# POLICY AND PROCEDURE

REACH for Tomorrow

## Policy Review and Revision Schedule

Effective Date: 08/15/2025

Approved By: Director of Medical and Clinical Services

Review Schedule: Annually or as Needed

Applies To: Integrated Primary Care/Behavioral Health, Day Treatment, PHP, Community Integration

### Purpose

To establish a structured process and timeline for the review, revision, and approval of all organizational policies and procedures at REACH for Tomorrow, ensuring continued compliance with CARF 2025 standards, OhioMHAS regulations, and other governing bodies.

### I. Policy Statement

REACH for Tomorrow maintains a comprehensive system to ensure all policies and procedures are:
- Reviewed annually for relevance, accuracy, and compliance.
- Updated promptly when regulations, clinical practices, or organizational needs change.
- Approved and documented through appropriate administrative channels.

All staff shall have access to current, approved versions of all policies and procedures.

### II. Scope

This schedule applies to all organizational, administrative, clinical, and program-specific policies across all REACH for Tomorrow locations and service lines.

### III. Responsibilities

| Role | Responsibilities |
|---|---|
| Executive Director | Oversees implementation of this schedule and final approval of revised policies. |
| Director of Medical and Clinical Services | Leads annual review of clinical, medical, and safety-related policies. |
| Quality Improvement (QI) Committee | Monitors the review cycle, ensures revisions are documented, and reports progress quarterly. |

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| Program Directors / Site Managers | Review program-specific policies and ensure staff understanding and implementation. |
| Compliance / Risk Manager | Tracks due dates, maintains policy archive, and ensures version control and accessibility. |

## IV. Review Schedule

All policies shall be reviewed at least annually, with certain high-risk areas requiring semi-annual review.

| Policy Category | Examples | Review Frequency | Responsible Reviewer(s) |
|---|---|---|---|
| Organizational Governance | Mission, Values, Code of Conduct, Conflict of Interest | Annually | Executive Director |
| Administrative Operations | HR, Training, Incident Reporting, Record Retention | Annually | Executive Director / HR Director |
| Clinical Services | Assessment, Treatment Planning, Discharge, Supervision | Annually | Director of Medical & Clinical Services |
| Medication Management | Prescribing, Storage, Disposal, Monitoring | Semi-Annually | Director of Medical & Clinical Services / Nurse Practitioner |
| Risk Management / Safety | Incident, Emergency Preparedness, Infection Control | Semi-Annually | Risk Manager / Safety Officer |
| Quality Improvement | CQI/QI, Data Collection, Performance Measurement | Annually | QI Committee |

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|---|---|---|---|
| Information Security / Privacy | HIPAA, 42 CFR Part 2, Data Breach Response | Annually | Compliance Officer / IT Lead |
| Program-Specific | PHP, IOP, SUD, Integrated Care | Annually | Program Director |
| Finance / Billing | Fee Schedule, Billing Accuracy, Sliding Scale | Annually | Fiscal Manager |
| Community Relations | MOUs, Referral Coordination, Stakeholder Feedback | Annually | Program Director / Executive Director |

## V. Revision Process

1. Initiation:
   - Any staff member may identify a policy needing revision and submit recommendations to the Compliance or QI Committee.
2. Drafting and Review:
   - Responsible department drafts revisions.
   - Reviewed by the Director of Medical and Clinical Services, Executive Director, or subject matter experts as appropriate.
3. Approval:
   - Final approval documented by the Executive Director and/or Board of Directors.
   - Updated version receives a new revision date and version number.
4. Distribution:
   - Updated policies are distributed electronically to all staff.
   - Outdated versions are archived for seven (7) years and marked “Superseded.”
5. Training and Implementation:
   - All affected staff must review and acknowledge updated policies.
   - Supervisors provide additional training when changes significantly affect operations or compliance.

## VI. Documentation and Tracking

The Policy Review Log will be maintained by the Compliance/Risk Manager and include:
- Policy title and number
- Responsible department
- Original issue date
- Last review and next scheduled review date
- Reviewer name(s) and signature(s)
- Revision summary and approval date

A quarterly report summarizing review progress will be presented to the Quality Improvement Committee.

## VII. Emergency and Regulatory Updates

Policies affected by changes in law, regulation, or accreditation standards (e.g., CARF updates, OhioMHAS directives, HIPAA amendments) shall be reviewed and revised immediately, outside of the normal annual cycle.

## VIII. Annual Summary Report

The QI Committee shall produce an annual Policy Review Summary Report listing:
- All policies reviewed and updated.
- Outstanding or delayed reviews.
- Recommendations for new policies or consolidation.
- Evidence of compliance with CARF and OhioMHAS standards.

## IX. Review and Approval

This schedule will be reviewed annually by the Executive Director, Director of Medical and Clinical Services, and Quality Improvement Committee to ensure continued compliance and effectiveness.