POST-TEST/CE EVALUATION FORM

CLINICALLY MEANINGFUL RESPONSE IN MDD: A MULTIDISCIPLINARY APPROACH

Date: _____ Center: _____

City, State: _____ Activity ID: 10194 EJ 29/10195 UJ 29

---

1. **Assessment of depression should include a mental status examination.**
   a. True
   b. False

2. **Which of the following is not a risk factor for treatment-resistant depression?**
   a. Alcohol or substance abuse
   b. Late age of onset of depression
   c. History of attempted suicide
   d. Anxiety disorder

3. **What comorbid conditions can contribute to treatment-resistant depression?**
   a. Cerebrovascular disease
   b. Substance abuse
   c. Neurodegenerative disorders
   d. All of the above

4. **Which of the following medications can cause symptoms of depression?**
   a. Acetaminophen
   b. Bupropion
   c. Clonidine
   d. None of the above

5. **Short depression screening scales include all except:**
   a. MADRS
   b. CUDOS
   c. QIDS
   d. PHQ-9

6. **Which of the following newer antidepressants is approved for bipolar depression only?**
   a. Vilazodone
   b. Lurasidone
   c. Levomilnacipran
   d. Vortioxetine

7. **What constitutes an adequate trial of an antidepressant?**
   a. Should continue for more than 4 weeks at a full therapeutic dose
   b. Whenever possible the dose should be increased above the minimum
   c. Intolerance and residual symptoms do not equal nonresponse
   d. All of the above

8. **In the STAR*D trial, two-thirds of responders responded by:**
   a. Week 2
   b. Week 4
   c. Week 6
   d. Week 8

Continues on the Following Page ➔

9. Combining two antidepressants is not a current common adjunctive strategy.

a. True b. False

10. Favored first-line therapies for major depressive disorder include:

a. Generic SSRIs

b. SNRIs

c. Bupropion

d. All of the above

11. What degree best describes you?

❍ MD/DO ❍ PA/PA-C ❍ NP ❍ RN ❍ PharmD/RPh ❍ PhD

❍ Other, please specify: _____

12. What is your area of specialization?

❍ Addiction Medicine ❍ General Practice

❍ Family Medicine ❍ Psychiatry/Mental Health

❍ OB/GYN & Women's Medicine ❍ Geriatrics

❍ Other, please specify:_____

13. Which of the following best describes your *primary* practice setting?

❍ Solo Practice ❍ Group Practice

❍ Government ❍ University/Teaching System

❍ Community Hospital ❍ HMO/Managed Care

❍ Non-profit/Community ❍ I do not actively practice

❍ Other, please specify:_____

14. How long have you been practicing medicine?

❍ More than 20 years ❍ 11-20 years

❍ 6-10 years ❍ 1-5 years

❍ Less than 1 year ❍ I do not directly provide care

15. Approximately how many patients do you see each week?

❍ Less than 50 ❍ 50-99 ❍ 100-149

❍ 150-199 ❍ 200+ ❍ I do not directly provide care

16. How many patients do you currently see each week with depression that have not responded appropriately to antidepressants?

❍ Less than 5 ❍ 5-15 ❍ 16-25

❍ 26-35 ❍ 36-45 ❍ 46-55

❍ 56 or more ❍ I do not directly provide care

Continues on the Following Page ➔

17. Please select the extent to which you agree/disagree that the activity supported the achievement of each learning objective:

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Utilize comprehensive history-taking and assessment tools to monitor for, and identify, inadequate treatment response and residual symptoms in major depressive disorder (MDD)	⑤	④	③	②	①
Implement appropriate treatments for MDD that address all symptoms of the disorder, including new and emerging antidepressants	⑤	④	③	②	①
Integrate into practice strategies for managing patients with partial response, or non-response in MDD	⑤	④	③	②	①
Provide appropriate care and counsel for patients and their families	⑤	④	③	②	①

18. Rate how well the activity achieved the following:

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
The faculty were effective in presenting the material	⑤	④	③	②	①
The content was evidence-based	⑤	④	③	②	①
The educational material provided useful information for my practice	⑤	④	③	②	①
The activity enhanced my current knowledge base	⑤	④	③	②	①
The activity provided appropriate and effective opportunities for active learning (eg, case studies, discussion, Q&A, etc)	⑤	④	③	②	①
The opportunities provided to assess my own learning were appropriate (eg, questions before, during or after the activity)	⑤	④	③	②	①

19. Based upon your participation in this activity, do you intend to change your practice behavior? (choose only one of the following options)

- ❍ I do plan to implement changes in my practice based on the information presented
- ❍ My current practice has been reinforced by the information presented
- ❍ I need more information before I will change my practice

20. Thinking about how your participation in this activity will influence your patient care, how many of your patients are likely to benefit?

Please use a number (example 250): _____

21. If you plan to change your practice behavior, what type of changes do you plan to implement? (check all that apply)

- ❍ Apply latest guidelines
- ❍ Change in pharmaceutical therapy
- ❍ Change in non-pharmaceutical therapy
- ❍ Change in diagnostic testing
- ❍ Choice of treatment/management approach
- ❍ Change in current practice for referral
- ❍ Change in differential diagnosis
- ❍ Other, please specify: _____

Continues on the Following Page ➔

22. How confident are you that you will be able to make your intended changes?

❍ Very confident ❍ Somewhat confident ❍ Unsure ❍ Not very confident

23. Which of the following do you anticipate will be the primary barrier to implementing these changes?

❍ Formulary restrictions
❍ Time constraints
❍ System constraints
❍ Patient adherence/compliance
❍ Insurance/financial issues
❍ Lack of multidisciplinary support
❍ Treatment-related adverse events
❍ Other, please specify: _____

24. Was the content of this activity fair, balanced, objective and free of bias?

❍ Yes ❍ No, please explain:

_____

_____

25. Please list any clinical issues/problems within your scope of practice that you would like to see addressed in future educational activities:

_____

_____

Request for Credit (*required fields) Please print legibly.

❍ I do not wish to participate in a follow-up survey for this activity to help determine its effectiveness and guide the type of education PIM provides in the future.

Name*_____ Degree* _____

Organization _____ Specialty* _____

Address* _____

City, State, ZIP* _____

Telephone_____ Fax _____

IMPORTANT: Your certificate will be EMAILED to your listed email address* below (please print legibly).

*Valid email address required for receipt of your certificate. You will receive your certificate from CEcertificate@pimed.com.

For Physicians Only

❍ I participated in the entire activity and claim 1.25 credits.

❍ I participated in only part of the activity and claim _____ credits.