

PROGRAM EVALUATION FORM

Satellite Broadcast
& Webcast: January 27, 2010

**Managing Rheumatoid Arthritis in the Primary Care
Setting**

Part 4 – DMARD Therapies by Primary Care Physicians

Code# **012710RHE**

University of Texas Southwestern Medical Center is committed to complying with the criteria set forth by the accreditation and continuing education agencies in order to provide this quality program. To receive credit for educational activities, you must successfully complete all program requirements.

IN ORDER TO RECEIVE CONTINUING EDUCATION CREDIT YOU MUST:

1. Attend the live broadcast/webcast program in its entirety.
 2. At the program, sign in on the Sign-in Sheet.
 3. Complete an Evaluation Form and a Credit Request Form.
- Submission information will be on the forms.

Which category best describes your discipline:

- Family Practice Physician
- General Internist
- Advanced Nurse Practitioner
- Physician Assistant
- Other

Program Satisfaction

	Strongly Disagree				Strongly Agree
Overall, I was satisfied with this offering.....	O	O	O	O	O
Content was applicable to my practice and/or research..... and valuable to me as a professional.	O	O	O	O	O
Offering was scientifically rigorous and clinical content..... was evidence based.	O	O	O	O	O
My practice or research will be influenced/impacted as..... a result of something I learned in this offering.	O	O	O	O	O

Course Director

John J. Cush, MD

	Strongly Disagree				Strongly Agree
Was knowledgeable about the subject matter.....	O	O	O	O	O
Communicated in a manner that held my attention.....	O	O	O	O	O
Used effective instructional techniques.....	O	O	O	O	O

Robin A. Hall, DO

Was knowledgeable about the subject matter.....	O	O	O	O	O
Communicated in a manner that held my attention.....	O	O	O	O	O
Used effective instructional techniques.....	O	O	O	O	O

**I Gained the Skills and/or Knowledge
that enabled me to:**

	Strongly Disagree				Strongly Agree
Understand the role of primary care in the management..... of rheumatoid arthritis (RA) and its comorbidities	O	O	O	O	O
Identify the clinical characteristics of RA and the concept..... of pattern recognition as it applies to chronic inflammatory arthritis	O	O	O	O	O
Identify histologic, anatomic, and physiologic considerations..... that contribute to the pathogenesis of RA	O	O	O	O	O
Describe treatment goals and/or outcome measures for managing RA	O	O	O	O	O
Devise strategies for implementing RA therapies to maximize..... their safety and efficacy	O	O	O	O	O
Apply evidence and best practices to manage the complexities.... of RA in the primary care setting	O	O	O	O	O
Describe the systemic complications of RA and integrate..... the treatment of comorbidities into patients' overall treatment plan	O	O	O	O	O

Program Evaluation

Program was valuable based on time involved and..... benefits received.	O	O	O	O	O
Program handouts were effective.....	O	O	O	O	O
Audiovisuals added value to the learning experience.....	O	O	O	O	O
How likely are you to take another UT Southwestern..... Medical Center professional education offering?	O	O	O	O	O
How likely are you to recommend a UT Southwestern..... Medical Center professional education offering to a colleague?	O	O	O	O	O
Was the format of this activity appropriate for the content being presented?	O	O	O	O	O
Did the method of presentation hold your interest and make the material easy to understand?	O	O	O	O	O
Content was fair-balanced and free of commercial bias.	O	O	O	O	O

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1. If we did not succeed in eliminating the perception of commercial bias, please give us specific examples so we can make the appropriate change.

2. What change(s), if any, do you plan to make in your practice as a result of participating in this activity?

3. Please share one idea or example this program offered that you will be able to take back and use in your profession.

4. Please list one thing that you liked most about today's broadcast.

5. Was there anything that you didn't like about today's broadcast?

6. Please provide any additional comments about today's broadcast.

Do we have permission to contact you in approximately three months to determine if you were able to implement changes in your practice as a result of this CME activity? Yes No

Optional Information (Please complete if we can contact you):

Name: _____
Facility Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____

