PURPOSE

The Medication Practice Guidelines serve a variety of functions; its primary goal is to standardize and optimize the delivery of psychiatric treatment to clients with mental illness in Santa Clara County.

These guidelines are based on the current state of knowledge in the field of psychiatry, incorporating national guidelines, algorithms, and expert recommendations. The content of each section of the guidelines was obtained with input from psychiatrists and pharmacists of various specialties and cultural backgrounds; section updates occur at regular intervals and are presented before the Psychiatric Practices group for approval.

The guidelines are not absolute and should not supersede the prescriber's clinical judgment; prescribers should tailor treatments based on careful consideration of the client's needs, personal and family preferences, and cultural background. Through appropriate documentation of the rationale, prescribers may deviate from the guidelines based on their best clinical judgment.

Additional purposes of the Medication Practice Guidelines include:

- To serve as an updated, readily accessible reference guide to medications, drug interactions, physical monitoring.
- To determine and quantify outlying patterns of care, relative to a standardized set of guidelines, through regular monitoring and reviews.
- To educate and orient new prescribers**,** locum tenens and temporary staff to the expectations for clinical practice.
- To provide greater public transparency regarding the medical treatment standards within the county.

Treatment detected outside the established guidelines will require review of the prescriber's documentation of justification and evidence of informed consent from the patient.

IMPORTANT CONSIDERATIONS

The following general guidelines apply to the prescribing of all classes of medications:

1. A thorough history should be documented in the chart; the information obtained at the initial assessment should be regularly re-evaluated and updated as the patient's status changes, and further information is obtained.

2. The documentation in the Assessment and Plan section of the progress notes should be reflective of the Subjective and Objective findings including the rationale for maintaining or adjusting the treatment accordingly.

As such, if the patient is considered stable with active symptoms documented, the rationale for maintaining the regimen should be clearly documented.

3. It is generally recognized that clients often do not report or under-report the use of substances including alcohol, over-the-counter remedies, and treatments from outside providers; all of which can profoundly affect treatment outcomes and client safety. Therefore, it is essential that prescribers routinely inquire about all agents that individuals are exposed to.

4. It is well-established that persons with mental illnesses commonly experience a variety of medical co-morbidities, and they are poor advocates for their medical health. It is therefore expected that providers ensure appropriate evaluation, monitoring and coordination of care with primary care providers and specialists providing care to such persons and document accordingly in the progress note.

5. In general, individual medications should be prescribed at adequate doses and duration prior to initiation of polypharmacy (described in detail in section text), to reduce risks to the client.

6. The following definition of Polypharmacy is based on: National guidelines, regulatory agencies such as: JCAHO and community/national prescribing practices: Polypharmacy is herein defined as:

   A) Two or more antipsychotics
   B) Antidepressants: Two or more: SSRIs, SNRIs, SSRI + SNRI
   C) Anti-anxiety/Hypnotic agents:
      - ≥2 benzodiazepines
      - ≥2 non-benzodiazepines
      - A benzodiazepine plus a non-benzodiazepine i.e. zolpidem, zaleplon and eszopiclone
   D) Two or more anticonvulsant mood stabilizers

When considering addition of more than one agent within a class, it is recommended to first titrate the initial agent to maximum tolerated dose; then provide clear supportive rationale for the additional agent(s).

When changing medications, a process of cross-tapering is recommended and may require up to 90 days to accomplish. If polypharmacy is necessary beyond the maximum period of 90 days to complete cross-tapering, clear documentation of the rationale for continuation of the polypharmacy is necessary.

Anti-dyskinetic, antihistamine, beta-blocking, thyroid medications and Low dose Trazodone (up to 200mg) used as a hypnotic is excluded from the calculation of polypharmacy.

Per Joint Commission; National Quality Measure HBIPS-5, the following constitute appropriate justifications for multiple antipsychotic medications:

A. Cross-titration
B. Minimum of 3 failed monotherapy
C. Augmentation to Clozapine
D. Other justification than above A-C
E. No justification/Unable to Determine

***On-going use of polypharmacy requires clear documentation of one of the above allowable justifications.**

Failed monotherapy must include specifics such as: dosage, duration of therapy and the clinical response.

For patients admitted or transferred on a polypharmacy regimen (as defined above), justification for continuing the regimen beyond 90 days must be clearly documented, including a risk-benefit analysis of maintaining versus changing to monotherapy. A justification that the patient's symptoms are stable on the regimen should be reserved for cases where the pt is either currently asymptomatic or experiencing only mild symptoms.

7. It is recognized that severely ill patients may require combinations of antipsychotic treatments (e.g., patients coming out of state hospitals and IMDs.) It is generally expected that the outpatient psychiatrists will re-evaluate the need to continue the discharge medications and consider adjustment of the regimen to reduce polypharmacy when the client has stabilized.

8. According to the Expert Consensus Guidelines on Optimizing Pharmacologic Treatment of psychotic disorders (2003): if a patient experiences symptom relapse despite compliance with treatment, it is recommended to switch to a different agent, maximize the dose of the current medications, or switch to long-acting injectable medications.

9. The lowest effective dose of any medication should generally be sought, especially in stable, chronic individuals or in the treatment of elderly, children, individuals with disabilities, and those with co-existing medical conditions.

10. If the prescribed medication is outside of the SCVH&HS formulary (for UMDAP patients), the necessity for such a regimen must be documented and approval of the Non-Formulary Drug Request (NFDR) Form required from the Medical Director or her designee.

11. If dosage levels in excess of the maximum listed in these guidelines are used, the necessity for such a regimen must be documented and approval of the Maximum Daily Dose (MDD) Exceed Request Form required from the Medical Director or her designee.

12. Because of the high prevalence of substance abuse within the treatment population, prescribers must be mindful of minimizing the risks of dependency and abuse of the medications prescribed. Specifically, caution is advised when prescribing benzodiazepines or stimulant medications to

individuals with known histories of any substance abuse. In general, provide the smallest quantity of medication and more frequent follow up appointments in these cases.

13. Various medications require assessment of vital signs in addition to routine laboratory monitoring according to the Medication Practice Guidelines. In cases where the patient is repeatedly unwilling/unable to obtain the required parameters, the physician should document the rationale for continuing the medications without monitoring the vital and the laboratory information.

    The documentation should include:

    A. The patient's rationale for not obtaining the required parameters (e.g., transportation, physical/mental illness, unavailability of correct size of BP cuff, etc.)

    B. The prescriber's plan of action to address barrier(s) to obtaining vitals and labs (e.g., obtaining assistance from case manager, providing psychoeducation regarding importance of vitals and laboratory monitoring.

    C. If the patient remains unwilling/unable to obtain labs after above steps A and B, then document:

        - The risk benefit analysis of continuing the treatment without assessment of required parameters,
        - Consideration of changing the regimen (to agents which do not require vital signs, lab assessment.
        - Or decreasing the quantity of medication prescribed (for safety and to continue to encourage the patient to obtain vitals and labs).

14. For patients with demonstrated medication non-adherence, the documentation should include the following steps to encourage medication adherence:

    A. Patient's explanation for the non-adherence.
    B. Psychoeducation regarding the risks associated with medication non-adherence.
    C. Specific strategies to improve/address the non-adherence (i.e., implementation of long-acting agents/injectables, utilization of pill boxes, blister packaging of medications, etc).

15. Patients are seen by their psychiatrist as frequently as clinically indicated. However, the standard of care requires that patients be scheduled for their routine face to face appointment at least every 90 days. On a case-by-case basis, the routine appointments may be extended out to 120 days as an exception. Such cases require clear documentation of rationale requiring such exception. The documentation needs to include:

    - Extenuating circumstances requiring 120 days return visits.
    - A description of patient's target symptoms; and justification for maintaining current regimen for the extended duration; this includes a statement that any residual symptoms are not significantly impairing patient's functioning**.**

- Controlled medications may be prescribed with quantity restrictions per the guideline; however, the refills may be increased to ensure adequate supply.

In non-routine situations when a patient is not seen for >3 months due to various reasons including "no shows and cancellations"; the prescriber needs to document the steps taken to ensure medication adherence and continuity of care by approving ONLY a full or partial refill. The documentation should include the following:

A. The extenuating circumstances resulting in extended periods beyond 90 days between the visits i.e., extended vacation, medical illness, lack of transportation or hospitalization.
B. Clinical status of patient, his/her medication adherence and if "bridging was required".

C. Coordination with the patient's case manager and the clinic manager to address issues such as: reminder calls or transportation that may be interfering with patient's on-going care.

16. Follow up, in person or by phone, after starting a medicine should occur by the child and adolescent psychiatrist within two to four weeks and at least monthly until the child/adolescent's symptoms are improved and stable on the medication. Once stable, visits can be less frequent and based on the clinical needs of the individual child/adolescent. As dosage of medicines are being increased or reduced, more frequent follow-up may be necessary.

17. Obesity is a serious health concern among the mentally ill population and can be a significant side effect of psychotropic medications. As such, prescribers should routinely evaluate and consider the risks/benefits of continuing the same regimen in patients who are experiencing significant weight changes. Referral to a primary care physician for physical health monitoring is expected for patients who are overweight (i.e., BMIs over 25).

18. Documentation of informed consent is necessary prior to initiation of any psychiatric medication and the consent form must be maintained in the chart (Electronic Medical Record). Informed consent discussion should also include a discussion of lab and vital signs monitoring requirements per the Medication Practice Guidelines. The standardized medication consent form may be used to obtain and document informed consent for various psychotropic medications, and it will be transferrable across the H&HS and the contract agencies. In other words, the patient will need to provide consent ONLY ONCE per medication and it will be valid if that specific medication at the dose/frequency/route consented is continued and the consent form is readily retrievable from the patient's chart (Electronic Medical Record). It is recommended to obtain consent for the maximum daily dose per the medication practice guidelines to minimize the need to re-consent the patient. When prescribing off label, the non-FDA box needs to be checked off. Once consent is obtained, the standardized medication consent form will be scanned in Healthlink under the Media tab and in the Behavioral Health Medication Consent Form folder by the department of Health Information Management. The standardized medication consent form is available on our website (www.sccmhd.org) and should be signed by the patient, parent, or guardian (as appropriate). When prescribing psychiatric medications to patients with developmental disabilities, it is recommended that support persons involved in the patient's care (e.g., family members, case workers, and residential care staff) be included in the informed

consent process and are encouraged to sign the medication consent forms. Medication Consent Form is a legal document, and the provider's signature (or electronic equivalent) must include his/her credential i.e., MD or Psych. NP/Psychiatric Nurse Practitioner and the date that the consent was obtained.

19. It is recognized that various medications are prescribed for psychiatric treatment that have not been approved by the FDA for these indications. This is especially true for children/adolescents and the geriatric population where FDA approvals are less common. The use of these non-FDA approved medications is acceptable but must be documented on the medication consent forms. The current medication guidelines list both FDA and non-FDA but commonly used agents.

20. The Department recognizes that while a primary treating psychiatrist and/or psychiatric nurse practitioner has been assigned, it is also routinely necessary for prescribers to cross-cover when the primary provider is not available. In such instances, temporarily prescribing medications without a face-to-face examination is acceptable; the covering physician derives the appropriate prescribing information from various sources including electronic medical record, paper chart documentation, pharmacy databases, and input from the treatment team.

21. Storage and use of "Sample Medications" provided by Pharmaceutical Companies for personal use or dispensing to patients is prohibited at Santa Clara County Valley Medical Center and Clinics. This decision was made by the Medical Executive Committee and communicated per the Memorandum Dated: February 4, 2003, by Dr. Kent Imai, the President of the Medical Staff.

22. **SB1291/WIC14717.5**

In 2022, CMS identified a core set of 20 behavioral health measures consisting of 7 measures from the Child Core Set and 13 measures from the Adult Core Set. In short, the Senate Bill 1291 and Section 14717.5 of Welfare and Institutions Code requires mental health plans to conduct annual review by external quality review organizations (EQRO). Below are several HEDIS measures (Healthcare Effectiveness Data and Information Set) related to Medical eligible minors and nonminor dependents in foster care:

1. Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication (HEDIS ADD). This measure is addressed in Item No. 16. Follow up, in person or by phone, after starting a medicine should occur by the psychiatrist within two weeks and at least monthly until the child/adolescent's symptoms are improved and stable on the medication. Once stable, visits can be less frequent and based on the clinical needs of the individual child/adolescent. As dosage of medicines are being increased or reduced, more frequent follow-up may be necessary.

2. Use of Multiple Concurrent Antipsychotics in children and Adolescents (HEDIS APC). This measure is addressed in the Polypharmacy section item No. 6.

3. Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM). 2020 APA Guidelines for Metabolic Monitoring are applicable to all patient populations. This issue is addressed in item no. 13 of this section and Section D: Required Laboratory and Exam Summery.

4. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP). This is the current practice at County of Santa Clara Department of Behavior Health Services.

5. The monitoring and trending of HEDIS measures related to antidepressant medication management (AMM) and adherence to antipsychotic medications in patients with Schizophrenia or Schizoaffective Disorder will commence in January, 2024.

Reference:

1. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-bh-core-set.pdf

2. http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.html

3. https://www.mhswi.com/content/dam/centene/MHSWI/Providers/PDFs/BH_HEDIS_Guide_NetworkHealth_2022.pdf