



Highlighted areas signify
where text changes will occur

Continuing Education Activity Evaluation



VA
HEALTH
CARE
Defining
EXCELLENCE
in the 21st Century

Advances in Management of Chronic Sinusitis: Balloon Sinuplasty

Name

June 6, 2012

YOUR NAME: _____ E-MAIL: _____

1. Please identify your profession:

☐ Physician/MD or DO ☐ Pharmacist ☐ Nurse Practitioner ☐ Physician Assistant ☐ Other: _____

2. Please rate the projected impact of the following objectives:

<i>This learning objective did (or will) increase/improve my:</i>		1= Not Applicable	2= No Impact	3= Moderate Impact	4= High Impact
Define the classic management of Chronic Sinusitis	Knowledge	(1)	(2)	(3)	(4)
	Competence	(1)	(2)	(3)	(4)
	Performance	(1)	(2)	(3)	(4)
	Patient Outcomes	(1)	(2)	(3)	(4)
Describe the new concept/tool of Balloon Sinuplasty	Knowledge	(1)	(2)	(3)	(4)
	Competence	(1)	(2)	(3)	(4)
	Performance	(1)	(2)	(3)	(4)
	Patient Outcomes	(1)	(2)	(3)	(4)
Identify the Balloon Sinuplasty technologies/techniques available	Knowledge	(1)	(2)	(3)	(4)
	Competence	(1)	(2)	(3)	(4)
	Performance	(1)	(2)	(3)	(4)
	Patient Outcomes	(1)	(2)	(3)	(4)

3. Please rate the speaker on the following: (1 = Poor, 3 = Average, 5 = Outstanding)

Degree of Balance,

Presentation Skills

Knowledge of Content

objectivity, & Scientific Rigor

Name, MD

(1) (2) (3) (4) (5)

(1) (2) (3) (4) (5)

(1) (2) (3) (4) (5)

4. Do you feel the activity was scientifically sound and free of commercial bias* or influence? ☐ Yes ☐ No, please explain: _____

*Commercial bias is defined as a personal judgment in favor of a specific product or service of a commercial interest.

5. Please indicate which of the following American Board of Medical Specialties/Institute of Medicine core competencies were addressed by this educational activity (select all that apply):

- | | | |
|--|---|--|
| <input type="radio"/> Patient care or patient-centered care | <input type="radio"/> System-based practice | <input type="radio"/> Medical knowledge |
| <input type="radio"/> Interpersonal and communication skills | <input type="radio"/> Interdisciplinary teams | <input type="radio"/> Employ evidence-based practice |
| <input type="radio"/> Practice-based learning & improvement | <input type="radio"/> Quality improvement | <input type="radio"/> None of the above |
| <input type="radio"/> Professionalism | <input type="radio"/> Utilize informatics | |

6. The content of this activity matched my current (or potential) scope of practice. ☐ Yes ☐ No, please explain: _____

[over]

7. How will you change your practice as a result of attending this activity (select all that apply)?
- ☐ Create/revise protocols, policies, and/or procedures
 - ☐ Change the management and/or treatment of my patients
 - ☐ This activity validated my current practice
 - ☐ I will not make any changes to my practice
 - ☐ Other, please specify: _____
8. Please indicate any barriers you perceive in implementing these changes.
- ☐ Cost
 - ☐ Lack of experience
 - ☐ Lack of opportunity (patients)
 - ☐ Lack of resources (equipment)
 - ☐ Lack of administrative support
 - ☐ Lack of time to assess/counsel patients
 - ☐ Reimbursement/insurance issues
 - ☐ Patient compliance issues
 - ☐ Lack of consensus or professional guidelines
 - ☐ No barriers
 - ☐ Other, please specify: _____
9. How will you address these barriers in order to implement changes in your knowledge, competency, performance, and/or patients' outcomes? _____
10. How might the format of this activity be improved in order to be most appropriate for the content presented (select all that apply)?
- ☐ Format was appropriate; no changes needed
 - ☐ Include more case-based presentations
 - ☐ Increase interactivity with attendees
 - ☐ Other, describe: _____
11. How satisfied were you with the following: **1= Not at All 2 = Slightly 3= Moderately 4= Mostly 5= Completely**
- | | | | | | |
|---|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| 1. Overall satisfaction with the program | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 |
| 2. Quality of instruction (consider the length of time, amount of materials, organization, and group participation) | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 |
| 3. Covered latest medical knowledge in this area | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 |
| 4. Program objective and balanced in discussion of available products and/or treatments | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 |
| 5. Program met standard objectives | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 |
- Additional comments: _____
12. What could improve this activity? _____
13. Based on your educational needs, please list any topics you would like to see addressed in future educational activities. _____
14. Other Comments: _____

PLEASE NOTE: You must complete all information on this evaluation and return within one week in order to receive your CME certificate of attendance and approved hour of category I CME credit.

Please return completed evaluations to Education Service. Use routing symbol [ES] or fax to 602-200-6005. Thank you.