Engaged Practice: Methods For Managing The Complexity Of Bipolar Disorder & Related Conditions

Gary Sachs, MD
Founder
Bipolar Clinic and Research Program
Massachusetts General Hospital
Boston, MA

Paul Keck, MD
President and Chief Executive Officer
Lindner Center of HOPE, Mason, OH
Craig and Frances Lindner Professor and Executive Vice Chairmen
University of Cincinnati College of Medicine
Department of Psychiatry
Cincinnati, OH
Speaker Profiles

Gary Sachs, MD

Position: Dr. Sachs was the founder and director of the Bipolar Clinic and Research Program and an Associate Professor of Psychiatry at the Harvard Medical School until 2010.

Education: Dr. Sachs earned his MD from the University of Maryland, School of Medicine in Baltimore, MD. He also completed a psychiatry residency at Massachusetts General Hospital in Boston, MA. He is board certified by the American Board of Psychiatry and Neurology.

Paul Keck, MD

Position: Dr. Keck is the President & Chief Executive Officer of the Lindner Center of HOPE. He is also the Craig and Frances Lindner Professor of Psychiatry and Neuroscience and Executive Vice Chairmen of the Department of Psychiatry at the University of Cincinnati College of Medicine.

Education: Dr. Keck completed his medical studies at Mount Sinai School of Medicine in New York, NY, and he also completed his residency in Psychiatry at McLean Hospital in Belmont, Massachusetts. Dr. Keck is board certified by the American Board of Psychiatry and Neurology.
This program was developed with the support of Otsuka Pharmaceutical Development & Commercialization, Inc. and Lundbeck, LLC. The speakers are compensated contractors of Otsuka Pharmaceutical Development & Commercialization, Inc.
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Objectives

• Discuss the challenges associated with managing the complexity of bipolar disorder and related conditions

• Review the concept of engaged practice and methods for optimizing work flow

• Demonstrate the efficacy of utilizing a disease management model for diagnosis and treatment
This presentation highlights a model of engaged practice for Bipolar Disorder and related conditions created by Dr. Sachs. Other models of engaged practice exist, and models appropriate for Bipolar Disorder may not be generalizable to other disorders.
Engaged Practice: Methods for Managing the Complexity of Bipolar Disorder & Related Conditions

Psychiatrists’ challenge: Provide a confident diagnosis and treatment guidance in the context of extreme complexity and time constraints.
What is Engaged Practice?

• A set of common principles
  – Accepted by the patient, their care providers and other stakeholders
  – Aims to enhance diagnosis and management
• Key principles and values:
  – Engagement is a means not an end
    • Higher level engagement can reward all stakeholders
      – Patients: Assume burden → may lead to improvements in access/care
      – Clinicians: Easier intake, easier management
        • Less administrative burden → may lead to more satisfaction
  – Collaboration begins with concordance
  – Preparation can enhance all interactions
    • Avoid wasting anyone's time
    • Measure what you want to manage (diagnosis and treatment)
  – Accumulate prospective personal outcomes
Tactics to Optimize the 15 Minute Visit?

- Do whatever is possible with the time available
- Schedule another visit – “Return to clinic”
- Defer action – “Continue present treatment”
- Look for alternatives

min, minute.
Asynchronous Engaged Practice Work Flow:
Shift Burden of Information Collection Outside Appointment

Shift
30 min from patient at home

Assessment Tools
- MADRS
- YMRS
- Quality of Life
- Current Wk Overview (self-report)

At-a-glance Follow-up Report

Sift
< 1 Sec

Gift
Clinician review < 15 seconds before visit

MADRS, Montgomery-Asberg Depression Rating Scale; min, minute; sec, second; Wk, week; YMRS, Young Mania Rating Scale.

The information provided by PsychU is intended for your educational benefit only. It is not intended as, nor is it a substitute for medical care or advice or professional diagnosis. Users seeking medical advice should consult with their physician or other healthcare professional.
### Engaged Practice Work Flow: Current Status Tab*

**SELF-ADMINISTERED PSYCHOACTIVE USE:**
- Caffeine (cups/day): 3
- Alcohol (drinks/week): 4
- Nicotine (packs/day): 1
- Drugs (days used): 0

**OTHER CONDITIONS:**
- Headaches: More than one
- Panic Attacks: one
- Binge/Purge: None
- Fever (days): 0
- Pain (0 - 10): 0
- Exercise (days): 0
- Weight (pounds): 177

**Depression-SR**

**PHQ-9 Total**: 12

**Functional Impact:**
- At Work: No at all
- Taking care of things at home: Somewhat
- Getting Along With people: Extremely

**Menstrual Status**
- Date of last menses: 16 Jan 2017
- Pregnant: No
- Menopausal: No

*This is an example of software that can aid in patient assessment. There are other similar software available.

PDF, portable document format; PHQ-9, The Patient Health Questionnaire; SR, self-report.

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**Engaged Practice Work Flow: Formal Measures Tab**

**AT A GLANCE VIEW:**

<table>
<thead>
<tr>
<th>MADRS items</th>
<th>Score</th>
<th>YMRS items</th>
<th>Score</th>
<th>Self Reported items</th>
<th>Score</th>
<th>Q-LES-Q items</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported Sadness</td>
<td>4</td>
<td>Elevated Mood</td>
<td>2</td>
<td>Sleep</td>
<td>0</td>
<td>Physical Health</td>
<td>5</td>
</tr>
<tr>
<td>Observed Sadness</td>
<td>4</td>
<td>Energy</td>
<td>3</td>
<td>Ability to enjoy pleasant things/usual activities</td>
<td>-1.5</td>
<td>Mood</td>
<td>1</td>
</tr>
<tr>
<td>Inner Tension</td>
<td>6</td>
<td>Sexual Interest</td>
<td>0</td>
<td>Self confidence/ Self Esteem</td>
<td>-1.5</td>
<td>Work</td>
<td>1</td>
</tr>
<tr>
<td>Reduced Sleep</td>
<td>2</td>
<td>Decreased need for sleep</td>
<td>1</td>
<td>Energy</td>
<td>-1.5</td>
<td>Household Activities</td>
<td>2</td>
</tr>
<tr>
<td>Reduced Appetite</td>
<td>3</td>
<td>Irritability</td>
<td>0</td>
<td>Ability to concentrate</td>
<td>-2.0</td>
<td>Social Relationships</td>
<td>2</td>
</tr>
<tr>
<td>Conc Difficulties</td>
<td>5</td>
<td>Speech</td>
<td>0</td>
<td>Distractibility</td>
<td>2.0</td>
<td>Family Relationships</td>
<td>4</td>
</tr>
<tr>
<td>Lassitude</td>
<td>4</td>
<td>Language/thought process</td>
<td>0</td>
<td>Appetite</td>
<td>-0.25</td>
<td>Leisure Activities</td>
<td>2</td>
</tr>
<tr>
<td>Inability to feel</td>
<td>5</td>
<td>Thought content</td>
<td>4</td>
<td>Physical restlessness/ agitation</td>
<td>1.5</td>
<td>Ability to Function</td>
<td>1</td>
</tr>
<tr>
<td>Pessimistic Thoughts</td>
<td>4</td>
<td>Disruptive/ Aggressive</td>
<td>0</td>
<td>Rate of movement or rate of speech</td>
<td>-1.5</td>
<td>Sex drive and interest</td>
<td>1</td>
</tr>
<tr>
<td>SI/ Morbid Thoughts</td>
<td>2</td>
<td>Appearance</td>
<td>1</td>
<td>Feel life isn’t worth living or suicidal thoughts</td>
<td>0</td>
<td>Economic status</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Insight</td>
<td>2</td>
<td>Talking</td>
<td>-1.5</td>
<td>Living/Housing situation</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Racing Thoughts</td>
<td>0</td>
<td>Ability to get around physically</td>
<td>5</td>
</tr>
<tr>
<td>MADRS total</td>
<td>39</td>
<td></td>
<td></td>
<td>Making plans or getting new projects started</td>
<td>-2.0</td>
<td>Vision in terms of ability to do work or hobbies</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Behavior others regard as excessive, foolish or risky</td>
<td>0</td>
<td>Overall sense of well being</td>
<td>2</td>
</tr>
</tbody>
</table>

| YMRS total             | 13    |                      |       | Q-LES-Q total                                   | 32.1% |

| PHQ-9 total            | 19    |                      |       |                                                  |       |

*This is an example of software that can aid in patient assessment. There are other similar software available.

DSM, Diagnostic and Statistical Manual of Mental Disorders; MADRS, Montgomery-Asberg Depression Rating Scale; PHQ-9, The Patient Health Questionnaire; QLESQ, Quality of Life Enjoyment Questionnaire; YMRS, Young Mania Rating Scale.
Engaged Practice Work Flow: Formal Measures Tab*

Algorithmic data transformation: Multiple inputs scored against DSM criteria

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Conc decision, concentration decision; Decr sleep, decreased sleep; Dep mood, depressed mood; DSM, Diagnostic and Statistical Manual of Mental Disorders; elev mood, elevated mood; FOI/RT, flight of ideas or racing thoughts.

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Engaged Practice Work Flow: Formal Measures*
Shifting Burden Outside Appointment, Makes it Easier to Do Our Job Well

LONGITUDINAL MEASURES:

<table>
<thead>
<tr>
<th>Assessments</th>
<th>Clinician time requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Wk Review + MADRS+ YMRS + QLESQ</td>
<td><strong>STEP-BD</strong></td>
</tr>
<tr>
<td>minutes required</td>
<td>(20 + 25 + 30 + 5) = 80</td>
</tr>
<tr>
<td>25 visit Total Minutes</td>
<td><strong>2000</strong></td>
</tr>
</tbody>
</table>

* This is an example of software that can aid in patient assessment. There are other similar software available.
Engaged Practice: Overview
Workflow Delivers High Benefit: Burden Ratio

Initial Assessment
Chief Complaint
Primary Diagnosis: Current Status
  Lifetime
  Bipolarity Index
15 Most Common Conditions
Treatment History
General Medical History
Family History

A few simple rules may enable confident diagnosis and a collaborative approach to care

Enhanced Clinical Interaction
• Pre-assessment
• Maximize use of high level skills
• Wiser recommendations
### DSM-5, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition; MDD, Major Depressive Disorder.

#### Make a Formal Diagnosis

Critical challenge:

DSM 5 field trials show diagnostic reliability modest/poor

**Solution:** Assess diagnostic confidence
Index of Diagnostic Confidence: Five Dimensions

20 point scale for each of the 5 dimensions

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Most convincing characteristic</td>
</tr>
<tr>
<td>15</td>
<td>Other convincing characteristics</td>
</tr>
<tr>
<td>10</td>
<td>Known associated feature suggestive of the disorder</td>
</tr>
<tr>
<td>5</td>
<td>Nonspecific feature suggestive of the disorder</td>
</tr>
<tr>
<td>0</td>
<td>No evidence of the disorder</td>
</tr>
</tbody>
</table>

## Bipolarity Index

<table>
<thead>
<tr>
<th>Dimension</th>
<th>20 Points</th>
<th>15 Points</th>
<th>10 Points</th>
<th>5 Points</th>
<th>2 Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Episode Characteristics</strong></td>
<td>Manic or mixed symptoms with &quot;prominent euphoria, grandiosity, or expansiveness&quot;</td>
<td>Mixed episode or dysphoria or irritable mania</td>
<td>Hypomanic symptoms, or cyclothymia, or mania following an antidepressant</td>
<td>Hypomanic symptoms following an antidepressant; or hypomania below DSM-IV threshold; or MDE with psychotic or atypical features; or postpartum depression</td>
<td>Recurrent MDD or history of psychotic episode</td>
</tr>
<tr>
<td><strong>Age of Onset (y)</strong></td>
<td>15-19</td>
<td>&lt;15 or 20-30</td>
<td>First episode, 30-45</td>
<td>First episode, &gt;45</td>
<td>—</td>
</tr>
<tr>
<td><strong>Illness Course (and Other Features)</strong></td>
<td>Manic episodes separated by periods of full recovery</td>
<td>Incomplete recovery between manic episodes; or hypomania with full recovery between episodes</td>
<td>History of Mania, incomplete recovery, any substance use; or psychosis occurs only during mood episodes; or repeated legal offenses associated with manic behavior (shop lifting, reckless driving, bankruptcy)</td>
<td>Repeated episodes of unipolar depression, (3 or more); or recurrent distinct hypomanias with incomplete recovery between episodes; or any of these co-occurring conditions: borderline personality disorder; anxiety disorder; ADHD with onset before puberty and periods of above average scholastic or social function; gambling or other risk behaviors without mania per se have (or would have if not concealed) pose a problem for patient family or friends; or perimenstrual exacerbating of mood symptoms</td>
<td>Hyperthymic temperament; ≥3 marriages; or 2 jobs in 2 years; or more than 2 advanced degrees</td>
</tr>
<tr>
<td><strong>Response to Medications</strong></td>
<td>Full recovery within 4 weeks of treatment with mood stabilizers</td>
<td>Full recovery within 12 weeks of treatment; or relapse within 12 weeks of stopping mood stabilizers; or switch to mania within 12 weeks of starting antidepressant</td>
<td>Worsening dysphoria or mixed state symptoms during antidepressant; or partial response to mood stabilizers within 12 weeks; or antidepressant induced rapid cycling or worsening thereof</td>
<td>Lack of response to 3 or more antidepressants; or mania/hypomania when antidepressant stopped</td>
<td>Immediate response, almost complete, to antidepressant within 1 week or less</td>
</tr>
<tr>
<td><strong>Family History</strong></td>
<td>At least first-degree relative (brother/ sister, parent, or child) with clear bipolar disorder</td>
<td>Second-degree relative with bipolar diagnosis; or first-degree relative with recurring unipolar depression and features suggestive of bipolar disorder</td>
<td>First-degree relative with recurring unipolar depression or schizoaffective disorder; or any relative with clear bipolar diagnosis; or any other relative with unipolar depression and symptoms suggestive of bipolar disorder</td>
<td>Any relative with possible bipolar illness; first-degree relative has clear problem with drugs or alcohol</td>
<td>First-degree relative has repeated episodes of depression; or has an anxiety disorder, an eating disorder, or ADHD</td>
</tr>
</tbody>
</table>

ADHD, attention-deficit/hyperactivity disorder; DSM-IV, Diagnostic and Statistical Manual of Mental Disorders, 4th ed.; MDD, major depressive disorder; MDE, major depressive episode; y, years.

Case Presentation 1*

Mr. A is a 28 year old attorney:
- He is normally an upbeat, high-energy person
- He now feels down and worn out by his job, and wants to withdraw from the world and sleep

Recent complaints include:
- Struggling to concentrate on his substantial work load
- Worrying about his work performance
- Feeling like he cannot contain his anxiety
- Second-guessing his career choice

Treatment
- He has not responded well to a trial of an antidepressant medicine

*Fictional case presentation.
Case Presentation 1: Assessment Review and Patient History*

- Results of MADRS and YMRS were reviewed and the patient:
  - Reports that he first felt down during his freshman year in college, saw a college counselor, and felt like he “popped out of it,” on his own
  - Has always been a high achiever, and reports that people say he has a type AAA personality
  - At times has felt nearly invincible in handling challenges in college and law school, and has many friends because of his outgoing personality
  - Reports that his father “drank too much and often,” and that his paternal grandmother was never diagnosed with, but appeared to have been depressed for long periods of time when he was growing up

*Fictional case presentation.

MADRS, Montgomery-Asberg Depression Rating Scale; YMRS, Young Mania Rating Scale.
Chief Complaint = “Depression”
You Make the Episode Diagnosis

Case 1: Mr. A*

*Fictional case presentations. This is an example of software that can aid in patient assessment. There are other similar software available.

Conc decision, concentration decision; Decr sleep, decreased sleep; Dep mood, depressed mood; DSM, Diagnostic and Statistical Manual of Mental Disorders; elev mood, elevated mood; FOI/RT, flight of ideas or racing thoughts; Guilt Dec SE, guilt or decreased self-esteem; Incr goal active, increased goal activities; Incr SE, increased self-esteem; MADRS, Montgomery-Asberg Depression Rating Scale; psychomotor agit, psychomotor agitation; SI morbid, suicidal ideation or morbid thoughts; WNL, none or within normal limits; YMRS, Young Mania Rating Scale.
**Assessing Diagnostic Confidence: Mr. A***

<table>
<thead>
<tr>
<th>Highest High episode</th>
<th>Age of onset</th>
<th>Course of illness</th>
<th>Response to treatment</th>
<th>Family History</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td>Brother diagnosed and treated for BP</td>
</tr>
<tr>
<td>The most convincing characteristic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Another convincing characteristic</td>
<td>Irritable psychotic mania without euphoria or expansive mood (age 25)</td>
<td>Depression age 12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td>Worsening dysphoria or mixed state symptoms during antidepressant; And only partial response to mood stabilizers within 12 weeks</td>
<td></td>
</tr>
<tr>
<td>Known associated feature suggestive of the disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonspecific feature suggestive of the disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No evidence of the disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Fictional case presentation.*
Case Presentation 2*

Mrs. B is a 38 year old sales manager:

– She reports having stress in her marriage because she feels that her husband is remote and uncommunicative
– Her sales job requires her to travel a number of days each month, wearing her out and taking a toll on her marriage
– She feels trapped in her job and marriage and cannot see any clear solutions
– She wonders whether she can continue on and reports that she “cannot sleep,” and consequently feels tired all the time

*Fictional case presentation.
Case Presentation 2: Assessment Review and Patient History*

- Results of MADRS and YMRS were reviewed and the patient:
  - Believes she had “mild ADD,” in high school, but she “grew out of it in college”
  - Has had previous hospitalization for manic episode
  - Suffered from periods of time when she felt unable to cope well with anxiety
  - Has never been treated for ADD or anxiety
  - Reports feeling guilty that she cannot juggle a good “work-life” balance
  - Has an uncharacteristically hard time organizing herself and feels at times like basic decisions are overwhelming
  - Has two young children, and wonders at times if her family would be better off without her
  - Reports that her mother’s sister struggled with an eating disorder and that her mother’s brother died of a drug overdose

*Fictional case presentation.

ADD, Attention Deficit Disorder; MADRS, Montgomery-Asberg Depression Rating Scale; YMRS, Young Mania Rating Scale.
Chief Complaint = “Depression”
You Make the Episode Diagnosis

Case 2: Mrs. B*

*Fictional case presentations. This is an example of software that can aid in patient assessment. There are other similar software available.

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### Assessing Diagnostic Confidence: Mrs. B*

<table>
<thead>
<tr>
<th>Highest High episode</th>
<th>Age of onset</th>
<th>Course of illness</th>
<th>Response to treatment</th>
<th>Family History</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 Most convincing characteristic</td>
<td></td>
<td>17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Euphoric episode without confounding substance misuse or medical condition</td>
<td></td>
<td>Multiple episodes with full inter-episode recovery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 Other convincing characteristics</td>
<td></td>
<td></td>
<td>Response to Valproate with recovery in 2nd month</td>
<td></td>
</tr>
<tr>
<td>Known associated feature suggestive of the disorder</td>
<td></td>
<td></td>
<td></td>
<td>Grandmother’s sister Hospitalized for manic-depression</td>
</tr>
<tr>
<td>10 Nonspecific feature suggestive of the disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 No evidence of the disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Fictional case presentation.
Mr. A After One Week of Treatment*

**AT A GLANCE DSM SYMPTOM SUMMARY REPORTED FOR WEEK OF 02/24/2016**

Past Week: Compared to Best week and Worst week in past two months: a little better moderately better

Sleep Range: Least and Most hours reported for any day in past week 7 - 8 hours

This summary brings together ratings from various computer administered scales and scores each on a common ordinal scale.

### Depression

- **MADRS**
- **Current Week**
- **Other**

### Mood Elevation

- **YMRS**
- **Current Week**
- **Other**

---

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Simple Schema for Practice of Personalized Medicine

Critical decision point

Menu of reasonable choices

Efficacy  Tolerability
Option A  +++  +++
Option B  ++   ++++
Option C  +++  ++

Negotiate

Intervention

Definitive Outcome

Measure-Based Guidance

Well  ILL

Eviden ce

A-F

Individual factors

Educate

Individual Factors for Consideration During Treatment

- **Course**¹
  - Polarity Predominance
  - Number / Frequency of prior episodes
  - Rapid Cycling
- **Index Episode**¹
  - Mixed Episodes
  - Psychosis
- **Residual Symptoms**¹
- **Gender**¹
- **Comorbid Psychiatric Illness**¹,²
  - Substance misuse
  - Anxiety Disorders
  - ADHD
- **Biomarkers (?)**
- **Prior Treatment Response**³
  - Acute
  - Prophylaxis
- **Adverse Effect Tolerance**
- **General Medical Disorder/Risk factors**³
  - Cardiac: Obesity, Hypertension
  - Endocrine: Thyroid, Diabetes
  - Hematopoietic/Immune Function
  - Age
- **Therapeutic Priority**²
  - Urgent Care Strategy
  - Sequential Strategy
- **Concordance**²

---

ADHD, Attention Deficit Hyperactivity Disorder.


Guidance for Clinical Management

- Construct your initial menu of reasonable choices: Offer proven treatment first
- Revise menu based on measured results
  - Aim for definitive outcome
  - Stop ineffective/intolerable treatments
  - Continue what works
Quality of Evidence

A. Double blind placebo controlled trial with adequate sample*
B. Double blind comparison studies with adequate sample*
C. Open comparison trials with adequate sample*
D. Uncontrolled observation or controlled study with ambiguous result
E. No published evidence (+/- class effect)
F. Available evidence negative

* statistical power ≥ 0.8 to detect meaningful differences at p< 0.05

Clinical Empiricism: Fund of Knowledge for Treatment Selection

Initial Selection: Base on best available evidence

- Retrospective reports and population based study results
  - My best recollection of my response to past treatment

Next Selection: Base on best available evidence

- Prospective personal results
  - My measured response over a course of prospective treatment
## Upcoming Virtual Fora*

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<th>Event</th>
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| Improving Healthcare For Mental Health Patients: Is Collaborative Care The Answer? | • Brent Forester, MD  
• Rebecca Roma, MD  
• Cheen Lum, PharmD, BCPP  
• Kathy Gonzalez, RN | Thursday, April 27, 2017 | 12:00—1:00pm EST |
| Dealing With Stigma In Mental Health: Are We Making Progress?       | • Patrick Corrigan, PsyD  
• Kent Alford, RN, BSN                                                      | Wednesday, May 10, 2017     | 12:00—1:00pm EST     |
| Integrated Care: Navigating The Evolving Health Care System In 2017  | • Sloan Manning, MD  
• Marla Moses, FNP, PMHNP  
• Clayton Chau, MD                                                            | Tuesday, May 16, 2017       | 12:00—1:00pm EST    |
| Looking Beyond Mood & Psychosis: A Focus On Neurocognition          | • Philip D. Harvey, PhD  
• Katherine Burdick, PhD                                                      | Wednesday, June 7, 2017     | 12:00—1:00pm EST    |
| Exploring Nonpharmacological Anti-Inflammatory Strategies In Mental Health: Connecting Science To Clinical Practice (Inflammation Part 2) | • Rakesh Jain, MD, MPH                                                      | Thursday, June 15, 2017     | 12:00—1:00pm EST    |

*Register for these programs at https://www.psychu.org/events/
Engaged Practice: Methods For Managing The Complexity Of Bipolar Disorder & Related Conditions

Gary Sachs, MD
Founder
Bipolar Clinic and Research Program
Massachusetts General Hospital
Boston, MA

Paul Keck, MD
President and Chief Executive Officer
Lindner Center of HOPE, Mason, OH
Craig and Frances Lindner Professor and Executive Vice Chairmen
University of Cincinnati College of Medicine
Department of Psychiatry
Cincinnati, OH