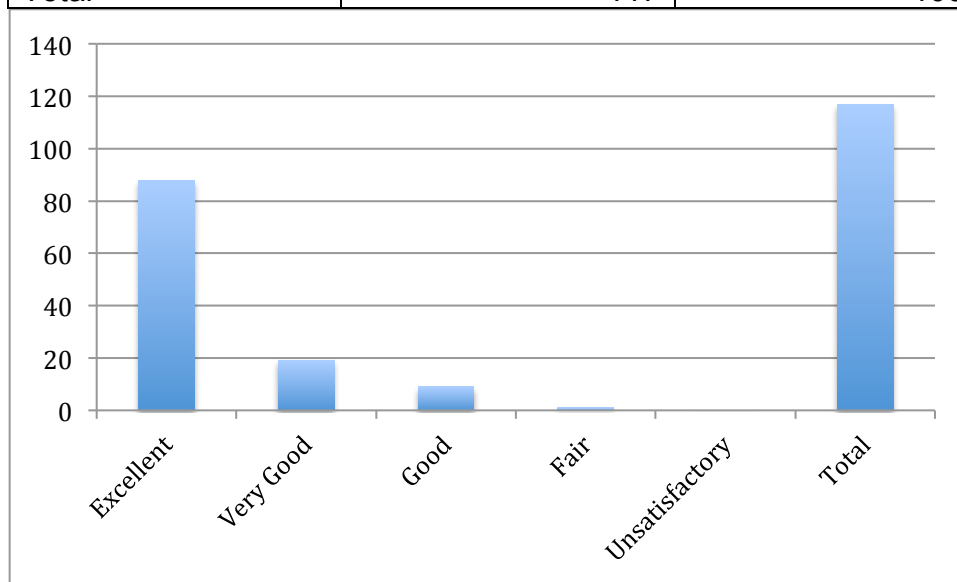
In terms of delivery of the presentation, please rate the effectiveness of the speaker:
 Franck Rahaghi (Alpha-1)

| Label | Frequency | Percent |
|----------------|-----------|---------|
| Excellent | 87 | 76% |
| Very Good | 24 | 21% |
| Good | 3 | 3% |
| Fair | 0 | 0% |
| Unsatisfactory | 1 | 1% |
| Total | 115 | 100% |



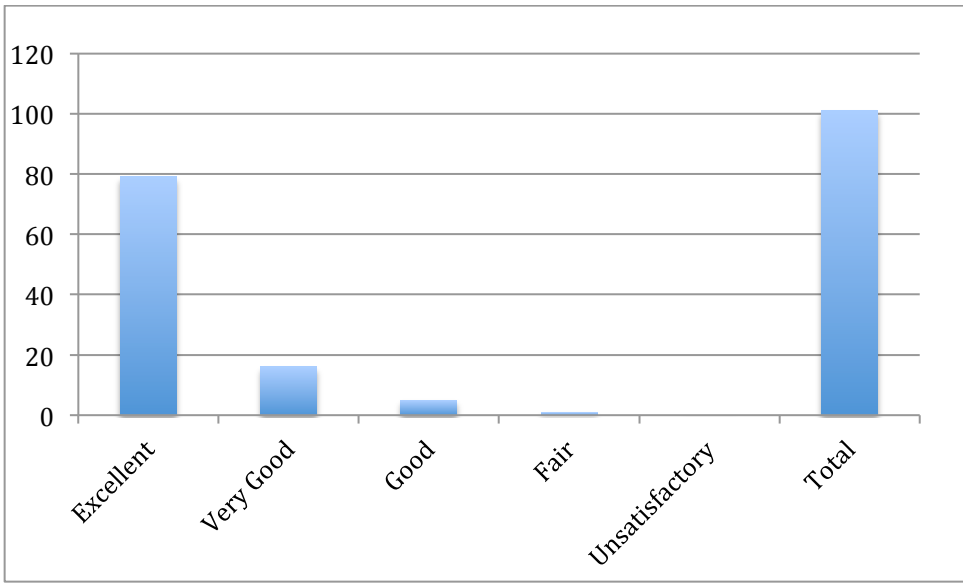
In terms of delivery of the presentation, please rate the effectiveness of the speaker:
 Patricia Munz, MSN, APN, CDE (Diabetes)

| Label | Frequency | Percent |
|----------------|-----------|---------|
| Excellent | 88 | 75% |
| Very Good | 19 | 16% |
| Good | 9 | 8% |
| Fair | 1 | 1% |
| Unsatisfactory | 0 | 0% |
| Total | 117 | 100% |



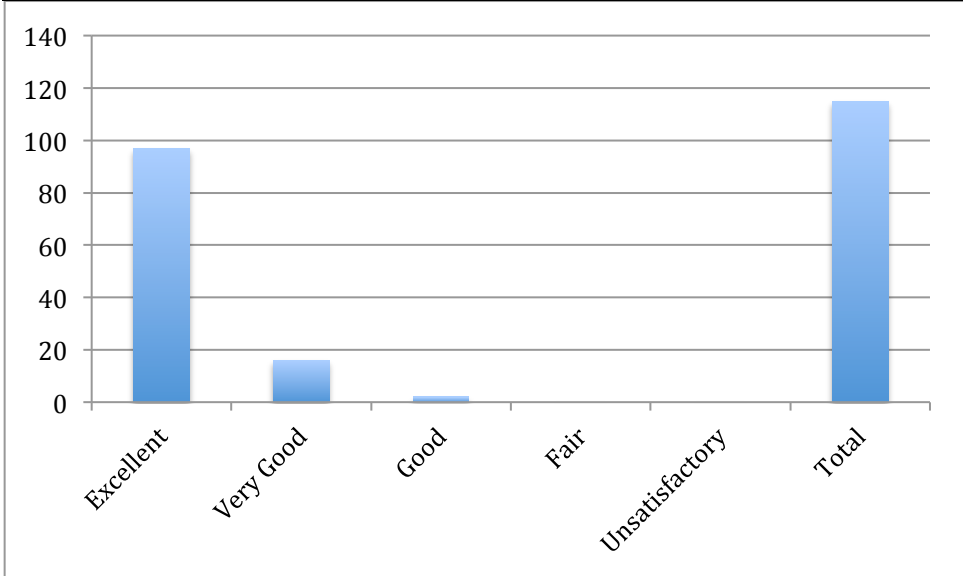
In terms of delivery of the presentation, please rate the effectiveness of the speaker:
 Paul Yamauchi, MD, PhD(Psoriasis)

| Label | Frequency | Percent |
|----------------|-----------|---------|
| Excellent | 79 | 78% |
| Very Good | 16 | 16% |
| Good | 5 | 5% |
| Fair | 1 | 1% |
| Unsatisfactory | 0 | 0% |
| Total | 101 | 100% |



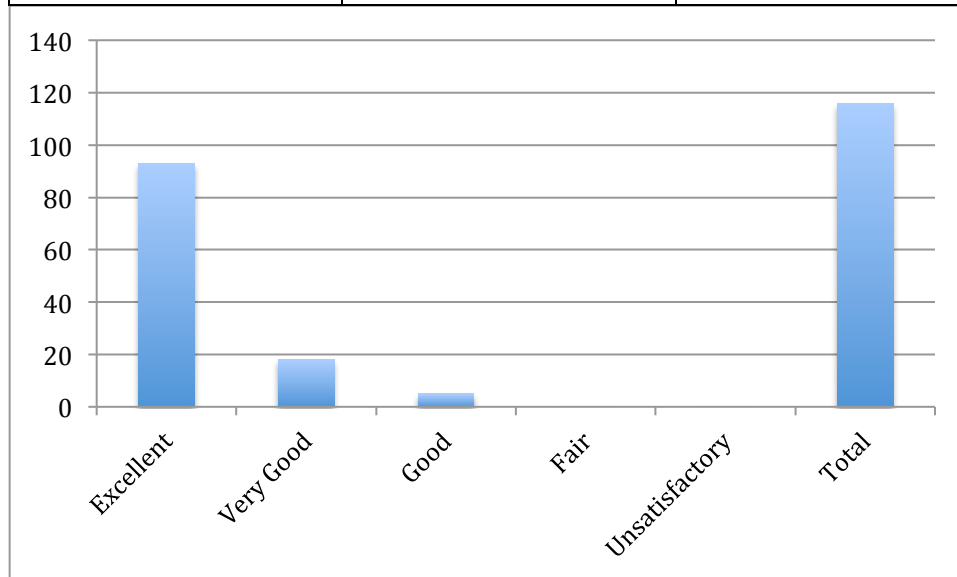
To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Gerald W. Dryden, MD (IBD)

| Label | Frequency | Percent |
|----------------|-----------|---------|
| Excellent | 97 | 84% |
| Very Good | 16 | 14% |
| Good | 2 | 2% |
| Fair | 0 | 0% |
| Unsatisfactory | 0 | 0% |
| Total | 115 | 100% |



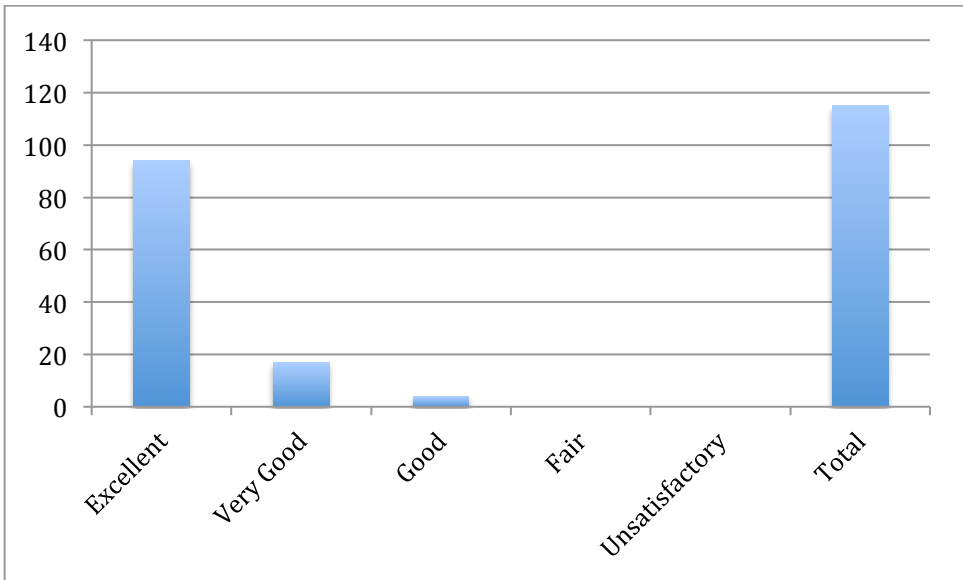
To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Franck Rahaghi, MD (Alpha-1)

| Label | Frequency | Percent |
|----------------|-----------|---------|
| Excellent | 93 | 80% |
| Very Good | 18 | 16% |
| Good | 5 | 4% |
| Fair | 0 | 0% |
| Unsatisfactory | 0 | 0% |
| Total | 116 | 100% |



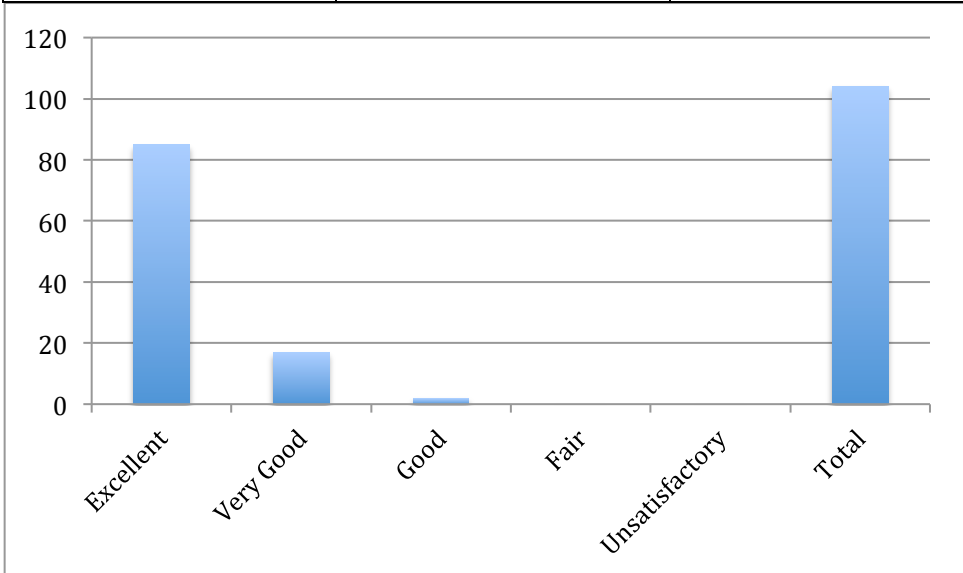
To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Patricia Munz, MSN, APN, CDE (Diabetes)

| Label | Frequency | Percent |
|----------------|-----------|---------|
| Excellent | 94 | 82% |
| Very Good | 17 | 15% |
| Good | 4 | 3% |
| Fair | 0 | 0% |
| Unsatisfactory | 0 | 0% |
| Total | 115 | 100% |



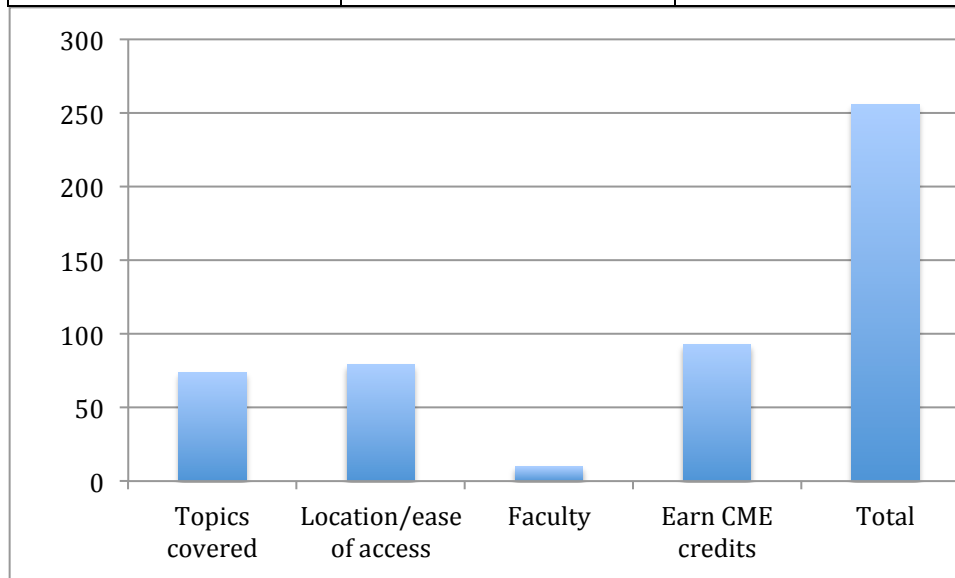
To what degree do you believe that the subject matter was presented fair, balanced, and free of commercial bias? Paul Yamauchi, MD, PhD (Psoriasis)

| Label | Frequency | Percent |
|----------------|-----------|---------|
| Excellent | 85 | 82% |
| Very Good | 17 | 16% |
| Good | 2 | 2% |
| Fair | 0 | 0% |
| Unsatisfactory | 0 | 0% |
| Total | 104 | 100% |



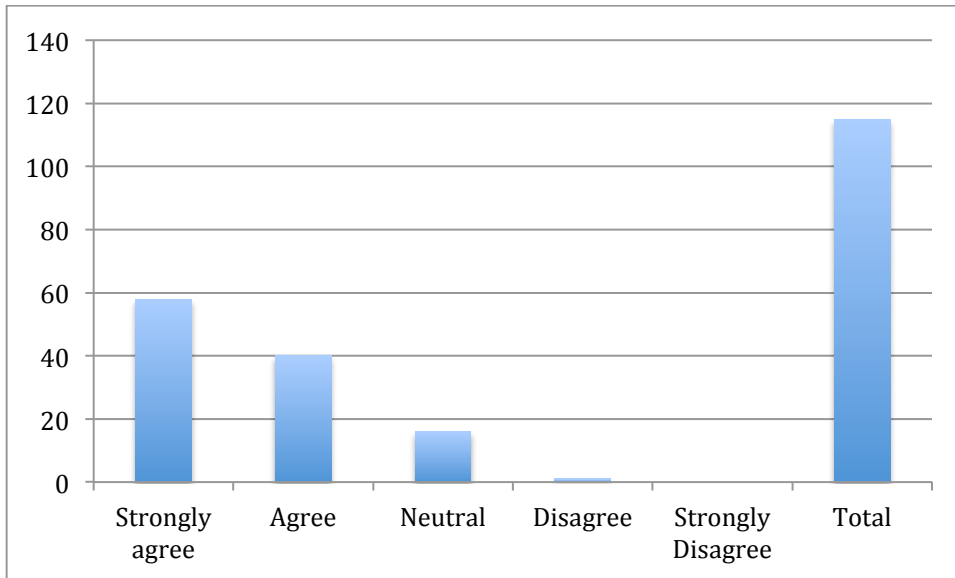
Which statement(s) best reflects your reasons for participating in this activity?

| Label | Frequency | Percent |
|-------------------------|-----------|---------|
| Topics covered | 74 | 29% |
| Location/ease of access | 79 | 31% |
| Faculty | 10 | 4% |
| Earn CME credits | 93 | 36% |
| Total | 256 | 100% |



Future CME activities concerning this subject matter are necessary.

| Label | Frequency | Percent |
|-------------------|-----------|---------|
| Strongly agree | 105 | 48% |
| Agree | 102 | 46% |
| Neutral | 12 | 5% |
| Disagree | 2 | 1% |
| Strongly Disagree | 0 | 0% |
| Total | 221 | 100% |



| As a result of this activity, I have learned new and useful strategies for patient care: List these strategies: - Pre |
|---|
| -Always think of AAT-1 deficiency as a possible cause of patient's Emphysema. |
| -Use IBD Questionnaire as a screening tool for diagnosis |
| -Explore all available treatment options for Psoriasis, before referring patients out. |
| 1. Identifying psoriasis and treatment modalities |
| 2. Improved communication with pts who use injectable insulin |
| 3. Possible treatments for UC/CD patients, including initiation of biologics. |
| AAT testing. Better discerning UC from CD |
| Accurate history and thorough physical exam |
| Appropriate medication regimen for mild, moderate versus severe IBD. Will initiate Basal Insulin Therapy on controlled Diabetes sooner. Plan to screen for AAT deficiency in COPD patients when appropriate. Differentiate atopic dermatitis from Psoriasis and treat accordingly |
| Appropriate medication used in IBD vs. Crohn's Disease. Checking AAT in early screening of COPD. Starting patients on insulin for first-time therapy when appropriate. The diverse features of psoriatic arthritis, RA and OA |
| assessment and monitoring |
| Patient history |
| followup |
| Assessment improvement. Psoriasis awareness. Treatment options |
| Be more aggressive with early treatment options. |
| behavior medicine |
| Better able to discuss these conditions with the patient and make treatment recommendations |
| Better communication, better clinical understanding |
| better history taking, knowing which tests to order |
| Check for AAT def in my COPD patients. Push diabetic injectables harder. Better recognition of IBD drugs |
| Check for Alpha-1 in COPD. Evaluate closely for psoriasis- avoid long use corticosteroid. Any Chrons needs dexo scan. Insulin can increase zu daily to desired level (I use I-2) |
| Clear acknowledgement and understanding of AAT deficiency, which I never before was aware of its importance. Speaker really drove his point |
| Clinical presentation/ HX, assess severity of PSA. Without Dx test for PSA- but needs to do test to R/o other differential- skin Bx, x-ray, blood test, etc. (TB test) Using tx algorithm for tx- local plaque- fx'd with combination of vie ointment and clohefasol. If systematic or severe - send to Dermatology |
| Combination tx for IBD |

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|--|
| diabetic management |
| Diagnosing and treating patients |
| Diagnosis of Psoriasis, symptoms and treatment. |
| Diagnostic strategies |
| Diagnostic test available |
| Discuss Diabetic management. Cardiac refer to IBS- teaching. Discuss co-morbid condition and relate to psoriasis |
| Discussing options in treatment for diabetes and early initiation of newer injectable therapies. |
| Discussion of AAT deficiency screening with COPD pts and refer to pulmonary as needed. Consider NMCT imaging for IBD pt evaluation to decrease frequency of radiologic exposure. Screen for comorbidities that can be associated with psoriasis. Use of percentage body affected area in treatment selection process of psoriasis pt |
| Disease barriers. Identify Alpha-1 deficiency to COPD. Encourage early insulin use in Diabetics. Provide more support to pts with psoriasis because they have frequent depression. Early identify IBS and treatment |
| early insulin implementation |
| Early treatment is key. Need to test for Alpha disorder. Biologics can tx psoriasis |
| Educational discussions with DM 2 patients to decrease their anxiety and provide realistic outcomes for them. |
| Emphasis was placed on listening to diabetic patients and not making them feel guilty or like failures regarding injectables. I think this is important for the medical management of all chronic diseases, but it takes time and patience. |
| Employ Individual Patient Assessment for specific symptoms |
| Use evidenced based treatment methods |
| Empower pt and better communication |
| Evaluating IBS and psoriasis especially |
| Exploring diagnostic tools in IBD, AAT deficiency suspect patients. Explore GARS communication tool in improving effective patient care/ med compliance. Tools to enforce injectable acceptance among diabetics needing this med |
| For DM management, initiate injection tx and close monitoring instead of waiting for slow response with oral med (only) |
| Gained knowledge and understanding to recognize who are at risk for complications from IBD, and implement treatment options, when to test for AAT deficiency, recognize glucotoxicity, when to initiate insulin therapy. Role of combining GLP 1 analogues and SGLT -2 inhibitors. Discuss the treatment protocol of psoriasis. |
| How to adequately diagnose and treat a person with Psoriasis and diabetes. |
| How to better manage my DMII patients. Testing needed done for COPD pts. Tx options for IBD |
| How to evaluate and treat IBS, diabetes, psoriasis, Alpha-antitrypsin deficiency |
| How to treat UC and Crohn's and IBS, Understanding AAT deficiency and testing. How to use injectable insulins |
| I am semiretired at the moment, but utilize this knowledge when I go back to work |
| I have learned how to differentiate better between IBD, UC, and Crohn's. I have learned the importance of testing patients for AATD for whom I have even a moderate index of suspicion. I learned some of the extra-pulmonary manifestations of AATD. I learned which groups of patients would benefit more from GLP-1s vs. SGLT-2 inhibitors. I learned how the physiology of glucotoxicity causes the effects with which patients present. I learned about some of the extra-dermatological manifestations of Psoriasis. I learned some ways to differentiate between the different arthritises, psoriatic vs RA vs Lupus. |
| I learned how to identify patients who might be in need of alpha-1 testing. |
| I mostly refer for psoriasis, but now I can speak more accurately as to up to date treatment |
| I now am aware of the need for increased screening and referral |
| I understand antitrypsin deficiency better now. |
| I will screen for Alpha 1 Antitrypsin more effectively |

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December 13, 2014 – Dallas, TX

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| <p>I will be better prepared to manage the comorbidities associated with OBD and help guide patients to treatment compliance</p> <p>I will have more effective discussions with my patients regarding insulin therapy and options for DM care</p> |
| <p>I work with mental health patients. This information helps me to understand their physical health problems that are affecting their mental health.</p> |
| <p>i'm glad emphasis was made on life style changes prior to medical implementation.</p> <p>in DM, i learned good guidelines for treating out of range a1c.</p> <p>IBD has been done to death, (conference wise;) there have to be non phram ways to treat this, too. but some patients have found these toxic pharm meds to be life changing. Life ending, too, sadly.</p> <p>psoriasis - again immune imbalance can be addressed non pharmacologically as well. these new highly toxic meds recommended have not been tested long enough and likely should have black box warnings attached.</p> |
| <p>IBD polyphenols , fecal transplant, probiotics</p> <p>AAT deficiency screening in high risk populations (tobacco and ETOH abuse)</p> <p>Biologics for tx of T cell mediated psoriasis. Autoantigen screening and long term efficacy of meds including risks (TB) screening</p> <p>Victoza in combination with basal insulin for targeted hgba1c. Big emphasis on diet modification when initiating Victoza to emphasize smaller meal size due to early satiety .</p> |
| <p>Identifying AAT patients and testing. Stepwise meds for UC and CD. Comorbidity assessment with psoriasis. Insulin adjustments based on lifestyle and A/C</p> |
| <p>Importance of pt provider rapport when it comes to control of chronic disease. I learned new approaches to improve patient rapport.</p> |
| <p>Improved assessment and I interventional skills</p> |
| <p>Improved diagnostic skills and tools. Promote patient education</p> |
| <p>Improved monitoring / management of IBD patient; new insight into recobnition Alpha 1 and screening for; updating knowledge of psoriasis / T cell lymphoma</p> |
| <p>in many different ways</p> |
| <p>incorporate updated testing and treatment for IBD, Psoriasis, AAT; avoid delayed treatment/clinical inertia.</p> |
| <p>Increase Alpha-1 testing in COPD pts. IBD-IBS- thought I knew it, now confused. DM- will step away sliding scale and learn new correction. Psoriasis- better understand dz</p> |
| <p>Increasing use of spirometry. Increasing AATD testing. Specific strategies for starting dose and titrating insulin calculations</p> |
| <p>Initiation of Insulin therapy. Management of Psoriatic Arthritis. IBD mod vs severe</p> |
| <p>Injectable GLP-1 initiation. AIA deficiency screening. Psoriasis identification</p> |
| <p>Intensive insulin therapy. GLP-1 injections. Psoriasis complications and caution</p> |
| <p>Knowledge</p> |
| <p>Make an order set to be checked when. R/o IBD</p> |
| <p>MORE AWARE OF NUANCES AND ADVANCES IN TREATMENT</p> |
| <p>more psoriasis treatments</p> |
| <p>most in area of testing for AAT deficiency</p> |
| <p>Most of these conditions I will still not likely treat, but I learned about how to identify the conditions or patients who are at risk, how to discuss options with patients, and learned about the different treatment regimens.</p> |
| <p>motivational interviewing strategies addressed by first speaker</p> |
| <p>Now aware I need to be testing for Alpha-1 AATD</p> |
| <p>Other injectables besides insulin for diabetes</p> |
| <p>People who stop smoking will have flow IBD- start tx based on severity. Only lab test can confirm Alpha-1. Supplemental scale. Use of GLP's</p> |
| <p>prioritizing needs and consideration of t cell mediated disease</p> |
| <p>relaying more up to date information in a more clear and concise manner while implementing emphasis on patient education</p> |

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|---|
| Screening all COPD patients for AAT deficiency |
| Use biologics appropriately to treat psoriasis |
| Discuss the value of injectable diabetes treatments with patients |
| Identify and treat IBD patients more effectively |
| Screening for AATD- making a protocol. Adding injectables in Diabetes treatment |
| Screening- testing and imaging |
| Spirometry after 2-3 months with COPD, Alpha-1 Antitrypsin. Insulin injections. Derm emergency- love it |
| Spirometry in office to test for and monitor COPD. Pulse oximeter |
| Step care for IBD. Test for AATD. Use GLP-1 more freely |
| Testing for Alpha-1 anti-trypsin deficiency dz. Glycomark and Fructosamine blood sugar |
| Testing for Anti-trypsin 1 in COPD patients |
| The DM talk was fabulous-when to use which drugs and approach with patients |
| The importance of insulin therapy. |
| How to monitor for psoriasis. |
| When you should test for AAT deficiency. |
| The importance of testing for AAT deficiency and starting tx. How to educate patient on insulin and DM treatment. |
| to be more aggressive with therapy to prevent complications |
| Treat more Psoriatic lesions. Do not overlook COPDers |
| Treat psychiatric patients that have co-morbidities that need to be taken in account when prescribing psychiatric medications |
| Treatment is based on extent of involvement of skin and joints. I will prescribe vitamin D cream more for topical combination cream |
| Treatment modalities |
| Treatment modalities for IBD. Screening criteria for Alpha-1 |
| Treatment options for IBD- ulcerative colitis and crohns disease. Screening criteria for AATD |
| Treatment options for IBD. Better management of Diabetes. Screening for Alpha-1. Better management of Psoriasis also diagnosis |
| Treatment steps/protocol to use in the care of Psoriasis. What works and what doesn't. |
| updated guidelines/management to IBD; |
| therapeutic communication with DM patients |
| Useful for practice' practical tips,and lectures are easily understandable |
| Using newer DM meds |
| When to test a patient dx'd with COPD for alpha-1 anti-trypsin deficiency. |
| Who to test for alpha one. Be more aggressive with injectable meds in diabetes management. |
| Will test for Alpha-1 and will discuss it further with pulmonologist. Psoriasis identification and tx |
| Y |
| Yes |

| What topics would you like to see offered as CME activities in the future? - Pre |
|---|
| "Stairway to DM" |
| - Hypertension pearls |
| Addiction medicine |
| Obesity |
| Polypharmacy in the elderly |
| Medical marijuana |
| Tele medicine |
| Aesthetic medicine/ obesity/ nutrition |
| ALSO OCCUPATIONAL HAZARDS, TREATMENTS AND SPORTS INJURIES |
| Alternative/ complimentary therapies/ Natura-pathic meds |
| Alzheimers, Dementia and controlling behavioral disturbances of Dementia |
| Anemia of chronic disease management in Geriatric care Lab monitoring |

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|---|
| Any topic update for primary care. Adult/ Geri.-Short term care, long term care |
| behavior medicine tx |
| Behavioral motivation of patients with Diabetes specifically |
| CAD for primary care |
| Pain management for primary care |
| Cardiac |
| Cardiovascular topics |
| CHF |
| CHF, Complications of HTN, Dyslipidemia |
| CHF. EKG interpretation |
| CHF/ Orthopedic injuries/Sepsis infection |
| Cold |
| Heart failure |
| Renal failure |
| Continence/ Incontinence of bladder. Podiatry= diabetic/ neuropathic ulcers of feet. More dermatology lectures |
| Depression management. Obesity |
| depression, obesity, sleep disorders, immunization |
| Depression. Suicide prevention. Anxiety. Weight Loss |
| Diabetes, Psoriasis |
| DVT/ PE. Stroke. Head Trauma. Breast Cancer. Colon Cancer. Lung Cancer |
| EKG interpretation |
| Radiology interpretation |
| EKG. Cystic Fibrosis. HTN. HLD |
| Hep-C, Tx, Evaluation. Updates in DM and Multiple Sclerosis, Rheumatoid Arthritis, Chronic pain syndrome in Cancer patient |
| HIV. Lupus. COPD. Hypertension. Cancers- all. Liver Disease. Hepatitis- all kinds |
| Hormone replacement therapy |
| Managing mild- moderate depression (not severe depression) |
| skin infections |
| HTN, Cholesterol issues |
| Hyperlipidemia guidelines. Hypertension guidelines. CKD |
| Hypertension |
| Anticoagulant use |
| Avoiding inappropriate testing and treatment for common complaints (show costs and potential savings) |
| Hypo/Hyperthyroidism, |
| Strokes |
| COPD |
| CHF |
| I am interested in everything! |
| I am open to a broad range of topics, especially if integrating all age groups |
| ihss |
| Immunization for preventative and travel requirement |
| Infectious disease updates |
| Infectious Disease updates. GYN |
| Info on new HIV preventative med therapy for high risk groups. Info on new pain management therapy in light of recent narcotic med use change |
| Insulin resistant screening and treatment. Systolic HTN in elderly |
| Kidneys/ B/P. Pulmonary- sarcoid. GF- Celiac |
| Low testosterone |
| Elevated estradiol in men |
| Prolactinoma |

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|---|
| Management of obesity in children and adolescents. |
| medical tests |
| More COPD- use of prednisone |
| More Diabetes medication. Heart Disease. Mental Illness. Antibiotics. EKG reviews |
| More Diabetes. Asthma. Fatty liver disease. HRT |
| More diabetes. HTN. Rheumatology |
| More of the same |
| More skin disorders |
| Musculoskeletal issues, back and knee pain, pain management (general) resistant HTN management, weight control, balancing female hormones. |
| Neuro topics- identify PD, AZ. Vertigo. HA |
| Neurology- any topics, infection disease- any topic |
| Obesity |
| Oral anti-diabetics. Thyroid disease. Hypertension Management |
| orthopaedic related |
| Orthopedic injury in primary care |
| Orthopedic. Urology. Cardiology. Pediatrics |
| Osteoporosis. Incontinence- urinary. Fatty liver |
| Osteoporosis |
| COPD |
| CAD |
| HYperlipidemia |
| Parkinson's. COPD with Dr. Rahaghi. Any topic with Dr. Yamauchi |
| Pediatric conditions. Mental health. Non narcotic pain management |
| personality disorders |
| Pharmacological treatment of HTN with different comorbidities. Pharmacologic treatment of hyperlipidemia. Anti-aging concepts with focus on hormone balance. |
| Post concussion care and recovery outcomes |
| Primary Immunodeficiency. Congenital Heart Defects. Review of Anemias |
| Psych mental health. Substance abuse. Integrated healthcare |
| psychiatry in general practice - improve PCPs and educate in current treatment models medical home concept in primary care COPD - real ATT in general population is very, very, very rare. Good emphasis on having and using spirometry in clinical practice. IBS alternative, complementary practices: there is much to be said for pain relief that IS NOT only acupuncture, chiropractic - we need to get other pain relief modalities into common use and be able to get insurance coverage. And trust me,(or contact me) there are a plethora of them. |
| Psychiatry. DSM-V changes/ updates |
| Recurrent urinary tract infections. |
| Review of types of insulin |
| Sarcoidosis. Uveitis. PTSD |
| Smoking cessation management- how to improve compliance/ success with pt. Anxiety/ Depression. Migraine headache |
| Thyroid disorders. Orthopedic disorders. Cardiovascular disorders |
| topic related to skin problem |
| Treatment of Depression and anxiety |
| Treatment/ Cure for Hep C. Depression |
| Tx of Abx uses in peds pt population. Lectures on back pain, chronic back pain or pain management and Arthritis |
| Update cancer screening guidelines. Holistic and alternative remedies- what are our patients taking and not telling us. Understanding for PC providers. New developments in Fatty liver disease, NASH and cirrhosis |

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|-------------------------|
| Urology, GYN |
| Women's Health Topics |
| Rectal and Anal Cancers |

Comments

Additional comments: - Pre

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|---|
| Although I am not a provider, the subject were very interesting and I learn a lot. |
| Being able to view presentations on mobile device would be great |
| Dallas location excellent. Topics covered excellent. Thank you for minimal breaks and maximizing CME for time |
| Dr. Dryden is very knowledgeable and informative for clinical practice. Dr. Rahaghi is very passionate and practical in his lecture. NP Munz is clear and informative- needs to cut down number of slides or talk faster! Dr. Yamauchi is funny and sharing good/ practical stories. Thank you |
| Dr. Yamauchi- best of day! Very enjoyable |
| Engaging speakers |
| Enjoyed the web cast with EXCEPTION that the slides / ?s did not move in sync with the speaker |
| Excellent as always. Really enjoyed Dr. Rahaghi. Really enjoyed Dr. Yamauchi. Dr. Dryden- very good presentation |
| Excellent choice of hotel location, easy to get to |
| Excellent program will recommend to friends and attend in future |
| Good- I am in primary care so the IBD talk was good, but not likely to change my practice. Will still refer IBD to specialist |
| Great speakers |
| How do we apply to be a speaker on "Stairway to DM?" pm.ackley@yahoo.com |
| I enjoyed the photographic portion of psoriasis presentation helps with making differentials in actual practice |
| I really appreciate getting free, well-rounded CME's! Thank you! Next time, please no 1 hour break for lunch. Let's bring a sack lunch and get out an hour early, especially on a Saturday, in December too. And please limit lectures to 1-hour each |
| I strongly disagree that "because insurance covers it, we should test it." i could barely understand psoriasis presenter for his heavy accent. Moderator was great as was pacing of conference. IBD presenter really spoke too fast for us to hear all the info. I wish i'd known (until last slide) that i could see graph answers by sliding my screen over to right. |
| I very much enjoyed this update. Thanks |
| I wish we did not have to take a lunch break. I would rather have had a sack lunch and just gone on with the next lecture |
| In the future, if only one afternoon session, then no lunch break is needed |
| It was a great presentation, organized well with good topics |
| Location at Dallas and Fort Worth area preferred |
| Make sure slides include references to BOTH PA's and NP's! Not just what nurses do or can do in a practice. Thank you |
| n/a |
| na |
| none (2) |
| NONE AT THIS TIME |
| One of the best talks on DM I have heard-very knowledgeable speaker and information was very useful to practice! |
| Overall good program |
| Please make the video smoother. I had to reconnect to the broadcast at least 10 times, grrrr....frustrating. |

| |
|--|
| Thank you (2) |
| Thank you for offering this!!! |
| Thanks |
| The IBD presentation was AWESOME. Interesting and very informative. Thanks |
| This was a very informative and interesting conference. Thank you very much for this opportunity |
| This was excellent. Thank you for providing such a forum |
| very good |
| Very good presentations |
| Very practical and enjoyable lecture. Thank you so much for providing this program |
| Very well organized. Easy access to live presentation with no technical difficulties. |