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# Continuity of Care in Patients with Schizophrenia or Bipolar Disorder During the COVID-19 Pandemic

Announcer:
Welcome to CME on ReachMD. This activity, entitled “Continuity of Care in Patients with Schizophrenia or Bipolar Disorder During the COVID-19 Pandemic” is provided by Prova Education and is supported by an independent educational grant from Alkermes.

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Dr. Citrome:
What measures can psychiatrists and mental health professionals take to support continuity of care in managing patients with schizophrenia or bipolar disorder during the COVID-19 pandemic? This is CME on ReachMD and I’m Dr. Leslie Citrome.

Dr. Aquila:
And I’m Dr. Ralph Aquila.

Dr. Citrome:
Together, we’ll be discussing exactly how to answer that major question. So, with that, Dr. Aquila, how can we engage patients with schizophrenia or bipolar disorder when we can’t see them as we usually would?

Dr. Aquila:
Well, thank you Les it’s a pleasure to be here. I would start by underscoring that these are certainly challenging times and it makes already a difficult job even more challenging, in particular we’re working with people with serious and persistent mental illness. The therapeutic alliance, as you well know from many years of experience is key for our ability to keep people engaged. How do you do that and how do we maintain that with the current situation, I think is one of the big challenges. So, certainly, maintaining a schedule, trying to keep things as much as normal as possible is what we need to do. But, again, as you know oftentimes when you’re working with people with serious mental illness, the need for flexibility has to be there. In other words, we also have to be willing to kind of shift our appointment times around and make sure that people can get a face to face of some sort, or at least a communication of some sort to keep the process going and to keep people willing to continue to see us and to continue, most importantly, taking their medication.

Dr. Citrome:
You know in terms of what’s happening in our community just north of New York City, I had a chance to talk to the psychiatrist who’s in charge of the Assertive Community Treatment Team. Now, I’ve been a consultant to that agency for quite some time and, basically, she was telling me the phone visits are actually working quite well, in that their no-show rate is down to 0, because when they call, you know, someone is there. And if someone is not able to have that conversation then and there it could, you know, be in an hour later, or two hours later, or maybe the next day. But it gets done. And when someone is not answering their phone, someone else at home can go and get them. So, it actually is working out better in terms of getting that contact done. And what was also found is that some patients actually find it somewhat easier to talk about stuff on the telehealth session rather than when they were discussing things live. It is very curious. There are some patients who actually preferred not to have the video on and just to have the audio conversation. So, we’re discovering actually ways to enhance the therapeutic alliance. And I was quite surprised to hear about that and, you know,

reflecting upon that when thinking about my own phone sessions that I've been having with my patients, you know, they sound pretty good on the phone and they seem to be pretty engaged.

Dr Aquila:
Dr. Citrome, I think that there's been some really interesting points that have been made. I guess what I would wanna know is can you kinda walk us through what a typical telehealth visit would look like the structure the differences between an in-person visit I think we touched on it slightly but I would like to hear you maybe get in a little greater depth as to how you have been conducting these telehealth kind of interactions.

Dr. Citrome:
Up until the COVID-19 crisis, it was actually very restrictive. You had to use an app that was HIPAA compliant and we weren't sure about how to bill for this. It was a lot of unanswered questions but with COVID-19 there's been a few policy changes. Number one, we can use any app and it doesn't necessarily have to be HIPAA compliant, at least for now. And billing is actually now been straightened out, so, you can get paid for the work that you do. So, this is very different. Now, in terms of what technology to use, patients often have a phone rather than a computer. And, so, this is kinda limiting for them but I would urge you and I would urge clinicians to consider using their computer rather than the phone in order to have better control over the technology as well as seeing the patient on a bigger screen. And if you're doing examinations such as motor assessments, which we need to do if we have patients on antipsychotics, for example it's often very helpful for the patient to have someone there with them to hold the phone so that you can look at their hands and, you know, see them, how they walk, and so on. That kind of a specialty area but nevertheless it's a consideration if we're gonna do business over telehealth.

Now, confidentiality sometimes is an issue. So, you need to be mindful about who else is there. I usually recommend going, you know, into the car, into the basement, somewhere where they are more sure to privacy if that's gonna be a concern. But the technology is there. In terms of apps you know, Ralph I was really hesitant regarding Zoom and all of that. I read into an app on Doximity which is actually HIPAA compliant that once you get that app on your phone or tablet, it sends actually a text message to your patient, who can then just click on it and then you're connected. Although, I heard bandwidth problems can occur but I have not encountered that. I'm sure the technology will get better over time.

So, beyond telehealth, actually, Ralph, I wanted to ask you, what other applications or digital solution have you found helpful in your practice?

Dr. Aquila:
So, we've actually set up this virtual clubhouse, as some may know Fountain House is a clubhouse model rehabilitation. So, we do have different platforms besides just Zoom or other kind of interactive computer platforms. We are also using an app called Slack that I think many of you audience may be familiar with and then just basic old-fashioned telephone and text messaging kind of interactions. But we are trying to be as creative as possible and as I said, some of the key factors and some of the other key tools that we're using are Slack which I think some in the audience may be familiar with. It's an app which kind of allows for different groups to kind of communicate amongst themselves and with and with staff.

Dr. Citrome:
For those just tuning in you're listening to CME on ReachMD. I'm Dr. Leslie Citrome and I'm joined by Dr. Ralph Aquila. We are discussing continuity of care in patients with bipolar disorder or schizophrenia during the COVID-19 pandemic, especially the importance of continuing treatment, particularly patients being managed on long-acting injectables.

Dr. Aquila:
So, as a segue into that, which I think is a really important question which I've been reading about a little here and a little there. The notion of switching people or taking them off their long-acting injectables because of the COVID crisis and the risk of exposure. What's your thoughts on that, Les, as far as making the switch from long-acting to oral medications?

Dr. Citrome:
Well, honestly, I think it's a terrible idea to take someone who's stable, functioning reasonably well on a long-acting injectable antipsychotic and then putting them in a position where their need to take an oral medicine every day, which they may not be used to doing anymore and there was a reason that they were placed on a long-acting injectable. It was either their choice because it was a hassle to take a medicine every day and it was easier to get the injection or they were nonadherent and maybe nonadherent because cognitively they were not intact enough to accomplish adherence, or maybe they were covertly nonadherent because some days they would feel more suspicious and didn't wanna take medicine or felt that they were fine and they felt they didn't need medicine, so, that fluctuating degree of insight was a problem. So, it would be a mistake to switch patients to an oral medicine when they've been successful on a long-acting. Now, I say this and I know that there were some clinics that closed down. They actually said to patients,

you know, "Well, you're not gonna be able to come in and we're gonna just send a prescription to your pharmacy and you're gonna have to pick it up and take the medicine and, you know, we'll be in contact by phone." Boy, that that's not a way to do it. And what ended up happening is that patients didn't bother picking up their medicine, or if they did pick up their medicine, they didn't take it as prescribed or as necessary and did not do well. So, this is a problem. I would encourage those who are wondering what to do about this to make accommodations to give people their long-acting injectable. We know that LAIs are essential for many patients in maintaining their mental health status, to maintain their stability and their functionality. Many risks are involved when switching from LAI back to an oral medication. There's also issues about missing a dose, and how long can you wait? Well, you know, we do have some flexibility there. There are some medicines that you do have a longer period of time before it is imperative to restart and you have to know your medicines to know which options are available there. But, boy, I would not wanna take them off the LAI. If anything I just wanna say if anything, maybe think about LAIs that have longer periods in between dosing.

Dr. Aquila:
Yes, I think you're absolutely on target. There are numerous reasons why we switch people to long-actings and I think taking them off is really a recipe for disaster. And especially in these times you're gonna compound that because if somebody does decompensate and ends up needing to be picked up by police or EMS, I mean, it's gonna make things even more complicated, expose even more people to the risk of COVID-19. So, the issue about trying to keep people on their long-actings, I think it's fundamental the issue that there are even longer lasting meds now available as something that we should be thinking about. Then I guess, one other thought, and I'm not maybe you can speak to this I know some states' pharmacies are administering long-acting injectables and that could be yet one other solution if clinics shut down, as you underscored, or if clinicians aren't able to give a long-acting injectable.

Dr. Citrome:
You know, sometimes also I get the question well, is it really safe to give the LAI, you know, you're in contact with the person and so on. If someone is not acutely ill they don't have COVID-19 symptoms, they don't have a temperature, if all parties wear PPE, a mask and you wear gloves anyway when administering the injection it's a safe procedure. As long as you space patients apart, they don't hang out together, you know, in close quarters waiting for their injection, but spaced apart, with social distancing, that's how we do it in our local community, it can get done.

Dr. Aquila:
Right, and that's exactly what I've been doing, what we've been doing. Of course, we know there are asymptomatic patients out there but it seems like the viral load does not seem to be that high in those patients and if you are wearing masks, especially an N95 mask the chances of the practitioner of getting the illness is pretty slim.

Dr. Citrome:
You know, my best practice is asking the questions before they come in. If they have a fever, if they've been sick, has anyone else in the house been sick? Have they been practicing social distancing? Have they been out of the house? Have they been anywhere where they could be exposed? Getting those questions serves two purposes. One is, of course, it's your risk management to prevent potentially being exposed to COVID-19 but the other is to reinforce to patients that this is serious and you're serious about it and what they hear on the news is really – should be seriously considered, and patients do have a therapeutic alliance with you and will listen to you and this serves to further the bond between you and the patient as well.

Dr. Citrome:
Well, this has certainly been a valuable conversation. And before we wrap up, Dr. Aquila, can you share with our audience the one take home message you want them to remember from our discussion?

Dr. Aquila:
I would really underscore how we as clinicians have an important relationship with our patients and how that therapeutic alliance is key in keeping patients engaged over the long-term. This crisis, too, will end and I just really believe that we need to maintain that therapeutic alliance to the best of our abilities and that we still have a key role in our patients' lives, and that we need to do the best to continue the kind of treatment that we've been providing, which includes, in many instances, long-acting injectables and that we should try every which way to make sure that the patients are able to get that.

Dr. Citrome:
That's great, Dr. Aquila. And from my vantage point, I think the biggest takeaways from today is that long-acting injectables remain a foundational and fundamental treatment for our patients. They got on it for a reason and taking them off unnecessarily does them a disservice. We need to find ways of engaging patients to continue this treatment and ways of providing it and there are several ways of doing so. We've been successful in our own community in doing so as well, and we're at the epicenter.

Dr. Aquila:

I would just add that as you well know, and you've said this, every time you take a pill, it's a reminder that there's something wrong with you. And a long-acting injectable takes away that daily reminder that there's something the matter with you and it allows you to focus on bigger and better things.

Dr. Citrome:
Unfortunately, that's all the time we have for today, so, I wanna thank our audience for your participation, and thank you, Dr. Aquila, for joining me and sharing all of your valuable insights. It was great speaking with you today.

Dr. Aquila:
As always, Les, pleasure, and thank you for this opportunity and best wishes and best practices to everyone.

Dr. Citrome:
Thank you.

Announcer:
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