# Community Medical Center
## CME Post-Activity Evaluation

CME Activity/Lecture Title: **Substance Use Disorder and Acute Pain Management Strategies**
Activity Date: **June 15, 2023**
Speaker(s) and Affiliation: **Andrew Vassallo, PharmD, BCPS, BCCCP**

**OBJECTIVES:** At the conclusion of this activity, the attendee should be able to:

- Discuss utilization of a multi – modal approach to pain control and judicious use of opioids
- Recognize and treat patients with opioid dependence, withdrawal, and substance use disorder
- Utilize the services of RWJBarnabas Health Peer Recovery Services

1. Do you **intend** to make changes or apply learnings to your practice as a result of this educational activity?

| **Yes**, I **plan** to make changes ❒ | **Yes**, I'm **considering** changes ❒ | **No**, I *already* practice these recommendations ❒ | **No**, I don't think this applies to my practice ❒ |
|---|---|---|---|

If **Yes**, describe two things you intend to try or do differently as a result of this educational activity **(REQUIRED)**:

If **No**, describe your perceived barriers to change **(REQUIRED)**:

2. Do you feel this educational activity will improve your ❒ ***clinical performance*** ❒ ***competence*** and/or ❒ ***patient outcomes***?

3. Identify the major strengths of this educational activity: *(check all that apply)*

❒ Speaker(s) ❒ Networking
❒ Discussion ❒ AV/Support materials ❒ Facilities
❒ Clinical Case Presentations ❒ Demos/Hands-on ❒ Other: _____ *(Describe)*
❒ Knowledge gained ❒ Case Vignettes

4. Was this educational activity appropriate for your level of training? ❒ Yes ❒ No: _____ *(Describe)*

5. Was the educational format of this activity appropriate for the setting, objectives and desired results of the activity? ❒ Yes ❒ No: _____ *(Describe)*

6. Were the educational activity's objectives met? ❒ Yes ❒ No: _____ *(Describe)*

7. Did the speaker(s) provide objectives at the beginning of the program and demonstrate a thorough knowledge of the subject? ❒ Yes ❒ No: _____ *(Describe)*

8. Was this educational activity free of commercial bias? ❒ Yes ❒ No: _____ *(Describe)*

9. What **additional** education and training would be helpful to your practice? Suggestions for future programs:

_____

10. Additional Comments: _____

*I certify I have attended 1 hour of this Continuing Medical Education Activity:*

_____ _____
***SIGNATURE*** ***PRINT NAME***

**EMAIL:** _____
**Please include your email for full credit.**
**Return via fax: (732) 557-8935 or email: Jennifer.Kuzma@rwjbh.org**