

# POLICY AND PROCEDURE

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## REACH for Tomorrow

### **Policy Title: Verification of Diagnosis and Treatment Plan Alignment**

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 ensure that all medications prescribed within REACH for Tomorrow are consistent with the client's verified diagnosis and individualized treatment plan.

This policy safeguards against inappropriate prescribing, promotes clinical consistency, and aligns documentation with CARF standards, Ohio Administrative Code, and best-practice guidelines.

#### **II. Scope**

This policy applies to all prescribers, clinicians, nurses, and support staff involved in assessment, treatment planning, and medication management across all REACH for Tomorrow service lines, including Outpatient, IOP, PHP, and Integrated Primary Care/Behavioral Health programs.

#### **III. Policy Statement**

All prescribing decisions must be based on a confirmed diagnosis supported by clinical assessment and must align with the client's individualized treatment plan goals.

Medication is never prescribed in isolation; it must be integrated into a holistic care plan addressing behavioral, physical, and psychosocial needs.

Verification of diagnosis and treatment plan alignment is documented in the electronic health record (EHR) and reviewed during routine quality assurance processes.

#### **IV. Procedure**

##### **A. Verification of Diagnosis**

##### **1. Diagnostic Source:**

- Diagnosis must be derived from a comprehensive clinical assessment consistent with DSM-5 and ICD-10 standards.

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- The assessment is completed by a qualified clinician (LPCC, LISW, LICDC, or equivalent) or prescriber and must be updated at least annually or with any major clinical change.

### 2. Medical Review:

- The prescriber reviews the diagnosis prior to initiating or changing medication.  
- If diagnostic uncertainty exists, further evaluation (labs, collateral input, or consultation) must be completed before prescribing.

### 3. Documentation:

- The diagnosis and diagnostic rationale must be documented in the EHR under the Assessment and Plan section.  
- Each prescribed medication must list the corresponding diagnosis code (ICD-10) supporting medical necessity.

## B. Alignment with the Treatment Plan

### 1. Plan Integration:

- All medication interventions must support at least one active goal or objective within the client's treatment plan.  
- The treatment plan should reflect the purpose of each prescribed medication.

### 2. Review and Updates:

- Treatment plans are reviewed at least every 90 days, or as clinically indicated.  
- Prescribers ensure that treatment plan updates correspond with medication changes.

### 3. Interdisciplinary Coordination:

- Prescribers and therapists collaborate to confirm that behavioral goals, functional objectives, and pharmacologic interventions are aligned.  
- Communication is documented in the EHR through progress notes or case conference documentation.

### 4. Medication-Specific Treatment Goals:

- Each medication must have a clearly defined purpose and expected outcome (e.g., "reduce anxiety symptoms by 50% as measured by GAD-7").  
- Prescribers evaluate progress toward these outcomes during medication management follow-ups and adjust care plans as needed.

## C. Documentation Requirements

Each client's record must include the following:

- Verified and current diagnosis(es)
- Rationale for medication choice linked to diagnosis and treatment goal
- Current medication list and reconciliation
- Evidence of interdisciplinary communication (case conference, shared note, or message)
- Updated treatment plan reflecting medication purpose, dosage, and target outcomes
- Documentation of review dates and signature by prescriber and clinical lead

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### D. Quality Review Process

#### 1. Chart Audits:

- Conducted quarterly by the Director of Medical and Clinical Services or designee to ensure documentation alignment between diagnosis, treatment plan, and prescribed medications.

#### 2. Medication Management Committee Oversight:

- Reviews trends and identifies areas for improvement in diagnostic accuracy and treatment planning consistency.

#### 3. Corrective Actions:

- Any discrepancies found during the audit must be corrected within 7 business days.
- Recurrent issues are addressed through supervision or targeted staff training.

### V. Roles and Responsibilities

- Prescribers: Verify diagnosis, ensure alignment with treatment goals, and document rationale before prescribing.
- Clinical Staff (Therapists, QMHS, Case Managers): Ensure treatment plans are current and reflect medication interventions.
- Director of Medical and Clinical Services: Oversees audit process, corrective action, and compliance reporting. Provides oversight and clinical guidance for complex cases and ensures CARF compliance.

### VI. Performance Indicators

The following indicators are tracked and reviewed as part of the annual QI and performance measurement plan:

- Percentage of prescriptions with linked, documented diagnosis codes
- Percentage of medication-related treatment plan updates completed within required timeframe
- Audit compliance rate for medication-treatment plan alignment
- Number of discrepancies corrected during audit follow-up