12th Annual Primary Care Conference

Moving Forward Together in an Era of Isolation

January 9, 2021

Session Objectives and Resources

To claim credit, you are expected to complete the competency questions found in the Survey Monkey Conference Evaluation.

https://www.surveymonkey.com/r/PCP-Jan9

Upon completion of the survey, you will be taken to a web page where you will be able to download your completion certificate. Nursing certificates will be emailed the week of January 11, 2021.

Enjoy the conference!

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Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to 3.0 MOC points in the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program. Participants will earn MOC points equivalent to the amount of CME credits claimed for the activity. It is the CME activity provider's responsibility to submit participant completion Information to ACCME for the purpose of granting ABIM MOC credit. In order to claim MOC credit, learners must grant permission for Piedmont Healthcare to share completion data with the American Board of Internal Medicine (ABIM) through the Program Activity and Reporting Systems (PARS) of the Accreditation Council for Continuing Medication Education (ACCME).

This conference has been approved for 3.0 hours of Pharmacy CE Credits by the Georgia Society of Health System Pharmacists. The Georgia Society of Health System Pharmacists is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.

PHC is approved as a provider of nursing continuing professional development by South Carolina Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

Practical Aspects of Assessment and Management of Depression in the Primary Care Setting | Rohini Mehta, MD

Rohini Mehta, MD is an assistant professor in the Department of Psychiatry and Health Behavior and a board-certified Psychiatrist. She earned a Bachelor's of Science degree from McGill University in Montreal, Q.C., and her medical degree from the Virginia Tech Carilion School of Medicine in Roanoke, VA. After completing her residency in psychiatry from MedStar Georgetown University Hospital in Washington, D.C., where she served as Chief Resident, Dr. Mehta held a clinical position at the Charlie Norwood Veterans Affairs Medical Center in Augusta, GA before joining the faculty at the Medical College of Georgia to serve as a Clinician Educator. Dr. Mehta has received numerous accolades, including induction into the Gold Humanism Honor Society, the Leonard M. Tow Humanism in Medicine award, the American Psychiatric Association Resident Recognition Award, and a teaching award. Her clinical interests include mood and anxiety disorders, and she is passionate about medical education.

Learning Objectives:
At the conclusion of this session, the learner will be able to:

1. Recognize symptoms consistent with a depressive disorder
2. Understand the role and utility of rating scales in the assessment of depression
3. Understand the initial treatment rationale when depression is identified

Competency Questions:

Question 1: Which of the following factors, if present, would be inconsistent with a diagnosis of major depressive disorder?

A) History of hypomania
B) No prior suicide attempt
C) Lack of response to a 12 week SSRI trial
D) Abnormal findings on a CBC, especially low H/H
E) Any lifetime history of recreational drug use

Question 2: A 37y.o. female come in 4 weeks after her initial appointment, where she was diagnosed with a depressive disorder and started on sertraline 25mg x 1 week, which was then increased to 50mg daily. She reports a partial response to the medication as evidenced by her PHQ-9 score decreasing from a 17 to 13. She denies suicidality or medication related side effects. What is the next best step in management?

A) Continue current dose of sertraline
B) Recommend an internet-based psychotherapy program
C) Increase sertraline to 100mg daily (max recommended dose is 200mg daily)
D) Start bupropion for augmentation of anti-depressant
E) Switch sertraline to fluoxetine for management of depression

Resources for further study:

1) Park LT, Zarate CA Jr. Depression in the Primary Care Setting. N Engl J Med. 2019 Feb 7;380(6):559-568. doi: 10.1056/NEJMcp1712493. PMID: 30726688; PMCID: PMC6727965.

2) American Psychiatric Association Practice Guideline for the Treatment of Patients With Major Depressive Disorder: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf

Substance Use Disorder Screening | Richard Amar, MD

Dr. Richard Amar is a board-certified General and Addiction psychiatrist. He obtained his medical degree from MCP-Hahnemann University School of Medicine in Philadelphia, Pennsylvania, and completed his General Psychiatry Residency and Addiction Psychiatry Fellowship at Emory University School of Medicine in Atlanta, Georgia. Prior to joining the Talbott medical staff in 2011, Dr. Amar worked with veterans for eight years at the Atlanta Veterans Affairs Medical Center, where he was the Medical Director of the Evening Intensive Outpatient (IOP) and the STaR (Substance Abuse, Trauma, and Recovery) Programs. Dr. Amar has a specific interest in developmental and psychological trauma, and is trained in Eye Movement Desensitization and Reprocessing (EMDR). He is a coauthor of several peer-reviewed addiction journal articles. Dr. Amar's approach to patient care is holistic, combining his expertise in pharmacology and psychotherapy with other modalities including nutrition, exercise, mindfulness and yoga.

Learning Objectives:

At the conclusion of this session, the learner will be able to:

1. Determine when substance use disorder (SUD) screening is indicated.
2. Utilize evidence-based screening tools with patients in the primary care or other settings.
3. Determine next best steps based on screening results.

Competency Questions:

Question 1: Which of the following is **TRUE** of screening for SUDs in the primary care setting?

A) Primary care providers should expect to see less SUDs, and possibly no SUDs, over the coming months.
B) SUDs are uncommon in the primary care setting.
C) Primary care providers play an important role in the evaluation and treatment of SUDs.
D) We are seeing increased SUDs due to increased hand- washing.

Question 2: Which of the following is **NOT** an evidenced-based screen for SUDs?

A) CAGE-AID
B) AUDIT
C) TWEAK
D) SOUS-VIDE
E) CRAFFT

Question 3: True or False: There are no evidence-based guidelines or standards for treating SUDs in the primary care setting.

Resources for Further Study

- https://crafft.org/about-the-crafft
- http://msc.sagepub.com/content/15/1/50.full
- https://www.asam.org/asam-criteria/about

- https://www.drugabuse.gov/sites/default/files/audit.pdf
- https://www.gov.uk/guidance/nhs-population-screening-explained
- https://pubs.niaaa.nih.gov/publications/assessingalcohol/instrumentpdfs/74_tweak.pdf

References and Acknowledgements

- https://www.samhsa.gov
- https://www.drugabuse.gov
- https://www.asam.org
- https://www.niaaa.nih.gov
- CDCHAN-00438; CDC Health Alert Network, December 17, 2020
- The Nielsen Company. Rebalancing the COVID-19 Effect on Alcohol Sales. May 7, 2020
- Pollard MS, Tucker JS, Green HD. Changes in Adult Alcohol Use and Consequences During the COVID-19 Pandemic in the US. JAMA Network Open 2020 3(9):e2022942
- Aldridge A, Linford R, Bray J. Substance use outcomes of patients served by a large US implementation or Screening, Brief Intervention and Referral to Treatment (SBIRT). Addiction. 2017 Feb 112 Suppl 2:43-53.
- Galanter M, Kleber H. Textbook of Substance Abuse Treatment, 4th ed. APPI, Washington 2008.
- Parran T (2006). Substance Abuse Screening, Assessment and Brief Intervention. Chicago, IL. ASAM Review Course in Addiction Medicine.
- Russell M. New Assessment Tools for Risk Drinking During Pregnancy: T-ACE, TWEAK and others. 1994 Alcohol Health and Research World.
- Sokol RJ. Delaney-Black V. Nordstrom B. Fetal alcohol spectrum disorder. JAMA. 2003;22:2296–2999.
- US Preventative Services Task Force. Screening and Behavioral Counseling Interventions to Reduce Unhealthy Alcohol Use in Adolescents and Adults. JAMA. 2018;320 (18) 1899-1909.
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Violence Prevention in Healthcare | Mike Hodges, MD

Mike has been a pioneer in proactive security solutions including leading the development of a collaborative workplace violence prevention program that has reduced incidents of workplace violence by over 50% at his facility. Prior to healthcare, Mike was a member of the U.S. Army where his service included response to Hurricane Katrina, and combat tours in both Iraq and Afghanistan. He is a recipient of the Vizient Brilliance Award for Innovation, the 2018 Montague Boyd Excellence in Publishing Award, the Bronze Star Medal, and the Humanitarian Service Medal among other awards. Mike has published articles in international journals and presented nationally related to healthcare violence prevention and healthcare security officer training. Mike currently edits and distributes the Proactive Security blog, and is a co-host of the Proactive Security Podcast.

Learning Objectives:

At the conclusion of this session, the learner will be able to:

1. Understand the scope of workplace violence within a healthcare environment.
2. Know the common pattern of escalating behavior.
3. Have an understanding of practical de-escalation responses and personal safety techniques.

Competency Questions:

Question 1: Which industry is the most violent industry in the United States according to Bureau of Labor Statistics data?

A) Healthcare and social assistance
B) Retail trade
C) Manufacturing
D) Construction

Question 2: True or False – When a person is becoming defiant and verbally aggressive it is important to utilize a team approach to help set limits and mitigate potential violence.

Question 3: True or False – Often your instincts can help you mitigate victimization, it is important to listen to your gut feelings about danger.

Resources for further study:

https://proactivesecurity.blog/

https://www.amazon.com/Proactive-Security-Podcast/dp/B08JJS16J6

https://www.amazon.com/Clinicians-Guide-Violence-Risk-Assessment/dp/1606239848/ref=sr_1_1?dchild=1&keywords=clinicians+guide+to+violence+risk&qid=1610047152&s=audible&sr=1-1

https://cdn.ymaws.com/www.iahss.org/resource/collection/48907176-3B11-4B24-A7C0-FF756143C7DE/IAHSS_Foundation_-_De-Escalation_Training.pdf

https://cdn.ymaws.com/www.iahss.org/resource/collection/48907176-3B11-4B24-A7C0-FF756143C7DE/IAHSS_Foundation_-_Threat_Assessment_Strategies_to_Mitigate_Violence_in_Healthcare.pdf

The Orthopedic Physical Exam | Tracy Ray, MD

Dr Tracy Ray is a native of Marietta and a graduate of Berry College who then went on to complete his medical school training at MCG in Augusta. After completion of his FM residency in Tuscaloosa, AL, he trained in Sports Medicine at the Cleveland Clinic in Cleveland, OH. He is happy to now have returned to his home state after working with Dr James Andrews in Birmingham and most recently, with the Duke University Blue Devils in Durham, NC. He is the current President of the largest, physician-member, sports society in the world- the American Medical Society for Sports Medicine.

Learning Objectives:

At the conclusion of this session, the learner will be able to:

1) Describe components of a thorough MSK exam of the shoulder.
2) Describe the components of a thorough MSK exam of the knee.
3) Use pertinent negatives and positives of the exam to create a differential diagnosis.

Competency questions:

Question 1: Common ligamentous tests for the knee include…

A) Lachman test
B) McMurray maneuver
C) Posterior drawer test
D) A and C
E) All of the above

Question 2: 28 yo male with no previous or acute history of trauma to his right shoulder presents with 2 week history of insidious onset of right shoulder pain. On exam he has full ROM with a painful arc, positive Hawkin's and Neer tests but a positive drop-arm sign. What is the most likely diagnosis?

A) Shoulder dislocation
B) Adhesive capsulitis
C) Rotator cuff tendonitis/subacromial bursitis
D) AC separation

Resources for Further Study

1. Macleod's Physical Examination Of The Musculoskeletal System OSCE Guide 2016
2. https://www.youtube.com/watch?v=8RzL0YhjfXc
3. Stanford video: https://stanfordmedicine25.stanford.edu/the25/shoulder.html
4. **Knee Pain in Adults and Adolescents: The Initial Evaluation in American Family Physician** https://www.aafp.org/afp/2018/1101/p576.html

Everything You Need to Know About Knee Pain | Kelly Ward, PA-C

Kelly Ward received his Physician Assistant degree from Emory University in Atlanta, Georgia. He has worked in the Athens area for over 20 years. Prior to attending Physician Assistant school, Kelly worked as an athletic trainer with the University of Georgia. He currently serves as a Team Clinician with the University of Georgia and assists Dr. Robert Hancock in all aspects of orthopedic sports medicine care. Kelly treats all sports related orthopedic conditions. He has a special interest in non-operative treatment and prevention of athletic injuries. He is proficient in the utilization of musculoskeletal ultrasound as a means of both diagnostic and treatment of athletic injuries. In his spare time, Kelly enjoys spending time with his family and friends. He is a sports enthusiast and enjoys the outdoors.

Learning Objectives:

At the conclusion of this session, the learner will be able to:

1. Discuss common causes of knee pain seen in the primary care setting
2. Review common clinical presentations, diagnostic tools, and treatment options
3. Discuss referral for orthopedic surgical management

Competency Questions

Question 1: All of the following recommendations listed in the clinical practice guideline for the treatment of osteoarthritis demonstrate Level I evidence except?

A) Patients with symptomatic OA of the knee who are overweight (BMI >25) should be encouraged to lose weight and maintain their weight at a lower level with an appropriate program of dietary modification and exercise
B) Patients with symptomatic OA of the knee be encouraged to participate in low-impact aerobic exercise
C) Patients should not receive a prescription for glucosamine and/or chondroitin sulfate or hydrochloride when presenting with symptomatic OA of knee
D) Patients with symptomatic OA of the knee should perform range of motion/flexibility exercises on a daily basis

Question 2: Which of the following intra-articular injection treatment option has demonstrated Level I evidence of decreasing pain in a symptomatic OA knee with a Kellgren-Lawrence Grade I-II weight bearing radiograph for up to one year

A) Hyaluronic Acid
B) Ketorolac
C) Leukocyte poor PRP
D) Corticosteroid

Exercise is Medicine for Back Pain | Joel Hardwick, ACSM

Joel Hardwick received his undergraduate degree in Exercise Science from Georgia State University in Atlanta, Georgia. He has worked as a Clinical Exercise Physiologist and Cancer Exercise Trainer for Piedmont Atlanta Hospital for more than 4 years. Joel has experience translating exercise as medicine for a wide range of patients presenting with cardiovascular, pulmonary, or metabolic diseases. He has a unique interest in exercise oncology and actively supports and manages pre-habilitation/rehabilitation efforts in the clinical practice, particularly with breast and pancreatic cancers. Joel is proficient in applying physiological concepts and their responses to exercise as a means for managing and treating chronic diseases over all age ranges. Joel stays active by playing pickleball and cycling on the Atlanta beltline.

Learning Objectives:

At the conclusion of this session, the learner will be able to:

1. Understand clinical exercise physiology and its role in Exercise as Medicine
2. Identify the utility of exercise as a tool to prevent and manage low back pain
3. Explore common myths associated with exercise and low back pain and develop safe and effective strategies to integrate into practice.

Competency Questions

Question 1: Patient A is a 45-year-old male with no known history of cardiac, pulmonary, or metabolic disease presents to clinic today for annual check up. He is sedentary and mentions he has a high-pressure desk job and has felt slight low back tightness but no pain. What recommendations would you give for this patient?

A) Stretch the hamstrings and low back.
B) Strengthen core.
C) Recommend a yoga or Pilates class.
D) Encourage proper sitting form, walking program, and core stability exercise.

Question 2: Patient X is a 57-year-old female with a history of hypertension, type II diabetes, obesity, and is sedentary. She presents in clinic today for a routine check up but mentions she has had low back pain on and off for 6-months. What recommendations would you give her?

A) Walk it off, you will be okay.
B) Refer to a specialist.
C) Tell her to lose weight to reduce back pain.
D) Give her an injection.

Resources:

1. Kim LH, Vail D, Azad TD, et al. Expenditures and Health Care Utilization Among Adults With Newly Diagnosed Low Back and Lower Extremity Pain. *JAMA Netw Open.* 2019;2(5):e193676.
2. Shiri R, Coggon D, Falah-Hassani K. Exercise for the Prevention of Low Back Pain: Systematic Review and Meta-Analysis of Controlled Trials. *Am J Epidemiol.* 2018;187(5):1093-1101.
3. de Campos TF, Maher CG, Fuller JT, Steffens D, Attwell S, Hancock MJ. Prevention strategies to reduce future impact of low back pain: a systematic review and meta-analysis. *Br J Sports Med.* 2020.
4. Hoy D, Brooks P, Blyth F, Buchbinder R. The Epidemiology of low back pain. *Best Pract Res Clin Rheumatol.* 2010;24(6):769-781.
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6. Ronai P. Exercise Recommendations for Cardiac Patients with Chronic Nonspecific Low Back Pain. *Journal of Clinical Exercise Physiology.* 2019;8(4):144-156.