

Advances in Cardiology for Primary Care

4th Annual Naples Cardiovascular Summit

February 21-22, 2025 | Arthrex One Conference Center | Naples, FL



EVALUATION FORM

1. Please rate the impact of the following objectives:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Met objectives as listed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
This activity increased my competence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
This activity improved my performance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
This activity will improve my patient outcomes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

3. Do you feel the activity was scientifically sound and free of commercial bias* or influence?

Please explain: _____ Yes No

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

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):

- | | | |
|---|--|---|
| <input type="checkbox"/> Patient care or patient-centered care | <input type="checkbox"/> System-based practice | <input type="checkbox"/> Medical knowledge |
| <input type="checkbox"/> Interpersonal and communication skills | <input type="checkbox"/> Interdisciplinary teams | <input type="checkbox"/> Employ evidence-based practice |
| <input type="checkbox"/> Practice-based learning & improvement | <input type="checkbox"/> Quality improvement | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Professionalism | <input type="checkbox"/> Utilize informatics | |

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)?

- | | |
|--|---|
| <input type="checkbox"/> Format was appropriate; no changes needed | <input type="checkbox"/> Add a hands-on instructional component |
| <input type="checkbox"/> Include more case-based presentations | <input type="checkbox"/> Schedule more time for Q and A |
| <input type="checkbox"/> Increase interactivity with attendees | <input type="checkbox"/> Other, describe: _____ |
| <input type="checkbox"/> Add breakouts for Subtopics | |

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

Are you requesting MOC credit for your attendance? If yes, please ensure your email address is clearly indicated.

Email: _____

Participants requesting MOC credit will receive an email with additional instructions in the week after the summit.