Body System: Psychogenic

Session Topic: Bipolar Disorder

Educational Format		Faculty Expertise Required
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. Please describe your interest and plan for teaching a PBL on your proposal form.

Professional Practice Gap	Learning Objective(s) that will close the gap and meet the need	Outcome Being Measured
• Physicians are often unsure of when to screen for bipolar disorder. • Physicians are often lack confidence to evaluate bipolar disorder and coexisting psychological issues. • There have been significant changes between the DSM-IV and the DSM-V with regard to the diagnosis of bipolar and related disorders • Physicians frequently face many barriers to bipolar disorder guideline implementation • Electronic Health Records (EHR) and PHQ data are frequently not used to optimize bipolar disorder management • Recent studies show possible increased risk of cardiac malformations when exposed to lithium	1. Screen patients at risk for having bipolar disorder using a validated screening tool. 2. Evaluate patients with bipolar disorder for comorbid conditions, and treat or coordinate referral and follow-up as appropriate. 3. Develop collaborative treatment plans with evidence-based pharmacotherapy and psychotherapy; including screening for suicidal ideation and substance misuse, evaluating adherence to treatment, and recognizing metabolic complications of pharmacotherapy. 4. Provide patients with individual or group psychoeducation to prevent relapse and improve treatment adherence.	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.

or lamotrigine during the first trimester		

Faculty Instructional Goals

Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management
- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
    - Visit http://www.aafp.org/journals for additional resources
    - Visit http://familydoctor.org for patient education and resources
- Provide recommendations for screening patients at risk for having bipolar disorder (e.g. major depressive disorder) using a validated screening tool.
- Provide recommendations for evaluating patients with bipolar disorder for comorbid conditions, and treat or coordinate referral and follow-up as appropriate.
- Provide strategies and resources for developing collaborative treatment plans with evidence-based pharmacotherapy and psychotherapy; including screening for suicidal ideation and substance use disorder, evaluating adherence to treatment, and recognizing metabolic complications of pharmacotherapy.
- Propose strategies and resources to help learners provide patients with individual or group psychoeducation to prevent relapse and improve treatment adherence.

Needs Assessment

In a given year, nearly 21 million U.S. adults (about 9.5% of the population) have a mood disorder, which includes major depressive disorder, dysthymic disorder and bipolar disorder. Many depressive disorders co-occur with anxiety disorders (such as panic disorder, obsessive-compulsive disorder and post-traumatic stress disorder) and substance use disorder. The burden of mental illness is significant for many Americans; it is estimated that nearly 45% of those who have a diagnosable mental disorder meet the criteria for two of more disorders; and some studies suggest that patients with bipolar disorder have a lifetime prevalence of at least one co-occurring disorder was 92 percent.[1-4] The 12 month prevalence of bipolar disorder among the U.S. adult population is 2.6%, and less than half (48.8%) of those with the disorder receive treatment.[2] The Centers for Disease Control and Prevention (CDC) reports that bipolar disorder is the most expensive behavioral health care diagnosis, and has the highest hospitalization rate (39.1%) among behavioral health diagnoses.[5]

Data from a recent American Academy of Family Physicians (AAFP) CME Needs Assessment survey indicate that family physicians have statistically significant and meaningful gaps in the medical skill necessary to provide optimal care and management patients with bipolar disorder.[6] More specifically, CME outcomes data from 2012 and 2013 AAFP Assembly: *Mood Disorders, Depression, and Bipolar Disorders*, and 2015 AAFP FMX (formerly Assembly) *Bipolar Disorder* sessions suggest that physicians have knowledge and practice gaps with regard to standardized clinical monitoring and follow-up; consistent use of patient health questionnaire (PHQ) and other screening tools; screening for comorbid conditions; appropriate use of pharmacologic treatments; being aware that bipolar disorder is underdiagnosed; and efficiently managing bipolar disorder within the time frame of a typical office visit.[7-9]

A review of the literature validates these and other practice gaps with regard to diagnosing and managing bipolar disorder in adults, summarized as follows:[2,10-18]

- There have been significant changes between the DSM-IV and the DSM-V with regard to bipolar and related disorders.
- Bipolar disorders are often misdiagnosed, particularly among those patients with depression; resulting in delayed treatment.
- A lack of recognition and treatment of comorbid conditions often lead patients with bipolar illness to have a chronic course with high disability, unemployment rates, and mortality.
- Physicians often exhibit poor adherence to bipolar management guidelines.
- Physicians are often unfamiliar with evidence-based treatment recommendations.
- There is often a lack of coordination of care between primary care and psychiatrists.
- There is often lack of access to psychiatrists, leaving many family physicians to manage patients with mental illness on their own, or while waiting for availability with psychiatry.

Physicians may improve their care of patients with bipolar disorder by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:[10,19-23]

- Bipolar disorder is often undiagnosed, and patients will often present with subsyndromal mixed states.
- It is important to ask patients with major depressive disorder if they have manic symptoms, as this symptom has significant diagnostic and therapeutic implications; the Mood Disorder Questionnaire is a validated screening tool for bipolar disorder, and should be considered for patients with depressive symptoms that do not meet the DSM-V criteria for depression
- Interpretation of the mental status examination must take into account the patient's native language, education level, and culture.
- Although screening can detect cognitive decline and dementia, there is no evidence that screening improves patient outcomes.
- The Mini-Cog and revised Addenbrooke's Cognitive Examination are preferred alternatives to the Mini-Mental State Examination for dementia screening, and the Montreal Cognitive Assessment is a preferred alternative to detect mild cognitive impairment.

- Atypical antipsychotics and mood-stabilizing agents can be helpful in the treatment of both depression with mixed symptoms and mania with mixed symptoms.
- Patients 12 to 18 years of age should be screened for depressive disorders in practice settings with systems in place to support accurate diagnosis, psychotherapy, and follow-up.
- Lithium, valproate, and some antipsychotics are effective treatments for acute mania in bipolar disorders.
- Lithium, valproate, lamotrigine, and some antipsychotics are effective treatments for acute depression in bipolar disorders.
- Lithium, valproate, lamotrigine, and some atypical antipsychotics are effective for maintenance therapy of bipolar disorders.
- Social support in recognizing early warning signs of mood relapse improves outcomes in patients with bipolar disorders.
- Mania should be treated with lithium, divalproex, or an atypical antipsychotic medication.
- Bipolar depression should be treated with quetiapine, olanzapine/fluoxetine combination, or lamotrigine.
- Once mood episodes are successfully treated, effective acute phase medications should be continued for maintenance of euthymia with appropriate medication monitoring.
- All patients should be offered individual or group psychoeducation to prevent relapse and improve treatment adherence.
- Psychiatric medications are the primary treatment for schizophrenia and bipolar disorder, but CBT provides additional benefits.
- For many psychiatric conditions, CBT provides similar outcomes or additional benefits compared with psychiatric medications alone.
- Benzodiazepine use should be avoided in patients who are receiving CBT because it can interfere with exposure therapy.

Faculty should be prepared to discuss recent research suggesting that fetal lithium or lamotrigine exposure during the first trimester, may increase the risk of cardiac malformations.[24]

Physicians can improve patient satisfaction with the referral process by using readily available strategies and tools such as, improving internal office communication, engaging patients in scheduling, facilitating the appointment, tracking referral results, analyzing data for improvement opportunities, and gathering patient feedback.[25,26]

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Bipolar disorders: a review[19]
- The Mental Status Examination[23]
- Screening for depression[21]
- Common Questions About Cognitive Behavior Therapy for Psychiatric Disorders[22]
- AAFP Mood Disorder Questionnaire[27]
- Adding health education specialists to your practice[28]
- Envisioning new roles for medical assistants: strategies from patient-centered medical homes[29]
- The benefits of using care coordinators in primary care: a case study[30]
- Engaging Patients in Collaborative Care Plans[31]
- Medication adherence: we didn't ask and they didn't tell[32]
- Encouraging patients to change unhealthy behaviors with motivational interviewing[33]
- Integrating a behavioral health specialist into your practice[34]
- Simple tools to increase patient satisfaction with the referral process[25]
- FamilyDoctor.org. Bipolar Disorder | Overview (patient education)[35]

References

1. Ostergaard SD, Bertelsen A, Nielsen J, Mors O, Petrides G. The association between psychotic mania, psychotic depression and mixed affective episodes among 14,529 patients with bipolar disorder. *Journal of affective disorders.* 2013;147(1-3):44-50.
2. National Institute of Mental Health (NIMH). Bipolar Disorder Among Adults. *Health & Education* 2014;
3. National Institute of Mental Health (NIMH). Statistics. 2010;
4. Merikangas KR, Herrell R, Swendsen J, Rossler W, Ajdacic-Gross V, Angst J. Specificity of bipolar spectrum conditions in the comorbidity of mood and substance use disorders: results from the Zurich cohort study. *Archives of general psychiatry.* 2008;65(1):47-52.
5. Centers for Disease Control and Prevention. Burden of Mental Illness. *Mental Health* 2011;
6. American Academy of Family Physicians (AAFP). CME Needs Assessment: Common Medical Procedures. *Market Research In Brief*. Leawood KS: AAFP; 2014.
7. American Academy of Family Physicians (AAFP). 2012 AAFP Scientific Assembly: CME Outcomes Report. Leawood KS: AAFP; 2012.
8. American Academy of Family Physicians (AAFP). 2013 AAFP Scientific Assembly: CME Outcomes Report. Leawood KS: AAFP; 2013.
9. American Academy of Family Physicians (AAFP). AAFP FMX CME Outcomes Report. Leawood KS: AAFP; 2015.

10. Hu J, Mansur R, McIntyre RS. Mixed Specifier for Bipolar Mania and Depression: Highlights of DSM-5 Changes and Implications for Diagnosis and Treatment in Primary Care. *The primary care companion to CNS disorders.* 2014;16(2).
11. Hirschfeld RM, Cass AR, Holt DC, Carlson CA. Screening for bipolar disorder in patients treated for depression in a family medicine clinic. *The Journal of the American Board of Family Practice / American Board of Family Practice.* 2005;18(4):233-239.
12. Stang P, Frank C, Yood MU, Wells K, Burch S, Muma B. Bipolar disorder detection, ascertainment, and treatment: primary care physician knowledge, attitudes, and awareness. *Primary care companion to the Journal of clinical psychiatry.* 2006;8(3):147-152.
13. Jenkins MM, Youngstrom EA, Washburn JJ, Youngstrom JK. Evidence-Based Strategies Improve Assessment of Pediatric Bipolar Disorder by Community Practitioners. *Professional psychology, research and practice.* 2011;42(2):121-129.
14. Leboyer M, Kupfer DJ. Bipolar disorder: new perspectives in health care and prevention. *The Journal of clinical psychiatry.* 2010;71(12):1689-1695.
15. Ghouse AA, Sanches M, Zunta-Soares G, Swann AC, Soares JC. Overdiagnosis of bipolar disorder: a critical analysis of the literature. *TheScientificWorldJournal.* 2013;2013:297087.
16. American Psychiatric Association (APA). *Diagnostic and statistical manual of mental disorders: DSM V.* 5th ed. Washinton DC: American Pyschiatric Publishing; 2013.
17. American Psychiatric Association (APA). Highlights of Changes from DSM-IV-TR to DSM-5. 2013;
18. Bongards EN, Zaman R, Agius M. Can we prevent under-diagnosis and misdiagnosis of bipolar affective disorder? Repeat audits to assess the epidemiological change in the caseload of a community mental health team when bipolar disorder is accurately assessed and diagnosed. *Psychiatria Danubina.* 2013;25 Suppl 2:S129-134.
19. Price AL, Marzani-Nissen GR. Bipolar disorders: a review. *American family physician.* 2012;85(5):483-493.
20. Connolly KR, Thase ME. The clinical management of bipolar disorder: a review of evidence-based guidelines. *The primary care companion to CNS disorders.* 2011;13(4).
21. Maurer DM. Screening for depression. *American family physician.* 2012;85(2):139-144.
22. Coffey SF, Banducci AN, Vinci C. Common Questions About Cognitive Behavior Therapy for Psychiatric Disorders. *American family physician.* 2015;92(9):807-812.
23. Norris D, Clark MS, Shipley S. The Mental Status Examination. *American family physician.* 2016;94(8):635-641.
24. Patorno E, Huybrechts KF, Bateman BT, et al. Lithium Use in Pregnancy and the Risk of Cardiac Malformations. *The New England journal of medicine.* 2017;376(23):2245-2254.
25. Jarve RK, Dool DW. Simple tools to increase patient satisfaction with the referral process. *Family practice management.* 2011;18(6):9-14.
26. American Academy of Family Physicians (AAFP). FPM Toolbox: Referral Management. 2013;
27. American Academy of Family Physicians (AAFP). Mood Disorder Questionnaire.
28. Chambliss ML, Lineberry S, Evans WM, Bibeau DL. Adding health education specialists to your practice. *Family practice management.* 2014;21(2):10-15.

29. Naughton D, Adelman AM, Bricker P, Miller-Day M, Gabbay R. Envisioning new roles for medical assistants: strategies from patient-centered medical homes. *Family practice management.* 2013;20(2):7-12.
30. Mullins A, Mooney J, Fowler R. The benefits of using care coordinators in primary care: a case study. *Family practice management.* 2013;20(6):18-21.
31. Mauksch L, Safford B. Engaging Patients in Collaborative Care Plans. *Family practice management.* 2013;20(3):35-39.
32. Brown M, Sinsky CA. Medication adherence: we didn't ask and they didn't tell. *Family practice management.* 2013;20(2):25-30.
33. Stewart EE, Fox CH. Encouraging patients to change unhealthy behaviors with motivational interviewing. *Family practice management.* 2011;18(3):21-25.
34. Reitz R, Fifield P, Whistler P. Integrating a behavioral health specialist into your practice. *Family practice management.* 2011;18(1):18-21.
35. FamilyDoctor.org. Bipolar Disorder | Overview. 2000;

