Chapter: **CLINICAL PRACTICE**
Title: **PSYCHOTROPIC MEDICATION IN COMMUNITY-BASED SETTINGS**

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Proposed by: Traci Smith 01/24/2025
Chief Executive Officer Date

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I. ABSTRACT

This policy establishes the standards of Macomb County Community Mental Health (MCCMH), an official agency of the County of Macomb, on the prescription, use, administration, storage/disposal, and evaluation of medications.

II. APPLICATION

This policy shall apply to all directly operated and contract network providers of MCCMH.

III. POLICY

It is the policy of MCCMH that:

A. Provider panel psychiatrists and other individuals who perform medication related activities for MCCMH persons served shall do so pursuant to the provisions of this policy;

B. Safe and appropriate standards and procedures shall be maintained for the use, storage/disposal, administration, and prescription of medications; and

C. Prescription and administration of medications shall be evaluated and monitored through a planned, systematic, and criteria-based process to assure the appropriate, safe, and effective use of psychotropic medications.

IV. DEFINITIONS

A. Community-Based Settings
For the purposes of this policy, community-based settings refer to non-hospital settings.

B. Licensed Provider other than Psychiatrist
Nurse Practitioner (NP) or a Physician Assistant (PA) working under a collaborative agreement with a Physician (MD/DO).

C. Medication Administration
The process of giving a physician-prescribed oral medication, injection, intravenous (IV), or topical medication treatment.

D. Medication Review
A clinical service performed by duly licensed individuals with prescriptive privileges granted by the state for the purpose of evaluating and monitoring medications taken by the person, their side effects, and the need for continuing or changing the regimen, resulting in a prescription order.

E. Medication Stockpiling
Inappropriate and at times excessive accumulation of prescribed medication for later use.

F. Medication Use Evaluation
Process by which data is collected and assessed for the purpose of medication use evaluations under the oversight of the MCCMH Clinical Risk Management Committee (CRMC).

G. Nurse
An individual who is engaged in the practice of nursing. "Practice of Nursing" means the systematic application of substantial specialized knowledge and skill, derived from the biological, physical, and behavioral sciences to the care, treatment, counsel, and health teaching of individuals who are experiencing changes in the normal health processes or who require assistance in the maintenance of health and the prevention or management of illness, injury, or disability. The scope of practice includes the teaching, direction, and supervision of less skilled personnel in the performance of delegated nursing activities.

H. Patient Assistance Program (PAP)
Provides financial assistance or drug free product (through in-kind product donations) to low income individuals to augment any existing prescription drug coverage.

I. Physician
An individual licensed by the state to engage in the practice of medicine or osteopathic medicine and surgery under article 15 of the Public Health Code, 1978 PA 368, MCL 333.16101 to 333.18838. "Practice of Medicine" means the diagnosis, treatment, prevention, cure, or relieving of a human disease, ailment, defect, complaint, or other physical or mental condition by attendance, advice, device, diagnostic test, or other means; offering or undertaking to do any of these acts.

J. Psychiatrist
An individual who is one or more of the following:
1. A physician who has completed a residency program in psychiatry approved by the accreditation council for graduate medical education or the American Osteopathic Association, or who has completed 12 months of psychiatric rotation and is enrolled in an approved residency program;
2. A psychiatrist employed by or under contract with the Department of Health and Human Services or a community mental health services program on March 28, 1996;

3. A physician who devotes a substantial portion of his or her time to the practice of psychiatry and is approved by the Director of the Department of Health and Human Services, or his or her designee.
4. A "Child and Adolescent Psychiatrist" means one or more of the following:
    a. A physician who has completed a residency program in child and adolescent psychiatry approved by the accreditation council for graduate medical education or the American Osteopathic Association or who has completed 12 months of child and adolescent psychiatric rotation and is enrolled in an approved residency program;
    b. A psychiatrist employed by or under contract as a child and adolescent psychiatrist with the Department of Health And Human Services or a community mental health services program on March 28, 1996, who has education and clinical experience in the evaluation and treatment of children or adolescents with serious emotional disturbance;
    c. A psychiatrist who has education and clinical experience in the evaluation and treatment of children or adolescents with serious emotional disturbances and is approved by the Director of the Department of Health and Human Services, or his or her designee.

K. Psychotropic Medication
Any medication administered for the treatment or amelioration of disorders of thought, mood, or behavior.

V. STANDARDS

A. General Standards

1. Prior to the initial prescribing of psychotropic medications, a psychiatric evaluation shall be completed to document:

    a. Identifying information;

    b. Description of the problem/chief complaint;

    c. The history of the illness and pertinent medical/substance use history;

    d. Past and current medication (medical, psychiatric, over the counter) effectiveness, allergies, adverse drug reactions, if known;

    e. Pertinent and relevant psychosocial information (personal/family history, substance use/abuse/dependence, occupational/educational, legal, psychiatric);

    f. Mental status examination (attitude/behavior/appearance, stream of mental activity, emotional reactions, mental trend and content of thought, sensorium, mental grasp and capacity, memory, insight and judgment);

    g. The appropriate diagnosis according to the current APA Diagnostic and Statistical Manual;

h. Recommendations for management of each of the identified problems;

i. Recommendations for management and treatment of identified target signs and symptoms with appropriate medications; and

j. Prognosis and projected termination/discharge date.

Note: See MCCMH MCO Policy 2-015, "Psychiatric Evaluation" for additional information.

2. When clinically indicated, baseline laboratory studies shall be obtained prior to the use of psychotropic medications. Such studies shall occur after considering the person's medical history, pharmacology of the proposed psychotropic medication, and anticipated duration of use. The MCCMH Chief Medical Officer may direct prescribing physicians to clarify the rationale of laboratory tests related to psychotropic medication. Refer to Exhibit B, "Laboratory Services Utilization Review Clarification Request Form," as an example of a clarification request form that the MCCMH Chief Medical Officer may ask a prescribing physician to complete and return.

3. Before initiating a course of psychotropic drug treatment for a person, the prescriber or a licensed health professional acting under the delegated authority of the prescriber shall do both of the following:

   a. Explain the specific risks and most common adverse side effects associated with that drug; and

   b. Provide the individual with a written summary of those common adverse side effects.

4. Informed consent shall be obtained prior to ordering medication unless the medication is administered pursuant to a court order, or the administration of the medication is necessary to prevent physical injury to the recipient or another.

   a. In the latter circumstance, consent shall be obtained as soon as possible post-administration of the medication, but such medication administration shall not exceed 48 hours.

   b. Absent informed consent, the duration of the use of psychotropic medications shall be as short as possible and at the lowest possible dosage that is therapeutically effective.

   c. The use of psychotropic medications shall be terminated as soon as there is little likelihood that the person will pose a risk of harm to himself, herself, or others.

   d. Informed consent shall be obtained pursuant to MCCMH MCO Policy 9-601,"Informed Consent for Psychotropic Medications."

5. Ongoing training and education regarding medications shall be provided to appropriate clinical staff.

6. Appropriate practice guidelines on the monitoring of certain psychotropic drug levels and their potential side effects should be in accordance with the most current American Psychiatric Association Guidelines and American Academy of Child and Adolescent Psychiatry, as it pertains to adults or children/adolescent populations.

7. Persons served, or their parents or guardians, shall be actively involved in making decisions related to the use of medications.

8. Medication reviews by physicians shall be done at least once every quarter, or more often as specified in the individual plan of service and based on the person's clinical status.

    a. These reviews shall note the person's current psychotropic medications; medications prescribed by their PCP or specialists (including over the counter and herbal medications); current physical and mental state; response to medication using baseline target symptoms; side effects of medications (i.e., extrapyramidal symptoms, abnormal involuntary movements); use of multiple simultaneous medications; and rationale for continuing, changing, discontinuing, or adding medication.

    b. The necessity of a psychiatric evaluation shall be determined according to MCCMH MCO Policy 2-015, "Psychiatric Evaluation."

9. Medication reviews may be performed by other professionals who have prescription privileges in accordance with state law.

10. Persons served shall be prescribed the optimal effective dose of medication for as long as clinically indicated and documented in their clinical record.

11. A discussion of the dosage range of the medication that the physician plans to prescribe to treat the person's psychiatric disorder shall be documented, including the clinical rationale for doses more than current FDA approved usage limits. The MCCMH Chief Medical Officer may request clarification from physician providers of the rationale for prescribing a psychotropic medication when the cost or indication for such medication is in question. Refer to Exhibit C, "Drug Utilization Review Clarification Request Form" for an example form.

12. When psychotropic medication(s) are prescribed for behavioral control, a behavior management plan shall be completed, approved by the MCCMH Behavior Management Committee, and made a part of the treatment plan, in accordance with MCCMH MCO Policy 8-008, "Behavior Treatment Plan Review Committee."

13. MCCMH shall ensure that only medication that is authorized in writing by a physician is given to a person upon their leave or discharge from the provider's program and that enough medication is made available to ensure they have an adequate supply until they can become established with another provider, not to exceed thirty (30) days preferably as standard unless the prescriber determines the risks outweigh the benefits. If so, the appropriate clinical rationale shall be documented in the medical record.

14. Psychotropic medication shall not be prescribed or administered to people as punishment, for the convenience of staff, or as a substitute for other appropriate treatment.

15. MCCMH shall routinely screen and assess individuals for substance use, abuse, or dependence. Psychotropic medication shall not be withheld due to current substance use or abuse, where such medication is indicated.

16. Periodic reviews by the CRMC, or a subgroup thereof, shall evaluate and monitor the appropriate use of psychotropic medication by each network provider.

17. The administration and prescribing of the various classes of psychotropic medications shall conform to the standards of the medical community and all applicable local, state, and federal laws and regulations pertaining to medications and controlled substances.

18. Each provider shall record the administration of all medication in the person's clinical record.

19. Each provider shall meet its accrediting body's standards for medication use evaluations.

20. This policy shall be reviewed at least annually by the MCCMH Chief Medical Officer.

21. The practices and procedures for the ordering and administration of psychotropic medication to children and adolescents shall adhere to the guidelines set forth in Exhibit G, "Psychotropic Medication Use in Children and Adolescents ."

22. Medication may be administered to prevent physical harm or injury after signed documentation of the physician is placed in a person's clinical record, and when the actions of a person or other objective criteria clearly demonstrate to a physician that the person poses a risk of harm to himself, herself, or others.

23. Special Consideration must be given related to pregnancy and breastfeeding. The risks and benefits of initiating or continuing psychopharmacological treatment in those instances require careful consideration.

    a. Women of childbearing age should be encouraged to speak to their licensed prescriber if they intend to become pregnant.

    b. Women of childbearing age should be checked for pregnancy according to American Psychiatric Association and American Academy of Child and Adolescent Psychiatry guidelines, as applicable.

    c. Safe treatment alternatives in pregnancy and breastfeeding may include:

        i. Limiting any polypharmacy whenever possible.

        ii. Limiting or avoiding the use of non-essential psychotropics (i.e., benzodiazepines).

iii. Decreasing dosing levels while still ensuring therapeutic effectiveness.

d. The impact of untreated illness on the mother and the fetus must be considered. This may include the possibility of increased risk of obstetric complications, developmental complications, and congenital malformations associated with pharmacological treatment. Hormonal changes during this period, emotional stress, and personal and social changes in the life of the expectant mother all affect the course of mental health problems.

e. Risk–benefit assessments in these cases include:

i. Assessing the potential effect of illness on the mother, the fetus, and the family; and the potential effects of treatment on the mother and the fetus.

ii. Evaluating the safety of drugs, not only anatomical malformations, but also long-term behavioral teratogenicity potential for withdrawal in the fetus at and after birth.

iii. Educating the pregnant individual and those that may have a place in their life (guardians, spouse, etc.) with correct consent to exchange information about the risks and benefits of the different treatments.

f. Clear discussion must occur on the side-effects of treatment for the newborn and the mother as well as the problems associated with lack of treatment.

g. The possibility of alternative treatment methods and their strengths and weaknesses must be thoroughly discussed and appropriately documented by the licensed prescriber. As it relates to breastfeeding, according to Kronefeld et al. (2017), psychotropic medications are expected to be present at low levels in breast milk with no clinical significance. An individual risk-benefit assessment of treatment is necessary.

h. The known and unknown risks of exposure must be balanced with the risks of untreated maternal illness in the mother and her desire to breastfeed. Coordination of care with the newborn's healthcare provider is strongly encouraged.

24. Other special dietary needs related to psychotropic medication:

a. Certain medications depending on their type such as Monoamines Oxidases used in the treatment of depression, Disulfiram used in the treatment of alcohol use disorder, and others may require individuals to follow specific dietary restrictions when taking them. Some medications, to avoid limiting their effectiveness, may also be required to follow certain specific recommendations.

b. The licensed prescriber is responsible for providing appropriate education on any special dietary needs or dietary adjustments or other adjustments an

individual may have to follow when applicable depending on the type of medications being prescribed.

c. Nursing staff and pharmacy staff may also assist in further educating the individuals, as applicable.

d. Persons served should be encouraged to have these discussions with their pharmacy provider and take advantage of the verbal, printed, and electronically accessed educational information as encouraged by the licensed prescribers, pharmacies, and nursing.

B. Medication Specific Standards

1. Neuroleptics

a. Prior to initiation of neuroleptic therapy and at least annually thereafter, the psychiatrist shall administer an abnormal involuntary movement scale (AIMS) to the person. Refer to Exhibit D, "Abnormal Involuntary Movement Scale." For MCCMH directly operated and contract network providers who utilize the FOCUS electronic medical record system, the AIMS worksheet can be accessed under Medication Review.

b. The initial AIMS must be completed for each newly admitted person who is prescribed anti-psychotic medications at the time of completion of the initial psychiatric assessment for baseline information. When evidence demonstrates that the frequency of AIMS testing should be increased, those must be appropriately accounted for. This can occur when medication type or dosage changes and when new onset or progression of tardive dyskinesia is identified. It is recommended that in those instances those are done on each visit as changes are happening. People with a diagnosis of tardive dyskinesia that is non-changing, regardless of medication regimen, shall be re-evaluated at least annually. If a person is uncooperative or unable to participate in the AIMS evaluation, the staff conducting the assessment must describe the circumstances in the clinical record (including the person's condition) that hinder the completion of the assessment. At a medication review visit while the person is on neuroleptic therapy, the physician/nurse practitioner shall document the presence or absence of abnormal involuntary movements including extrapyramidal symptoms (akathisia, bradykinesia, rigidity, tremor, and dystonia).

c. For individuals presenting with symptoms of tardive dyskinesia (regardless of current medication), an AIMS worksheet shall be completed at least quarterly. If clinically indicated, persons served shall be referred for a neurology consultation.

d. Individuals receiving neuroleptic therapy shall be monitored for metabolic syndrome according to the guidelines set forth by the American Psychiatric Association.

e. Clozapine

i. Before initiating Clozapine therapy, the person's baseline target symptoms, physical examination (including weight), and lab work including CBC and differential, SMAC, LFTs and EKG, shall be obtained as indicated. The person's weight should be monitored quarterly. He/she shall have ruled out any disease or condition that will contraindicate use of clozapine.

ii. Clozapine monitoring and periodic white blood cell (WBC) count monitoring shall be in accordance with current FDA standards. The prescribing physician or a nurse designee shall enroll each person prescribed clozapine into the Clozapine REMS system. (See Exhibit E and I)

iii. If a person who is hospitalized is to be discharged and continue to receive clozapine, they shall be seen by a MCCMH physician prior to expiration of the discharge prescription to arrange for regimen continuation.

iv. Baseline target symptoms shall be assessed and documented at the initiation of therapy and should be reassessed periodically. Clozapine treatment may continue if the target symptoms continue to improve. However, if the target symptoms do not show any improvement in 3-6 months, discontinuation of Clozapine should be considered.

v. Termination of clozapine therapy is usually managed by gradual dosage reduction over a 1-to-2-week period. However, abrupt interruption or discontinuation may be required by medical conditions such as severe leukopenia or agranulocytosis. Individuals must have regular WBC counts with differential for four weeks after discontinuation.

f. Risperdal Consta, Invega Sustenna, and other Atypical Antipsychotic Long-Acting Injectable Medications (LAI)

i. LAIs are covered by Medicaid Health Plans, if a person needs assistance with PMP. Authorization must be obtained from the MCCMH Chief Medical Officer or Chief Clinical Officer for a MCCMH psychiatrist to initiate or to continue LAI use if started by a non-MCCMH physician. Refer to Exhibit F, "Prior Authorization Request Example."

2. Lithium

a. Prior to a person being placed on lithium therapy, a pre-lithium work-up shall be performed.

b. A pre-lithium work-up includes:

i. Medical history to assess cardiac, renal, or thyroid function and previous untoward reactions to lithium.

ii. Physical examination, including weight

iii. Laboratory work

a) CBC with differential

b) BUN, Serum creatinine

c) Electrolytes

d) T_3, T_4, T_7, TSH

e) Urinalysis

f) EKG, as determined by the physician

g) Pregnancy test, if applicable

c. Generally, the therapeutic level for lithium is 0.5-1.5 meq. / liter. The clinical presentation of the person should guide the physician in assessment of toxicity which may or may not correlate with serum levels. Lithium levels shall be obtained, and thyroid and kidney function monitored at least annually, and whenever necessary.

3. Stimulants

a. Prior to the prescription of psychostimulants for children, a comprehensive psychiatric evaluation shall be performed. Refer to Exhibit G, "Psychotropic Medication Use in Children and Adolescents."

b. A laboratory work-up shall be performed including CBC and differential, chemistry profile, and EKG as indicated.

c. Baseline data shall include height, weight, blood pressure, and pulse, with periodic follow-up at the physician's discretion.

C. Medication Orders

1. Physicians shall prescribe medications only after face-to-face contact with the person. Exceptions to face-to-face contact may be granted for short term treatment renewal (i.e., 30 days) at the discretion of the treating psychiatrist.

2. The amount of medication prescribed shall be appropriate to ensure that the person has an adequate supply (no more than a 31-day supply at one time). Medication orders must be reviewed and reordered at least every 90 days, or more frequently as specified by the ordering physician, or as required by state law.

3. Prescriptions shall contain the following:

    a. Legible handwriting (if written)

    b. The name of the person

    c. The date the prescription was written

    d. The name of the medication, strength, form, and quantity to be dispensed by the pharmacy

    e. Metric system references and the absence of leading decimal points

    f. Approved abbreviations and symbols

    g. Directions clearly indicating the quantity, frequency, and route of administration

    h. Printed name of the prescribing physician

    i. Signature of the prescribing physician

    j. NPI number of the prescribing physician

    k. DEA number, as needed

    l. An indication of the number of refills

4. Oral or telephone orders by the physician for medications shall be permitted only in urgent or emergent situations and shall comply with the following requirements:

    a. Received only by a designated person (e.g., an MCCMH nurse);

    b. Read back word for word to ensure accuracy of the order by the prescriber and the nurse obtaining the order;

    c. Confirmed by the prescribing physician;

    d. Immediately recorded as an oral or telephone order;

    e. Countersigned by the prescribing physician immediately after the urgent situation if verbal or during the physician's next clinic day if by telephone;

    f. Orders "urgent" shall be defined as requiring immediate action or attention without such the person can be reasonably expected to be harmed or have a potential loss of function. Orders "emergent" shall be defined as serious, unexpected situations requiring immediate action without which the person can be reasonably expected to be harmed, have loss of function, or possibly die.

g. Immediately following the acceptance of the order, the RN will document the time, date, and order that was read back into the electronic medical record. As soon as possible, the outcome of the situation that required the order, where the order was sent, how the order was used, and the reason the order was needed will be placed as a note in the EMR to explain how it meets the criteria of urgent or emergent.

5. Controlled Substances

a. In accordance with pertinent regulations and to maximize safety and efficiency, all prescriptions will be transmitted electronically except as permitted by law. This ensures legibility, documentation, and accessibility of information.

b. Controlled substances shall not be reordered on the same prescription blank as non-controlled substances.

6. Prescriptions are not valid for more than one year from the original date of the prescription.

7. With some exception, MCCMH provider psychiatrists generally should not prescribe "as needed" (prn) doses.

D. Medication Administration

1. All state regulations pertaining to the safe handling and dispensing of medications shall be followed. Refer to Attachment A, "Procedural Guidelines for the Safe Handling, Storage and Disposal of Medications" for additional information.

2. Medications shall be administered by or under the supervision of personnel who are qualified, trained, and ordered by an appropriately licensed prescriber.

3. Medication to be administered shall be verified with the prescribing physician's orders and properly prepared for administration.

4. Two means of identification shall be used prior to medication administration, and each dose of medication properly recorded by the person administering the medication. Methods of identification may include but may not be limited to a person's knowledge of social security number, date of birth, a state identification card, a driver's license, an insurance/Medicaid card, or staff recognition of the person.

5. Injectable medication shall be administered as soon as possible after the dose has been prepared.

6. Injectable medication shall be administered by the individual who prepared the dose, except where unit dose packaging is used.

7. Administration window for injectable medications is no sooner than three (3) calendar days prior to the dose being due and no later than three (3) calendar days after the dose is due. Any days outside of this will require discussion with the ordering physician and documentation of that discussion highlighting why the injection is being given outside of this timeframe and the ordering physician's approval (Example: holiday weekends, missed appointments, refusals, etc.).

8. Administration of medications shall be done for one individual at a time following the eight rights listed below:

    a. Right Person- Using 2 identifiers.

    b. Right Medication- Check the order and medication label.

    c. Right Dose- Check the order and verify calculations with another nurse if necessary.

    d. Right Route- Check appropriateness of ordered route and that the individual can use this route.

    e. Right Time- Check current time, when last dose given, and frequency ordered.

    f. Right Documentation- Document administration after giving the order.

    g. Right Reason- Consider the individual's health history and revisit the reasons for long-term medication use.

    h. Right Response- Make sure that the drug led to the desired effect, document response into the medical record, and report to the ordering physician as appropriate.

9. Administration of medications including controlled drugs shall be adequately documented in the person's clinical record in accordance with prescribed state laws.

10. There shall be documentation in the person's plan of service if he/she needs assistance in taking oral medication or has special dietary needs and restrictions associated with medication use. Regular evaluation of the need for assistance shall be documented in the person's file through periodic reviews of the plan of service.

11. The telephone number of the nearest Poison Control Center shall be visibly posted for use at all locations where medications are administered. The Poison Control Center telephone number shall also be placed on every phone at MCCMH service units and in the Administrative Office.

12. Universal precautions shall be employed when preparing and administering injectable medications.

13. After a multiple treatment medication vial has been punctured, it must be dated and initialed by a MCCMH provider panel nurse.

14. Medications may be administered to a person to prevent physical harm or injury under the following conditions:

    a. After signed documentation of the physician's rationale for ordering the medication is placed in the person's clinical record; and

    b. When the actions of the person or other objective criteria clearly demonstrate to a physician that the person poses a risk of harm to himself/herself or others and the physician documents such observation. Such medication administration shall not exceed 48 hours. Absent informed consent, the duration of the use of psychotropic medications shall be as short as possible and at the lowest possible dosage that is therapeutically effective. The use of psychotropic medications shall be terminated as soon as there is little likelihood that the recipient will pose a risk of harm to himself, herself, or others.

15. The Standardized Medication Administration Schedule shall be adhered to, as found in MCCMH MCO Policy 2-017, "Abbreviations, Acronyms and Symbols Approved for Record Use," Exhibit A.

E. Storage / Disposal of Medication, Needles, and Syringes

1. Each site where medications are stored shall develop and implement procedures that will make provisions for the following:

    a. Outdated or otherwise unusable medications, used needles and syringes shall be disposed of through a medical waste management system. Disposal of medication shall be documented and signed by the MCCMH provider panel nurse or designee and one witness;

    b. Designation of a properly controlled medication preparation area and locked storage cabinet or medication cart;

    c. Storage of medications under appropriate conditions to protect their integrity, stability, and effectiveness; and

    d. An inventory logging procedure reflecting receipt and distribution (specific to the person), whereby medications are inventoried, labeled, and dispensed under the supervision of the MCCMH provider panel psychiatrist for:

        i. Injectable medications

            a) Ordered by the MCCMH provider panel psychiatrist through the drug wholesaler or contracted pharmacy; or

b) Ordered by the MCCMH provider panel psychiatrist through the pharmaceutical companies' Patient Assistance Programs (PAP) for qualifying persons served.

ii. Sample medications received from pharmaceutical company representatives.

iii. Medication received under PAP.

a) When medication is given to a person under a PAP, the MCCMH provider shall have them sign a letter of receipt of medication on an annual basis. Refer to Exhibit H for an example letter.

b) For directly operated MCCMH Programs refer to MCCMH MCO Policy 10-065 "Injection Medication Documentation and Procedures."

2. For procedures associated with the safe storage and disposal of medications, refer to Exhibit A, "Procedural Guidelines for the Safe Handling, Storage, and Disposal of Medications."

F. Medication Stockpiling

1. There are several risks associated with medication stockpiling. It is the responsibility of licensed prescribers and treatment teams to help educate individuals on the risks of medication stockpiling and assist them in implementing strategies to mitigate those risks.

2. All medication-related incidents of network providers shall be reported pursuant to MCCMH MCO Policy 9-321, "Person Served Incident, Accident, Illness, Death, or Arrest Report."

G. Medication Use Evaluation

1. The MCCMH Clinical Risk Management Committee (CRMC) shall recommend and identify, for each provider, specific medication related issues on which to conduct a medication use evaluation. Medication use evaluations shall be conducted on an annual basis, or more often if needed, as directed by the MCCMH CRMC.

2. Classes and categories of medications chosen for evaluation shall be selected from below:

a. Medications that are prescribed most frequently;

b. Medications that pose significant risk;

c. Medications that have, in the past, shown problems associated with their use;

d. Medications that have known interactions with other medications that significantly alter their toxicity or their pharmacologic effects; and

e. Medications that cost significantly more than other medications of comparable pharmacologic effect.

3. Data collection an organization shall address:

a. Data source;

b. Data collection method;

c. Appropriateness of the sampling;

d. Frequency of the data collection; and

e. Process for comparing cumulative data with the threshold for evaluation.

4. Thresholds for evaluation shall be established to identify the level or point in the cumulative data which will require intensive evaluation to determine whether an actual problem or opportunity to improve exists.

5. Copies of the providers' medication use evaluations shall be sent to the MCCMH Chief Medical Officer for review by the CRMC. The summary reports of the findings shall be used to identify problem areas and develop corrective plans of action.

6. Monitoring may be conducted by the MCCMH CRMC to evaluate the effectiveness of the corrective plan of action and to identify opportunities for improvement.

7. The MCCMH CRMC shall monitor and make recommendations regarding providers' medication use evaluations, and any observable trends thereof, to the MCCMH Quality Committee.

8. After the Medication Use Evaluation:

a. The provider shall forward the data obtained from the medication use evaluation to the MCCMH Chief Medical Officer, who shall present it to the CRMC for review.

b. The MCCMH CRMC shall review the data, identify any problems, develop a recommendation, and send it to the provider.

c. The provider shall review the recommendation and develop a plan of correction, if needed, and forward the proposed plan of correction to the MCCMH Chief Medical Officer for review by the CRMC.

d. If the MCCMH CRMC approves the proposed plan of correction, CRMC shall advise the provider who will be responsible for implementing the plan.

9. Report to the MCCMH Quality Committee

a. The CRMC shall submit a written report to the Quality Committee on findings regarding medication use evaluations and recommended plans of correction.

b. The Quality Committee, based on CRMC reports, shall make recommendations to the Chief Executive Officer related to the prescribing and administering of medication in ongoing efforts to continuously improve quality of care.

VI. PROCEDURES

Procedures are contained in Exhibit A, "Procedural Guidelines for Safe Handling, Storage and Disposal of Medications." These procedures are to be followed by all direct and contract providers who handle medications. Contract providers who have their own forms and procedures that are acceptable to their accrediting bodies shall ensure that their procedures and forms follow the intent, content, and comply with the requirements of this policy, including Exhibit A.

VII. REFERENCES / LEGAL AUTHORITY

A. MCL 333.7103.

B. MCL 333.17001 et seq.

C. MCL 333.17201 et seq.

D. Michigan Administrative Code R. 330.7158.

E. MDHHS Guidelines for Psychotropic Medication, APF 153.

F. MCCMH MCO Policy 9-601, "Informed Consent for Psychotropic Medication."

G. MCCMH MCO Policy 2-015, "Psychiatric Evaluation."

H. MCCMH MCO Policy 8-008, "Behavior Treatment Plan Review Committee."

I. MCCMH MCO Policy 9-321, "Consumer Incident, Accident, Illness, Death, Or Arrest Report."

J. Commission on Accreditation of Rehabilitation Facilities (CARF) 2022 Behavioral Health Standards Manual, §2. E., "Medication Use."

K. American Psychiatric Association Pharmacological Screening Criteria Guidelines.

L. American Academy of Child and Adolescent Psychiatry Guidelines.

M. Macomb County Community Mental Health Exposure Control Plan/ Bloodborne Infectious Diseases.

N. Clozapine Risk Evaluation and Mitigation Strategy Program Reporting Guidelines.

O. Kohen, Dora. "Psychotropic Medication in Pregnancy." *Advances in Psychiatric Treatment*, vol. 10, no. 1, 2004, pp. 59–66., doi:10.1192/apt.10.1.59.

P. Kronenfeld, Nirit et al. "Use of Psychotropic Medications in Breastfeeding Women." Birth defects research vol. 109,12 (2017): 957-997. doi:10.1002/bdr2.1077

Q. Bonsall, L. (2011). 8 rights of medication administration. Lippincott Nursing Center. Retrieved from https://www.nursingcenter.com/ncblog/may-2011/8-rights-of-medication-administration

VIII. EXHIBITS

A. Procedural Guidelines for the Safe Handling, Storage and Disposal of Medication

B. Laboratory Services Utilization Review Clarification Request form (example)

C. Drug Utilization Review Clarification Request form (example)

D. Abnormal Involuntary Movement Scale (AIMS), as adapted from the FOCUS electronic medical records system

E. Clozaril REMS How to Start

F. Prior Authorization Request (example)

G. Psychotropic Medication Use in Children and Adolescents

H. Letter of Receipt of Medication under Patient Assistance Program (example)

I. How to Start Clozapine and Monitor Patients