Community Medical Center
CME Post-Activity Evaluation

CME Activity/Lecture Title: **Burdensome Transitions of Care for Patients with Advanced Illness**
Speaker(s) and Affiliation: **Marianne Holler, D.O., FACOI, FAAHPM**

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

- **Recognize the issues surrounding medically fragile patient**
- **Help patients make decisions based on goals**

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 2 hours of this Continuing Medical Education Activity:

_____ _____
SIGNATURE ***PRINT NAME***

EMAIL: _____
Please include your email or fax number for full credit. Certificate will be emailed or faxed to you.
Return via fax: (732) 557-8935 or email: cms@rwjbh.org