FRAMEWORKS
in Health and Quality

Understanding and Diagnosing Bipolar Disorder

Treatment for Individuals With Bipolar Disorder

A Resource for Payers

Frameworks resources are intended for educational purposes only and are intended for healthcare professionals and/or payer representatives. They are not intended as, nor are they a substitute for, medical care, advice, or professional diagnosis. Healthcare professionals should use independent medical judgment when considering *Frameworks* educational resources. Those seeking medical advice should consult with a healthcare professional. *Frameworks* resources are not intended as reimbursement or legal advice. Users should seek independent, qualified professional advice to ensure their organization is in compliance with the complex legal and regulatory requirements governing healthcare services, and that treatment decisions are made consistent with the applicable standards of care. *Frameworks* is sponsored by Otsuka Pharmaceutical Development & Commercialization, Inc.

February 2018 MRC2.UNB.X.00116

Treatment for Individuals With Bipolar Disorder

The estimated direct and indirect costs of bipolar I and II disorders in 2009 were **$30.7 billion** and **$120.3 billion**, respectively.[5]

Economic Impact of Bipolar Disorder

Bipolar disorder is a chronic mental illness, and refers to a spectrum that encompasses several diagnoses, including bipolar I, bipolar II, and cyclothymic disorder.[1,2]

Bipolar I disorder, marked by extreme manic episodes, has a lifetime prevalence of 2.1% and a 12-month prevalence of 1.5%.[2,3] This equates to approximately 4.9 million and 3.7 million adult Americans, respectively, who are affected.[3] The onset of bipolar disorder typically begins between the ages of 15-24.[4] It can be diagnosed at any age; however, the average age of onset for bipolar I disorder is 22 years.[3] There is often a considerable interval between onset and first treatment or first hospitalization.[4]

Bipolar disorder is one of the most costly of all mental health conditions. In one study of commercial claims data from 1996, while **only 3% of 1.7 million patients were identified with bipolar disorder**, they accounted for **12.4% of the total plan expenditures**.[5] In another study of healthcare utilization and costs from 2004 to 2007 in an employee-sponsored, self-funded plan, patients with bipolar disorder had higher adjusted mean costs per member per month than patients with asthma, coronary artery disease, depression, and diabetes – with the exception of patients who had both diabetes and coronary artery disease (n=455; approximately $2000).[5,6]

Healthcare Utilization and Costs[5,6]

Illness	Adjusted Mean Costs
Asthma	~$900 (n=2770)
Coronary artery disease	~$1250 (n=1759)
Depression	~$1300 (n=1290)
Diabetes	~$1250 (n=1418)
Bipolar disorder	~$1700 (n=122)

The Challenges Presented to Health Plans

Care is likely to be more expensive for those patients with a delayed diagnosis of bipolar disorder.[5]

In a constituency survey by the National Depressive and Manic-Depressive Association, only one in four individuals with bipolar disorder reported receiving an accurate diagnosis within three years of first experiencing symptoms.[7] The misdiagnosis of bipolar disorder can have negative consequences, and delayed diagnosis may lead to higher costs and worsening clinical outcomes.[5,7]

Greater than 33% of patients with bipolar disorder remained misdiagnosed for ten or more years, delaying treatment.[7]

Additionally, while estimates vary across the literature, the average bipolar medication nonadherence rate is reported to be 40%. Nonadherence is associated with outcomes such as relapse, hospitalization, functional impairment, and suicidality.[8]

Patients with bipolar disorder are more likely to commit suicide—more so than any other psychiatric or general medical diagnosis.[5]

In addition, suicide attempts are costly. In comparing the one year before and after 352 patients' first suicide attempt, one study found that the mean healthcare cost more than doubled following the attempt. A large cost increase was seen during the month following the attempt in inpatient and emergency services; however, there were lasting increases in outpatient and prescription costs.[5]

Treatment for Individuals With Bipolar Disorder

Patients with bipolar disorder, including bipolar I, may face challenges which contribute to low treatment rates.[3]

Comorbidities

Patients with bipolar disorder are more likely to have other psychiatric disorders.[5,9] Comorbid conditions are associated with longer episodes of illness, shorter periods of remission, poor treatment compliance, and suicidality.[5]

Adverse side effects

Patients with bipolar disorder may experience unwanted side effects from some medications, or combination of medications.[9]

Finances

Patients with bipolar disorder may lack insurance or face other financial barriers.[3]

Poor insight

Patients with bipolar disorder may lack insight, which may interfere with their ability to make treatment decisions.[4]

Stigma

Frequently cited as a barrier to mental healthcare, stigma is associated with reduced treatment seeking.[10]

While there is no cure for bipolar disorder, treatment can decrease related morbidity and mortality.[4]

Treatment of Bipolar Disorder

Bipolar disorder is a condition which generally requires long-term treatment. While there is no cure for bipolar disorder, treatment can decrease related morbidity and mortality.[4]

Medication Therapy

With regard to treatment, medication therapy is considered to be one essential component.[4] Federal Drug Administration approval includes indications for medications which have passed rigorous scientific reviews for specific uses in specific disorders.[11,12] Medications which have been used to treat bipolar disorder have included:

- Mood stabilizers[13]
- Antidepressants[13]
- Antipsychotics[14]

Psychosocial Interventions

Psychosocial interventions which may be considered for patients with bipolar disorder include:

- Psychoeducation[9]
- Cognitive behavioral therapy[9]
- Family-focused therapy[9]
- Interpersonal and social rhythm therapies[9]
- Group psychotherapy[4]
- Peer support[15]

In conjunction with medication, psychosocial interventions, which focus on illness management tactics, may offer some benefit to patients with bipolar disorder.[9]

Treatment for Individuals With Bipolar Disorder

Promoting Treatment

Medicaid, as the single largest payer of mental health services, recognizes that it is able to promote evidence-based practices for mental health patients, including those with bipolar disorder diagnoses. In reviewing the Medicaid data, there are recommendations which other stakeholders may find beneficial.[16]

Encourage integrated, collaborative care

Interdisciplinary relationships can provide for rapid referral of a patient when needed.[17] Additionally, there is a high frequency of medical comorbidities in patients with bipolar disorder, potentially necessitating physical health monitoring and preventative screening.[9,16] A patient-centered team approach may offer the greatest likelihood of success.[9]

Encourage psychosocial interventions

In one study of patients with bipolar spectrum disorder age 18 years and older, a systematic care management program reduced the frequency and severity of manic episodes.[18] In conjunction with pharmacotherapy, other studies have shown psychoeducational programs focused on early symptom recognition reduced manic episodes, psychoeducational programs focused on self-management skills reduced subsequent mania and depression, those focused on cognitive behavioral therapy reduced frequency of mania and depression, and family-focused psychoeducation reduced mood disorder symptoms and risk of relapse.[18] Consider examining the extent to which the psychosocial interventions being reimbursed are aligned with evidence-based practices and how you are monitoring and tracking the services.[16]

Examine whether policies and practices delay care

Medicaid data showed that higher copays and more stringent prior-authorization procedures were associated with a decreased rate of continuous medication use.[16] Also, consider whether policies regarding medications, such as fail-first policies and limits on quantity or refills, are potentially impacting patients.[16] Nonadherence is associated with outcomes such as relapse, hospitalization, functional impairment, and suicidality.[8]

Monitor quality

The National Behavioral Health Quality Framework, developed by the Substance Abuse and Mental Health Services Administration, provides a method by which to examine and prioritize quality for prevention, treatment, and recovery elements. The framework is designed for multiple levels, including the payer level.[19] Claims and enrollment data may be used to track progress toward the goals of the framework, as well as irregularities in how patients are receiving care and services.[16]

Consider examining the extent to which the psychosocial interventions being reimbursed are aligned with evidence-based practices.[16]

References: 1. Bipolar disorder. National Alliance on Mental Illness web site. https://www.nami.org/Learn-More/Mental-Health-Conditions/Bipolar-Disorder. Accessed June 20, 2017. **2.** American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. Arlington, VA: American Psychiatric Association Publishing; 2013. **3.** Blanco C, Compton WM, Saha TD, et al. Epidemiology of DSM-5 bipolar I disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions – III. *J Psychiatry Res*. 2017;(84):310-317. **4.** Hirschfeld R, Bowden CL, Gitlin MJ, et al. *Practice Guideline for the Treatment of Patients With Bipolar Disorder*, 2nd ed. Arlington, VA: American Psychiatric Association Publishing; 2002. **5.** Jann MW. Diagnosis and treatment of bipolar disorder in adults: a review of the evidence on pharmacologic treatments. *Am Health Drug Benefits*. 2014;7(9):489-499. **6.** Williams MD, Shah ND, Wagie AE, et al. Direct costs of bipolar disorder versus other chronic conditions: an employer-based health plan analysis. *Psychiatric Serv*. 2011;62(9):1073-1078. **7.** Living with bipolar disorder: how far have we really come? National Depressive and Manic-Depressive Association web site. http://www.dbsalliance.org/pdfs/bphowfar1.pdf. Published 2001. Accessed June 21, 2017. **8.** Gaudiano BA, Weinstock LM, Miller IW. Improving treatment adherence in bipolar disorder: a review of current psychosocial treatment efficacy and recommendations for future treatment development. *Behav Modif*. 2008;32(3):267-301. **9.** Culpepper L. The diagnosis and treatment of bipolar disorder: decision-making in primary care. *Prim Care Companion CNS Disord*. 2014;(16)3. **10.** Dockery L, Jeffery D, Schauman O, et al. Stigma- and non-stigma related treatment barriers to mental healthcare reported by service users and caregivers. *Psychiatry Res*. 2015;228:612-619. **11.** U.S. Food & Drug Administration. How drugs are developed and approved. http://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/. Updated September 2015. Accessed June 21, 2017. **12.** FDA approved drugs for psychiatry/psychology. CenterWatch web site. https://www.centerwatch.com/drug-information/fda-approved-drugs/therapeutic-area/17/psychiatry-psychology. Accessed June 21, 2017. **13.** Ketter TA, eds. Mood stabilizers and second-generation antipsychotics: pharmacology, drug interactions, adverse effects, and dosing. In Ketter, TA, ed. *Advances in Treatment of Bipolar Disorders*. Arlington, VA: American Psychiatric Association Publishing; 2005. **14.** Geddes JR, Miklowitz DJ. Treatment of bipolar disorder. *Lancet*. 2013;381(9878):1672-1682. **15.** Peer support research. Depression and Bipolar Support Alliance web site. http://www.dbsalliance.org/site/PageServer?pagename=wellness_peer_support_research. Accessed June 24, 2017. **16.** Assistant Secretary for Planning and Evaluation; US Department of Health and Human Services. Evidence-based treatment for schizophrenia and bipolar disorder in state Medicaid programs: issue brief. https://aspe.hhs.gov/system/files/pdf/76496/sbpdIB.pdf. Published February 1, 2012. Accessed June 24, 2017. **17.** Susman JL. Improving outcomes in patients with bipolar disorder through establishing an effective treatment team. *Prim Care Companion J Clin Psychiatry*. 2010;12(suppl 1):30-34. **18.** Simon GE, Ludman EJ, Bauer MS, et al. Long-term effectiveness and cost of a systematic care program for bipolar disorder. *Arch Gen Psychiatry*. 2006;63(5):500-508. **19.** National Behavioral Health Quality Framework. Substance Abuse and Mental Health Services Administration web site. https://www.samhsa.gov/data/national-behavioral-health-quality-framework. Updated October 2014. Accessed June 24, 2017.

February 2018 MRC2.UNB.X.00116

FRAMEWORKS
in Health and Quality

Understanding and Diagnosing Bipolar Disorder

Combating Stigma

A Resource for Payers

Frameworks resources are intended for educational purposes only and are intended for healthcare professionals and/or payer representatives. They are not intended as, nor are they a substitute for, medical care, advice, or professional diagnosis. Healthcare professionals should use independent medical judgment when considering *Frameworks* educational resources. Those seeking medical advice should consult with a healthcare professional. *Frameworks* resources are not intended as reimbursement or legal advice. Users should seek independent, qualified professional advice to ensure their organization is in compliance with the complex legal and regulatory requirements governing healthcare services, and that treatment decisions are made consistent with the applicable standards of care. *Frameworks* is sponsored by Otsuka Pharmaceutical Development & Commercialization, Inc.

February 2018 MRC2.UNB.X.00117

Combating Stigma

The onset of bipolar disorder typically begins **between the ages of 15-24.** There is often a considerable interval between onset and first treatment or first hospitalization.[7]

Stigma and Bipolar Disorder

Patients with mental illness, such as bipolar I or another bipolar disorder, experience stigma that may negatively impact their care.[1] Unfortunately, the healthcare system is one of the key environments in which patients with mental illness experience stigma and discrimination.[2]

Bipolar I, marked by extreme manic episodes, has a **lifetime prevalence of 2.1%** and a **12-month prevalence of 1.5%**.[3,4] This equates to approximately **4.9 million** and **3.7 million** adult Americans, respectively, who are affected.[4]

Though the literature regarding stigma specifically related to bipolar is limited, there is substantial research related to stigma and mental illnesses.[5] This resource is based upon this knowledge, and surmises that patients with bipolar disorder may be subject to the same types of stigma as those patients with other mental illnesses.

Combating Stigma

Stigma has been identified as one of the primary barriers to accessing care and to receiving equitable quality of care.[2] It is frequently cited as a barrier to mental healthcare and is associated with reduced treatment seeking.[6]

For people with mental illness, stigma can lead to[2]:

- Inadequate access to proper treatment
- Less treatment compliance
- Breakdown of the therapeutic relationship
- Greater avoidance of healthcare services

Effectively combating stigma ultimately requires multidimensional, multilevel approaches that address stigma holistically, from programming to structural change.[2] Payers are in a unique position to champion anti-stigma initiatives. In recognizing the potential impact of stigma, payers are able to structure programs and offer education in order to combat it.

Strategies that payers may employ to address stigma:

Committing to the cause

Consider a public campaign showing your support in the effort to combat stigma. The Substance Abuse and Mental Health Services Administration offers a guide for developing a local, regional, or statewide initiative to combat stigma, which is available on their web site.[8]

Offer skill-based training to staff and providers

Targeted training can offer an avenue by which providers can learn what to do to help. The "what to do to help" approach, for example, has been used as part of some anti-stigma programs.[2]

Offer support

Speaking with others who have bipolar disorder can help patients to better understand and gain greater control over their illness. Patients engaged in peer support programs have been shown to be more likely to utilize behavioral health services of all kinds.[9] Groups such as the National Alliance on Mental Illness and the Depression and Bipolar Support Alliance offer local and internet supports.[10,11]

Underscore autonomy

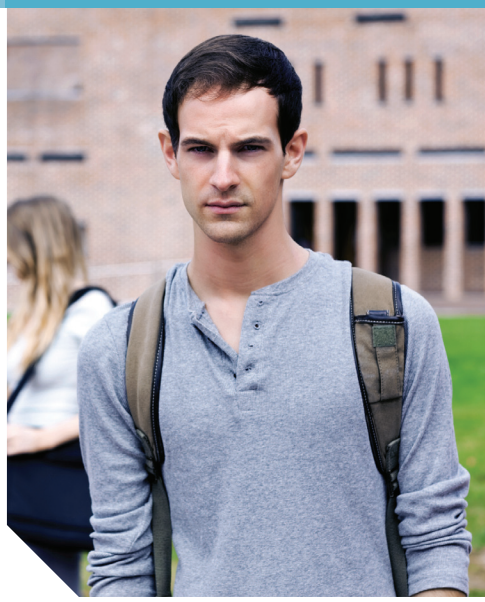
Stigma contributes to the belief that patients with mental illness are unable to make their own decisions.[1] Among the resources directed at patients, you can encourage autonomy by offering a Psychiatric Advanced Directive, which outlines a patient's wishes when they are unable to do so themselves.[12]

Ask professionals and leaders to help combat stigma

More voices lead to more awareness.[13]

Portray people realistically

Patients with bipolar disorder experience periods without symptoms. Avoid depicting the illness and the patient's symptomology as always being in an acute episode, and instead, describe their entire life and the cycles of their condition.[14]



Stamp Out Stigma, an initiative by the Association for Behavioral Health and Wellness, is one example of a campaign to publicly address stigma.[15]

Types of Stigma

Stigma falls into four categories

Public stigma is based on the endorsement of a stereotype of mental illness by the general population. For example, the idea that a patient with mental illness is unreliable may result in a provider disbelieving a physical complaint.[13]

Self-stigma is the result of the patient internalizing the discriminatory beliefs and then acting based on the internal belief. For example, if a patient believes a stereotype which suggests that people with mental illness are unreliable, they may believe that they are not reliable enough to keep up with the demands of a job because of their mental illness.[13]

Label avoidance refers to a third type of stigma, where a patient may not seek mental health services in order to avoid being labeled.[13]

Structural stigma refers to societal norms and institutional practices which may limit the opportunities and resources available to a stigmatized patient.[16] This type of stigma may be visible in a lack of integrated care services or a lack of appropriate referrals to behavioral health providers.[17]

Healthcare providers and health plan workers are not immune to stigmatizing behavior. They typically see patients with mental illness when they are most unwell, which may give a biased view of the patient and their chance of recovery.[2]

References: 1. Corrigan P, Watson A. Understanding the impact of stigma on people with mental illness. *World Psychiatry.* 2002;(1):16-20. **2.** Ungar T, Knaak S, Szeto AC. Theoretical and practical considerations for combating mental illness stigma in health care. *Community Ment Health J.* 2016;(52):262-271. **3.** American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. Arlington, VA: American Psychiatric Publishing; 2013. **4.** Blanco C, Compton WM, Saha TD, et al. Epidemiology of DSM-5 bipolar I disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions – III. *J Psychiatry Res.* 2017;(84)310-317. **5.** Griffiths KM, Carron-Arthur B, Parsons A, et al. Effectiveness of programs for reducing the stigma associated with mental disorders. A meta-analysis of randomized controlled trials. *World Psychiatry.* 2014;(13),161-175. **6.** Dockery L, Jeffery D, Schauman O, et al. Stigma- and non-stigma related treatment barriers to mental healthcare reported by service users and caregivers. *Psychiatry Res.* 2015;228:612-619. **7.** Hirschfeld R, Bowden CL, Gitlin MJ, et al. *Practice Guideline for the Treatment of Patients With Bipolar Disorder*, 2nd ed. Richmond, VA: American Psychiatric Association. 2002. **8.** Developing a Stigma Reduction Initiative. SAMHSA Pub No. SMA-4176. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. samhsa.gov. https://store.samhsa.gov/product/Developing-a-Stigma-Reduction-Initiative-with-CD-/SMA06-4176. Published January 2006. Accessed June 21, 2017. **9.** National Academies of Sciences, Engineering, and Medicine. *Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change*. Washington, DC: The National Academies Press; 2016. **10.** Find your local NAMI. National Alliance On Mental Illness web site. https://www.nami.org/Find-Your-Local-NAMI. Accessed June 21, 2017. **11.** Depression and Bipolar Support Alliance. Peer support. http://www.dbsalliance.org/site/PageServer?pagename=peer_landing. Accessed June 21, 2017. **12.** Scheyett A. Psychiatric advanced directives: empowering consumers with serious mental illnesses. National Association of Social Workers web site. http://www.helpstartshere.org/health-and-wellness/disabilities/disabilities-your-options-psychiatric-advance-directives-empowering-consumers-with-serious-mental-illnesses.html. Accessed June 21, 2017. **13.** Corrigan P. Lessons learned from unintended consequences about erasing the stigma of mental illness. *World Psychiatry.* 2016;(15)67-73. **14.** 10 Ways to Combat Discrimination With Compassionate Language. Depression and Bipolar Support Alliance web site. http://www.dbsalliance.org/site/PageServer?pagename=dbsa_language. Accessed June 22, 2017. **15.** Association for Behavioral Health and Wellness. Stamp out stigma. http://stampoutstigma.com/about.html. Updated 2012. Accessed June 21, 2017. **16.** Corrigan PW, Druss BG, Perlick DA. The impact of mental illness stigma on seeking and participating in mental health care. *Psychol Sci Public Interest.* 2014;15(2):37-70. **17.** Pugh T, Hatzenbuehler M, Link B; for the Committee on the Science of Changing Behavioral Health Social Norms. http://sites.nationalacademies.org/cs/groups/dbassesite/documents/webpage/dbasse_170045.pdf. Published August 2015. Accessed June 21, 2017.

February 2018 MRC2.UNB.X.00117

FRAMEWORKS
in Health and Quality

Understanding and Diagnosing Bipolar Disorder

Diagnosing Bipolar Disorder

A Resource for Payers

Frameworks resources are intended for educational purposes only and are intended for healthcare professionals and/or payer representatives. They are not intended as, nor are they a substitute for, medical care, advice, or professional diagnosis. Healthcare professionals should use independent medical judgment when considering *Frameworks* educational resources. Those seeking medical advice should consult with a healthcare professional. *Frameworks* resources are not intended as reimbursement or legal advice. Users should seek independent, qualified professional advice to ensure their organization is in compliance with the complex legal and regulatory requirements governing healthcare services, and that treatment decisions are made consistent with the applicable standards of care. *Frameworks* is sponsored by Otsuka Pharmaceutical Development & Commercialization, Inc.

February 2018 MRC2.UNB.X.00115

Diagnosing Bipolar Disorder

Bipolar Disorder: A Spectrum

Bipolar disorder is a chronic mental illness and refers to a spectrum that encompasses several diagnoses, including bipolar I, bipolar II, and cyclothymic disorder.[1,2]

Bipolar I disorder, marked by extreme manic episodes, has a lifetime prevalence of 2.1% and a 12-month prevalence of 1.5%.[2,3] This equates to approximately 4.9 million and 3.7 million adult Americans, respectively, who are affected.[3]

While bipolar II disorder seems to be more common in women, bipolar I disorder affects men and women equally. The onset of bipolar disorder typically begins between the ages of 15-24. There is often a considerable interval between onset and first treatment or first hospitalization.[4]

Sometimes called manic depressive disorder, bipolar disorder is a serious mental illness that causes dramatic shifts in mood, energy, and activity levels. Moods can range from manic or hypomanic episodes—characterized by periods of elation, inflated self-esteem, grandiosity, decreased need for sleep, increased talkativeness, racing thoughts or ideas, and energized behavior—to periods of depression and hopelessness.[5]

Patients may experience significant distress and/or impairment in important areas of functioning, such as work, cognition, and interpersonal relationships.[2]

Economic Impact of Bipolar Disorder

Bipolar disorder is one of the most costly of all mental health conditions.[6] In one study of commercial claims data from 1996, while only 3% of 1.7 million patients were identified with bipolar disorder, they accounted for 12.4% of the total plan expenditures.[6] Healthcare costs are dramatically higher for patients with bipolar disorder than those without, largely because of increased medical utilization, although direct mental health spending is also higher.[7]

In one study of healthcare utilization and costs from 2004 to 2007 in an employee-sponsored, self-funded plan, patients with bipolar disorder had higher adjusted mean costs per member per month than patients with asthma, coronary artery disease, depression, and diabetes—with the exception of patients who had both diabetes and coronary artery disease (n=455; approximately $2000).[6,8]

Healthcare Utilization and Costs[6,8]

Illness	Adjusted Mean Costs
Asthma	~$900 (n=2770)
Coronary artery disease	~$1250 (n=1759)
Depression	~$1300 (n=1290)
Diabetes	~$1250 (n=1418)
Bipolar disorder	~$1700 (n=122)

The same study further evaluated these costs and considered the distribution of specialty care costs. They determined that the top 20% (by cost) of patients with bipolar disorder accounted for 64% of the total costs and were more likely to be women with more comorbidities. The same top 20% of patients with bipolar disorder also had significantly higher hospital admission rates and more hospital days compared with the remaining 80%.

The estimated direct and indirect costs of bipolar I and II disorders in 2009 were **$30.7 billion** and **$120.3 billion**, respectively.[9]

Diagnosing Bipolar Disorder

Biploar Disorder: Diagnostic Challenges

In a constituency survey by the National Depressive and Manic-Depressive Association, only one in four individuals with bipolar disorder reported receiving an accurate diagnosis within three years of first experiencing symptoms.[10]

Greater than 33% of patients with bipolar disorder remained misdiagnosed for ten or more years, delaying treatment.[10]

Why do misdiagnoses happen?

Unipolar depression is more common than bipolar depression, and patients with bipolar disorder are more likely to present with depression.[11] Patients may also experience a series of depressive episodes before ever experiencing a manic, hypomanic, or mixed episode.[12,13]

The symptoms of depression for a patient with bipolar disorder may be similar to the symptoms of depression for a patient without bipolar disorder. This may potentially lead to a misdiagnosis.[11]

Patients with bipolar disorder may have symptoms which prompt providers to consider diagnoses such as attention-deficit/hyperactivity disorder, personality disorders, panic disorders, substance use disorders, or schizophrenia spectrum disorders.[2]

Potential Consequences of Misdiagnosis

The misdiagnosis of bipolar disorder can have negative consequences, and delayed diagnosis may lead to higher costs and worsening clinical outcomes.[6,11]

The treatment that a treatment team may recommend for a different diagnosis, such as major depressive disorder, may not provide the same response in patients with bipolar disorder.[6,11] Negative consequences may not be limited to mental health; patients with untreated bipolar disorders have higher rates of death from cardiovascular causes.[12]

Additionally, care for patients with a delayed diagnosis of bipolar disorder may be more costly than for those patients with an early diagnosis. An analysis of the California Medicaid program comparing patients with delayed diagnosis of bipolar disorder to patients with early diagnosis showed that patient costs increased by $10 per month before a correct diagnosis and decreased by $1 per month afterward. The same analysis showed that the annualized total cost for a patient with delayed diagnosis was $2316 higher at year six compared to those patients with early diagnosis.[6]

Delayed diagnosis may lead to higher costs and worsening clinical outcomes.[6]

Diagnosing Bipolar Disorder

Early diagnosis may reduce the risk of relapse and improve response to treatment.[12]

Supporting Diagnosis of Bipolar Disorder

Screening for bipolar disorder may improve efficiency and increase sensitivity in detection.[4] When using a structured interview, approximately 21% to 26% of patients who present with depression or anxiety will meet criteria for a bipolar disorder diagnosis.[12]

Payers may wish to consider educating providers on the following resources:

- **Mood Disorder Questionnaire (MDQ):** A 15-question validated self-reporting tool. Patients answer questions regarding symptoms, symptom clusters, and functional impairment. When used, the MDQ can help identify almost three-quarters of patients with bipolar disorder and screen out the diagnosis in 90% of those who do not have it.[11] It is available through the Substance Abuse and Mental Health Services Administration (SAMHSA).[14]

- **Standards for Bipolar Excellence (STABLE):** A resource toolkit published by the SAMHSA. It includes screening tools, assessments, and best practice information for monitoring bipolar disorder.[15]

- **Hypomania/Mania Symptom Checklist (HCL-32):** A 32-question validated self-reporting tool. It has questions on emotional state, usual mood/activity/energy, and symptoms. When used, the HCL-32 can help identify 80% of patients with bipolar disorder and screen out the diagnosis in 51% of those patients who do not have it.[11]

Strategies for Payers

With the knowledge that bipolar disorder is a mental illness, payers may be able to employ the following strategies, which have been recommended for mental illnesses in order to support diagnosis and treatment.

Combat stigma

Stigma has been identified as one of the primary barriers to access care.[16] It is frequently cited as a barrier to mental healthcare and is associated with reduced treatment seeking.[17] Bipolar disorder is common in primary care settings.[12] Reducing discrimination in these settings may help the chances of effective screening and early intervention for mental health conditions.[18]

Encourage innovative solutions for access

The lack of access to psychiatric services is a challenge and may cause delays in treatment. Innovative strategies for mental health services which payers may wish to consider include[18]:

- **Telepsychiatry**, which can be used for consultation
- **Colocation of psychiatric and primary care services**, which may increase each specialty's knowledge of the other's standards and promote functional integration
- **Collaborative care model**, which is a team model, may identify gaps in care and improve the team's ability to brainstorm solutions. It may also contribute to early intervention by way of a culture shift in how providers practice

Educate primary care providers

Primary care providers are usually the ones who make the diagnosis and initially treat patients with mental health issues. Encourage primary care providers to improve their skills in interviewing patients and diagnosing mental health conditions.[18]

Strategies for employers:

- Combat stigma
- Encourage innovative solutions for access
- Educate primary care providers

References: 1. Bipolar disorder. National Alliance on Mental Illness web site. https://www.nami.org/Learn-More/Mental-Health-Conditions/Bipolar-Disorder. 2015. Accessed July 6, 2017. **2.** American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. Arlington, VA: American Psychiatric Association Publishing; 2013. **3.** Blanco C, Compton WM, Saha TD, et al. Epidemiology of DSM-5 bipolar I disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions – III. *J Psychiatry Res*. 2017;(84):310-317. **4.** Hirschfeld R, Bowden CL, Gitlin MJ, et al. *Practice Guideline for the Treatment of Patients With Bipolar Disorder*, 2nd ed. Arlington, VA: American Psychiatric Association Publishing; 2002. **5.** Bipolar disorder. National Institute of Mental Health web site. https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml/. Updated April 2016. Accessed July 6, 2017. **6.** Jann MW. Diagnosis and treatment of bipolar disorder in adults: a review of the evidence on pharmacologic treatments. *Am Health Drug Benefits*. 2014;7(9):489-499. **7.** Bryant-Comstock L, Stender M, Devercelli G. Health care utilization and costs among privately insured patients with bipolar 1 disorder. *Bipolar Disord*. 2002;4(6):398-405. **8.** Williams MD, Shah ND, Wagie AE, et al. Direct costs of bipolar disorder versus other chronic conditions: an employer-based health plan analysis. *Psychiatry Serv*. 2011;62(9):1073-1078. **9.** Dilsaver SC. An estimate of the minimum economic burden of bipolar I and II disorders in the United States: 2009. *J Affect Disord*. 2011;129(1-3):79-83. **10.** Living with bipolar disorder: how far have we really come? National Depressive and Manic-Depressive Association web site. http://www.dbsalliance.org/pdfs/bphowfar1.pdf. Published 2001. Accessed June 21, 2017. **11.** Hirschfeld RM. Differential diagnosis of bipolar disorder and major depressive disorder. *J Affect Disord.* 2014;169(suppl 1):S12-S16. **12.** Price AL, Marzani-Nissen GR. Bipolar disorders: a review. *Am Fam Physician*. 2012;85(5):483-493. **13.** Manning JS. Tools to improve differential diagnosis of bipolar disorder in primary care. *Prim Care Companion J Clin Psychiatry*. 2010;12(1):17-22. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2902192/. Published 2010. Accessed June 30, 2017. **14.** The Mood Disorder Questionnaire (MDQ) – overview. STABLE National Coordinating Council Resource Toolkit Workgroup. Substance Abuse and Mental Health Services Administration web site. http://www.integration.samhsa.gov/images/res/MDQ.pdf. Accessed July 7, 2017. **15.** STABLE Resource Toolkit. STABLE National Coordinating Council Resource Toolkit Workgroup. http://www.integration.samhsa.gov/images/res/STABLE_toolkit.pdf. Accessed July 7, 2017. **16.** Ungar T, Knaak S, Szeto AC. Theoretical and practical considerations for combating mental illness stigma in health care. *Community Ment Health J.* 2016;(52):262-271. **17.** Dockery L, Jeffery D, Schauman O, et al. Stigma- and non-stigma related treatment barriers to mental healthcare reported by service users and caregivers. *Psychiatry Res*. 2015;228:612-619. **18.** National Council Medical Director Institute. The psychiatric shortage: causes and solutions. National Council for Behavioral Health. https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage_National-Council-.pdf. Published March 28, 2017. Accessed July 8, 2017.

February 2018 MRC2.UNB.X.00115