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Bridging Inpatient to Outpatient Schizophrenia Care: Solutions for Safer Transitions

Announcer:
You're listening to *NeuroFrontiers* on ReachMD, and this episode is sponsored by Bristol Myers Squibb. Here's your host, Dr. Shelina Ramnarine.

Dr. Ramnarine:
This is *NeuroFrontiers* on ReachMD, and I'm Dr. Shelina Ramnarine. Joining me to discuss strategies for strengthening the transition from inpatient to outpatient schizophrenia care are Dr. Michelle Scargle and Dr. Margaret Emerson. Dr. Scargle is the chief psychiatrist at Concord Health in Clearwater, Florida. Dr. Scargle, welcome to the program.

Dr. Scargle:
Thank you for having me.

Dr. Ramnarine:
And Dr. Emerson is the Clinical Associate Professor and a board-certified Advanced Practice Psychiatric Nurse Practitioner at the University of Nebraska College of Nursing in Omaha, Nebraska. Dr. Emerson, it's great to have you with us as well.

Dr. Emerson:
Thanks so much. It's my pleasure.

Dr. Ramnarine:
Well, let's hear from you first, Dr. Scargle, and start with some background. Based on your experience, what are the most common pitfalls during the transition from inpatient to outpatient schizophrenia care, and how do these pitfalls impact patient outcomes?

Dr. Scargle:
Sometimes, patients fall through the cracks, right? In a perfect world, everybody would have a fantastic support system waiting for them with open arms as they're discharged from the hospital back home; they'd have a relative that picked up their medication at the pharmacy and had it ready for them and monitored, made sure they got their medication, and made sure they had a doctor's appointment scheduled and got them to the appointment. But oftentimes for many of our patients with schizophrenia, this is not the case.

So sometimes patients are discharged and they have a prescription for their medication, but they don't have transportation to go pick it up. Or sometimes, because they maybe have some cognitive functioning issues because of their schizophrenia, they're forgetful. They may very easily forget to take the medication. And oftentimes, they just don't have a support system to make sure that they have the appointment to be able to see the outpatient physician or clinician to be able to take good care of them after they're a stabilized inpatient.

Dr. Ramnarine:
It definitely sounds like there are a lot of different steps in that transition of care. So with those pitfalls in mind, let's continue to talk about this, Dr. Scargle, and focus on some solutions. How early should discharge planning begin during a psychiatric hospitalization, and what specific elements help create a safer handoff?

Dr. Scargle:
I think that we should start planning for discharge as soon as the patient's admitted to the hospital because you want to be supportive in thinking about continuity of care and maintenance of what you're going to achieve inpatient when they're discharged, right? I think that

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having assigned a single coordinator of care—whether that's a case manager or a social worker—is really helpful because sometimes there's a lot of people trying to do the same job and, again, patients fall between the cracks.

If there are family that can be supportive of the patient, it's great to get them involved while the patient's in the hospital to do some psychoeducation and to help them know how to be supportive and what the needs might be to smooth the transition to outpatient care. I think it's also really important to think about the patient as a whole human being because they're being admitted for stabilization of psychosis, most likely, but patients that have schizophrenia also struggle a lot with physical health issues. So maybe they need to get a primary care doctor established.

Also, many of our patients with schizophrenia have housing difficulties. They might be homeless. So start from the point of admission to recognize: what are the needs outside of the hospital, and can we establish with a group home? Can we get them an outpatient case manager to be able to start working on these things sooner rather than later?

Dr. Ramnarine:
You already mentioned medication, and so turning to you now, Dr. Emerson, medication continuity post-discharge is critical. So what's your typical approach here, especially when patients face systemic barriers to access or to adherence?

Dr. Emerson:
I think that's a great question because medication continuity after discharge can be a significant factor in keeping somebody with schizophrenia stable, but sometimes, it's one of the hardest things to get right. So I would totally agree with Dr. Scargle that the planning process should start before discharge, and I would agree with starting it right when the patient is admitted and really taking the time to sort out the insurance barriers and follow-up plans—creating those so they're realistic for the patient.

But one of the things I found as an outpatient provider is that oftentimes, the medications may be covered at a very sustainable rate during the hospitalization, but once they get discharged, those things are not necessarily covered in the same way. And so one approach that I've had is circling back with the inpatient programs that I typically get patients referred from and letting them know what the challenges may be and our ability to maintain them on certain medications or certain strategies that are readily accessible in the inpatient unit but aren't so in the community. And so circling back and closing that loop has been very beneficial for us because there are folks that are going to fall through the cracks if we're not looking at some of the barriers and challenges that they're going to experience. And so looking at those opportunities to communicate with everybody involved in their care has been something that I found to be advantageous.

Dr. Ramnarine:
For those just tuning in, you're listening to *NeuroFrontiers* on ReachMD. I'm Dr. Shelina Ramnarine, and I'm speaking with Drs. Michelle Scargle and Margaret Emerson about how we can optimize schizophrenia care across inpatient, ER, and community settings.

So if we look at this from a multidisciplinary perspective, Dr. Emerson, which care team members would you say are most essential in supporting smooth transitions?

Dr. Emerson:
I love this question because I think every member of the team has an essential role in making those transitions go smoothly. I think what matters the most in terms of the key role here is that communication needs to be consistent, and everyone is giving the same message to the patient. If you think about all the information we're trying to cover with patients, there's just a vast amount, and so it’s paramount that our psychiatric providers, nurses, social workers, and case managers are all on the same page so that we're consistently giving a message of supporting the patients and recognizing that there's a potential for them to be confused or overwhelmed.

So it's less for me about any one role being the most important and really thinking that the team's alignment is the key role that needs to be clear to everybody because that's really what drives safe and coordinated care transition.

Dr. Ramnarine:
So certain technological advances, like EHR integrated discharge tools and AI models that predict readmission risk, are also being explored to streamline transitions. But based on what you've seen, Dr. Emerson, are those tools living up to their promise in practice?

Dr. Emerson:
So this field is obviously evolving as we speak, so while EHR-integrated discharge tools and AI-based readmission prediction models seem to have some great theoretical promise in improving care coordination, flagging high-risk patients, and reducing preventable readmissions, their real-world impact can be a little bit inconsistent.

And so we're seeing practice-related challenges where data integration and workflow alignment can be major obstacles. And we have predictive tools that can run adjacent to existing EHRs, but the opportunity for them to actually be embedded completely is not

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universally taken up at this point. And some of the model generalizability for these technology advances lack the diversity that reflects the settings that we may be seeing. So the algorithms that are available are commonly developed in large academic systems, and so they don't always perform well in the community or rural settings in the way that we would like, where the demographics, resource constraints, and clinical practices may differ from how the model was originally developed.

Dr. Ramnarine:
Well, we've certainly covered a lot today, so let's bring this all together before we close. Dr. Scargle, how can we embed these solutions, like standardized discharge planning, digital handoffs, and medication continuity, into routine schizophrenia care?

Dr. Scargle:
So we're always evolving as a field, right? And I think everybody really has the same goal in mind in supporting the patient. We want to try to prevent relapse and rehospitalization because every time an individual with schizophrenia has a recurrent psychotic episode, the state of being psychotic is actually neurotoxic to the nervous system, so we really want to make sure that we're trying the best that we can. I agree wholeheartedly with Dr. Emerson that there's a lot of growth to be had in this field of digital therapeutics. But I have to tell you, I'm excited about the possibilities.

We still need to make sure we're being diligent and doing all of the human, practical things in the transition from inpatient to outpatient—for example, sitting down with the patient and their support person and reconciling the medication. I can't tell you how often I'll have a patient come out of the hospital, and they'll see me like the week later, and they've gone back to taking their old regimen of mental health medications plus the new ones. So it's the basic reconciling—making sure that there's an appointment that's within a reasonable amount of time with their outpatient provider and that they have a case manager.

But ideally, if we can get the digital therapeutics to be more user friendly and more accessible, we have so many possible benefits. There are apps that can help reach out to patients in those days following discharge that'll remind them to take their medication. Just check in on them. We have a lot of data that shows that if a patient has somebody checking on them—even with a text in the days following discharge—they have hope and they have more motivation to continue with the healthy treatment plans of discharge. I think that we have to be diligent in making sure that the patient's needs are paramount and just lean into these digital therapeutics as they continue to improve for our patients.

Dr. Ramnarine:
With those final comments in mind, I want to thank my guests, Dr. Michelle Scargle and Dr. Margaret Emerson, for joining me to share their insights on bridging transitions in schizophrenia care. Dr. Scargle, Dr. Emerson, it was great speaking with you both today.

Dr. Scargle:
Thank you very much for having me.

Dr. Emerson
Thank you for the opportunity to speak on such an important topic.

Announcer:
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