

Office of Continuing Medical Education

1300 York Avenue, Box 16 Telphone: 646-962-6931

# New York, NY 10065 Fax: 646-962-1488

**FINAL CME ACTIVITY REPORT**

**(for one-time and jointly Provided activities)**

Please complete this Final CME Activity Report for your department's recent CME activity. This report is due within 30 days of the completion of the activity.

Submit this summary to the Office of Continuing Medical Education, Box 16

|  |  |
| --- | --- |
| **Course #:**  |  |
| **Title of Activity:**  |  |
| **Course Directors:**  |  |
| **Coordinator Name:** |  |
| **CME Credits:** |  |
| **Date of Activity:**  |  |

**I. FINAL ATTENDANCE SUMMARY**

**TOTAL # of attendees:**

**TOTAL # of M.D.’s: (MD/DO)**

**TOTAL # of non-M.D.’s: (NP/RN/PA/Other)**

**II. FINAL EVALUATION SUMMARY**

Number Of Attendees For This Activity:

Total Number Of Evaluations Collected For This Report:

**(> 80% response rate required)**

 Response Rate:      %

**If you used an evaluation form different from the form provided by the CME Office at Weill Cornell,**

**please summarize your data in a format similar to that below.**

1. Please indicate your profession: **# # # #**

MD/DO  NP/RN PA Other:

**2.** Please indicate the extent to which you believe this activity will enhance your performance as a physician in the following areas of medical competence: ***(where applicable) 1 = Not at all 5 = Significant***

 A. Medical Knowledge (e.g. Biomedical, clinical, epidemiological, and social sciences):

 **Average:      N/A** (# respondents):

 **List areas of enhanced knowledge gained from this series:**

Bottom of Form

 B. Diagnostic and Treatment Strategies/Quality Improvement (e.g. New evidence, identification of opportunities for clinical improvement, evidence-based practice recommendations):

 **Average:      N/A** (# respondents):

 **List diagnostic or treatment strategies you are likely to implement in your practice:**

Bottom of Form

 C. Professionalism and Effectiveness with Patients and Care Teams (e.g. Interpersonal skills,

 identification of different patient values and needs, medical infomatics).

 **Average:      N/A** (# respondents):

 **List overall patient care and management strategies you are likely to implement in**

 **your practice:**

Bottom of Form

Bottom of Form

 **3. Do you feel the activity was free of # Yes # No**

 **commercial bias or influence.**

**If no, please describe your concerns and identify the presenter(s) and presentation title(s):**

**4. Do you feel the activity was scientifically sound, # Yes # No**

**evidence-based, objective, and balanced.**

**If no, please describe your concerns and identify the presenter(s) and presentation title(s):**

**5**. **Weill Cornell Medical College has a CME mission statement that includes expected results articulated in terms of changes in competence, performance, or patient outcomes that will be the result of the program. Do you feel this activity succeeded in fulfilling our CME Mission and resulted in changes in:**

 a. Competence **# Yes # No**

 b. Performance **# Yes # No**

 c. Patient Outcomes **# Yes # No**

**6. Please indicate any barriers you perceive in changing your practice in response to this**

 **educational experience.**

**# Respondents # Respondents**

     No barriers      Lack of Time to assess/counsel patients

     Cost      Reimbursement/insurance issues

     Lack of experience      Patient compliance issues

     Lack of opportunity (patients)      Lack of consensus or professional guidelines

     Lack of resources (equipment)      Other *(please specify):*

     Lack of administrative support

**7. How will you address these barriers in order to implement these changes in your practice?**

**8. Was the format of this activity appropriate # Yes**       **# Somewhat**       **# No**

 **to the content presented?**

If **No or Somewhat**, how might the format be improved?

**# Respondents:**

      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 *(please specify):*

**9. What else could improve this activity?**

**10. Based on your educational needs and/or perceived practice gaps in your specialty, please list any topics you would like to see addressed in future educational activities.**

**11. Other Comments:**

**COURSE DIRECTOR’S OVERALL ASSESSMENT**

As Course Director, please comment on this course’s success in meeting its stated goals based upon data collected: (SCALE: 1 = NOT AT ALL 5 = VERY SUCCESSFUL)

1. Addressing knowledge gaps. **SCALE: 1 = Not at all 5 = Very Successful**

(*Please circle a number below)*

**1 2 3 4 5**

1. Addressing gaps in competence. **SCALE: 1 = Not at all 5 = Very Successful**

(*Please circle a number below)*

**1 2 3 4 5**

1. Adressing performance gaps. **SCALE: 1 = Not at all 5 = Very Successful**

(*Please circle a number below)*

**1 2 3 4 5**

Is there anything you would do differently for future iterations of this activity?

*(Please comment in text box below)*

**III. FINAL BUDGET SUMMARY**

**TOTAL FINAL EXPENSES**

|  |
| --- |
|  |
| **SPEAKER HONORARIA:** **list for each speaker; attach addt’l list if needed** |  |
|  | $ |
|  | $ |
|  | $ |
|  | $ |
|  | $ |
|  | $ |
|  | $ |
|  | $ |
| Faculty housing, travel, meals, misc. | $ |
| Room Rental and A/V Rental | $ |
| Meals/Coffee Breaks | $ |
| Brochure Printing including Labels, Postage and Labor | $ |
| Advertisements/Marketing | $ |
| Syllabi/handouts | $ |
| Supplies for CME (badges, certificates, etc.) | $ |
| Messengers/FedEx/Taxis | $ |
| FAX/Phones | $ |
| Contract Personnel | $ |
| Contingency | $ |
| Other expenses: | $ |
|  |  |
| SUB-TOTAL OF EXPENSES | $ |

|  |
| --- |
| **CORNELL CME FEES (where applicable)** |
| Joint Sponsor Fee | $ |
| Commercial Support Fee(s) | $ |
| Exhibitor Fee(s) | $ |
| CME Administrative Fee |  |
| CME Monitor Fee (where applicable) | $ |
| TOTAL WEILL CORNELL CME FEES | $ |

|  |
| --- |
| **TOTAL EXPENSE FOR THIS CME ACTIVITY: $\_\_\_\_\_\_\_\_\_\_\_\_** |

**TOTAL FINAL REVENUE**

|  |
| --- |
|  |
| ***SOURCES OF REVENUE:*** |  |
| **Weill Cornell Departmental Funding** | $ |
| Tuition-full | $ |
| **Tuition-discounted (residents, fellows, affiliates, medical students)** | $ |
|  |
| **NON-PROFIT SUPPORT (list):** | $ |
|  | $ |
|  | $ |
| **COMMERCIAL SUPPORT (list):** |  |
|  | $ |
|  | $ |
|  | $ |
|  |  |
|  | $ |
| **EXHIBIT FEES (list):** | $ |
|  | $ |
|  | $ |
|  | $ |
| **OTHER SUPPORT** List all other commercial sponsors/organizations providing outside support and intended use of funds | $ |
|  | $ |
|  | $ |
|  | $ |
| TOTAL REVENUE | $ |

|  |  |
| --- | --- |
| **GROSS REVENUES** | $ |
| **GROSS EXPENSES** | $ |
| **NET INCOME/LOSS** | $ |

|  |  |
| --- | --- |
| **Honoraria** will be paid to speakers from the following Cornell Account: |  |
| **Income** from this course will be deposited to the following Cornell Account: |  |
| **Deficits** and all CME related fees for this activity will be the responsibility ofthe Department and the following Cornell account will be debited: |  |

Course Director's Signature:

**X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### IV. CHECKLIST and ATTACHMENTS

In order for your report to be considered complete, you must include the following:

1. Final Activity Report (includes evaluation summary and budget)

2. Sign in sheets/attendance lists

3. A copy of your CME Information page distributed to attendees

1. A copy of your brochure and/or announcement

5. Completed Clinical Content Review and Validation Monitor Form

6. CD/ICR Conflict of Interest Resolution Forms for Individual Speakers (if applicable)

**As a reminder………..**

**Please do not send original evaluation forms.**

 **Hold them in your file and include *ONLY* a summary.**

**Activity files, evaluation data and attendance records must be maintained for six years after the date of the activity.**