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

**Measure Number** (*if previously endorsed*)**:** 0418 (3132/3148)

**Measure Title**: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

**IF the measure is a component in a composite performance measure, provide the title of the Composite Measure here:** None

**Date of Submission**: 12/9/2016

|  |
| --- |
| **Instructions**  *Complete 1a.1 and 1a.12 for all measures.*  *Complete* ***EITHER 1a.2, 1a.3 or 1a.4*** *as applicable for the type of measure and evidence.*  *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.*   * 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. * Contact NQF staff regarding questions. Check for resources at [Submitting Standards webpage](http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx). |

|  |
| --- |
| **Note: The information provided in this form is intended to aid the Standing 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.* (*A PRO-based performance measure is not a survey instrument. Data may be collected using a survey instrument to construct a PRO measure.)*

Intermediate clinical outcome (*e.g., lab value*): Click here to name the intermediate outcome

Process: Depression screening and follow-up plan

Appropriate use measure: Click here to name what is being measured

Structure: Click here to name the structure

Composite: Click here to name what is being measured

**1a.12** **LOGIC MODEL** Diagram or briefly describe the steps between the healthcare structures and processes (e.g., interventions, or services) and the patient’s health outcome(s). The relationships in the diagram should be easily understood by general, non-technical audiences. Indicate the structure, process or outcome being measured.

Diagnosing and treating depression leads to improved health and quality of life

Patients have a qualifying encounter where they are screened for depression

Patients either screen positive or negative for depression

Patients who screen positive for depression receive follow-up care

**\*\*RESPOND TO ONLY ONE SECTION BELOW -EITHER 1a.2, 1a.3 or 1a.4) \*\***

**1a.2** **FOR OUTCOME MEASURES including PATIENT REPORTED OUTCOMES- State the rationale supporting the relationship between the health outcome (or PRO) to at least one healthcare structure, process (e.g., intervention, or service).**

N/A

**1a.3.****SYSTEMATIC REVIEW(SR) OF THE EVIDENCE (for intermediate outcome, PROCESS, or STRUCTURE PERFORMANCE measures) If the evidence is not based on a systematic review go to section 1a.4) If you wish to include more than one systematic review, add additional tables.**

**What is the source of the systematic review of the body of evidence that supports the performance measure? A systematic review is a scientific investigation that focuses on a specific question and uses explicit, prespecified scientific methods to identify, select, assess, and summarize the findings of similar but separate studies. It may include a quantitative synthesis (meta-analysis), depending on the available data. (IOM)**

Clinical Practice Guideline recommendation (with evidence review)

US Preventive Services Task Force Recommendation

☐ Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*)

☐ Other

|  |  |
| --- | --- |
| **Source of Systematic Review:**   * **Title** * **Author** * **Date** * **Citation, including page number** * **URL** | * **Screening for Depression in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement** * **Albert L. Siu, MD, MSPH, on behalf of the U.S. Preventive Services Task Force** * **Published February 9, 2016** * **U.S. Preventive Services Task Force. Screening for depression in children and adolescents: U.S. Preventive Services Task Force Recommendation Statement. Ann Intern Med. 2016 Mar 1;164(5):360-366** * [**https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-children-and-adolescents-screening1?ds=1&s=depression**](https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-children-and-adolescents-screening1?ds=1&s=depression)   **Previous Submission**:  Williams, S.B., O´Connor, E.A., Eder, M., Whitlock, E.P. (2009). Screening for Child and Adolescent Depression in Primary Care Setting: A Systematic Evidence Review for the US Preventive Services Task Force. Pediatrics, 123, e716-e735. doi:10.1542/peds.2008-2415 |
| Quote the guideline or recommendation verbatim about the process, structure or intermediate outcome being measured. If not a guideline, summarize the conclusions from the SR. | “The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. (B recommendation)” (p. 360)  **Previous Submission**:  “The US Preventive Health Services Task Force recommends screening of adolescents (aged 12 to18 years) for (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive behavioral or interpersonal), and follow-up (Grade B recommendation)” (AHRQ, 2010, p. 141) |
| Grade assigned to the **evidence** associated with the recommendation with the definition of the grade | Moderate: “The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as: the number, size, or quality of individual studies; inconsistency of findings across individual studies; limited generalizability of findings to routine primary care practice; and lack of coherence in the chain of evidence.  As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.” (p. 367)  **Previous Submission:**  \*Please see 1c.13 at end of document for grading of evidence for the USPSTF and ICSI guidelines which was provided in the previous submission |
| Provide all other grades and definitions from the evidence grading system | As indicated in Appendix Table 2 (p. 360).  High: “The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.”  Low: “The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: the limited number or size of studies; important flaws in study design or methods; inconsistency of findings across individual studies; gaps in the chain of evidence; findings that are not generalizable to routine primary care practice; and a lack of information on important health outcomes. More information may allow an estimation of effects on health outcomes.”  **Previous Submission:**  \*Please see 1c.12 at end of document for grading of evidence for the USPSTF and ICSI guidelines which was provided in the previous submission |
| Grade assigned to the **recommendation** with definition of the grade | B Recommendation: “The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.” (p. 367)  **Previous Submission:**  USPSTF Grade B: The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial. |
| Provide all other grades and definitions from the recommendation grading system | As indicated in Appendix Table 1 (p. 360).  A: “The USPSTF recommends the service. There is high certainty that the net benefit is substantial.”  C: “The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.”  D: “The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.”  I statement: “The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.”  **Previous Submission does not provide this information.** |
| Body of evidence:   * Quantity – how many studies? * Quality – what type of studies? | The USPSTF conducted a systematic evidence review to update its 2009 recommendation on screening for child and adolescent major depressive disorder (MDD) in primary care settings. Compared to its 2009 review, USPSTF narrowed the scope of this evidence review to focus exclusively on screening for and treating MDD. The USPSTF excluded studies of paroxetine because in 2003 the U.S. Food and Drug Administration (FDA) recommended not to use paroxetine to treat MDD in children and adolescents. The USPSTF examined evidence on the benefits and harms of screening; the accuracy of screening tests feasible for use in primary care; and the benefits and harms of treatment with psychotherapy, medications, and collaborative care models in patients ages 7 to 18 years. USPSTF limited treatment studies to those that were implemented in or required referrals from primary care settings to ensure that the patient population was similar to patients who would be identified through screening.  The USPSTF found five good- or fair-quality studies of the accuracy of MDD screening instruments in children and adolescents ages 11 years or older. It also found eight good- or fair-quality randomized controlled trials (RCTs) that reported health outcomes in children or adolescents with screen-detected MDD: four for patients who were treated with selective serotonin reuptake inhibitors (SSRIs), two involving psychotherapy, one on SSRIs combined with psychotherapy, and one on collaborative care. Most trials were restricted to adolescent’s ages 12 to 14 years or older; only two of the four SSRI trials included children ages 7 or 8 years (p. 364).  **Previous Submission:**  \*Please see 1.c.5 and 1c.6 at end of document for body of evidence for the USPSTF and ICSI guidelines which was provided in the previous submission |
| Estimates of benefit and consistency across studies | The USPSTF found adequate evidence that screening tests can accurately identify MDD in adolescents and that treatment of adolescents with screen-detected MDD is associated with beneficial reductions in symptoms. The USPSTF therefore concluded with moderate certainty that screening for MDD in adolescents ages 12 to 18 years is associated a moderate net benefit (p. 365). Although the USPSTF found no studies that directly evaluated whether screening for MDD in adolescents in primary care settings leads to improved health and other outcomes, there is adequate evidence that treatment of MDD detected through screening in adolescents is associated with moderate benefit, for example, by reducing the severity of depression or improving depression symptoms (p. 361).  **Previous Submission:**  \*Please see 1c.7 at end of document for Estimates of benefit and consistency across studies for the USPSTF and ICSI guidelines which was provided in the previous submission |
| What harms were identified? | The USPSTF found no direct evidence to suggest that screening or treatment for MDD in adolescents or children leads to potential harms. Seven trials in the USPSTF review pertaining to the use of SSRIs (five trials), psychotherapy with or without SSRIs (one trial), or collaborative care (one trial) reported on harms, but none found significant differences between intervention groups. The USPSTF noted, however, that some of the studies had insufficient power to detect differences on some of the measured outcomes.  **Previous Submission:**  \*Please see 1c.8 at end of document for harms identified for the USPSTF and ICSI guidelines which was provided in the previous submission. |
| Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR? | This guideline was published in 2016 and is the most recent systematic review completed.  **The 2016 guideline is an update of the 2009 release, submitted in the previous submission.** |

|  |  |
| --- | --- |
| **Source of Systematic Review:**   * **Title** * **Author** * **Date** * **Citation, including page number** * **URL** | * **Screening for Depression in Adults US Preventive Services Task Force Recommendation Statement** * **Albert L. Siu, MD, MSPH; and the US Preventive Services Task Force (USPSTF)** * **Published January 26, 2016** * **US Preventive Services Task Force (USPSTF). Screening for Depression in Adults: US Preventive Services Task Force Recommendation Statement. JAMA. 2016; 315(4):380-387. doi:10.1001/jama.2015.18392.** * **<https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-adults-screening1?ds=1&s=depression>**   **Previous Submission:**  U.S. Preventive Services Task Force (2009). Screening for Depression in Adults: U.S. Preventive Services Task Force Recommendation Statement. Annals of Internal Medicine, 151 (11), 784-792. Retrieved from:  http://annals.org/article.aspx?articleid=745304  USPSTF Grade B and Grade C recommendation |
| Quote the guideline or recommendation verbatim about the process, structure or intermediate outcome being measured. If not a guideline, summarize the conclusions from the SR. | “The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)” (p. 360).  **Previous Submission:**  The US Preventive Health Services Task Force (USPSTF) recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. Grade B Recommendation” (AHRQ, 2010, p. 136) |
| Grade assigned to the **evidence** associated with the recommendation with the definition of the grade | As indicated in Appendix Table 2 (p. 367).  Moderate: “The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as: the number, size, or quality of individual studies; inconsistency of findings across individual studies; limited generalizability of findings to routine primary care practice; and lack of coherence in the chain of evidence.  As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.”  **Previous Submission:**  \*Please see 1c.13 at end of document for grading of evidence for the USPSTF and ICSI guidelines which was provided in the previous submission |
| Provide all other grades and definitions from the evidence grading system | As indicated in Appendix Table 2 (p. 367).  High: “The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.”  Low: “The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: the limited number or size of studies; important flaws in study design or methods; inconsistency of findings across individual studies; gaps in the chain of evidence; findings that are not generalizable to routine primary care practice; and a lack of information on important health outcomes. More information may allow an estimation of effects on health outcomes.”  **Previous Submission:**  \*Please see 1c.12 at end of document for grading of evidence for the USPSTF and ICSI guidelines which was provided in the previous submission |
| Grade assigned to the **recommendation** with definition of the grade | As indicated in Appendix Table 1 (p. 367).  Graded B Recommendation: “The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.”  **Previous Submission:**  USPSTF Grade B: The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.) |
| Provide all other grades and definitions from the recommendation grading system | As indicated in Appendix Table 1 (p. 367). A: “The USPSTF recommends the service. There is high certainty that the net benefit is substantial. Offer or provide this service.”  C: “The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.”  D: “The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.”  I statement: “The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.”  **Previous Submission does not provide this information.** |
| Body of evidence:   * Quantity – how many studies? * Quality – what type of studies? | The USPSTF found convincing evidence that screening tests accurately identify depression in the general adult population, and that there are benefits to treating depression once diagnosed. Nine good- or fair-quality trials addressed screening in general adults and older adults (p.384). The evidence from five RCTs, in addition to indirect evidence reviewed for the 2009 recommendation, indicates that there is moderate certainty that screening for depression in adults is of moderate benefit (p. 385).  In terms of treatment, two systematic reviews concluded that antidepressants were effective in treating depression in older adults. Two good-quality systematic reviews found that older adults who received psychotherapy were more than twice as likely to have remission as those who received no treatment (p. 384).  For pregnant and postpartum women, the USPSTF reviewed 23 studies comparing the accuracy of the Edinburgh Postnatal Depression Scale with diagnostic interview, and found that the instrument had an acceptable positive predictive value for detecting MDD. The USPSTF identified six good- or fair-quality RCTs that assessed the effect of screening for depression in pregnant and postpartum women that support recommending depression screening for this group (p. 384).  Eighteen trials examined the benefits of treatment interventions in women who screened positive for depression in primary care or community settings. Of these, 15 focused on postpartum women and 3 involved pregnant women. Ten RCTs found that cognitive behavioral therapy (CBT) benefits both postpartum and pregnant women; the remaining eight trials did not find sufficient evidence to draw conclusions about the effectiveness of treatment in these populations (p. 385).  The USPSTF review found seven studies that compared suicide-related events in adults who received SSRIs and other antidepressants versus placebo. None of the studies showed a significant increase in suicide completion among adults taking antidepressants, but given the rarity of this event, they may not have had sufficient power to detect differences between treatment groups (p. 385).  The majority of the evidence on the harms of antidepressants in pregnant and postpartum women comes from a good-quality comprehensive systematic review on the comparative effectiveness and safety of antidepressant treatment for depression in this population. The review, which included 124 observational studies, showed that second-generation antidepressant use during pregnancy may be associated with a small increase in the risk of several outcomes, including preeclampsia, miscarriage, and respiratory distress (p. 385).  **Previous Submission:**  \*Please see 1.c.5 and 1c.6 at end of document for body of evidence for the USPSTF and ICSI guidelines which was provided in the previous submission |
| Estimates of benefit and consistency across studies | The USPSTF concluded with at least moderate certainty that there is a moderate net benefit to screening for depression in adults, including older adults, and in pregnant and postpartum women who receive care in clinical practices that have CBT or other evidence-based counseling available after screening (p. 381).  The USPSTF also found adequate evidence that programs that screen for depression and have adequate support systems in place improve clinical outcomes in both the general adult population and among pregnant and postpartum women specifically. Improvement in outcomes included reduction and remission of depression symptoms (p. 380).  **Previous Submission:**  **\***Please see 1c.7 at end of document for Estimates of benefit and consistency across studies for the USPSTF and ICSI guidelines which was provided in the previous submission |
| What harms were identified? | “The USPSTF found adequate evidence that the magnitude of harms of screening for depression in adults is small to none. The USPSTF found adequate evidence that the magnitude of harms of treatment with CBT in postpartum and pregnant women is small to none” (p. 380).  “The USPSTF found that second-generation antidepressants (mostly selective serotonin reuptake inhibitors [SSRIs]) are associated with some harms, such as an increase in suicidal behaviors in adults aged 18 to 29 years and an increased risk of upper gastrointestinal bleeding in adults older than 70 years, with risk increasing with age; however, the magnitude of these risks is, on average, small. The USPSTF found evidence of potential serious fetal harms from pharmacologic treatment of depression in pregnant women, but the likelihood of these serious harms is low. Therefore, the USPSTF concludes that the overall magnitude of harms is small to moderate” (p. 381).  **Previous Submission:**  \*Please see 1c.8 at end of document for harms identified for the USPSTF and ICSI guidelines which was provided in the previous submission. |
| Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR? | This guideline was published in 2016 and is the most recent systematic review completed.  **The 2016 guideline is an update of the 2009 release, submitted in the previous submission.** |

|  |  |
| --- | --- |
| **Source of Systematic Review:**   * **Title** * **Author** * **Date** * **Citation, including page number** * **URL** | * **Health Care Guideline Adult Depression in Primary Care** * **Institute for Clinical Systems Improvement (ICSI)** * **March 2016** * **Trangle M, Gursky J, Haight R, Hardwig J, Hinnenkamp T, Kessler D, Mack N, Myszkowski M. Institute for Clinical Systems Improvement. Adult Depression in Primary Care. Updated March 2016. Pp.1-131** * [**https://www.icsi.org/guidelines\_\_more/catalog\_guidelines\_and\_more/catalog\_guidelines/catalog\_behavioral\_health\_guidelines/depression/**](https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_behavioral_health_guidelines/depression/)   **Previous Submission:**  ICSI References below:  Wilkinson, J., Bass, C., Diem, S., Gravley, A., Harvey, L., Hayes, R., Johnson, K., Maciosek, M., McKeon, K., Milteer, L., Morgan, J., Rothe, P., Snellman, L., Solberg, L., Storlie, C., Vincent, P. (2012). Institute for Clinical Systems Improvement. (18th ed.). Health care guideline: Preventive services for adults. Retrieved from: http://www.icsi.org/preventive\_services\_for\_adults/preventive\_services\_for\_adults\_4.htm  Wilkinson, J., Bass, C., Diem, S., Gravley, A., Harvey, L., Hayes, R., Johnson, K., Maciosek, M., McKeon, K., Milteer, L., Morgan, J., Rothe, P., Snellman, L., Solberg, L., Storlie, C., Vincent, P. (2011). Institute for Clinical Systems Improvement (17th ed.). Preventive Services for Children and Adolescents. |
| Quote the guideline or recommendation verbatim about the process, structure or intermediate outcome being measured. If not a guideline, summarize the conclusions from the SR. | All recommendations are contained within a table on pages 8-10. We have included below those that are most relevant to this measure:  “Clinicians should routinely screen all adults for depression using a standardized instrument” (p. 8).  “Clinicians should establish and maintain follow-up with patients” (p. 10).  “Clinicians should screen and monitor depression in pregnant and post-partum women” (p. 10).  **Previous Submission:**  The Institute for Clinical Systems Improvement Preventive Services for Adults Health Care Guideline recommendation:  “Routine depression screening should be recommended for adult patients (including older adults but only if the practice has staff-assisted ‘systems in place to ensure that positive result are followed by accurate diagnosis, effective treatment and careful follow-up.’ The optimum interval for rescreening is unknown (O’Connor, 2009 [Systematic Review])” (ICSI, 2012, p.25)  The Institute for Clinical Systems Improvement Level II Services for Children and Adolescents recommendation:  “Screen adolescents (ages 12-18) for major depressive disorder, but only when systems are in place for in their organization to ensure accurate diagnosis, careful selection of treatment and close follow-up” (ICSI, 2011, p.18). |
| Grade assigned to the **evidence** associated with the recommendation with the definition of the grade | All three of the recommendations listed above were graded as Low Quality Evidence: “Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change. The estimate or any estimate of effect is very uncertain.” (p. 4)  **Previous Submission:**  \*Please see 1c.13 at end of document for grading of evidence for the USPSTF and ICSI guidelines which was provided in the previous submission |
| Provide all other grades and definitions from the evidence grading system | ICSI utilizes the Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology system.  Visit <http://www.gradeworkinggroup.org/> for more information about GRADE.  High Quality Evidence: **“**Further research is veryunlikely to change ourconfidence in theestimate of effect.” (p. 4)  Moderate Quality Evidence: “Further research islikely to have animportant impact onour confidence in theestimate of effect andmay change theestimate.” (p. 4)  **Previous Submission:**  \*Please see 1c.12 at end of document for grading of evidence for the USPSTF and ICSI guidelines which was provided in the previous submission |
| Grade assigned to the **recommendation** with definition of the grade | Strong Recommendation for Low Quality Evidence: “The work group feels that the evidence consistently indicates the benefit of this action outweighs the harms. This recommendation might change when higher quality evidence becomes available.” (p. 4)  **Previous Submission:**  \*Please see 1c.13 at end of document for grading of recommendation for the ICSI guidelines which was provided in the previous submission |
| Provide all other grades and definitions from the recommendation grading system | Strong Recommendation for High Quality Evidence: “The work group is confident that the desirable effects of adhering to this recommendation outweigh the undesirable effects. This is a strong recommendation for or against. This applies to most patients.” (p. 4)  Weak Recommendation for High Quality Evidence: “The work group recognizes that the evidence, though of high quality, shows a balance between estimates of harms and benefits. The best action will depend on local circumstances, patient values or preferences.” (p. 4)  Strong Recommendation for Moderate Quality Evidence: “The work group is confident that the benefits outweigh the risks but recognizes that the evidence has limitations. Further evidence may impact this recommendation. This is a recommendation that likely applies to most patients.” (p. 4)  Weak Recommendation for Moderate Quality Evidence: “The work group recognizes that there is a balance between harms and benefits, based on moderate quality evidence, or that there is uncertainty about the estimates of the harms and benefits of the proposed intervention that may be affected by new evidence. Alternative approaches will likely be better for some patients under some circumstances.” (p. 4)  Weak Recommendation for Low Quality Evidence: “The work group recognizes that there is significant uncertainty about the best estimates of benefits and harms.” (p. 4)  **Previous Submission:**  \*Please see 1c.12 at end of document for grading of recommendation for the ICSI guidelines which was provided in the previous submission |
| Body of evidence:   * Quantity – how many studies? * Quality – what type of studies? | The authors used a consistent and defined literature search process to develop and revise the ICSI guidelines. First, ICSI staff, in consultation with the work group and a medical librarian, conducted a literature search to identify systematic reviews, randomized clinical trials, meta-analyses, other guidelines, regulatory statements, and any other pertinent literature. Work group members then evaluated the identified literature using the GRADE methodology (p. 131).  For this guideline, ICSI reviewed 12 systematic reviews, 17 meta-analyses, 18 RCTs, 1 meta-regression, and 2 guidelines.    The body of evidence related to screening all adults and pregnant and post-partum women was of low to moderate quality. The body of evidence for establishing a follow-up plan was of high quality.  **Previous Submission:**  \*Please see 1.c.5 and 1c.6 at end of document for grading of recommendation for the ICSI guidelines which was provided in the previous submission |
| Estimates of benefit and consistency across studies | For the recommendation: “Clinicians should routinely screen all adults for depression using a standardized instrument,” ICSI determined that screening results in finding and treating more depressed patients, leading to better outcomes and improved functioning not only for depression, but also for other co-morbid conditions. There is also some evidence that screening may reduce overall, long-term medical costs for depressed patients (p. 14).  For the recommendation: “Clinicians should establish and maintain follow-up with patients,” ICSI determined that appropriate, reliable follow-up is highly correlated with improved response and remission scores. Follow-up is also correlated with the improved safety and efficacy of medications and helps prevent relapse (p. 50).  For the recommendation: “Clinicians should screen and monitor depression in pregnant and post-partum women,” ICSI determined that screening patients leads clinicians to find and treat more patients with depression. Furthermore, untreated prenatal depression is associated with negative pregnancy outcomes such as poor maternal self-care, poor nutrition, preterm labor, and low birth weight. Untreated prenatal depression is also associated with negative effects on children such as developmental delay and cognitive impairment (p. 122).  **Previous Submission:**  \*Please see 1c.7 at end of document for grading of recommendation for the ICSI guidelines which was provided in the previous submission |
| What harms were identified? | The only harms identified for all three recommendations were the cost of screening patients who are not depressed, and the potential additional cost of unnecessary follow-up visits (p. 14, p. 50, p. 122).  **Previous Submission:**  \*Please see 1c.8 at end of document for grading of recommendation for the ICSI guidelines which was provided in the previous submission |
| Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR? | We have not identified any additional new studies published since the release of this guideline that would change its conclusions.  The ICSI guideline is often based upon the USPSTF recommendations. The 2016 guideline is an update of the 2012 release, submitted in the previous submission The 2011 adolescent recommendations submitted in the previous submission are currently under review and being updated, but will likely be consistent with the USPSTF adolescent recommendations. |

**Previous Submission:**

Grade assigned to the **evidence** associated with the recommendation with the definition of the grade

**1c.13 Grade Assigned to the Body of Evidence:** Overall Evidence Grading: SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: improved recognition and diagnosis of depression, and improved depression outcomes, but not consistently high quality evidence. There is considerable and consistent patient-oriented research evidence, in addition to clinical recommendation statements, documenting the prevalence and burden of depression among adolescents, the importance of screening for depression among adolescents, and the availability of depression screening tools.

Provide all other grades and definitions from the evidence grading system

**1c.12 If other, identify and describe the grading scale with definitions:** The Strength of Recommendation Taxonomy (SORT)

An A-level recommendation is based on consistent and good-quality patient-oriented evidence; a B-level recommendation is based on inconsistent or limited-quality patient-oriented evidence; and a C-level recommendation is based on consensus, usual practice, opinion, disease oriented evidence, or case series for studies of diagnosis, treatment, prevention, or screening. The quality of individual studies is rated 1, 2, or 3; numbers are used to distinguish ratings of individual studies from the letters A, B, and C used to evaluate the strength of a recommendation based on a body of evidence.

Body of evidence:

* Quantity – how many studies?

**1.c.5 Quantity of Studies in the Body of Evidence** *(Total number of studies, not articles*)**:**

Numerous studies were reviewed in the body of the evidence. Refer to 1c.6 for details of studies within evidence. Evidence is annually reviewed through an environmental scan of the measure focus and target population. The measure specification’s rationale and clinical recommendation statements were reviewed and revised based on the current evidence found in the environmental scan.

For complete list of evidence with grading, refer to section 1c 15.

Quality – what type of studies?

**1c.6 Quality of Body of Evidence (***Summarize the certainty or confidence in the estimates of benefits and harms to patients across studies in the body of evidence resulting from study factors. Please address: a) study design/flaws; b) directness/indirectness of the evidence to this measure (e.g., interventions, comparisons, outcomes assessed, population included in the evidence); and c) imprecision/wide confidence intervals due to few patients or events*)**:** The articles in the body of evidence review numerous studies addressing the measure focus and/or target population. They are listed in detail below:

• Borner et al. 2010 is one study examining the potential use of the Patient Health Questionnaire (PHQ-2) screening instrument for depression in adolescents when seen by their primary care physician.

• Coyle et al. 2003 is a consensus statement in which the expert panel reviewed 104 studies including many randomized controlled trials and other studies to make recommendations about risk factors, diagnosis, treatment and services in children and adolescents with mood disorders.

• Dunn et al. 2012 is one study which evaluated the psychometric properties of an adapted version of the Modified Depression Scale among 9th-12th graders in Boston through a school-based survey. This article also reviewed and compared at least 15 randomized controlled trial results, measurement tool literature and numerous review articles.

• Feinberg et al. 2009 is one study in which 42 women were screened for maternal depression and reported gaps in care for postpartum women.

• Liberto 2012 is an integrated review of 35 articles (which included both quantitative and qualitative research studies) addressing literature on screening for depression and help-seeking behaviors by postpartum women during pediatric well-baby visits; to identify gaps in the literature relating to depression and help-seeking behaviors; and to discuss implications for practice and future research.

• Pratt et al. 2008 is a data brief with data derived from the National Health and Nutrition Examination Survey, 2005-2006 The report did reference at least four randomized controlled trials.

• Williams et al. 2009 is a systematic evidence review by the U.S. Preventive Services Task Force which included 4 systematic reviews/meta-analyses and 31 studies (including fair to good quality randomized, controlled trials)

• Healthy People 2020 are a comprehensive framework of evidence-based objectives and goals targeted to improve the health behaviors of a nation which references numerous high quality data sets and randomized controlled trials.

• U.S. Preventive Services Task Force 2009 is a recommendation statement in which the researchers reported results of multiple randomized trials studies and meta-analyses for each aspect of diagnosis, treatment and follow-up as well as additional research-based studies.

The body of evidence consists of a total of thirteen evidences (excluding the three clinical guidelines listed in evidence guideline recommendation section 1c.16-1c.24). Two evidences have SORT Study quality level 1: good-quality patient-oriented evidence (Liberto, 2012 & Williams et al., 2009), One evidence has a USPSTF Grade B and Grade C Recommendation (USPSTF, 2009). Eight evidences have SORT Study quality level 2: limited-quality patient-oriented evidence (Borner et al., 2010; Centers for Disease Control and Prevention, 2007; Dunn et al., 2012; Feinberg et al., 2009; Geriatric Mental Health Foundation, 2008;Pratt & Brody, 2008; Steinman et al., 2007; Unützer et al., 2009). Two evidences have SORT Study quality level 3: other evidence: guideline (U.S. Department of Health and Human Services, 2011; Coyle et al., 2003). The evidence bears directly on the importance, benchmarking, performance gaps and disparities of depression screening and follow-up in the outpatient setting and the potential reduction of negative outcomes with improved recognition and diagnosis of depression, and improved depression outcomes. Since the studies show consistently statistically significant effects, there are no issues of "imprecision/wide confidence intervals due to few patients or events".

Estimates of benefit and consistency across studies

**1c.7 Consistency of Results across Studies** *(Summarize the consistency of the magnitude and direction of the effect):* Consistency of results across studies: While the magnitude of the effects varies from study to study, the effects are consistently positive.

What harms were identified?

**1c.8 Net Benefit** *(Provide estimates of effect for benefit/outcome; identify harms addressed and estimates of effect; and net benefit - benefit over harms)***:**

Studies show consistent benefits while detecting no harm and yielding consistent net benefits.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1a.4 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.4.1** **Briefly SYNTHESIZE the evidence that supports the measure.** A list of references without a summary is not acceptable.

**1a.4.2 What process was used to identify the evidence?**

**1a.4.3.** **Provide the citation(s) for the evidence.**