Policy Title: Defined Clinical Monitoring Parameters (Vitals, Labs, EKGs)

Effective Date: 08/15/2025

Approved By: Director of Medical and Clinical Services

Review Schedule: Annually or as Needed

Applies To: All Programs — Outpatient MH/SUD, IOP, PHP, and Integrated Primary Care/Behavioral Health

I. Purpose

To establish evidence-based standards for clinical monitoring of persons served who are prescribed medications to ensure safe, effective treatment and early identification of adverse effects in compliance with CARF, FDA, and Ohio Board of Pharmacy standards.

II. Scope

Applies to all prescribing, nursing, and clinical staff involved in collecting, reviewing, or documenting vital signs, laboratory results, or diagnostic tests related to medication management.

III. Policy Statement

All clients prescribed medications shall undergo baseline and ongoing clinical monitoring appropriate to their medications, comorbidities, and individualized treatment plan. Documentation of vitals, laboratory results, and diagnostic tests must be maintained in the EHR and reviewed regularly by the prescribing provider.

IV. Clinical Monitoring Standards

A. Baseline Evaluation

Prior to initiating medication therapy, prescribers ensure completion of baseline vitals, laboratory work, and diagnostic testing, including EKGs when indicated by medication class or client risk factors.

B. Ongoing Monitoring

Ongoing monitoring occurs at clinically appropriate intervals. The following table summarizes general monitoring standards:

Medication Category	Monitoring Parameters	Frequency
Stimulants (ADHD)	BP, HR, weight, sleep, appetite	Baseline, monthly x3, then quarterly
Antipsychotics	Weight/BMI, BP, glucose, A1c, lipids, EPS, EKG (QTc)	Baseline, 3 months, annually
Mood Stabilizers (lithium, valproate, carbamazepine)	CMP, CBC, drug levels, TSH, renal function	Baseline, 1–2 weeks post-start, every 3–6 months
Antidepressants	BP, HR, weight, mood, suicidality	Baseline, titration, then quarterly
Benzodiazepines/Sedatives	BP, HR, respiratory rate, sedation level	Baseline and each visit
Buprenorphine / MAT	UDS, LFTs, adherence, withdrawal/craving	Baseline, monthly x3, then quarterly

C. Vital Signs

Vital signs (BP, HR, RR, temperature, weight) are documented at each provider visit or as clinically indicated. Oxygen saturation and pain level are recorded when appropriate.

D. Laboratory and Diagnostic Orders

All laboratory and EKG orders must be entered and tracked through the EHR. Providers review and sign results, document findings, and follow up on abnormalities in accordance with the Abnormal Results and Follow-Up Policy.

E. Documentation and Follow-Up

Results are documented in the client record, including date completed, findings, and next scheduled due date. Abnormal or overdue results prompt follow-up by the provider or designee, with actions documented in the EHR.

V. Quality Assurance and Oversight

The Director of Medical and Clinical Services reviews monitoring compliance quarterly. The Medication Management Committee evaluates trends, overdue results, and corrective

actions as part of the organization's quality improvement plan.

VI. Training

Prescribers and nursing staff receive initial and annual training on medication monitoring standards, documentation procedures, and abnormal result management.