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

**Measure Number** (*if previously endorsed*)**:** 1885

**Measure Title**: Depression Remission at Six Months

**IF the measure is a component in a composite performance measure, provide the title of the Composite Measure here:** Click here to enter composite measure #/ title

**Date of Submission**: Click here to enter a date

Please Note: Text in black is based on the original evidence form. Although the adult guideline language has been restructured for clarity, the evidence for this measure has not changed significantly since the previous endorsement, but we have added evidence that supports including adolescents in the measure and this new content is in redtext.

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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*): Click here to name the intermediate outcome

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.**

**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*).**

Adults:

Source: ICSI Guideline for Major Depression in Adults in Primary Care 17th edition March 2016

<https://www.icsi.org/_asset/fnhdm3/Depr.pdf>

Major depression is a treatable cause of pain, suffering, disability and death, yet primary care clinicians detect major depression in only one-third to one-half of their patients with major depression *(Williams Jr, 2002 ; Schonfeld, 1997).*

Usual care for depression in the primary care setting has resulted in only about half of depressed adults getting treated *(Kessler, 2005)* and only 20-40% showing substantial improvement over 12 *months (Unützer, 2002; Katon, 1999).*

Recommendations and algorithm notations supporting depression outcomes and duration of treatment according to ICSI’s Health Care Guideline:

**Recommendation:** Clinicians should establish and maintain follow-up with patients. Appropriate, reliable follow-up is highly correlated with improved response and remission scores. It is also correlated with the improved safety and efficacy of medications and helps prevent relapse. [Recommendation 7a page 50]

**Proactive follow-up contacts** (in person, telephone) based on the collaborative care model have been shown to significantly lower depression severity (Unützer, 2002). In the available clinical effectiveness trials conducted in real clinical practice settings, even the addition of a care manager leads to modest remission rates (Trivedi, 2006b; Unützer, 2002). Interventions are critical to educating the patient regarding the importance of preventing relapse, safety and efficacy of medications, and management of potential side effects. Establish and maintain initial follow-up contact intervals (office, phone, other) (Hunkeler, 2000; Simon, 2000).

**PHQ-9 as monitor and management tool.** The PHQ-9 is an effective management tool, as well, and should be used routinely for subsequent visits to monitor treatment outcomes and severity. It can also help the clinician decide if/how to modify the treatment plan (Duffy, 2008; Löwe, 2004). Using a measurement-based approach to depression care, PHQ-9 results and side effect evaluation should be combined with treatment algorithms to drive patients toward remission. A five-point drop in PHQ-9 score is considered the minimal clinically significant difference (Trivedi, 2009). Every time that the PHQ-9 is assessed, suicidality is assessed, as well. If the suicidality was indeed of high risk, urgent referral to crisis specialty health care is advised. In case of low suicide risk, the patient can proceed with treatment in the primary care practice (Huijbregts, 2013).

**Care Algorithm:** Has the patient reached remission? [Algorithm annotation 7b page 51]

The goals of treatment should be to achieve remission, reduce relapse and recurrence, and return to previous level of occupational and psychosocial function.

**Full remission** is defined as a two-month period devoid of major depressive signs and symptoms (American Psychiatric Association, 2013: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition). If using a PHQ-9 tool, remission translates to PHQ-9 score of less than 5 (Kroenke, 2001). Results from the STAR\*D study showed that remission rates lowered with more treatment steps, but the overall cumulative rate was 67% (Rush, 2006).

**Response** is defined as a 50% or greater reduction in symptoms (as measured on a standardized rating scale). Partial response is defined as a 25-50% reduction in symptoms. This definition is based on how the depression literature defines response.

**Response and remission take time.** In the STAR\*D study, longer times than expected were needed to reach response or remission. In fact, one-third of those who ultimately responded did so after six weeks.

Of those who achieved remission by Quick Inventory of Depressive Symptomatology (QIDS), 50% did so only at or after six weeks of treatment (Trivedi, 2006b). If the primary care clinician is seeing some improvement, continue working with that patient to augment or increase dosage to reach remission. This can take up to three months.

A reasonable criterion for extending the initial treatment: assess whether the patient is experiencing a 25% or greater reduction in baseline symptom severity at six weeks of therapeutic dose. If the patient's symptoms are reduced by 25% or more, but the patient is not yet at remission, and if medication has been well tolerated, continue to prescribe. Raising the dose is recommended (Trivedi, 2006b).

Improvement with psychotherapy is often a bit slower than with pharmacotherapy. A decision regarding progress with psychotherapy and the need to change or augment this type of treatment may require 8 to 10 weeks before evaluation (Schulberg, 1998).

**Care Algorithm:** Continuation and Maintenance Treatment Duration Based on Episode [Algorithm annotation 7c page 51]

Acute therapy is the treatment phase focused on treating the patient to remission. Acute therapy typically lasts 6-12 weeks but technically lasts until remission is reached (American Psychiatric Association, 2010). Full remission is defined as a two-month period devoid of major depressive signs and symptoms (American Psychiatric Association, 2013; Diagnostic and Statistical Manual of Mental Disorders, 5th Edition).

Continuation therapy is the four-to-nine month period beyond the acute treatment phase during which the patient is treated with antidepressants, psychotherapy, ECT or other somatic therapies to prevent relapse (American Psychiatric Association, 2010). Relapse is common within the first six months following remission from an acute depressive episode; as many as 20-85% of patients may relapse (American Psychiatric Association, 2010).

This measure assesses achievement of remission, which is a desired outcome of effective depression treatment and monitoring.

Adult Depression in Primary Care- Guideline Aims

* Increase the percentage of patients with major depression or persistent depressive disorder who have improvement in outcomes from treatment for major depression or persistent depressive disorder
* Increase the percentage of patients with major depression or persistent depressive disorder who have a follow-up to assess of response to treatment.
* Improve communication between the primary care physician and the mental health care clinician (if patient is co-managed).

Guidelines that Support the Relationship of the Health Outcome to Care Processes and Interventions for Adolescents:

American Academy of Child and Adolescent Psychiatry Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorders (2007)

<http://www.jaacap.com/article/S0890-8567(09)62053-0/pdf>

Recommendations supporting depression outcomes and duration of treatment according to AACAP guideline:

* Treatment of depressive disorders should always include an acute and continuation phase; some children may also require maintenance treatment. The main goal of the acute phase is to achieve response and ultimately full symptomatic remission (definitions below).
* Each phase of treatment should include psychoeducation, supportive management, and family and school involvement
* Education, support, and case management appear to be sufficient treatment for the management of depressed children and adolescents with an uncomplicated or brief depression or with mild psychosocial impairment
* For children and adolescents who do not respond to supportive psychotherapy or who have more complicated depressions, a trial with specific types of psychotherapy and/or antidepressants is indicated

Definitions:

**Response:** No symptoms or a significant reduction in depressive symptoms for at least 2 weeks

**Remission:** A period of at least 2 weeks and <2months with no or few depressive symptoms

**Recovery:** Absence of significant symptoms of depression (e.g., no more than 1 to 2 symptoms) for greater than 2 months

**Relapse:** A DSM episode of depression during the period of remission

**Recurrence:** The emergence of symptoms of depression during the period of recovery (a new episode)

Guidelines for Adolescent Depression in Primary Care (GLAD-PC) (2007)

<http://www.glad-pc.org/>

Guidelines for adolescent depression in primary care (GLAD-PC): II. Treatment and ongoing management

[www.pediatrics.org/cgi/content/full/120/5/e1313](http://www.pediatrics.org/cgi/content/full/120/5/e1313)

Recommendations supporting depression outcomes and duration of treatment according to GLAD-PC:

Recommendations for Ongoing Management of Depression:

* Mild depression: consider a period of active support and monitoring before starting other evidence based treatment
* Moderate or severe major clinical depression or complicating factors:
  + consultation with mental health specialist with agreed upon roles
  + evidence based treatment (CBT or IPT and/or antidepressant SSRI)
* Monitor for adverse effects during antidepressant therapy
  + clinical worsening, suicidality, unusual changes in behavior
* Systematic and regular tracking of goals and outcomes
  + improvement in functioning status and resolution of depressive symptoms
  + regardless of the length of treatment, all patients should be monitored on a monthly basis for 6 to 12 months after the full resolution of symptoms

*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.

**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*):

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

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

**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.*)

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

**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*):

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

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

**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.*)

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

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

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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*):

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

***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?**

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

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

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

**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*)

**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*)

**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*)

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

**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**.

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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?**

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