



Enduring Material: "Responsible Deprescribing for the Seriously and Terminally Ill"
Lisa Maurer, D.O.

PARTICIPANT REQUIREMENTS: (PLEASE READ)

IN ORDER TO OBTAIN CME CREDIT, PARTICIPANTS MUST

1. Listen/Watch the conference recording
2. View the Activity PowerPoint/materials provided.
3. Complete this CME Activity Evaluation and take the post-test, in its entirety.
4. Return the completed evaluation/posttest form to Jessica Adamson, CME Coordinator at JAdamson@lmhealth.org or print and fax to (220) 564-4012 or print and internal mail to Medical Staff office.

Pre and Post Test Information: You must complete the pre and posttest to be awarded CME credit. Passing score will be 2 out of 3 answers correct or receive a score of 66% or greater. Your test score and feedback will be emailed to you upon receipt of your evaluation.

PRETEST: Please select the correct answers to the questions below.

- Deprescribing is primarily about stopping treatment because the patient is choosing hospice care. ☐ True ☐ False
- Physicians are generally willing to stop medications that they did not start. ☐ True ☐ False
- One barrier to deprescribing is that it take time. ☐ True ☐ False

EVALUATION

Please rate the impact of the following course objectives. As a result of attending this activity, I am better able to:

- Understand that addressing polypharmacy is one of the best things we can do for our patients
☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree
- Discuss the definition and reason to perform responsible deprescribing
☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree
- Apply the OncPal deprescribing guideline as a useful tool to support the process for cancer patients with a limited life expectancy
☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

1. 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 judgement in practice (knowing how to do something)**

- | | |
|--|--|
| • This activity increased my knowledge | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • This activity increased my competence | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • This activity increased my performance | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • This activity will improve my patient outcome | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • This activity will improve my communication skills | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • This activity addresses practice-based systems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • This activity addresses system-based practice | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please make sure to complete the evaluation and attestation on the second page.

If you answer "yes" to any of the items above, please describe: _____

2. Rate the speaker on knowledge/content of the presentation

☐ Excellent ☐ Above Average ☐ Average ☐ Below Average ☐ Poor

3. Was this activity FREE of commercial bias or influence? ☐ Yes ☐ No If no, please explain:

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

7. Do you feel this activity was evidence-based? ☐ Yes ☐ No If no, please explain:

8. Do you plan to make changes to your practice as a result of attending this activity?

☐ Yes (please explain) ☐ No (please explain) ☐ N/A (I do not work with patients)

If yes, please explain with examples. If no, please indicate any perceived barriers to implementing changes.

POSTTEST: Please select the correct answers to the questions below.

- Deprescribing is primarily about stopping treatment because the patient is choosing hospice care. ☐ True ☐ False
- Physicians are generally willing to stop medications that they did not start. ☐ True ☐ False
- One barrier to deprescribing is that it take time. ☐ True ☐ False

Topic Suggestions: _____

Comments: _____

By signing this form

- ❖ I attest that I have completed the participant requirements for this CME activity.
- ❖ I agree that any patient health information will be kept confidential. HIPAA rules apply to any patient health information discussed or reviewed at this conference.

Your evaluation of this program and speaker(s) will be used as feedback toward improving our continuing medical education programming. Your name will NOT be shared with the speakers, only your answers and evaluation of the program.

Name: _____ **Date:** _____

☐ Physician ☐ Non-Physician: _____

☐ I would like a certificate for my completion of this activity.

Thank you for your feedback, it is much appreciated!