

Pharmacologic Approach to Behavioral Health Urgent Care

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Meaghan Rudolph MS PCNS PMHCNS-BC

MGH Dept Psychiatry, Urgent Care Psychiatry Clinic

MGH Institute of Health Professions

Disclosures

Neither I nor my spouse have a relevant financial relationship with a commercial interest to disclose

Expectations



Frame



Outpatient Urgent Care

Urgent vs Emergency
Non-ED management



Can be applied to urgent situations in different settings



General principles, building on current practices, case examples

Urgent Care vs Emergency Dept

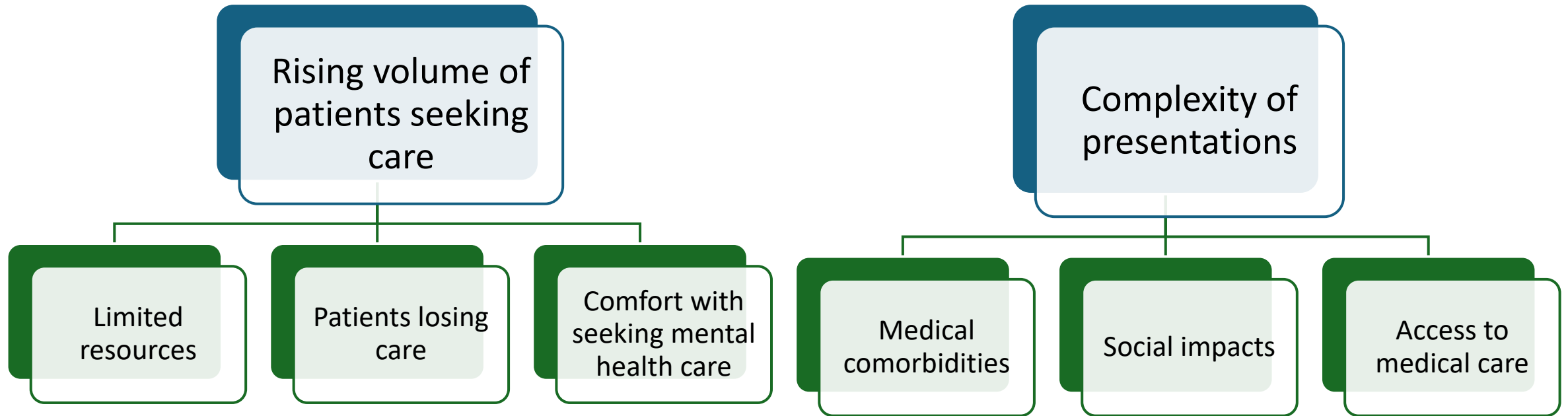
Urgent Care Clinic

- **Evaluation and Assessment**
- **Stabilization** and Crisis intervention Focus is on **stabilization** and immediate needs
- Rapid Access to Mental Health Care
- Medication Management
- Not long-term care replacement

Emergency Department

- **Evaluation and Assessment**
- **Stabilization** of Immediate threat to self or others
- Management of life-threatening situations
- Safety containment

What is Urgent Care Psychiatry? (and *why* do we need it?)



Conditions that aren't emergencies....yet

Value of Behavioral Health Urgent Care

Limited data

Challenges with studying those in crisis

Knowns

- Risks without care
- Risks post discharge
 - Suicide
 - Discontinuation of medication
 - Substance Use
 - Symptom relapse
 - Social and Environmental stressors

• ***But Building evidence***

- ED diversion
- Care coordination
- Improved Follow-up and adherence to plans
- Patient and family satisfaction

Behavioral Health Urgent Care

Practice based evidence vs evidence based practice





How to meet the needs

- Various treatment modalities
 - Walk-in clinics
 - Appointments <24 hr
 - Medical urgent care (in conjunction)
- MGH Urgent Care Psychiatry
 - Multidisciplinary team
 - Psychiatrists, Psych APPs, RNs, SW, Psychologists
 - Administrative support: referrals, community liaison, scheduling
 - Adapted and modified to meet needs of
 - Patients
 - Referring providers
 - Department and System
 - External demands

MassHealth's Behavioral Health Urgent Care:

<https://www.mass.gov/info-details/behavioral-health-urgent-care>

Goal:

Prioritize **rapid relief** and **safety**

How?

- Acknowledge Suffering
- Rapid assessment and stratification of risk
- Stabilization (short term)
- Medication
- Education
- Referral and transitions in care



Prescribing Strategies



Focus is on Therapeutic Intent
vs Specific medication:

- Stabilization and bridging

vs

- Initiation of long-term treatment

or

- Rapid sedation

What are we **not** doing in Urgent Care?



**Nuanced or
“tweaking”**



2nd opinion



**Interventions
requiring close
monitoring or labs**

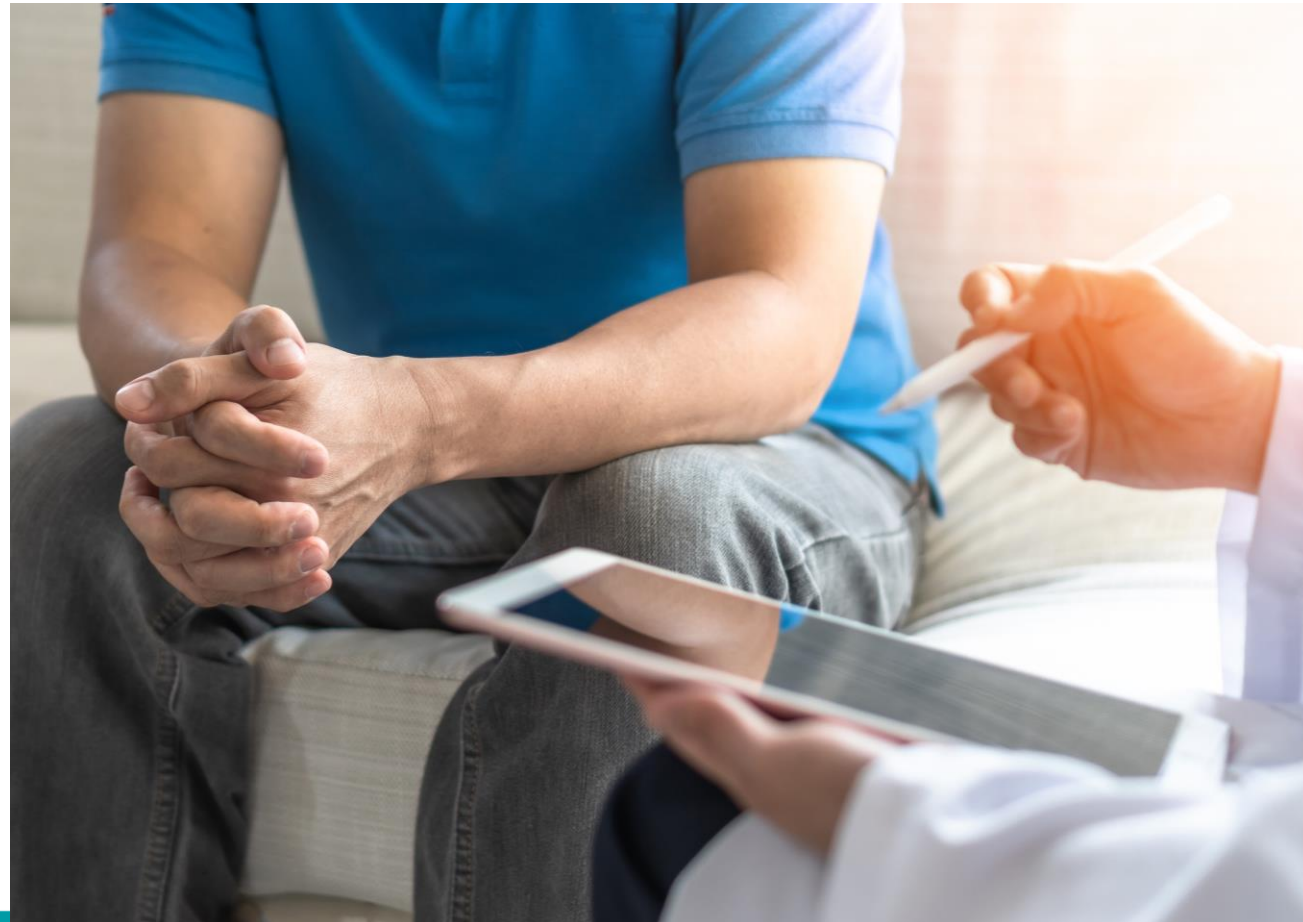


**Non-urgent med
changes**

ADHD management

Taper off

Setting Patient (and family) Expectations



- **Patient expectations and perception of priority may *not* be same as provider**
 - Review clinic scope
 - Discuss treatment priorities
 - Behavioral expectations
- Clear review
 - What can be provided
 - Limitations of clinic/providers
 - Available resources

Engagement and Setting the Environment for Patients in Crisis: Build on Basics

Safe Physical Space: For patient as well as staff

Environmental adjustments: Quiet, private space, minimal stimulation

Participation: Family or identified support

Cultural sensitivity & trauma-informed care

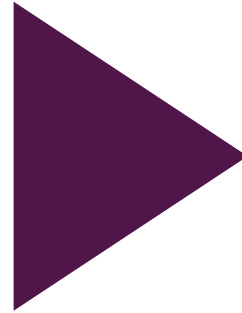
Verbal de-escalation strategies: Tone, posture, validation.

Know *Your* Resources

- Assessment tools
- Medical work-up
 - Lab with rapid resulting
 - ECG
 - Scans
- Pharmacy
- Follow-ups in Urgent Clinic?
- Connections to long term care?
- Referrals?
- Higher Level of Care?
- Contact Post visit?
- Resources to provide patients and families



“Don’t let
perfection be
the enemy of
the good”



Reduce
suffering as
able with the
resources
available to us



Waited for care
now more acute



From higher level
of care



More complex



Any diagnosis

Rapid/Brief/Targeted Assessment



Triage essentials: Identifying and ruling out organic factors

What can you rule out?
Who already asked?
What tools are available to you?



Use the quick structured tools:

C-SSRS, AIMS, BPRS, CIWA, COWS, etc.



Brief *but thorough* psychiatric history:

Need to know vs full history
Targeted evaluation of symptom of focus



Risk stratification of key safety aspects: SI, violence, behaviors, psychosis, sub withdrawal, cognition.

Is this psychiatric?
Or something
else?

Hammer finds the
nail

How was the
patient referred?

- PCP?
- Self?
- Specialist?
- Non-clinician?

What work up has
already
happened?

Rule out medical
causes (as able)

Psychopharmacology in Urgent Care Psych



RAPID ONSET



**SHORT TERM VALUE
AND EFFICACY**

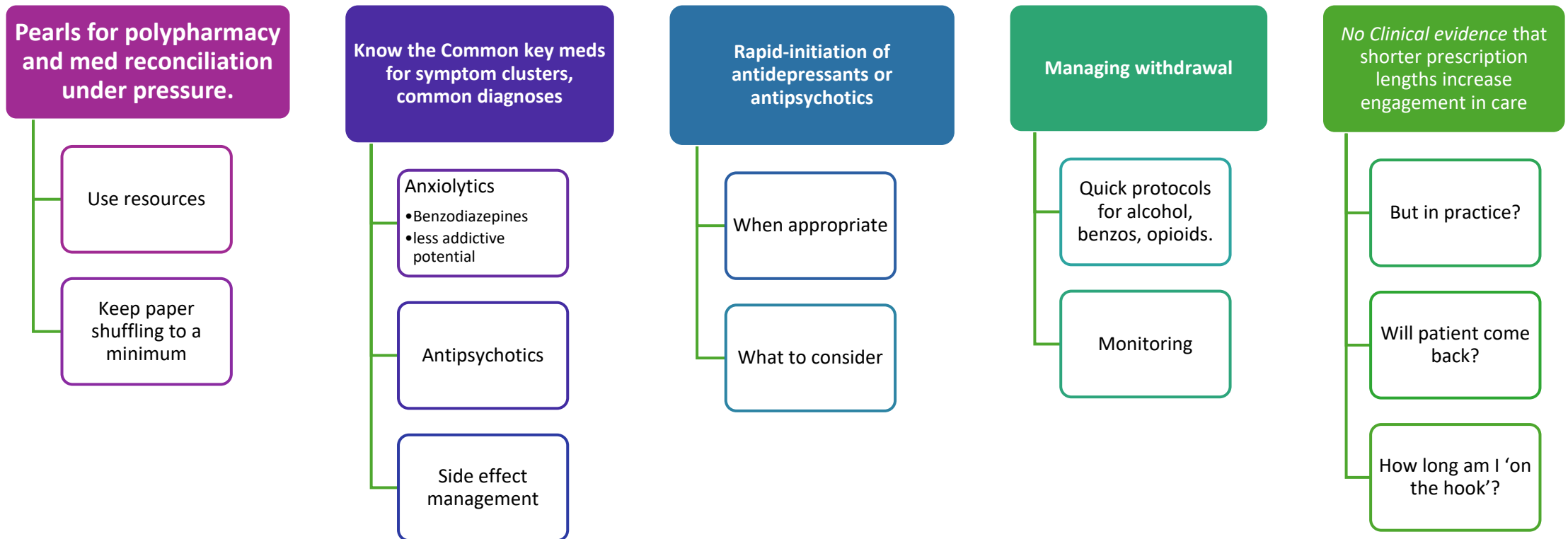


**MINIMAL RISK OF
ADVERSE EVENTS**



**LITTLE TO NO
MONITORING NEEDS**

Key Psychopharm Strategies



Role of Substance Use

- Assessment
 - Screening tools
 - Interview
 - Tox screen
 - NOT just illicit
 - Supplements
 - Herbal remedies
 - Energy drinks
- Collateral
- What symptoms are attributable to substance?
 - Acute intoxication
 - Withdrawal
 - Dependence
- How does this influence on the current clinical picture?
 - Interaction with psych tx
 - Direct med interaction, exacerbation of effects

Primary Substance Use Disorder



What is the patient perspective on treatment?

Primary dx refer to standards
Meet where at
Determine availability of resources for treatment
Longer acting agents
Withdrawal management



Available Resources?

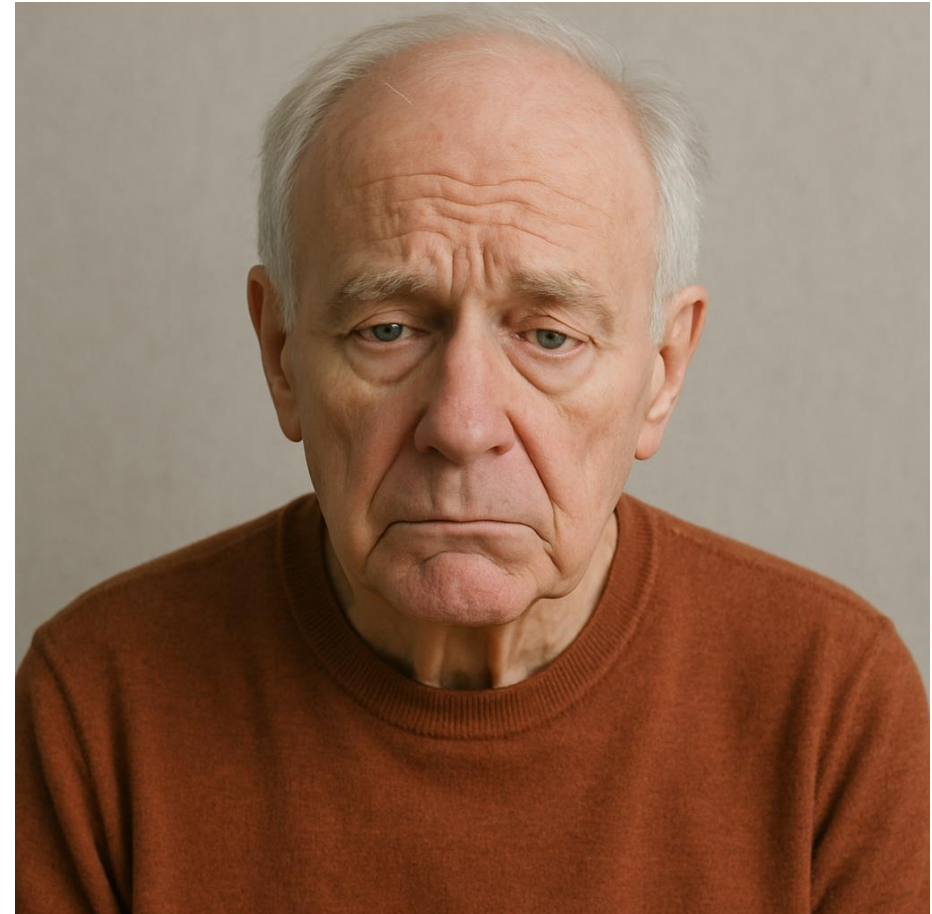
MAT
Monitoring



Determine direct and indirect influence on psychiatric management

Frank

- 75 years old
- Referred by PCP at community clinic.
- No history of mental illness
- Recent death of wife, bladder CA
- Not sleeping, trouble falling and staying
- Calling PCP office with concerning symptoms, work up has been negative thus far for medical issues, pt insistent something is wrong.
- Decrease in social activities, no longer going to club
- Ambulates slowly and with ill fitting clothing into the appointment.
- “my doctor told me he could not help me and I had to come here”
- Hands you recent paperwork from PCP



Next Steps and Plan for Frank

- Review

- No available labs, reports PCP said ok
- Paperwork from PCP was sleep hygiene
- Med list
 - unremarkable
 - no potential interactions
 - But newly taking 10mg lisinopril

- Assessment

- C-SSRS (low risk), PHQ-9 21
- MDD moderate, anxious distress

- Plan

- Has prescriber, not psych, but prescriber
- Standard of care
 - SSRI based on side effects, possible PRN
 - Education
 - Pass off
- IF
 - +SI
 - No follow-up, no care: Starting dose, titrate up? On the hook?
 - How long of a prescription?
 - Share resources to get connected

Suicidal Thoughts or Actions

- Manage only what you have the resources to manage
- Triage and refer out
 - Collateral
 - Passoff
- Safety
- Validated screening tools:
 - **Ask Suicide-Screening Questions (ASQ) pedi and adolescent**
 - Validation in emergency settings
 - AAP rec
 - Initial PHQ-9, then:
 - C-SSRS 12 and older

Treatment in Urgent Care?

Evidence for
SI specific:

- Ketamine
- Lithium
- Clozapine

BUT All
higher risk in
this setting

SSRIs (SNRI)
first line
MDD

- Side effect Profile
- Tolerability

Unipolar vs Bipolar Depressive Episode

- Standard assessments
 - PHQ-9, mood as above, C-SSRS
 - Mild to Moderate, vs +SI
- Standard of Care
 - Symptom and side effect profile based
 - Mindful of side effect management
 - quetiapine or lurasidone
- Adaptations for Urgent Care?
 - Labs, follow-up



Bipolar assessment tools

- IS this mania?
- Self vs Clinician administered- save time
- Collateral
- Validated in psych and Primary care settings:
 - Mood Disorder Questionnaire (MDQ)
 - Brief
 - Self report
 - Hypomania Checklist-32 (HCL-32)
 - Bipolar Spectrum Diagnostic Scale (BSDS).

Hirschfeld et al 2000

Mild to Moderate Mania and Hypomania

- Assess and determine ***severity***
- *Discontinue* any contributing agents
 - Stimulants, antidepressant
 - Medical tx
- Monotherapy- first line
 - Mild to moderate
 - Severe should be higher level of care (guideline for tx same)
 - Risperidone, olanzapine

Based on Meta analysis of efficacy (indirect comparison) of agents for Monotherapy

Side effect profiles, tolerability override

In order:

Risperidone
Haloperidol
Olanzapine
Cariprazine
Lithium
Carbamazepine
Paliperidone
Aripiprazole
Asenapine
Quetiapine
Ziprasidone
Valproate (or divalproex)
(Yildiz et al 2015)



Sleep Disturbance

- Can influence all other areas
- Sleep disorder vs symptom?
- Med induced?
- Sleep specialists say treat the insomnia AND the comorbid
- CBT- First Line
 - Availability
 - Willingness vs comorbid s/s
- *Then* med intervention
- What options may provide multiple benefits
 - Side effect
 - Few primary FDA approved
- Low addiction potential
- Short term pharm interventions



s/s Psychosis?

- What is it?
 - **Urgent care often other cause**, esp if out of the blue
 - Primary psychotic disorder?
 - Brewing
 - Rapid onset...urgent care
 - Mood disorder with psychotic features?
 - Exacerbation of symptoms of known prior dx
 - Something else
 - Medical
 - Adverse reaction
 - Substance induced
- Can this situation be safely managed outpatient/urgent care?
 - Agitation
 - Level of Safety
 - Symptoms
 - Actions based on AH/VH/ delusions

Planning

- Treatment options for meds based on **primary diagnosis**
- Treatment Guidelines for Primary psych diagnosis, standard of care
- Tolerability vs relapse
 - Take something vs nothing
 - Indication for dx
- Greater (general) tolerability profile
 - lurasidone
 - Ziprasidone
- Side effect profile
- Oral only
 - Access to follow-ups
 - Trial needed PO pre LAI in most
- Tailor to individual patient situation
 - Body weight
 - QTc interval
 - Sedation

(Schneider-Thoma et al 2022)

Self presentation of panic

- Michael, 35 years old
- Lost his job
- Reports “panicking” everyday and cannot function to look for a new job
- Immigration status
- Self presented
- No recent medical care
- Concerned has a GI issue and possibly migraines
- Worried may lose housing
- Recent separation from girlfriend
- Biting nails during interview, restless
- Needs “something”
- Medical walk in gave 3 pills lorazepam



Acute Anxiety and Panic

- What is the dx?
- Maintenance SSRI/SNRI
 - First line (GAD, panic)
 - Based on setting- value of starting a long term?
 - SE profile
 - Proceed w usual strategies, standard of care
- Short Acting
 - Urgent care- what next?
 - Rapid relief vs dependence risk
 - Benzodiazepines- are we setting up?
 - Anticonvulsants (gabapentin)
 - Other: Buspirone, hydroxyzine



Munkholm et al, 2024

Lowest Risk Highest Efficacy

Hydroxyzine

- 15-30 min onset
- Comparable efficacy to benzodiazepines?
- Low dependence risk

Propranolol (non-FDA panic)

- 30-60 min onset
- Low dependence risk

Buspirone

- No acute efficacy (days/weeks), bridge
- GAD

Benzodiazepines

- Minutes for onset
- High Dependence
- Setting specific concerns
- Clonazepam
 - possible lower risk
 - longer half life

Coordination of Care



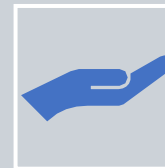
Interdisciplinary teamwork: Clear Roles and Scope of APPs, MDs, SW, Psychologists, nursing, security.



Dispo planning: Outpatient with follow-up?
PHP vs IOP, ED or inpatient



Documentation tips: Charting efficiently for legal protection and continuity, as well as clarity for other providers.



Handoffs: Ensuring safe and warm transitions when escalating and transitioning care.

Keys to Success

Set, and review
expectations

Acknowledge and
Relieve suffering as
able

Assess,
re-assess

Interventions:

- Least risk
- Highest potential benefit for relief

Clear plan for
follow-up

Transition in Care

- Referrals
- Pass Off

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