



STABLE

STAndards for Bipolar Excellence

A Performance Measurement
& Quality Improvement Program

PERFORMANCE MEASURES

STABLE Performance Measure

<p>Measure: Depression: Screening for bipolar mania/hypomania prior to treatment for depression</p>	
<p>Summary: This measure assesses the percentage of patients presenting with depression who were assessed, prior to the initiation of treatment, for the presence of prior or current symptoms and/or behaviors associated with mania or hypomania.</p>	
<p>Clinical Rationale: Bipolar Disorder is an episodic illness with a variable course: <ul style="list-style-type: none"> ▪ It is generally a lifetime condition associated with significant disability ▪ It is frequently unrecognized, underdiagnosed, and thus, not treated appropriately Recognition Considerations <ul style="list-style-type: none"> ▪ Depressive episodes are the frequent presenting characteristics of both major depressive disorder and bipolar disorder ▪ Symptomatic bipolar disorder patients spend, on average, 33% of their time in a depressive phase compared to about 11% of their time in a manic/hypomanic phase⁽¹⁾ ▪ Bipolar patients report considerable distress associated with their depressive symptoms and seek treatment for depression⁽²⁾ ▪ Bipolar depressive episodes are not only more numerous but, on average, also last longer than a patient's manic or hypomanic episodes⁽³⁾ ▪ Patients generally do not recognize or spontaneously report prior episodes of hypomania as these periods may be considered as normal happiness or well-being⁽⁴⁾ ▪ The most common incorrect diagnosis associated with bipolar disorder is unipolar depression⁽⁵⁾ </p>	
<p>Denominator Population: Patients diagnosed and treated for unipolar depression</p> <p>Data Sources:</p> <ul style="list-style-type: none"> ▪ Administrative data ▪ Medical Record 	<p>Numerator Population: Patients who receive an assessment, prior to treatment for unipolar depression, that includes consideration of current and/or prior manic or hypomanic symptoms or behaviors</p> <p>Data Source:</p> <ul style="list-style-type: none"> ▪ Medical Record
<p>Initial Case-finding Guidance: Patients with a diagnosis involving unipolar depression ICD9CM or DSM IV TR: 296.2x; 296.3x; 300.4 or 311</p>	
<p>STABLE Resource Toolkit: The following instruments are recommended by the STABLE National Coordinating Council for use in screening for bipolar disorder. The tools are available in the STABLE Resource Toolkit.</p> <ul style="list-style-type: none"> ▪ Mood Disorders Questionnaire (MDQ): Brief self-report tool ▪ CIDI-based Bipolar Disorder Screening Scale: Brief clinician-administered tool 	
<p>References:</p> <ol style="list-style-type: none"> 1. Post RM, Calabrese JR, Bipolar depression: the role of atypical antipsychotics; Expert Rev. Neurother. 2004 Nov; 4 (6 Suppl 2): S27-33 2. Angst J, Do many patients with depression suffer from bipolar disorder?; Can. J Psychiatry, vol. 51, Jan 2006 3-6 3. Thase MD, Bipolar depression: issues in diagnosis and treatment, Harv. Rev. Psychiatry, 2005 Spt-Oct; 13 (5): 257-71 4. Berk M, Dodd S, Bipolar II disorder: a review, Bipolar Disorders 2005: 7: 11-21 5. Kupfer DJ, Emerging therapies for bipolar depression, J Clin Psychiatry 67:7, July 2006 1140-1151 	

STABLE Performance Measure

Measure:

Depression: Screening for bipolar mania/hypomania prior to treatment for depression

Endorsed by the National Quality Forum, December 2006

Measure Specifications:**Denominator:**

Patients 18 years of age or older with an initial diagnosis or new presentation/episode of depression

AND

Documentation of a diagnosis involving unipolar depression; to include at least one of the following:

- Codes 296.2x; 296.3x. 300.4 or 311 documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms
- Diagnosis or impression documented in chart indicating "depression"
- Use of a screening/assessment tool for depression with a documented score or conclusion that the patient is clinically depressed and indication that this information is used to establish or substantiate the diagnosis

AND

Documentation of treatment for depression, to include at least one of the following:

- Antidepressant pharmacotherapy

AND/OR

- Psychotherapy and/or counseling for depression; provided at practice site or through referral

Numerator:

Documentation of a screening or assessment that considers the presence or absence of current and/or prior symptoms or behaviors of mania or hypomania. Sources of this documentation may include the following:

- Clinician statement in patient record regarding inquiry regarding the presence or absence of current or prior symptoms or behaviors associated with mania or hypomania
- Use of a bipolar disorder screening or assessment tool for mania/hypomania symptoms or behaviors

AND

Timeframe:

Documentation of the screening or assessment for mania/hypomania must be present prior to, or concurrent with, the visit where the treatment plan for depression (pharmacotherapy and/or psychotherapy) is documented

STABLE Performance Measure

<p>Measure: Bipolar Disorder or Depression: Assessment for risk of suicide</p>	
<p>Summary: This measure assesses the percentage of patients diagnosed with bipolar disorder, or with unipolar depression, who receive an initial assessment that considers the risk or suicide.</p>	
<p>Clinical Rationale: Bipolar Disorder and Risk of Suicide <ul style="list-style-type: none"> ▪ Unipolar depression and bipolar disorder are associated with a significant risk of suicide. The risk of completed suicide is higher in bipolar disorder than in unipolar depression^(1,2) ▪ Patients with bipolar disorder are at high risk for suicide; rates as high as 80% of patients with bipolar disorder have been reported with either suicidal ideation or suicide attempts⁽³⁾ ▪ Suicide completion rates in patients with bipolar I disorder have been reported as high as 10-15% with some studies reporting higher rates in patients with bipolar II disorder⁽³⁾ ▪ Among the phases of bipolar disorder, depression is associated with the highest suicide risk, followed by mixed states and presence of psychotic symptoms with episodes of mania being least associated with suicide⁽⁴⁾ ▪ Data from a large study reporting STEP-BD baseline data identified that of patients with bipolar disorder, 60% had a history of prior suicide attempts and that this finding was consistent with other large studies that show a strong association between prior history of suicide attempts and new attempts or completed suicide in patients with bipolar disorder⁽⁵⁾ Assessing Risk of Suicide <ul style="list-style-type: none"> ▪ All patients should be asked about suicidal ideation, intention to act on these ideas, and extent of plans or preparation for suicide⁽⁴⁾ </p>	
<p>Denominator Population: Patients diagnosed with bipolar disorder OR Patients diagnosed with unipolar depression</p> <p>Data Sources:</p> <ul style="list-style-type: none"> ▪ Administrative data ▪ Medical Record 	<p>Numerator Population: Patients who receive an initial assessment for bipolar disorder (or unipolar depression) that includes an appraisal of the risk of suicide</p> <p>Data Source:</p> <ul style="list-style-type: none"> ▪ Medical Record
<p>Initial Case-finding Guidance: Patients with a diagnosis involving bipolar disorder ICD9CM or DSM IV TR: 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80-82; 296.89; or 301.13 Patients with a diagnosis involving unipolar depression ICD9CM or DSM IV TR: 296.2x; 296.3x; 300.4 or 311</p>	
<p>STABLE Resource Toolkit: The following instruments are recommended by the STABLE National Coordinating Council for use in assessing the risk of suicide. The tools are available in the STABLE Resource Toolkit.</p> <ul style="list-style-type: none"> ▪ Suicide Behaviors Questionnaire-revised (SBQ-R): Brief self-report tool ▪ The Suicidal Ideation and Risk Level Assessment: Brief clinician-administered tool 	
<p>References:</p> <ol style="list-style-type: none"> 1. Raja M, Azzoni A, Suicide attempts: differences between unipolar and bipolar patients and among groups with different lethality risk, J Affect Disord. 2004 Nov 1; 82(3): 437-42 2. Zalsman G, Braun M, Arendt M, et al., A comparison of the medical lethality of suicide attempts in bipolar and major depressive disorders, Bipolar Disord. 2006 Oct; 8 (5 Pt 2): 558-65 3. Valtonen H, Suominen K, Mantere O, et al., Suicidal ideation and attempts in bipolar I and II disorders, J Clin Psych, 2005 Nov; 66 (11): 1456-62 4. American Psychiatric Association, Practice Guideline for the Treatment of Patients with Bipolar Disorder, Am J Psychiatry 159: 4, April 2002 Supplement 5. Marangell LB, Bauer MS, Dennehy EB, et al. Prospective predictors of suicide and suicide attempts in 1,556 patients with bipolar disorder followed for up to 2 years, Bipolar Disorders 2006: 8: 566-575 	

STABLE Performance Measure

Measure:

Bipolar Disorder or Depression: Assessment for risk of suicide

Endorsed for Bipolar Disorder by National Quality Forum, December 2006

Measure Specifications:**Denominator:****Denominator = Bipolar Disorder:**

Patients 18 years of age or older with an initial diagnosis or new presentation/episode of bipolar disorder

AND

Documentation of a diagnosis involving bipolar disorder; to include at least one of the following:

- Codes 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80; 296.81; 296.82; 296.89; 301.13 documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms
- Diagnosis or impression documented in chart indicating bipolar disorder
- Use of a screening/assessment tool for bipolar disorder with a score or conclusion that patient has bipolar disorder and documentation that this information is used to establish or substantiate the diagnosis

Denominator = Unipolar Depression:

Patients 18 years of age or older with an initial diagnosis or new presentation/episode of depression

AND

Documentation of a diagnosis involving unipolar depression; to include at least one of the following:

- Codes 296.2x; 296.3x. 300.4 or 311 documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms
- Diagnosis or impression documented in chart indicating "depression"
- Use of a screening/assessment tool for depression with a documented score or conclusion that the patient is clinically depressed and that indication that this information is used to establish or substantiate the diagnosis

Numerator:

Documentation of an assessment for risk of suicide; to include at least one of the following

- Documented clinician evaluation of the presence or absence of suicidal ideation or intention
- Documented reference to comments the patient made that relate to the presence or absence of thoughts of suicide/death
- Documented reference to use, or presence in the chart of, a screening tool or patient assessment form that addresses suicide

AND

Timeframe:

Documentation of the assessment for risk of suicide must be present prior to, or concurrent with, the visit where the diagnosis and/or treatment plan is first documented.

STABLE Performance Measure

<p>Measure: Bipolar Disorder or Depression: Assessment for substance use</p>	
<p>Summary: This measure assesses the percentage of patients with bipolar disorder, or unipolar depression, who receive an initial assessment that considers alcohol and chemical substance use.</p>	
<p>Clinical Rationale: Bipolar Disorder, Major Depression & Substance Use</p> <ul style="list-style-type: none"> ▪ Between 40-70% of people with bipolar disorder have a history of substance use disorder^(1,2) ▪ A current or past comorbid substance use disorder may lead to worse outcomes for bipolar disorders, including more symptoms, more suicide attempts, longer episodes and lower quality of life⁽¹⁾ ▪ Substance abuse may obscure or exacerbate mood swings that have no other apparent external cause⁽³⁾ ▪ Substance abuse may also precipitate mood episodes or be used by patients to self-treat in an attempt to improve the symptoms of episodes⁽³⁾ ▪ Alcohol or chemical substance abuse or dependence is a frequent comorbidity of major depressive disorder and a detailed history of the patient's substance use should be obtained⁽⁴⁾ ▪ Patients suffering from major depressive disorder with comorbid addiction are more likely to require hospitalization, more likely to attempt suicide and less likely to comply with treatment than are patients with these disorders of similar severity not complicate by these factors⁽⁴⁾ 	
<p>Denominator Population:</p> <p>Patients diagnosed with bipolar disorder OR Patients diagnosed with unipolar depression</p> <p>Data Sources:</p> <ul style="list-style-type: none"> ▪ Administrative data ▪ Medical Record 	<p>Numerator Population:</p> <p>Patients who receive an initial assessment for bipolar disorder (or unipolar depression) that includes consideration of alcohol/chemical substance use</p> <p>Data Source:</p> <ul style="list-style-type: none"> ▪ Medical Record
<p>Initial Case-finding Guidance: Patients with a diagnosis involving bipolar disorder ICD9CM or DSM IV TR: 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80-82; 296.89; or 301.13 Patients with a diagnosis involving unipolar depression ICD9CM or DSM IV TR: 296.2x; 296.3x; 300.4 or 311</p>	
<p>STABLE Resource Toolkit: The following instruments are recommended by the STABLE National Coordinating Council for use in assessing substance use. The tools are available in the STABLE Resource Toolkit.</p> <ul style="list-style-type: none"> ▪ AUDIT-C: Brief self-report tool for alcohol use ▪ CAGE-AID: Brief self-report tool; adaptation of CAGE that also includes drug use 	
<p>References:</p> <ol style="list-style-type: none"> 1. Ostacher, MJ; Sachs, GS, Update on Bipolar Disorder and Substance Abuse: Recent Findings and Treatment Strategies, J Clin Psychiatry 2006; 67[9]:e10 2. Regier DA, Farmer ME, Rae DS, et al. Comorbidity of mental disorders with alcohol and other drug abuse: results from the Epidemiologic Catchment Area (ECA) Study, JAMA 1990; 264:2511-1518 3. American Psychiatric Association, Practice Guideline for the Treatment of Patients with Bipolar Disorder, Am J Psychiatry 159: 4, April 2002 Supplement 4. American Psychiatric Association, Practice Guideline for the Treatment of Patients with Major Depressive Disorder (2000) 	

STABLE Performance Measure

Measure:

Bipolar Disorder or Depression: Assessment for substance use

Endorsed by the National Quality Forum, December 2006

Denominator:**Denominator = Bipolar Disorder:**

Patients 18 years of age or older with an initial diagnosis or new presentation/episode of bipolar disorder

AND

Documentation of a diagnosis involving bipolar disorder; to include at least one of the following:

- Codes 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80; 296.81; 296.82; 296.89; 301.13 documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms
- Diagnosis or impression documented in chart indicating bipolar disorder
- Use of a screening/assessment tool for bipolar disorder with a score or conclusion that patient has bipolar disorder and indication that this information is used to establish or substantiate the diagnosis

Denominator = Unipolar Depression:

Patients 18 years of age or older with an initial diagnosis or new presentation/episode of depression

AND

Documentation of a diagnosis involving unipolar depression; to include at least one of the following:

- Codes 296.2x; 296.3x. 300.4 or 311 documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms
- Diagnosis or impression documented in chart indicating "depression"
- Use of a screening/assessment tool for depression with a score or conclusion that the patient is clinically depressed and indication that this information is used to establish or substantiate the diagnosis

Numerator:

Documented assessment for use of alcohol and chemical substance use; to include at least one of the following:

- Clinician documentation regarding presence or absence of alcohol and chemical substance use
- Patient completed history/assessment form that addresses alcohol and chemical substance use that is documented as being noted/acknowledged by clinician performing the assessment
- Use of screening tools that address alcohol and chemical substance use

AND

Timeframe:

Documentation of the assessment for alcohol and chemical substance use must be present prior to, or concurrent with, the visit where the diagnosis and/or treatment plan is first documented

STABLE Performance Measure

<p>Measure: Bipolar Disorder: Use of antimanic agent in BD I with mania/hypomania, mixed, or cycling</p>	
<p>Summary: This measure assesses the percentage of patients with BD I with mania/hypomania, mixed or cycling symptoms and behaviors who have evidence of use of a pharmacotherapy agent with antimanic properties during the first 12 weeks of treatment.</p>	
<p>Clinical Rationale:</p> <p>Goals of Acute Treatment: Mania or Mixed Episodes</p> <ul style="list-style-type: none"> ▪ If present, a rapid response to agitation, aggression and impulsivity is desired⁽¹⁾ ▪ Remission of symptoms with a return to usual levels of psychosocial functioning⁽¹⁾ <p>Initial Treatment Considerations</p> <ul style="list-style-type: none"> ▪ Treatment selection is dependent on illness severity, associated clinical features such as rapid cycling or psychosis, and patient preference⁽¹⁾ ▪ Treatment choice should also consider patient history, potential side effects and individual therapeutic response to specific pharmacotherapy agents⁽²⁾ <p>Initial Treatment Recommendations</p> <ul style="list-style-type: none"> ▪ Refer to published guidelines for 1st stage, 2nd stage, etc. detailed recommendations ▪ Guidelines suggest lithium or valproate (divalproex/divalproex sodium/valproate sodium/valproic acid) alone or in combination with an antipsychotic; Alternatives to lithium or valproate may include carbamazepine^(1,2,3) ▪ It is noted that typical antipsychotics are associated with significant acute neurologic side effect risks (extrapyramidal) and long-term risk of tardive dyskinesia^(1,2,3) ▪ Clozapine has been noted as an effective antimanic therapy in treatment-resistant bipolar disorder; however, it is recommended with caution due to monitoring and safety concerns⁽²⁾ 	
<p>Denominator Population:</p> <p>Patients with Bipolar I Disorder episodes with</p> <ul style="list-style-type: none"> ▪ Manic/hypomanic symptoms or behaviors ▪ Mixed symptoms or behaviors ▪ Cycling symptoms or behaviors <p>Data Sources:</p> <ul style="list-style-type: none"> ▪ Administrative data ▪ Medical Record 	<p>Numerator Population:</p> <p>Patients with evidence of use of an antimanic agent during the first 12 weeks of pharmacotherapy treatment</p> <p>Data Sources:</p> <ul style="list-style-type: none"> ▪ Medical Record ▪ If available, administrative data that indicates specific pharmacotherapy
<p>Initial Case-finding Guidance: Patients with diagnosis of Bipolar I Disorder; manic/hypomanic, mixed or cycling ICD9CM or DSM IV TR : 296.0x; 296.1x; 296.4x; 296.6x</p>	
<p>Specialty-specific Measure: This measure is recommended by the STABLE National Coordinating Council as a specialty-specific measure for psychiatry as the denominator requires specific documentation of diagnostic information indicating Bipolar I Disorder and the symptoms, behaviors, or episodes that are being addressed.</p>	
<p>References:</p> <ol style="list-style-type: none"> 1. Practice Guideline for the Treatment of Patients with Bipolar Disorder (2002 Revision); American Psychiatric Association; Am J Psychiatry 159:4, April 2002 Supplement; Also, Guideline Watch (2006) Update to the above guidelines, Hirschfeld R, American Psychiatric Association, 2006 2. Suppes T, Dennehy E, Hirschfeld R, Altshuler L, Bowden D, Calabrese J, Ketter T, Sachs G, Swann A, The Texas Implementation of Medication Algorithms: Update to the Algorithms for Treatment of Bipolar I Disorder, J Clin Psychiatry 2005; 66:870-886 3. Keck PE, Perlis R, Otto M; Carpenter D, Ross R, Docherty J, Treatment of Bipolar Disorder 2004; The Expert Consensus Guideline Series, Postgraduate Medicine – A Special Report, December 2004 	

STABLE Performance Measure

<p>Measure:</p> <p style="text-align: center;">Bipolar Disorder: Use of antimanic agent in BD I with mania/hypomania, mixed, or cycling</p>				
<p>Measure Specifications:</p> <p>Denominator:</p> <p>Patients 18 years of age or older with an initial diagnosis or new presentation/episode of bipolar disorder</p> <p>AND</p> <p>Documentation of Bipolar I Disorder with manic/hypomanic; mixed; or cycling symptoms or behaviors; to include at least one of the following:</p> <ul style="list-style-type: none"> ▪ Codes 296.0x; 296.1x; 296.4x; 296.6x documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms ▪ Diagnosis or impression documented in chart indicating Bipolar I Disorder with current symptoms or behaviors of mania/hypomania; mixed state symptoms or behaviors; or indications of cycling. <p>Denominator Exclusion:</p> <p>Exclude case from denominator population if numerator-required pharmacotherapy is not prescribed and the reason(s) for not prescribing is documented in chart, such as: not clinically indicated; not prescribed for related medical reasons (allergy, drug interaction); or not prescribed for patient reasons (patient refusal), etc.</p> <p>Numerator:</p> <p>Documented treatment with at least on pharmacotherapy agent with antimanic properties (See data dictionary reference below)</p> <p>AND</p> <p>Timeframe:</p> <p>Documentation of the bipolar disorder pharmacotherapy must be within the first 12 weeks of treatment</p>				
<p>Data Dictionary Reference:</p> <p>The table provided below does not indicate preferred treatment but rather is inclusive of those agents that are construed to be reasonably appropriate in accordance with available pharmacotherapy and current guidelines as of January 2007.</p>				
Lithium Agents	Anticonvulsant Agents / Mania or Hypomania or Mixed	Antipsychotic Agents		
lithium carbonate	carbamazepine	Atypical	Typical	
lithium citrate	divalproex	aripiprazole	chlorpromazine	thioridazine
	divalproex sodium	clozapine	fluphenazine	thiothixene
	valproate acid	olanzapine	haloperidol	trifluoperazine
	valproic sodium	quetiapine	loxapine HCL	
		risperidone	mesoridazine	
		ziprasidone	molindone HCL	
		Atypical Combination: olanzapine-fluoxetine		

STABLE Performance Measure

<p>Measure: Bipolar Disorder: Use of mood stabilizing or antimanic agent in BD I with depression</p>	
<p>Summary: This measure assesses the percentage of patients with Bipolar I Disorder with depressive symptoms and behaviors who have evidence of use of a mood stabilizing or antimanic agent during the first 12 weeks of pharmacotherapy treatment.</p>	
<p>Clinical Rationale:</p> <p>Goals of Acute Treatment: Bipolar Disorder Depressive Episodes</p> <ul style="list-style-type: none"> ▪ Remission of symptoms with a full return to usual levels of psychosocial functioning ⁽¹⁾ ▪ Avoid mood destabilization and precipitating a manic or hypomanic episode ^(1,2) <p>Initial Treatment Considerations</p> <ul style="list-style-type: none"> ▪ Treatment selection is dependent on illness severity, associated clinical features and patient preference ⁽¹⁾ ▪ Treatment choice should also consider patient history, potential side effects and individual therapeutic response to specific pharmacotherapy agents ⁽²⁾ <p>Initial Treatment Recommendations</p> <ul style="list-style-type: none"> ▪ Refer to published guidelines for 1st stage, 2nd stage, etc. detailed recommendations ^(1,2,3) ▪ Guidelines suggest lithium or lamotrigine alone or in combination with an atypical antipsychotic or lithium or lamotrigine alone or in combination, simultaneously, with an antidepressant ^(1,2,3) ▪ Stage 3, Stage 4, and for TIMA- Stage 5, guideline recommendations include the use of additional antimanic and antipsychotic agents, significantly expanding the selection options ▪ The use of antidepressants even in combination with a mood stabilizing or antimanic agent has been associated with some controversy over their liability to induce a mood switch. ^(2,3) ▪ Typical antipsychotics have been associated with significant acute neurologic side effect risks (extrapyramidal) and long-term risk of tardive dyskinesia ^(1,2,3) 	
<p>Denominator Population: Patients with Bipolar I Disorder with symptoms or episodes that involve depression</p> <p>Data Sources:</p> <ul style="list-style-type: none"> ▪ Administrative data ▪ Medical Record 	<p>Numerator Population: Patients with evidence of use of a mood-stabilizing or antimanic agent during the first 12 weeks of pharmacotherapy treatment</p> <p>Data Sources:</p> <ul style="list-style-type: none"> ▪ Medical Record ▪ If available, administrative data that indicates specific pharmacotherapy
<p>Initial Case-finding Guidance: Patients with diagnosis of Bipolar I Disorder, with depression ICD9CM or DSM IV TR: 296.5x</p>	
<p>Specialty-specific Measure: This measure is recommended by the STABLE National Coordinating Council as a specialty-specific measure for psychiatry as the denominator requires documentation of diagnostic information indicating Bipolar Disorder I and the specific symptoms, behaviors, or episodes that are being addressed.</p>	
<p>References:</p> <ol style="list-style-type: none"> 1. Practice Guideline for the Treatment of Patients with Bipolar Disorder (2002 Revision); American Psychiatric Association; Am J Psychiatry 159:4, April 2002 Supplement ; Also, Guideline Watch (2006) Update, Hirschfeld RM, American Psychiatric Association, 2006 2. Suppes T, Dennehy E, Hirschfeld R, Altshuler L, Bowden D, Calabrese J, Ketter T, Sachs G, Swann A, The Texas Implementation of Medication Algorithms: Update to the Algorithms for Treatment of Bipolar I Disorder, J Clin Psychiatry 2005; 66:870-886 3. Keck PE, Perlis R, Otto M, Carpenter, Ross R, Docherty J, Treatment of Bipolar Disorder 2004; The Expert Consensus Guideline Series, Postgraduate Medicine – A Special Report, December 2004 	

STABLE Performance Measure

<p>Measure:</p> <p style="text-align: center;">Bipolar Disorder: Use of mood stabilizing or antimanic agent in BD I with depression</p>																																																	
<p>Measure Specifications:</p> <p>Denominator:</p> <p>Patients 18 years of age or older with an initial diagnosis or new presentation/episode of bipolar disorder</p> <p>AND</p> <p>Documentation of Bipolar I Disorder with depressive symptoms, behaviors or episodes; to include at least one of the following:</p> <ul style="list-style-type: none"> ▪ Code 296.5x documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms ▪ Diagnosis or impression documented in chart indicating Bipolar I Disorder with current depressive symptoms, behaviors or episodes <p>Denominator Exclusion:</p> <p>Exclude case from denominator population if numerator-required pharmacotherapy is not prescribed and the reason(s) for not prescribing is documented in chart, such as; not clinically indicated; not prescribed for related medical reasons (allergy, drug interaction); or not prescribed for patient reasons (patient refusal, etc.)</p> <p>Numerator:</p> <p>Documented treatment with at least one pharmacotherapy agent with mood stabilizing or antimanic properties (See data dictionary reference below)</p> <p>AND</p> <p>Timeframe:</p> <p>Documentation of the stated pharmacotherapy must be within the first 12 weeks of treatment</p>																																																	
<p>Data Dictionary Reference:</p> <p>The table provided below does not indicate preferred treatment but rather is inclusive of those agents that are construed to be reasonably appropriate in accordance with available pharmacotherapy and current guidelines as of January 2007.</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="width: 20%;">Lithium Agents</th> <th style="width: 20%;">Anticonvulsant Agents / Depressive</th> <th colspan="3">Antipsychotic Agents</th> </tr> <tr> <td></td> <td></td> <th style="width: 15%;">Atypical</th> <th colspan="2">Typical</th> </tr> </thead> <tbody> <tr> <td>lithium carbonate</td> <td>carbamazepine</td> <td></td> <td>chlorpromazine</td> <td>thioridazine</td> </tr> <tr> <td>lithium citrate</td> <td>divalproex</td> <td>aripiprazole</td> <td>fluphenazine</td> <td>thiothixene</td> </tr> <tr> <td></td> <td>divalproex sodium</td> <td>olanzapine</td> <td>haloperidol</td> <td>trifluoperazine</td> </tr> <tr> <td></td> <td>lamotrigine</td> <td>quetiapine</td> <td>loxapine HCL</td> <td></td> </tr> <tr> <td></td> <td>valproic acid</td> <td>risperidone</td> <td>mesoridazine</td> <td></td> </tr> <tr> <td></td> <td>valproate sodium</td> <td>ziprasidone</td> <td>molindone HCL</td> <td></td> </tr> <tr> <td></td> <td></td> <td colspan="3">Atypical Combination olanzapine-fluoxetine</td> </tr> </tbody> </table>					Lithium Agents	Anticonvulsant Agents / Depressive	Antipsychotic Agents					Atypical	Typical		lithium carbonate	carbamazepine		chlorpromazine	thioridazine	lithium citrate	divalproex	aripiprazole	fluphenazine	thiothixene		divalproex sodium	olanzapine	haloperidol	trifluoperazine		lamotrigine	quetiapine	loxapine HCL			valproic acid	risperidone	mesoridazine			valproate sodium	ziprasidone	molindone HCL				Atypical Combination olanzapine-fluoxetine		
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STABLE Performance Measure

<p>Measure: Bipolar Disorder: Avoidance of antidepressant monotherapy in BD I</p>	
<p>Summary: This measure assesses the percentage of patients with BD I symptoms and behaviors who received monotherapy with an antidepressant agent during the first 12 weeks of treatment.</p>	
<p>Clinical Rationale: Goals of Acute Treatment: <ul style="list-style-type: none"> ▪ Avoidance of mood destabilization and precipitating a manic or hypomanic episode ^(1,2) ▪ Remission of symptoms with a return to usual levels of psychosocial functioning⁽¹⁾ Initial Treatment Recommendations <ul style="list-style-type: none"> ▪ Prescription of antidepressants in the absence of a mood stabilizer is not recommended for bipolar I patients⁽¹⁾ ▪ Due to the risks of mania induction and cycle acceleration, antidepressant monotherapy is not recommended an appropriate maintenance treatment for patients with BD I, most recent episode depressed⁽²⁾ ▪ In addition to recommendations to avoid antidepressant monotherapy in BD I, the 2004 Consensus Guidelines⁽³⁾ and the TMAP guidelines ⁽²⁾ provide cautionary guidance regarding the inclusion of an antidepressant in combination with additional pharmacotherapy (mood stabilizing agent or antipsychotic agent) in the treatment regimen for a patient with bipolar depression with a history of rapid cycling or antidepressant-induced mania </p>	
<p>Denominator Population: Patients diagnosed with Bipolar I Disorder (any type of episode)</p> <p>Data Sources:</p> <ul style="list-style-type: none"> ▪ Administrative data ▪ Medical Record 	<p>Numerator Population: Patients who receive only antidepressant monotherapy during the first 12 weeks following initiation of pharmacotherapy treatment</p> <p>Data Sources:</p> <ul style="list-style-type: none"> ▪ Medical Record ▪ If available, administrative data, that indicates specific pharmacotherapy
<p>Initial Case-finding Guidance: Patients with diagnosis of Bipolar I Disorder ICD9CM or DSM IVTR: 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7</p>	
<p>References:</p> <ol style="list-style-type: none"> 1. Practice Guideline for the Treatment of Patients with Bipolar Disorder (2002 Revision); American Psychiatric Association; Am J Psychiatry 159:4, April 2002 Supplement ; Also, Guideline Watch (2006) Update, Hirschfeld, RM, American Psychiatric Association, 2006 2. Suppes T, Dennehy E, Hirschfeld R, Altshuler L, Bowden D, Calabrese J, Ketter T, Sachs G, Swann A, The Texas Implementation of Medication Algorithms: Update to the Algorithms for Treatment of Bipolar I Disorder, J Clin Psychiatry 2005; 66:870-886 3. Keck PE, Perlis R, Otto M, Carpenter D, Ross R, Docherty J, Treatment of Bipolar Disorder 2004; The Expert Consensus Guideline Series, Postgraduate Medicine – A Special Report, December 2004 	

STABLE Performance Measure

<p>Measure: Bipolar Disorder: Avoidance of antidepressant monotherapy in BD I</p>																																															
<p>Measure Specifications:</p>																																															
<p>Denominator:</p> <p>Patients 18 years of age or older with an initial diagnosis or new presentation/episode of bipolar disorder</p> <p>AND</p> <p>Documentation of Bipolar I Disorder; to include at least one of the following:</p> <ul style="list-style-type: none"> ▪ Codes 296.0x; 296.1x; 296.4x; 296.5x; 296.7x; 296.7 documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms ▪ Diagnosis or impression documented in chart indicating Bipolar I Disorder 																																															
<p>Denominator Exclusion:</p> <p>Monotherapy antidepressant agent prescribed and the reason(s) for not prescribing additional bipolar disorder pharmacotherapy (antimanic agent or mood stabilizing agent) are documented in chart, such as; not prescribed for medically-related reasons (allergy, previous drug reactions; drug interaction); not prescribed for patient reasons (patient refusal) etc.</p>																																															
<p>Numerator:</p> <p>Documentation of use of antidepressant during the first 12 weeks of pharmacotherapy treatment (See data dictionary reference below)</p> <p>AND</p> <p>Determination that no mood stabilizing agent or antipsychotic agent was prescribed during the first 12 weeks of pharmacotherapy treatment for bipolar disorder</p> <p>AND</p> <p>Timeframe: Documentation of the numerator-stated pharmacotherapy issue continues for first 12 weeks of treatment</p>																																															
<p>Data Dictionary Reference: The table below provides antidepressant reference information and is current as of January 2007</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="width: 25%;">MAOIs</th> <th style="width: 25%;">Tri- or Tetra-cyclics</th> <th style="width: 25%;">SSRIs</th> <th style="width: 25%;">Other</th> </tr> </thead> <tbody> <tr> <td>isocarboxazid</td> <td>amitriptyline HCL</td> <td>citalopram</td> <td>bupropion</td> </tr> <tr> <td>moclobemide</td> <td>amoxapine</td> <td>escitalopram</td> <td>trazodone</td> </tr> <tr> <td>phenelzine sulfate</td> <td>clomipramine</td> <td>fluoxetine</td> <td>venlafaxine</td> </tr> <tr> <td>tranylcypromine sulfate</td> <td>desipramine</td> <td>fluvoxamine</td> <td>duloxetine HCL</td> </tr> <tr> <td></td> <td>doxepin</td> <td>mirtazapine</td> <td></td> </tr> <tr> <td></td> <td>imipramine</td> <td>nefazodone</td> <td></td> </tr> <tr> <td></td> <td>maprotiline</td> <td>paroxetine</td> <td></td> </tr> <tr> <td></td> <td>nortriptyline</td> <td>sertraline</td> <td></td> </tr> <tr> <td></td> <td>protriptyline</td> <td></td> <td></td> </tr> <tr> <td></td> <td>trimipramine</td> <td></td> <td></td> </tr> </tbody> </table>				MAOIs	Tri- or Tetra-cyclics	SSRIs	Other	isocarboxazid	amitriptyline HCL	citalopram	bupropion	moclobemide	amoxapine	escitalopram	trazodone	phenelzine sulfate	clomipramine	fluoxetine	venlafaxine	tranylcypromine sulfate	desipramine	fluvoxamine	duloxetine HCL		doxepin	mirtazapine			imipramine	nefazodone			maprotiline	paroxetine			nortriptyline	sertraline			protriptyline				trimipramine		
MAOIs	Tri- or Tetra-cyclics	SSRIs	Other																																												
isocarboxazid	amitriptyline HCL	citalopram	bupropion																																												
moclobemide	amoxapine	escitalopram	trazodone																																												
phenelzine sulfate	clomipramine	fluoxetine	venlafaxine																																												
tranylcypromine sulfate	desipramine	fluvoxamine	duloxetine HCL																																												
	doxepin	mirtazapine																																													
	imipramine	nefazodone																																													
	maprotiline	paroxetine																																													
	nortriptyline	sertraline																																													
	protriptyline																																														
	trimipramine																																														

STABLE Performance Measure

<p>Measure: Bipolar Disorder: Monitoring for weight gain</p>	
<p>Summary: This measure assesses the percentage of patients with bipolar disorder who were monitored for weight gain during initial 12 week period of treatment.</p>	
<p>Clinical Rationale:</p> <p>General Population Issues; Overweight and Obesity</p> <ul style="list-style-type: none"> ▪ Data from the National Center for Health Statistics show that 30% of U.S. adults 20 years of age and older—over 60 million—people are obese <p>Metabolic Effects Associated with Overweight or Obese Conditions</p> <ul style="list-style-type: none"> ▪ Increases in adiposity, particularly visceral abdominal fat, are associated with decreases in insulin sensitivity in individuals both with and without psychiatric disease⁽¹⁾ ▪ Increasing prevalence rates of overweight or obese individuals raise concerns regarding the risks of many health conditions associated with insulin resistance, including hyperglycemia and hyperlipidemia leading to Type 2 diabetes and/or cardiovascular disease⁽²⁾ <p>Bipolar Disorder and Weight Gain</p> <ul style="list-style-type: none"> ▪ The estimated prevalence of obesity in persons with bipolar disorder ranges from 13.0-49.0 percent in various studies; with an unknown percentage attributable to lifestyle-related issues associated with the condition^(3,4) ▪ Treatment with pharmacotherapy associated with bipolar disorder, particularly the various antipsychotics, has been associated with an additional increase in weight ranging from less than 2 lbs up to 10 lbs⁽⁵⁾ 	
<p>Denominator Population:</p> <p>Patients diagnosed with bipolar disorder</p> <p>Data Sources:</p> <ul style="list-style-type: none"> ▪ Administrative data ▪ Medical Record 	<p>Numerator Population:</p> <p>Patients who have had actual weight documented twice within the initial 12 weeks of treatment</p> <p>Data Source:</p> <ul style="list-style-type: none"> ▪ Medical Record
<p>Initial Case-finding Guidance: Patients with a diagnosis involving bipolar disorder ICD9CM or DSM IV TR: 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80-82; 296.89; or 301.13</p>	
<p>STABLE Resource Toolkit: The STABLE National Coordinating Council has recommended metabolic monitoring when treating with antipsychotic agents. The following documentation tool is available in the STABLE Resource Toolkit.</p> <ul style="list-style-type: none"> ▪ Metabolic Monitoring Flow Sheet: Brief documentation tool for office-based practice 	
<p>References:</p> <ol style="list-style-type: none"> 1. Newcomer, JW, Medical Risk in Patients with Bipolar Disorder and Schizophrenia; J Clin Psychiatry 2006; 67 (Suppl 9) 25-30 2. American Diabetes Association. Consensus development conference on antipsychotic drugs and obesity and diabetes. Diabetes Care 2004; 27:596-601 3. Fagiolini A, Frank E, Scott JA, et al. Metabolic syndrome in bipolar disorder, findings from the Bipolar Disorder Center for Pennsylvanians. Bipolar Disord 2005;7:424-430 4. McElroy SL, Frye MA, Suppes T, et al. Correlates of overweight and obesity in 644 patients with bipolar disorder. J Clin Psychiatry 2002; 63:207-213 5. Newcomer JW, Haupt DW, The Metabolic Effects of Antipsychotic Medications, Can J Psychiatry, Vol 51, No 8, July 2006; 480-491 	

STABLE Performance Measure

Measure:

Bipolar Disorder: Monitoring for weight gain

Measure Specifications:**Denominator:**

Patients 18 years of age or older with an initial diagnosis or new presentation or episode of bipolar disorder

AND

Documentation of a diagnosis involving bipolar disorder; to include at least one of the following:

- Codes 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80; 296.81; 296.82; 296.89; 301.13 documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms
- Diagnosis or impression documented in chart indicating bipolar disorder
- Use of a screening/assessment tool for bipolar disorder with a score or conclusion that patient has bipolar disorder and indication that this information is used to establish or substantiate the diagnosis

Numerator:

- Two instances of documentation of weight (See data dictionary reference below)

AND

Timeframe:

Documentation must include at least two recordings of weight within the first 12 weeks of treatment

Data Dictionary Reference:

Measure developers did not accept self-report or clinical estimation as meeting numerator criterion for monitoring weight; obtaining actual weight is recommended

STABLE Performance Measure

<p>Measure: Bipolar Disorder: Monitoring for extrapyramidal symptoms</p>	
<p>Summary: This measure assesses the percentage of patients diagnosed with bipolar disorder and treated with an antipsychotic agent who were assessed for the presence of extrapyramidal symptoms twice within the first 24 weeks of treatment.</p>	
<p>Clinical Rationale:</p> <p>Extrapyramidal Symptoms</p> <ul style="list-style-type: none"> ▪ Extrapyramidal symptoms refer to movement disorders that occur when there is a disruption of the brain's extrapyramidal system. Extrapyramidal Symptoms are referred to as EPS^(1,5) ▪ EPS neurological side effects include akathisia, a motor restlessness, and muscle rigidity and tremor, which are sometimes referred to as drug-induced Parkinsonian symptoms^(1,4,5) ▪ EPS also includes tardive dyskinesia and acute dystonia, rare but severe side effects that also relate to disruption of the extrapyramidal system. Sometimes these symptoms are referred to as distinct side effects due to their severity^(1,4,5) <p>Extrapyramidal Symptoms and Antipsychotic Agents</p> <ul style="list-style-type: none"> ▪ Typical antipsychotics are associated with significant acute neurologic side effects^(1,3) ▪ Tardive dyskinesia (TD) is the principal adverse effect of long-term typical (first generation) antipsychotic treatment; however, studies indicate that TD still occurs with atypical (second generation) antipsychotic agents⁽⁵⁾ ▪ Atypical (second generation) antipsychotics have been reported to have a lower rate of EPS, particularly acute dystonia and drug-induced Parkinsonism⁽²⁾ <p>Monitoring for Extrapyramidal Symptoms</p> <ul style="list-style-type: none"> ▪ Patients with bipolar disorder should be regularly monitored for iatrogenic adverse effects of antipsychotic medication including extrapyramidal symptoms⁽⁴⁾ ▪ Regular examination for early signs of tardive dyskinesia is an appropriate monitoring plan⁽⁵⁾ 	
<p>Denominator Population: Patients diagnosed and treated for bipolar disorder with an antipsychotic agent</p> <p>Data Sources:</p> <ul style="list-style-type: none"> ▪ Administrative data ▪ Medical Record 	<p>Numerator Population: Patients assessed for extrapyramidal symptoms (EPS) twice during initial 24 weeks of treatment</p> <p>Data Source:</p> <ul style="list-style-type: none"> ▪ Medical Record
<p>Initial Case-finding Guidance: Patients with a diagnosis involving bipolar disorder ICD9CM or DSM IV TR: 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80-82; 296.89; or 301.13</p>	
<p>STABLE Resource Toolkit: The following instruments are recommended by the STABLE National Coordinating Council for use in assessing extrapyramidal symptoms. The tools are available in the STABLE Resource Toolkit.</p> <ul style="list-style-type: none"> ▪ Abnormal Involuntary Movement Scale (AIMS): Clinician tool used to assess tardive dyskinesia. ▪ Antipsychotic Symptom Checklist (ASC): Captures adverse effects of antipsychotic agents 	
<p>References</p> <ol style="list-style-type: none"> 1. Wirshing W, Movement disorders associated with neuroleptic treatment. J. Clin Psychiatry 2001; 62 (Suppl.21): 15-18 2. Miller D, Yatham L, Lam R, Comparative efficacy of typical and atypical antipsychotics as add-on therapy to mood stabilizers in the treatment of acute mania. J Clin Psychiatry 2001; 62: 975-980 3. Keck PE, Perlis R, Otto M, Carpenter D, Ross R, Docherty J, Treatment of Bipolar Disorder 2004; The Expert Consensus Guideline Series, Postgraduate Medicine, A Special Report, December 2004 4. Yatham LN, Kenned, SH, et al.; Canadian Network for Mood and Anxiety Treatments (CANMAT) guidelines for the managements of patients with bipolar disorder: consensus and controversies, Bipolar Disorders 2005; 7(Suppl. 3): 5-69 5. Tarsy D, Baldessarini R, Epidemiology of Tardive Dyskinesia: Is Risk Declining with Modern Antipsychotics?, Movement Disorders Vol 21, No 5, 2006, 589-598 	

STABLE Performance Measure

<p>Measure: Bipolar Disorder: Monitoring for extrapyramidal symptoms</p>																												
<p>Measure Specifications:</p> <p>Denominator:</p> <p>Patients 18 years of age or older with an initial or new episode of bipolar disorder</p> <p>AND</p> <p>Documentation of a diagnosis involving bipolar disorder; to include at least one of the following:</p> <ul style="list-style-type: none"> ▪ Codes 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80; 296.81; 296.82; 296.89; 301.13 documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms ▪ Diagnosis or impression documented in chart indicating bipolar disorder ▪ Use of a screening/assessment tool for bipolar disorder with a score or conclusion that patient has bipolar disorder and indication that this information is used to establish or substantiate the diagnosis <p>AND</p> <p>Documentation of treatment with an antipsychotic agent (See data dictionary reference below)</p> <p>Numerator:</p> <p>Assessment of extrapyramidal symptoms to include a documented reference of at least one of the following: (See data dictionary reference below)</p> <ul style="list-style-type: none"> ▪ Clinician narrative information concerning patient's EPS symptoms documented in chart ▪ Clinician scored EPS tool is present in chart ▪ Patient's self-reported symptoms (may be included on an assessment tool or preprinted form) are documented in chart <p>AND</p> <p>Timeframe: Documentation must include at least two recordings within the first 24 weeks of treatment</p>																												
<p>Data Dictionary References: Antipsychotic agents available as of January 2007</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="width: 25%;">Atypical</th> <th style="width: 25%;"></th> <th colspan="2" style="width: 50%;">Typical</th> </tr> </thead> <tbody> <tr> <td>aripiprazole</td> <td>quetiapine</td> <td>chlorpromazine</td> <td>molindone</td> </tr> <tr> <td>clozapine</td> <td>risperidone</td> <td>fluphenazine</td> <td>thioridazine</td> </tr> <tr> <td>olanzapine</td> <td>ziprasidone</td> <td>haloperidol</td> <td>thiothixene</td> </tr> <tr> <td></td> <td></td> <td>loxapine HCL</td> <td>trifluoperazine</td> </tr> <tr> <td></td> <td></td> <td>mesoridazine</td> <td></td> </tr> <tr> <td colspan="4">Atypical-Combination: olanzapine-fluoxetine</td> </tr> </tbody> </table> <p>EPS reference: For the purposes of this STABLE performance measure, EPS includes:</p> <ul style="list-style-type: none"> ▪ Akathisia: Motor restlessness; inability to resist the urge to move; pacing and inability to sit still ▪ Drug-induced Parkinsonism: Tremors and muscular rigidity or extreme slowness of movement ▪ Dyskinesia (Tardive Dyskinesia): Impairment of control over ordinary muscle movement, spasmodic involuntary movements often affecting the mouth, lips and tongue; can affect trunk and rest of body ▪ Acute Dystonia: Sudden muscular contractions producing distortions, often affects neck, eyes, trunk 	Atypical		Typical		aripiprazole	quetiapine	chlorpromazine	molindone	clozapine	risperidone	fluphenazine	thioridazine	olanzapine	ziprasidone	haloperidol	thiothixene			loxapine HCL	trifluoperazine			mesoridazine		Atypical-Combination: olanzapine-fluoxetine			
Atypical		Typical																										
aripiprazole	quetiapine	chlorpromazine	molindone																									
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		loxapine HCL	trifluoperazine																									
		mesoridazine																										
Atypical-Combination: olanzapine-fluoxetine																												

STABLE Performance Measure

<p>Measure: Bipolar Disorder: Monitoring lithium serum levels</p>	
<p>Summary: This measure assesses the percentage of patients diagnosed with bipolar disorder and treated with lithium who have evidence of a lithium serum medication level within 12 weeks of beginning treatment.</p>	
<p>Clinical Rationale:</p> <p>Side Effects of Lithium</p> <ul style="list-style-type: none"> ▪ Up to 75% of patients on lithium experience some side effects, but most are minor (polyuria; polydipsia, weight gain, cognitive problems, sedation or lethargy) and can be reduced or eliminated by dose adjustment or dosage schedule⁽¹⁾ ▪ Tremor affects up to 65% of patients treated with lithium and a severe tremor may be a sign of toxicity. Nausea and diarrhea or blurred vision may also be side effects of toxicity^(1,2) <p>Lithium Levels</p> <ul style="list-style-type: none"> ▪ Target lithium levels are generally 0.8-1.1 mmol/L⁽³⁾ ▪ Serum concentrations of 0.5 to 1.2 meq/L may be therapeutic according to individual patient response and side effects⁽¹⁾ ▪ Patients can experience toxic effects with levels above 1.5 meq/L such as marked tremor, nausea and diarrhea, or blurred vision; levels above 2.0 meq/L are have been associated with life-threatening side effects, such as neurotoxicity, delirium and encephalopathy^(1,2) <p>Monitoring of Serum Lithium Levels</p> <ul style="list-style-type: none"> ▪ Lithium level monitoring is required due to the medication's narrow therapeutic index^(1,2) ▪ Check lithium level after initial dosage and after each dosage increase⁽¹⁾ ▪ It is recommended to obtain serum levels approximately 5 days after a dosage adjustment as this is when the steady state is reached^(1,3) ▪ Long-term monitoring recommendations are to check every 3-6 months in patients with stable lithium levels and whenever the clinical status changes^(1,3) 	
<p>Denominator Population:</p> <p>Patients diagnosed and treated for bipolar disorder with a lithium agent</p> <p>Data Sources:</p> <ul style="list-style-type: none"> ▪ Administrative data ▪ Medical Record 	<p>Numerator Population:</p> <p>Patients with a serum medication level within 12 weeks of beginning treatment with lithium</p> <p>Data Source:</p> <ul style="list-style-type: none"> ▪ Medical Record
<p>Initial Case-finding Guidance: Patients with a diagnosis involving bipolar disorder ICD9CM or DSM IV TR: 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80-82; 296.89; or 301.13</p>	
<p>References:</p> <ol style="list-style-type: none"> 1. Practice Guideline for the Treatment of Patients with Bipolar Disorder (2002 Revision); American Psychiatric Association; Am J Psychiatry 159:4, April 2002 Supplement 2. Freeman M, Freeman S, Lithium: Clinical Considerations in Internal Medicine, The American Journal of Medicine (2006) 119, 478-481 3. Yatham LN, Kennedy, SH, et al.; Canadian Network for Mood and Anxiety Treatments (CANMAT) guidelines for the managements of patients with bipolar disorder: consensus and controversies, Bipolar Disorders 2005; 7(Suppl. 3): 5-69 	

STABLE Performance Measure

Measure:

Bipolar Disorder: Monitoring lithium serum levels

Measure Specifications:**Denominator:**

Patients 18 years of age or older with an initial or new episode of bipolar disorder

AND

Documentation of a diagnosis involving bipolar disorder; to include at least one of the following:

- Codes 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80; 296.81; 296.82; 296.89; 301.13 documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms
- Diagnosis or impression documented in chart indicating bipolar disorder
- Use of a screening/assessment tool for bipolar disorder with a score or conclusion that patient has bipolar disorder and indication that this information is used to establish or substantiate the diagnosis

AND

Documentation of treatment with a lithium (lithium carbonate; lithium citrate)

Denominator Exclusion:

Exclude case from denominator population if clinician requests patient to obtain serum lithium level but then subsequently documents that the patient failed to comply with clinician request.

Numerator:

Documentation of reference to serum blood levels in chart must include;

- Documentation that serum blood levels were requested

AND

- Results, or information about results, were obtained and placed/documentated in the patient record

AND

Timeframe:

Documented results or narrative reference to results are recorded within 12 weeks of date of first order for lithium

STABLE Performance Measure

<p>Measure: Bipolar Disorder: Screening for hyperglycemia when atypical antipsychotic agent prescribed</p>	
<p>Summary: This measure assesses the percentage of patients diagnosed with bipolar disorder and treated with an atypical antipsychotic agent who receive at least one screening for hyperglycemia within the initial 16 weeks of treatment.</p>	
<p>Clinical Rationale: Bipolar Disorder, Antipsychotic Medications, & Abnormalities in Glucose Regulation <ul style="list-style-type: none"> ▪ In patients with bipolar disorder abnormalities in glucose regulation that relate to dysregulation in various physiologic systems have been studied and reported⁽¹⁾ ▪ Treatment with atypical (second generation) antipsychotic medications has been associated with weight gain and resulting impaired glucose metabolism, exacerbation of existing type 1 and type 2 diabetes, new onset of type 2 diabetes and diabetic ketoacidosis⁽²⁾ ▪ Case reports and controlled studies indicate that some atypical antipsychotic medications are associated with adverse effects on glucose metabolism independent of adiposity⁽¹⁾ Monitoring of Glucose Regulation⁽³⁾ <ul style="list-style-type: none"> ▪ Six sets of metabolic monitoring guidelines for persons taking antipsychotic medications are currently recognized (Mount Sinai; Australia; American Diabetes Association-American Psychiatric Association; Belgium; and United Kingdom) ▪ All monitoring guidelines recommend the Fasting Plasma Glucose as a baseline test ▪ Although baseline monitoring is indicated as soon as feasible, when possible, monitoring prior to antipsychotic treatment initiation is preferable as the results may influence antipsychotic choice, especially when elevated risk factors are identified ▪ When fasting is not feasible to obtain (patient cooperation; cost/time), alternatives considered acceptable were the HbA1c (Mount Sinai; United Kingdom) or the Random Plasma Glucose (Mount Sinai; Australia; United Kingdom); these are not diagnostic for diabetes; however, they can be used as screening tests with follow-up if elevation is found. ▪ Finger stick glucose testing is not recommended for screening; however, it is considered to be useful in emergency situations to rule out frank hyperglycemia / diabetic ketoacidosis. </p>	
<p>Denominator Population: Patients diagnosed with bipolar disorder and treated with an atypical antipsychotic agent</p> <p>Data Sources:</p> <ul style="list-style-type: none"> ▪ Administrative data ▪ Medical Record 	<p>Numerator Population: Patients who are screened for evidence of hyperglycemia within 16 weeks after initiating treatment with an atypical antipsychotic agent</p> <p>Data Source:</p> <ul style="list-style-type: none"> ▪ Medical Record
<p>Initial Case-finding Guidance: Patients with a diagnosis involving bipolar disorder ICD9CM or DSM IV TR: 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80-82; 296.89; or 301.13</p>	
<p>STABLE Resource Toolkit: The STABLE National Coordinating Council has recommended metabolic monitoring when treating with antipsychotic agents. The following documentation tool is available in the STABLE Resource Toolkit.</p> <ul style="list-style-type: none"> ▪ Metabolic Monitoring Flow Sheet: Brief documentation tool for office-based practice 	
<p>References:</p> <ol style="list-style-type: none"> 1. Taylor V, MacQueen G, Association Between Bipolar Disorder and Metabolic Syndrome: A Review; J Clin Psychiatry 67:7, July 2006, 1034-1041 2. Haupt D, Newcomer J, Hyperglycemia and antipsychotic medications, J Clin Psychiatry 2001; 62 (suppl 27): 15-26 3. Cohn T, Sernyak M, Metabolic Monitoring for Patients Treated with Antipsychotic Medications, Can J Psychiatry, Vol 51, No 8, July 2006, 492-501 	

STABLE Performance Measure

Measure:

Bipolar Disorder: Screening for hyperglycemia when atypical antipsychotic agent prescribed

Endorsed by National Quality Forum, December 2006

Measure Specifications:**Denominator:**

Patients 18 years of age or older with an initial diagnosis or new episode/presentation of bipolar disorder

AND

Documentation of a diagnosis of bipolar disorder; to include at least one of the following:

- Codes 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80; 296.81; 296.82; 296.89; 301.13 documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms
- Diagnosis or impression documented in chart indicating bipolar disorder
- Use of a screening/assessment tool for bipolar disorder with a score or conclusion that patient has bipolar disorder and indication that this information is used to establish or substantiate the diagnosis

AND

Documentation of treatment with an atypical antipsychotic agent (See data dictionary reference below)

Denominator Exclusion:

Exclude case from denominator population if clinician requests patient to obtain screening test for hyperglycemia but then subsequently documents that the patient failed to comply with clinician request.

Numerator:

Screening for hyperglycemia must include documentation of one of the following:

- Reference in chart that test was ordered or requested and that results or information about results was obtained
- Lab results documented or filed in chart or available in patient's electronic medical record

AND

Timeframe:

Test results documented or recorded within 16 weeks after the initiation of a second generation atypical antipsychotic medication

Data Dictionary Reference:

Atypical antipsychotic agents available as of January 2007

aripiprazole	quetiapine
clozapine	risperidone
olanzapine	ziprasidone
Combination: olanzapine-fluoxetine	

STABLE Performance Measure

<p>Measure: Bipolar Disorder: Monitoring for hyperlipidemia when atypical antipsychotic agent prescribed</p>	
<p>Summary: This measure assesses the percentage of patients diagnosed with bipolar disorder and treated with an atypical antipsychotic agent who received at least one assessment for hyperlipidemia within the initial 16 week period of treatment.</p>	
<p>Clinical Rationale: Dyslipidemia & Antipsychotic Medications <ul style="list-style-type: none"> ▪ Body fat (BMI, but more specifically, visceral abdominal fat as evidenced in waist circumference) is a strong predictor of cardiovascular disease⁽¹⁾ ▪ Increased adiposity is associated with decreased insulin sensitivity and the initiation of insulin resistance syndrome^(1,2) ▪ Insulin resistance syndrome encompasses disturbances in lipid metabolism with a characteristic dyslipidemia that includes increases in fasting plasma triglyceride, and atherogenic changes in low-density lipoproteins⁽¹⁾ ▪ Patients on antipsychotic treatment have been associated with increased risk for weight gain and metabolic dyslipidemia with elevations of triglyceride⁽²⁾ Monitoring of Lipid Regulation⁽³⁾ <ul style="list-style-type: none"> ▪ Six sets of metabolic monitoring guidelines for persons taking antipsychotic medications are currently recognized (Mount Sinai; Australia; American Diabetes Association-American Psychiatric Association; Belgium; United Kingdom) ▪ Five groups unanimously recommend measuring fasting lipids with the United Kingdom group being silent on the issue ▪ Adequate fasting is necessary to obtain a valid LDL and triglyceride levels. ▪ Although baseline monitoring is indicated as soon as feasible, when it is possible, monitoring prior to antipsychotic treatment initiation is preferable as the results may influence antipsychotic choice, especially when elevated risk factors are identified </p>	
<p>Denominator Population: Patients diagnosed with bipolar disorder and treated with an atypical antipsychotic agent</p> <p>Data Sources:</p> <ul style="list-style-type: none"> ▪ Administrative data ▪ Medical Record 	<p>Numerator Population: Patients who are assessed for hyperlipidemia within 16 weeks after initiating treatment with an atypical antipsychotic agent</p> <p>Data Source:</p> <ul style="list-style-type: none"> ▪ Medical Record
<p>Initial Case-finding Guidance: Patients with a diagnosis involving bipolar disorder ICD9CM or DSM IV TR: 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80-82; 296.89; or 301.13</p>	
<p>STABLE Resource Toolkit: The STABLE National Coordinating Council has recommended metabolic monitoring when treating with antipsychotic agents. The following documentation tool is available in the STABLE Resource Toolkit.</p> <ul style="list-style-type: none"> ▪ Metabolic Monitoring Flow Sheet: Brief documentation tool for office-based practice 	
<p>References:</p> <ol style="list-style-type: none"> 1. Newcomer, JW, Medical Risk in Patients with Bipolar Disorder and Schizophrenia, J Clin Psychiatry 2006; 67 (suppl 9) 25-30 2. Newcomer JW, Metabolic risk during antipsychotic treatment, Clin Ther. 2004 Dec; 26(12): 1936-46 3. Cohn T, Sernyak M, Metabolic Monitoring for Patients Treated with Antipsychotic Medications, Can J Psychiatry, Vol 51, No 8, July 2006, 492-501 	

STABLE Performance Measure

Measure:

Bipolar Disorder: Monitoring for hyperlipidemia when atypical antipsychotic agent prescribed

Measure Specifications:**Denominator:**

Patients 18 years of age or older with an initial diagnosis or new episode/presentation of bipolar disorder

AND

Documentation of a diagnosis of bipolar disorder; to include at least one of the following:

- Codes 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80; 296.81; 296.82; 296.89; 301.13 documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms
- Diagnosis or impression documented in chart indicating bipolar disorder
- Use of a screening/assessment tool for bipolar disorder with a score or conclusion that patient has bipolar disorder and indication that this information is used to establish or substantiate the diagnosis

AND

Documentation of treatment with an atypical antipsychotic agent. (See data dictionary reference below)

Denominator Exclusion:

Exclude case from denominator population if clinician requests patient to obtain screening test for hyperlipidemia but then subsequently documents that the patient failed to comply with clinician request.

Numerator:

Assessment for hyperlipidemia_must include documentation of one of the following:

- Reference in chart lab that a lipid profile was ordered or requested and results or information about results was obtained
- Lab results filed in chart or available in patient's electronic medical record

AND

Timeframe:

Test results documented or recorded within 16 weeks after the initiation of a second generation atypical antipsychotic medication

Data Dictionary Reference:

Atypical antipsychotic agents available as of January 2007

aripiprazole	quetiapine
clozapine	risperidone
olanzapine	ziprasidone
Combination: olanzapine-fluoxetine	

STABLE Performance Measure

<p>Measure: Bipolar Disorder: Providing condition-specific education and information</p>	
<p>Summary: This measure assesses the percentage of patients diagnosed and treated for bipolar disorder who are provided with education and information about their illness and treatment within 12 weeks of initiating treatment.</p>	
<p>Clinical Rationale:</p> <p>The Role of Education in Psychiatric Treatment</p> <ul style="list-style-type: none"> ▪ Specific goals of psychiatric treatment for bipolar disorder include providing education to assist the patient in understanding and accepting their illness and to reinforce the patient's collaborative role in the treatment of this persistent condition⁽¹⁾ ▪ Patient's who do not believe or understand that they have a serious illness are less likely to adhere to long-term treatment regimens that can improve their health status⁽¹⁾ ▪ Patients and families can also benefit from an understanding of the role of psychosocial stressors and other disruptions in precipitating or exacerbating mood episodes ▪ Patients should know how to recognize and report early signs and symptoms of relapse; this has been shown to improve relapse time periods, social functioning, and employment⁽²⁾ <p>Providing Education</p> <ul style="list-style-type: none"> ▪ Clinicians should provide information about treatment options and costs involving specific medications, including dosing strategies, side effect profiles, drug interactions, potential toxicity and other safety considerations⁽³⁾ ▪ Over a period of time, health care professionals should gradually introduce facts about the illness as the patient's ability to accept and retain this information will vary over time⁽¹⁾ ▪ Printed material can assist in reinforcing education provided by the health care provider⁽¹⁾ 	
<p>Denominator Population: Patients diagnosed and treated for bipolar disorder</p> <p>Data Sources:</p> <ul style="list-style-type: none"> ▪ Administrative data ▪ Medical Record 	<p>Numerator Population: Patients who receive education/information about bipolar disorder within 12 weeks of initiating treatment</p> <p>Data Source:</p> <ul style="list-style-type: none"> ▪ Medical Record
<p>Initial Case-finding Guidance: Patients with a diagnosis involving bipolar disorder ICD9CM or DSM IV TR: 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80-82; 296.89; or 301.13</p>	
<p>STABLE Resource Toolkit: The STABLE National Coordinating Council recommends that durable educational materials (pamphlets; books; video resources) be provided to reinforce the educational information and message. The following educational resource material is available in the STABLE Resource Toolkit.</p> <ul style="list-style-type: none"> ▪ Listings of national patient advocacy and support organizations with links to their websites and recommendations about educational materials that these organizations offer ▪ A STABLE Project developed Mood Chart: A patient self-monitoring and reporting tool 	
<p>References:</p> <ol style="list-style-type: none"> 1. Practice Guideline for the Treatment of Patients with Bipolar Disorder (2002 Revision); American Psychiatric Association; Am J Psychiatry 159:4, April 2002 Supplement 2. Yatham LN, Kennedy SH, et al.; Canadian Network for Mood and Anxiety Treatments (CANMAT) guidelines for the management of patients with bipolar disorder: consensus and controversies, Bipolar Disorders 2005; 7(Suppl. 3): 5-69 3. Suppes T, Dennehy E, Hirschfeld R, Altshuler L, Bowden, Calabrese J, Ketter T, Sachs G, Swann A, The Texas Implementation of Medication Algorithms: Update to the Algorithms for Treatment of Bipolar I Disorder, J Clin Psychiatry 2005; 66:870-886 	

STABLE Performance Measure

Measure:

Bipolar Disorder: Providing condition-specific education and information

Measure Specifications:**Denominator:**

Patients 18 years of age or older with an initial or new episode of bipolar disorder

AND

Documentation of a diagnosis involving bipolar disorder; to include at least one of the following:

- Codes 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80; 296.81; 296.82; 296.89; 301.13 documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms
- Diagnosis or impression documented in chart indicating bipolar disorder
- Use of a screening/assessment tool for bipolar disorder with a score or conclusion that patient has bipolar disorder and indication that this information is used to establish or substantiate the diagnosis

AND

Documentation of treatment for bipolar disorder with relevant pharmacotherapy; a mood stabilizing agent and/or an antipsychotic agent

Numerator:

Documentation of providing condition-specific education (see note below) about bipolar disorder in one of the following ways:

- Provision at the practice site and provided by a licensed clinician
- Provision of a psychosocial psychoeducation intervention

Note: Condition-specific education includes the following types of information; not all are required to meet the intent of the numerator criteria; however, providing only medication-related information does not meet the intent of this performance measure

- Diagnosis-related (prognosis; treatment options; aims of treatment, etc.)
- Medication (type; purpose; side effects; monitoring)
- Risks and potential consequences of non-adherence to treatment recommendations
- Recognition and understanding of symptoms of episode recurrence
- Strategies for coping with symptoms
- Lifestyle management and related skills (sleep; activity; eating; social stimulation)

AND

Timeframe:

Documentation reference that education was provided within 12 weeks following initiation of treatment for bipolar disorder

STABLE Performance Measure

<p>Measure: Bipolar Disorder: Monitoring change in symptom complex</p>	
<p>Summary: This measure assesses the percentage of patients diagnosed and treated for bipolar disorder who are monitored for change in their symptom complex within 12 weeks of initiating treatment.</p>	
<p>Clinical Rationale:</p> <p>Acute Treatment Phase and Remission</p> <ul style="list-style-type: none"> ▪ Recovery includes remission of symptomatology, functional recovery, prevention of relapse or recurrence and improved quality of life⁽¹⁾ ▪ The 2002 APA Practice Guideline for the Treatment of Patients with Bipolar Disorder states that the goal of acute treatment is stabilization of the episode with the goal of remission, defined as “a complete return to baseline level of functioning and a virtual lack of symptoms” <p>Bipolar Disorder and Response to Treatment</p> <ul style="list-style-type: none"> ▪ The mood episodes of bipolar disorder are delineated in DSM-IV by symptomatology; therefore, diagnosing and assessing response to treatment involves symptom monitoring ▪ As defined by Tohen⁽²⁾ improvement in bipolar disorder involves two concepts involving symptoms; syndromal recovery, a sustained symptomatic recovery lasting for 8 weeks and symptomatic remission, a more stringent concept that is defined as a more symptom-free state^(1,2) <p>Monitoring Symptomatology</p> <ul style="list-style-type: none"> ▪ Recognizing and monitoring signs and symptoms of manic and depressive symptoms is critical in assessing patient status⁽³⁾ ▪ The use of a graphic display or timeline of mood symptoms can be helpful in identifying early or recurrent signs or symptoms and in involving the patient in treatment⁽⁴⁾ 	
<p>Denominator Population: Patients diagnosed and treated for bipolar disorder</p> <p>Data Sources:</p> <ul style="list-style-type: none"> ▪ Administrative data ▪ Medical Record 	<p>Numerator Population: Patients who were assessed for change in their symptom complex, using a validated tool or a monitoring form, within 12 weeks of initiating treatment for bipolar disorder</p> <p>Data Source:</p> <ul style="list-style-type: none"> ▪ Medical Record
<p>Initial Case-finding Guidance: Patients with a diagnosis involving bipolar disorder ICD9-CM or DSM IV TR: 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80-82; 296.89; or 301.13</p>	
<p>STABLE Resource Toolkit: The following tools are recommended by the STABLE National Coordinating Council for use in assessing the risk of suicide. The tools are available in the STABLE Resource Toolkit.</p> <ul style="list-style-type: none"> ▪ Altman Self Rating Scale for Mania – Clinician scored instrument ▪ Self Report Form for Mood Episodes – “Waiting Room” self-report tool, includes symptoms ▪ Symptom Monitoring Flow Chart: Brief documentation tool for office-based practice 	
<p>References:</p> <ol style="list-style-type: none"> 1. Harvey P, Defining and Achieving Recovery From Bipolar Disorder, J Clin Psychiatry 2006; 67 (suppl 9) 14-18 2. Tohen M, Zarate CA Jr, Hennen J, et al.; The McLean-Harvard First-Episode Mania Study: prediction of recovery and first recurrence. Am J psychiatry 2003; 160: 2099-2107 3. Keck PE, Defining and Improving Response to Treatment in Patients With Bipolar Disorder; J Clin Psychiatry 2004; 65 (suppl 15) 25-29 4. Post RM, Roy-Byrne PP, Uhde TW: Graphic representation of the life course of illness in patients with affective disorder. AM J Psychiatry 1988; 145: 844-848 	

STABLE Performance Measure

Measure:

Bipolar Disorder: Monitoring change in symptom complex

Measure Specifications:**Denominator:**

Patients 18 years of age or older with an initial diagnosis or new episode/presentation of bipolar disorder

AND

Documentation of a diagnosis of bipolar disorder; to include at least one of the following:

- Codes 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80; 296.81; 296.82; 296.89; 301.13 documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms
- Diagnosis or impression documented in chart indicating bipolar disorder
- Use of a screening/assessment tool for bipolar disorder with a score or conclusion that patient has bipolar disorder and indication that this information is used to establish or substantiate the diagnosis

AND

Documentation of treatment for bipolar disorder with relevant pharmacotherapy; a mood stabilizing agent and/or an antipsychotic agent

Numerator:

Symptom monitoring documentation must include the following:

- Assessment of the patient's symptom complex; to include at least three symptoms involved with a bipolar disorder episode
- Assessment of any change (indication of difference; better, worse, same, etc.) in the symptoms in response to treatment
- Use of a symptom monitoring tool or a symptom monitoring flow sheet that supports assessment of change-over-time

AND

Timeframe:

Monitoring of change in symptom complex requires an initial assessment and at least one follow-up assessment within the first 12 weeks following start of treatment for bipolar disorder

STABLE Performance Measure

Measure: Bipolar Disorder: Recommending adjunctive psychosocial interventions	
Summary: This measure assesses the percentage of patients with bipolar disorder who receive a recommendation for an adjunctive psychosocial intervention, including evidence-based therapies, within 12 weeks of initiating treatment.	
Clinical Rationale: The Role of Psychosocial Interventions <ul style="list-style-type: none"> ▪ Psychotherapy is a critical component of bipolar disorder treatment in addition to pharmacotherapy⁽¹⁾ ▪ Evidence-based psychosocial interventions have been found to improve treatment adherence, reduce likelihood of recurrence and extend time to new episodes⁽¹⁾ ▪ Initially focusing on issues relating to medication adherence, psychosocial strategies are now recommended to include broader strategies to promote mood stability, address comorbid conditions, improve understanding in support of treatment adherence, recognition of relapse and collaborative self-management^(2,3,4) ▪ Interventions that support return to role functioning and that address stressors and interpersonal communications are considered beneficial for remission and recovery^(2,3) Types of Psychosocial Interventions <ul style="list-style-type: none"> ▪ Evidence-based: Family-focused therapy (FFT); Cognitive behavioral therapy (CBT), formal psychoeducation, and Interpersonal Therapy (IPT) with or without a social rhythm component (IPSRT) have been supported through well developed clinical trials^(5,6,7,8,9) and are incorporated into guideline recommendations^(1,2,3) ▪ Brief supportive and group psychotherapy are also suggested, as alternative strategies⁽²⁾ 	
Denominator Population: Patients diagnosed and treated for bipolar disorder Data Sources: <ul style="list-style-type: none"> ▪ Administrative data ▪ Medical Record 	Numerator Population: Patients with a recommendation for psychosocial intervention within 12 weeks of initiating treatment Data Source: <ul style="list-style-type: none"> ▪ Medical Record
Initial Case-finding Guidance: Patients with a diagnosis involving bipolar disorder ICD9CM or DSM IV TR: 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80-82; 296.89; or 301.13	
References: <ol style="list-style-type: none"> 1. Practice Guideline for the Treatment of Patients with Bipolar Disorder (2002 Revision); American Psychiatric Association; Am J Psychiatry 159:4, April 2002 Supplement; AND 2006 Guideline Watch update, Hirschfeld RM, American Psychiatric Association 2. Keck PE, Perlis R, Otto M, Carpenter D, Ross R, Docherty J, Treatment of Bipolar Disorder 2004; The Expert Consensus Guideline Series, Postgraduate Medicine – A Special Report, December 2004 3. Yatham LN, Kennedy, SH, et al.; Canadian Network for Mood and Anxiety Treatments (CANMAT) guidelines for the management of patients with bipolar disorder: consensus and controversies, Bipolar Disorders 2005; 7(Suppl. 3): 5-69 4. Vieta E, et al.; Evidence-based Research on the Efficacy of Psychologic Interventions in Bipolar Disorders: A Critical Review, Current Psychiatry Reports; 2005, 7:449-455 5. A randomized study of family-focused psychoeducation and pharmacotherapy in the outpatient management of bipolar disorder, Arch Gen Psychiatry 2003; 60:904-912 6. A randomized controlled study of cognitive therapy for relapse prevention for bipolar affective disorder: outcome of the first year. Arch Gen Psychiatry 2003; 60:145-152 7. Psychoeducation efficacy in bipolar disorders: beyond compliance enhancement, J Clin Psychiatry 2003; 64:1101-1105 8. A randomized trial on the efficacy of group psychoeducation in the prophylaxis of recurrences in bipolar patients whose disease is in remission, Arch Gen Psychiatry 2003; 60:402-407 9. Two-year outcomes for interpersonal and social rhythm therapy in individuals with bipolar I disorder, Arch Gen Psychiatry; 62:996-1004 	

STABLE Performance Measure

<p>Measure: Bipolar Disorder: Recommending adjunctive psychosocial interventions</p>
<p>Measure Specifications:</p> <p>Denominator: Patients 18 years of age or older with an initial or new episode of bipolar disorder</p> <p>AND</p> <p>Documentation of a diagnosis involving bipolar disorder; to include at least one of the following:</p> <ul style="list-style-type: none">▪ Codes 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80; 296.81; 296.82; 296.89; 301.13 documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms▪ Diagnosis or impression documented in chart indicating bipolar disorder▪ Use of a screening/assessment tool for bipolar disorder with a score or conclusion that patient has bipolar disorder and documentation that this information is used to establish or substantiate the diagnosis <p>AND</p> <p>Documentation of treatment for bipolar disorder with relevant pharmacotherapy; a mood stabilizing agent and/or an antipsychotic agent</p> <p>Denominator Exclusion: Documentation that psychosocial interventions are (1) not indicated or (2) patients refuses to consider/discuss, or (3) source of referral for psychosocial practice not available in community</p> <p>Numerator: Documentation that adjunctive psycho-social intervention(s) were recommended (See data dictionary reference below) Recommendation may include the following</p> <ul style="list-style-type: none">▪ Interventions provided at practice site▪ Referral to psychologist/therapist or psychiatrist outside of practice site for psychosocial services▪ Referral to a mental health clinic or hospital-based OP program for psychosocial services▪ Referral to a support/advocacy provided community-based program for psychosocial services <p>AND</p> <p>Timeframe: Documentation of recommendation for adjunctive psychosocial intervention(s) should occur within 12 weeks of initiating treatment for bipolar disorder</p>
<p>Data Dictionary Reference: Evidence-based Psychosocial Interventions:</p> <ul style="list-style-type: none">▪ CBT: Cognitive Behavioral Therapy▪ FFT: Family Focused Therapy▪ IPT: Interpersonal Therapy (IPT) with or without Social Rhythm (IPSRT) component▪ Psychoeducation <p>Other psychosocial interventions: The following therapies are not as well supported in clinical trials, but may also be considered to the extent that they encompass the recommended psychosocial strategies</p> <ul style="list-style-type: none">▪ PST: Problem-Solving Therapy▪ PST: Problem-Solving Treatment (PST-Primary Care)▪ PSP: Brief Psychodynamic Supportive Psychotherapy▪ BSC: Brief Support Counseling (active listening; coping strategies; perspective)

STABLE Performance Measure

<p>Measure: Bipolar Disorder: Monitoring change in level-of-functioning</p>	
<p>Summary: This measure assesses the percentage of patients diagnosed and treated for bipolar disorder who are monitored for change in their level-of-functioning in response to treatment.</p>	
<p>Clinical Rationale:</p> <p>Recovery in Bipolar Disorder</p> <ul style="list-style-type: none"> ▪ Recovery includes remission of symptomatology, minimizing relapse or recurrence and maximizing functioning and improving quality of life⁽¹⁾ ▪ Achieving treatment-related symptomatic improvement does not necessarily mean that the functional recovery is achieved⁽¹⁾ ▪ Functional recovery involves the ability to sustain and maintain social, occupational, educational and independent living activities and relationships⁽¹⁾ <p>Bipolar Disorder & Response to Treatment</p> <ul style="list-style-type: none"> ▪ The 2002 APA Practice Guideline for the Treatment of Patients with Bipolar Disorder defines remission during the acute phase of treatment as “a complete return to baseline level of functioning and a virtual lack of symptoms” ▪ The ability to function involves more than the presence or absence of symptoms as some patients with bipolar disorder function well despite having severe symptoms while others have few symptoms but can be dysfunctional⁽²⁾ ▪ Monitoring response to treatment in bipolar disorder should extend beyond symptom reduction to include a focus on a person’s improvement in level-of functioning⁽²⁾ <p>Measuring Level-of-functioning</p> <ul style="list-style-type: none"> ▪ Level-of-functioning instruments measure a person’s ability to interact with others, form relationships and handle day-to-day tasks⁽³⁾ ▪ Self-report of level of functioning has been found to have an important role in treatment as it encourages patient participation and collaborative dialogue⁽³⁾ 	
<p>Denominator Population: Patients diagnosed and treated for bipolar disorder</p> <p>Data Sources:</p> <ul style="list-style-type: none"> ▪ Administrative data ▪ Medical Record 	<p>Numerator Population: Patients whose level of functioning was evaluated during the initial assessment and again within 12 weeks of initiating treatment</p> <p>Data Source:</p> <ul style="list-style-type: none"> ▪ Medical Record
<p>Initial Case-finding Guidance: Patients with a diagnosis involving bipolar disorder ICD9CM or DSM IV TR: 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80-82; 296.89; or 301.13</p>	
<p>STABLE Resource Toolkit: The following instruments are recommended by the STABLE National Coordinating Council for use in monitoring level-of-functioning. This tool is available in the STABLE Resource Toolkit.</p> <ul style="list-style-type: none"> ▪ Sheehan Disability Scale: A brief self-report tool 	
<p>References:</p> <ol style="list-style-type: none"> 1. Harvey P, Defining and Achieving Recovery From Bipolar Disorder, J Clin Psychiatry 2006; 67 (suppl 9) 14-18 2. Keck PE, Defining and Improving Response to Treatment in Patients With Bipolar Disorder; J Clin Psychiatry 2004; 65 (suppl 15) 25-29 3. O’Malia L, McFarland B, et.al, A Level-of-Functioning Self-Report Measure for Consumers With Severe Mental Illness, Psychiatric Services, March 2002, Vol 53, No. 3 26-331 	

STABLE Performance Measure

Measure:

Bipolar Disorder: Monitoring change in level-of-functioning

Endorsed by National Quality Forum, December 2006

Measure Specifications:**Denominator:**

Patients 18 years of age or older with an initial diagnosis or new episode/presentation of bipolar disorder

AND

Documentation of a diagnosis of bipolar disorder; to include at least one of the following:

- Codes 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80; 296.81; 296.82; 296.89; 301.13 documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms
- Diagnosis or Impression or “working diagnosis” documented in chart indicating bipolar disorder
- Use of a screening/assessment tool for bipolar disorder with a score or conclusion that patient has bipolar disorder and indication that this information is used to establish or substantiate the diagnosis

AND

Documentation of treatment for bipolar disorder with relevant pharmacotherapy; a mood stabilizing agent and/or an antipsychotic agent

Denominator Exclusion:

Documentation that patient refuses to provide level-of-functioning information or complete a monitoring form or tool

Numerator:

Documentation of monitoring the patient’s level-of-functioning (See data dictionary reference below)

Level-of-functioning monitoring may occur in any of following ways:

- Documentation in patient chart using level-of-functioning monitoring tool
- Patient verbal self-report of level-of-functioning documented by clinician in record
- Clinician documented review of patient-completed monitoring form or mood diary

AND

Timeframe:

Documentation of assessment of level-of-functioning at time of initial assessment and again, at least once, within 12 weeks of initiating treatment

Data Dictionary Reference:

Level-of-functioning includes the following:

- occupational participation/attendance
- academic participation/attendance
- social functioning including involvement with family or significant others, and
- independence in activities associated with daily living such as maintaining personal care needs, caring for family, taking care of place of residence, etc.