Advancements in Basal Insulin:
Tailoring Treatment to Patient Needs

Friday, November 10, 2017 | 12:30-13:30
Session ID no. 186648-090

After attending this session, participants will be able to:
- Recognize the role of basal insulin therapy in the T2DM treatment continuum.
- Identify and overcome barriers to insulin initiation and optimization from the patient and physician perspective, including hypoglycemia.
- Differentiate basal insulin options, with a focus on the newer basal insulins.
- Individualize basal insulin treatment based on patient characteristics and insulin profiles.

Jean-François Yale, MD, CSPQ, FRCPC
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Dr. Yale is a Professor of Medicine in the Division of Endocrinology and Metabolism at the McGill University Health Centre. Dr. Yale chaired the clinical and scientific section of the Canadian Diabetes Association (CDA; now Diabetes Canada) from 1992 to 1994, chaired the expert panel that published the guidelines for hypoglycemia in 2001, and is a member of the committee. Dr. Yale has been the Director for the development of CDA clinical practice guidelines for the prevention and treatment of diabetes since 1995. His research interests (195 publications) include the prevention of hypoglycemia, intensive treatment of type 1 and 2 diabetes, and involvement in many multicentre studies including ACCORD, ORIGIN, TECOS, and SAVOR-TIMI.

This program has been certified by the College of Family Physicians of Canada and the Quebec office for up to 1.00 Group Learning credits.

This program was supported in part by educational funding from Novo Nordisk Canada Inc.
Advancements in Basal Insulin: Tailoring Treatment to Patient Needs

Faculty/presenter disclosure

- Presenter: Jean-François Yale, MD, CSPQ, FRCPC

- Relationships with commercial interests:
  - Speakers Bureau/Honoraria: Abbott, AstraZeneca, Bayer, Boehringer-Ingelheim, Eli Lilly, Janssen, Merck, Novo Nordisk, Sanofi, Takeda
  - Consulting Fees: Abbott, AstraZeneca, Bayer, Boehringer-Ingelheim, Eli Lilly, Janssen, Merck, Novo Nordisk, Sanofi, Takeda
  - Other – participated in clinical trial: Bayer, Boehringer-Ingelheim, Eli Lilly, Mylan, Sanofi

Disclosure of commercial support

- This program has received financial support from Novo Nordisk Canada Inc. in the form of educational funding
- This program has received in-kind support from Novo Nordisk Canada Inc. in the form of logistical support
- Potential for conflict(s) of interest:
  - Dr. Yale has received payment/funding, etc. from the companies listed in the disclosures whose products are discussed in the program, including:
    - Eli Lilly Canada Inc.: Insulin glargine U100 (Basaglar™), Insulin NPH (Humulin®)
    - Sanofi-aventis Canada Inc.: Insulin glargine U100 (Lantus®), Insulin glargine U300 (Toujeo™)
  - Novo Nordisk Canada Inc. distributes three products that will be discussed in this program:
    - Insulin NPH (Novolin® ge)
    - Insulin detemir (Lemleco™)
    - Insulin degludec (Tresiba™)
  - Dr. Yale will receive an honorarium from the CPCC/FMF committee for this session
Mitigating potential bias

Bias in this program has been mitigated using independent content validation as follows:

- All content has been reviewed by a physician steering committee, pharmacist expert reviewers, the College of Family Physicians of Canada, the FMOQ (Fédération des médecins omnipraticiens du Québec), the Canadian Council on Continuing Education in Pharmacy (CCCEP) and the Ordre du Pharmaciens Québec (OPQ)
- All data have been sourced from clinically accepted evidence
- All support used in justification of patient care recommendations conforms to generally accepted standards, the Canadian Diabetes Association 2013 Clinical Practice Guidelines and 2016 interim update, as well as the most recently available clinical data

Planning committee

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  - Clinical Pharmacist, Lethbridge, Alberta

Program objectives

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Module 1: Type 2 Diabetes and Insulin Therapy

Insulin therapy options in T2DM

Basal
- Insulin degludec U100/U200
- Insulin detemir
- Insulin glargine U100
- Insulin glargine U300
- NPH insulin

Bolus
- Faster-acting insulin aspart
- Insulin aspart
- Insulin glulisine
- Insulin lispro U100/U200

Premixed
- Biphasic insulin aspart
- Insulin lispro/lispro protamine suspension
- Premixed regular-NPH


The need for basal insulin in T2DM:
Type 2 diabetes is progressive and is characterized by a decline in β-cell function and insulin resistance

- 50% of β-cell function is already lost at diagnosis
- β-cell function will continue to decline despite treatment

Treatment will need to be adjusted and intensified over time, and insulin may be required.
Short- and long-term benefits of basal insulin therapy in T2DM

Most potent antihyperglycemic effect with no dose ceiling

Early glucose control reduces the risk of macro- and microvascular complications

A1C: 1% reduction in A1C
14% reduction in fatal/non-fatal MI
14% reduction in all-cause mortality
37% reduction in microvascular endpoints

Relative risk reduction sustained long term

Factors to consider when individualizing insulin treatment in T2DM

Effective A1C control with no dose ceiling
Minimizing risk of hypoglycemia
Effective FPG lowering
Minimizing weight gain
Cardiovascular safety

The 2016 CDA Clinical Practice Guidelines Interim Update continues to recommend insulin as an option for second-line treatment in T2DM

Basal insulin use has increased, but targets are still not being met

DM-SCAN survey in T2DM (2012)

Increased use of basal insulin relative to previous surveys
Only 50% of patients achieving A1C ≤7%
Why is glycemic control not being achieved with insulin?

**Perception of insulin**

- **True or False?**
  - Insulin $\rightarrow$ diabetes complications
  - Insulin = death or "end-of-line"
  - Insulin = patient "failure"
  - Insulin $\neq$ positive impact on treatment and health

**Hypoglycemia**

- Hypoglycemia is the most common adverse event in insulin therapy, regardless of A1C level

- HAT study & IN-HYPO survey in T2DM

- Overall hypoglycemia: 51.4% experienced in last 30 days (non-severe daytime hypoglycemia: 37.3 events per patient-year)
- Nocturnal hypoglycemia: 29.7% experienced in last 30 days (events per patient-year: 12.7)
- Severe hypoglycemia: 37.9% experienced in last year (events per patient-year: 1.8)

- 85% of Canadian patients do not speak to their physicians about hypoglycemia
The burden of hypoglycemia

Physiological
- Continued poor glycemic control
- Increased risk of long-term health consequences, e.g., mortality
- Weight gain

Psychological
- Increased fear leading to:
  - Mood changes
  - Changes in behaviour
  - Reduced or skipped doses

Financial
- Increased PG monitoring
- Work absenteeism/presenteeism
- Increased visits to clinic

- Increased risk of long-term health consequences, e.g., mortality
- Weight gain


Module 2: Basal Insulin Options

Properties of an ideal basal analogue

- Longer duration of action
  - Control fasting blood glucose with one injection per day in all individuals
- Flat time-action profile (no peak)
  - Lower risk of hypoglycemia
- Predictability (less day-to-day and within-day variability)
  - Potential for titration to lower FPG target without hypoglycemia

What does "variability" mean?

What are our basal insulin options in 2017?

- Novolin® ge NPH
- Humulin® N
- Insulin detemir (IDet)
- Insulin glargine (IGlar) U100
- Lantus® Basaglar™ U300
- Toujeo™
- Levemir®
- Tresiba® U100/U200

Basal insulin through time

- Animal insulin preparations
- NPH insulin
- Basal insulin analogues
  - Insulin detemir
  - Insulin glargine
  - Insulin degludec

FPG
A1C
NPH = IDet = IGlar
NPH > IDet & IGlar
NPH < IDet & IGlar
IGlar

Mode of protraction: How do the options compare?

- Crystals
  - NPH and insulin glargine form precipitates at injection site that delays dissolution and absorption
  - Electronic microscopic visualization of insulin glargine
    - NPH = 5-10
    - IGlar U100 = 12
    - IGlar U300 has:
      - 3X concentration
      - 1/3 injection volume
      - 1/3 depot surface area

- Duration of action (hours)
  - NPH = Max 24
  - IGlar = Max 24
  - U300 has:
    - Up to 36
Multihexamers

Insulin degludec forms stable, multihexamer chains, which slowly and consistently dissociate. Beyond 42 λ Duration of action (hours)

Mode of protraction:
How do the options compare?

- Hexamer
  - Half life (hours): 5–7 (dose dependent)
- Multihexamers
  - 25
  - Up to 24

Hexamer aggregates

Insulin detemir forms hexamer aggregates, which slowly dissociate, enter the bloodstream and bind albumin, which further slows absorption.

IGlar U300 vs. IGlar U100:
Comparable A1C lowering & higher insulin dose

- non-inferiority achieved
- FPG mean decrease (-3.41 mmol/L vs. -3.80 mmol/L)
- larger end-of-trial dose (15% greater dose with U300)
- mean weight change (non-significant: 0.49 kg gained vs. 0.71 kg)
- 1° hypoglycemia endpoint
  - % reporting hyp (wk 9 → 6 months)
  - non-significant for confirmed or severe hypoglycemia (overall & nocturnal)

IDeg vs. IGlar U100:
Comparable A1C lowering & significantly greater FPG reduction

- non-inferiority achieved
- larger mean change (significant: -3.8 mmol/L vs. -3.3 mmol/L)
- similar end-of-trial dose (0.59 U/kg vs. 0.60 U/kg)
- mean weight change (non-significant: 2.4 kg gained vs. 2.5 kg)
- 1° hypoglycemia endpoint
  - Annual hypo rate
  - Significant reduction for nocturnal and severe; non-significant for overall

Results were maintained at 2 years
Is the hypoglycemia risk reduction "real"?

Challenges

- Open-label design
- Excluded patients at risk of hypoglycemia

More rigorous design

- Double-blind & crossover
- Enrolled patients with a high risk of hypoglycemia

For example:
- Experienced a severe hypo within the last year
- eGFR 30–59 mL/min/1.73m²
- Had hypoglycemia unawareness

IDeg vs. IGlar U100:

Comparative A1C lowering & lower hypoglycemia rate, for patients at high risk of hypoglycemia

- Non-inferiority achieved
- FPG mean change
  - Mean FPG decreased to 6.0 mmol/L
  - End of trial dose
  - Similar end-of-trial dose
  - Mean weight change
    - Non-significant: at crossover and at end of trial

1st hypoglycemia endpoint
- Annual hypo rate
  - Significant reduction for overall, nocturnal and severe

Cardiovascular safety of basal insulin established in two long-term, cardiovascular outcome trials

**ORIGIN – Glargine U100**

- Study Design
- Open-label design
- Glargine vs. standard of care
  - >12,000 patients at high risk of CV events:
    - With IFG, IGT or newly detected T2DM, or established T2DM
    - Insulin-naïve
    - Mean A1C: 6.5%
    - Mean diabetes duration: 5.4 yrs

**DEVOTE – Degludec**

- Study Design
- Double-blind design
- Degludec vs. glargine U100
  - Each in combination with standard of care
  - >7,000 patients at high risk of CV events:
    - With T2DM
    - Insulin-naïve or experienced
    - Mean A1C: 6.4%
    - Mean diabetes duration: 16 yrs
Cardiovascular safety of basal insulin established in two long-term, cardiovascular outcome trials

**ORIGIN – Glargine U100 Results**
- Non-inferiority: HR: 1.00 vs. SOC
- Hypoglycemia: Severe and non-severe: significantly increased

**DEVOTE – Degludec Results**
- Non-inferiority: HR: 0.91 vs. IGlar U100
- Hypoglycemia: Severe: significantly decreased

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Basal insulin product options and features

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Total units per pen (units)</th>
<th>Maximum dose for injection (units)</th>
<th>In use time (days)</th>
<th>Pen type</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPH Novolin® ge NPH</td>
<td>300</td>
<td>60</td>
<td>28</td>
<td>Cartridge</td>
</tr>
<tr>
<td>NPH Humulin® N</td>
<td>300</td>
<td>60</td>
<td>28</td>
<td>KwikPen®*</td>
</tr>
<tr>
<td>Insulin detemir</td>
<td>300</td>
<td>80</td>
<td>42</td>
<td>FlexTouch®*</td>
</tr>
<tr>
<td>Insulin glargine</td>
<td>300</td>
<td>80</td>
<td>28</td>
<td>SoloSTAR®*</td>
</tr>
<tr>
<td>Insulin degludec</td>
<td>300</td>
<td>80</td>
<td>56</td>
<td>FlexTouch®</td>
</tr>
<tr>
<td>Insulin degludec</td>
<td>600</td>
<td>160</td>
<td>56</td>
<td>SoloSTAR®</td>
</tr>
</tbody>
</table>

*Also available in cartridges for use in durable/refillable pens; max dose in durable pens may differ from max dose in prefilled pens above

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Module 3: Case studies
Tips to streamline basal insulin starts and follow-ups

1) Block time to discuss and start insulin and to follow-up with Allied HCPs

2) Start Basal Insulin Checklist

3) Basal Insulin Follow-up Checklist

Case #1: Vishal

HEALTH STATUS
- Diagnosed with T2DM diabetes 8 years ago
- Has never been prescribed insulin
- A1C: 8.8%
- BMI: 33.0 kg/m²
- FPG: 13.2 mmol/L
- BP: 131/83 mmHg
- eGFR: 65 mL/min/1.73m²
- Medications: Metformin, DPP-4 inhibitor, SGLT2 inhibitor and rosuvastatin

OTHER INFORMATION
- Missed a follow-up appointment due to temporary relocation for job
- "I saw my father have a severe hypoglycemic event when he took insulin. I'm afraid that will happen to me."

Is Vishal a good candidate to initiate basal insulin?

A. Yes
B. No, he should stay on his current regimen
C. No, he should add another/switch to another NIAHA
D. Other

Discuss with those around you or write in your notebook.
1. **Explain** why insulin is needed

Over time, the pancreas produces less insulin, causing elevated blood sugar and possibly complications.

**How would you address Vishal's concerns?**

“I saw my father have a severe low when he took insulin. I'm afraid that will happen to me.”

**Discuss** with those around you or write in your notebook:

Fear, misconceptions, resistance

2. **Explain** how to start and adjust

**Teach how to titrate basal insulin**

**Long-acting** (Glargine, insulin detemir, insulin glulisine)

- **START with 10 units once daily**
- **ADJUST dose once a day based on 1 HbA1c value from that morning**
- **Increase by 1 unit if above individualized target**
- **DOSING once daily at the same time each day**

**Ultra-long-acting** (Tresiba®)

- **START with 10 units once daily**
- **ADJUST dose once a week based on 1 FPG value from that morning**
- **Increase by 4 units if above individualized target**
- **DOSING once daily at the same time each day**

**REMEMBER:** Insulin has no dose ceiling!
Example basal insulin prescriptions

<table>
<thead>
<tr>
<th>Drug</th>
<th>Preparation</th>
<th>Dosage</th>
<th>Titration</th>
<th>Target FPG</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tresiba® SoloSTAR®</td>
<td>200 U/mL</td>
<td>+needles</td>
<td>Start at 10 units once daily</td>
<td>Titrate once a day until FPG target (5.5 mmol/L*) reached. If above FPG target, + 4 units. If below FPG target, - 4 units.</td>
<td>FPG target (5.5 mmol/L*) can be modified based on patient characteristics, i.e., elderly patients.</td>
</tr>
<tr>
<td>Lantus® SoloSTAR®</td>
<td>100 U/mL</td>
<td>+needles</td>
<td>Start at 10 units once daily</td>
<td>Titrate once a day until FPG target (5.5 mmol/L*) reached. If above FPG target, + 1 units. If below FPG target, - 1 units.</td>
<td>FPG target (5.5 mmol/L*) can be modified based on patient characteristics, i.e., elderly patients.</td>
</tr>
</tbody>
</table>

3. Demonstrate the pen

- Show a sample injection
- Give the first injection in office
- Arrange step-by-step, hands-on training with allied health team

4. Educate the patient on low blood sugar

**Recognize symptoms**

- **Autonomic**
  - Sweating
  - Nausea
  - Pallor
  - Palpitations
- **Neuroglycopenic**
  - Dizziness
  - Cold sweat
  - Speech difficulty
  - Impaired thinking
- **Neuralgic**
  - Headache
  - Nausea

**Treatment**

- Test blood glucose
- Eat 15 g of fast-acting carbohydrate
- Wait 15 minutes
- Test again and repeat if necessary
- Wait 45-60 min before driving
- If next meal > 1 hr away, eat another 15 g carbohydrate and 1 ounce of protein

Encourage your patients to track their lows and to discuss them with you.
Start Basal Insulin Checklist – Vishal

4. **Educate** the patient on low blood sugar

*Driving recommendations for patients treated with insulin (non-commercial drivers)*

1. Measure SMBG immediately before and **at least every 4 hours**
2. Have SMBG equipment and **fast-acting carbohydrate** within easy reach
3. **Stop driving, test and treat** as soon as hypoglycemia and/or impaired driving are suspected
4. **Do not drive when BG level is <4.0 mmol/L**
   - If BG is <4.0 mmol/L, persons should not drive until at least 45 minutes after ingestion of carbohydrate and BG is at least 5.0 mmol/L

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**What are you going to follow-up on with Vishal?**

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**Start Basal Insulin Checklist – Vishal**

5. **Book** a follow-up appointment

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**Case #1: Vishal’s 1 month follow-up**

**HEALTH STATUS**
- Has been taking basal insulin for 1 month
- Current dose: 28 units
- Says he is hesitant to continue increasing dose
- FPG: 8.9 mmol/L (↓4.3 mmol/L)

**OTHER INFORMATION**
- “I have been feeling ‘off’.”
- “My dose is almost 3 times what it was when I started.”
- “One time I fell asleep before taking my dose. I called the pharmacy in the morning when I remembered, but I wasn’t really sure how much to take.”

Vishal, 57
Construction worker
Private Coverage
Basal Insulin Follow-up Checklist

1. How is the patient progressing toward target FPG?

2. Ask about hypoglycemia at every visit

3. Assess injection technique and site rotation

4. Determine next steps

Basal Insulin Follow-up Checklist – Vishal

1. How is the patient progressing toward target?

Review progress toward FPG target

What is the current basal insulin dose?

- Insulin has no maximum dose!
- If a dose is missed:
  - NPH/IGlar/IDet
  - Check BG frequently; do not double dose
  - IDeg
  - Based on clinical trials, changing the dosing time does not compromise efficacy or safety. Inject when remembered, endure minimum 8 hours between doses

Address patient concerns

- My dose is almost 3 times what it was when I started.
- "One time I fell asleep before taking my dose."
- 8.9 mmol/L (↓ 4.3 mmol/L last month)
- 28 units (started at 10 U)

Basal Insulin Follow-up Checklist – Vishal

2. Ask about hypoglycemia at every visit

Symptoms

- How often did they experience symptoms?

BG <4 mmol/L

- How many times was BG <4 mmol/L?

Factors

- Time of day, type of meal, activity & exercise?

Review

- Review prevention & management
Basal Insulin Follow-up Checklist – Vishal

3. Assess injection technique and site rotation

- How many times did the patient use each needle?
- Ask the patient to show you where they inject

How to Assess Injection Technique

[Image showing injection sites]


Basal Insulin Follow-up Checklist – Vishal

4. Determine next steps

What are your next steps with Vishal?

- A) No change
- B) Continue titrating basal dose to target
- C) Discontinue basal insulin and add a NIAHA
- D) Switch to a different basal insulin
- E) A combination of the above

Discuss with those around you or write in your notebook

Case #2: Deborah

HEALTH STATUS
- Diagnosed with T2DM diabetes 12 years ago
- On 43 units of NPH insulin for 4 years
- A1C: 7.9%
- BMI: 30.4 kg/m²
- FPG: 8.8 mmol/L
- Shared that some days it’s 5 mmol/L and other days it’s 15 mmol/L.
- BP: 135/91 mmHg
- eGFR: 75 mL/min/1.73m²
- Medications: NPH, metformin, DPP-4 inhibitor, gliclazide, fluvastatin and valsartan

OTHER INFORMATION
- "I haven’t been sleeping well. I wake up sweaty and have frequent headaches in the morning."
- "I haven’t told my daughter; she will worry because I had a severe hypoglycemic event last winter."
- "I do not want to increase my insulin dose further."

Deborah, 69
Retired Post Office Employee
Private Coverage
Basal Insulin Follow-up Checklist – Deborah

1. How is patient progressing toward target?

- Review progress toward FPG target: 8.8 mmol/L (range 4–15 mmol/L) (A1C 7.9%)
- What is the current basal insulin dose? 43 units of NPH insulin for 4 years (also on gliclazide)
- Deborah’s dose is causing variable control and hypoglycemia. Her FPG is not getting to target.

Address patient concerns

Basal Insulin Follow-up Checklist – Deborah

2. Ask about hypoglycemia at every visit

- Symptoms: BG < 4 mmol/L
- Factors: Both hypoglycemia and hyperglycemia, Nocturnal hypoglycemia, Fear of severe low, Type of meal, activity & exercise?
- Review: Review options to reach target and reduce hypoglycemia

Basal Insulin Follow-up Checklist – Deborah

3. Assess injection technique and site rotation

- How many times did the patient use each needle?
- Ask the patient to show you where they inject

**Rasal Insulin Follow-up Checklist – Deborah**

4. Determine next steps

**What are your next steps with Deborah?**

- Discuss with those around you or write in your notebook

A) No change
B) Advise Deborah to increase snacking
C) Reduce NPH dose
D) Split NPH into 21 units qam + 22 units qpm
E) Switch to a basal insulin analogue
F) Stop gliclazide

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**Rasal Insulin Follow-up Checklist – Deborah**

4. Determine next steps

<table>
<thead>
<tr>
<th>Action to reduce low BG</th>
<th>Reach target?</th>
<th>Other Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Snack</td>
<td>No</td>
<td>↑ weight</td>
</tr>
<tr>
<td>Reduce NPH</td>
<td>No</td>
<td>variability</td>
</tr>
<tr>
<td>Split NPH to BID</td>
<td>No</td>
<td>more frequent injections, ↑ daytime hypo risk</td>
</tr>
<tr>
<td>Switch to insulin analogue</td>
<td>Yes</td>
<td>↓ hypoglycemia, cost/coverage</td>
</tr>
<tr>
<td>Stop gliclazide</td>
<td>No</td>
<td>↑ NPH dose; hypoglycemia may continue</td>
</tr>
</tbody>
</table>

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**Review: How to switch basal insulins in T2DM**

- From once-daily basal: 1:1
- From BID basal: ↓20%
- From IGLAR U300: ↓20%

Followed by daily or weekly titration (depending on insulin)

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Summary

### All insulins have high efficacy
- Start low, go slow
- Keep increasing the dose until FPG target is reached safely
- No maximum dose

### Get to target with as few hypoglycemic episodes as possible
- Basal insulin analogues are recommended over NPH due to lower nocturnal hypoglycemia
- IDeg demonstrated lower overall, severe and nocturnal hypoglycemia vs. IGlar U100

### Minimize weight gain
- Insulin analogues may have less weight gain than NPH

### Proven cardiovascular safety
- OBJGON (JSil U100) demonstrated CV safety vs. standard of care
- DEVOTE (IDeg) demonstrated CV safety vs. IGlar U100
Advancements in Basal Insulin:
Tailoring Treatment to Patient Needs

Ancillary Session at the Family Medicine Forum | CERT+ Session ID# 186648-090

Evaluation Form

Date: Friday, November 10, 2017 at 12:30 p.m.  Location: Palais des congrès, Montreal

Please rate the question in this evaluation according to the following scale:

<table>
<thead>
<tr>
<th>1-Strongly disagree</th>
<th>2-Disagree</th>
<th>3-Neutral</th>
<th>4-Agree</th>
<th>5-Strongly agree</th>
</tr>
</thead>
</table>

**The Program**
The program content enhanced my knowledge.
The program was relevant to my practice.
The program met the stated learning objectives.
The program addressed a gap in my knowledge.
The program was well organized.
Adequate time was allotted for interaction and discussion.

**The Presenter**
The presenter delivered the content clearly.
Questions and discussions were well moderated.
Time was efficiently managed.

Please indicate which CanMEDS-FM roles you felt were addressed during this educational activity. (select all that apply)

- [ ] Family Medicine Expert
- [ ] Collaborator
- [ ] Scholar
- [ ] Professional
- [ ] Manager

Did the activity respect the « Ethical code of CME Providers¹ »?

Yes  No

If not, please explain (Ref.: 1. http://www.cemcq.qc.ca)

Did you perceive any degree of bias in any part of the program?

Yes  No

If yes, please explain:

Please describe what you felt was the most effective part of the program.

Please identify an important concept/idea that you learned.

How will you change your practice based on what you learned today?

1. 
2. 

Do you have any other learning needs related to this topic?

Other comments or suggestions about any aspect of the program: