**POST ACTIVITY EVALUATION**

**Preceptor’s Lounge AY 22/23 Series: Assessment Tools for Clinical Training**

*August 3, 2022*

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1. **How would you rate the overall quality of this activity?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Excellent** | **Good** | **Fair** | **Poor** |
|  |  |  |  |

1. **Please rate the impact of the following course objectives.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *As a result of attending this activity, I am better able to:* | **Strongly Agree** | **Agree** | **Disagree** | **Strongly Disagree** |
| Describe the various assessment tools used during the clinical years of undergraduate medical training |  |  |  |  |
| Explain how the assessments work together to create a comprehensive picture of performance in each domain |  |  |  |  |
| Build skills to easily complete clinical assessments in real time |  |  |  |  |

1. **Please rate the projected impact of this activity on your knowledge, competence, performance, and patient outcomes.**

\* Competence is defined as the ability to apply knowledge, skills, and judgment in practice (knowing how to do something)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **No Change** |
| This activity increased my knowledge. |  |  |  |
| This activity increased my competence. |  |  |  |
| This activity improved/will improve my performance. |  |  |  |
| This activity will improve my patient outcomes. |  |  |  |

If you answered 'yes' to any of the items above, please describe:

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|  |

1. **Please rate the following speakers on their knowledge/content.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Excellent** | **Above Average** | **Average** | **Below Average** | **Poor** |
| ***Assessment Matters,* Dr. Elizabeth McMurtry, DO** |  |  |  |  |  |
| Comments: | | | | | |

1. **Do you feel this activity was free of commercial bias or influence?**

\*Commercial bias is defined as a personal judgment in favor of a specific product or service of an ineligible company.

Yes

No

If no, please explain.

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| --- |
|  |

1. **Do you feel this activity was evidence-based?**

Yes

No

If no, please explain.

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1. **Do you plan to make any changes to your practice as a result of attending this activity?**

Yes

No

N/A (I do not work with patients)

Please explain with examples.

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1. **Please indicate any perceived barriers to implementing these changes.** Select all that apply.

Cost

Lack of knowledge

Lack of time to assess/counsel patients

Reimbursement/Insurance issues

Patient compliance issues

Lack of administrative support/resources

Lack of consensus or professional guidelines

No barriers

Other, please specify.

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1. **Please list suggestions you have for future topics based on questions you have encountered in your practice, or ideas for future educational activities.**

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1. **Additional Feedback/Comments:**

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