Longitudinal Urgent Care Psychiatry (LUCY)

Policies and Guidelines

Updated 1/8/19

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Overview

Longitudinal Urgent Care Psychiatry (LUCY) is a model for delivering ambulatory psychiatric care to patients without scheduling appointments in advance. Although having a consistent ambulatory provider and scheduling regular clinical appointments can strengthen the therapeutic relationship and can facilitate recovery by providing structure to the treatment plan, not all patients with psychiatric conditions successfully recover in this traditional model. In fact, many patients lose access to care psychiatric care entirely because they are unable to regularly keep appointments that are scheduled in advance.

Unfortunately, the patients who are the most vulnerable to poor health outcomes are also the most likely to lose access to care on the basis of missed health appointments. Missed appointments are well-known to correlate with poverty, underinsurance, low educational level, and racial minority status. Missed appointments also correlate with increased severity of depression and higher psychiatric comorbidity in general. Although clinic staff may traditionally interpret missed appointments as ambivalence or resistance to care, patients with low socioeconomic status face significant barriers to keeping appointments that are scheduled in advance, including housing instability, inconsistent telephone access, employment commitments, transportation difficulties, and child care, which often lead to poor utilization of a traditional clinic model. The end result is that many patients with the highest level of need are discharged by their providers and referred to other facilities, where they continue to miss their appointments and face termination in a cycle that has been aptly called “musical clinics” because it does not end with stable engagement in treatment.

The primary purpose of the LUCY model is to offer a safety net for those patients who cannot consistently keep outpatient psychiatry appointments that are scheduled in advance. Although some kinds of psychiatric treatment cannot be administered safely or effectively without regular clinic attendance (e.g., clozapine or psychoanalysis, respectively), many patients could obtain some benefit from other treatments even if face-to-face contact with their providers is inconsistent. Providers practicing in the LUCY model seek to identify which treatments can be safely administered without scheduling regular visits and to design a treatment plan that is effective while at the same time flexible enough to accommodate an unpredictable schedule.

Although many patients seek care in the LUCY model because they have not succeeded in a traditional model, others seek care in the LUCY model out of a preference for faster care or convenience. These include patients who need a psychiatric evaluation and treatment sooner than a scheduled appointment can be offered and do not want to go to an emergency department, patients who have another psychiatrist that is unavailable, and patients who find scheduling appointments in advance to be more inconvenient than a prolonged waiting room time on a day that is flexible.

Glossary

LUCY: Longitudinal Urgent Care Psychiatry

BPS: Brigham Psychiatric Specialties, umbrella term describing all ambulatory psychiatry practices at Brigham Health, including general psychiatry, neuropsychiatry, geriatric psychiatry, and women's mental health

221 Longwood: Address and informal title of the flagship BPS clinic, also referred to as "221L." The 221L clinic houses 7 staff psychiatrists, 13 psychiatry residents, 6 social workers (SW), and 3 psychologists who provide general psychiatry services including psychopharmacology, psychotherapy, and care management.

Psych Triage: an office of non-clinicians who field psychiatry referrals and schedule psychiatry intake appointments when appropriate

Partners eCare (PeC): the electronic health record and order entry system utilized by hospital systems affiliated with Partners Healthcare, including Brigham Health. PeC is serviced by Epic.

"Primary LUCY patient": a patient who is receiving psychiatric care exclusively through LUCY and is not expected to successfully enroll in a traditional clinic model (i.e., a model with a consistent ambulatory provider and scheduled appointments) at BPS in the near future, as determined by not having an appointment already scheduled with a new psychiatrist or by expressing a preference to continue receiving care exclusively through LUCY.

"Rapid access patient": a patient who is receiving psychiatric care through LUCY but is expected to enroll in a traditional clinic model (i.e., a model with a consistent ambulatory provider and scheduled appointments) at BPS in the near future, as determined by having an appointment already scheduled with a new psychiatrist.

*Patients may change categories between LUCY and rapid access by scheduling, cancelling, or missing an appointment with a new provider in the traditional clinic model. Therefore, "primary LUCY" versus "rapid access" is a distinction of treatment status and not a description of the patient as an individual human being. This distinction is made solely because the treatment plan should take into account the expected follow-up options that are available within BPS. However, some patients with a history of missing prior appointments may not be allowed to schedule a new intake at BPS right away.

"Coverage patient": a patient who is receiving regular psychiatric care through another provider but accesses care temporarily through LUCY because his or her regular provider is unavailable

Referral Process

Referrals to BPS are typically placed by other Brigham Health providers (often a primary care provider) through an electronic order via PeC. However, patients may alternatively be instructed to call the psych triage office directly, or they may self-refer. Upon receiving a referral, the psych triage staff reviews the patient's record in PeC to determine eligibility for receiving care through BPS. To be eligible for treatment at BPS, patients must have established treatment with other Brigham Health providers and must not have previously been discharged from BPS on the basis of missed appointments. Psych triage staff will also determine, based on information included in the electronic referral or based on the patient's problem list in PeC, whether the patient should be scheduled with a general psychiatrist or a psychiatry sub-specialist. In the traditional clinic model, patients eligible for the general psychiatry are scheduled for the next available psychiatry intake, which may be with an attending psychiatrist or a psychiatry resident. Patients who are not eligible for treatment at BPS are provided with community referrals.

With the opening of LUCY, an additional option now exists for patients who are referred to BPS but have previously been discharged on the basis of recurrent missed appointments. These patients are not offered a traditional appointment, but instead they are referred to a social worker (SW) with 0.05 FTE dedicated to managing the LUCY program. The SW may also receive referrals directly from other providers who believe LUCY would be appropriate for their patients. This SW calls the patient directly and explains the LUCY model, while also offering the option of receiving a community referral. The patients are invited to check in at the front desk at 221L between 12:00-3:15pm on the following Wednesday afternoon and are told that they can be seen on a first-come, first-served basis. If the following Wednesday afternoon does not work for them, or if they miss the next session, they may arrive at any subsequent Wednesday afternoon session and still expect to receive care. Patients are advised that on high-volume days it may be difficult to accommodate all patients who arrive for care, and therefore receiving care that day is not guaranteed; however our clinic will try to accommodate as many patients as possible on high-volume days. The SW keeps a running list of which patients were invited to LUCY each week, which patients indicated they were planning to come, and which patients arrived for an encounter.

If patients who are eligible for care at BPS indicate to psych triage staff that they would like to be seen more quickly than the traditional clinic can accommodate with a scheduled intake appointment, the psych triage staff will notify the patient that they will investigate whether any alternative options are available. The psych triage staff will then as the SW whether there is room to accommodate a rapid access referral in that week's LUCY session. The SW will review her list, and if fewer than 10 patients have already been referred to that week's session she will inform the psych triage staff that the rapid access patient may be invited to the next LUCY session. The psych triage staff will next return the patient's call and provide information about LUCY. A total of 10 patients may be referred to LUCY from both the primary LUCY and the rapid access pools on any given week.

If a patient is invited to LUCY, arrives for a LUCY session, and receives an encounter with the LUCY psychiatrist, that patient is considered enrolled in LUCY. If a patient is invited to LUCY but does not arrive for the session, the SW will inform the referring provider that the patient was not enrolled in LUCY that week but may try again at any future LUCY session.

If a patient is not invited to LUCY and arrives for a LUCY session requesting care, the front desk staff will contact the SW to ask whether the patient is eligible for BPS services. The SW will review whether the patient has other Brigham Health providers, and if the patient is eligible by this criterion he/she will be placed in line to see the LUCY psychiatrist along with those who were invited. If the patient does not have other Brigham Health providers, he/she is not eligible for treatment at BPS and will not be placed in line to see the LUCY psychiatrist. The SW will instead offer assistance establishing care with a new Brigham Health primary care provider or will offer community psychiatry referrals.

Clinical Encounters

When a patient checks in for LUCY at the front desk, the front desk staff asks whether the patient has previously been seen in the LUCY clinic. If the patient answers no, the front desk staff adds that patient to the LUCY psychiatrist's schedule as a "Walk-in Initial," which uses a 60-minute slot. If the patient answers yes, the front desk staff adds the patient to the LUCY psychiatrist's schedule as a "Walk-in" with a 30-minute slot. Patients are added to the schedule in the order that they arrive, and all appointments are spaced 30 minutes apart regardless of the slot size (i.e., the slot size is used to calculate slot utilization for the LUCY clinician but does not impact the schedule).

The first appointment nominally starts at 1:00pm, but the LUCY psychiatrist typically begins seeing the first patient at 12:30. Many patients arrive very early in order to ensure that they are seen as soon as possible, and thus they are available at 12:30. But equally importantly, we hypothesize that seeing all patients more quickly than they expect to be seen improves their experience with the clinic. For an initial appointment, a full initial psychiatric assessment is conducted, similar to an initial assessment in the traditional clinic. However, whereas an initial assessment in the traditional clinic takes 60 minutes every time based on the schedule, the initial assessment in LUCY takes only exactly as much time as it requires. A typical LUCY initial evaluation takes 40 minutes, but some evaluations take more time and others take less. At the end of the visit, the patient may be asked to return within a specific time frame (for example, if a new medication is started that requires close follow-up), or the patient may be asked to follow up with a social worker as a next step and return to LUCY as needed (for example, if a new medication is started that requires clinical follow-up but not necessarily with the prescriber if treatment is going well, e.g., an SSRI in a patient with low bipolar risk). A maximum of 6 months supply of medication can be prescribed at a single LUCY visit. An exception to this is when patients are well-known, are stable on a consistent medication regimen for >1 year, and do not require medical monitoring at less than 1-year intervals (for example, a patient with a stable chronic psychosis who has a high level of support from non-psychiatrists who can provide clinical monitoring in the event of symptom changes). Such patients may receive prescriptions lasting up to 1 year at a time.

The note template for initial LUCY visits is .LUCYINITIAL.

At the completion of the initial encounter note, the LUCY psychiatrist will send the note to the patient's primary care provider via PeC, along with an explanation of the LUCY model. The LUCY provider may request assistance from the primary care provider or other members of the primary care team in the follow-up management of the patient, if appropriate. Examples might include routine monitoring of SSRI medications, or management of a stable CNS stimulant for ADHD. Examples might also include appropriate medical management recommendations identified at the psychiatry encounter, such as referral to a sleep study to rule out obstructive sleep apnea.

If patients who previously completed an intake in LUCY presents for a return encounter, this return encounter is problem-focused and typically takes 15 minutes, although some return encounters may

take more or less time if needed. The LUCY provider will review the previous LUCY progress note to ensure that the treatment plan is consistent.

If patients with other BPS providers present to LUCY needing coverage, this encounter typically takes 15-20 minutes. Coverage encounters typically take more time than LUCY return encounters because the providers in the traditional BPS clinic do not document with the explicit intention of passing off care to a LUCY provider, and thus review of the progress notes requires more effort. Coverage patients are also more likely to present in a crisis than patients who are only receiving care in LUCY.

The note template for all return encounters in LUCY is .LUCYRETURN. On this template, there is a place to enter the regular psychiatry provider. For coverage patients, the regular psychiatry provider should be documented. For patients who are receiving care only in LUCY, the word LUCY should be documented here.

If the patient requires or requests referrals to other outpatient behavioral health services, including psychotherapy or community psychiatry referrals, the LUCY psychiatrist will place a referral request with the psychiatry department's resource specialist through PeC. The resource specialist will contact the patient with the appropriate referrals within 2 weeks.

If the patient requires a referral to a partial hospital program at the time of the LUCY encounter, the SW will be asked to meet with the patient and facilitate that referral. If the SW is not immediately available to meet with the patient, the SW will be asked to call the patient before the end of the following business day to facilitate that referral.

If the patient requires inpatient psychiatric treatment at the time of the LUCY encounter, the psychiatrist will place the patient on an involuntary hold in accordance with Massachusetts General Laws Section 12. The psychiatrist will notify the front desk staff of the intention to file Section 12, and the front desk staff will notify security staff and call an ambulance for transportation to the emergency department.

If a patient checked in for a LUCY encounter but is not tolerating the waiting room well (e.g., causing a stir, bothering staff, bothering other patients, etc), the SW will be asked to meet with the patient in advance of the psychiatry visit. The SW might determine at that time that the patient cannot tolerate the waiting room due to psychiatric symptoms, and the LUCY psychiatrist may meet with the patient ahead of the other patients waiting, if clinically appropriate. If the LUCY psychiatrist meets with the patient ahead of the other patients waiting, the patient should wait in the SW's office instead of the waiting room so that other waiting patients do not see this patient skip the line. The SW should collect clinical information from the patient and present that information to the psychiatrist in order to save time at the psychiatrist encounter.

Billing

Clinical encounters in LUCY are billed in exactly the same way as clinical encounters that take place in the traditional model. New evaluations are typically billed as a 90792, and return visits are typically billed as a 99211-99215. Patients for whom a different BPS psychiatrist billed a 90792 encounter within the last 3 years receive a follow-up code instead of a new evaluation code, regardless of whether the encounter in LUCY is an initial visit.

Because two different BPS providers cannot both bill for a 90792 code for the same patient within 3 years, this poses a potential productivity problem for psychiatrists practicing in the traditional model, who may see rapid access patients several months after an initial visit in LUCY. In effect, the LUCY psychiatrist might “steal” the productivity bonus associated with the 90792 code from the psychiatrist practicing in the traditional model. We have found that in practice this rarely happens. We have explored the option of having the LUCY provider bill for a consult code instead of a 90792, which would obviate this problem. However, finding the correct billing code for a consult takes more time than billing a 90792 for every new patient, and our service has determined that this time would be better spent caring for patients. We have also determined that a 90792 code more accurately describes the work that is being conducted by the LUCY provider. Therefore, our current plan is to continue using traditional initial and follow-up billing codes in LUCY for the time being.

Coverage

Because the provider for LUCY is inconsistent between sessions, the primary provider for LUCY patients is a dummy provider that is effectively only available on Wednesday afternoons. If LUCY patients call the clinic on days other than Wednesday, that call is handled in the same way as any other call that is placed by a patient whose provider is unavailable. When a provider is unavailable, her/his patients' calls are forwarded to the on-call psychiatrist for the day, in the form of an in-basket message through PeC. The on-call psychiatrist reviews the information and determines whether she/he can respond through the staff member who originally fielded the call (for example, non-clinical questions or medication refill requests), should call the patient directly to discuss clinical information, should try to schedule the patient into an opening within her/his personal schedule, or should refer to LUCY.

It is common that issues arise between LUCY sessions that the on-call psychiatrist does not immediately know how best to handle. When this happens, the medical director of LUCY is brought in to the discussion and asked to offer guidance.

It is also common that other providers in the Brigham Health system, who do not receive an orientation to the LUCY clinic and expect that the same psychiatrist who provided a clinical encounter in psychiatry has become the patient's primary psychiatrist, will reach out to a LUCY psychiatrist directly to communicate about the treatment plan. In such cases, the psychiatrist is encouraged to answer the other provider's questions as well as she/he can, inform the other provider that the patient does not have a regular primary psychiatrist at BPS and instead is accessing care through a different model, and briefly explain the LUCY model. Typically, the LUCY SW should be included in these communications in order to facilitate continuity of care should the patient returns to LUCY and see a different provider.

Prescribing Benzodiazepines

The LUCY clinician may encounter requests for benzodiazepines, including new prescriptions, refills, early refills, etc. She/he should make decisions regarding whether to prescribe a benzodiazepine according to what appears clinically appropriate at the time, based upon the clinical evaluation and what has been documented in the patient's chart. If any benzodiazepine is prescribed, the LUCY psychiatrist should clearly document that a discussion about prescribing controlled substances in an urgent care setting took place, using the smartphrase .LUCYBENZO:

We discussed the fact that benzodiazepines are controlled substances, exposure to which carries significant risks including falls, motor vehicle accidents, confusion, dementia, and addiction. For a medication in this class to be prescribed safely, it must be done in the context of a treatment plan in which the goals, the outcomes, and safe prescribing limits are all transparent. Typically, this means that all benzodiazepine prescriptions, including refills, go through a single provider who oversees that treatment plan. In some circumstances, such as this one, where gaps exist in the treatment plan but the overall risk/benefit ratio continues to favor the use of a benzodiazepine the Longitudinal Urgent Care Psychiatry provider can prescribe it. However, if the recipient of this prescription does not adhere strictly to the treatment plan or exhibits signs of adverse effects from the prescription, including non-medical use, the overall risk/benefit ratio may shift, and it will no longer be appropriate for a Longitudinal Urgent Care Psychiatry provider to prescribe it. The patient appeared to understand this discussion and expressed agreement.

For coverage patients (who already have another regular psychiatry provider):
For a NEW benzodiazepine prescription: This evaluation *must* include a review of MassPAT. If the LUCY clinician determines that prescribing a new benzodiazepine is appropriate at the encounter, she/he may supply a sufficient quantity to bridge the patient to her/his next scheduled appointment with her/his usual provider or up to 3 months, whichever is less.

For benzodiazepine REFILLS: This evaluation *may* include a review of MassPAT and *must* include a review of the last documented contact between the patient and her/his usual provider (in which a MassPAT review may already be documented). If the LUCY clinician determines that prescribing a benzodiazepine refill is appropriate, she/he may supply a sufficient quantity to bridge the patient until the usual provider returns to clinic or up to 1 month, whichever is less.

Special circumstances:
*Usual provider recently declined a request for benzodiazepine prescription or refill:
    **The LUCY psychiatrist is responsible for reviewing the last documented encounter with the usual provider. If the usual provider declined the request at this encounter or documented instructions not to prescribe benzodiazepines, the LUCY psychiatrist should not prescribe a benzodiazepine.

However, the LUCY psychiatrist may offer a second opinion and discuss it with the patient's usual provider.

*Usual provider left the clinic:

**If BPS is expected to provide care going forward and the patient is eligible for a new BPS intake, this patient should be considered a rapid-access patient, and the algorithm for rapid-access patients should be followed. The LUCY psychiatrist should confirm that a new intake has been scheduled, and if not should ensure that this is scheduled before the patient leaves the clinic.

**If the patient would benefit from having her/his care directly managed by a psychiatrist but is not eligible for a new scheduled intake based on history of missed appointments, this patient should be considered a primary LUCY patient and the algorithm for LUCY patients should be followed. The structure of LUCY should be described to the patient, and a community referral should be offered. If an extended discussion regarding the structure of LUCY is required (particularly if the patient has not had an opportunity to speak with SW about it), the SW may be enlisted to assist with this discussion.

**If BPS is NOT expected to provide care going forward, the patient has been discharged from the clinic. The LUCY psychiatrist and the patient together should determine whether a new referral to BPS is appropriate. If a new BPS referral is NOT appropriate, the LUCY psychiatrist may offer a consultation with recommendations for the primary care provider to follow but should not prescribe any medications.

*Usual provider is on extended leave, e.g. parental:

**If the patient is being covered by a specific BPS provider, the usual guidelines should be followed with the covering provider acting as the usual provider

**If the patient is not being covered by a specific BPS provider, the LUCY psychiatrist may supply a quantity sufficient to last until the usual provider returns from leave or up to 6 months, whichever is sooner, for either a refill or a new prescription.

*Last benzodiazepine refill was prescribed by a covering provider:

**The LUCY psychiatrist is discouraged from supplying a refill in this case. There may be circumstances where this is still appropriate, e.g., the patient tried to reach the usual provider since the last encounter or did not expect limits to have been set around controlled substances in which a limited supply might be offered, and in such cases the LUCY psychiatrist may supply the refill.

For primary LUCY patients:

<u>For a NEW benzodiazepine prescription</u>: This evaluation *must* include a review of MassPAT. If the LUCY clinician determines that prescribing a new benzodiazepine is appropriate at the encounter, she/he may supply a quantity of up to 6 months.

<u>For CONTINUING a benzodiazepine prescription previously managed by another provider</u>: This evaluation *must* include a review of MassPAT. If the LUCY clinician determines that continuing a benzodiazepine is appropriate at the encounter, she/he may supply a quantity of up to 6 months.

<u>For benzodiazepine REFILLS</u>: This evaluation *must* include a review of MassPAT and *must* include a review of the last documented LUCY encounter (in which a MassPAT review may already be

documented). If the LUCY clinician determines that prescribing a benzodiazepine refill is appropriate, she/he may supply a quantity of up to 6 months.

Special circumstances:

*The previous LUCY psychiatrist documented that a benzodiazepine was not appropriate:

**The LUCY psychiatrist is generally discouraged from supplying a refill in this case. If the LUCY psychiatrist disagrees with the previous clinician's assessment that a benzodiazepine would not be appropriate, the LUCY psychiatrist should explain to the patient that in the setting of provider disagreement she/he is unlikely to be able to receive benzodiazepine prescriptions consistently in a setting such as LUCY where she/he is receiving psychiatric care from multiple providers, and therefore if the patient chooses to prioritize receiving a benzodiazepine prescription she/he should also prioritize establishing care in a traditional psychiatry clinic model with a single, regular provider. If the LUCY psychiatrist believes that the benzodiazepine prescription is truly medically necessary, she/he may either supply a short taper (in the setting of withdrawal risk) or refer the patient to a partial hospital program.

**The LUCY psychiatrist should document that she/he declined the patient's request for a benzodiazepine and why

For rapid-access patients:

For a NEW benzodiazepine prescription: This evaluation *must* include a review of MassPAT. If the LUCY clinician determines that prescribing a new benzodiazepine is appropriate at the encounter, she/he may supply a quantity of up to 6 months or until the date of the scheduled intake, whichever is shorter.

For CONTINUING a benzodiazepine prescription previously managed by another provider: This evaluation *must* include a review of MassPAT. If the LUCY clinician determines that prescribing a new benzodiazepine is appropriate at the encounter, she/he may supply a quantity of up to 6 months or until the date of the scheduled intake, whichever is shorter.

For benzodiazepine REFILLS: Situations in which a refill is required between the time of the initial prescription and the time of the scheduled BPS intake should be rare and would be considered Special Circumstances unless the wait time for a BPS intake grows to exceed 6 months. If this is the case, this evaluation *may* include a review of MassPAT and *must* include a review of the last documented LUCY encounter (in which a MassPAT review may already be documented). If the LUCY clinician determines that prescribing a benzodiazepine refill is appropriate, she/he may supply a quantity of up to 6 months or until the date of the scheduled intake, whichever is shorter.

Special circumstances:

*The patient missed or cancelled one scheduled BPS intake:

**The LUCY psychiatrist may offer up to one additional prescription lasting until the next scheduled intake or up to 3 months, whichever is shorter.

*The clinic or clinician cancelled one or more scheduled BPS intakes:

**The LUCY psychiatrist may offer up to one additional prescription lasting until the next scheduled intake or up to 3 months, whichever is shorter

*The patient missed or cancelled two scheduled BPS intakes:

**The patient should be reclassified as a primary LUCY patient, and the algorithm for LUCY patients should be followed. The patient should not be offered a third scheduled BPS intake.

*ANY previous LUCY psychiatrist documented that a benzodiazepine was not appropriate:

**The LUCY psychiatrist is discouraged from supplying a benzodiazepine in this case. If the LUCY psychiatrist disagrees with the previous clinician's assessment that a benzodiazepine would not be appropriate, the LUCY psychiatrist should explain to the patient that in the setting of provider disagreement she/he is unlikely to be able to receive benzodiazepine prescriptions consistently in a setting such as LUCY where she/he is receiving psychiatric care from multiple providers, and therefore if the patient chooses to prioritize receiving a benzodiazepine prescription she/he should also prioritize keeping her/his scheduled BPS intake. If the LUCY psychiatrist believes that the benzodiazepine prescription is truly medically necessary, she/he may either supply a short taper (in the setting of withdrawal risk) or refer the patient to a partial hospital program.

Prescribing CNS Stimulants

The LUCY clinician may encounter requests for CNS stimulants, including new prescriptions, refills, early refills, etc. She/he should make decisions regarding whether to prescribe a CNS stimulant according to what appears clinically appropriate at the time, based upon the clinical evaluation and what has been documented in the patient's chart. If any CNS stimulant is prescribed, the LUCY psychiatrist should clearly document that a discussion about prescribing controlled substances in an urgent care setting took place, using the smartphrase .LUCYSTIMULANTS:

We discussed the fact that CNS stimulants are controlled substances, exposure to which carries significant risks including agitation, insomnia, weight loss, addiction, and in some cases psychosis. For a medication in this class to be prescribed safely, it must be done in the context of a treatment plan in which the goals, the outcomes, and safe prescribing limits are all transparent. Typically, this means that all CNS prescriptions, including refills, go through a single provider who oversees that treatment plan. In some circumstances, such as this one, where gaps exist in the treatment plan but the overall risk/benefit ratio continues to favor the use of a CNS stimulant, the Longitudinal Urgent Care Psychiatry provider can prescribe it. However, if the recipient of this prescription does not adhere strictly to the treatment plan or exhibits signs of adverse effects from the prescription, including non-medical use, the overall risk/benefit ratio may shift, and it will no longer be appropriate for a Longitudinal Urgent Care Psychiatry provider to prescribe it. The patient appeared to understand this discussion and expressed agreement.

For coverage patients:
<u>For a NEW stimulant prescription</u>: Patients should generally be discouraged from seeking a new evaluation for ADHD from a LUCY psychiatrist if they already have a regular BPS provider, although they may not provide complete information to the referrer or may self-refer. In most cases, a prescription for ADHD is not emergently required, and the LUCY psychiatrist may simply convey her/his assessment to the patient's usual BPS provider instead of prescribing. Exceptions are described under Special circumstances. If a new CNS stimulant is prescribed, the evaluation *must* include a review of MassPAT and a review of the last documented contact between the patient and her/his usual BPS provider.

<u>For stimulant REFILLS</u>: This evaluation *may* include a review of MassPAT and *must* include a review of the last documented contact between the patient and her/his usual provider (in which a MassPAT review may already be documented). If the LUCY clinician determines that prescribing a stimulant refill is essential (e.g., final exams, a specific critical work task), she/he may supply a sufficient quantity to complete the required task or until her/his usual BPS provider becomes available, whichever is sooner.

<u>Special circumstances</u>:
*Indication for stimulant is for fatigue or depression
**If the usual BPS provider is expected to return within 1 week, the LUCY psychiatrist should not prescribe the stimulant but will instead convey this recommendation to the usual provider.

**If the usual BPS provider is not expected to return within 1 week, the LUCY psychiatrist may prescribe the stimulant directly for up to 1 month

*Usual provider recently declined a request for stimulant prescription or refill:

**The LUCY psychiatrist is responsible for reviewing the last documented encounter with the usual provider. If the usual provider declined the request at this encounter or documented instructions not to prescribe stimulants, the LUCY psychiatrist should not prescribe a stimulant. However, the LUCY psychiatrist may offer a second opinion and discuss it with the patient's usual provider.

*Usual provider left the clinic:

**If BPS is expected to provide care going forward for indications other than ADHD, and the patient is eligible for a new BPS intake, this patient should be considered a rapid access patient, and the algorithm for rapid access patients should be followed. The LUCY psychiatrist should confirm that a new intake has been scheduled, and if not should ensure that this is scheduled before the patient leaves the clinic.

**If the patient would benefit from having her/his care directly managed by a psychiatrist but is not eligible for a new scheduled intake based on history of missed appointments, this patient should be considered a primary LUCY patient and the algorithm for LUCY patients should be followed. The structure of LUCY should be described to the patient, and a community referral should be offered. If an extended discussion regarding the structure of LUCY is required (particularly if the patient has not had an opportunity to speak with SW about it), the SW may be enlisted to assist with this discussion.

**If ADHD is the only indication for psychiatric care, the LUCY psychiatrist should provide an evaluation for ADHD as a consultation and should offer recommendations for the primary care provider to follow but should not prescribe any medications directly. The patient should be instructed to seek a stimulant prescription, if appropriate from her/his primary care provider. The LUCY psychiatrist should communicate this recommendation to the primary care provider through InBasket.

*Usual provider is on extended leave, e.g. parental:

**If the patient is being covered by a specific BPS provider, the usual guidelines should be followed with the covering provider acting as the usual provider

**If the patient is not being covered by a specific BPS provider, the LUCY psychiatrist may supply a quantity sufficient to last until the usual provider returns from leave or up to 3 months, whichever is sooner, for either a refill or a new prescription.

*Last stimulant refill was prescribed by a covering provider:

**The LUCY psychiatrist is discouraged from supplying a refill in this case. There may be circumstances where this is still appropriate, e.g., the patient tried to reach the usual provider since the last encounter or did not expect limits to have been set around controlled substances in which a limited supply might be offered, and in such cases the LUCY psychiatrist may supply the refill.

For primary LUCY patients:

<u>For a NEW stimulant prescription</u>: The LUCY psychiatrist should not start a new stimulant prescription except under Special Circumstances. If a new stimulant prescription is warranted, the LUCY psychiatrist should encourage the patient to seek this upon establishing care in a traditional psychiatric clinic model.

Alternatively, if the patient's psychiatric condition is not otherwise complicated, the LUCY psychiatrist may reach out to the primary care provider to discuss whether the patient is sufficiently engaged in primary care that a stimulant trial could be successful there.

For CONTINUING a stimulant prescription previously managed by another provider: The LUCY psychiatrist should not continue a stimulant prescription after the patient has been discharged from regular psychiatric care except under Special Circumstances. If continuing the stimulant prescription is warranted, the LUCY psychiatrist should encourage the patient to seek this upon re-establishing care in a traditional psychiatric clinic model. Alternatively, if the patient's psychiatric condition is not otherwise complicated, the LUCY psychiatrist may reach out to the primary care provider to discuss whether the patient is sufficiently engaged in primary care that a stimulant trial could be successful there.

For stimulant REFILLS: At this time, there are not any foreseen Special Circumstances in which a LUCY patient should expect to receive stimulant refills in LUCY.

Special circumstances:

*The patient appears to need a stimulant medication for upcoming school finals (or similar critical, time-limited task)

**It would not be appropriate to start a NEW stimulant prescription at this time without knowledge from prior experience regarding how it could affect the patient and without capacity for follow-up. If the patient's psychiatric condition is not otherwise complicated, the LUCY psychiatrist may discuss the situation with the patient's primary care provider and explore whether the patient is sufficiently engaged in primary care that a stimulant trial could be successful there.

**If the patient is looking for a CONTINUED prescription, and has previously found a particular stimulant to be helpful and tolerated it well, the LUCY psychiatrist may discuss the situation with the patient's primary care provider and explore whether the patient is sufficiently engaged in primary care that a stimulant trial could be successful there.

**If the patient's psychiatric condition is sufficiently complex that a stimulant prescription could not safely be managed by a primary care provider, it is most likely that safely prescribing a stimulant also requires close management by a regular psychiatrist who consistently oversees the treatment plan. Therefore, LUCY psychiatrists should not prescribe stimulants to this group and should not recommend prescribing stimulants to these patients' primary care providers.

*A stimulant would be appropriate for fatigue related to a specific medical condition (e.g., cancer, SLE)

**A recommendation to consider the stimulant should be given to the primary care provider or specialist managing the specific medical condition.

For rapid access patients:

For a NEW stimulant prescription: The LUCY psychiatrist should not provide a new stimulant prescription except under Special Circumstances. If the LUCY psychiatrist determines that a stimulant is appropriate, she/he will document the recommendations for consideration by the provider who conducts the scheduled BPS intake. The LUCY psychiatrist may also discuss the situation with the patient's primary

care provider and explore whether the patient is sufficiently engaged in primary care that a stimulant trial could be successfully started there.

For CONTINUING a benzodiazepine prescription previously managed by another provider: This evaluation *must* include a review of MassPAT. If the LUCY clinician determines that continuing a stimulant is appropriate at the encounter, she/he may supply a quantity of up to 3 months or until the date of the scheduled intake, whichever is shorter.

For stimulant REFILLS: Situations in which a refill is required between the time of the initial prescription and the time of the scheduled BPS intake should be rare and would be considered Special Circumstances unless the wait time for a BPS intake grows to exceed 3 months. If this is the case, this evaluation *may* include a review of MassPAT and *must* include a review of the last documented LUCY encounter (in which a MassPAT review may already be documented). If the LUCY clinician determines that prescribing a CNS refill is appropriate, she/he may supply a quantity of up to 3 months or until the date of the scheduled intake, whichever is shorter.

Special circumstances:

*The patient missed or cancelled one scheduled BPS intake:

**The LUCY psychiatrist may offer up to one additional prescription of sufficient quantity to a specific critical, time-limited task (e.g., finals).

*The clinic or clinician cancelled one or more scheduled BPS intakes:

**The LUCY psychiatrist may offer up to one additional prescription lasting until the next scheduled intake or up to 3 months, whichever is shorter.

*The patient missed or cancelled two scheduled BPS intakes:

**The patient should be reclassified as a LUCY patient, and the algorithm for LUCY patients should be followed. The patient should not be offered a third scheduled BPS intake.

*The previous LUCY psychiatrist documented that a stimulant was not appropriate:

**The LUCY psychiatrist is discouraged from prescribing a stimulant in this case. If the LUCY psychiatrist disagrees with the previous clinician's assessment that a stimulant would not be appropriate, the LUCY psychiatrist may document the recommendation in her/his evaluation for consideration by the psychiatrist who conducts the scheduled BPS intake.

Note Templates

Urgent Care Psychiatry - Initial Evaluation

@TD@

@NAME@, a @AGE@ @SEX@, for Psychiatry Urgent Care visit.
Patient is referred by @PCP@.

Chief complaint: "***"
Face to face time:

HPI:
@NAME@ is a @AGE@ @SEX@ presents for urgent care evaluation. Before the start of this evaluation we reviewed the structure of the Longitudinal Urgent Care Psychiatry clinic, and the patient understands that our purpose today is to provide a bridge to a sustainable comprehensive care setting during a period in which access to care would otherwise be lost, and not to establish an ongoing care relationship.

Review Of Systems:

Medical Review Of Systems:
{ros; complete:30496}

History:

Past Psychiatric History:

History of episodes consistent with mania or hypomania?:
History of psychosis?:
History of post-traumatic symptoms?:
History of obsessive-compulsive symptoms?:
History of disordered eating symptoms?:
History of suicide attempts?:
History of self-injury?:
History of violence/aggresion?:

Psychiatric hospitalizations:

Psychotherapy experience:

Medication trials:

Substance Abuse History:

Medical History:
@PROB@

History of head injury/trauma?:
History of seizures?:

For women of childbearing age:
Number of lifetime pregnancies/births:
Last menstrual period:
Current birth control method:

@MED@

@ALLERGY@

Family History:

Social History:

History of domestic violence exposure:
Current abuse or intimidation:
Legal problems:
Access to weapons:
Military experience:
Spirituality:
Learning style:
Pt strengths/ability to participate in care:

Current Evaluation:

Vitals: @VITALS@

Mental Status Evaluation:
Appearance: {mental status; appearance:304110001}
Behavior: {mental status; behavior:304110002}
Psychomotor Activity: {mental status; psychomotor activity:304110003}
Musculoskeletal: {mental status; musculoskeletal:304110004}
Station/Gait: {mental status; station/gait:304110006}
Speech: {mental status; speech:304110007}
Mood: {mental status; mood:304110009}
Affect: {mental status; affect:304110005}
Thought Process: {mental status; thought process:304110008}
Associations: {mental status; associations:304110021}
Thought Content: {mental status; thought content:304110010}

Suicidal/Homicidal Ideation: {mental status; suicidal/homicidal:304110020}
Perceptions/Experiences: {mental status; perceptions/experiences:304110012}
Insight: {mental status; insight/judgment:304110018}
Judgment: {mental status; insight/judgment:304110018}

Orientation/Sensorium: {mental status; sensorium:304110013}
Fund of Knowledge: {mental status; fund of knowledge:304110017}
Attention/Concentration: {mental status; attention:304110015}
Language: {mental status; language:304110019}
Memory: {mental status; memory:304110014}

Relevant Labs/Studies:
@LASTLABG(3M)@

Assessment – Diagnosis – Goals:

@APBEGIN@
FORMULATION:

DIAGNOSES: ***

Risk assesssment:
( ) Low
( ) Other:

Treatment provided at this visit:

Next steps to consider if first-line treatment is not successful (if any):

Recommended follow-up plan:

This patient was seen for an Urgent Care Psychiatry evaluation and has not yet established care with an identified primary clinician. Medical treatment provided at this visit may warrant follow-up before longitudinal psychiatric care can be established; therefore, since the patient does not het have a primary psychiatric provider, she/he may return to Urgent Care Psychiatry or may follow up with other existing providers (such as primary care). If the patient returns to Urgent Care Psychiatry, she/he may be seen by a different clinician at that visit. Similarly, if the patient has additional questions about the care provided today or requires psychiatric assistance over the phone, she/he may reach a different clinician.
@APEND@

Longitudinal Urgent Care Psychiatry (LUCY) - Progress Note

@SUBJECTIVEBEGIN@
Chief Complaint: ***
Primary psychiatry clinician: ***

HPI:
@NAME@ is a @AGE@ @SEX@ presents for urgent care evaluation. Before the start of this evaluation we reviewed the structure of the Longitudinal Urgent Care Psychiatry (LUCY) clinic, and the patient understands that our purpose today is to provide a targeted assessment and treatment in a timely manner but not to replace or establish an ongoing care relationship.

PFSH updates today:

Review of Systems
{Review of Systems:304110048}
@SUBJECTIVEEND@

@OBJECTIVEBEGIN@
Mental Status Exam
@VITALS@

Appearance: {mental status; appearance:304110001}
Behavior: {mental status; behavior:304110002}
Psychomotor Activity: {mental status; psychomotor activity:304110003}
Musculoskeletal: {mental status; musculoskeletal:304110004}
Station/Gait: {mental status; station/gait:304110006}
Speech: {mental status; speech:304110007}
Mood: {mental status; mood:304110009}
Affect: {mental status; affect:304110005}
Thought Process: {mental status; thought process:304110008}
Associations: {mental status; associations:304110021}
Thought Content: {mental status; thought content:304110010}
Suicidal/Homicidal Ideation: {mental status; suicidal/homicidal:304110020}
Perceptions/Experiences: {mental status; perceptions/experiences:304110012}
Insight: {mental status; insight/judgment:304110018}
Judgment: {mental status; insight/judgment:304110018}

Orientation/Sensorium: {mental status; orientation/sensorium:304110013}
Fund of Knowledge: {mental status; fund of knowledge:304110017}
Attention/Concentration: {mental status; attention:304110015}
Language: {mental status; language:304110019}
Memory: {mental status; memory:304110014}.

Data:
@LASTLABG(30D)@

@OBJECTIVEEND@

@APBEGIN@
Formulation:

Risk assesssment:
[ ] Low
[ ] Other

Diagnosis:
Interval progress:

Treatment provided at this visit:

Next steps to consider (if any):

Recommended follow-up plan:

Communications:
Duration of visit:

This patient was seen for a Urgent Care Psychiatry visit. Medical treatment provided at this visit may warrant follow-up, however follow-up should be conducted with the patient's regular primary psychiatric provider. If the patient does not yet have a primary psychiatric provider, she/he may return to Urgent Care Psychiatry or may follow up with other existing providers (such as primary care). If the patient returns to Urgent Care Psychiatry, she/he may be seen by a different clinician at that visit. Similarly, if the patient has additional questions about the care provided today or requires psychiatric assistance over the phone, she/he may reach a different clinician.
@APEND@