Advances in Cardiology for Primary Care

3rd Annual Naples Cardiovascular Summit

March 1-2, 2024
Arthrex One Conference Center

NCH ROONEY HEART INSTITUTE | Allina Health MINNEAPOLIS HEART INSTITUTE

EVALUATION FORM

1. Please rate the impact of the following objectives:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Meet objectives as listed	☐	☐	☐	☐	☐

2. 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	If yes, please describe:
This activity increased my knowledge.	☐	☐	☐	_____
This activity increased my competence.	☐	☐	☐	_____
This activity improved my performance.	☐	☐	☐	_____
This activity will improve my patient outcomes.	☐	☐	☐	_____

3. Do you feel the activity was scientifically sound and free of commercial bias* or influence? Yes ☐ No ☐
Please explain: _____

**Commercial bias is defined as a personal judgment in favor of a specific product or service of a commercial interest.*

4. Please identify how you will change your practice as a result of attending this activity (select all that apply).

- ☐ This activity validated my current practice; no changes will be made
- ☐ Create/revise protocols, policies, and/or procedures
- ☐ Change the management and/or treatment of my patients
- ☐ Other, please specify: _____

5. Please indicate any barriers you perceive in implementing these changes.

- ☐ Cost
- ☐ Lack of experience
- ☐ Lack of opportunity (patients)
- ☐ Lack of resources (equipment)
- ☐ Lack of administrative support
- ☐ Lack of time to assess/counsel patients
- ☐ Reimbursement/insurance issues
- ☐ Patient compliance issues
- ☐ Lack of consensus or professional guidelines
- ☐ No barriers
- ☐ Other, please specify: _____

6. Will you attempt to address these barriers in order to implement changes in your competence, performance, and/or patients' outcomes?

- ☐ No – Why not? _____
- ☐ Yes – How? _____

7. Please indicate which of the following American Board of Medical Specialties/Institute of Medicine core competencies were addressed by this educational activity (select all that apply):

- ☐ Patient care or patient-centered care
- ☐ Interpersonal and communication skills
- ☐ Practice-based learning & improvement
- ☐ Professionalism
- ☐ System-based practice
- ☐ Interdisciplinary teams
- ☐ Quality improvement
- ☐ Utilize informatics
- ☐ Medical knowledge
- ☐ Employ evidence-based practice
- ☐ None of the above

8. The content of this activity matched my current (or potential) scope of practice. Yes ☐ No ☐

If no, please explain: _____

9. How might the format of this activity be improved for the content presented (select all that apply)?

- ☐ Format was appropriate; no changes needed
- ☐ Include more case-based presentations
- ☐ Increase interactivity with attendees
- ☐ Add breakouts for Subtopics
- ☐ Add a hands-on instructional component
- ☐ Schedule more time for Q and A
- ☐ Other, describe: _____

10. Overall, were the speakers knowledgeable regarding the content? Yes ☐ No ☐

If no, please explain: _____

11. Overall, were the presentations balanced, objective, and scientifically rigorous? Yes ☐ No ☐

If no, please explain: _____

12. Was there an opportunity to discuss practice-relevant issues with the speakers? Yes ☐ No ☐

If no, please explain: _____

13. Describe any presentations that were exceptional: _____

14. Describe any presentations that did not meet your needs or expectations: _____

15. Please describe any clinical situations that you find difficult to manage or resolve that you would like to see addressed in future educational activities:

_____

PLEASE RETURN COMPLETED EVALUATIONS
INCOMPLETE EVALUATIONS WILL NOT RECEIVE CREDIT. THANK YOU.

Name: _____ **License Number (Florida MD or DO):** _____

Amount of Credits requested (Friday maximum of 9 credits, Saturday maximum of 4 credits, total of 13 credits)

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