Client: HMSA: PQSR 2007

Measure Title: TREATMENT OF MAJOR DEPRESSION

Disease State: Depression

Indicator Category: Disease Management

Strength of Recommendation: A

Clinical Intent: To ensure that all eligible members diagnosed with major depression receive appropriate follow-up treatment and/or services.

Physician Specialties: Refer to PQSR 2007 Specialty Matrix

Clinical Rationale: Disease Burden

- Major depression is a common and very disabling disorder with extensive social, medical, and economic impact. Of the estimated 17.5 million Americans who are affected by some form of depression, 9.2 million have major or clinical depression.[1]
- The World Health Organization identified major depression as the fourth leading cause of worldwide disease in 1990, causing more disability than either ischemic heart disease or cerebrovascular disease.[2]
- In 2001-02, more than one in ten non-institutionalized adult Americans were estimated to have had a major depressive disorder at some point in their lifetime, with 6.6% having a major depressive disorder during the past 12 months.[3]
- Despite the potential risks and widely available evidence-based clinical guidelines, data suggest that many patients are not being managed optimally. For example, less than one quarter of all adults diagnosed with depression receive treatment.[4]
- Between 1995-96 and 2001-02, the adult antidepressant visit rate (i.e., the number of visits with an antidepressant drug per 100 persons aged 18 and over) increased from 17 to 28 per 100 adults.[5]

Reason for Indicated Intervention or Treatment

- Treatment (pharmacotherapy, counseling, or pharmacotherapy AND counseling) for depression is associated with a reduction in depression symptoms and suicide rates as well as improved functioning and health status.[6-9]

Evidence supporting Intervention or Treatment

- Using at least a 50% improvement in depressive symptoms as an outcome, a meta-analysis of 81 trials comparing newer anti-depressants and placebos involving more than 10,000 adults with major depression in the outpatient setting undergoing acute phase treatment found that relative to placebo, treatment was more effective (relative benefit 1.6, [CI 1.5 10 1.7]).[10]
- Again using at least a 50% improvement in depressive symptoms as an outcome, a meta-analysis of 150 trials comparing newer anti-depressants to older antidepressants involving more than 16,000 adults found no difference between these categories (relative benefit 1.0 [CI 0.97 to 1.06]).[10]
- Overall, multiple studies have concluded that the evidence does not support favoring one class of antidepressant medication over another based on clinical outcomes, quality of life outcomes, or overall treatment costs.[5, 11-
• A recent meta-analysis suggested that a combination of psychotherapy and pharmacotherapy is more effective than pharmacotherapy alone. Combination therapy may be particularly useful in improving treatment adherence.[17]

• A randomized controlled trial of 240 outpatients compared the efficacy in moderate to severe depression of antidepressant medications with cognitive therapy in a placebo-controlled trial. At 8 weeks, response rates in medications (50%) and cognitive therapy (43%) groups were both superior to the placebo (25%) group. At 16 weeks, response rates were 58% in each of the active conditions; remission rates were 46% for medication, 40% for cognitive therapy. Cognitive therapy was found to be comparable but less effective than medication, and the degree of effectiveness may depend on a high level of therapist experience or expertise.[9]

• An analysis of National Vital Statistics from the Centers for Disease Control and Prevention in all U.S. counties found that increases in prescriptions for selective serotonin reuptake inhibitors (SSRIs) and other new-generation non-SSRIs are associated with lower suicide rates both between and within counties over time and may reflect antidepressant efficacy, compliance, a better quality of mental health care, and low toxicity in the event of a suicide attempt by overdose.[1, 4]

• A multicenter randomized control trial of 18 primary care clinics compared 1,801 elderly patients (age 60 and older) receiving the intervention protocol treatment of depression (pharmacotherapy or counseling) versus usual primary care treatment of depression. Intervention patients experienced significantly better physical functioning at one year than usual-care patients as measured using between-group differences on the PCS of 1.71 (95% confidence interval (CI)=0.96-2.46) and IADLs of -0.15 (95% CI=-0.29 to -0.01). Intervention patients were also less likely to rate their health as fair or poor (37.3% vs 52.4%, P<.001).[3]

Clinical Recommendations

• The American Psychiatric Association treatment recommendations for major depressive disorder state that successful treatment requires a thorough assessment while treatment options include a number of medications, a variety of psychotherapeutic approaches, electroconvulsive therapy (ECT), and other treatment modalities (e.g., light therapy) that may be used alone or in combination.[5, 18]

• The Institute for Clinical Systems Improvement (ICSI) guideline for treatment of adult major depression supports a range of treatment plans, including psychotherapy, and pharmacotherapy. The ICSI guidelines state that “For antidepressant medications, adherence to a therapeutic dose and meeting clinical goals are more important than the specific drug selected.”[19]

Source

Health Benchmarks, Inc. adapted this measure using components from the 2007 HEDIS measure “Antidepressant Medication Management” and a published algorithm for using administrative data to identify patients with depression.[20]

Denominator

Continuously enrolled members ages 19 years or older by the end of the measurement year who had a diagnosis of major depression at least once in an inpatient setting or twice in an outpatient or emergency room setting in the year starting 90 days prior to the start of the measurement year.
Relevant Billing Codes:

**Denominator**

*Exclusion*

Members with an acute mental health or substance abuse inpatient stay during the 1-90 days after the index date (exclusive of the index date).

**Numerator**

Members who had evidence of treatment or follow-up for depression consisting of either a prescription for an antidepressant medication (0-90 days after the index date), an outpatient encounter in which depression was evaluated, or counseling with a mental health specialist during the 1-90 days after the index date.
Interpretation of Score

High score implies better performance

Physician Attribution

Score all physicians (in the selected specialties) who saw the member during the 0-90 days after the index date.

References

17. Pampallona, S., et al., Combined pharmacotherapy and psychological


<table>
<thead>
<tr>
<th>Indicator Classification</th>
<th>Measures applicable to patients receiving diagnostic workups for a symptom or condition that delineate appropriate laboratory or radiological testing to be performed (e.g. evaluation of thyroid nodule; pregnancy test in patients with vaginal bleeding or abdominal pain)</th>
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</thead>
<tbody>
<tr>
<td>Effective of Care</td>
<td>Measures applicable to asymptomatic individuals that are designed to prevent the onset of the targeted condition (e.g. immunizations).</td>
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<tr>
<td>Prevention</td>
<td>Measures applicable to asymptomatic patients who have risk factors or pre-clinical disease, but in whom the condition has not become clinically apparent (e.g. pap smears; screening for elevated blood pressure).</td>
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<tr>
<td>Screening</td>
<td>Measures applicable to individuals diagnosed with a condition that are part of the treatment or management of the condition (e.g. cholesterol reduction in patients with diabetes; radiation therapy following breast conserving surgery; appropriate follow-up after acute event).</td>
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<tr>
<td>Disease Management</td>
<td>Measures applicable to patients taking medications with narrow therapeutic windows and/or potential preventable significant side effects or adverse reactions (e.g. thyroid stimulating hormone (TSH) testing after levothyroxine dose change; hepatic enzyme monitoring for patients using antimycotic pharmacotherapy).</td>
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<tr>
<td>Medication Monitoring</td>
<td>Measures applicable to patients taking medications for chronic conditions that are designed to assess patient adherence to medication (e.g. adherence to lipid lowering medication).</td>
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<tr>
<td>Medication Adherence</td>
<td>Measures applicable to patients receiving treatment for a symptom or condition that advocate appropriate utilization of laboratory and pharmaceutical resources (e.g. conservative use of imaging for low back pain; inappropriate use of antibiotics for viral upper respiratory infection).</td>
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Strength of Recommendation Based on a Body of Evidence

FIGURE 2. Algorithm for determining the strength of a recommendation based on a body of evidence (applies to clinical recommendations regarding diagnosis, treatment, prevention, or screening). While this algorithm provides a general guideline, authors and editors may adjust the strength of recommendation based on the benefits, harms, and costs of the intervention being recommended. (USPSTF = U.S. Preventive Services Task Force)