County of Sacramento Department of Health and Human Services Division of Behavioral Health Services Policy and Procedure		Policy Issuer (Unit/Program)	**QM**
		Policy Number	**QM-07-02**
		Effective Date	**04/19/1996**
		Revision Date	**08/01/2020**
Title: **Medication Monitoring**		Functional Area: **Interface with Physical Health Care**	
Approved By: **Alexandra Rechs, LMFT** Program Manager, Quality Management **Glen Xiong, MD** Medical Director, Sacramento County Behavioral Health Services Center **Robert Horst, MD** Medical Director, Child and Family Services			

Background/Context:

Medication Monitoring falls under the umbrella of quality improvement monitoring in psychiatry. As defined in the Manual of Psychiatric Quality Assurance: "The goal of quality assurance is to ensure that the important aspects of medical care are delivered in accordance with pre-established standards of acceptable medical practice."

The quality improvement process under the Sacramento County Division of Behavioral Health Services (DBHS) mandates that each contracted or county operated program shall include in their Quality Improvement Plan at least the following components: 1) Utilization Review; 2) Medication Monitoring; and 3) Peer Review. The Medication Monitoring Committee has been established to meet the County objectives, as well as State mandates in quality improvement for medication monitoring.

Purpose:

The intended purpose of medication monitoring is to establish a process to promote the appropriate use and management of psychotropic and other medications. Systematic monitoring is intended to meet the following objectives:

1. Monitor and promote the safe and effective use of psychotropic medications;

2. Reduce the inappropriate use of medications;

3. Promote the proper prescribing and monitoring of psychotropic agents by the prescriber;

4. Monitor medication adherence and informed consent;

5. Improve quality of medication services by monitoring of appropriate documentation to reduce the risk of adverse drug reactions through proper documentation of side effects, adherence and response to medications and also regular lab work and EKG'S when necessary

To achieve these ends, the Medication Monitoring Committee uses evidence based practices and approved criteria developed by the County Pharmacy and Therapeutics (P&T) Committee to assess various aspects of the treatment process. Through informational and corrective feedback to the providers, the goals for quality care can be attained.

Details:

A. Medication Monitoring Committee
The Medication Monitoring Committee is a multi-disciplinary committee comprised of Adult and Child specific committees which meet bi-monthly to review professional practices involving medication treatment for inpatient (Sacramento County Mental Health Treatment Center - MHTC) and outpatient (Integrated Services Agency - ISA, Regional Support Teams - RST Clinics, and Children Mental Health Service Contracts) populations. This committee is formulated and regulated by the procedures set forth in the MHP contract with Department of Health Care Services

Under the County Quality Assurance and Performance Improvement (QAPI) Plan, the Medication Monitoring Committee reports to the County Quality Improvement Committee.

The Medication Monitoring Committee is made of medical, nursing and clinical staff. Representatives from the outpatient programs are invited to attend meetings. The core of the committee members is comprised of the County Medical Director, a Quality Improvement representative and the Medication Monitoring Pharmacist. Participation and attendance at the medication monitoring meetings is open to all program representatives.

The administration of the Medication Monitoring Committee shall be the responsibility of the Quality Management Program Manager. The Medical Director shall chair the Medication Monitoring Committee meetings and be responsible for review of psychiatric and medical practices. The Medication Monitoring Pharmacist shall be responsible for reporting medication monitoring findings in committee meetings, and for submitting a summary report to the Quality Management Program Manager.

B. Audit Requirements
A structured medication monitoring “Screening Criteria and Compliance ‘’ audit tool, approved by the Pharmacy & Therapeutics Committee (P&T) is utilized at each audit. (See Attachment I). The Medication Monitoring Committee reviews the tool and screening criteria periodically and when necessary, based on current evidence based practices, presents its concerns for criteria changes to the P&T Committee.

Ongoing audits are conducted at each outpatient program and at the Mental Health Treatment Center where medication services have been provided. Medication audits will utilize the “Screening Criteria and Compliance” tool whose explanation is found in the “Medication Monitoring Criteria Explained” (attachment 2). Audits will follow the “Medication Monitoring Standards and Guidelines,” which is a separate set of written guidelines for the purpose of chart audits. The minimum chart sample size for audit can be determined by the Behavioral Health Adult or Children’s Services Medical Director if special circumstances require to increase number of charts. These special circumstances may include but are not limited to: State/Federal audit requests, plans of correction, program improvement projects

focusing on medical services, or other legitimate concerns which can potentially arise requiring to audit more charts beyond the 5%. This number, however, cannot fall below five percent (5%) annually. Agencies will be asked to randomly select from active cases in order to obtain the required minimum standard. The number of charts reviewed at the Mental Health Treatment Center will be at least 5% of the average monthly admissions computed on an annual basis. .

C. Meetings

Medication Monitoring Committee meetings are held bimonthly at the Sacramento Mental Health Treatment Center on even numbered months (February, April, June, August, October, December) Announcements of upcoming meetings will be sent out by the Medication Monitoring Pharmacist at least a week ahead of the scheduled meeting to committee members and to all programs whose audit findings will be presented. It is highly recommended that representatives from the programs being audited are in attendance for the reporting of their specific audit findings.
The Medication Monitoring Pharmacist is responsible for taking minutes to document the activities and outcomes of the meeting.

D. Reporting and Corrective Actions

The Medication Monitoring Pharmacist presents audit findings at the Medication Monitoring meetings. The Medication Monitoring Committee collectively decides on whether any corrective measures need to be taken based on audit findings. In the event a correction is required, the Medication Monitoring Pharmacist, with approval from the Chair of the Medication Monitoring Committee, sends a corrective memo of notification to the program. This is sent to the programs' Medical Director, Program Director, Program Manager and Clinical Director. The memo will outline the specific corrective measures for which a response is expected. An acknowledgement of the receipt of the corrective memo is expected within 30 days. The program manager will be responsible for taking the necessary corrective actions, which should be reported to the Medication Monitoring Pharmacist who is required to report outcome back to the Medication Monitoring Committee at the next meeting. If resolution is unattainable, it can be referred to the Committee for further review or investigation.

In addition, each program's audit report will be mailed to the program and is to be reviewed by the Physician, Physician Assistant (PA), Nurse Practitioner (NP), Clinic Director and Program Manager and documented on the "Signature Statement" (see Attachment 3). The signed signature statement is the Medication Monitoring Committee's way of obtaining verification that the program is in agreement with the outcome of the audit findings. The Signature Statement is to be returned to the Medication Monitoring Pharmacist and will be kept in a binder with the programs' corresponding audit findings.

Copies of all audit findings from both Adult and Child/Adolescent programs are sent to the appropriate contract monitors. The Quality Management Program Manager receives copies of both Child/Adolescent and Adult Outpatient audit findings.

After approval of minutes by the Medical Directors of Child/Adolescent and Adult Outpatient, the Medication Monitoring Pharmacists distributes minutes to all committee members and programs. The minutes will also be sent to the County Quality Improment

Committee. Where errors have been identified, a copy of the corrective measures and outcomes shall be filed in the same binder with the programs' corresponding audit reports and another copy will be filed with the minutes. Responses to corrective memos will be reported back to the Medication Monitoring Committee at the next meeting.

E. Thresholds

The thresholds for the medication monitoring criteria are implicit to meet 100%, but less than 100% does not necessarily imply substandard care. It may warrant further investigation or review.

Reference(s)/Attachments:

Attachment 1- Medication Monitoring tools

Attachment 2- Explanation of Medication Monitoring Criteria

Attachment 3- Medication Monitoring Signature Statement

Related Policies:

- Informed Consent for Psychotropic Medication QM-10-32
- Medication Support Staff Electronic Documentation Requirements QM-00-06

Distribution:

Enter X	DL Name	Enter X	DL Name
X	Mental Health Staff	X	Children's Contract Providers
X	Mental Health Treatment Center	X	Alcohol and Drug Services
X	Adult Contract Providers		

Contact Information:

Quality Management Information
QMInformation@saccounty.net

(Attachment 1)

SACRAMENTO COUNTY HEALTH AND HUMAN SERVICES
DIVISION OF MENTAL HEALTH

ADULT MEDICATION MONITORING

Agency……...Date…….

Age ……Gender…….

Chart#……..Initials……

Physician……Reviewer…….

DSM-5 Diagnoses…… ……..

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Medications…… ……..

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Screening Criteria and Compliance	**Yes**	**No**	**N/A**	**#**	**%**
1. Is there documentation of hx of drug & /or food allergies or contraindications in Order Connect?	_____	_____	_____	_____	_____
2. For female clients of child bearing age, was pregnancy addressed in progress notes at each physician encounter? Reasons for N/A (including postmenopausal) can be endorsed in AMSP.	____	____	____	____	____
3. Is the dosage level within the FDA or community accepted ranges?	____	_____	____	_____	____
4. Is there documented rationale for use of community accepted dose ranges?	_____	_____	_____	_____	____
5. Justified use of 2 drugs in same class excluding antidepressants, Trazodone and mood stabilizers?	_____	_____	_____	_____	____
6. Justified use of 4 or more psychotropics?	____	____	____	____	____

7. Is there a valid, signed and dated, informed consent with all required elements fully completed? (medication, target symptoms, type, dosage and frequency ranges, method, expected duration, refusal of meds) ____ ____ ____ ____ ____

8. Is there documentation of presence or absence of side effects in each progress note? ____ _____ ____ _____ ____

9 .Is there documentation of response to current medications in each progress note? _____ _____ ____ ____ ____ ___

10. Is there documentation of rationale for changes in medication or dose? ____ ____ ____ ____ ____

11. Is there documentation of adherence to medications in each progress note? ____ ____ ____ ____ ____

12. Has the client been seen by the provider quarterly or 3x/yr. if stable? ____ ____ ____ ____ ____
(or has client on NP medication panel been seen by psychiatrist annually?)

13. When a psychotropic medication was added or discontinued, was there progress note documentation for follow up w/in 4-6 weeks, either face to face with medical or nursing staff or via phone? ____ ____ ____ ____ ____

14. If on antipsychotics, is the presence or absence of TD documented annually in an AIMS, AMSP or at least biannually in progress notes? ____ ____ ____ ____ ____

15. Are labs ordered to initiate/monitor drug therapy where indicated?

a. Lithium-Baseline + annual CBC, SCr or BUN, TSH & levels, EKG
If ≥50 years of age & electrolytes if necessary ____ ____ ____ ____ ____
1. Weight-baseline + annual ____ ____ ____ ____ ____

b. Depakote/Tegretol-Baseline & annual CBC, LFTs & levels ____ ____ ____ ____ ____
1. Weight-baseline + annual ____ ____ ____ ____ ____

c. Other: Clozaril-ANC (in addition to below) ____ ____ ____ ____ ____
Atyp Antipsychotic (Baseline + 1 x/yr.)
HbA_{1c} /Fasting Glucose ____ ____ ____ ____ ____
(Baseline+annual) -Cholesterol ____ ____ ____ ____ ____
(Baseline + annual) -Triglycerides ____ ____ ____ ____ ____
(Baseline + 2 x/yr.) -Weight ____ ____ ____ ____ ____

d. Topamax-(C02) on electrolyte panel, baseline, at 3 months + annual ____ ____ ____ ____ ____
____ ____ ____ ____ ____

e. Trileptal-Na^+ (baseline, at 3 months +annual)

f. Lamictal (see dosing protocol) ____ ____ ____ ____ ____

16. Current labs in chart (within the year) ____ ____ ____ ____ ____

Revised 12/8/17

SACRAMENTO COUNTY HEALTH AND HUMAN SERVICES
DIVISION OF MENTAL HEALTH

ADULT MEDICATION MONITORING
CRISIS RESIDENTIAL

Agency……...Date…….

Age ……Gender…….

Chart#……..Initials……

Physician……Reviewer…….

DSM-5 Diagnoses……

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Medications……

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Screening Criteria and Compliance	**Yes**	**No**	**N/A**	**#**	**%**
1. Is there documentation of hx of drug & /or food allergies or contraindications in Order Connect?	____	____	____	____	____
2. For female clients of child bearing age, was pregnancy addressed at least in a single progress note? Reasons for N/A (including Postmenopausal) is required.	____	____	____	____	____
3. Is the dosage level within the FDA or community accepted ranges?	____	_____	_____	_____	_____

4. Is there documented rationale for use of

community accepted ranges? ____ _____ _____ _____ _____

5. Justified use of 2 drugs in same class excluding antidepressants, Trazodone, and mood stabilizers? ____ ____ ____ ____ ____

6. Justified use of 4 or more psychotropics? ____ ____ ____ ____ ____

7. Is there a valid, signed and dated, informed consent with all required elements fully completed? (medication, target symptoms, type, dosage and frequency ranges, method, expected duration, refusal of meds). ____ ____ ____ ____ ____

8. Is there documentation in progress note of presence or absence of side effects? ____ ____ ____ ____ ____

9. Is there documentation in progress note of response to current medications? ____ ____ ____ ____ ____

10. Is there documentation of rationale for changes in medication or dose? ____ ____ ____ ____ ____

11. Is there documentation in progress note of adherence to medications? ___ ____ ____ ____ ____

12. If on antipsychotics, is the presence or absence of TD documented in an AIMS, or addressed in progress notes? ____ ____ ____ ____ ____

13. Are labs ordered to initiate/monitor drug therapy where indicated?

a. Lithium-Baseline + annual CBC, SCr or BUN, TSH & levels, EKG If ≥50 years of age & electrolytes if necessary ____ ____ ____ ____ _____

1. Weight-baseline + annual ____ ____ ____ ____ ____

b. Depakote/Tegretol-Baseline & annual CBC, LFTs & levels ____ ____ ____ ____ ____

1. Weight-baseline + annual ____ ____ ____ ____ ____

c. Other Clozaril-ANC (in addition to below) ____ ____ ____ ____ ____

Atyp Antipsychotic (Baseline + 1 x/yr.)

HbA_{1c} /Fasting Glucose ____ _____ _____ ____ _____

(Baseline+annual) -Cholesterol ____ ____ ____ ____ ____

(Baseline + annual) -Triglycerides ____ ____ ____ ____ ____

(Baseline + 2 x/yr.) -Weight ____ ____ ____ ____ ____

d. Topamax-(C02) on electrolyte panel, baseline, at 3 months + annual ____ ____ ____ ____ ____

____ ____ ____ ____ ____

e Trileptal-Na^+ (baseline, at 3 months +annual)

f. Lamictal (refer to dosing protocol) ____ ____ ____ ____ ____

14. Current labs in chart (within the year). ____ ____ ____ ____ ____

Revised 12/8/17

SACRAMENTO COUNTY DEPARTMENT OF HEALTH SERVICES.
DIVISION OF BEHAVIORAL HEALTH

CHILD AND ADOLESCENT MEDICATION MONITORING

Agency…… Date…….

Age ……Gender……..

Chart#…… Initials……

Physician……Reviewer……

DSM-5 Diagnoses…… ……

…… ……

Medications

Screening Criteria and Compliance Yes/No N/A #/%

1. Is there documentation of hx of drug &/or food allergies? (In Order Connect widget for AVATAR using agencies and progress notes or similar tool for non-AVATAR agencies) _____ _____ _____

2. For female clients 9 years and above, was pregnancy addressed in progress notes at each physician encounter? Reasons for N/A should be documented. _____ _____ _____

3. Is the dosage level within the FDA ranges? _____ _____ _____

4. Is there documented rationale for off label use? _____ _____ _____

5. Justified use of 2 drugs in same class? _____ _____ _____

6. Justified use of 4 or more psychotropics? ____ ____ ____

7. Is the necessity of treatment evaluated annually in AMSP complete with Client/caregiver signature? _____ _____ _____

Screening Criteria and Compliance Yes/No N/A #/%

8. Is there a valid, signed and dated, informed consent with all required elements fully completed? (medication, target symptoms, type, dosage and frequency ranges, method, expected duration, refusal of meds-where applicable) _____ _____ _____

9. If IC is from Court, is it current (w/in 6 months of issue)? _____ _____ _____

10. Is there documentation of presence or absence of side effects in each progress note? _____ _____ _____

11 .Is there documentation of response to current medications in each progress note? _____ _____ _____ _

12. Is there documentation of rationale for changes in medication or dose? ____ _____ _____

13. Is there documentation of adherence to medications in each progress note? ____ ____ _____

14. Has the client been seen by the provider at least quarterly if stable? ____ ____ ____

15. When a psychotropic medication was added or significantly changed, was there progress note documentation for follow up w/in 4-6 weeks?

16. If on antipsychotics, is the presence or absence of TD documented annually in an AIMS, AMSP or at least biannually in progress notes? ____ ____ _____

17. Are vitals documented every 3 months? (in vitals widget for AVATAR using agencies and in progress notes or similar tool for non-AVATAR users?)

BP/Pulse ____ ____ ____

Ht/Wt ____ ____ ____

BMI ____ ____ ____

18. Are labs ordered to initiate/monitor drug therapy where indicated (include date)? _____

a. Lithium- CBC, SCr or BUN, TSH & levels. (Baseline + annually and as clinically indicated)

_____ _____ _____

b. Depakote/Tegretol- CBC, LFTs & levels
Baseline + annually and as clinically indicated)

_____ _____ _____

Screening Criteria and Compliance Yes/No N/A #/%

c. Other: Clozaril-ANC (in addition to below)
Atyp Antipsychotic

_____ _____ _____

HbA_{1c} /Fasting Glucose
(Baseline + at 3 months +1 x/yr. thereafter)

_____ _____ _____

Cholesterol
(Baseline + at 3 months +1 x/yr. thereafter)

_____ _____ _____

Triglycerides
(Baseline + at 3 months +1 x/yr. thereafter)

_____ _____ _____

d. Topamax-(C02) on electrolyte
panel, baseline, at 3 months + annual

_____ _____ _____
_____ _____ _____

e. Trileptal-Na^+ (baseline, at 3 months +annual)

f. Lamictal (see dosing protocol) ------ ------- -------

19. Current labs in chart (within the year)

_____ _____ _____

Revised 12/18

SACRAMENTO COUNTY DEPARTMENT OF HEALTH SERVICES
DIVISION OF BEHAVIORAL HEALTH

Child and Adolescent Medication Monitoring

Agency: _____Date:_____

Client's Chart Number: _____Initials:_____

Physician: _____Reviewer:_____

Screening Criteria for ADHD Treatment	**Yes**	**No**	**N/A**
1. Is the medication used for Attention Deficit Disorders or Narcolepsy?	____	____	____
2. Is the dosage level within the generally accepted AACAP accepted ranges? (Reference American Academy of Child/Adolescent Psychiatry guidelines)?			
Clonidine 0.025mg-0.4mg/day, taper when dc			
Guanfacine 0.5-4mg/day			
3. Is the necessity of treatment evaluated annually in AMSP complete with client/caregiver signature?	____	____	____
4. No more than 2 med changes or dose increases in any 7 day period. (should we revisit the need for this criterion?)	____	____	____
5. Explanation for use of 4 or more psychotropic medications.	-------	--------	--------
6. Justification for off label use? .	____	____	____
7. Is there documentation of a valid, signed and dated informed consent with all required elements fully completed? (medication, target symptoms, type, dosage and frequency ranges, method, expected duration, and refusal of meds where applicable)?	____	____	____
a. If IC is from Court, is it current (w/in 6 months of issue)?	____	____	____
8 Is there documentation of food or drug allergies? (In Order Connect widget for AVATAR using agencies and progress notes or similar tool for non-AVATAR agencies)?	____	____	____
9. Is the medication prescribed in absence of relative contraindications?	____	____	____
History of substance abuse			
Hypertension			
Symptomatic cardiovascular disease			
Hyperthyroidism			
History of psychosis			
Pregnant or nursing			
Less than 5 years old without therapy trial first			
a. If relative contraindication present, is a note in the chart supporting use of medication in this patient?	____	____	____
10. Is there documentation of presence or absence of side effects in each progress note?	____	____	____
11. Is there documentation of response to current medication in each progress note?	____	____	____
12. Is there documentation of client's adherence to medication in each progress note?	____	____	____

13. Are vitals documented every 3 months? (in vitals widget for AVATAR using agencies and progress notes or similar tool for non AVATAR users)?

BP/Pulse ____ ____ ____

Ht/Wt. ____ ____ ____

BMI ____ ____ ____

14. When a new medication was started, was the client seen by a physician within 4-6 weeks? ____ ____ ____
    a. For a dosage change, did the physician write a progress note? within 4-6 weeks? ____ ____ ____
15. Was the client seen at least quarterly?
16. Is there documentation of CURES verification prior to treatment and every four months thereafter if treatment is ongoing? ____ ____ ____

DSM-5 Diagnoses: _____ ***Age:*** ____ ***Sex:*** ____

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Medications: _____

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Comments: _____

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Revised 12/18

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MENTAL HEALTH URGENT CARE CLINIC

DATE _____ CHART #_____ PT INITIALS_____ AGE _____ GENDER _____AUDITOR _____

PSYCHIATRIC DX:_____Provider_____

PD/SUBSTANCE ABUSE DX/MEDICAL DX_____

MEDICATIONS	NOTES

DRUG/TEST	ORDERED	Y	N	NA	AUDITING NOTES
Lithium	SCr/BUN, CBC, TSH/Lithium level-baseline				
	EKG if 50 or older				
	Level: 5-6 days after starting/dose Δ				
	Weight -baseline				
Depakote/Tegretol	CBC, LFT, Depakote level-baseline				
	Level: 3-5 days after starting/dose Δ				
	Weight-baseline				
Atypical Antipsychotic	Clozaril – ANC-baseline				
	Blood Glucose-baseline				
	Cholesterol -baseline				
	Triglycerides-baseline				
	Weight – baseline				
Topiramate	CO2 - Baseline				
Lamicatal	(refer to dosing protocol)				
Oxcarbazepine	Na-baseline				
ALL LABS	**Documentation of labs recommended is required**				
Pregnancy Rule Out	**/OR/** Documentation of menopause				

	Y	N	NA	AUDITING NOTES
Food/drug allergies/contraindications in Order Connect				
Informed Consent(s) for Psychiatric Medications				
Doses w/in acceptable FDA or community accepted range(s)				
Receiving two or more psychotropics in the same class?				
Rationale for use of 4 or more psychotropics				
Rationale for medication/dose changes				
Documentation of side effects				
Documentation of compliance				
Documentation of Response				

(Attachment 2)

SACRAMENTO COUNTY HEALTH AND HUMAN SERVICES
DIVISION OF MENTAL HEALTH

MEDICATION MONITORING CRITERIA EXPLAINED

1. For Avatar using programs, documentation of history of drug / or food allergies or contraindications is required in AVATAR. For non-Avatar using programs, similar documention in progress note or programs' allergy widget is required.
2. For female clients 9 years and above, documentation of pregnancy rule out is required at each encounter with provider (Physician, Nurse Practitioner and Physician's Assistant) . Reasons for not applicable such as postmenopausal or premenarche are to be endorsed in AMSP or progress notes.
3. Dosage level outside FDA ranges requires documented rationale for use for all. This includes community accepted dose ranges and off label use.
    a. All medication use requires documented rationale. Use of medication off label requires specific documentation justifying the off label use in children. Medication use without adequate rationale will be reviewed by the medication monitoring committee.
    b. Medication dosages exceeding FDA maximums will be reviewed by the medication monitoring committee. Specific rationale justifying the elevated dose is required.
4. Documented justification is required if client is receiving two antipsychotics.
5. Documented justification is required if client is on four or more psychotropics.
6. The necessity of treatment is to be evaluated annually in an AMSP, complete with client/caregiver and provider's signatures.
7. A valid, signed and dated informed consent, with all elements completed, is required. For any given medication, a new consent is required if the dosage range of the existing consent is outside the current prescribed dose range. Informed consents are perpetual.
8. A JV220 (application for psychotropic medications) and/or a JV223 (court approval for use of psychotropic medications) is required if client is a court dependent. JV223'S are current for up to 6 months from date of approval. For a given medication, a new application is required if the dosage range is outside the range of the original.
9. For children, are medications prescribed in the absence of relative contraindations such as history of substance abuse, hypertension, symptomatic cardiovascular disease, hyperthyroidism, history of psychosis, pregnant or nursing, less than 5 years old without therapy trial first?
10. If relative contraindication is present, is there supporting progress note documentation?
11. Documentation of the presence/absence of side effects to medications is required in each progress note.
12. Documentation of the response to medications is required in each progress note.
13. Documented rationale for changes in medication or dose is required.
14. Documentation of adherence to medications is required in each progress note.
15. Clients are to be seen at least quarterly. For adults, if client is on nursing medication panel, client is to be seen by psychiatrist annually.
16. For ADHD meds, progress note documentation for follow up within 4-6weeks is required for dosage changes and when new meds are started.

17. For child psychotropic tool, documentation is required within 4-6 weeks of start of new meds and when there is a significant change to medications.
18. For Adults, documentation is required for follow up within 4-6 weeks at the start or discontinuation of meds. Follow up can be achieved face to face with medical or nursing staff or via phone
19. If on antipsychotics, the presence or absence of Tardive Dyskinesia (TD) is to be documented annually in an AIMS, AMSP or at least biannually in progress notes. As a reminder, TD monitoring is not considered covered under "side effects" Monitoring should be evaluated separately.
20. For Children, documentation of CURES verification is required prior to treatment and every four months thereafter if treatment is continuous.
21. For Urgent care, documentation of labs recommended is required.
22. Vitals widget usage for the documentation of Height/ Weight, Blood Pressure/Pulse and BMI is required at least every 3 months for children and at baseline and annually for adults.

Laboratory Analysis

-Lithium - CBC, SCr/ BUN, TSH and levels (Baseline + at least annually for both children and adults and as clinically indicated for children) - An EKG is required if age >50.

-Valproic acid/ Carbamazepine CBC, LFT'S and levels (Baseline + at least annually for both children and adults and as clinically indicated for children).
-Other- Clozaril ANC (in addition to all required labs for antipsychotics)
-Antipsychotics- HbA1C/Fasting glucose (Baseline, at 3 months and annually thereafter for children and baseline and annually for adults)
-Cholesterol (Baseline, at 3 months and annually thereafter for children and baseline and annually for adults)
-Triglycerides (Baseline, at 3 months and annually thereafter for children and baseline and annually for adults)
-Topamax – (C02) on electrolyte panel (Baseline, at 3 months and annually for children and baseline and annually for adults.

-Trileptal –Na+ (Baseline, at 3 months and annually for children and baseline and annually for adults)
-Lamictal (no lab monitoring required. Approved dosing protocol is to be followed)

-Current labs should be within the year.

(Attachment 3)

SACRAMENTO COUNTY HEALTH AND HUMAN SERVICES
DIVISION OF MENTAL HEALTH

MEDICATION MONITORING SIGNATURE STATEMENT

The Medication Monitoring audit for the month of: _____

has been reviewed with the following clinic staff
(Physician, NP, PA, Clinic Director, Program Manager)

_____	_____
Name	***Date***
_____	_____
Name	***Date***
_____	_____
Name	***Date***
_____	_____
Name	***Date***
_____	_____
Name	***Date***
_____	_____
Name	***Date***

_____
Name of Clinic

_____
Clinic Manager

_____
Date

Please return this form to: **Sacramento Mental Health Treatment Center Pharmacy**
2150 Stockton Boulevard #541
Sacramento, CA 95817

Mail code: 44-001