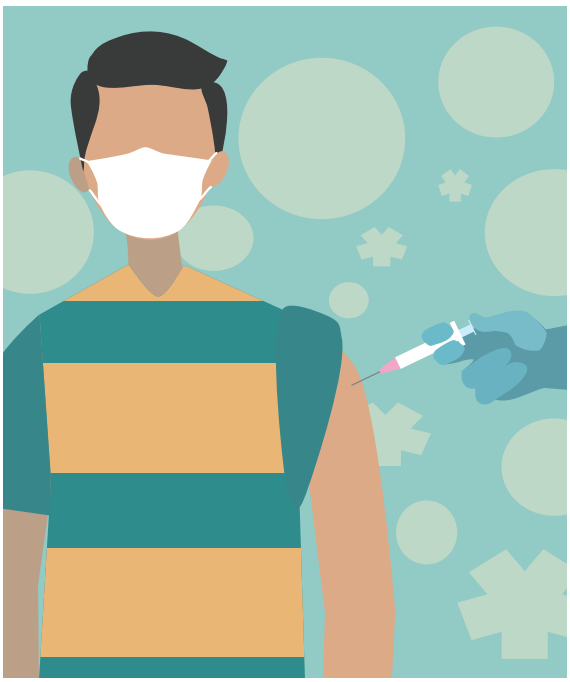
Drive-up pharmacotherapy during the COVID-19 pandemic

This solution allows patients to safely receive medications that must be administered in person



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My medical career began during a tragedy. I started medical school in August 2001 at New York University, a few dozen blocks north of the World Trade Center in Manhattan. Several weeks later, the September 11 terrorist attacks devastated the city, and the rest of our country. Though we knew virtually nothing yet about practicing medicine, my entire class put on our scrubs and ran to the Bellevue Hospital emergency department to see if there was anything we could do to help. In the end, there was not much we could do that day, but the experience seared into us the notion that a physician stands tall in a crisis and does whatever it takes to help.

For me, the recent emergency we are facing with the coronavirus disease 2019 (COVID-19) pandemic has brought back bone-chilling memories of that time, especially because New York City has been one of the hardest-hit cities in the world. It's hard for anyone to change routines on a dime, but I'm fortunate to run a solo private practice with a small administrative staff. I was able to pivot my medication management and therapy patients to 100% telepsychiatry overnight, even though I quite dislike the emotional distancing that the physical separation creates. However, I do administer some treatments that require my patients' physical presence: long-acting injectable (LAI) antipsychotics, and intranasal esketamine. I consider both to be life-saving interventions, so I had to figure out how to continue offering those services while doing my part to keep everyone healthy.

continued

Craig Chepke, MD, FAPA
Adjunct Assistant Professor of Psychiatry
University of North Carolina School of Medicine
Chapel Hill, North Carolina
Medical Director, Excel Psychiatric Associates, PA
Huntersville, North Carolina
Medical Director, Timber Ridge Treatment Center
Gold Hill, North Carolina

Disclosure
The author is a consultant to and speaker for Janssen Pharmaceuticals and Otsuka Pharmaceuticals.

Drive-up pharmacotherapy

Clinical Point

If we are creative and flexible, we can overcome any challenge to meeting our patients' needs

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Drive-up LAI antipsychotics

Many of my patients who receive LAIs are on formulations that are injected into the deltoid, so I transitioned to having them drive up to the front door of my office and roll up their sleeve so I could administer the injection without them leaving their car. If it was possible to convert a monthly deltoid injection to an equivalent quarterly deltoid injection, I accelerated that process. It took a little more thought to figure out how to best manage patients who had been getting gluteal injections. Deltoid injections are more convenient, but for certain antipsychotics, the only available LAI formulations that allow intervals longer than 1 month require gluteal administration due to the injection volume and pharmacokinetic considerations. Because of privacy and safety considerations, I didn't feel gluteal injections would be feasible or appropriate for drive-up administration.

Maintaining patients on their gluteal injections would provide a longer duration between doses, but because patients would have to come inside the office to get them, there would be a higher risk of COVID-19 transmission. Converting them to a once-monthly equivalent with the same molecule and comparable dosage given in the deltoid via drive-up would reduce the risk of viral transmission, but requiring more frequent injections would increase the likelihood they might not show up for all doses during this crisis. I spoke with several other psychiatrists about this dilemma, and several of them favored lengthening the injection cycle as the top priority during this time. However, given the exponential curve of viral transmission in a pandemic, time is of the essence to "flatten the curve." I decided that prioritizing the reduction of infection risk was paramount, and so I began switching my patients receiving gluteal injections with a longer duration to deltoid injections with a shorter duration. I can only hope I made the right decision for my patients, staff, and family.

Drive-up esketamine

Then came the hardest question—how do I continue to provide intranasal esketamine to my patients? There is an (appropriately) rigid Risk Evaluation and Mitigation Strategy protocol in place that requires patients to be monitored in a medically supervised health care setting for 2 hours after receiving esketamine. Having a patient in the office for at least 2 hours would create a tremendous risk for viral transmission, even in the best-case scenario of using personal protective equipment and stringent efforts to sterilize the space. I didn't consider putting the treatments on hold because esketamine is indicated solely for patients with treatment-resistant depression, and these patients couldn't be effectively managed with conventional oral antidepressants. I decided I'd have to figure out a way to adapt the drive-up LAI administration process for esketamine treatments as well.

In my practice, esketamine monitoring usually occurs in a treatment room that has a back entrance to a small, private parking lot. I realized that if I had the patients pull around the building and park in the spot right outside the window, we could maintain direct observation from inside the office while they sat in their car! Patients are not permitted to drive after receiving an esketamine treatment, so we take possession of their car keys to prevent them from driving off before the end of the monitoring period. We give them one of our automatic blood pressure cuffs to take the required blood pressure readings, and they relay the results through a video telemedicine connection. We also enlist the patient's designated driver to provide an additional set of eyes for monitoring. When the observation period ends, the cuff is retrieved and sanitized.

Meeting our patients' needs

Our duty to our patients is vital during a crisis, and they deserve everything in our power that we can offer them. We can't be complacent in our routines and let our fears of what might or might not happen paralyze us from moving forward. If we are flexible and creative, we can rise to overcome any challenge to meeting our patients' needs. Throughout this ordeal, I've seen some of the patients I was most worried about turn out to be some of the most resilient. When our patients have risen to the occasion, what excuse do we have not to do the same?