**National Quality Forum—Evidence (subcriterion 1a)**

**Measure Number: 2606 (New Measure)**

**Measure Title**: **Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)**

**IF the measure is a component in a composite performance measure, provide the title of the Composite Measure here:** **Not applicable.**

**Date of Submission: 7/25/2014**

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| **Instructions**  *For composite performance measures:*  *A separate evidence form is required for each component measure unless several components were studied together.*  *If a component measure is submitted as an individual performance measure, attach the evidence form to the individual measure submission.*   * Respond to all questions as instructed with answers immediately following the question. All information needed to demonstrate meeting the evidence subcriterion (1a) must be in this form. An appendix of *supplemental* materials may be submitted, but there is no guarantee it will be reviewed. * If you are unable to check a box, please highlight or shade the box for your response. * Maximum of 10 pages (*incudes questions/instructions*; minimum font size 11 pt; do not change margins). ***Contact NQF staff if more pages are needed.*** * Contact NQF staff regarding questions. Check for resources at [Submitting Standards webpage](http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx). |

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| **Note: The information provided in this form is intended to aid the Steering Committee and other stakeholders in understanding to what degree the evidence for this measure meets NQF’s evaluation criteria.**   1a. Evidence to Support the Measure Focus The measure focus is evidence-based, demonstrated as follows:   * Health outcome: [**3**](#Note3) a rationale supports the relationship of the health outcome to processes or structures of care. Applies to patient-reported outcomes (PRO), including health-related quality of life/functional status, symptom/symptom burden, experience with care, health-related behavior. * Intermediate clinical outcome: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4)that the measured intermediate clinical outcome leads to a desired health outcome. * Process: [**5**](#Note5) a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured process leads to a desired health outcome. * Structure: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured structure leads to a desired health outcome. * Efficiency: [**6**](#Note6) evidence not required for the resource use component.   **Notes**  **3.** Generally, rare event outcomes do not provide adequate information for improvement or discrimination; however, serious reportable events that are compared to zero are appropriate outcomes for public reporting and quality improvement.  **4.** The preferred systems for grading the evidence are the U.S. Preventive Services Task Force (USPSTF) [grading definitions](http://www.uspreventiveservicestaskforce.org/uspstf/grades.htm) and [methods](http://www.uspreventiveservicestaskforce.org/methods.htm), or Grading of Recommendations, Assessment, Development and Evaluation [(GRADE) guidelines](http://www.gradeworkinggroup.org/publications/index.htm).  **5.** Clinical care processes typically include multiple steps: assess → identify problem/potential problem → choose/plan intervention (with patient input) → provide intervention → evaluate impact on health status. If the measure focus is one step in such a multistep process, the step with the strongest evidence for the link to the desired outcome should be selected as the focus of measurement. Note: A measure focused only on collecting PROM data is not a PRO-PM.  **6.** Measures of efficiency combine the concepts of resource use and quality (see NQF’s [Measurement Framework: Evaluating Efficiency Across Episodes of Care](http://www.qualityforum.org/Publications/2010/01/Measurement_Framework__Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx); [AQA Principles of Efficiency Measures](http://www.aqaalliance.org/files/PrinciplesofEfficiencyMeasurementApril2006.doc)). |

**1a.1.This is a measure of**: (*should be consistent with type of measure entered in De.1*)

Outcome

Health outcome: Click here to name the health outcome

Patient-reported outcome (PRO): Click here to name the PRO

*PROs include HRQoL/functional status, symptom/symptom burden, experience with care, health-related behaviors*

Intermediate clinical outcome (*e.g., lab value*): **Patients with blood pressure control of <140/90 mm Hg**

Process: Click here to name the process

Structure: Click here to name the structure

Other: Click here to name what is being measured

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**HEALTH OUTCOME/PRO PERFORMANCE MEASURE**  *If not a health outcome or PRO, skip to* [*1a.3*](#Section1a3)

**1a.2.** **Briefly state or diagram the path between the health outcome (or PRO) and the healthcare structures, processes, interventions, or services that influence it.**

**Not applicable.**

**1a.2.1.** **State the rationale supporting the relationship between the health outcome (or PRO) to at least one healthcare structure, process, intervention, or service (*i.e., influence on outcome/PRO*).**

**Not applicable.**

*Note: For health outcome/PRO performance measures, no further information is required; however, you may provide evidence for any of the structures, processes, interventions, or service identified above.*

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**intermediate outcome, PROCESS, or STRUCTURE PERFORMANCE measure**

**1a.3.****Briefly state or diagram the path between structure, process, intermediate outcome, and health outcomes**. Include all the steps between the measure focus and the health outcome.

**The rate in this measure relates to the desired outcome in the following way: Patient with a serious mental illness (schizophrenia, bipolar I disorder, or major depression) is diagnosed with diabetes → Health care provider monitors patient’s blood pressure → Patient’s blood pressure level is adequately controlled (i.e. < 140/90 mmHg) → Patient has significant reduction in potentially serious complications of uncontrolled hypertension and improved long-term clinical outcomes (desired outcome).**

**1a.3.1.** **What is the source of the systematic review of the body of evidence that supports the performance measure?**

Clinical Practice Guideline recommendation – ***complete sections*** [***1a.4***](#Section1a4)***, and*** [***1a.7***](#Section1a7)

US Preventive Services Task Force Recommendation – ***complete sections*** [***1a.5***](#Section1a5) ***and*** [***1a.7***](#Section1a7)

Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*) – ***complete sections*** [***1a.6***](#Section1a6) ***and*** [***1a.7***](#Section1a7)

Other – ***complete section*** [***1a.8***](#Section1a8)

*Please complete the sections indicated above for the source of evidence. You may skip the sections that do not apply.*

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**1a.4. CLINICAL PRACTICE GUIDELINE RECOMMENDATION**

**1a.4.1.** **Guideline citation** (*including date*) and **URL for guideline** (*if available online*):

**American Diabetes Association. (2014). Standards of Medical Care in Diabetes. Guideline available from:** [**http://care.diabetesjournals.org/content/37/Supplement\_1/S14.full.pdf+html**](http://care.diabetesjournals.org/content/37/Supplement_1/S14.full.pdf+html)**, accessed June 11, 2014.**

**James PA, Oparil S, Carter BL, et al. (2014). 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC-8). JAMA. 311:507-520.**

**URL: http://jama.jamanetwork.com/article.aspx?articleid=1791497**

**1a.4.2.** **Identify guideline recommendation number and/or page number** and **quote verbatim, the specific guideline recommendation**.

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* **People with diabetes and hypertension should be treated to a systolic blood pressure (SBP) goal of <140 mmHg (Recommendation Grade: B)**
* **Patients with diabetes should be treated to a diastolic blood pressure (DBP) <80 mmHg (Recommendation Grade: B)**

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* **Recommendation 5: In the population aged 18 years or older with diabetes, initiate pharmacologic treatment to lower BP at SBP ≥140 mm Hg or DBP ≥90 mm Hg and treat to a goal SBP lower than mm Hg and goal DBP <90 mm Hg (Recommendation: Expert Opinion -Grade E)**

**1a.4.3.** **Grade assigned to the quoted recommendation with definition of the grade:**

**American Diabetes Association Grading System:**

|  |  |
| --- | --- |
| **Level of Evidence** | **Description** |
| **B** | **Supportive evidence from well-conducted cohort studies:**   * **Evidence from a well-conducted prospective cohort study or registry,** * **Evidence from a well-conducted meta-analysis of cohort studies** |
| **Supportive evidence from a well-conducted case-control study** |

**Joint National Committee-8 Grading System:**

|  |  |
| --- | --- |
| **Evidence Quality Rating** | |
| **Quality Rating** | **Type of Evidence** |
| **Moderate** | **RCTs with minor limitations affecting confidence in, or applicability of, the results** |
| **Well-designed, well-executed non–randomized controlled studies and well-designed, well-executed observational studies** |
| **Well-conducted meta-analyses of such studies** |
| **Moderately certain about the estimate of effect; further research may have an impact on our confidence in the estimate of effect and may change the estimate** |

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| --- | --- |
| **Strength of Recommendation** | |
| **Grade** | **Strength of Recommendation** |
| **E** | **Expert Opinion: there is insufficient evidence or evidence is unclear or conflicting, but this is what the committee recommends** |
| **Net benefit is unclear** |
| **Balance of benefits and harms cannot be determined because of no evidence, insufficient evidence, unclear evidence, or conflicting evidence, but the committee thought it was important to provide clinical guidance and make a recommendation** |
| **Further research is recommended in this area** |

**1a.4.4. Provide all other grades and associated definitions for recommendations in the grading system.** (*Note: If separate grades for the strength of the evidence, report them in section 1a.7.*)

**American Diabetes Association Grading System:**

|  |  |
| --- | --- |
| **Level of Evidence** | **Description** |
| **A** | **Clear evidence from well-conducted, generalizable randomized controlled trials that are adequately powered, including:**   * **Evidence from a well-conducted multicenter trial,** * **Evidence from a meta-analysis that incorporated quality ratings in the analysis** |
| **Compelling nonexperimental evidence, i.e., “all or none” rule developed by the Center for Evidence-Based Medicine at the University of Oxford** |
| **Supportive evidence from well-conducted randomized controlled trials that are adequately powered, including:**   * **Evidence from a well-conducted trial at one or more institutions,** * **Evidence from a meta-analysis that incorporated quality ratings in the analysis** |
| **C** | **Supportive evidence from poorly controlled or uncontrolled studies:**   * **Evidence from randomized clinical trials with one or more major or three or more minor methodological flaws that could invalidate the results** * **Evidence from observational studies with high potential for bias (such as case series with comparison with historical controls)** * **Evidence from case series or case reports** |
| **Supportive evidence from a well-conducted case-control study** |
| **E** | **Conflicting evidence with the weight of evidence supporting the recommendation** |

**Joint National Commitee-8 Grading System:**

|  |  |
| --- | --- |
| **Evidence Quality Rating** | |
| **Quality Rating** | **Type of Evidence** |
| **High** | **Well-designed, well-executed RCTs that adequately represent populations to which the results are applied and directly assess effects on health outcomes** |
| **Well-conducted meta-analyses of such studies** |
| **Highly certain about the estimate of effects; further research is unlikely to change our confidence in the estimate of effect** |
| **Low** | **RCTs with major limitations** |
| **Non–randomized controlled studies and observational studies with major limitations affecting confidence in, or applicability of, the results** |
| **Uncontrolled clinical observations without an appropriate comparison group (e.g., case series, case reports)** |
| **Physiological studies in humans** |
| **Meta-analyses of such studies** |
| **Low certainty about the estimate of effect; further research is likely to have an impact on our confidence in the estimate of effect and is likely to change the estimate.** |

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| --- | --- |
| **Strength of Recommendation** | |
| **Grade** | **Strength of Recommendation** |
| **A** | **Strong Recommendation: there is high certainty based on evidence that the net benefit is substantial** |
| **B** | **Moderate Recommendation: there is moderate certainty based on evidence that the net benefit is moderate to substantial or there is high certainty that the net benefit is moderate** |
| **C** | **Weak Recommendation: there is at least moderate certainty based on evidence that there is a small net benefit** |
| **D** | **Recommendation Against: there is at least moderate certainty based on evidence that it has no net benefit or that risks/harms outweigh benefits** |
| **N** | **No Recommendation For or Against: there is insufficient or evidence is unclear or conflicting** |
| **Net benefit is unclear** |
| **Balance of benefits and harms cannot be determined because of no evidence, insufficient evidence, unclear evidence, or conflicting evidence, and the committee thought no recommendation should be made** |
| **Further research is recommended in this area** |

**1a.4.5. Citation and URL for methodology for grading recommendations** (*if different from 1a.4.1*)**:**

**Not applicable.**

**1a.4.6. If guideline is evidence-based (rather than expert opinion), are the details of the quantity, quality, and consistency of the body of evidence available (e.g., evidence tables)?**

Yes **→ *complete section*** [***1a.7***](#Section1a7)

No **→ *report on another systematic review of the evidence in sections*** [***1a.6***](#Section1a6) ***and*** [***1a.7***](#Section1a7)***; if another review does not exist, provide what is known from the guideline review of evidence in*** [***1a.7***](#Section1a7)

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**1a.5.** **UNITED STATES PREVENTIVE SERVICES TASK FORCE RECOMMENDATION**

**1a.5.1.** **Recommendation citation** (*including date*) and **URL for recommendation** (*if available online*):

**Not applicable.**

**1a.5.2.** **Identify recommendation number and/or page number** and **quote verbatim, the specific recommendation**.

**Not applicable.**

**1a.5.3.** **Grade assigned to the quoted recommendation with definition of the grade**:

**Not applicable.**

**1a.5.4. Provide all other grades and associated definitions for recommendations in the grading system.** (*Note: the* *grading system for the evidence should be reported in section 1a.7.*)

**Not applicable.**

**1a.5.5. Citation and URL for methodology for grading recommendations** (*if different from 1a.5.1*)**:**

***Complete section*** [***1a.7***](#Section1a7)

**Not applicable.**

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**1a.6. OTHER SYSTEMATIC REVIEW OF THE BODY OF EVIDENCE**

**1a.6.1.** **Citation** (*including date*) and **URL** (*if available online*):

**Not applicable.**

**1a.6.2.** **Citation and** **URL for methodology for evidence review and grading** (*if different from 1a.6.1*)**:**

**Not applicable.**

***Complete section*** [***1a.7***](#Section1a7)

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**1a.7. FINDINGS FROM SYSTEMATIC REVIEW OF BODY OF THE EVIDENCE supporting the measure**

*If more than one systematic review of the evidence is identified above, you may choose to summarize the one (or more) for which the best information is available to provide a summary of the quantity, quality, and consistency of the body of evidence. Be sure to identify which review is the basis of the responses in this section and if more than one, provide a separate response for each review.*

**1a.7.1.** **What was the specific structure, treatment, intervention, service, or intermediate outcome addressed in the evidence review?**

**Evidence highlights the need and important of monitoring, controlling, and treating high blood pressure in diabetics, especially among vulnerable populations.**

**American Diabetes Association:**

**The American Diabetes Association’s guidance is directed towards monitoring blood pressure among diabetics and treating hypertension to a blood pressure goal of less than 140/80 mmHg. Blood pressure monitoring should be performed by a trained provider and supplemented by home blood pressure measurement. To lower high blood pressure, the American Diabetes Association recommends that providers advise patients on both lifestyle changes and pharmacological treatment to produce long-term reduction of hypertension. Effective mitigation of hypertension can reduce both the risk of cardiovascular disease and microvascular complications among diabetics.**

**Joint National Committee-8:**

**The Joint National Committee-8 recommends achievement of blood pressure lower than 140/90 mmHg for diabetics, which is similar to the Joint National Committee-8’s blood pressure recommendation for non-diabetic populations. Both hypertension and controlled blood pressure should be regularly monitored and treated (if necessary) to reduce the risk of macrovascular diabetic complications and cardiovascular disease. Treatment of high blood pressure should include both pharmacological remedies (i.e. antihypertensives), diet, weight control, and regular exercise.**

**1a.7.2.** **Grade assigned for the quality of the quoted evidence with definition of the grade**:

**American Diabetes Association Grading System:**

|  |  |
| --- | --- |
| **Level of Evidence** | **Description** |
| **B** | **Supportive evidence from well-conducted cohort studies:**   * **Evidence from a well-conducted prospective cohort study or registry,** * **Evidence from a well-conducted meta-analysis of cohort studies** |
| **Supportive evidence from a well-conducted case-control study** |

**Joint National Commitee-8 Grading System:**

|  |  |
| --- | --- |
| **Evidence Quality Rating** | |
| **Quality Rating** | **Type of Evidence** |
| **Moderate** | **RCTs with minor limitations affecting confidence in, or applicability of, the results** |
| **Well-designed, well-executed non–randomized controlled studies and well-designed, well-executed observational studies** |
| **Well-conducted meta-analyses of such studies** |
| **Moderately certain about the estimate of effect; further research may have an impact on our confidence in the estimate of effect and may change the estimate** |

|  |  |
| --- | --- |
| **Strength of Recommendation** | |
| **Grade** | **Strength of Recommendation** |
| **E** | **Expert Opinion: there is insufficient evidence or evidence is unclear or conflicting, but this is what the committee recommends** |
| **Net benefit is unclear** |
| **Balance of benefits and harms cannot be determined because of no evidence, insufficient evidence, unclear evidence, or conflicting evidence, but the committee thought it was important to provide clinical guidance and make a recommendation** |
| **Further research is recommended in this area** |

**1a.7.3. Provide all other grades and associated definitions for strength of the evidence in the grading system.**

**American Diabetes Association Grading System:**

|  |  |
| --- | --- |
| **Level of Evidence** | **Description** |
| **A** | **Clear evidence from well-conducted, generalizable randomized controlled trials that are adequately powered, including:**   * **Evidence from a well-conducted multicenter trial,** * **Evidence from a meta-analysis that incorporated quality ratings in the analysis** |
| **Compelling nonexperimental evidence, i.e., “all or none” rule developed by the Center for Evidence-Based Medicine at the University of Oxford** |
| **Supportive evidence from well-conducted randomized controlled trials that are adequately powered, including:**   * **Evidence from a well-conducted trial at one or more institutions,** * **Evidence from a meta-analysis that incorporated quality ratings in the analysis** |
| **C** | **Supportive evidence from poorly controlled or uncontrolled studies:**   * **Evidence from randomized clinical trials with one or more major or three or more minor methodological flaws that could invalidate the results** * **Evidence from observational studies with high potential for bias (such as case series with comparison with historical controls)** * **Evidence from case series or case reports** |
| **Conflicting evidence with the weight of evidence supporting the recommendation** |
| **E** | **Expert consensus or clinical experience** |

**Joint National Committee-8 Grading System:**

|  |  |
| --- | --- |
| **Evidence Quality Rating** | |
| **Quality Rating** | **Type of Evidence** |
| **High** | **Well-designed, well-executed RCTs that adequately represent populations to which the results are applied and directly assess effects on health outcomes** |
| **Well-conducted meta-analyses of such studies** |
| **Highly certain about the estimate of effects; further research is unlikely to change our confidence in the estimate of effect** |
| **Low** | **RCTs with major limitations** |
| **Non–randomized controlled studies and observational studies with major limitations affecting confidence in, or applicability of, the results** |
| **Uncontrolled clinical observations without an appropriate comparison group (e.g., case series, case reports)** |
| **Physiological studies in humans** |
| **Meta-analyses of such studies** |
| **Low certainty about the estimate of effect; further research is likely to have an impact on our confidence in the estimate of effect and is likely to change the estimate.** |

|  |  |
| --- | --- |
| **Strength of Recommendation** | |
| **Grade** | **Strength of Recommendation** |
| **A** | **Strong Recommendation: there is high certainty based on evidence that the net benefit is substantial** |
| **B** | **Moderate Recommendation: there is moderate certainty based on evidence that the net benefit is moderate to substantial or there is high certainty that the net benefit is moderate** |
| **C** | **Weak Recommendation: there is at least moderate certainty based on evidence that there is a small net benefit** |
| **D** | **Recommendation Against: there is at least moderate certainty based on evidence that it has no net benefit or that risks/harms outweigh benefits** |
| **N** | **No Recommendation For or Against: there is insufficient or evidence is unclear or conflicting** |
| **Net benefit is unclear** |
| **Balance of benefits and harms cannot be determined because of no evidence, insufficient evidence, unclear evidence, or conflicting evidence, and the committee thought no recommendation should be made** |
| **Further research is recommended in this area** |

**1a.7.4.** **What is the time period covered by the body of evidence? (*provide the date range, e.g., 1990-2010*). Date range**:

* **American Diabetes Associtaiton: 1993-2012**
* **Joint National Commitee-8: 1996-2010**

**QUANTITY AND QUALITY OF BODY OF EVIDENCE**

**1a.7.5.****How many and what type of study designs are included in the body of evidence**? (*e.g., 3 randomized controlled trials and 1 observational study*)

**American Diabetes Association:**

**The American Diabetes Association’s blood pressure guidelines are primarily based upon evidence obtained from randomized controlled trials and meta-analyses/systematic reviews. Specifically, the guidelines were based upon evidence obtained from:**

* **5 Randomized controlled trials (including the ACCORD, ADVANCE, HOT, UKPDS studies)**
* **2 Meta-analyses/systematic reviews**
* **2 Observational studies**
* **1 Cohort study**
* **1 Prospective observational study**

**Joint National Committee-8:**

**When developing their guidelines, the Joint National Committee-8 drew from evidence primarily obtained from randomized controlled trials. Specifically, the Joint National Committee-8 reviewed:**

* **5 Randomized controlled trials**
* **1 Meta-analysis/systematic review**

**1a.7.6.** **What is the overall quality of evidence across studies in the body of evidence**? (*discuss the certainty or confidence in the estimates of effect particularly in relation to study factors such as design flaws, imprecision due to small numbers, indirectness of studies to the measure focus or target population*)

**Overall, the quality of evidence supporting the guidelines is moderate to strong with several randomized controlled trials and meta-analyses/systematic reviews to support the lowering of blood pressure to less than 140/90 among patients with diabetes.**

**ESTIMATES OF BENEFIT AND CONSISTENCY ACROSS STUDIES IN BODY OF EVIDENCE**

**1a.7.7.** **What are the estimates of benefit—magnitude and direction of effect on outcome(s) across studies in the body of evidence**? (*e.g., ranges of percentages or odds ratios for improvement/ decline across studies, results of meta-analysis, and statistical significance*)

**Hypertension is a major risk factor for microvascular complications and cardiovascular disease (CVD) and is a commonly found comorbidity for diabetic patients. Studies included in the ADA evidence review show the benefit of controlling specific CVD risk factors in preventing or slowing the onset of disease. Randomized clinical trials, such as the ACCORD and ADVANCE trial presented in the ADA evidence review demonstrate that lowering blood pressure to <140 mm Hg systolic and <80 mm Hg diastolic for diabetic individuals is associated with a number of benefits including a reduction of coronary heart disease, stroke, and nephropathy. The ACCORD trial showed a statistically significant reduction in both stroke (fatal and non-fatal) through intensive blood pressure treatment. While there were no differences in renal function nor microvascular complications between the control and treatment group, there was an observed reduction in albuminuria rates. The ADVANCE trial showed a reduction in cardiovascular disease, total mortality, and combined microvascular and macrovascular outcomes via treatment with an ACE inhibitor and a thiazide-type diuretic. Another recent RCT study including 448 type 2 diabetic patients showed a reduction of CVD events and mortality with administration of antihypertensive medication at bedtime and appropriate follow-up (Hermida, 2011). Additionally, a meta-analysis of randomized trials for type 2 diabetics only showed a 1% absolute risk reduction, however, 35% relative reduction in stroke (McBrien, 2012).**

**Strong evidence shows that controlled blood pressure (<150/90 mm hg) for adults 60 years and older reduces stroke, heart failure, and coronary heart disease (CHD). Evidence from trials showing the benefit of reducing SBP to 140 mm Hg or lower in adults with diabetes.**

**Citations:**

**Hermida, R. (2011). Bedtime Dosing of Antihypertensive Medications Reduces Cardiovascular Risk in CKD. Journal of the American Society of Nephrology.**

**McBrien, K. (2012). Intensive and Standard Blood Pressure Targets in Patients with Type 2 Diabetes Mellitus: Systematic Review and Meta-Analysis. JAMA Internal Medicine. 172(17):1296-1303.**

**1a.7.8.** **What harms were studied and how do they affect the net benefit (benefits over harms)?**

**Evidence suggests that a systolic blood pressure level of greater than 140 mm Hg is harmful and clinicians should treat all patients to achieve and maintain blood pressure below this value. However, hypertensive patients require multiple-drug therapies to reach treatment goals for blood pressure and there is a need for addressing barriers to medication adherence such as cost and side effects. Other than potential drug side effects for treating hypertension, no other harms were studied and included in the ADA evidence review. While the harms of antihypertensive treatment were considered in the Joint National Committee panel recommendations, the evidence review was not designed to determine whether adverse events resulted in harms that significantly changed or outweighed the beneficial health outcomes. No other harms were mentioned as part of this evidence review.**

**UPDATE TO THE SYSTEMATIC REVIEW(S) OF THE BODY OF EVIDENCE**

**1a.7.9.** **If new studies have been conducted since the systematic review of the body of evidence, provide for each new study: 1) citation, 2) description, 3) results, 4) impact on conclusions of systematic review**.

**There have been no new studies that contradict the current body of evidence.**

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**1a.8 OTHER SOURCE OF EVIDENCE**

*If source of evidence is NOT from a clinical practice guideline, USPSTF, or systematic review, please describe the evidence on which you are basing the performance measure.*

**1a.8.1** **What process was used to identify the evidence?**

**Not applicable.**

**1a.8.2.** **Provide the citation and summary for each piece of evidence.**

**Not applicable.**