

Measure Title COMPLIANCE WITH ANTI-DEPRESSANT THERAPY DURING THE ACUTE PHASE OF ILLNESS

Disease State Major Depression **Indicator Classification¹** Patient Adherence

Strength of Recommendation² A Treatment for Depression
 B Physician Impact on Adherence

Physician Specialties Family Practice, Gerontology, Internal Medicine, Psychiatry

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 evidenced 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]
- NCQA data shows that in 2004 only 60.7% of eligible patients received the recommended continuity of supply of their pharmacotherapy after a new episode of depression.[5]

Reason for Indicated Intervention or Treatment

- A range of pharmacological treatments are available that are cost effective, feasible, and efficacious in either the primary care or specialty mental health care setting.[6-10]
- Effective treatment can reduce and/or eliminate depression symptoms [11], improve health-related quality of life [12], and, improve occupational performance and productivity among people with MDD.[13]
- Up to 50 percent of patients will stop their antidepressant within the first month of initiating treatment.[14]
- 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.[6]

Evidence supporting Intervention or Treatment

- Two randomized controlled trials of over 350 primary care patients newly diagnosed with depression comparing usual care to a collaborative care intervention consisting of: increased intensity and frequency of visits over

the first 4 to 6 weeks of treatment (visits 1 and 3 with a primary care physician, visits 2 and 4 with a mental health specialist); continued surveillance of adherence to medication regimens during the continuation and maintenance phases of treatment; and videotaped and written patient education materials found more patients in the intervention with adequate dosages of antidepressant medication at 90 days. (75.5 vs. 50.0%, $p < 0.01$ and 69.6 vs. 39.5 %, $p < 0.01$).[15, 16]

- A randomized controlled trial of 250 primary care patients with depression comparing usual care to medication adherence counseling by a nurse found counseling increased adherence (OR 2.7, 95% CI 1.6-4.8).[17]
- A randomized controlled trial of 163 primary care practices and 407 patients comparing usual care to a depression management program including: education for patients delivered by physician, educational video and booklet for patients, continuing medical education for physicians on evidenced based depression treatment, care management from a mental health worker, and psychiatrist support found greater adherence to treatment among those patients in the intervention group (69.3 vs. 18.5 % of patients filled at least three prescriptions, $p < 0.001$).[18]
- Revealing the difficulty of influencing patient behavior, a handful of collaborative care studies have found no impact of interventions designed to improve adherence[19]. A randomized controlled trial of 302 primary care patients comparing usual care to an nurse telehealth care program in which nurses provided regular telephone support to patients and emphasized the importance of medication adherence found no difference in medication adherence. (73.0 vs. 80.0% at 6 weeks, $p = 0.17$ and at 54.0 vs. 56.0 % 6 months, $p = 0.74$).[20]
- Randomized, controlled trials have shown that active outreach and follow-up lead to improved outcomes for major depression. [21-24]
- Other studies have demonstrated the feasibility of this type of intervention. [25-27]
- Randomized, controlled trials have shown that collaborative care programs that involve enhanced patient education (via pamphlets and videotapes) and integration of several psychiatric visits into the primary care treatment of patients with depression significantly enhanced outcomes compared with usual care.[15, 28]
- No well designed trials have specifically evaluated the ability of physician counseling (without other collaborative care components) to impact adherence to antidepressant therapy.
- A recent Cochrane Database meta-analysis of studies aimed at improving medication adherence (not specifically focused on depression treatment) found that almost all of the interventions that were effective for long-term care were complex, including combinations of more convenient care, information, reminders, self-monitoring, reinforcement, counseling, family therapy, and other forms of additional supervision or attention by a health care provider (physician, nurse, pharmacist or other).[29]

Clinical Recommendations

- In an effort to address the issue of poor adherence, the Institute for Clinical Systems Improvement guidelines for Major Depressive Disorder treatment recommend that physicians can improve adherence by emphasizing to their patients: 1) when and how often to take the medicine; 2) the need for at least 2-4 weeks of treatment before beneficial effects may be noticed; 3) the need to take medication even

after feeling better; 4) the need to consult with the doctor before discontinuing medication; and 5) what to do if problems or questions arise. ICSI Guidelines state that “For antidepressant medications, adherence to a therapeutic dose and meeting clinical goals are more important than the specific drug selected.” [30]

- The American College of Physicians clinical guidelines suggest that both older and newer classes of antidepressant medications are effective in treating major depression, and that anti-depressant medication should be continued at the same dose for at least 4 months beyond initial recovery or improvement to decrease the probability of short term relapse.[31]
- The American Psychiatric Association practice guideline for the treatment of patients with major depressive disorder suggests that “when pharmacotherapy is part of the treatment plan, it must be integrated with psychiatric management and any other treatments being provided... Patients who have started taking antidepressant medication should be carefully monitored to assess their response to pharmacotherapy as well as the emergence of side effects, clinical condition and safety... Factors to consider in determining the frequency of patient monitoring include severity of illness, the patient’s cooperation with treatment, the availability of social supports, and the presence of comorbid general medical conditions. Visits should also be frequent enough to monitor and address suicidality and to promote treatment adherence. In practice, the frequency of monitoring during the acute phase of pharmacotherapy can vary from once a week in routine cases to multiple times per week in more complex cases.”[32] A 2005 update to these guidelines again emphasized the efficacy of both psychotherapy and pharmacotherapy. [33]

Source	Adapted from the Health Plan Employer Data and Information Set (HEDIS®) 2006 Technical Specification
Denominator	Continuously enrolled members ages 18 years or older as of the 120 th day of the measurement year, who were newly diagnosed with major depression and who began antidepressant therapy during the one year period beginning 245 days prior to the start of the measurement year.
Denominator Exclusion	Members with a prior history of depression, antidepressant medication, or an acute mental health/substance abuse inpatient stay during the 245 days after the index episode start date.
Numerator	<p>Members who filled a sufficient number of separate prescriptions/refills of antidepressant medication to provide continuous treatment for at least 84 days following the index prescription date (who had enough medication to cover at least 84 out of 114 days following the index diagnosis date).</p> <p>Continuous treatment is defined to allow gaps in medication up to a total of 30 days during the 84-day period. Allowable medication changes or gaps include a period gap to change medication or treatment gaps to refill the same medication.</p> <p>Regardless of the number of gaps, the total number of gap days may be no more than 30 days.</p> <p>To determine continuity of treatment during the 84-day period, sum the number of gap days to the number of treatment days for a maximum of 114 days (i.e. 84</p>

treatment days + 30 gap days = 114 days). For all prescriptions filled within 114 days after the index prescription date, the treatment days should be counted beginning with the index prescription and continue until a total of 84 treatment days have been established. Members whose gap days exceed 30 or who do not have 84 treatment days within 114 days after the index prescription date will not be counted in the numerator.

Interpretation of Score

High score implies better performance.

Physician Attribution

Score all physicians (in the selected specialties) who saw the member during the reporting year.

External Files Required for Analysis

Antidepressants_medlist_2006.xls
Source: NCQA website
Updated Annually

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¹ **Indicator Classification** (Adapted from Health Plan Employer Data Information Set (HEDIS®) technical specifications)

Diagnosis	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)
Effectiveness of Care	
Prevention	Measures applicable to asymptomatic individuals that are designed to prevent the onset of the targeted condition (e.g. immunizations).
Screening	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).
Disease Management	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).
Medication Monitoring	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)
Medication Adherence	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).
Utilization	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).

Strength of Recommendation Based on a Body of Evidence

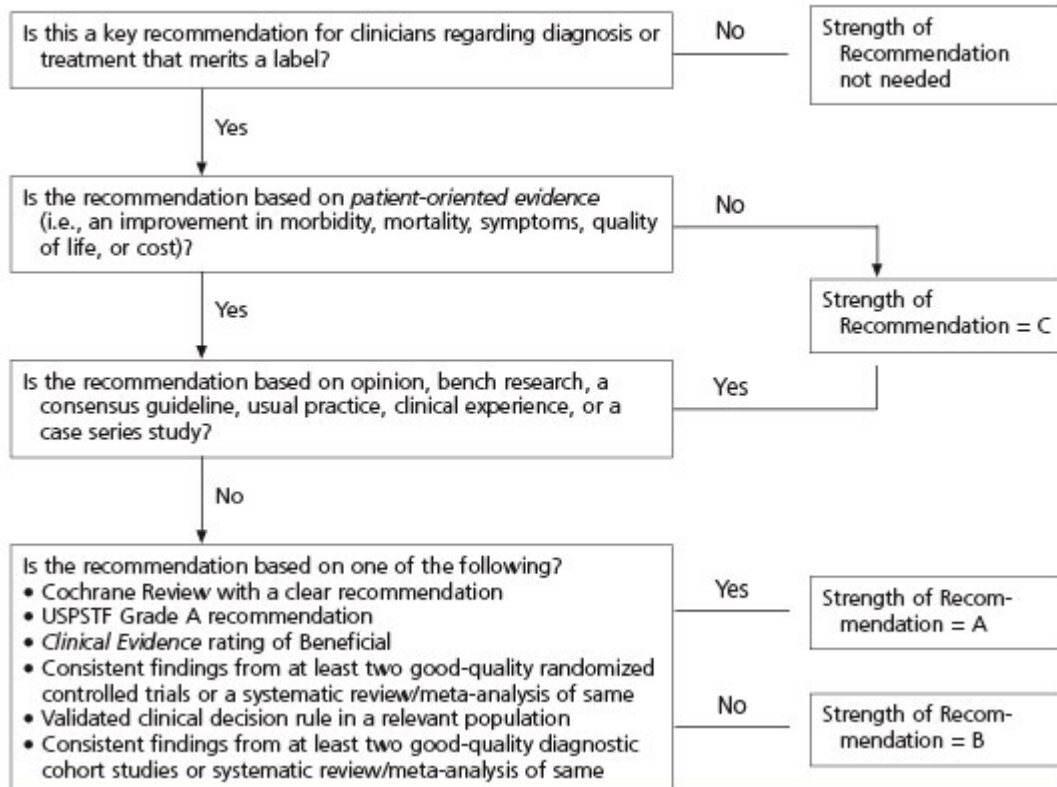


FIGURE 2. Algorithm for determining the strength of a recommendation based on a body of evidence (applies to clinical recommendations regarding diagnosis, treatment, prevention, or screening). While this algorithm provides a general guideline, authors and editors may adjust the strength of recommendation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