Goal D Evaluation Form for SEI Simulation Consortium

	This section is to be completed by AHEC center.
Program Name:	
Start Date:	**End Date:**

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

Participant Information

First Name:		**Last Name:**		**Maiden Name**:	
Birthdate: (mm/dd/yyyy)		**Work Email:**			

Veteran Status: ☐ Active Duty ☐ Military Reservist ☐ Veteran (Prior Service) ☐ Veteran (Retired) ☐ No Service

What best describes your profession? (Select one)

☐ Behavioral Health: Clinical Social Work	☐ Nursing: Community health nursing	☐ Other: Allied Health
☐ Behavioral Health: Clinical Psychology	☐ Nursing: Home Health Aide	☐ Other: Athletic Training
☐ Behavioral Health: Counseling Psychology	☐ Nursing: Nurse Administrator	☐ Other: Community Health Worker
☐ Behavioral Health: Marriage/Family Therapy	☐ Nursing: Nurse Educator	☐ Other: First Responder/EMT
☐ Behavioral Health: Other Social Work	☐ Nursing: Nurse Midwife	☐ Other: Health Ed. Specialist
☐ Behavioral Health: Other Psychology	☐ Nursing: NP: Family	☐ Other: Health Informatics/ H.I.T.
☐ Behavioral Health: Pastoral/Spiritual Care	☐Nursing: NP: Other: _____	☐ Other: Lay and Family Caregiver
☐ Behavioral Health: Substance Abuse/Addictions	☐ Nursing: Other: _____	☐ Other: Medical Assistant
☐ Dentistry: Dental Hygiene	☐ Physician Assistant	☐ Other: Nutritionist
☐ Dentistry: General Dentistry	☐ Physical Therapy	☐ Other: Occupational Therapy
☐ Dentistry: Other: _____	☐ Public Health: Biostatistics	☐ Other: Office/Support Staff
☐ Medicine: Family Medicine	☐ Public Health: Health Promotion	☐ Other: Optometry
☐ Medicine: Internal Medicine	☐ Public Health: Environ. Health	☐ Other: Pharmacy
☐ Medicine: Obstetrics and Gynecology	☐ Public Health: Epidemiology	☐ Other: Respiratory Therapy
☐ Medicine: Other Specialty: _____	☐ Public Health: HP&M	☐ Other: Speech Therapy
☐ Nursing: CNA	☐ Public Health: Infectious Disease	☐ Other:_____
☐ Nursing: Registered Nurse (RN)	☐ Public Health: Other	

Demographic Information

Gender	☐ Male ☐ Female	**Where did you grow up?**	☐ Rural Area ☐ Urban Area

Race (check all that apply)

☐ **Black or African American** (e.g. can include those with origins from the Black racial groups of Africa)
☐ **Native Hawaiian or Pacific Islander** (e.g. can include those with origins from Guam, Samoa, and other Pacific Islands)
☐ **White/Caucasian** (e.g. can include those with origins from Europe, the Middle East, or North Africa.)
☐ **American Indian or Alaska Native** (e.g. can include those with origins from North/South/Central America who maintain tribal affiliation or community attachment.)
☐ **Asian** (e.g. can include those with origins from Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam)
☐ **Other**: _____

Ethnicity: ☐ Hispanic/Latinx ☐ Not Hispanic/Latinx ☐ Prefer Not to Answer ☐ Other:_____

Employment Information

Employer Name							
Address:		**City**		**State**		**Zip:**	
Do you work in a:	Medically Underserved Community? ☐ Yes ☐ No Primary Care Setting? ☐ Yes ☐ No Rural Area? ☐ Yes ☐ No						

What best describes your place of employment? (Select one)

☐ Academia	☐ Nonprofit organization (faith based)
☐ Community health center	☐ Nonprofit organization (not faith based)
☐ Federal government– branch:	☐ Nursing home
☐ Federally qualified health center	☐ Rural health clinic
☐ For-profit organization	☐ School-based health center
☐ Health professional shortage area	☐ State government
☐ Hospital	☐ State health department
☐ Local government	☐ Veteran's Administration (VA)
☐ Local health department	☐ Other: _____

Please complete evaluation on back.

Goal D Evaluation Form for SEI Simulation Consortium

	Instructions:
	Please **circle** the number that **best** answers how much you agree with each statement **BEFORE** and **AFTER** participating in this simulation learning experience. This survey deigned to be a *retrospective* look at what you knew before this experience what you gained as a result of this program/experience.
	1= Strongly Disagree 2= Disagree 3= Not sure 4= Agree 5= Strongly Agree

Survey Questions:	**BEFORE** this simulation learning experience:	**AFTER** this simulation learning 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
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
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
I plan to apply this CE program to my licensure/certification requirements.	N/A	☐ Yes ☐ No