

EVALUATION FORM  
*Improving CVD Risk in Patients With Type 2 Diabetes: A Multifactorial Approach*  
*Hypertension Control: Getting to Goal*  
Project ID: 4523ES22

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Please print the form and fax it back to the number indicated below. Please allow up to 3 weeks for the statement of credit to be mailed to you only upon receipt of a completed activity evaluation form and a completed posttest with a score of 70% or better.

**Program Exam—Session 1 “Hypertension Control: Getting to Goal”**

1. Individuals diagnosed with diabetes mellitus type 2 constitute approximately \_\_\_\_ of the adult US population.
  - a. 1%
  - b. 3%
  - c. 7%
  - d. 15%
  
2. According to guidelines from the JNC 7, the American Diabetes Association, and the National Kidney Foundation the current goal for blood pressure in patients with type 2 diabetes is less than:
  - a. 120/75 mm Hg
  - b. 130/80 mm Hg
  - c. 135/85 mm Hg
  - d. 140/90 mm Hg
  
3. Diuretics and beta blockers are not to be used as first-line agents for blood pressure reduction in patients with diabetes because of the negative effects they can have on glycemic control.
  - a. True
  - b. False
  
4. Which two antihypertensive agents offer nephro-protection and reduced congestive heart failure in addition to blood pressure reduction?
  - a. ACE inhibitors and angiotensin-receptor blockers
  - b. ACE inhibitors and renin inhibitors
  - c. Angiotensin-receptor blockers and renin inhibitors
  - d. Diuretics and ACE inhibitors
  
5. Annual direct medical costs for diabetes in the US are in excess of \_\_\_\_\_.
  - a. \$20 billion
  - b. \$50 billion
  - c. \$90 billion
  - d. \$150 billion

**Please answer the following questions by circling the appropriate rating:**

5 = Outstanding      4 = Good      3 = Satisfactory      2 = Fair      1 = Poor

**Extent to Which Program Activities Met the Identified Purpose**

Provide the most current information available on the diagnosis, management, and treatment of cardiovascular disease

5 4 3 2 1

**Extent to Which Program Activities Met the Identified Objectives**

*After completing this activity, participants should be better able to:*

- Describe evidence that treating diabetes and metabolic disorders can help prevent CVD events  
5 4 3 2 1
- Choose strategies for achieving blood pressure goals in patients with diabetes  
5 4 3 2 1
- Explain microalbuminuria as a treatment target for prevention of nephropathy and CVD  
5 4 3 2 1
- Describe the relationship of specific antihypertensive and glucose-lowering agents to congestive heart failure  
5 4 3 2 1

**Overall Effectiveness of the Activity**

Was timely and will influence how I practice      5 4 3 2 1  
Will assist me in improving patient care      5 4 3 2 1  
Fulfilled my educational needs      5 4 3 2 1  
Avoided commercial bias or influence      5 4 3 2 1

**Impact of the Activity**

*The information presented:*  
(check all that apply)

- Reinforced my current practice/treatment habits.       Will improve my practice/patient outcomes.
- Provided new ideas or information I expect to use.       Enhanced my current knowledge base.

Will the information presented cause you to make any changes in your practice?

- Yes       No

If yes, please describe any change(s) you plan to make in your practice as a result of this conference:

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How committed are you to making these changes?  
5 (Very committed)    4    3    2    1 (Not at all committed)

**Future Activities**

Do you feel future activities on this subject matter are necessary and/or important to your practice?

- Yes       No

Please list any other topics that would be of interest to you for future educational activities:

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#### Follow-up

As part of our continuous quality improvement effort, we conduct postactivity follow-up surveys to assess the impact of our educational interventions on professional practice. Please indicate if you would like to participate in such a survey:

- Yes, I would be interested in participating in a follow-up survey.  
 No, I'm not interested in participating in a follow-up survey.

Additional comments about this activity:

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#### Request for Credit

Name \_\_\_\_\_ Degree \_\_\_\_\_

Organization \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

Signature \_\_\_\_\_ Date Completed \_\_\_\_\_

#### For Physicians Only

I certify my actual time spent to complete this educational activity to be:

- I participated in the entire activity and claim 0.75 credits.  
 I participated in only part of the activity and claim \_\_\_\_\_ credits.

**Please fax back to (973) 525-1891.**