



Goal D Health Professionals Evaluation Form - Provided for SEI Sim Consortium Use in 2017-2018

The Indiana AHEC Network is required to report general demographic information about participants in the categories below. This data will be confidentially maintained and will be referenced periodically to evaluate the effectiveness of AHEC services and programs. We appreciate your cooperation in the completion of this form. Please type or print clearly.

AHEC Center: EI Program Start Date / / End Date: / / Contact hours:
Simulation Title:
Shaded section to be completed by AHEC center staff or Simulation Educator

First Name Last Name Maiden Name Date of birth

Work Organization Address City State Zip

Email Phone

Identified Gender:

- Male
Female
Prefer not to answer

Race (check all that apply)

- Black or African American
Native Hawaiian or Pacific Islander
White
American Indian or Alaska Native
Asian
Other:

Ethnicity

- Hispanic/Latino
Not Hispanic/Latino
Other:

Where did you grow up?

- Urban area
Rural area

What is your military status?

- Active Duty
Military Reservist
Veteran (Prior service)
Veteran (Retired)
No service

Do you work in any of the following settings?

- Primary Care
Rural Area
Medically Underserved Community

What best describes your role? (Select one)

- Behavioral Health: Clinical Psychology
Behavioral Health: Clinical Social Work
Behavioral Health: Counseling Psychology
Behavioral Health: Marriage/Family Thera
Behavioral Health: Other Psychology
Behavioral Health: Other Social Work
Behavioral Health: Pastoral/Spiritual Care
Behavioral Health Psychology
Dentistry: Dental Assistant
Dentistry: Dental Hygiene
Dentistry: General Dentistry
Dentistry: Oral Surgery Dentistry
Dentistry: Orthodontic Dentistry
Dentistry: Pediatric Dentistry
Medicine: Family Medicine
Medicine: Geriatrics
Medicine: Internal Medicine
Medicine: Obstetrics and Gynecology
Medicine: Other Specialty
Medicine: Pediatrics
Medicine: Psychiatry
Nursing: Certified Nursing Assistant (CNA)
Nursing: Registered Nurse (RN)
Nursing: Clinical Nurse Specialist (CNS)
Nursing: Community health nursing
Nursing: Home Health Aide
Nursing: LPN/LVN
Nursing: Nurse Administrator
Nursing: Nurse Educator
Nursing: Nurse Midwife
Nursing: NP Adult
Nursing: NP Family
Nursing: NP Pediatrics
Nursing: NP Other:
Nursing: Other
Nursing: Public Health
Other: Allied Health
Other: Athletic Training
Other: Chiropractor
Other: Community Health Worker
Other: First Responder/EMT
Other: Health Education Specialist
Other: Health Informatics/ H.I.T.
Other: Lay and Family Caregiver
Other: Medical Assistant
Other: Nutritionist
Other: Occupational Therapy
Other: Office/Support Staff
Other: Optometry
Other: Other
Other: Pharmacy
Other: Physical Therapy
Other: Respiratory Therapy
Other: Speech Therapy
Physician Assistant
Public Health: Biostatistics
Public Health: Health Promotion
Public Health: Environmental Health
Public Health: Epidemiology
Public Health: HP&M
Public Health: Infectious Disease
Public Health: Injury Control & Prevention
Public Health: Other
Public Health: SBS

Please continue on back

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**What best describes your place of employment? (Select all that apply)**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Federally qualified health center        | <input type="checkbox"/> Community health center           |  |
| <input type="checkbox"/> Nursing home                             | <input type="checkbox"/> School-based health center        | <input type="checkbox"/> Rural health clinic |
| <input type="checkbox"/> State health department                  | <input type="checkbox"/> Local health department           | <input type="checkbox"/> Hospital            |
| <input type="checkbox"/> Veteran's Administration (VA)            | <input type="checkbox"/> Academia                          | <input type="checkbox"/> Local government    |
| <input type="checkbox"/> National Health Service Corp (NHSC) Site | <input type="checkbox"/> Health professional shortage area | <input type="checkbox"/> State government    |
| <input type="checkbox"/> Nonprofit organization (faith based)     | <input type="checkbox"/> Federal government- branch: _____ |  |
| <input type="checkbox"/> Nonprofit organization (not faith based) | <input type="checkbox"/> For-profit organization           |  |
| <input type="checkbox"/> Other: _____                             |  |  |

**Please circle the number that best answers how much you agree with each statement BEFORE and AFTER participating in this simulation or series of simulations.**

1= Strongly disagree 2= Disagree 3= Not sure 4= Agree 5= Strongly agree

|  | BEFORE this<br>program/experience | AFTER this<br>program/experience |
|--|-----------------------------------|----------------------------------|
| I know how interprofessional team-based care can help or harm patient care.                            | 1 2 3 4 5                         | 1 2 3 4 5                        |
| I know how social determinants (housing, income, work, food access) can affect patient care.           | 1 2 3 4 5                         | 1 2 3 4 5                        |
| I know how a person's culture and/or background may impact their care and health outcomes.             | 1 2 3 4 5                         | 1 2 3 4 5                        |
| I understand how a patient's behavioral/mental health needs may affect their care.                     | 1 2 3 4 5                         | 1 2 3 4 5                        |
| <hr/>  |                                   |                                  |
| I have access to tools & resources to improve patient care.  | 1 2 3 4 5                         | 1 2 3 4 5                        |
| I am confident in my ability to solve problems in order to improve patient care.                       | 1 2 3 4 5                         | 1 2 3 4 5                        |
| <hr/>  |                                   |                                  |
| I plan to use quality improvement skills and tools to improve patient care.                            | 1 2 3 4 5                         | 1 2 3 4 5                        |
| I plan to try at least one practice improvement idea to improve patient care within the next 6 months. | 1 2 3 4 5                         | 1 2 3 4 5                        |
| <hr/>  |                                   |                                  |
| I plan to apply this CE program to my licensure/certification requirements.                            | N/A                               | Yes      No                      |