

**Westchester Academy of Medicine**

Office of Continuing Medical Education

45 Beekman Ave, Unit 727 Telephone: 914-967-9100

# Sleepy Hollow, NY 10591

**CME POST-ACTIVITY SUMMARY/ANALYSIS**

Please complete the Attendance information and the CME Post-Activity Summary/Analysis for your recent CME activity.

|  |  |
| --- | --- |
| **Organization:** |  |
| **Title of Activity:** |  |
| **Date of Activity:** |  |
| **Course Directors:** |  |
| **Speaker(s) Name:** |  |
| **Contact Name/Phone** |  |
| **CME Credits:** |  |
|  |  |

**I. FINAL ATTENDANCE SUMMARY**

**(Please Attach Attendance List)**

**TOTAL # of attendees:**

**TOTAL # of M.D.’s: (MD/DO)**

**TOTAL # of non-M.D.’s: (NP/RN/PA/Other)**

**II. FINAL EVALUATION SUMMARY**

**Total Number Of Evaluations Returned For This Report:**

Total Number of Evaluations Completed by Physicians:

Total Number of Evaluations Completed by Non-Physicians:

**Were verbal or written disclosures made? Yes \_\_\_\_\_ No \_\_\_\_\_\_**

**1.** The intended result of this activity was to change:

□ Knowledge/Competence □ Performance □ Patient Outcomes

**2.** Was the result achieved? Yes □ No □

**3**. Based on the evaluation data received, provide an analysis of the change to learner’s knowledge/competence (Post-Activity) and/or performance/patient outcomes (Long-Term Post Activity) as identified in your objectives.

**Please respond in terms of:**

* **What areas of enhanced medical knowledge was gained?**
* **What diagnostic or treatment strategies, patient care and/or management strategies are likely to be implemented?**
* **Did the activity meet (or not meet) the knowledge gap(s)?**
* **Did the learners move from Current Practice to Best Practice?**
* **Do the learners now understand what they did not understand before?**
* **Did you meet the mission of the program?**

(**Use the space below, add attachments if necessary). This section should be a narrative, is required, and must be completed. (ACCME Criteria 11).**

**5. Overall was the presentation(s) free of Yes No No Response**

**commercial bias\* or influence?**

**If no, please describe:**

**6. Did participants identify any barriers to the implementation of the strategies or skills taught?**

**#Respondents # Respondents**

     No barriers      Lack of Time to assess/counsel patients

     Cost      Reimbursement/insurance issues

     Lack of experience      Patient compliance issues

     Lack of opportunity (patients)      Lack of consensus or professional guidelines

     Lack of resources (equipment)      Other *(please specify):*      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

     Lack of administrative support

**7. How will barriers be addressed?**

**8. Based on educational needs or perceived gaps, list topics for future programs:**

**COURSE DIRECTOR’S OVERALL ASSESSMENT**

**As Course Director, please comment on this course’s success in meeting its stated goals/learning objectives based upon data collected:**

1. Addressing knowledge gaps. **SCALE: 1 = Not at all; 5 = Very Successful; N/A**

(*Please circle a number below)*

**1 2 3 4 5 N/A**

1. Addressing gaps in competence. **SCALE: 1 = Not at all; 5 = Very Successful; N/A**

(*Please circle a number below)*

**1 2 3 4 5 N/A**

1. Addressing performance gaps. **SCALE: 1 = Not at all; 5 = Very Successful; N/A**

(*Please circle a number below)*

**1 2 3 4 5 N/A**

**9. Why did you rate the success of the program in meeting its stated goals/learning objectives as you did?**

*(Please comment in text box below)*

**10. Is there anything you would do differently for future iterations of this activity?**

**(Please comment in text box below)**