

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 funded service 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 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 TTY or 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 that is sufficient to communicate meaningfully with consumers.

Service Planning

8. 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. The Provider also shall use and abide by 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.
9. The Provider agrees to abide by procedures identified by the Department for the implementation of the child or youth's Individualized Service/Treatment Plan.
10. 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).
11. 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 Individualized Service/Treatment Plans, reviews of Individualized Service/Treatment Plans and Assessments.
12. 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, youth, parent and guardian of the risks and benefits of the method or model and alternative methods or models. The provider shall clearly document the target symptoms of the treatment, how they will be measured and improvement determined.
13. 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.
14. The provider of medications shall clearly document the target symptoms of the treatment, how they will be measured and improvement determined.

Service Standards

15. 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.
16. 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.
17. 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.

System of Care Principles.

18. 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/>.
19. 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>

20. By **January 1, 2010**, the Provider shall administer a system of care self Assessment Tool approved by the Department that addresses the principles referenced in paragraphs 18 and 19 herein.

21. By **January 1, 2011**, Provider, in collaboration with Children's Behavioral Health Services, will include in its Quality Improvement Plan developed under Rider "A" areas of need identified by the Assessment Tool and plans to meet those needs

22. By **January 1, 2010**, the Provider shall create and communicate to all staff and make available to consumers and the Program Administrator a formal statement of commitment to implementing trauma informed system of care principles, referring to the principles stated in paragraphs 18 and 19 herein.

Co-Occurring Capability

23. The goal of DHHS is that all Providers become Co-occurring Disorder (COD) Capable. (COD-C) This expectation is reflected in DHHS policy and it is expected that all Providers achieve this by 2011. A COD capable program "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."

24. To assist Providers in the development of COD Capability, CBHS requires Providers to take the following steps towards COD competence and provide documentation to the Program Administrator on or before **January 1, 2010**:

- a. Create and communicate to all staff a formal statement of intent to become and description of a COD capable program;
- b. Organize and document a formal Continuous Quality Improvement process included in its Quality Improvement Plan developed under Rider "A" that will begin to address this goal;
- c. Develop a written protocol or policy that describes its service approach to people who have experienced co-occurring mental illness and substance abuse or other co-occurring conditions; and
- d. Train staff in the interrelationship of mental illness and mood altering substances, the identification of available resources, and the referral and treatment process.

Additional information regarding the Co-Occurring State Integration Initiative is available at <http://www.maine.gov/dhhs/osa/about/cosig/>."

Screening

25. The Provider shall institute a discrete screening process for identifying people who have experienced trauma and other complex, co-occurring needs and diagnoses using a standard tool to be provided by the Department. By **January 1, 2010**, the Provider shall provide documentation of the training of staff and implementation of such a screening process to the Program Administrator.

Miscellaneous

26. Critical Incidents. The Provider shall use and abide by 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.
27. Anticipated Program Closure. The Provider must communicate in writing directly with the Director of Children's Behavioral Health Services regarding any anticipated closing of the Provider's operations or any program 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. The written communication shall include specifics including, but not limited to, the date of expected closure, description of any and all programs affected, number of clients to be impacted, plans for addressing the needs of the clients to be affected, and the name and contact information for the person(s) responsible for the care of clients to be affected and their records.
28. 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 a referrals to other Providers. The Provider shall document all communications with the client or family related to this paragraph.
29. 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)
30. 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 Children's Mental Health Block Grant funds:
 - 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.