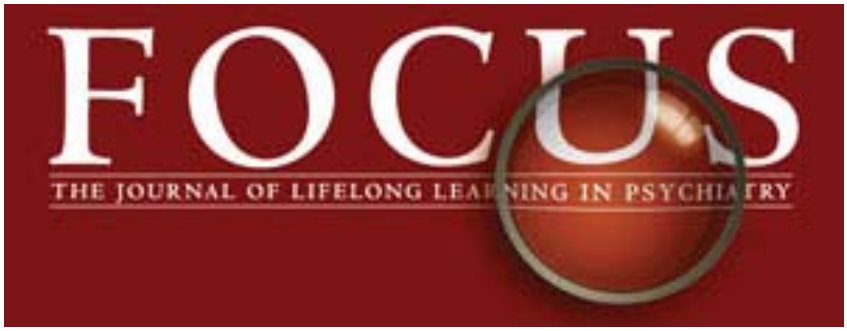

Performance in Practice: Sample Tools for the Care of Patients with Major Depressive Disorder

Free – 5 hours of CME credit for completing the PIP survey

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To earn CME credit for this Survey Program, psychiatrists should use the Sample Real Time Performance in Practice Tool (Appendix B) as indicated. After using the performance in practice tool, participants should fully complete the survey on page 35 and send the survey page by mail to APA CME 1000 Wilson Boulevard, Suite 1825 Rosslyn VA 22209, or fax to 703 907 7849, or send by email to educme@psych.org.

Target Audience
Psychiatrists treating patients with major depressive disorder, psychiatrists preparing for recertification.

Learning Objective
After completion of this activity psychiatrists will have the foundation for subsequent performance improvement initiatives aimed at enhancing outcomes for patients with major depressive disorder.

Accreditation Statement
The APA is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Designation Statement
APA designates this educational activity for a maximum of 5 *AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

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Abstract: To facilitate continued clinical competence, the American Board of Medical Specialties and the American Board of Psychiatry and Neurology are implementing multi-faceted Maintenance of Certification programs, which include requirements for self-assessments of practice. Because psychiatrists may want to gain experience with self-assessment, two sample performance-in-practice tools are presented that are based on recommendations of the American Psychiatric Association's Practice Guideline for the Treatment of Patients with Major Depressive Disorder. One of these sample tools provides a traditional chart review approach to assessing care; the other sample tool presents a novel approach to real-time evaluation of practice. Both tools can be used as a foundation for subsequent performance improvement initiatives that are aimed at enhancing outcomes for patients with major depressive disorder.

Psychiatrists, like other medical professionals, are confronted by a need to maintain specialty specific knowledge despite an explosion in the amount of new information and the ongoing demands of clinical practice. Given these challenges, it is not surprising that researchers have consistently found gaps between actual care and recommended best-practices (1–10). In attempting to enhance the quality of delivered care, a number of approaches have been tried with varying degrees of success. Didactic approaches, including dissemination of written educational materials or practice guidelines, produce limited behavioral change (11–19). Embedding of patient-specific reminders into routine care can lead to benefits in specific quality measures (11, 13–16, 20–23) but these improvements may be narrow in scope, limited to the period of intervention or unassociated with improved patient outcomes (24–27). Receiving feedback after self or peer-review of practice patterns may also produce some enhancements in care (13–15, 23, 28–30). Given the limited effects of the above approaches when implemented alone, the diverse practice styles of physicians and the multiplicity of contexts in which care is delivered, a combination of quality improvement approaches may be needed to improve patient outcomes (14, 19, 28, 29, 31–34).

With these factors in mind, the American Board of Medical Specialties and the American Board of Psychiatry and Neurology are implementing multi-faceted Maintenance of Certification (MOC) Programs that include requirements for self-assessments of practice through reviewing the care of at least 5 patients (35). As with the original impetus to create specialty board certification, the MOC programs are intended to enhance quality of patient care in addition to assessing and verifying the competence of medical practitioners over time (36, 37). Although the MOC phase-in schedule will not require completion of a Performance in Practice (PIP) unit until 2014 (35), individuals may wish to begin assessing their own practice patterns before

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Table 1. Aspects of Major Depressive Disorder Treatment Addressed by Sample Performance-In-Practice Tools

Recommendation	Source of Recommendation[1]	Performance Tool[2]
Identify signs and symptoms of depression	MDD PG	A, B, PCPI
Assess suicidal ideation, plans and intent	MDD PG; SB PG	A, B, PCPI
Identify past or current symptoms of mania or hypomania	MDD PG; BP PG	A, B
Identify past and current substance use disorders, including nicotine, alcohol and other substances	MDD PG; SUD PG; SB PG	A, B
Identify other past and current co-occurring psychiatric disorders	MDD PG	A, B
Identify past and current general medical conditions	MDD PG	A, B
Use treatments that are concordant with practice guideline recommendations (see Appendix A).	MDD PG	A, B, PCPI
Integrate treatment of any substance use disorders or other co-occurring psychiatric disorders with treatment for MDD	MDD PG; SUD PG; SB PG	A, B
Provide education to patients/families about depression and its treatment	MDD PG	A, B
Consider factors such as age, sex, ethnicity, cultural or religious beliefs in planning treatment	MDD PG	B
Assess the patient's level of functioning in social, occupational and other important realms	MDD PG	B
Determine whether cognitive impairment is present	MDD PG	B
Determine whether aggressive behavior is present	SB PG	B
Determine whether suicide attempts or other self-harming behaviors are present	MDD PG; SB PG	B
Determine the degree of adherence to treatment	MDD PG	B
Determine if side effects of treatment are present and, if so, which ones	MDD PG	B

[1] Source of Recommendation: MDD PG= Practice Guideline for the Treatment of Patients with Major Depressive Disorder (38); SUD PG= Practice Guideline for the Treatment of Patients with Substance Use Disorders (61); BP PG = Practice Guideline for the Treatment of Patients with Bipolar Disorder (42); SB PG = Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors (62)
[2] Performance Tool: A = Sample retrospective PIP tool of Appendix A; B = Sample prospective PIP tool of Appendix B; PCPI = Major depressive disorder measures of the American Medical Association Physician Consortium for Performance Improvement (63)

that time. To facilitate such self-assessment related to the treatment of depression, this paper will discuss several approaches to reviewing one's clinical practice and will provide sample PIP tools that are based on recommendations of the American Psychiatric Association's Practice Guideline for the Treatment of Patients with Major Depressive Disorder (38).

Traditionally, most quality improvement programs have focused on retrospective assessments of practice at the level of organizations or departments (39). The Healthcare Effectiveness Data and Information Set (HEDIS) measures of the National Committee for Quality Assurance (NCQA) (40) are a commonly used group of quality indicators that measure health organization performance. When used under such circumstances, quality indicators are typically expressed as a percentage that reflects the extent of adherence to a particular indicator. For example, in the quality of care measures for bipolar disorder (41) derived from the American Psychiatric Association's 2002 Practice Guideline for the Treatment of Patients with Bipolar Disorder (42), one of the indicators is that "Patients in an acute depressive episode of bipolar disorder who are treated with antidepressants, [are] also receiving an antimanic agent such as valproate or lithium." In this example, to calculate the percentage of patients for whom the indicator is fulfilled, the numerator will be the "Number of patients in an acute depressive episode of bipolar disorder, who are receiving an antidepressant, and who are also receiving an

anti-manic agent such as valproate or lithium." and the denominator will be the "Number of patients in an acute depressive episode of bipolar disorder who are receiving an antidepressant" (41).

As in the above example, most quality indicators are derived from evidence-based practice guidelines, which are intended to apply to typical patients in a population rather than being universally applicable to all patients with a particular disorder (43, 44). In addition, practice guideline recommendations are mainly informed by data from randomized controlled trials. Patients in such trials may have significant differences from those seen in routine clinical practice (45), including clinical presentation, preference for treatment, response to treatment, and presence of co-occurring psychiatric and general medical conditions (43, 46, 47). These differences may result in treatment decisions for individual patients that are clinically appropriate but not concordant with practice guideline recommendations.

When quality indicators are used to compare individual physicians' practice patterns, quality measures can be influenced by practice size, patients' sociodemographic factors and illness severity as well as other practice-level and patient-level factors. For example, when small groups of patients are receiving care from an individual physician, a small shift in the number of individuals receiving a recommended intervention could lead to large shifts in the resulting rates of concordance with evidence-based care. Without appropriate application of case-mix adjustments, across-practice comparisons may result in erroneous conclusions about the quality of care being delivered (48, 49). For patients with complex conditions or multiple disorders receiving simultaneous treatment, composite measures of overall treatment quality may yield more accurate appraisals than measurement of single quality indicators (50–52).

With the above caveats, however, use of retrospective quality indicators can be beneficial for individual physicians who wish to assess their own patterns of practice. If a physician's self-assessment identified aspects of care that frequently differed from key quality indicators, further examination of practice patterns would be helpful. Through self-assessment, the physician may determine that deviations from the quality indicators are justified, or he may acquire new knowledge and modify practice to improve quality. It is this sort of self-assessment and performance improvement efforts that the MOC PIP program is designed to foster.

Appendices A and B provide sample PIP tools, each of which is designed to be relevant across clinical settings (e.g., inpatient, outpatient), straightforward to complete and usable in a pen-and-paper format to aid adoption. Although the MOC program requires review of at least 5 patients as part of each PIP unit, it is important to note that larger samples will provide more accurate estimates of quality within a practice. Appendix A provides a sample retrospective chart review PIP tool that assesses the care given to patients with major depressive disorder. Although it is designed as a self-assessment tool, this form could also be used for retrospective peer-review initiatives. As with other retrospective chart review tools, some questions on the form relate to the initial assessment and treatment of the patient whereas other questions relate to subsequent care. Appendix B provides a prospective review form that is intended to be a cross-sectional assessment and could be completed immediately following a patient visit. As currently formatted, Appendix B is designed to be folded in half to allow real-time feedback based upon answers to the initial practice-based questions. This approach is more typical of clinical decision support systems that provide real-time feedback on the concordance between guideline recommendations and the individual patient's care. In the future, the same data recording and feedback steps could be implemented via a web-based or electronic record system enhancing integration into clinical workflow (53). This will make it more likely that psychiatrists will see the feedback as interactive, targeted to their needs and clinically relevant. Rather than relying on more global changes in practice patterns to enhance individual patients' care, such feedback also provides the opportunity to adjust the treatment plan of an individual patient to improve patient-specific outcomes (54–56). However, data from this form could also be used in aggregate to plan and implement broader quality improvement initiatives. For example, if self-assessment using the sample tools suggests that signs and symptoms of depression are inconsistently assessed, consistent use of more formal rating scales such as the PHQ-9 (57–59) could be considered.

Each of the sample tools attempts to highlight aspects of care that have significant public health implications (e.g., suicide, obesity, use of tobacco and other substances) or for which gaps in guideline adherence are common. Examples include underdetection and undertreatment of co-occuring substance use disorders (5) and the relatively low concordance with practice guideline recommendations for use of psychosocial therapies and for treatment of psychotic features with MDD (4). Table 1 summarizes specific aspects of care that are measured by these sample PIP tools. Quality improvement suggestions that arise from completion of these sample

tools are intended to be within the control of individual psychiatrists rather than dependent upon other health care system resources.

After using one of the sample PIP tools to assess the pattern of care given to a group of 5 or more patients with major depressive disorder, the psychiatrist should determine whether specific aspects of care need to be improved. For example, if the presence or absence of co-occurring psychiatric disorders has not been assessed or if these disorders are present but not addressed in the treatment plan, then a possible area for improvement would involve greater consideration of co-occurring psychiatric disorders, which are common in patients with MDD.

These sample PIP tools can also serve as a foundation for more elaborate approaches to improving psychiatric practice as part of the MOC program. If systems are developed so that practice-related data can be entered electronically (either as part of an electronic health record or as an independent web-based application), algorithms can suggest areas for possible improvement using specific, measurable, achievable, relevant and time-limited objectives (60). Such electronic systems could also provide links to journal or textbook materials, clinical practice guidelines, patient educational materials, drug-drug interaction checking, evidence based tool kits or other clinical materials. In addition, future work will focus on developing more standardized approaches to integrating patient and peer feedback with personal performance review, developing and implementing programs of performance improvements and reassessment of performance and patient outcomes.

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NOTES

Appendix A. Sample Retrospective Chart Review Performance-in-Practice Tool for the Care of Patients with Major Depressive Disorder

Instructions: Choose 5 patients with a primary diagnosis of major depressive disorder. If the answer to a given question is "Yes", place a check mark in the appropriate box. If the answer to the question is "No" or "Unknown", leave the box unchecked. After reviewing the charts of all 5 patients, complete the final column to determine the relative proportion of patients to whom the recommendation was followed. Any rows for which the total is <2 may be a useful focus for quality improvement efforts.

Guideline recommendation being reviewed	Patient					Number of patients with checkmark in row?
	#1	#2	#3	#4	#5	
Did the initial evaluation assess:						
Signs/symptoms of major depression:	☐	☐	☐	☐	☐	_/5
Suicidal ideation/plans/intent	☐	☐	☐	☐	☐	_/5
Substance use/abuse/dependence						
Nicotine	☐	☐	☐	☐	☐	_/5
Alcohol	☐	☐	☐	☐	☐	_/5
Other substances	☐	☐	☐	☐	☐	_/5
Presence/absence of general medical conditions	☐	☐	☐	☐	☐	_/5
Presence/absence of other co-occurring psychiatric disorders	☐	☐	☐	☐	☐	_/5
History of hypomanic or manic episodes	☐	☐	☐	☐	☐	_/5
Referring to the chart on the reverse side, was treatment concordant with guideline recommendations:						
During the initial acute phase of treatment?	☐	☐	☐	☐	☐	_/5
At the time of the chart review (if the treatment plan differs from that in the initial phase of treatment)?	☐	☐	☐	☐	☐	_/5
Has the treatment plan addressed:						
Patient education about illness/treatments	☐	☐	☐	☐	☐	_/5
Co-occurring substance use disorders	☐	☐	☐	☐	☐	__/__ (# applicable)
Other co-occurring psychiatric disorders	☐	☐	☐	☐	☐	__/__ (# applicable)

Appendix A. (continued) Recommendations for APA Practice Guideline Concordant Treatment of Major Depressive Disorder

Acute Phase of Treatment
(focused on inducing symptom remission)

Clinical presentation	Guideline treatment will include:
Mild MDD (minor functional impairment, few symptoms beyond those required for diagnosis)	Antidepressant therapy alone OR Psychotherapy alone[1] OR Combined treatment with psychotherapy[1] and antidepressant medication[2] (if preferred by patient)
Moderate MDD (greater degree of functional impairment, some symptoms beyond those required for diagnosis)	Antidepressant therapy alone OR Psychotherapy alone[1] OR Combined treatment with psychotherapy[1] and antidepressant medication[2] OR Electroconvulsive therapy (if preferred by the patient and depression is chronic)
Severe MDD (marked interference with social or occupational function; several symptoms in excess of those required for diagnosis)	Antidepressant therapy alone OR Combined treatment with psychotherapy[1] and antidepressant medication[2] OR Electroconvulsive therapy (if preferred by the patient, if the patient has responded preferentially to ECT in the past or if rapid treatment response is essential)
MDD with psychotic features	Combined treatment with an antidepressant and an antipsychotic medication OR Electroconvulsive therapy
MDD with catatonic features	Benzodiazepines OR Electroconvulsive therapy

Continuation Phase of Treatment
(focused on preserving symptom remission over the 16 to 20 weeks after the acute phase of treatment)

If acute phase treatment included:	Guideline concordant treatment will include:
Psychotherapy	Continued psychotherapy
Antidepressant medication	Antidepressant medication of a comparable dose to that used for acute treatment
Electroconvulsive therapy (ECT)	Pharmacotherapy or psychotherapy; continuation ECT is an acceptable alternative if pharmacotherapy or psychotherapy have not preserved remission in past

Maintenance Phase of Treatment
(focused on protecting against recurrence of major depressive episodes)

If treatment to prevent depressive recurrence is indicated[3] and acute treatment included:	Guideline concordant treatment will include:
Psychotherapy	Continued psychotherapy, with a decrease in visit frequency generally occurring if cognitive behavioral therapy or interpersonal therapy are used
Antidepressant medication	Antidepressant medication, generally at a comparable dose to that used for acute treatment
Electroconvulsive therapy (ECT)	Pharmacotherapy or psychotherapy; maintenance ECT may be considered if pharmacotherapy or psychotherapy have not preserved remission in past

[1] The presence of significant psychosocial stressors, intrapsychic conflict, interpersonal difficulties, co-occurring personality disorders or poor adherence with treatment may add to the rationale for treating with psychotherapy.
[2] In patients who have experienced only partial response to adequate trials of medications or psychotherapy alone, combination treatment may be considered.
[3] Indications for maintenance phase treatment are based upon risk of recurrence (including consideration of number of prior episodes; presence of co-occurring conditions; residual symptoms between episodes), severity of episodes (including consideration of suicidal ideas and behaviors; psychotic features; severe functional impairments), side effects experienced during continuation therapy, or patient preferences.

Appendix B. Sample "Real-Time" Performance-in-Practice Tool for Patients with Depression

This "real time" PIP tool is intended to be a prospective cross-sectional assessment that could be completed immediately following a patient visit. As currently formatted, the tool is designed to be folded in half to allow real-time feedback based upon answers to initial practice based questions. Up to 5 hours additional CME credit can be earned through use of the PIP tool and completion of the survey.

Patient Characteristics: Age: ☐			Sex: ☐	
Estimated duration of depressive illness:				
Length of time in treatment for current depressive episode:				
Which of the following is the patient experiencing?				To establish a diagnosis of depression, at least 5 of these symptoms need to be experienced nearly every day over a two week period (with one of the symptoms being either depressed mood or loss of interest or pleasure). However, other symptom assessment intervals may be appropriate when monitoring the presence or absence of symptoms over time. If associated symptoms of depression are not routinely assessed (as indicated by multiple boxes on the left that are checked as unassessed or unknown), consider using a standardized tool for assessing and recording depressive symptoms such as the PHQ-9.
	Yes	No	Unknown	
Little interest or pleasure in doing things?	☐	☐	☐	
Feeling down, depressed, or hopeless?	☐	☐	☐	
Trouble falling or staying asleep, or sleeping too much?	☐	☐	☐	
Feeling tired or having little energy?	☐	☐	☐	
Poor appetite or overeating?	☐	☐	☐	
Negative feelings about self?	☐	☐	☐	
Trouble concentration?	☐	☐	☐	
Psychomotor retardation or agitation?	☐	☐	☐	
Thoughts of suicide, self-harm, or being better off dead?	☐	☐	☐	
If the patient has thoughts of suicide, self-harm or being better off dead, was there a specific inquiry into:				When patients are experiencing thoughts of suicide, self-harm or of being better off dead, more detailed questioning is crucial. The presence of suicide plans or intent indicates a significant increase in suicide risk. An intention to use a highly lethal suicide method (e.g., guns, hanging, jumping) will also confer an increase in suicide risk. When a suicide method is identified, the accessibility of the method is an additional part of the inquiry.
Suicide plans	Yes ☐		No ☐	
Suicide intent	Yes ☐		No ☐	
Suicide methods	Yes ☐		No ☐	
Is the patient experiencing clinically significant distress or impairment in social, occupational, or other important areas of functioning that is a change from their baseline level of function?	Yes ☐	No ☐	Unknown ☐	The presence of clinically significant distress or functional impairment is one of the criteria used in making a diagnosis of depression. In addition to being a primary focus of patients and their families, functional impairment is a major determinant of illness related disability and should be routinely assessed. Distress and impairment are equally important to assess in examining response to treatment. If clinically significant distress or functional impairment are present, consider whether a change in treatment plan is indicated. Depending on the duration of treatment and persistence of symptoms, consideration may be given to changing a medication dose, modifying or adding a psychosocial treatment, changing or adding a medication, or revising the primary diagnosis.

Appendix B. Sample "Real-Time" Performance-in-Practice Tool for Patients with Depression (p. 2 of 6)

Current Depressive Diagnosis:				In establishing a diagnosis of depression, it is essential to determine whether the patient has had multiple depressive episodes or only a single episode of depression as this will have implications for treatment planning. It is also important to identify other co-occurring psychiatric disorders as part of the initial assessment. Such disorders are common in depressed patients and need to be considered in planning care.
Other Psychiatric Diagnoses: Anxiety disorder(s):	Current	Past	Unknown	
	☐	☐	☐	
Nicotine dependence	☐	☐	☐	
Alcohol use disorder:	☐	☐	☐	
Other substance use disorder:	☐	☐	☐	
Personality disorder:	☐	☐	☐	
Other:	☐	☐	☐	
Other psychiatric issues:				The presence of psychotic symptoms in a depressed patient will generally necessitate treatment with an antipsychotic and an antidepressant medication or with ECT.
Psychosis	☐	☐	☐	
Impaired cognition	☐	☐	☐	Cognitive impairment may be associated with depression, medication side effects or other underlying causes. It can also influence adherence with treatment and patient safety.
Problematic use of alcohol or other substances (not meeting criteria for a substance use disorder diagnosis)	☐	☐	☐	Use of alcohol or other substances can be problematic in depressed patients and can influence treatment response and suicide risk even in the absence of a substance use disorder.
Additional psychiatric history:	Yes	No	Unknown	
Hospitalizations	☐	☐	☐	A history of hospitalization, suicide attempts or other self-harming behaviors is relevant in estimating suicide risk. The presence or absence of aggressive behaviors can also be important to risk assessment.
Suicide attempts	☐	☐	☐	
Other self-harming behaviors	☐	☐	☐	
Aggressive behavior	☐	☐	☐	
Mania/Hypomania	☐	☐	☐	If not specifically assessed, manic or hypomanic episodes may not be reported. The treatment of a depressive episode may need to be modified if Bipolar I or Bipolar II disorder is identified, as use of an antidepressant in bipolar patients may be associated with occurrence of hypomanic or manic episodes.
				If any of the aspects of psychiatric diagnosis, symptoms or history on this page are not routinely assessed, increasing rates of assessment may be a useful goal for performance improvement.

Appendix B. Sample "Real-Time" Performance-in-Practice Tool for Patients with Depression (p. 3 of 6)

General Medical Conditions (including side effects of meds):	Yes	No	Unknown	
Hypertension	☐	☐	☐	When present, general medical conditions and their treatments can contribute to depressive symptoms or require adjustments in medication doses. Medications prescribed for psychiatric disorders can interact with those for general medical conditions and can produce side effects in various organ systems (e.g., renal or thyroid difficulties with lithium, seizures with clozapine and other psychotropic medications, glucose dysregulation and hyperlipidemia with second generation antipsychotic medications). In addition, individuals with psychiatric illnesses may be at increased risk of acquiring general medical conditions (e.g., HIV and Hepatitis C acquired through intravenous substance use, cardiovascular and respiratory conditions through smoking). Weight gain is common with psychiatric medications and obesity contributes to morbidity and mortality. Sleep apnea can be an unrecognized complication of obesity that can be exacerbated by sedating medications.
Cardiovascular disorders	☐	☐	☐	
Asthma/COPD	☐	☐	☐	
Renal disorders	☐	☐	☐	
Hepatic disorders	☐	☐	☐	
Infectious diseases (e.g., HIV, Hepatitis C)	☐	☐	☐	
Thyroid disease	☐	☐	☐	
Seizure disorder	☐	☐	☐	
Sleep apnea	☐	☐	☐	If general medical conditions and medication related side effects are not being routinely identified, this may be a useful focus of performance improvement efforts
Obesity	☐	☐	☐	
Diabetes	☐	☐	☐	
Hyperlipidemia	☐	☐	☐	
Other:	☐	☐	☐	
If obesity is present, is the patient's weight being monitored?				
	Yes ☐		No ☐	Given the rise in obesity as a public health problem and the common occurrence of weight gain with psychotropic medications, monitoring of weight and recommendations about weight control strategies are increasingly relevant elements of treatment planning.
have nutrition and exercise been discussed?				
	Yes ☐		No ☐	
If the patient has current general medical conditions, has contact been made with the patient's primary care physician?				Collaborating with other clinicians is an important part of psychiatric management. When a patient has a current general medical condition, communication with the patient's primary care physician may be indicated.
	Yes ☐		No ☐	
Current non-psychiatric medication(s)	Dose	Frequency	Route	Knowledge of medications that patients are receiving for treatment of non-psychiatric disorders is important in looking for potential drug-drug interactions and interpreting reported side effects of treatment. Such information can also alert the clinician to the presence of general medical conditions that may not have been reported by the patient (e.g., hypertension, hyperlipidemias) or to side effects of treatment that may require changes in medications or medication doses.

Appendix B. Sample "Real-Time" Performance-in-Practice Tool for Patients with Depression (p. 4 of 6)

Current psychiatric medication(s)	Dose	Frequency	Route	
				Knowledge of medications that patients are receiving for treatment of psychiatric disorders is important in assessing the patient's response to treatment and interpreting reported side effects of treatment. In reviewing the list of the patient's current medications, infrequently administered medications (e.g., long-acting injectable antipsychotic medications) should not be overlooked. If the patient has residual symptoms, assess the adequacy of the medication dose and determine if changes in medication, medication dose or concomitant psychosocial therapy are indicated.

Has the potential for drug-drug interactions been assessed for the patient's current medication regimen? Yes ☐ No ☐ N/A ☐	Many psychotropic medications are metabolized through the cytochrome P450 and uridine 5′-diphosphate glucuronosyl-transferase enzyme systems, have high degrees of binding to plasma proteins or act on the P-glycoprotein transporter in the gastrointestinal tract. Consequently, there are many opportunities for clinically relevant drug-drug interactions to occur when patients are receiving psychotropic medications. If identification of potential drug-drug interactions is not routinely done, this may be a useful focus for performance improvement.
If any of the patient's medications require laboratory monitoring (e.g., medication blood levels, evaluation of side effects), has this been performed? Yes ☐ No ☐ N/A ☐	Specific medications may also require blood level monitoring or other follow-up laboratory testing to assess for the presence of side effects. If such monitoring is indicated but sometimes overlooked, this may also be a useful focus for performance improvement initiatives.
Is each medication essential? Yes ☐ No ☐	Continued use of non-essential medications increases costs as well as side effects and drug-drug interactions. With the fragmentation of health care, medications that were intended to be tapered may have been continued inadvertently. As a result, patients may be taking multiple medications of the same class without evidence in the literature that this improves outcomes. Regular review of patients' medication regimens may help determine which medications are essential (and should not be stopped) and which may be able to be tapered and discontinued.

Other somatic treatment approaches:

	Current	Past	Unknown	
Electroconvulsive therapy	☐	☐	☐	The current and past use of other somatic treatment approaches is relevant to treatment planning as well as to assessment of therapeutic responses and treatment-related side effects. Inquiring about past experiences with these treatments is sometimes overlooked as part of the evaluation of patients with depression.
Vagal nerve stimulation therapy	☐	☐	☐	
Other:	☐	☐	☐	

Appendix B. Sample "Real-Time" Performance-in-Practice Tool for Patients with Depression (p. 5 of 6)

Psychosocial treatments used (by psychiatrist or other clinicians):	Current	Past	Unknown	
Psychodynamic psychotherapy	☐	☐	☐	The current and past use of psychosocial treatment approaches is relevant to treatment planning as well as to assessment of therapeutic responses. Inquiring about past experiences with these treatments is sometimes overlooked as part of the evaluation of patients with depression. If the past and current use of psychosocial treatments is not routinely assessed, this may be a useful focus for performance improvement. If psychosocial treatments are being provided by other clinicians, it will be crucial to collaborate with these clinicians in the care of the patient.
Cognitive psychotherapy	☐	☐	☐	
Behavioral psychotherapy	☐	☐	☐	
Interpersonal psychotherapy	☐	☐	☐	
Supportive psychotherapy	☐	☐	☐	
Education about illness or treatment	☐	☐	☐	
Medication management	☐	☐	☐	
Self-management approaches	☐	☐	☐	
Other:	☐	☐	☐	
In reviewing the psychosocial treatment approaches that are being used:				If psychosocial treatment approaches are infrequently utilized as part of the treatment of depressed patients, this might prompt a review of typical treatment planning approaches. If the psychosocial treatments being employed do not adequately address core symptoms or residual symptoms, modifications in the patient's plan of treatment may be indicated depending upon factors such as the type and duration of treatment.
Does the treatment approach adequately target core symptoms? Yes ☐ No ☐				
Are modifications needed to address residual symptoms? Yes ☐ No ☐				
Estimated degree of adherence to treatment: Good ☐ Fair ☐ Poor ☐ Unknown ☐				Difficulty adhering to treatment is a common cause of inadequate response. Treatment of depression can be enhanced by assessing adherence, providing additional education to patients and their involved family members and discussing barriers to adherence such as costs, concerns about medication use, complexity and side effects of medication regimens and obstacles to keeping appointments (e.g., transportation, childcare, schedule constraints).
Is additional education or discussion of the treatment plan needed to enhance the patient's understanding and adherence? Yes ☐ No ☐				
Estimated magnitude of treatment-related side effects: Severe ☐ Moderate ☐ Mild ☐ Unknown ☐				Assessment of side effects of treatment is crucial in all patients and could be a focus for performance improvement if not routinely determined. Although side effects are less commonly considered in patients receiving psychosocial treatments, intensive insight oriented treatments or exposure therapies may be associated with increases in anxiety for some patients. With antidepressant medication, common side effects include sleep-related effects (i.e., sedation, insomnia), gastrointestinal effects (e.g., diarrhea, constipation, nausea), restlessness/anxiety, sexual dysfunction, headache, and anticholinergic effects. Effects on cardiac conduction can be a particular problem with tricyclic antidepressants. For all antidepressants, the FDA has issued warnings that the potential for increased suicidal thoughts or behaviors with antidepressant therapy in individuals under the age of 25 must be balanced against the benefits of treatment.
Side effects experienced:				

Appendix B. Sample "Real-Time" Performance-in-Practice Tool for Patients with Depression (p. 6 of 6)

Based upon the severity of the patient's depressive disorder, is the overall treatment approach concordant with that recommended practice guideline on the preceding page? Yes ☐ No ☐ What patient specific factors (if any) have led to modifications in the approach to treating the patient's depression compared to that recommended by the practice guideline?	Although care is often noted to diverge from guideline based recommendations, other evidence suggests that providing guideline-concordant care is likely to improve patient outcomes. However, these data are based upon populations of patients and the samples in randomized trials (on which guidelines are typically based) have different characteristics than patients seen in actual practice. If a patient's plan of treatment does diverge from that recommended in the practice guideline, it is useful to consider the patient-specific factors relevant to the treatment plan as well as the rationale for the current plan of care. If patients' treatment plans infrequently follow guideline recommendations, this might serve as a focus for performance improvement.
If the patient has current or past co-occurring psychiatric disorders, are these being addressed in the treatment plan? Yes ☐ No ☐ N/A ☐	Co-occurring psychiatric disorders are common in depressed patients and need to be considered in planning care. Including treatment for each disorder in the treatment plan is likely to improve outcomes for each disorder. Substance use disorders, in particular, are often underrecognized and undertreated, despite the fact that integrated treatment is effective. Performance improvement efforts might be focused on increasing the rates of treatment for all co-occurring disorders or may focus on specific disorders with high rates of occurrence in individuals with depression (e.g., smoking cessation in individuals with nicotine dependence).
Has the treatment plan considered factors such as age, sex, ethnicity, culture, and religious/spiritual beliefs that may require a modified treatment approach? Yes ☐ No ☐ N/A ☐	In individualizing the patient's plan of treatment, factors such as age, sex, ethnicity, culture and religious/spiritual beliefs are essential yet are often overlooked. If such factors are unassessed or infrequently incorporated into treatment planning, this might serve as a focus for performance improvement.
	Are any changes in this patient's treatment plan likely as a result of this review process?
	Are any performance improvement initiatives or further reviews of practice planned as a result of this review process?

Sample "Real-Time" Performance in Practice Tool for Patients with Depression
Survey Form and CME Certification **Begin date February 2008,**
End date February 2011.

To earn CME credit for this ***Survey Program***, psychiatrists should use the **Sample Real Time Performance in Practice Tool** as indicated. After using the performance in practice tool, participants should fully complete this survey and send it by mail to APACME 1000 Wilson Boulevard, Suite 1825 Rosslyn VA 22209, or fax to 703 907 7849, or send by email to educme@psych.org.

Objective: After completion of this activity psychiatrists will have the foundation for subsequent performance improvement initiatives aimed at enhancing outcomes for patients with major depressive disorder.

The APA is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. APA designates this educational activity for a maximum of 5 AMA PRA Category 1 credits. Physicians should only claim credit commensurate with the extent of their participation in the activity.

		1	2	3	4	5	
1. Overall, I am satisfied with the usefulness of this PIP tool in assessing my practice patterns.	Strongly disagree	0	0	0	0	0	Strongly agree
2. This PIP tool was difficult for me to use.	Strongly disagree	0	0	0	0	0	Strongly agree
3. The questions and information on this PIP tool were worded clearly.	Strongly disagree	0	0	0	0	0	Strongly agree
4. The organization of information on this PIP tool was clear.	Strongly disagree	0	0	0	0	0	Strongly agree
5. I was able to complete this PIP tool rapidly.	Strongly disagree	0	0	0	0	0	Strongly agree
6. Completing this PIP tool had no effect on my knowledge about treating patients with depression.	Strongly disagree	0	0	0	0	0	Strongly agree
7. By completing this PIP tool, I have identified at least one way in which I can improve my care of patients.	Strongly disagree	0	0	0	0	0	Strongly agree
8. Completing this PIP tool has helped me to verify that I am providing appropriate care to my patients.	Strongly disagree	0	0	0	0	0	Strongly agree
9. Completing this PIP tool was a good use of my time.	Strongly disagree	0	0	0	0	0	Strongly agree
10. Reviewing my patterns of practice is a good use of my time.	Strongly disagree	0	0	0	0	0	Strongly agree

List the most helpful aspects of this PIP tool:

1.

2.

3.

List the least helpful aspects of this PIP tool:

1.

2.

3.

How do you plan to use the information gained from this self-assessment in your practice?

How might we improve upon this PIP tool in the future?

Additional comments:

Please evaluate the effectiveness of this CME activity by answering the following questions.

1. Achievement of educational objectives: YES _____ NO _____

2. Material was presented without bias: YES _____ NO _____

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