

RIDER E

PROGRAM REQUIREMENTS

Mental Health Services

The following provisions specify program requirements for this agreement.

I. GENERAL PROVISIONS

- A. Eligibility.** All individuals meeting clinical and programmatic criteria for any Office of Adult Mental Health Services (OAMHS)-funded service are eligible for that service without regard to income, within existing resources. The Provider in accordance with an approved fee schedule or established residential rate may charge a fee.
- B. Service Planning.**
1. The Provider shall use uniform intake and assessment tools and procedures and shall report 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. The Provider shall electronically transmit identified uniform data elements in accordance with specifications established by the Department.
 2. The Provider shall abide by and implement the Individualized Support Plan (ISP) policies, procedures, practices, and/or protocols established by the Department for carrying out its approved ISP Plan pursuant to *Bates v. DHHS* (AMHI Consent Decree), including, without limitation, (i) requirements for supporting Community Integration Service staff in their role of coordinating and monitoring progress on ISPs, and (ii) procedures for completing initial and subsequent 90-day reviews in a timely manner.
- C. Service Standards.** The provision of services to a client shall not be contingent on the receiving of 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 such service, the provider shall assist in the referral process if the individual desires.
- D. Availability of Peer and Family Support.** The Provider is required to give all new clients information regarding services available through peer support organizations/groups. The Provider is also required to include among their services the referral of family members, with whom the providers have contact, to area family support groups such as NAMI-Maine. When referring a family member to a family support group the agency shall provide information regarding

the group and shall additionally offer to call the support group to give the family member's name and means whereby the support group may contact him or her.

E. Licensure and Location

1. The Provider shall maintain a valid Certificate of Licensure as a Mental Health Agency in accordance with 34-B M.R.S.A. § 1203-A and/or other required licensure during the term of this Agreement.
2. The Provider shall make every effort to deliver necessary services where the clients are located, in the event that clients are unable to come to the Provider's office to receive services.
3. The Provider shall report to the DHHS Licensing Division and to the DHHS mental health team leader all major programming and structural changes in programs funded, seeded, or licensed by DHHS. Any program changes that add, alter or eliminate existing services must be negotiated with the mental health team leader 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; (4) significant changes in the organizational structure; (5) changes in the executive director or name or ownership of the agency; or 6) relocation of services.

F. Co-occurring Mental Health and Substance Abuse Disorders. In support of the DHHS statewide initiative to create a system welcoming to clients with co-occurring mental health and substance abuse disorders, the Provider agrees to the following:

1. The Provider shall not deny services to any individual solely on the basis of the individual's having a known substance use/abuse disorder in addition to their mental illness;
2. The Provider shall maintain a written protocol or policy that describes its service approach to individuals with a co-occurring mental health and substance abuse disorder; and
3. The Provider shall ensure that appropriate staff receives training in the interrelationship of mental illness and substance abuse, the identification of available resources, and the referral and treatment process.
4. The provider shall institute a discrete screening process for identifying people with complex, co-occurring needs and diagnoses using a standard tool to be provided by the Department

The goal of DHHS is that all providers become 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.”

To assist providers in the development of COD Capability, OAMHS requires providers to take the following steps towards COD competence in the FY09 contract period:

- a. Providers will create and communicate to all staff a formal statement of intent to become COD capable and provide a copy of that statement
- b. Providers will organize a formal Continuous Quality Improvement process that will begin to address this goal and document that step

The achievement of co-occurring competence is a long term process. The steps required above are the first of a set of benchmarks that will be required in subsequent contract years.

- G. 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. The client shall not be charged for this service.
- H. Accessibility for the Deaf and Hard of Hearing.** The Provider shall maintain and periodically test appropriate telecommunication equipment including TTY, videophone, or amplified telephone. Equipment must be available and accessible for use by clients and staff for incoming and outgoing calls. The Provider shall ensure that appropriate staff has 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., in the local telephone books, as well as in the statewide TTY directory. The Provider, at its expense, shall obtain the services of a qualified sign language interpreter or other adaptive service or device when requested by a consumer or family member. 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.
- I. Deaf and/or Severely Hard of Hearing.** Providers who serve deaf and/or severely hard of hearing consumers shall:
1. Provide visible or tactile alarms for safety and privacy (e.g., fire alarms, doorbell, door knock light);
 2. 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

3. Train staff in use and maintenance of all adaptive equipment in use in the program, including but not limited to hearing aids, assistive listening devices, TTY, fax machine, television caption controls, and alarms.

The Maine Center on Deafness www.mainecenterondeafness.org offers assistance to individuals who need specialized telecommunications devices.

J. Provider Responsibilities: Deaf, Hard of Hearing and/or Nonverbal. 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:

1. Provide ongoing training in sign language and visual gestural communication to all staff on all shifts who need to communicate meaningfully with these clients, and shall document staff attendance and performance goals with respect to such training;
2. 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
3. Ensure that staff has a level of proficiency in sign language that that is sufficient to communicate meaningfully with consumers.

K. Annual Survey. The Provider is required to support and participate in the Annual Mental Health Data Infrastructure Consumer and Family Satisfaction Survey Project in accordance with the protocols developed by the DHHS Office of Quality Improvement. The surveys are administered directly by the Department. Provider agencies will be required to assist in notifying clients about the survey prior to administration, encouraging client participation and addressing client questions regarding surveys.

Three surveys are used for specific populations, including: the Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Survey (for ages 18 and older); the Youth Services Survey for Families (YSSF) (families of children below 12 and younger); and the Youth Services Survey (YSS) (for youth between the ages of 13 and 18).

II. CONSENT DECREE COMPLIANCE

A. The Provider agrees to provide services in a manner consistent with terms of this section and to work cooperatively with the Department in fulfilling its requirements under the "AMHI Consent Decree" in *Bates vs. DHHS*, Civil Action No. 89-88 (Me. Superior Ct., Kennebec County), the terms of which are incorporated herein by reference. Nothing elsewhere in this Agreement should be read to restrict or limit requirements in this section

B. All Providers. All providers of services subject to this Rider E shall comply with the following:

1. The Provider shall have in place a grievance policy and procedure in compliance with the Rights of Recipients of Mental Health Services.
2. The Provider shall notify all clients who apply for services of their rights under the Bates v. DHHS Consent Decree and under the Rights of Recipients of Mental Health Services. Furthermore, the Provider shall notify clients of their right to name a designated representative or representatives to assist them. The Provider shall also provide information to clients regarding available advocacy programs.
3. Providers of comprehensive mental health services are required to have a consumer on their Board of Directors. This may be a current or former consumer who self discloses as a consumer and does not have to be a consumer of the provider's services. Other mental health providers are required to either have a consumer on their Board of Directors or to have a consumer advisory committee.
4. The Provider shall submit a written treatment or service plan to the community support worker when requested by the community support program. The written treatment or service plan shall include a description of the service to be provided and any applicable terms included in the ISP. The written treatment or service plan or written service agreement shall also include a statement that the Provider agrees that it will not discontinue or otherwise interrupt services which the Provider agrees to deliver to the client, without complying with the following terms:
 - a) The Provider shall obtain prior written approval from the Department for class members;
 - b) If written approval is obtained as specified above, and, as a result, services to the client will be discontinued or otherwise interrupted, the Provider shall give thirty days advance written notice to the client, to the client's guardian, if any, and to the client's community support worker. If the client poses a threat of imminent harm to persons employed or served by the Provider, the Provider shall give notice which is reasonable under the circumstances;
 - c) The Provider shall give notice as may be required by law or regulation following the applicable, most stringent of Chapter II of the MaineCare Benefits Manual, DHHS Licensing Regulations, or the Bates v. DHHS Consent Decree; and
 - d) The Provider shall assist the client and the client's community support worker in obtaining the services from another provider.
5. The Provider shall maintain current client records which chart progress toward achievement of goals and which meet applicable requirements of the settlement agreement, contracts, law, regulations, and professional standards.

6. The Provider shall maintain a manual of up-to-date job descriptions for each mental health service position. The job descriptions shall clearly define areas of responsibility, including those required in the Bates v. DHHS Consent Decree.
7. The Provider shall establish a performance evaluation protocol for each direct service position.
8. The Provider shall verify that all its employees who perform client services have received training consisting of, but not limited to:
 - a) The legal rights of persons with mental illness;
 - b) Identification of, response to, and reporting of client abuse, neglect and exploitation;
 - c) Specific job responsibilities;
 - d) The agency mission;
 - e) Client privacy and confidentiality;
 - f) Physical intervention techniques, if applicable;
 - g) The terms of the Bates v. DHHS Settlement Agreement;
 - h) The perspectives and values of consumers of mental health services, including recovery and community inclusion. This portion of the training shall be delivered, at least in part, by consumers;
 - i) The ISP planning process;
 - j) Introduction to mental health services systems, including,
 - (1) The role of Riverview Psychiatric Center/Dorothea Dix Psychiatric Center in the mental health system,
 - (2) The responsibilities of various professional and staff positions within the mental health system;
 - k) Family support services;
 - l) Principles of Psychosocial Rehabilitation (PSR); and
 - m) Resources within the mental health service system.
9. The Provider shall not assign staff to duties requiring direct involvement with clients until staff has received the orientation training listed in section II.10.a)-f) above, except where the duties are performed under direct supervision.
10. The Provider shall ensure that employees do not implement physical intervention techniques unless they have received training in the use of a gradually progressive system of alternatives that involves the least restrictive means of interpersonal and physical interaction while maintaining a high level of dignity and respect. Examples of such training include The Mandt System or NAPPI.
11. The Provider shall ensure that all non-medical staff that has client contact is trained in the identification of adverse reactions to psychoactive medications, first aid, and reporting requirements.

12. Specific training may be waived for any employee who the agency verifies has recently received training through prior employment at another licensed community mental health agency in Maine.
13. The Provider shall ensure that professional staff is required to meet the continuing education requirements necessary to maintain their licenses.
14. The Provider shall accept referrals of all Bates v. DHHS Consent Decree class members for services provided under their contract with the Department except as provided in paragraph 277 of the Bates v. DHHS Consent Decree.
15. The Department has established seven Community Service Network (CSN) areas:
 1. Aroostook County
 2. Hancock, Washington, Penobscot and Piscataquis Counties
 3. Kennebec and Somerset Counties
 4. Knox, Lincoln, Sagadahoc, and Waldo Counties
 5. Androscoggin, Franklin, and Oxford Counties, including northern Cumberland County (Bridgton et. al.)
 6. Cumberland County, excluding northern Cumberland County (Bridgton et. al.)
 7. York County

Except as noted below, the Provider must participate in CSNs in the geographic areas in which the provider offers any of the following services:

- Crisis Services (including Crisis Stabilization Units;
- Peer Services;
- Community Support Services (Community Integration, Intensive Community Integration, Assertive Community Treatment Services, Daily Living Support, Skills Development, and Day Support Services);
- Outpatient Therapy;
- Medication Management;
- Residential Services;
- Vocational Services;
- Community Hospitalization Services (including services in hospitals that do and hospitals that do not provide inpatient psychiatric services).

If the Provider offers limited services or services in more than one CSN area, then, the Provider may request an exemption from requirements to participate in the CSN. The Provider shall make that request to the Agreement Administrator in writing.

CSN participation includes entering into a Memorandum of Understanding (MOU) and appointing a representative to the CSN who will attend monthly CSN meetings and who is authorized to make commitments on behalf of the Provider, participating in activities to assure appropriate governance, and participating in activities to assure that the goals of the CSN are achieved.

Maintenance of Agency Information

The providers will notify the Agreement Administrator within 5 working days of a change to information included on the Provider Summary Page, using a form available from the Agreement Administrator.

Continuity of Care

Providers must, to the extent permitted by consumers, seek appropriate releases of information at intake and with every treatment/service plan update to improve continuity of care. Agencies shall plan with consumers for appropriate releases of information and educate consumers about the benefits of shared information to continuity of care. If the consumer does not permit a release of information to another provider of service, then the record must document this attempt to secure a release.

C. Providers of Community Support Services (defined herein as CI, ICI, ACT)

The Community Support Services Provider must:

- Providers must assign a CSW within 2 days to class members who are hospitalized at the time of application for CSW services, and must meet with the class member within four days of discharge. Providers must assign a CSW within 3 days to class members who are not hospitalized at the time of application. Non-class members must be assigned a CSW within 7 days. Application means the date on which the request for a CSW was made by the consumer or person acting on behalf of the consumer.
- Provide 24/7 access to Community Integration (CI), Intensive Community Integration (ICI), and Assertive Community Treatment (ACT) consumer records (including the ISP, the crisis plan, health care advance directives, medical information as available, and basic demographic and service information that might be needed during a crisis) for better continuity of care during a psychiatric crisis. Additionally, the CSW is responsible for maintaining the name of the prescriber of psychiatric medications and up to date contact information for that prescriber;
- Assign a community support worker to each consumer receiving CI services and assure that a substitute worker is assigned to the consumer when the regular worker is not available (for example, if the regular worker is out sick, is on vacation or has resigned) and that the consumer is informed of the substitute worker's name;
- Ensure that community support workers (CI, ICI, and ACT) develop Individual Support Plans (ISPs) collaboratively and convene ISP meetings as directed by the consumer, and actively coordinate services that are part of the

Individual Service Plans. Documented consent of the consumer shall be necessary for the ISP meeting to be held without the presence of the consumer;

- Ensure that community support workers (IC, ICI, ACT) develop and maintain up-to-date crisis plans and advance directives with each consumer, or document when and why this hasn't occurred. Additionally, it shall be the role of the community support worker to review with the consumer both the ISP and the crisis plan whenever there is a major psychiatric event;
- Ensure that community support workers (CI, ICI, ACT) receive not only annual training on the importance of work to recovery, but also ongoing training to improve engagement skills regarding work and documenting work goals in each ISP;
- Ensure that each consumer's assigned or substitute CI worker, ICI team member, or ACT team member attends (in person or by telephone or videoconference) the consumer's treatment and discharge planning meetings at state and private psychiatric hospitals, as well as at community hospitals with psychiatric units;
- Ensure that there is coordination with the consumer's ISP and the hospital's treatment and discharge plan while the consumer is in the hospital;
- Ensure that the hospital receives a copy of the consumer's ISP as soon as the provider is aware of the admission;
- Ensure that CI Services are available face to face Monday through Friday during normal business hours of no less than 40 hours per week and that availability shall be based on consumer need;
- Employment specialists on ACT teams are to focus on employment functions with the expectation that 90% of the employment specialists' work time will be devoted to vocational/employment support related tasks;
- During regular business hours the first line of responsibility for crisis resolution is the consumer's community support worker;
- Enter into a memorandum of agreement with crisis providers outlining at a minimum the procedures, including relevant telephone and pager numbers, for 24/7 access to consumer records as discussed above.

D. Providers of Crisis Services. The Crisis Services Provider must:

- Ensure 24/7 availability of crisis workers for Emergency Departments within the community service network;
- Facilitate service during a psychiatric emergency and implement the rapid response protocol;
- Collect data on consumers who are denied admission to a psychiatric hospital though a bed is available and on consumers who are denied admission to a crisis stabilization unit though a bed is available. The data must include the reasons for rejection, the date of occurrence, and the disposition of the consumer. This data will be submitted within two working days to the regional mental health team leader in a format designed by OAMHS;
- Provide information to community support providers regarding the provision of crisis services and any psychiatric inpatient or CSU admission to any of their CSS clients within 24 hours of contact;

- Act as the contact for Emergency Departments to retrieve consumer record information from the CSS (Community Integration, Intensive Community Integration, or Assertive Community Treatment) provider;
- Report any concerns about the possible inappropriate use of blue papers to the Regional Mental Health Team Leader or their designee within 24 hours.

E. Providers of PNMI and Specialized Nursing Facility Services. The PNMI and Specialized Nursing Facility Services Provider must:

- Notify residents of all applicable rights of appeal from a discharge decision;
- Clarify that any transfer of a resident to an acute hospital neither constitutes a transfer nor a discharge for purposes of contracts or regulations; and
- Obtain OAMHS approval for discharges and participate in discharge planning.

F. Providers of Individual and Group Counseling Services. The Individual and Group Counseling Services Provider must:

- Insure that they are the first responders for client crisis situations during normal business hours and that after hour coverage is available either through its own staff or through formal agreement with the local crisis service provider.
- Submit a written copy of the agency's current after hour coverage policy, including procedures for accessing on call staff, with or prior to the submission of its first quarterly report.
- Submit a copy of the current signed agreement for crisis services, including any financial remuneration, in the case where the local crisis service is utilized for after hour coverage.