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

**Measure Number** (*if previously endorsed*)**:** 0105

**Measure Title**: Antidepressant Medication Management

**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

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| **Instructions**  *Complete 1a.1 and 1a.2 for all measures. If instrument-based measure, complete 1a.3.*  *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). |

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| **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:   * Outcome: [**3**](#Note3) Empirical data demonstrate a relationship between the outcome and at least one healthcare structure, process, intervention, or service. If not available, wide variation in performance can be used as evidence, assuming the data are from a robust number of providers and results are not subject to systematic bias. * 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. * For measures derived from patient reports, evidence should demonstrate that the target population values the measured outcome, process, or structure and finds it meaningful. * Process measures incorporating Appropriate Use Criteria: See NQF’s guidance for evidence for measures, in general; guidance for measures specifically based on clinical practice guidelines apply as well.   **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 Grading of Recommendations, Assessment, Development and Evaluation [(GRADE) guidelines](http://www.gradeworkinggroup.org) and/or modified GRADE.  **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

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: Continuation of antidepressant medications for people newly treated with medications

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.2** **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.

Measure continuation of antidepressant medication >> Identify people diagnosed with major depression who were recently prescribed an antidepressant medication >> Assess adherence to medication within the acute and continuation phases of treatment >> Identify people who are not continuing their pharmacotherapy >> Improve rates of relapse by focusing on improving adherence to antipsychotics for people who begin treatment >> Less episodes of major depression and lower morbidity

**1a.3** **Value and Meaningfulness:**  **IF** this measure is derived from patient report, provide evidence that the target population values the measured ***outcome, process, or structure*** and finds it meaningful. (Describe how and from whom their input was obtained.)

N/A

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

**1a.2** **FOR OUTCOME MEASURES including PATIENT REPORTED OUTCOMES - Provide empirical data demonstrating the relationship between the outcome (or PRO) to at least one healthcare structure, process, intervention, or service.**

N/A

**1a.3.****SYSTEMATIC REVIEW(SR) OF THE EVIDENCE (for intermediate outcome, PROCESS, or STRUCTURE PERFORMANCE measures, including those that are instrument-based) 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

***Table 1: Clinical Practice Guideline 1***

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| **Source of Clinical Practice Guideline:**   * **Title** * **Author** * **Date** * **Citation, including page number** * **URL** | * Practice guideline for the treatment of patients with major depressive disorder, third edition * American Psychiatric Association (APA) * October 2010. (The American Psychiatric Association reaffirmed the currency of the guideline in October 2015.) * American Psychiatric Association. Practice guideline for the treatment of patients with major depressive disorder, third edition. Arlington (VA): American Psychiatric Association; 2010 Oct. p. 152 * https://www.guideline.gov/summaries/summary/24158/Practice-guideline-for-the-treatment-of-patients-with-major-depressive-disorder-third-edition |
| 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. | ~~•“Successful treatment of patients with major depressive disorder is promoted by a thorough assessment of the patient and close adherence to treatment plans. Treatment consists of an acute phase, during which remission is induced; a continuations phase, during which remission is preserved; and a maintenance phase, during which the susceptible patients is protected against the recurrence of a subsequent major depressive episode.”~~  •“An antidepressant medication is recommended as an initial treatment choice for patients with mild to moderate major depressive disorder [I: Recommended with substantial clinical confidence] and definitely should be provided for those with severe major depressive disorder unless electroconvulsive therapy (ECT) is planned [I: Recommended with substantial clinical confidence].”  •Patients should be given a realistic notion of what can be expected during the different phases of treatment, including the likely time course of symptom response and the importance of adherence for successful treatment and prophylaxis [I].  •During the acute phase of treatment, patients should be  carefully and systematically monitored on a regular basis  to assess their response to pharmacotherapy, identify the  emergence of side effects (e.g., gastrointestinal symptoms,  sedation, insomnia, activation, changes in weight, and cardiovascular,  neurological, anticholinergic, or sexual side effects),  and assess patient safety [I].  •“During the continuation phase of treatment, the patient should be carefully monitored for signs of possible relapse [I: Recommended with substantial clinical confidence]. Systematic assessment of symptoms, side effects, adherence, and functional status is essential [I: Recommended with substantial clinical confidence], and may be facilitated through the use of clinician- and/or patient-administered rating scales [II: Recommended with moderate clinical confidence]. To reduce the risk of relapse, patients who have been treated successfully with antidepressant medications in the acute phase should continue treatment with these agents for 4–9 months [I: Recommended with substantial clinical confidence].” |
| Grade assigned to the **evidence** associated with the recommendation with the definition of the grade | “The type of evidence supporting the recommendations is not specifically stated.  In order for the reader to appreciate the evidence base behind the guideline recommendations and the weight that should be given to each recommendation, the summary of treatment recommendations is keyed according to the level of confidence with which each recommendation is made (see "Major Recommendations" field). Each rating of clinical confidence considers the strength of the available evidence. When evidence from randomized controlled trials and meta-analyses is limited, the level of confidence may also incorporate other clinical trials and case reports as well as clinical consensus with regard to a particular clinical decision.”  All recommendations above received a [I] grade (Recommended with substantial clinical confidence)  ~~The pharmacotherapy recommendations received a [I] grade (Recommended with substantial clinical confidence)~~ |
| Provide all other grades and definitions from the evidence grading system | N/A |
| Grade assigned to the **recommendation** with definition of the grade | Pharmacotherapy recommendations received a [I] grade (Recommended with substantial clinical confidence) |
| Provide all other grades and definitions from the recommendation grading system | APA RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATION  Each recommendation is identified as falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. The three categories represent varying levels of clinical confidence:  [I] Recommended with substantial clinical confidence.  [II] Recommended with moderate clinical confidence.  [III] May be recommended on the basis of individual circumstances. |
| Body of evidence:   * Quantity – how many studies? * Quality – what type of studies? | Quantity: Within the APA guideline, recommendations specific to pharmacotherapy adherence reference 4 randomized double-blind clinical trials, 1 clinical trial, and 1 qualitative review.  Here are some examples of the studies referenced by the APA guideline. One randomized double-blind trial (Keller, 1998) looked at 635 outpatients at 12 sites who met criteria for major depression. Another randomized double-blind trail (Keller, 2007) included 1096 outpatients who were offered two different types of antidepressants to examine the effect of mediation on the prevention of recurring depressive episodes. A meta-analysis (Hansen, 2008) was conducted of RCTs, meta-analyses and observational studies published between 1980 and 2007 and found an overall benefit to continuation and maintenance of antidepressant pharmacotherapy.  Quality: The APA Guideline recommends with substantial clinical confidence that people with mild to major depression should adhere to appropriate pharmacotherapy (antidepressants). |
| Estimates of benefit and consistency across studies | The benefit of adherence to antidepressant medications is a reduction in the recurrence rate of new episodes of depression. The guidelines and evidence note that pharmacotherapy is most effective when the physician identifies the most effective medication for each patient. This performance measure focuses on continuation of medication during the acute and continuation phases of treatment. Evidence suggests that physicians can help maximize the efficacy of medication treatment by monitoring the effects of the medication and the dosage.  Across included studies, guidelines agree that antidepressants are an effective way to treat people with major depression, if steps are taken to help patients adhere to their medications. |
| What harms were identified? | The guidelines and evidence note that pharmacotherapy is most effective when the physician identifies the most effective medication for each patient. The harms stem from a lack of adherence to medications. |
| Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR? | N/A |

***Table 2: Clinical Practice Guideline 2***

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| **Source of Clinical Practice Guideline:**   * **Title** * **Author** * **Date** * **Citation, including page number** * **URL** | * Management of Major Depressive Disorder in Adults in the Primary Care Setting * Department of Veterans Affairs, and Health Affairs, Department of Defense * May 2000 * Management of Major Depressive Disorder in Adults in the Primary Care Setting. Washington, DC: VA/DoD Evidence Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense; May 2000. Office of Quality and Performance publication 10Q-CPG/MDD-00. * <http://www.oqp.med.va.gov/cpg/MDD/MDD_Base.htm>      * VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder * The Department of Veterans Affairs and the Department of Defense * April 2016 * VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder. Washington, DC: VA/DoD Evidence-Based Practice Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense; April 2016. Office of Quality and Performance publication * https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf   NOTE: In 2009, the VA and DoD published a Clinical Practice Guideline (CPG) for the Management of Major Depressive Disorder (2009 MDD CPG), which was based on evidence reviewed through 2007. The current document is an update to the 2009 MDD CPG. The CPG states: “The MDD CPG Work Group focused largely on developing new and updated recommendations based on the evidence review conducted for the priority areas addressed by the key questions. In addition to those new and updated recommendations, the CPG Work Group considered the current applicability and relevance of the remaining recommendations that were made in the previous 2009 MDD CPG. While these remaining 2009 recommendations were reviewed by the group, the literature supporting these recommendations was not reviewed as part of a systematic literature search. Therefore, the determination of carrying forward or modifying these prior recommendations was based on expert opinion as well as on the evidence review from the previous version of the guideline. In order to be fully transparent, Appendix F [recommendation table] displays all the recommendations from the 2009 MDD CPG and the information regarding how 2009 recommendations were incorporated into the 2016 MDD CPG, including the recommendation category and the 2016 recommendation to which it corresponds, if applicable.”  We have included both the 2009 and 2016 grades/categories for each recommendation included below. |
| 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. | “When antidepressant pharmacotherapy is used, the following key messages should be given to enhance adherence to medication: [B: A recommendation that clinicians provide (the service) to eligible patients.]  •Most people need to be on medication for at least 6 to 12 months after adequate response  •It usually takes 2 to 6 weeks before improvements are seen  •Continue to take the medication even after feeling better  •Do not discontinue taking medications without first discussing with your provider”  1. “As first-line treatment for uncomplicated mild to moderate MDD, we recommend offering one of the following treatments based on patient preference, safety/side effect profile, history of prior response to a specific medication, family history of response to a medication, concurrent medical illnesses, concurrently prescribed medications, cost of medication and provider training/competence:  •Evidence-based psychotherapy:  • Acceptance and commitment therapy (ACT)  • Behavioral therapy/behavioral activation (BT/BA)  • Cognitive behavioral therapy (CBT)  • Interpersonal therapy (IPT)  • Mindfulness-based cognitive therapy (MBCT)  • Problem-solving therapy (PST)  •Evidence-based pharmacotherapy:  • Selective serotonin reuptake inhibitor (except fluvoxamine)(SSRIs)  • Serotonin–norepinephrine reuptake inhibitor (SNRIs)  • Mirtazapine  • Bupropion  • The evidence does not support recommending a specific evidence-based psychotherapy or pharmacotherapy over another.” [2009 Evidence Grade: A, B. 2016 Grade: Strength: Strong For, Category: Reviewed, New-replaced]  2. We suggest offering a combination of pharmacotherapy and evidence-based psychotherapy for the treatment of patients with MDD during a new episode of care when the MDD is characterized as:  • Severe (i.e., PHQ-9 >20)  • Chronic (duration greater than two years)  • Recurrent (with three or more episodes)”  [2009 Evidence Grade: A. 2016 Grade: Strength: Weak For, Category: Reviewed, New-replaced]  3. “In patients who have demonstrated partial or no response to initial pharmacotherapy monotherapy (maximized) after a minimum of four to six weeks of treatment, we recommend  switching to another monotherapy (medication or psychotherapy) or augmenting with a second medication or psychotherapy.” [2009 Evidence Grade: None. 2016 Grade: Strength: Strong For, Category: Reviewed, New-replaced]  4. “After initiation of therapy or a change in treatment, we recommend monitoring patients at least monthly until the patient achieves remission. At minimum, assessments should include a measure of symptoms, adherence to medication and psychotherapy, and emergence of adverse effects.” [2009 Evidence Grade: C, B. 2016 Grade Strength: Strong For, Category: Reviewed, Amended] |
| Grade assigned to the **evidence** associated with the recommendation with the definition of the grade | ~~Pharmacotherapy continuation receive an [A] grade~~  Note: As explained above, the evidence review for these recommendations is from the 2009 CPG. The evidence was graded using the USPSTF evidence grading system.  1. 2009 Evidence Review Grade: A- a strong recommendation that the clinicians provide the intervention to eligible patients. Good evidence was found that the intervention improves important health outcomes and concludes that benefits substantially outweigh harm.; B- a recommendation that clinicians provide (the service) to eligible patients. At least fair evidence was found that the intervention improves health outcomes and concludes that benefits outweigh harm.  2. 2009 Evidence Review Grade: A- a strong recommendation that the clinicians provide the intervention to eligible patients. Good evidence was found that the intervention improves important health outcomes and concludes that benefits substantially outweigh harm.  3. Evidence not graded.  4. 2009 Evidence Review Grade: B- a recommendation that clinicians provide (the service) to eligible patients. At least fair evidence was found that the intervention improves health outcomes and concludes that benefits outweigh harm.; C- no recommendation for or against the routine provision of the intervention is made. At least fair evidence was found that the intervention can improve health outcomes, but concludes that the balance of benefits and harms is too close to justify a general recommendation. |
| Provide all other grades and definitions from the evidence grading system | D: Recommendation is made against routinely providing the intervention to asymptomatic patients.  At least fair evidence was found that the intervention is ineffective or that harms outweigh benefits. |
| Grade assigned to the **recommendation** with definition of the grade | Note: As explained above, the recommendation grade (including both a “strength” and “category”) for these recommendations was updated in the 2016 CPG, while the evidence was reviewed in 2009.  1. 2016 Grade: Strength: Strong For, Category: Reviewed, New-replaced. The CPG recommends offering this option for care. Recommendation from previous CPG that has been carried over to the updated CPG that has been changed following review of the evidence.  2. 2016 Grade: Weak For, Category: Reviewed, New-replaced. The CPG suggests offering this option for care. Recommendation from previous CPG that has been carried over to the updated CPG that has been changed following review of the evidence.  3. 2016 Grade: Strength: Strong For, Category: Reviewed, New-replaced. The CPG recommends offering this option for care. Recommendation from previous CPG that has been carried over to the updated CPG that has been changed following review of the evidence.  4. 2016 Grade Strength: Strong For, Category: Reviewed, Amended. The CPG recommends offering this option for care. Recommendation from the previous CPG that has been carried forward to the updated CPG where the evidence has been reviewed and a minor amendment has been made |
| Provide all other grades and definitions from the recommendation grading system | ~~VA/DOD RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATION~~  ~~A: A strong recommendation that the clinicians provide the intervention to eligible patients.~~  ~~Good evidence was found that the intervention improves important health outcomes and concludes that benefits substantially outweigh harm.~~  ~~B: A recommendation that clinicians provide (the service) to eligible patients.~~  ~~At least fair evidence was found that the intervention improves health outcomes and concludes that benefits outweigh harm.~~  ~~C: No recommendation for or against the routine provision of the intervention is made.~~  ~~At least fair evidence was found that the intervention can improve health outcomes, but concludes that the balance of benefits and harms is too close to justify a general recommendation.~~  ~~D: Recommendation is made against routinely providing the intervention to asymptomatic patients.~~  ~~At least fair evidence was found that the intervention is ineffective or that harms outweigh benefits.~~  ~~I: The conclusion is that the evidence is insufficient to recommend for or against routinely providing the intervention.~~  ~~Evidence that the intervention is effective is lacking, or poor quality, or conflicting, and the balance of benefits and harms cannot be determined.~~  The relative strength of the recommendation is based on a binary scale, “Strong” or “Weak.” A strong recommendation indicates that the Work Group is highly confident that desirable outcomes outweigh undesirable outcomes. If the Work Group is less confident of the balance between desirable and undesirable outcomes, they present a weak recommendation.  Similarly, a recommendation for a therapy or preventive measure indicates that the desirable consequences outweigh the undesirable consequences. A recommendation against a therapy or preventive measure indicates that the undesirable consequences outweigh the desirable consequences.  Using these elements, the grade of each recommendation is presented as part of a continuum:  • Strong For (or “We recommend offering this option …”)  • Weak For (or “We suggest offering this option …”)  • Weak Against (or “We suggest not offering this option …”)  • Strong Against (or “We recommend against offering this option …”)  Additional Recommendation Categories and Definitions  • Reviewed- New-added: New recommendation following review of the evidence  • Reviewed- Not changed: Recommendation from previous CPG that has been carried forward to the updated CPG where the evidence has been reviewed but the recommendation is not changed  • Reviewed- Deleted: Recommendation from the previous CPG that has been removed based on review of the evidence  • Not reviewed- Not changed: Recommendation from previous CPG that has been carried forward to the updated CPG, but for which the evidence has not been reviewed  • Not reviewed- Deleted: Recommendation from the previous CPG that has been removed because it was deemed out of scope for the updated CPG |
| Body of evidence:   * Quantity – how many studies? * Quality – what type of studies? | The VA/DOD guideline cited 2 RCTs, 2 systematic reviews, and 1 clinical study. In the VA/DOD guideline, several of the same RCTs were cited as the APA and ICSI guidelines. One of the systematic review (Vergouwen et al., 2003) examined antidepressant medication adherence, and found that collaborative care approaches consistently enhanced adherence during both the acute and continuation phase of treatments, as well as led to improved clinical benefits. |
| Estimates of benefit and consistency across studies | The benefit of adherence to antidepressant medications is a reduction in the recurrence rate of new episodes of depression. The guidelines and evidence note that pharmacotherapy is most effective when the physician identifies the most effective medication for each patient. This performance measure focuses on continuation of medication during the acute and continuation phases of treatment. Evidence suggests that physicians can help maximize the efficacy of medication treatment by monitoring the effects of the medication and the dosage.  Across included studies, guidelines agree that antidepressants are an effective way to treat people with major depression, if steps are taken to help patients adhere to their medications. |
| What harms were identified? | The guidelines and evidence note that pharmacotherapy is most effective when the physician identifies the most effective medication for each patient. The harms stem from a lack of adherence to medications. |
| Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR? | N/A |

***Table 3: Clinical Practice Guideline 3***

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| **Source of Clinical Practice Guideline:**   * **Title** * **Author** * **Date** * **Citation, including page number** * **URL** | * Institute for Clinical Systems Improvement. Major Depression in Adults in Primary Care * Trangle, M., et al. * May 2012 * Trangle M, Dieperink B, Gabert T, Haight B, Lindvall B, Mitchell J, Novak H, Rich D, Rossmiller D, Setter¬lund L, Somers K. Institute for Clinical Systems Improvement. Major Depression in Adults in Primary Care.http://bit.ly/Depr0512. Updated May 2012. * Institute for Clinical Systems Improvement: Recommendations for the Diagnosis and Treatment of Major Depression in Adults in Primary Care * Trangle, M., et al. * March 2016 * Trangle M, Gursky J, Haight R, Hardwig J, Hinnenkamp T, Kessler D, Mack N, Myszkowski M. Adult depression in primary care. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2016 Mar. 131 p. [394 references] * https://guideline.gov/summaries/summary/50406/adult-depression-in-primary-care?q=Depression+Adult+in+Primary+Care |
| 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. | 1. “For patients with chronic major depression, start with combined antidepressant medication and psychotherapy.” (Quality of Evidence: High; Strength of Recommendation: Strong)  •“Antidepressant medications and/or referral for psychotherapy are recommended as treatment for major depression. Factors to consider in making treatment recommendations are symptom severity, presence of psychosocial stressors, presence of comorbid conditions, and patient preferences. Physical activity and active patient engagement are also useful in easing symptoms of major depression.  2. “Before initiating treatment, it is important to establish a therapeutic alliance with the patient regarding diagnosis and treatment options (in which there is overlap in the patient's and clinician's definition of the problem and agreement on which steps are to be taken by each).” (Quality of Evidence: Low; Strength of Recommendation: Strong)  3. “Clinicians should establish and maintain follow-up with patients.” (Quality of Evidence: High; Strength of Recommendation: Strong)  •If the primary care provider is seeing incremental improvement, continue working with that patient to increase medication dosage or augment with psychotherapy or medication to reach remission. This can take up to three months. Don't give up on the patient whether treating in primary care or referring. Studies have shown that primary care can be just as successful as specialty care.  - For medication treatment, patients may show improvement at two weeks but need a longer length of time to really see response and remission. Most people treated for initial depression need to be on medication at least 6-12 months after adequate response to symptoms. Patients with recurrent depression need to be treated for three years or more.” |
| Grade assigned to the **evidence** associated with the recommendation with the definition of the grade | ~~“Guideline” grade~~  Evidence is reviewed using Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology. The work group then reaches consensus and categorizes evidence into the following categories for use in the guideline:  High: Further research is very unlikely to change confidence in the estimate of effect.  Low: Further research is very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate or any estimate of effect is very uncertain. |
| Provide all other grades and definitions from the evidence grading system | Moderate Quality Evidence: Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate. |
| Grade assigned to the **recommendation** with definition of the grade | 1 and 3: High Quality Evidence with Strong Recommendation: 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.  2: Low Quality Evidence with Strong Recommendation: 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. |
| Provide all other grades and definitions from the recommendation grading system | ~~ICSI RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATION~~  ~~GRADE Methodology~~  High Quality Evidence with Weak Recommendation: 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.  Moderate Quality Evidence with Strong Recommendation: 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.  Moderate Quality Evidence with Weak Recommendation: The work group recognizes that there is a balance between harms and benefit, 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.  Low Quality Evidence with Weak Recommendation: The work group recognizes that there is significant uncertainty about the best estimates of benefits and harms. |
| Body of evidence:   * Quantity – how many studies? * Quality – what type of studies? | Frequently refers to APA guideline. The ICSI guideline includes 3 studies showing high level evidence (GRADE rating), 1 systematic review, and 5 studies showing low level evidence (GRADE rating), The three studies demonstrating high level evidence were RCTs that looked at the impact of adherence on relapse with various numbers of participants (386, 153, and 386 respectively). One of the five studies showing low level of evidence was an observational study that looked at a total of 4,052 patients with major depression and the effect of antidepressant maintenance on relapse rates. |
| Estimates of benefit and consistency across studies | With regards to initiating treatment, the cited evidence found consistency across studies that “antidepressant treatment with psychotherapy outperforms either treatment as monotherapy and more rapidly begins the process of reversing symptoms, suffering and functional impairment in a condition that can go on for decades untreated. Psychotherapy can produce quality-of-life improvements and lower health and human services costs.”  With regards to follow-up with patients in treatment, the cited evidence found consistency across studies that “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.” |
| What harms were identified? | With regards to initiating treatment, “Combined medication and psychotherapy increase short-term costs. Access to high-quality psychotherapy is not available in many primary care settings. In a 2000 study of chronic major depression, which excluded pure dysthymic disorder, the overall drop-out rate was the same for the three treatment groups, but reasons for dropping out varied. More patients dropped out of the medication-alone arm because of adverse events, and more psychotherapy patients withdrew consent because therapy was too time consuming, they did not want psychotherapy, or they wanted medication. This highlights the need to consider patient preferences. The benefits of psychotherapy are delayed and may cause some patients to give up on it prematurely.”  Potential harms associated with proper follow-up care with patients in treatment may include added expense and unnecessary visits. However, “Benefits appear to outweigh potential harms by a wide margin.” |
| Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR? | N/A |

***Table 4: Meta-Analysis 1***

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| **Source of Meta-Analysis:**   * **Title** * **Author** * **Date** * **Citation, including page number** * **URL** | * Antidepressant Drug effects and Depression Severity: A Patient Level Meta-Analysis * Fournier, J., et al. * January, 2010 * Fournier, J.C., et al. 2010. Antidepressant drug effects and depression severity: A patient-level meta-analysis. JAMA 303(1): 47-53. * https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3712503/pdf/nihms483345.pdf |
| 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. | This meta-analysis concluded that, among studies comparing the relative benefit of antidepressant medication vs placebo in the treatment of major or minor depressive disorder, the magnitude of superiority increased as baseline severity of depression increased, as measured by the Hamilton Rating Scale for Depression. |
| Grade assigned to the **evidence** associated with the recommendation with the definition of the grade | The evidence was not graded |
| Provide all other grades and definitions from the evidence grading system |  |
| Grade assigned to the **recommendation** with definition of the grade | The evidence was not graded |
| Provide all other grades and definitions from the recommendation grading system |  |
| Body of evidence:   * Quantity – how many studies? * Quality – what type of studies? | The sample consisted of participants from five randomized placebo-controlled trials of an FDA approved antidepressant in the treatment of Major or Minor Depressive Disorder (five major depressive disorder, one minor depression). The pooled sample for the analysis included 434 patients in the antidepressant medication (ADM) group and 284 patients in the placebo group. |
| Estimates of benefit and consistency across studies | Across the data from the included studies, this meta-analysis found “the efficacy of ADM treatment for depression varies  considerably as a function of symptom severity.” The results suggest that for mild and moderate depression baseline symptoms, ADM treatment may not demonstrate significant results when compared to placebo. The study builds off earlier work by Zimmerman et al., that suggests Hamilton Depression Rating Scale scores of 18-20 are appropriate for ADM, and instead finds that baseline scores of 25 and over show a significant ADM drug-placebo difference. |
| What harms were identified? | No harms were identified. Patients who initiated treatment with ADM with baseline scores below 25 demonstrated nonexistent-to-negligible drug effects. |
| Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR? | None identified. |

***Table 5: Meta-Analysis 2***

|  |  |
| --- | --- |
| **Source of Meta-Analysis:**   * **Title** * **Author** * **Date** * **Citation, including page number** * **URL** | * Antidepressants for treatment of depression in primary care: a systematic review and meta-analysis. * Arroll, B., et al. * December 2016. * Arroll, B., et al. 2016. Antidepressants for treatment of depression in primary care: a systematic review and meta-analysis. J Prim Health Care. 8(4): 325-334. * https://www.ncbi.nlm.nih.gov/pubmed/29530157 |
| 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. | “This study updates the Cochrane review by including newer antidepressant classes and calculating numbers needed to treat (NNTs) for individual drugs where data were available. There was evidence to support the effectiveness of tricyclic antidepressants (TCAs) and serotonin selective reuptake inhibitors (SSRIs) when compared to placebo, and evidence of efficacy for serotonin–norepinephrine reuptake inhibitor (SNRIs) and noradrenergic and specific serotonergic antidepressant (NaSSA).” |
| Grade assigned to the **evidence** associated with the recommendation with the definition of the grade | The evidence was not graded |
| Provide all other grades and definitions from the evidence grading system |  |
| Grade assigned to the **recommendation** with definition of the grade | The evidence was not graded |
| Provide all other grades and definitions from the recommendation grading system |  |
| Body of evidence:   * Quantity – how many studies? * Quality – what type of studies? | The final review included 17 randomized control trials. Selection criteria included antidepressant studies with a randomly assigned  placebo group where half or more subjects were recruited from primary care. |
| Estimates of benefit and consistency across studies | The authors discuss consistency across medication-to-placebo studies that conclude antidepressants are effective for patients in primary care with depression. |
| What harms were identified? | No harms were identified. |
| Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR? | N/A |

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**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.*

~~Studies found outside guidelines: 2 RCTs; 1 systematic review; 1 meta analysis; 2 fact sheets; 1 qualitative review; 2 prospective studies; 1 survey study; 1 case study. One of the RCT study (Rost, 2001) looked at 479 adult patients from 12 primary care practices to identify primary care practices that improved adherence to medication for new episodes of depression. The referenced meta-analysis (Fournier, 2010) identified randomized placebo-controlled trials that examined whether antidepressant medication represented effective treatment for people with major depression and found substantial evidence to support pharmacotherapy.~~

Studies found outside guidelines: 2 RCTs; 1 qualitative reviews; 2 prospective studies; 2 survey studies; 1 case study; and 1 fact sheet. One RCT study (Rost, 2001) looked at 479 adult patients from 12 primary care practices to identify primary care practices that improved adherence to medication for new episodes of depression.

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

The body of evidence found that the use and adherence of antidepressants were associated with better outcomes for people in terms of lower rates of relapse and lower rates of new episodes of major depression. The evidence and the focus of this measure, adherence to antidepressants for people with major depression, are directly related.

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

A targeted literature review was conducted to identify evidence.

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

Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry 2005;62:617–627

Burcusa, S.L., W.G. Iacono. 2007. Risk for recurrence in depression. Clin Psychol Rev 27(8): 959-85.

Melartin, T.K., H.J. Rytsala, U.S. Leskela, P.S. Lestela-Mielonen, T.P. Sokero, E.T. Isometsa. 2005. Continuity is the main challenge in treating major depressive disorder in psychiatric care. J Clin Psychiatry 66(2):220-7.

Johnston, K., W. Westerfield, S. Momim, R. Phillipi. 2009. The direct and indirect costs of employee depression, anxiety, and emotional disorders—An employer case study. J of Occ and Envt Med 51(5): 564-77.

Katon W, Russo, J, Von Korff M, et al. Long-term effects of a collaborative care intervention in persistently depressed primary care patients. J Gen Intern Med. 2002;17:741-748.

Rost K, Nutting P, Smith J, et al. Improving depression outcomes in the community primary care practice: a randomized trial of the quest intervention. Quality Enhancement by Strategic Teaming. J Gen Intern Med. 2001;16:143-149.

Simon, G.E. 2002. Evidence review: efficacy and effectiveness of antidepressant treatment in primary care. Gen Hosp Psychiatry 24(4):213-24.

Stewart, W.F., J.A. Ricci, E. Chee, S.R. Hahn, D. Morganstein. 2003. Cost of lost productive work time among US workers with depression. JAMA 289(23):3135-44.

The National Alliance on Mental Illness. 2009. Major Depression Fact Sheet. http://www.nami.org/Template.cfm?Section=Depression&Template=/ContentManagement/ContentDisplay.cfm&ContentID=88956 (October 27, 2011)