



Compliance Matters

In this issue:

2-3

Regulations Revision
Review

4-5

It's Elementary...

6

Puzzling!



The summer may be winding down, but it's full steam ahead as we plan for the second annual CBH Compliance Forum.

Please save the date: November 9th.

A highlight of this year's program will be an interactive panel discussion featuring providers and representatives of state and local enforcement agencies who will share their perspectives and real life situations in the behavioral healthcare field. Stay tuned for additional information and registration.

In this month's edition of *Compliance Matters*, we introduce the seventh, and final, element of an effective compliance program: *Corrective Actions*. Typically, once an area of non compliance has been identified, the next step in the process to remediation is development of a corrective action plan (CAP). Conducting a root cause analysis, creating measurable solutions with deadlines, identifying point people, and on-going monitoring are all key elements of an effective CAP. We hope that our review of the seven elements will assist you as you review your own compliance plans and activities for 2018.

Enjoy!

- Donna E.M. Bailey
Chief of Staff & Compliance Officer

!POP QUIZ!

Spring Issue Answer:

On average Philadelphia receives 41.5 inches of rainfall annually.

Summer Issue Question:

What are the names of the "squares" that William Penn, the civil engineer for the City of Philadelphia, designed?

(Hint: There are 5)

*Answer in our Autumn issue.

Regulations Revision Review

DHS/OMHSAS has proposed revisions to the regulations governing Outpatient Psychiatric Services and Psychiatric Outpatient Clinics (55 PA Code Chapters 1153 and 5200). The regulations were published formally in the Pa Bulletin on August 12, 2017, with a 30-day comment period after publication. The expected date of delivery of the final-form regulation is October 2017.

CBH Compliance has reviewed the proposed regulation and highlighted some of the key changes. The list is not exhaustive, and we encourage providers to review the full text of the proposed rulemaking, available at <http://www.pabulletin.com/index.asp>.

STAFFING

- **Psychiatrist** coverage requirements have changed to allow clinics to maximize the utilization of psychiatric time to provide clinical oversight and direct care to individuals with complex needs receiving services at the clinic (§5200.22). Key changes:
 - Minimum 2 hours per week per FTE clinical staff (no longer minimum 16 hpw)
 - 50% of the required time must be a psychiatrist present in the program and 50% may be provided by the psychiatrist using telepsychiatry (prior written approval of the Department required) or by Advanced Practice Professionals licensed to prescribe medication in this Commonwealth, or a combination. An *Advanced Practice Professional* is defined as a person who holds a current Pennsylvania license as a CRNP with a mental health certification or a Physician Assistant with a mental health certification or at least a year of experience working in a behavioral health setting working under the supervision of a psychiatrist (§5200.3).
- The definition of **Mental Health Professional** (MHP) was revised. Staff must meet one of the required credentials:
 - (i) Has a graduate degree from a college or university that is accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation (CHEA) in a generally recognized clinical discipline which includes mental health clinical experience.
 - (ii) Has an equivalent degree from a foreign college or university that has been evaluated by the Association of International Credential Evaluators, Inc. (AICE) or the National Association of Credential Evaluation Services (NACES). The Department will accept a general equivalency report from the listed evaluator agencies to verify a foreign degree or its equivalency.
 - (iii) Is licensed in a generally recognized clinical discipline which includes mental health clinical experience.
- A **Clinical Director** and **Clinical Supervisor** are now required as part of the psychiatric clinic structure (§5200.11 & §5200.21).
- Requirements for **Clearances / CPSL checks** have been updated:
 - For clinics serving children: all staff, including volunteers, having direct contact with individuals, must have current Criminal History Check, Child Abuse Certification, and Mandated Reporter Training in accordance with 23 Pa CS 6301-6386 and Chapter 3490 (§5200.24).
 - Clinic shall develop and implement written policies and procedures regarding personnel decisions based on the criminal history and child abuse certifications, including volunteers.
- A written plan for regular, ongoing **staff development and training** is required (§5200.22).

Continued on page 3

GROUP THERAPY

- The maximum number of participants for **group therapy** is now 12 (up from 10) (§1153.2).

DOCUMENTATION

- Psychiatrist must review **Assessment** and initial **Treatment Plan** within 30 days of intake (§1153.14 & §5200.32).
- Changes in frequency of **Treatment Plan**:
 - Initial plan within 30 days of intake. Required signatures: Client, MHP, and Psychiatrist.
 - Updates within 180 days, or more frequently if clinically indicated. Required signatures: Client and MHP. Psychiatrist must sign update(s) at minimum within one year following the previous psychiatric review and approval.
 - Individual receiving services must participate in developing the plan (§1153.52).
- All **medications prescribed** must be documented in the individual medical record (§5200.42).
- Regulatory language has been updated to include **securing “records, written and electronic”** in accordance with all applicable Federal and State privacy and confidentiality statutes and regulations. (§5200.41)

Mobile Mental Health Treatment (MMHT)

- Mobile Mental Health Treatment (MMHT) rehabilitation services are now included in the chapters (§1153.2) and include Assessment; Individual, Family, and Group Therapy; Medication Visits in the individual's residence or approved community site (§1153.14)
- MMHT may be provided by a licensed outpatient clinic with an approved service description (§1153.11 & §1153.12 &

§5200.51). Services **MUST BE** loaded on the CBH Schedule A, and must be recommended by a physician or other licensed practitioner of the healing arts (LPHA), within the scope of his practice under State law (42 CFR ss 440.130(d)) (§1153.2 & §1153.52 & §5200.52).

- Assessment must include documentation of the disabling effects of a mental or physical illness that impeded or precludes the individual's ability to participate in services at the clinic.
- Non-billable (incompatible) services are identified and include:
 - Same-day services as other home- and community-based BH services to the same individual
 - MMHT services provided as a substitute for transportation to the clinic
 - Group psychotherapy provided in the individual's home
 - OP and MMHT services provided to nursing home residents on the grounds of the nursing home or under the corporate umbrella of the nursing home (§1153.14)

- *Gretchen Murchison, Team Leader
Routine Investigation and Training Unit*

It's Elementary...

Compliance Matters will use this column to publish an article each quarter regarding one of the seven core elements of a successful compliance program, as outlined by provisions in the Patient Protection and Affordable Care Act 42 U.S.C. § 18001 (2010)

You made it!! Well almost, you are at the beginning of the end. This is the seventh and final installment of *It's Elementary*, our series on the seven core elements of an effective compliance program. Number 7 on the list is Corrective Actions.

Many readers are familiar with corrective actions primarily through DBHDS' use of various kinds of corrective action plans. We have Quality Management's QIP (pronounced Qwips), NIAC's PIP (minus Gladys), and Compliance's own CAP (we prefer fitted or stretch-fit to the snapbacks...and one size fits all...please).

There is a whole world of corrective actions aside from the DBHDS' troika of plans. Providers are encouraged to construct their own corrective action plans based on the results of any internal review or audit. There is no need to wait for the dreaded DBHIDS generated request.

Correction Actions is also, in my opinion, the least discussed of the seven elements. It's almost as if you get to this point and you are able to implement corrective actions automatically. In my experience, it is not so easy. So, let's go over a couple key points.

Specifics are Important

Isn't that true for so many things in life? If you are like me and you are a fantasy sports geek (time for a breakout season this year for Kevin White!!), this was never more important than in the mid 90's. In fantasy baseball, if you didn't specify "Pedro Martinez from the Expos" or "Righty Pedro Martinez", you could have wound up with lefty journey man reliever Pedro Martinez. Probably a great guy, but that 1.5 whip is not going to help your team! It is the same basic principle in the CAP world. If your CAP requires a department to handle a change, the odds are stacked



against you. The "Oh....the other person will handle it" syndrome will settle in. Instead, specify key staff as being responsible for specific action steps. They can still utilize additional resources as needed, but having a single point of accountability helps ensure a sense of ownership.

Specifics are Important - Part Two

Specificity is so important that we need to keep talking about it. It is equally important to be specific about the mechanisms of change that are being proposed. Say your agency is having difficulty in getting treatment plans signed on time. A CAP that stops with "We will revise our treatment plan policy to ensure that all signatures are collected on time" is not likely to be effective. Answer the logical follow-up questions in your CAP until you have no additional follow-up questions as a general rule. So for our example, include answers to:

- How will the policy change be communicated

Continued on page 5

- What training, if any, will be provided to staff regarding the policy revision
- Who will be responsible for the policy revision and communication
- How will behavior changes, as a result of the policy change and training, be measured
- What is the time frame for the policy change and full implementation
- What is viewed as acceptable improvement
- When will progress be reviewed and how will revisions be made

Corrective Actions Must Be Realistic

I am all for optimism, don't get me wrong. But, there are limits. Just like I would never expect Vanderbilt to beat Alabama in a football game, there are some corrective actions that are just, well, unlikely. For example, if your agency is having issues with staff not signing their notes, is it realistic to expect that a single person review EVERY note prior to billing? If your agency is small, this may be possible. But, if you have a large agency or site, it is most likely not. Almost nothing is as defeating as starting down a path you KNOW you can't finish. Make the Corrective Action realistic while still dealing effectively with the problem. So, for the earlier example have frequent, randomly pulled checks. If in the random checks you notice 1-2 staff people being the most problematic, you have narrowed the scope further and can take actions to correct the issue with those individuals. (Also, don't forget to "catch the good"!)

Corrective Actions Must Be Measurable

Many times, the old CBH Credentialing Department, and now our friends in NIAC, have noted that an individual's treatment or recovery plan goals are not measurable. Well, the same yardstick applies to corrective actions. Your CAP must yield results that are measurable. How else can you determine if

the implemented changes are effective? Using the previous example of unsigned notes, those random pulls can easily lead to scores. Maybe in the first round of pulls only 60% of the notes reviewed were signed. A year into the CAP we would expect to see significant improvement. If not, well, that leads us to the next point.

Corrective Actions Can't Be Viewed as Static

Corrective Actions, like treatment plans and my two incredibly cute cats, are living things. CAPs have the benefit of not needing shots or having litter boxes cleaned. But allowances must be made to allow CAPs to be revised as needed. If CAP reviews show that the desired effect(s) are not happening, the CAP needs a revision. The American Society for Quality (ASQ) promotes a Plan, Do, Check, Act model for making effective changes. The Check and Act are tied together effectively in the model. ASQ guides individuals in the midst of a change or planning a change, like a Corrective Action, to check to see if the change is having the desired effect. When it is not, **act** to revise the plan and implement new changes.

Congratulations on making it to the end of the seven core elements series. These core elements serve as the foundation for an effective compliance program. These seven elements should be viewed as the minimum standard for compliance programs and the foundation on which to build any program! Now take some time to study up on other important things like the merits of double wire bound notebooks vs. single, the near extinction of eraser-mate pens, how Two Broke Girls lasted as long as it did yet Timeless got cancelled (and then resurrected)...you know, the important things.

- Ken Inness, Director of Compliance

In the next issue:

- Compliance Forum Follow Up
- The Return of NPAU Ka-Pow (Really!)
- More Junk Drawer
- Puzzling!

Do you have suggestions for future editions of *Compliance Matters* or do you know someone who wants to subscribe to the newsletter? (It's FREE!)

Contact Matthew Stoltz!
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CONFIDENTIALLY REPORT FRAUD, WASTE, and ABUSE.

1-800-229-3050 or

CBH.ComplianceHotline@phila.gov

PUZZLING!

H	O	V	L	Z	K	K	K	S	L	N	Z	E	F	S
V	U	C	H	D	O	I	H	N	Z	X	A	O	E	J
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F	J	N	N	K	W	O	W	E	Z	U	Y	W	R	N
Q	O	P	T	Q	C	P	S	S	F	M	E	F	K	D

Word List:

BALLPARK

BEACH

CODES

CORRECTIVE

EAGLES

ELEMENTS

FOOTBALL

FORUM

HUMIDITY

OCEAN

PHILLIES

RECORDS

REGULATIONS

SUNSHINE