Form Approved
OMB No. 0935-XXXX
Exp. Date XX/XX/20XX

**Online CME Activity Outcomes Survey**

|  |  |
| --- | --- |
| **Activity (#):** |  |
| **Date:**  |  |
| **Director:**  |  |

According to our records you attended this course. We would appreciate your taking a moment now to ***anonymously*** answer a few follow-up questions.

Your professional category/degree:

○ MD/DO—in practice ○ Nurse Specialist (e.g., CRNA, NP) ○ PA-C

○ MD/DO—Resident/Fellow ○ Nurse (e.g., RN, LVN) ○ Allied Health Professional

○ Pharmacist ○ PhD/PsyD/EdD/DrPH ○ Other

Have the knowledge and skills acquired as a result of the program helped enhance your quality of patient care? *(Select one answer.)*

Yes,... □ helped considerably

 □ helped somewhat

 □ helped slightly

* + No
	+ Not applicable

Did you try to make any change as a result of things learned during the program?

 *(Select one answer.)*

Yes,... □ working well

 □ with some success

 □ but with no success

No,... □ but still plan to

 □ but validated current practice

 □ due to prohibitive barriers

 □ not needed

* + Not applicable

Your responses will be kept confidential to the extent permitted by law, including AHRQ’s confidentiality statute, 42 USC 299c-3(c).

Public reporting burden for this collection of information is estimated to average 5 minutes per response, the estimated time required to complete the survey. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-XXXX) AHRQ, 540 Gaither Road, Room # 5036, Rockville, MD 20850.

Please list one change you made or tried to make:

**(TEXT BOX)**

Have you implemented the following?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Yes** | **Tried; but no success** | **Still plan to** | **Was practicing before activity** | **No** | **Not applicable** |
| Order upper GI and abdominal decompression for conditions such as malrotation of the intestine or intestinal atresias | □ | □ | □ | □ | □ | □ |
| Order fewer CBCs and blood cultures on identified high risk children than were ordered before attending this activity | □ | □ | □ | □ | □ | □ |

What barriers to change have you faced? *(Leave blank if not applicable.)*

|  |  |  |  |
| --- | --- | --- | --- |
|  | **None / Minimal** | **Sizeable** | **Insurmountable** |
| Insurance reimbursement | □ | □ | □ |
| Formulary | □ | □ | □ |
| Cost effectiveness | □ | □ | □ |
| Time management | □ | □ | □ |
| Administrative/Support staff | □ | □ | □ |
| Patient compliance | □ | □ | □ |

Please rate your knowledge or confidence level for each of the following:

|  |  |  |
| --- | --- | --- |
|  | ­ |  |
|  | **Knowledge of emerging drugs of use such as “fry,” salvia, divinorum, and anabolic steroids** |
|  |  |  No Some High Very HighKnowledge Knowledge Knowledge Knowledge 1 2 3 4 5 6 7 8 9 10 |
|  |  |  □ □ □ □ □ □ □ □ □ □  |
|  |  |  |
|  | **Confidence in recognizing children and adolescents with a drug overdose and administering appropriate treatment** |
|  |  |  No Some High Very HighConfidence Confidence Confidence Confidence 1 2 3 4 5 6 7 8 9 10 |
|  |  |  □ □ □ □ □ □ □ □ □ □  |
|  |  |  |
|  | **Confidence in identifying conditions in children with abdominal pain that require surgical intervention** |
|  |  |  No Some High Very HighConfidence Confidence Confidence Confidence 1 2 3 4 5 6 7 8 9 10 |
|  |  |  □ □ □ □ □ □ □ □ □ □  |
|  |  |  |
|  | **Confidence in managing genitourinary emergencies in children such as acute testicular disorders in males** |
|  |  |  No Some High Very HighConfidence Confidence Confidence Confidence 1 2 3 4 5 6 7 8 9 10 |
|  |  |  □ □ □ □ □ □ □ □ □ □  |