RIDER E
Program Requirements
Children's Behavioral Health Services

Eligibility and Access

1. All individuals meeting clinical and programmatic criteria for a DHHS Children's Behavioral Health Services provided under this Agreement are eligible for that service without regard to income. Fees shall be assessed in accordance with applicable statute, 34-B M.R.S.A. §1208(8) and rules promulgated thereunder.

2. The Provider shall not deny services to any person solely on the basis of the individual's having experienced trauma, a known mental illness or a known substance use/abuse disorder or because that individual takes prescribed psychoactive medications or participates in medication assisted treatment of their substance use.

3. The Provider shall not deny a referral or services to any child or youth if the child or youth meets MaineCare eligibility requirements for the service provided, except where provision of the service by the provider would be clinically or legally contraindicated. The Provider may utilize wait lists or other procedures to facilitate service delivery and prioritize client receipt of services based upon need as long as any such procedure is consistent with state and federal law.

Language Access

4. Interpretation Services (Communication Access). The Provider shall determine the primary language of individuals requesting services and ensure that the services are provided either by a bi-lingual clinician or with the assistance of a qualified interpreter when English is not the primary language. If not otherwise funded by MaineCare or some other source, the Provider shall obtain the service at its own expense. The client shall not be charged.

5. Accessibility for the Deaf and Hard of Hearing.
   a. The Provider shall maintain and periodically test a telecommunications device for the deaf (TTY) that is available and accessible for use by clients and staff for incoming and outgoing calls. The Provider shall ensure that appropriate staff have been trained in the use of the telecommunications device and that the TTY telephone number is published on all of the Provider's stationery, letterhead, business cards, etc., and in the local telephone books as well as in the statewide TTY directory.
   b. The Provider, shall obtain the services of a qualified sign language interpreter or other adaptive service or device when requested by a consumer or family member, and if not otherwise funded by MaineCare or some other source, shall obtain the service at its own expense. The client shall not be charged. Interpreters must be licensed with the Maine Department of Professional and Financial Regulation in the Office of Licensing and Registration. The Provider shall document the interpreter's name and license number in the file notes for each interpreted contact.

6. Deaf and/or severely hard of hearing. Providers who serve deaf and/or severely hard of hearing consumers shall:
   a. Provide visible or tactile alarms for safety and privacy (e.g., fire alarms, doorbell, door knock light);
   b. Provide or obtain from the Maine Center on Deafness loan program a TTYor fax as appropriate for the consumers' linguistic ability and preference and a similar device for the program office; and

c. Train staff in use and maintenance of all adaptive equipment in use in the program, including but not limited to: hearing aids, TTY, fax machine, caption controls on TV, and alarms.

7. Provider responsibilities: deaf, hard of hearing and/or nonverbal clients. Providers who serve deaf, hard of hearing, and/or nonverbal consumers for whom sign language has been determined as a viable means of communication shall:
   a. Provide ongoing training in sign language and visual gestural communication to all staff who need to communicate meaningfully with clients, and document staff attendance and performance goals with respect to such training;
   b. Develop clear written communication policies for the agency and each program of the agency, including staff sign/visual gestural proficiency expectations, and when and how to provide qualified sign language interpretation; and
   c. Ensure that staff have a level of proficiency in sign language that is sufficient to communicate meaningfully with consumers.

Tracking and Reporting

8. The Provider shall follow all policies, procedures and protocols developed by the Department, including without limitation procedures and protocols for tracking and reporting (i) grievances and rights violations, and (ii) critical incidents as defined by the Department. The Provider shall develop the capacity to electronically transmit identified uniform data elements in accordance with specifications established by the Department.

Service Planning

9. The Provider shall use uniform intake and assessment tools and procedures as prescribed by the Department, and shall report uniform data elements according to reporting schedules established by the Department.

10. The Provider agrees to abide by procedures identified by the Department for the implementation of the child or youth's Individualized Service/Treatment Plan or Individualized Plan of Care.

11. The Provider shall, except where clinically or legally contraindicated or for the purposes of clinical supervision, include children, youth, and parents and/or guardians in any Service or Treatment Planning and any other discussions about the care of the child or youth to the greatest extent possible and shall document such encounters, including attempts to secure the presence of such person(s).

12. The Provider shall maintain written documentation in the client's file indicating the reason for referral for any and all services being provided and shall include reference to the reason for referral in Assessments and Individualized Service/Treatment Plans or Individualized Plans of Care or reviews of Assessments and Individualized Service/Treatment Plans or Individualized Plans of Care.

13. Disclosure of methods and informed consent:

    a. The Provider shall document the treatment or service delivery method or model for each service provided to a client, indicating full disclosure to the child and youth (as appropriate), parent and/or guardian of the risks and benefits of the method or model and alternative methods or models.
    b. The Provider will ensure that services are consistent with principles of Evidence-Based Practice and that staff understand and consider empirical evidence, clinical expertise, and the values and preferences of families and youth in implementing treatments.

c. The provider shall clearly document the level of support in empirical research, where it exists, regarding the method or model employed; the provider will discuss this level of support, along with the higher level of support of alternative treatments (if such is the case), with the client.
d. The provider shall clearly document the target symptoms of the treatment, how they will be measured and improvement determined.

14. Providers of behavioral health services to a client shall communicate with the prescriber of any psychoactive medication(s) and document medication information obtained from such communications at least every three (3) months of service or sooner if clinically indicated.

15. The provider of medications shall clearly document the target symptoms of the treatment, how they will be measured and improvement determined.

Service Standards

16. All individuals who are receiving services are entitled to any and all other supports, services, benefits, or entitlements that are available to the general public in their communities. If an individual's assessment for needed services identifies a need for such support, service, benefit, or entitlement that the Provider is unable to provide, the Provider shall make a corresponding referral for that service and document the referral. The Provider shall offer any necessary provision or linking to case management functions, if the individual desires.

17. The Provider shall supply all staff training as required by the Department to ensure appropriate provision of services under this Agreement. The Provider's staffing of all service programs contracted herein shall be in accordance with its final approved budget submission for the contract period and shall be adequate to meet the needs of clients in the programs. The Provider shall notify the Program Administrator within twenty four (24) hours as to any staffing changes that cause the Provider to be in non-compliance with this paragraph.

18. The Provider shall not reduce, terminate, or otherwise interrupt services which the Provider hereby agrees to deliver to the client and which are described in this Agreement, without complying with the following terms: that the Provider shall give due process notification as required by MaineCare regulations, Chapter 1 of the MaineCare Benefits Manual.

19. The Provider shall ensure that the mental health license, if applicable for contracted services, is clearly displayed in all locations and that documentation, including but not limited to letterhead, service records, business cards, and public signs clearly and accurately state the name, address and primary phone number of the Provider.

20. The Provider is responsible for ensuring that all staff, employees, subcontractors or other individuals or entities providing any services on behalf of the Provider clearly explain to clients and families their relationship to the Provider verbally and in writing and include, in writing, contact information for the individual(s) responsible for responding to complaints or grievances on behalf of the Provider.

21. The Provider shall clearly explain verbally and in writing the roles and responsibilities of the Provider in addressing crisis situations.

22. The Provider shall maintain original clinical documentation within facilities, buildings or locations under its direct control and authority.

System of Care Principles.

23. The goal of DHHS is that Providers of Children's Behavioral Health Services are integrated in a Trauma Informed System of Care. Providers will promote the Federal Substance Abuse and Mental Health Services Administration's (SAMHSA) System of Care Principles of 1) Family Driven, 2) Youth Guided, and 3) Culturally and Linguistically Competent care. These three System of Care Principles are described at http://systemsofcare.samhsa.gov/.

24. An additional principle for a Maine's Children's Behavioral Health System of Care is that it is Trauma Informed. An agency that is Trauma Informed:

    1. **Definition:** Is able to define psychological trauma.
    2. **Trauma and Illness:** Understands the development over time of the perception of psychological trauma as a potential cause and/or complicating factor in medical or psychiatric illnesses.
    3. **Prevalence and Sequelae:** Is familiar with current research on the prevalence of psychological (childhood and adult) trauma in the lives of persons with serious mental health and substance abuse problems and is able to list possible sequelae of trauma (e.g. post traumatic stress disorder (PTSD), depression, generalized anxiety, self-injury, substance abuse, flashbacks, dissociation, eating disorder, revictimization, physical illness, suicide, aggression toward others).
    4. **Trauma-Related Dynamics:** Has a basic understanding of symptoms, feelings and responses associated with trauma and traumatizing relationships.
    5. **Trauma-Informed Services:** Understands key principles of trauma-informed services; ensuring physical and emotional safety; maximizing consumer choice and control; maintaining clarity of tasks and boundaries; ensuring collaboration in the sharing of power; maximizing empowerment and skill building.
    6. **Avoidance of Retraumatization:** Considers all consumers as potentially having a trauma history, understands how such individuals can be retraumatized and is able to interact with consumers in ways that avoid retraumatization.
    7. **Personal and Professional Boundaries:** Is able to maintain personal and professional boundaries in ways that are informed and sensitive to the unique needs of a person with a history of trauma.
    8. **Unusual or Difficult Behaviors:** Understands unusual or difficult behaviors as potential attempts to cope with trauma. Has respect for people's coping attempts and avoids rush to negative judgments.
    9. These Trauma Informed Competencies can be found at http://muskie.usm.maine.edu/cfl/Competencies/general.htm)

25. The Provider shall participate in administration of the Trauma Informed System of Care Agency Assessment as specified by the CBHS.

26. The Provider shall continue to make available to all staff and consumers a formal statement of commitment to implementing trauma informed system of care principles, referring to the principles stated herein.

Co-Occurring Capability

27. The goal of DHHS is that all Providers become Co-occurring Disorder (COD) Capable. (COD-C) as set forth at http://www.maine.gov/dhhs/cosii/provider/word/DefinitionCodCapable.doc This expectation is reflected in DHHS policy and it is expected that all Providers have achieved this by June 30, 2011. New providers have one calendar year from the date of the start of the contract to achieve this capability. The principles of a COD capable program include that it "is organized to welcome, identify, engage and serve individuals with co-occurring substance

abuse and mental health disorders and to incorporate attention to these issues in all aspects of program content and documentation. Such programs provide services that incorporate understanding of and approaches to substance abuse problems as they relate to and affect the mental health disorder." The principles apply as well to individuals who may have co-occurring Intellectual Disorders (Mental Retardation) and Pervasive Developmental Disorders.

28. The Provider shall make available to all staff and consumers a formal statement of commitment to implementing COD-C programs, referring to the principles state herein.

Additional information regarding the Co-Occurring State Integration Initiative is available at http://www.maine.gov/dhhs/cosii/index.shtml.

Continuous Quality Improvements Plans

29. The following regarding Continuous Quality Improvement is required:

    a. A written copy of the agency's Continuous Quality Improvement Plan or updated version of the plan from the previous year. The provider shall develop the plan with explicit consideration for the use of data available from the provider, the Department or its authorized agent and establish measurable goals and outcomes.

    b. Written documentation of measurable progress from the Provider's Continuous Quality Improvement Plan from the previous year. The documentation will minimally include progress on goals identified from the Trauma Informed System of Care Agency Assessment and agency self-assessments regarding Co-Occurring Capability.

    c. An updated formal statement of commitment to implementing Trauma Informed System of Care Principles and COD-C Programs for staff and consumers, referring to the principles stated herein.

30. All documentation shall be sent electronically to the Team Leader/Program Administrator of CBHS within the deadline for the first quarterly report required under Rider A under Reporting Content and Timing.

Screening

31. The Provider shall utilize the AC-OK Adolescent Screening Tool or other Department approved tool for identifying people who have experienced co-occurring disorders, trauma and mental health issues.

Miscellaneous

32. **Termination or Change of Work Performance.**
    The Provider shall report any anticipated closing of the Provider's operations at the earliest possible date and no later than sixty (60) days prior to the anticipated closure date, with the exception of reasonably unforeseen circumstances, to the Agreement Administrator and Program Administrator. This written communication shall be specific and include, and not be limited to, the date of expected closure, description of any and all programs affected, number of clients projected to be impacted, plans for addressing needs of the clients affected, and the name and contact information of the person(s) responsible for the care of clients affected and their records. The Provider shall assist the client and the client's case manager or other supports in obtaining services from another provider.

33. In addition, the Provider shall report to the Program Administrator all major programming and structural changes in programs funded, seeded, or licensed by DHHS within the time frame noted above. Any changes that add, alter or eliminate existing services must be negotiated and approved by the Program Administrator prior to implementation. Major program changes include, but are not limited to, the following: (1) the addition of new services or deletion of existing services; (2) serving a population not served by the agency previously; (3) significant increases or decreases in service capacity as defined by the governing body; (4) significant changes in the organizational structure as defined by the governing body; (5) changes in the executive director or name or ownership of the agency; or 6) relocation of services. For MaineCare funded services, the Provider shall give due process notification as required by MaineCare regulations, Chapter 1 of the MaineCare Benefits Manual.

34. **Wait Lists.** For any children or youth on a wait list for services with the Provider for over thirty (30) days and at every thirty (30) days thereafter, the Provider shall contact the child or youth's parent or legal guardian and provide information on the anticipated date of the start of service, information regarding other Providers of the service and/or contact information for the nearest office of Children's Behavioral Health Services in order to obtain information about other Providers, and offer assistance in making referrals to other Providers. The Provider shall document all communications with the client or family related to this paragraph. Provider shall not remove a child or youth from a waitlist without providing information for the youth and/or family about other Providers of the service and/or contact information for the nearest office of Children's Behavioral Health Services in order to obtain information about other Providers, and shall offer assistance in making referrals to other Providers. Provider shall not remove a child or youth from a waitlist or encourage a youth or family to volunteer to be removed from a wait list solely on the basis of length of time on a wait list.

35. **Staff Supervision.** Provider shall ensure that supervision is provided to all staff in compliance with Federal and State law and regulations, including but not limited to the MaineCare Benefits Manual and Licensing Regulations applicable to the contracted services.

36. **Responsibility for Staff.** The Provider is bound by all of the following: 1. DHHS Licensing Regulations applicable to the contracted services and Laws and Rules of Professional and Financial Regulation of the State of Maine; 2. Children's Behavioral Health Services Contracts; 3. All applicable sections of the MaineCare Benefits Manual; 4. Rights of Recipients of Children; 5. Rights of Recipients of Adults; 5. all court related judgments and decrees related to services. The Provider cannot change, restrict, suspend, or limit any of its obligations through contracts or any other agreements with individual clinicians, supervisors, consultants, subcontractors or any other individuals providing services. Provider shall not subcontract or otherwise delegate responsibility for performance of its obligations under this contract without seeking and obtaining written approval by CBHS.

37. The Provider shall participate in Department sponsored Provider meetings at the local, state and the regional/district level from which funds are contracted, and work cooperatively with the Department in responding to and carrying out the following activities:

    a. tracking requests for services for eligible individuals and, where necessary, facilitating referrals;
    b. Monitoring utilization of established standards practice guidelines as specified by the Department;
    c. Collaborating work (planning, coordinating, sharing information) with providers of case management, in-home support, and treatment and other child-serving Departments.

d. Collaboration with other agencies to maximize access to services and to facilitate transition planning from one service to another, one agency to another or from one system to another (e.g.: child to adult services)

38. Consistent with the requirements of Title V of the Public Health Service Act 42 U.S.C. 300x - 1 [et seq.] Section 1916: The Provider agrees that it will not expend Community Mental Health Services Block Grant:

a. to provide inpatient services;
b. to make cash payments to intended recipients of health services;
c. to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
d. to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
e. to provide financial assistance to any entity other than a public or nonprofit entity.