Tips for making the transition from inpatient to outpatient practice

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Years of outpatient practice and supervising residents as they move from inpatient to outpatient rotations prompted me to examine the advice I give to clinicians transitioning to outpatient care.

1. Slow down! Keep in mind that your full assessment may take more than 1 session. Take advantage of follow-up appointments to add details or round out your sense of what is going on with your patient.

2. You don't always have to 'do something.' We often feel that we need to "do something." Perhaps it's the difficulty of sitting with someone who's suffering, or our own feelings of helplessness. Recognize this urge and evaluate whether your findings are something you *must* act on or if it's your anxiety that is driving you.

3. Know the particulars of outpatient prescribing. Keep in mind that you should treat the whole person, not just her (his) symptoms. Sometimes it's appropriate to treat individual symptoms but the justification for this and any other medical decisions needs to be documented.

- **Be methodical.** Often, this means making one medication change at a time. Although the urgency of inpatient hospitalization sometimes necessitates starting several medications simultaneously, outpatient psychiatry rarely requires that step. Most illnesses in outpatients are chronic; clinicians need to balance the need for treatment with the understanding that the patient may require psychiatric medication indefinitely. Starting several medications at once often leaves the patient and psychiatrist wondering which medications are helping and which may be causing adverse effects.
- **Practice educated polypharmacy.** Be careful and deliberate; maximize dosages before adding adjunctive therapy. Consider interactions with other medications (such as warfarin or omeprazole), their side effects, and alternative psychosocial treatments.
- **Know the cost of medication.** Consider generic drugs or medications on the $4 list available at some pharmacies. Be cognizant of less expensive dosing options and combinations. For example, one month of duloxetine, 90 mg/d, costs $587 if prescribed as 30-mg pills; the same dosage costs $390 when prescribed as 30-mg pills and 60-mg pills.[1] Advise patients to shop around when purchasing prescriptions because cost can vary significantly among pharmacies.
- **Often, patients should be weaned off medications.**[2] Most selective serotonin reuptake inhibitors and serotonin-norepinephrine reuptake inhibitors can cause a discontinuation syndrome. Fluoxetine can be tapered faster; paroxetine and venlafaxine are notorious for causing issues. Abrupt discontinuation of mood stabilizers—especially lithium[3]—can cause rebound mania, and should be tapered cautiously.

References

1. DRX. Drug compare. https://drugcompare.destinationrx.com/Home.aspx. Accessed October 17, 2012.
2. Baldessarini RJ, Viguera AC, Tondo L. Discontinuing psychotropic agents. J Psychopharmacol. 1999;13(3):292-293; discussion 299.
3. Faedda GL, Tondo L, Baldessarini RJ, et al. Outcome after rapid vs gradual discontinuation of lithium treatment in bipolar disorders. Arch Gen Psychiatry. 1993;50(6):448-455.

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Disclosure

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