

Community Medical Center
CME Post-Activity Evaluation

CME Activity/Lecture Title: **Palliative Care and Hospice; The True Meaning of Patient Centered Care**
 Date: **May 23, 2024**
 Speaker(s) and Affiliation: **Shira Goldberg, MD**

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

- Develop a structured approach for evaluation of capacity and decision-making surrogates.
- Incorporate elements of interdisciplinary care into a goal oriented clinical plan.
- Identify dynamic changes in our health care system that serve as barriers to goals of care planning.
- Explore the principles of patient centered care using various media resources.

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

<u>Yes, I plan</u> to make changes <input type="checkbox"/>	<u>Yes,</u> I'm <u>considering</u> changes <input type="checkbox"/>	<u>No,</u> I <i>already</i> practice these recommendations <input type="checkbox"/>	<u>No,</u> I don't think this applies to my practice <input type="checkbox"/>
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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)*

- | | | |
|---|--|--|
| <input type="checkbox"/> Speaker(s)
<input type="checkbox"/> Discussion
<input type="checkbox"/> Clinical Case Presentations
<input type="checkbox"/> Knowledge gained | <input type="checkbox"/> Networking
<input type="checkbox"/> AV/Support materials
<input type="checkbox"/> Demos/Hands-on
<input type="checkbox"/> Case Vignettes | <input type="checkbox"/> Facilities
<input type="checkbox"/> Other: _____
(Describe) |
|---|--|--|

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: _____

11. Would you like this speaker to present again? Yes No

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