Enhancing Infant Mental Health Services in Early Steps

A manual to assist providers in determining funding sources for appropriate IMH services in Early Steps

Florida State University
Center for Prevention & Early Intervention Policy

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Overview

The first three years of life offer the most opportunity for development, yet the most vulnerability.[1] Vulnerability in the infant and toddler years can come in the form of developmental delays or disability due to a wide array of reasons such as prematurity, low birth weight, congenital disorder, birth defects or environmental factors such as child abuse and neglect. Part C early intervention services are designed to ameliorate the delays that can occur during this sensitive time and focuses on helping infants and toddlers learn the developmental skills that typically occur during the first three years of life. The Part C service model is one that requires service provision in the natural environment and utilizes a relationship-based approach that views parents/caregivers as partners in the early intervention process. The need for Part C services is compelling; the science irrefutable; and the opportunity is at hand to expand infant mental health services and achieve better outcomes for children enrolled in Part C programs.

This paper outlines four key components: The Need, The System, The Funding, and The Opportunities. We are particularly optimistic about the opportunities to enhance infant mental health services within Florida's Part C program, Early Steps.

The Need

Purpose

The purpose of this manual is to assist Part C programs, service providers, and referral sources to better understand the relevance and importance of integrating a focus on social-emotional development and well-being into their day-to-day interactions with families. The objectives of the manual are to help practitioners with the following:

- Define social-emotional development and infant mental health and how it relates to early intervention.
- Understand the federal guidelines that govern early intervention services — Individuals with Disabilities Education Act (IDEA) and Child Abuse Prevention and Treatment Act (CAPTA).
- Understand the unique social-emotional development issues of infants and toddlers in the child welfare system.
- Understand the Florida Part C Early Steps process and service provision parameters.
- Identify the appropriate mechanisms to bill for infant mental health services.

Introduction

For most families, the presence of an infant or toddler in the home presents times of joy and times of challenge. The joys stem from the possibilities that lie ahead, whereas the challenges stem from the inherent responsibility thrust upon parents for ensuring that their child's developmental needs are met. For some families, the developmental trajectory is not as predictable as they had hoped and they will need Part C Early Intervention Services (EIS) to assist them as they strive to lead their child along this developmental path. Early intervention services and supports provide a "protective buffer" for promoting the best possible developmental outcomes and enhancing the capacity of families to meet their child's developmental needs.

The importance of the "earliest years" is well documented. Advances in science, specifically neuroscience, have allowed us to move beyond thinking that early development is exclusively physical or

biological in nature. When assessing for developmental delays, it is important to look for psychological or social-emotional delays as well. This social-emotional or infant mental health component is highly dependent on caregiver-child interactions, cultural influences, and environmental factors that can put a child at risk for developmental issues or delays. Unfortunately, parents and service providers are often unaware of the importance of social-emotional development and key opportunities to intervene are overlooked or missed entirely. Expanding the developmental lens to include an infant mental health approach and the direct services that address social-emotional development can help ensure the best possible outcomes for Florida's children.

Children in Need of Services

Part C evolved from a medical model created to address birth defects and other established disabilities and delays, to an early intervention system that focuses on physical, cognitive, communication, social/emotional and self-help developmental skills. Developmental delays can impact children from upper or middle class families as well as children in families who are living in poverty or suffering unfortunate circumstances such as abuse or neglect. While *developmental delays* are indiscriminate in terms of economic status, research suggests there is a greater disparity of access to and enrollment in *services* based on race, socio-economic status, and involvement in the child welfare system. For example, black children are up to five times less likely to receive services than white children, and young children experiencing homelessness are "greatly" underrepresented in early childhood programs yet they present higher rates of developmental delays, social problems, and learning disabilities than children with a stable home.[2]

While Part C programs have excellent expertise in the areas related to interventions specific to developmental delays, such as physical therapy (PT), speech/language pathology (SLP), occupational therapy (OT) and specialized support/training for caregivers, the local multidisciplinary teams sometimes lack the expertise to adequately deal with environmental or socio-economic issues such as child maltreatment in the form of abuse or neglect, domestic violence, maternal depression, and substance abuse. In the cases in which the developmental delay is directly correlated with one of these issues, the "usual" therapeutic interventions of PT, SLP, or OT need to be provided within an infant mental health, trauma-informed framework to ensure that the underlying social-emotional issues are addressed.

A variety of different, but synonymous terms are used by systems that are invested in the mental health and well-being of young children. Medicaid, hospitals, health plans and physicians often use the term "behavioral health" while the Part C legislation and early childhood programs utilize the term "social-emotional development." Mental health clinicians and early childhood professionals use the term, "infant mental health" as synonymous with healthy social and emotional development.

ZERO TO THREE's widely embraced definition is as follows:

Infant mental health encompasses three distinct but interrelated realms:

1) the capacity of the child from birth to three to experience, regulate, and express emotions;
2) the ability of the child to form close and secure interpersonal relationships; and
3) the opportunity for the child to explore his or her environment and learn from exploration.

In a traditional mental health system, tiers are often referenced in terms of least restrictive to most restrictive interventions. The infant mental health tier system is not designed to work in the same manner. Level 3, the "treatment" tier, is not independent of the other levels. All three levels can be working in unison or independently. Each level has a primary focus and identified participants.

The chart below illustrates the continuum of services that are currently utilized in Florida. Note that at each level the goal is to strengthen the caregiver-child relationship through services and interventions that require different skill sets and educational levels on the part of the provider.

System of Care Continuum for Children Birth to Five

What is the Array of Infant Mental Health Services?	*Level 1* Strengthening the Caregiver/ Child Relationship, Responsive Caregiving	*Level 2* Developmental, Relationship-Focused Early Intervention	*Level 3* Infant Mental Health Treatment
Priority population	Expectant families and families of all children birth to age five	Families of children with delays, disabilities, health problems or multiple risk factors	Families with children or primary caregivers with severe mental health problems, or who have experienced abuse, neglect or violence
Description of services/interventions	Strengthening the caregiver/child bond by: • Helping caregivers to understand and respond appropriately to baby's cues • Incorporating brain development research and attachment theory into all aspects of pregnancy, birthing and child's daily care • Promoting continuity of care • Supporting the child's on-going emotional development within the context and culture of the family • Modeling responsive caregiving • Providing family support and education • Identifying early signs of problems that might impede the parent-child relationship • Referring for further screening/assessment	Strengthening the caregiver/child bond through: • Identifying emotional or attachment concerns • Integrating relationship-based practices into the child's existing services (therapies, medical treatment, foster care) • Providing direct services based on the context, culture, and needs of the child and family • Providing consultation to enhance responsive caregiving • Assisting the family in accessing specific infant mental health treatment if needed	Strengthening the caregiver/child dyad through: • Establishing a nurturing relationship based on trust and respect of family strengths • Providing therapeutic interventions for caregivers and young children with specific mental health needs • Providing ongoing, intensive treatment with parent/child dyad • Serving as a consultant to other service providers who work with infants and families
Professionals responsible for infant mental health services	Front-line caregivers including: • Parents • Child Care Providers • Health Care Providers • Home Visitors • Parent Educators • Social Workers • Child Protection Case Workers • Police Officers, Judges, Lawyers	Developmental Professionals including: • Social Workers (MSW), Psychologists, Mental Health Therapists • Child Development Specialists • Early Interventionists • Therapists (Occupational, Physical and Speech) • Maternal and Child Health Nurses • Developmental Pediatricians working in conjunction with child welfare, legal systems, & family service programs	Licensed mental health professionals having additional training in infant mental health including: • Child, adolescent, and adult psychopathology • Infant/toddler development • Quality of parent/infant interaction • Assessment and treatment within the parenting relationship • An understanding of context, culture and family systems • Dyadic, infant/parent psychotherapy

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Why Is Infant Mental Health Important?

Developmental delays in early childhood in the sensorimotor, language, and cognitive domains are often recognizable and measureable. An array of developmental assessments can be used to document the need and determine eligibility for early intervention services. On the other hand, problems in social-emotional and relationship areas of development in infants and toddlers are less easily recognized and/or measured. Consequently the problems often go undiagnosed or treated, and unfortunately the window of opportunity for prevention or early repair is missed.

Neuroscientific research on early brain development indicates that young children raised in environments where they are exposed to abuse and neglect or deprived of nurturing relationships are at the greatest risk for developmental issues. Research has also shown that early and sustained abuse or neglect can alter the physical architecture of the developing brain preventing the requisite development of neural and synaptic connections[3]. Deficient brain development can impact attachment, self-regulation and control, learning, and cognitive ability. Healthy attachment to a primary caregiver is the cornerstone for all domains of development (physical, cognitive, motor, language, and social-emotional).

The science of brain development has shown that the maximum impact for affecting learning and relationships is achieved during the first three years of life. Leading the way in the "science of early childhood" movement is Jack Shonkoff, MD at the Center on the Developing Child at Harvard University. Through the Center's decades of developmental research, Shonkoff and his colleagues have concluded the following:

1. Neural circuits, which create the foundation for learning, behavior, and health, are most flexible or "plastic" during the first three years of life. Over time, they become increasingly difficult to change.

2. Persistent "toxic" stress, such as extreme poverty, abuse and neglect, or primary caregiver depression, can damage the developing brain leading to lifelong problems in learning, behavior, and physical and mental health.
3. The brain is strengthened by positive early experiences—especially stable relationships with caring and responsive adults, safe and supportive environments, and appropriate nutrition.
4. Early social-emotional development and physical health provide the foundation upon which cognitive and language skills develop.
5. High-quality, early intervention services can change a child's developmental trajectory and improve outcomes for them, their families, and communities.[4]

Intervention is likely to be more effective and less costly when it is provided earlier in life rather than later.[5] These first years represent the foundation for who we are to become and early relational or behavioral problems cannot be overlooked as something that the child will outgrow.

Early Intervention Services

Federal Policies and Early Intervention Services

The Individuals with Disabilities Education Act (IDEA) was originally enacted by Congress in 1975 to ensure that all children with disabilities receive a free appropriate public education to meet their unique needs and prepare them for further education, employment, and independent living. The law has had multiple revisions over the years.

The key federal legislation addressing child abuse and neglect is the Child Abuse Prevention and Treatment Act (CAPTA), originally enacted in 1974, which sets forth a minimum definition of child abuse and neglect. CAPTA provides federal funding to states in support of prevention, assessment, investigation, prosecution, and treatment activities and also provides grants to public agencies and nonprofit organizations for demonstration programs and projects. This Act has also been amended several times and was most recently amended and reauthorized in 2010.

Part C of the Individuals with Disabilities Education Act (IDEA)

The Early Intervention Program for Infants and Toddlers with Disabilities, or Part C of the Individuals with Disabilities Education Act, is a federal grant program established in 1986 to assist states with operating a comprehensive program of services for children ages birth to three with established conditions, developmental delays, or who are "at risk" of developing a delay or special need that may affect their development or impede their education. Congress passed the most recent amendments in December 2004, with final regulations published in August 2006 (Part B for school-aged children) and in September 2011 (Part C, for infants and toddlers). Part C eligibility is determined by each state's definition of developmental delay and includes children with established physical or mental conditions that have a high probability of resulting in developmental delay. Examples of these conditions include: chromosomal abnormalities; genetic or congenital disorders; sensory impairments; inborn errors of metabolism; disorders reflecting disturbance of the development of the nervous system; congenital infections; severe attachment disorders; and disorders secondary to exposure to toxic substances, including fetal alcohol syndrome. States may choose to include children at risk for disabilities in the eligible group. An important part of the evaluation process for infants and toddlers includes informed clinical opinions of professionals experienced with development in the very young. The services component of Part C of the IDEA requires implementation in the natural environment or the community as opposed to a clinical setting.

Under Part C of the IDEA, early intervention programs should be designed to: 1) enhance the development of infants and toddlers with disabilities; 2) reduce educational costs by minimizing the need for special education; 3) minimize the likelihood of institutionalization and maximize independent living; and 4) enhance the capacity of families to meet their child's needs.[6] In order to achieve these intended outcomes, financial assistance is provided to states to accomplish the following:

- Develop and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency program of early intervention services for infants and toddlers with disabilities and their families.
- Facilitate the coordination of payment for early intervention services from federal, state, local, and private sources (including public and private insurance coverage).
- Enhance the states' capacity to provide quality early intervention services and expand and improve existing early intervention services being provided to infants and toddlers with disabilities and their families.
- Enhance the capacity of state and local agencies and service providers to identify, evaluate, and meet the needs of historically underrepresented populations, particularly minority, low-income, inner-city, and rural populations.

States are given flexibility in how they define or determine a developmental delay, which in turn means that there is variation in the determination of what constitutes the level of delay necessary to qualify for Part C services. The amount of delay necessary for services ranges from 20-50% delay in one or more areas (See **Appendix A**, *Summary Table of States' and Territories' Definitions of / Criteria for IDEA Part C Eligibility*). States also have latitude in defining "at-risk" populations and whether or not they will be served.[7]

Child Abuse Prevention and Treatment Act (CAPTA)

The high incidence of unmet needs and the potential benefits of early intervention for children encountering the child welfare system were so compelling that the federal government amended the Child Abuse Prevention and Treatment Act (CAPTA) in 2003 to ensure better access to Part C intervention services. This federal legislation requires that the child welfare system refer all infants and toddlers with substantiated abuse to the Early Intervention system for screening and, if eligible, for services. All Part C programs are now required to accept referrals of infants and toddlers with substantiated reports of maltreatment, who have been affected by illegal substance abuse, or experienced withdrawal symptoms from prenatal drug exposure.

The amendment is designed to address the need for early intervention services among the large number of young children in the child welfare system; however, the language allows for flexibility in interpretation and does not ensure that children will receive the services that they need. CAPTA does not require a universal definition of "substantiated" maltreatment, therefore the application of the legislation varies from state to state. Additionally, the language of the amendment only requires that a referral be made for Part C services. Once the referral is made, the child must still meet eligibility criteria to receive services. Unfortunately, the amendment fails to address the children involved in "unsubstantiated" cases or voluntary protective services cases, despite the compelling national data documenting that children in cases with "unsubstantiated findings" had the highest percentages of delays (65%).[8]

Overview of Florida's Part C Program: Early Steps

In Florida, children birth to three years of age who have an established condition or developmental delay may be eligible for Part C Early Intervention Services (EIS) through the state's Early Steps program. Early Steps is administered by Children's Medical Services (CMS) under the Florida Department of Health. An overview of the Early Steps program's core services, eligibility criteria, funding, and service delivery system are presented in this section.

Core Services

Early Steps is a relationship-based early intervention that fosters trust in parent-professional partnerships and supports healthy, positive parent-child interactions. Relationship-based services are both family-centered and strength-based. The overall goal of the system is to increase opportunities for infants and toddlers with disabilities to be integrated in their families and communities, and to learn, play and interact with children without disabilities. Early Steps is a federal entitlement program and has no financial eligibility requirements. Core services include:

- Comprehensive assessments of the needs of children birth to 36 months and their families.
- Development of the Individualized Family Support Plan (IFSP) that addresses the concerns, priorities, and outcomes for the family and identifies intervention and assistance services.
- Service coordination/case management to ensure that the child and family receive specific services identified on the IFSP.

Florida's Part C Eligibility Criteria

Florida's Part C eligibility requirement specifies that a child under the age of three is eligible for services if he/she has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay or if he/she has an existing developmental delay. Established conditions fall into one of the following areas:

- Genetic and metabolic disorders
- Neurological disorder
- Autism spectrum disorder
- Severe attachment disorder
- Sensory impairment (vision/hearing)
- Infants who weigh less than 1,200 grams at birth[9]

In Florida, a developmental delay must meet or exceed 1.5 Standard Deviations (SD) below the mean in two or more developmental domains, or 2.0 SD below the mean in one or more of these developmental domains:

- Communication
- Self-help/adaptive
- Cognitive
- Physical (includes motor skills)
- Social-emotional

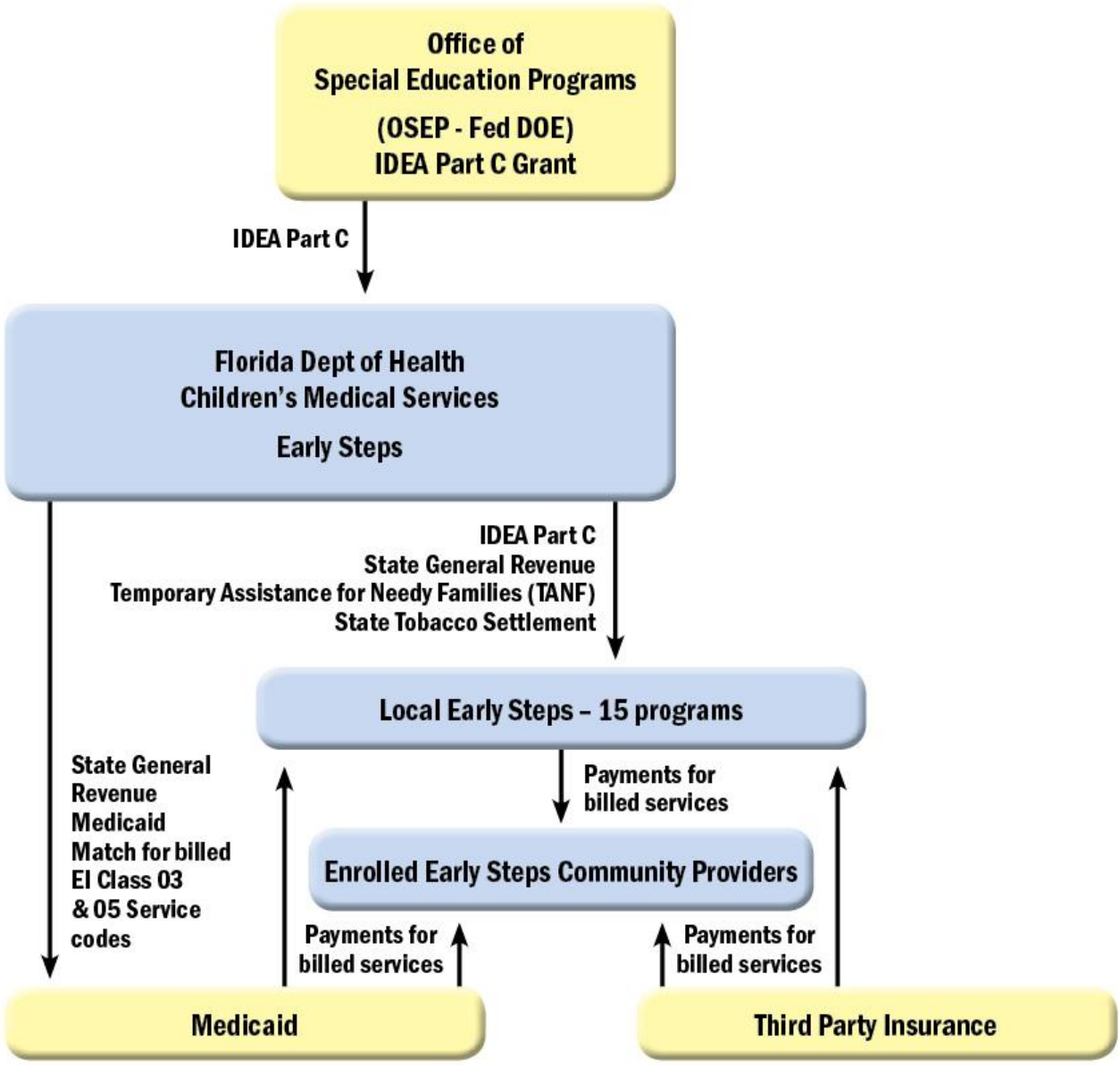
A trans-disciplinary team evaluation is conducted to evaluate overall development and determine eligibility using two or more of the following resources:

- Appropriate standardized instruments
- Observational assessments
- Developmental inventories
- Behavioral checklists
- Adaptive behavior scales
- Informed clinical opinion
- Reports from family members, medical providers, social workers, or educators

Funding of Florida's Early Steps

The Florida Department of Health administers the Early Steps program. The Early Steps program is implemented and monitored by the Children's Medical Services, Early Steps State Office (ESSO). ESSO contracts with a variety of community agencies, hospitals and universities in 15 different regions to provide services through the Local Early Steps (LES) programs. Early Steps receives funding through federal grants, as well as state allocations. Figure 1 illustrates the Early Steps flow of funds starting at the federal level, through the state level, and down to the 15 LES programs.

Figure 1. Early Steps Funding Flow Chart



Note: In 2012 (phased in), Local Early Steps began authorizing payments through a third party administrator, CMS-KIDS.

The Early Steps Service Delivery System

The Early Steps service delivery system supports families and caregivers by increasing their sense of competence and confidence regarding their child's development and learning, and by better defining their parental role in this process. The key components of service provision serve as the foundation for the family-centered Early Steps system:

- Recognize and respect the pivotal role of the family in the lives of children.
- Bring services into the child's life rather than fitting the child into services.
- Maximize each child's everyday natural learning opportunities.
- Enhance each child's development and participation in community life.
- Provide every child and family with a cohesive, consistent team for evaluation, intervention, and ongoing assessment.
- Identify a team member to build a working relationship to serve as the primary service provider to work with the caregiver and child.

In Early Steps, a family-centered approach focuses on helping the family cope with meeting the challenges of caring for infants and toddlers with developmental delays or an established condition. The family-centered approach empowers the family to work and partner with service providers and supports the family as they make decisions about which services will be most beneficial to their family. It encourages providers and families to support their child's need within everyday routines, activities, and places.

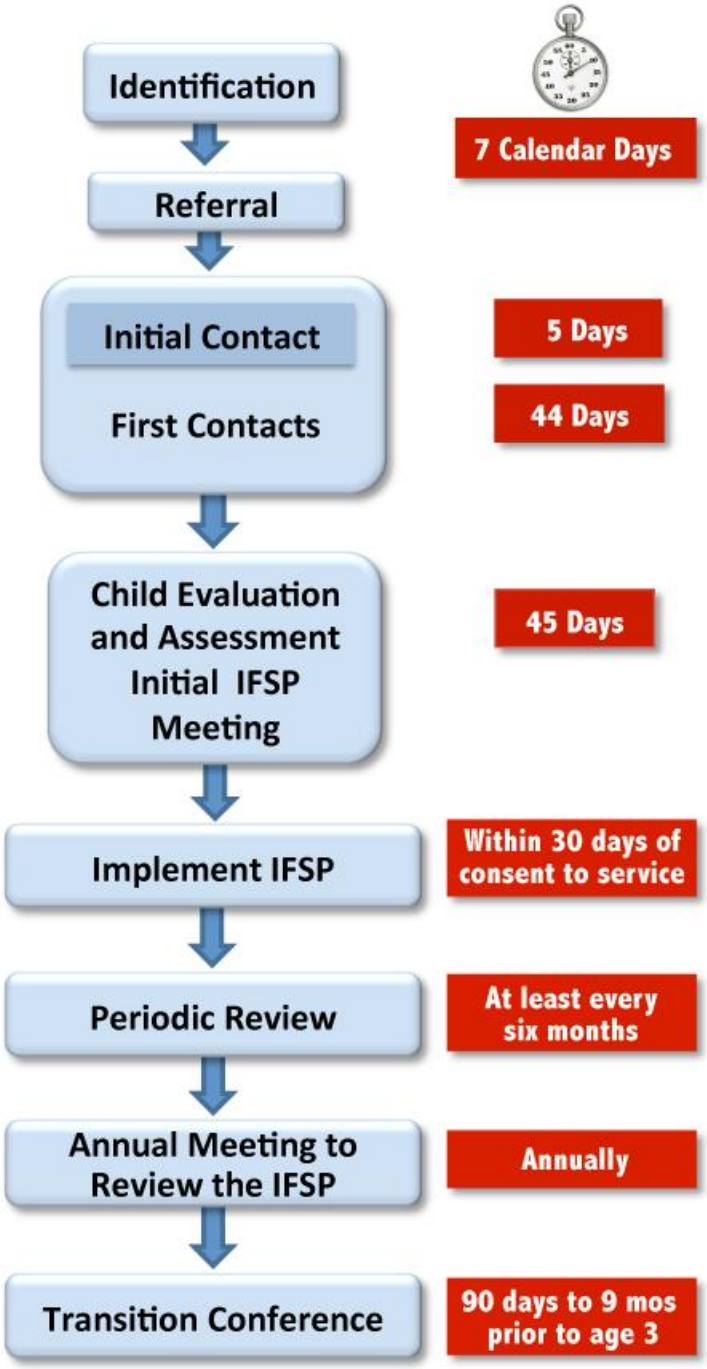
The Early Steps system utilizes a team-based Primary Service Provider (PSP) approach to service delivery. A team-based PSP approach is a family-centered, capacity building method to intervene with young children with established conditions or developmental delays. One member of a trans-disciplinary team is assigned to serve as the PSP, who:

- provides direct services to the child and family members/caregivers.
- shares content expertise and discusses evidence-based practice with other team members through consultation and coaching.
- uses coaching with parents and other primary caregivers to support and strengthen their confidence and competence in promoting child learning and development.

The PSP is the identified professional on the Individualized Family Support Plan (IFSP) team who works with the family/primary caregivers on a regular basis with other members of the IFSP team supporting the PSP's efforts. Supporting team members are those professionals who serve the child and family through consultation with the PSP, joint visits with the PSP, and coaching or direct services sessions with the child and family.

The Local Early Steps service delivery system is depicted in Figure 2.

Figure 2. The Early Steps Service Delivery System



Early Steps accepts **referrals** from parents as well as community agencies or facilities—such as hospitals, (including prenatal and postnatal facilities), physicians, early learning programs, local educational agencies, public health facilities, social service agencies and other health care providers. Referral sources are encouraged to use a screening tool to provide ongoing developmental monitoring to identify concerns that result in a referral to Early Steps. Recommended screening tools noted in the Early Steps policy handbook are: the *Ages and Stages Questionnaire (ASQ)*, the *Birth to Three Screener*, the *Battelle Screening Tool* or the *Early Learning Accomplishment Profile (ELAP) Screener*. However, if a child

appears to have a specific area of developmental concern, there is an option to utilize a screening instrument intended for that specific area. For example, with children suspected of having autism spectrum disorder, the LES program will obtain screening results from the child's medical home or other local community screening initiatives. If there is not a medical home or local screening initiative, the LES program may provide a screening for those children who are identified with communication or social-emotional concerns that may indicate autism spectrum disorder. The *Modified Checklist for Autism in Toddlers* (M-CHAT) or the *Communication and Symbolic Behavior Scales Developmental Profile* (CSBS DP) are the recommended screening instruments.

Starting with the initial contacts, families are provided with information on the purpose of the Early Steps program and what they can expect from Early Steps. Each family is assigned a service coordinator who conducts a family assessment at first contacts, with the family's permission, to include concerns about the child, typical daily routines and activities, the family's support network, concerns, priorities, and resources. This information helps the service coordinator identify appropriate Individualized Family Support Plan (IFSP) team members.

If a child does not have an established condition or obvious delay, an Early Steps developmental screening may occur during the **initial contact/first contact** stage of the system. The screening may occur in any of the following ways:

- Administering a developmental questionnaire or other appropriate parent-report tool either face-to-face or by telephone
- Mailing a developmental questionnaire to families with instructions on how to check their child's development
- A combination of a face-to-face visit using an approved tool, telephone contact, and mailed questionnaire

Based on information gathered during first contacts, an **evaluation and assessment** is planned. The evaluation and assessment focuses on the child's unique strengths and needs and includes the family as an integral part of the process. The area(s) of concern identified at the first contacts or the developmental screening is the focus of the evaluation, which determines the child's eligibility for Early Steps services. The *Developmental Assessment of Young Children (DAYC)* or the *Battelle Developmental Inventory (BDI-2)* are the recommended evaluation instruments; however, other evaluation instruments may be administered in specific discipline areas to further determine a child's eligibility.

The five required developmental domains for evaluation are:

1. Communication, which includes expressive and receptive communication skills (both verbal and non-verbal)
2. Self-help/adaptive, which refers to the ability to function independently within the environment and the competency to perform daily living activities such as sucking, eating, dressing, playing, etc., as appropriate to the child's gestational or chronological age
3. Cognitive, which refers to the acquisition, organization and ability to process and use information
4. Physical, which refers to vision and hearing as well as abilities with tasks requiring large and small muscle coordination, strength, stamina, flexibility and motor development appropriate for the child's developmental age
5. Social-emotional, which refers to interpersonal relationship abilities. This includes interactions and relationships with parents and caregivers, other family members, adults and peers, as well as behavioral characteristics (e.g., passive, active, curious, calm, anxious and irritable.)

The family will be enrolled in an Early Steps program if the evaluation and assessment indicate a developmental delay that meets eligibility criteria or the child has a documented established condition. It is at this point in the system that an **Individualized Family Support Plan (IFSP)** is developed. The IFSP is a written plan of early intervention services designed to meet the identified developmental outcomes for an individual child and family. The IFSP is constructed by a team that typically includes

the family, the service coordinator, evaluators, and service providers. The IFSP Team assists in the implementation of the services and reviews the child's progress toward achievement of identified outcomes. When appropriate, the team can make modifications to the IFSP and will assist in developing appropriate transition plans. Initiating appropriate services and supports to meet the child's needs is dependent upon the family's priorities and concerns. Implementation of the IFSP is intended to help families and caregivers gain the competence and confidence they need to support their child's learning and development and to mitigate the long-term negative impact of developmental delays.

The service coordinator must, at a minimum, have quarterly contact with families and providers to discuss IFSP goals and outcomes. The service coordinator is also required to make contact with the family at the initial IFSP meeting, the periodic review(s), and the annual IFSP review. **Periodic Reviews** of the IFSP are held at least every six months either through a face-to-face meeting or phone contact. A face-to-face **Annual Meeting** to review the IFSP is also required. In addition, a **Transition Plan** is developed to address services or supports that may be needed when a child transitions from the Early Steps system.

Responsibilities of Early Steps State Office (ESSO) Staff

The Early Steps State Office (ESSO) staff is accountable for the administration, oversight, and evaluation of all activities related to the fulfillment of Early Steps responsibilities. There are three major areas of responsibility: 1) Programmatic Activities; 2) Community Input and Information Sharing; and 3) Contract Activities. The following list provides examples of the activities conducted within each of the three major areas:

1. Programmatic Activities

- Designing funding methodology and allocation of funds
- Developing and disseminating policies and procedures
- Ensuring family involvement
- Establishing a system for personnel development and training
- Providing technical assistance and support
- Providing supervision and monitoring of Local Early Steps programs
- Developing public awareness materials and activities
- Maintaining a central directory database which contains a wide range of information on community services, counseling, diagnosis/evaluation, early intervention services, education and training, equipment, medical screening, special education services, and support groups and therapies for children and youth, birth to 21 years
- Providing system evaluation and continuous improvement activities

2. Community Input and Information Sharing

- Funding a position in the Department of Education to provide technical assistance to local education agencies who serve the birth through age two population. This position also facilitates transitions from Part C to Part B Programs.
- Collaborating with staff from the Agency for Health Care Administration to facilitate access to Medicaid funding for targeted case management and early intervention services.
- Working with staff from the Agency and the Department of Education in the quality assurance monitoring process to follow up, provide corrective action, or offer training and technical assistance.
- Requiring Local Early Steps program participation in local interagency councils/groups and School Readiness Coalitions as appropriate, and have interagency agreements with local education agencies, Children's Medical Services Network, the Department of Children and Families and other local community agencies that serve young children.
- Including broad representation of both state and local level stakeholders and constituencies on state level workgroups.

- Developing linkages with the Partnership for School Readiness at the state level and participation of Local Early Steps in School Readiness Coalitions in the designated service area.
- Collaborating with the Department of Children and Families to implement the Child Abuse Prevention and Treatment Act (CAPTA).

3. Contract Activities

The Early Steps system is divided into 15 local service areas across the state. These are referred to as Local Early Steps (LES) programs (see Figure 3). The ESSO contracts with these 15 LES programs. The contracted LESs are responsible for providing and coordinating services to eligible families at the local level. (See **Appendix B**, Early Steps Contact List, for service area contact information.)

Figure 3. Local Early Steps Programs

Responsibilities of Local Early Steps Programs

Each LES program employs service coordinators, family resource specialists (FRS), and other staff to ensure eligible infants and toddlers and their families have access to Part C services. Contracted Local Early Steps providers are responsible for:

- Providing early intervention services
- Ensuring the provision of IDEA – Part C core and required services
- Ensuring implementation of the Early Steps program components
- Implementing the Developmental Evaluation and Intervention (DEI) component of the Children's Medical Services program. (The DEI is a program to identify and track infants at high-risk for developmental disabilities. The program provides services to eligible infants who are admitted to hospital Neonatal Intensive Care Units. Infants must meet both medical and financial eligibility criteria and must be determined to need DEI services).

Each Local Early Steps program is also required to ensure the provision of certain programmatic and coordinative functions. Although a Medical Director is not required, it is a requirement that each LES program has a physician and psychologist available to provide appropriate clinical supervision for medical and psychological services. Additional coordination functions for the Local Early Steps include:

- Accessing Medicaid Funds/Third Party Payers (federal law requires that Part C is the payer of last resort)
- Assisting with enrollment of CMS Network Providers

Early Steps and the Child Abuse Prevention and Treatment Act (CAPTA)

To fulfill requirements of the federal legislation, the Department of Children and Families' (DCF) and Children's Medical Services' (CMS) interagency agreement stipulates that Early Steps will provide early intervention services to eligible children under the age of three who have a substantiated abuse or neglect case and who met criteria for established conditions or have a possible developmental delay. The referrals can originate from DCF, Child Protection Teams (CPT), Sheriffs' Protective Investigators, or community-based care (CBC) lead agencies. DCF has developed referral form *CF FSP5322 CAPTA Referral for Early Steps.* The referral should be completed and submitted within 48 hours of responding to the abuse or neglect call and must include the reason for the referral. If the child remains in the home and has not been referred for additional services by DCF, then the Local Early Steps must accept the referral even without an indication of developmental delay. Children in the child welfare system receiving a Comprehensive Behavioral and Health Assessment with indicators of possible developmental delay are also eligible for Early Steps screening under CAPTA.

The Local Early Steps program will screen or evaluate all children referred by DCF or its contracted agencies in accordance with Early Steps policy. The information or outcome of the child's screening or evaluation and any recommended service on the child's Individualized Family Support Plan (IFSP) will be shared with the CBC lead agency. The agencies agree to communicate, and where possible, coordinate provided services to maximize all available funding sources.

The CBC lead agency will follow up to determine if the child has been found eligible for Part C services and will support the participation of eligible children's families in Early Steps. The support may include: (1) assistance with transportation if necessary; (2) provision of written information about Early Steps; and (3) follow-up with the family and encouragement about the child's participation in Early Steps.

It is also important to note that Early Steps staff and providers are mandatory reporters of all instances of suspected or observed abuse or neglect.

Florida's Medicaid Service Delivery System

The information contained in this document may not be used as a substitute for any or all of the Medicaid Handbooks. Providers should consult the appropriate Medicaid Handbook(s) to ensure that all of the policy requirements are followed.

Medicaid Eligibility

Medicaid is an entitlement program authorized by Title XIX of the Social Security Act and is a partnership between the federal government and the state. Florida coverage for children and families is based on family income, and if a person has Supplemental Security Income (SSI), based upon a disability. Florida's Medicaid presumptive eligibility is generally as follows:

- Pregnant women –185% FPL
- Infants under age 1 – 200% FPL
- Children under 19 – 133% FPL
- Parents and other caretaker relatives and their spouses- income less than or equal to the Medically Needy Income Limit.
- Former foster children to age 26 - there is no income test for this group; however, the individual must have aged out of foster care in Florida.[10]

Covered Medicaid Services

States define the array of covered services in their Medicaid State Plan which is submitted to the Centers for Medicare and Medicaid for approval. Florida's list of mandatory and optional covered services can be found in the *Florida Medicaid Summary of Services Fiscal Year 12/13*.[11] One of the covered services is Community Behavioral Health. Additionally, states are required under the Early Periodic Screening Diagnostic and Treatment (EPSDT) federal law to ensure that children receive necessary medical services. Specifically the EPSDT benefit includes the following:

- Periodic and as-needed comprehensive assessments of physical, mental, and developmental health that begin at birth and last through adolescence;
- Childhood immunizations recommended by the Advisory Committee on Immunization Practice (ACIP);
- Periodic and as-needed vision, hearing, and dental services including preventive, restorative, and emergency dental care; eyeglasses; and hearing aids and other hearing devices; and
- Medically necessary diagnostic and treatment services needed to correct or ameliorate defects and physical and mental illnesses and conditions that fall within Medicaid's definition of "medical assistance," regardless of whether such treatments would be covered under the Medicaid State Plan in the case of beneficiaries ages 21 and older.[12]

Mental health services for Florida Medicaid eligible infants, young children, and their families are described in the *Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.*[13] This Handbook provides a description of the covered services and the appropriate level of practitioner to render the services. Additionally, the Handbook specifies limitations on services and combination of services. Under the EPSDT requirements, Medicaid must consider exceptions to the limits on services for children and adolescents. Also, there is no cost sharing for children's services under Medicaid.

Current Medicaid Service Delivery System in Florida

The *Florida Medicaid Summary of Services Fiscal Year 12/13*, cited above, also provides a description of Florida's Medicaid managed care program as of 2013, which includes the following managed care plan types.

- Children's Medical Services (CMS) Network
- Health Maintenance Organizations (HMOs)
- Medicaid Provider Access System (MediPass)
- Prepaid Dental Health Plans (PDHPs)
- Prepaid Mental Health Plans (PMHPs)
- Provider Service Networks (PSNs)

This section includes a brief overview of the current Florida Medicaid managed care system. Because providers of infant mental health services will be working with different managed care programs, it is important for the provider to understand the Medicaid system both before and after the implementation of the Statewide Medicaid Managed Care (SMMC) program. This understanding will aid in appreciating the types of changes that will result with the implementation of the Florida SMMC program in 2014. Below is a brief discussion of each of the plans listed above. This information is based on the *Florida Medicaid Summary of Services Fiscal Year 12/13*.

Children's Medical Services (CMS) Network and CMS Medipass

Children's Medical Services (CMS) Network and CMS Medipass provides a family centered system of care for Medicaid eligible children with special health care needs. CMS is administered by the Department of Health and the CMS Specialty Network is currently available in Broward and Duval Counties but will be available statewide beginning August 1, 2014. CMS Medipass is available in all other counties. Children with special health care needs are those children 20 years of age or younger whose chronic physical or developmental conditions require extensive preventive and maintenance care beyond that required by typically healthy children. CMS offers a full range of care that includes prevention and early intervention services, primary and specialty care, as well as long-term care for medically complex and fragile children. Most services are provided at or coordinated through CMS offices in local communities throughout the state. When necessary, children are referred to CMS-affiliated medical centers. These centers provide many specialty programs with follow-up care provided at local CMS offices. For more information, please visit www.cms-kids.com.

Health Maintenance Organizations (HMO)

The Florida Medicaid program enters into contracts with health maintenance organizations (HMOs) to provide prepaid Medicaid services to a defined population of enrolled Medicaid recipients. At the time that the *Summary of Services* was published, over one million Medicaid recipients were enrolled in 18 HMOs throughout the state. Many counties have at least two plans from which recipients can choose. However, some counties have no HMOs. HMOs are prepaid a fixed, monthly rate per member in each of the various eligibility categories, by age groups, to provide all the covered services required by each member during the month. This rate is known as a capitation rate. The HMO contracts with local providers to render services through the HMOs provider network.

MediPass

MediPass is a primary care case management program that is available statewide. MediPass primary care providers are responsible for providing or arranging for the recipient's primary care and for referring the recipient for other necessary medical services on a 24-hour basis. Recipients select the primary care provider of their choice from those participating in MediPass. The Medipass primary care provider is responsible for making referrals for services that the recipients need with the exception of certain services. Neither a MediPass prior authorization, nor a referral from the MediPass provider, is required for vision, hearing, family planning, or dental services. Additionally, a MediPass referral is not required for Prescribed Pediatric Extended Care (PPEC) or Medical Foster Care (MFC). These services require prior authorization through other processes. Medicaid providers working through MediPass bill the Medicaid fiscal agent directly for services rendered.

Prepaid Dental Health Plans (PDHPs)

PDHPs are Medicaid managed dental care options available to Medicaid recipients who are 20 years of age or younger and are not enrolled in a health plan that provides dental services.

Prepaid Mental Health Plans (PMHPs)

MediPass does not cover mental health services. The recipients assigned to MediPass for their physical health care services receive their mental health services through the Prepaid Mental Health Plans (PHMP). Recipients in Medicaid reform pilot counties are excluded from the regular PMHP. These areas of Florida include Broward, Duval, Baker, Clay, and Nassau Counties.

The Prepaid Mental Health Plans are comprehensive managed mental health care service plans that are available to a defined population of enrolled Medicaid recipients. Each PMHP must provide the following services:

- Community mental health services (not including substance abuse treatment services)
- Mental health intensive case management services (adults 18 years of age or older)
- Mental health-related inpatient, outpatient, and emergency hospital services
- Mental health targeted case management services

PMHPs are paid on a capitated, prepaid fixed monthly rate per member in each of the various eligibility categories, by age groups, to provide all the covered services required by each member during the month. The PMHPs contract with behavioral health services providers to render the services for the Medicaid recipient.

Child Welfare PMHP

The Child Welfare PMHP is a specialized PMHP to address the needs of Medicaid-eligible children who are receiving child protective services from the Department of Children and Families (DCF). The child must be in the DCF Florida Safe Families Network eligibility file. Children living in Escambia, Santa Rosa, Okaloosa, Walton, Polk, Manatee, Hardee, Highlands, and Broward Counties are excluded.

This PMHP provides all the services listed above under the general PMHP and also offers additional mental health services to address the needs of these children. These additional services include specialized therapeutic foster care and therapeutic group care. The Child Welfare PMHP is paid a capitation rate similar to the other PMHPs.

Provider Service Networks (PSNs)

The Florida Medicaid program enters into contracts with provider service networks (PSNs) to provide Medicaid services to a defined population of enrolled Medicaid recipients. In 2012-13, about 250,000 Medicaid recipients are enrolled in nine PSNs throughout the state. A PSN is established or organized and operated by a health care provider or group of affiliated health care providers that meet the requirements of section 409.912(4)(d), Florida Statutes. PSNs provide a substantial portion of the health care items and services contracted directly through the provider or affiliated group of providers. The health care providers must have a controlling interest in the governing body of the PSN. In addition, to be approved for contract, the PSN applicant must meet all applicable health plan requirements specified in ss. 409.908, 409.912, 409.91211, 409.9122, 409.9124, and 409.913, F.S. and applicable requirements specified in Chapter 641, F.S.

PSNs may be paid fee-for-service or through capitation payments for covered services. Fee-for-service PSNs are paid monthly primary care case management fees, as well as administrative allocation payments per member, based on eligibility categories and age groups. Providers rendering services are paid on a fee-for-service basis. The Agency for Health Care Administration (AHCA) conducts periodic financial reconciliations to determine cost-savings. If cost-savings did not occur, the PSN may be required to refund a portion of the administrative allocation payments received. Capitated PSNs are prepaid a fixed

monthly rate per member in each of the various eligibility categories, by age groups, to provide all the covered services required by each member during the month.

Provider Overview

The current Medicaid service delivery system is changing significantly. In 2011, the Florida Legislature created Part IV of Chapter 409, Florida Statutes directing the Agency for Health Care Administration to create the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has two key components: Long-term care and Managed Medical Assistance (MMA). The MMA procurement process began in the fall of 2013 and implementation is scheduled to be complete by October 2014.

Under the SMMC program, covered services will be provided through participating health plans. These health plans were selected via a competitive process and will provide the services listed in their contracts. The health plans cannot be more restrictive in amount, duration and scope than the respective Handbooks for each of the services. Recipients will have the ability to choose from more than one health plan so they can select the plan that will best suit their needs. The two types of health plans will be HMOs and PSNs.

The majority of Medicaid recipients will receive their services from standard MMA health plans intended for the general Medicaid population and as described previously. There are two other types of health plans that will serve young children under the age of five. Through the competitive process, AHCA selected a specialty health plan to serve children in the child welfare system including children in both in-home and out-of-home care. The Sunshine State Health Plan will provide both behavioral health and physical health care services to children in child welfare in all AHCA regions. CMS Medipass will be phased out and the CMS Network will also become a specialty statewide health plan in October of 2014.

Providers interested in providing services to SMMC Managed Medical Assistance program enrollees will need to enter into contracts or provider agreements with the MMA plans in order to provide services. Interested providers should contact the MMA plans in their areas for contracting opportunities. See **Appendix C** for a list of the provider relations representatives for each plan. The MMA program plans are responsible for the credentialing and re-credentialing of providers in their network. The plans establish criteria for all providers that, at a minimum, meet the Agency's Medicaid participation standards outlined in the Medicaid handbooks. Each provider who wishes to participate in a plan's network must work directly with the plan to meet the plan's credentialing requirements. Providers must complete the credentialing process for each plan individually. The following types of information are frequently requested as part of the credentialing process:

- Curriculum vitae
- Malpractice history
- License
- Professional references
- Personal information including National Provider Identifier

Except where specified in the law, providers and the MMA plans will negotiate mutually agreed-upon rates as part of their contract.

Provider Types

The MMA program includes behavioral health care services. To render these services, a practitioner must contract with the health plans in the region where they wish to provide services. There are two types of Medicaid community providers delineated in the *Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook* that can provide behavioral health care services. The providers include 1) group providers including community mental health and or substance abuse centers; and 2) individual practitioners licensed to provide mental health services linked with a group provider of community behavioral health services. The group providers will contract with the health plans to provide all the services available within their organization—which could include infant and early childhood mental health services. The community mental health centers may employ unlicensed practitioners with a

master's degree in a related field who work under the supervision of a licensed practitioner. The community mental health center will bill the health plans for their services. Individual licensed practitioners may contract with a health plan as an independent practitioner. To provide Medicaid services, infant and early childhood mental health practitioners must either independently contract with a health plan or work for a contracted group care provider such as a community mental health center.

The same situation applies to the Child Welfare Specialty Plan and the CMS Network. Providers must have a provider agreement within the CMS Network to serve their enrollees and must contract or have a provider enrollment agreement with Sunshine State Health Plan to provide Medicaid services for children in child welfare.

Group providers and individual providers must adhere to the specific Medicaid handbooks that govern the service being provided, such as the *Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook* as well as the *Provider General Handbook.*[14] The handbooks outline the policies and procedures needed to provide infant mental health services and receive reimbursement for covered services provided to eligible recipients.

Obtaining a Medicaid Provider Number

Community behavioral health providers are listed as non-institutional providers in the *Florida Medicaid Provider General Handbook*. Under contract as a Medicaid group provider for behavioral health, the group practice must:

- Employ, or have under contract, a psychiatrist or a physician who is linked with the Medicaid group provider.
- Achieve compliance on a community behavioral health services provider pre-enrollment certification review (must be operational to receive the review).
- Have an organizational National Provider Identifier (NPI). To obtain information about the NPI numbers visit https://npiregistry.cms.hhs.gov/NPPESRegistry/
- Have a NPI number for all clinical staff that are going to be registered as treating practitioners.

The agency also must complete and submit all the required forms for a group provider. The application packet is available on the Medicaid fiscal agent's web-site at www.mymedicaid-florida.com. The interested applicant should select *Public Information for Providers* and the *Enrollment* tabs to access the on-line enrollment Wizard.

The *Florida Medicaid Provider General Handbook* defines who can provide services under Florida's Medicaid program. In order to bill Medicaid for community behavioral health care services, the group provider must have treating practitioners enrolled in the Medicaid program that are referred to in the *Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook* as Licensed Practitioner of the Healing Arts (LPHA). These practitioners are required to oversee the completion of the treatment plans and service delivery. A treating practitioner must enroll as a Provider Type 07 and must be linked in the Medicaid system with the behavioral health group practice Provider Type 05.

For mental health services, LPHAs must be:

- Clinical social workers licensed in accordance with Chapter 491, F.S.
- Mental health counselors, licensed in accordance with Chapter 491, F.S.
- Marriage and family therapists licensed in accordance with Chapter 491, F.S.
- Psychologists licensed in accordance with Chapter 490, F.S.
- Clinical Nurse Specialists (CNS) with a subspecialty in child/adolescent psychiatric and mental health or psychiatric and mental health licensed in accordance with Chapter 496, F.S.
- Psychiatric advance registered nurse practitioners licensed in accordance with Chapter 464, F.S.

- Psychiatric physician assistants licensed in accordance with Chapters 458 and 459, F.S.

Additionally the following defined professionals can provide services.

A **master's level practitioner** is an individual with one of the following:

- A master's degree from an accredited university or college with a major in the field of counseling, social work, psychology, nursing, rehabilitation, special education, health education, or a related human services field with one of the following:
    a. Two years of professional experience in providing services to persons with behavioral health disorders
    b. Current supervision under a licensed practitioner of the healing arts
- Master level practitioners hired after July 1, 2014 with degrees other than social work, psychology, marriage and family therapy, or mental health counseling must have completed graduate level coursework in at least four of the following thirteen content areas: human growth and developments; diagnosis and treatment of psychopathology; human sexuality; counseling theories and techniques; group theories and practice; dynamics of marriage and family systems; individual evaluation and assessment; career ad lifestyle assessment, research and program evaluation; personality theories; social and cultural foundational counseling in community settings; and substance abuse disorders.

A **treating practitioner** is a licensed practitioner of the healing arts, psychiatrist or other physician, who authorizes services on behalf of the Medicaid group. The treating practitioner must be independently enrolled in the Medicaid program.

The **bachelor's level infant mental health practitioner** must have completed 20 hours of documented training in the following areas, prior to working with this age population:

- Early childhood development
- Behavior observation
- Developmental screening
- Parent and child intervention and interaction
- Functional assessment
- Developmentally appropriate practice for serving infants
- Young children and their families
- Psychosocial assessment and diagnosis of young children
- Crisis intervention training

Bachelor's level practitioners who have had the above training through conferences, workshops, continuing education credits, or academic training are not required to repeat the training.

Bachelor's level infant mental health practitioners must be supervised by a master's level practitioner with two years of experience with recipients under the age of 6 years or by a licensed practitioner of the healing arts.

Prior to managed care, LPHAs were unable to bill Medicaid unless they were employed in an enrolled Medicaid Community Behavioral Health group practice. Under the managed care program, licensed practitioners are able to become part of the health plans' provider network. The health plans require that the licensed practitioner have a Medicaid provider number. The LPHA can obtain the number through a direct enrollment process with Medicaid as discussed above.

Registering as a Provider with Florida Medicaid

The Medicaid Medical Assistance health plans contract with enrolled Medicaid providers to render services. However, the health plans have the option of registering a provider in the Medicaid system if they are not already enrolled. If the health plan determines that it is necessary to include a practitioner on

their network who is not an enrolled Medicaid provider, they have the option of enrolling that provider with Medicaid and obtaining a Medicaid provider number for the practitioner. A practitioner only needs one provider number. Therefore, if one health plan registers them, then they are an enrolled provider and do not have to be registered again. Health plans may, in general, be hesitant to enroll a provider that does not have a history of providing Medicaid services. However, for services where there is a dearth of qualified providers, such as infant and early childhood mental health therapists, they are more likely to do so. The health plan must submit the *Managed Care Treating Provider Registration* form to Medicaid. When a Medicaid provider enrollment number is obtained through the registration process the practitioner is limited to billing through health plans and is unable to bill Medicaid directly. Given that the majority of persons will be enrolled in a health plan in the future there will be very little Medicaid direct billing.

Billing for Services

To provide services under the MMA program, providers must:

- have a provider agreement or contract with the managed care plan;
- be fully enrolled in Medicaid or registered with Medicaid as a managed care provider at the time services are provided;
- ensure that the recipient is enrolled in a Medicaid MMA program prior to delivering services;
- receive authorization from the managed care plan to provide services; and
- bill the managed care plan directly for MMA covered services provided to enrolled participants.

The plans accept claims from providers in HIPAA compliant formats. For service authorization or contracting opportunities, providers should contact the plan. The MMA plan will respond to inquiries, questions, and concerns from participating providers, including provider billing and payment.[15]

The Centers for Medicare and Medicaid Services require the use the CMS standard claims form, CMS 1500 for billing non-institutional services. The health plans must use this claim form as well. In a managed care system, the providers usually bill the managed care company (health plan) on a fee-for-service basis. Health plans have the option of pre-authorizing services and will specify which services must be pre-authorized. Usually basic outpatient services do not require prior authorization, up to a certain number of service units. Each health plan has a provider manual that provides instructions as to how to bill for services, prior authorization requirements, credentialing requirements, etc. They provide online and individual training for providers.

One problem often encountered by new providers is the denial of claims. If the claim form is not filled out properly, the claim will be denied resulting in delay or loss of payment. Providers should work very closely with the health plans on any denials to correct errors and ensure that subsequent claims are approved. The health plan's provider relations staff will assist providers in improving their submission of "clean claims." Providers that routinely submit claims that are not properly complete risk the chance that they will be dropped from the health plan's network.

Compliance Program

It is recommended that the provider have an established compliance/audit protocol to ensure that services are rendered in accordance with the *Florida Medicaid Behavioral Health Services Coverage and Limitations Handbook*. AHCA and health plans will do retrospective reviews and may recoup inappropriate payments. The best protection for compliance issues is to fully review and follow this Handbook closely and have an internal audit program to periodically review claims and the required documentation/coding. Services must be coded properly with the diagnostic information supporting the type of service provided which is reflected by the procedure code that is in the Handbook.

Florida's IMH Coding Accomplishments

In 2001, Florida was the first state in the nation to develop a "crosswalk" from the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* or the

DC:0-3 (which provides clinical criteria for categorizing mental health and developmental disorders in infants and toddlers) to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) (the coding system Medicaid recognizes). This crosswalk assists clinicians to bill for IMH services. The crosswalk was "blessed" by Dr. Robert Harmon and deemed to be "as clinically sound as possible." Its use was then supported by the Florida's Agency for Health Care Administration and Department of Children and Families (DCF).

Florida's AHCA has led the nation in its efforts to provide permissive language to treat infants, young children, and their families. As early as 2001, the *Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook* was revised to include Section 5, "Services for Children Ages 0-5 Years," and encouraged the use of DC:0-3 for assistance in determining the infant's or child's ICD-9-CM code. The original Section 5 language has been incorporated into the 2014 version of the Handbook. Another important change in the revised Handbook is the addition of "Individual and Family Therapy," which gives the treating therapist a mechanism for providing therapies such as Child-Parent Psychotherapy,[16] with or without the child present.

Reimbursable Behavioral Health Diagnoses for Medicaid

The *Florida Community Behavioral Health Services Coverage and Limitations Handbook* does not specify diagnoses that must be assigned for reimbursement; however, it is highly recommended that the following ICD-9-CM diagnostic ranges are considered:

- 290 through 298.9
- 300 through 301.9, 302.7
- 303 through 312.4
- 312.81 through 314.9
- 315.3, 315.31, 315.5, 315.8, and 315.9

Additionally, Medicaid requires that services are deemed as "medically necessary" which is defined as follows:

> *The medical or allied care, goods, or services furnished or ordered must:*
>
> *(a) Meet the following conditions:*
>
> 1. *Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;*
> 2. *Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;*
> 3. *Be consistent with generally accepted professional medical standards as determined by the Medicaid program and not experimental or investigational;*
> 4. *Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and*
> 5. *Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.*

Medicaid does not pay for community behavioral health services for treatment of autism, pervasive developmental delay, non-emotional or non-behavioral based developmental disability, or mental retardation.

Medicaid encourages use of the *DC:0-3* for assistance in determining the infant or child's ICD-9-CM diagnosis (or most recent version); however, it is recommended that clinicians utilize the 2005 revised version of the manual, *DC:0-3R.* Most mental health clinicians, regardless of their specialization, are trained to diagnose utilizing the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5*) and are familiar with its codes and descriptors. Clinicians who have not been trained in infant mental health and the use of the DC:0-3R or who have not previously billed for services, may not be familiar with the need to "crosswalk" diagnoses from DC:0-3R to ICD-9 CM codes. AHCA endorses and

supports use of Florida's Crosswalk from DC:0-3R to ICD-9-CM codes for purposes of determining the appropriate ICD-9-CM code for billing. (See **Appendix D**, *Florida's Revised Crosswalk for DC:0-3R.*)

The *Florida Medicaid Community Behavioral Health Coverage and Limitations Handbook* provides descriptions and instructions on how and when to complete forms, letters or other documentation. Any clinician providing treatment services and billing Medicaid should be well versed in the Handbook, refer to it often, and seek clarification from their area AHCA office if they are uncertain of the requirements. The Handbook also outlines the procedure codes and their components applicable to infant mental health therapeutic service delivery.

As stated above, providers must be very cognizant of compliance issues. Handbook requirements are very stringent in nature and must be met in order to receive payment for services. Clinicians who are credentialed to provide services under Medicaid are subject to periodic audits to ensure that the documentation requirements are adhered to. This level of oversight, coupled with the rigid structure, is often a disincentive for clinicians to either join or stay in the Medicaid network of providers; however, once the system is understood, it is not as cumbersome as it appears.

Most Common Procedure Codes

There are several "procedures" typically billed during the course of infant mental health treatment. Each of these codes can be found in the *Florida Medicaid Behavioral Health Coverage and Limitations Handbook.*

Description of Service	Procedure Code	Modifier 1	Limits
In-Depth Assessment, New Patient, Mental Health (also telemedicine)	H0031	HO	One event per fiscal state year*
In-Depth Assessment, Established Patient, Mental Health (also telemedicine)	H0031	TS	One event per state fiscal year*
Limited Functional Assessment, Mental Health (also telemedicine)	H0031		Three events per state fiscal year*
Treatment Plan Development, New and Established Patient, Mental Health	H0032		One event per provider type per state fiscal year
Mental Health Treatment Review	H0032	TS	One at least every six months
Brief Behavioral Health Status Exam (also telemedicine)	H2010	HO	10 15-minute units per state fiscal year*
Individual/Family Therapy	H2019	HR	26 hours per calendar year (more can be requested but has to be done in advance)
In-Depth Assessment, New Patient, Mental Health - telemedicine	H0031	HO	One event per state fiscal year*
Individual/Family Therapy (also telemedicine)	H2019	HR	26 hours per calendar year, per recipient per state fiscal year. There is a maximum daily limit of four quarter-hour units (1 hour)

**** Not reimbursable on the same day that a psychiatric evaluation, bio-psychosocial assessment, or in-depth assessment has been completed by a qualified treating practitioner.***

H0031-HO In-Depth Assessment, New Patient or **H0031-TS In-Depth Assessment, Existing Patient.**
For children ages 0-5 years, the assessment must include the following components:

- Presenting symptoms and behaviors
- Developmental and medical history— history of pregnancy and delivery, past and current medical conditions and developmental milestones
- Family psychosocial and medical history (may be as reported or based upon collateral information)
- Family functioning, cultural and communication patterns
- Current environmental conditions and stressors

- Clinical interview with the primary caretaker and observation of the caregiver-infant (child) relationship and interactive patterns
- Provider's observation and assessment of the child including affective, language, cognitive, motor, sensory, self-care and social functioning

Additionally, the assessment must include an integrated summary that is developed after the assessment has been completed. The summary identifies and prioritizes the infant or child's needs, establishes a diagnosis, provides an evaluation of the efficacy of past interventions, and helps to determine the care and services to be provided.

H0031: Limited Functional Assessment. This assessment is restricted to the administration of the Functional Assessment Rating Scale (FARS), the Children's Functional Assessment Rating Scale (C-FARS), the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC-2R), or any other functional assessment required by the Department of Children and Families (DCF). Medicaid reimburses a maximum of three (3) limited functional assessments, per recipient, per state fiscal year (July 1-June 30). Although not specified in the Handbook, DCF currently allows the use of the *Child and Adolescent Needs and Strengths 0-3* (CANS-0 to 3).[17] See **Appendix E** for the form. The CANS-0 to 3 is a tool developed to assist in the management and planning of services to children from birth until three years old to achieve permanency, inclusion, and healthy development. It incorporates commonly used clinical and diagnostic markers from the fields of psychology, pediatrics, and obstetrics. The CANS-0 to 3 is designed to be used either as a *prospective information integration* tool for decision support during the process of planning services or as a *retrospective decision support* tool based on the review of existing information for use in the design of high quality systems of services. As a *prospective* information integration tool, the CANS-0 to 3 provides a structured profile of children along a set of dimensions relevant to case service decision-making. The CANS-0 to 3 provides information regarding the service needs of the child and their family for use during the development of the individual plan of care. As a *retrospective* decision support tool, the CANS-0 to 3 provides an assessment of the children currently in care and the functioning of the current system in relation to the needs and strengths of the child and family. It clearly points out "service gaps" in the current services system. This information can then be used to design and develop the community-based, family-focused system of care appropriate for the target population and the community. The CANS-0 to 3 manual is Retrieved from http://www.dcf.state.fl.us/programs/samh/mentalhealth/docs/cans1.pdf.

H0032: Treatment Plan Development, New and Established Patient. The individualized treatment plan is a structured, goal-oriented schedule of services developed jointly by the recipient and the treatment team. A Brief Behavioral Health Status Examination, Psychiatric Evaluation or other assessment conducted by a licensed practitioner of the healing arts must be completed prior to the development of the treatment plan. An assessment by a licensed practitioner of the healing arts completed within the past six months may be used to satisfy this requirement.

The plan must contain written treatment-related goals and measurable objectives. The treatment plan must contain the following elements:

- The recipient's diagnosis code(s) consistent with assessments
- Goals that are individualized, strength-based, and appropriate to the recipient's diagnosis, age, culture, strengths, abilities, preferences, and needs, as expressed by the recipient
- Measurable objectives with target completion dates that are identified for each goal
- A list of the services to be provided (treatment plan development, treatment plan review, and evaluation or assessment services provided to establish a diagnosis and to gather information for the development of the treatment plan need not be listed)
- The amount, frequency and duration of each service for the six month duration of the treatment plan (e.g., 4 units of therapeutic behavioral onsite services 2 days per week for 6 months). It is not permissible to use the terms "as needed," "p.r.n.," or to state that the recipient will receive a service "x to y times per week"

- Dated signature of the recipient's parent, guardian, or legal custodian (if the recipient is under the age of 18)
- Signatures of the treatment team members who participated in development of the plan
- A signed statement by the treating practitioner that services are medically necessary and appropriate to the recipient's diagnosis and needs;
- Discharge criteria; and
- Medicaid reimburses one treatment plan development per provider, per state fiscal year (July 1 through June 30). Medicaid reimburses a maximum total of two per fiscal year.

H0032-TS: Treatment Plan Review. The treatment plan review is a process conducted to ensure that treatment goals, objectives, and services continue to be appropriate to the recipient's needs and to assess the recipient's progress and continued need for services. The treatment plan review requires the participation of the recipient and the treatment team identified in the recipient's individualized treatment plan.

A formal review of the treatment plan must be conducted at least every six months. The treatment plan may be reviewed more often than once every six months when significant changes occur.

H2010 HO: Brief Behavioral Health Status Exam. A brief behavioral health status exam is a brief clinical, psychiatric, diagnostic, or evaluative interview to assess behavioral stability or treatment status. A licensed practitioner of the healing arts, physician, psychiatrist, or a master's level certified addictions professional must provide the brief behavioral health status exam. A brief behavioral assessment is not reimbursable on the same day that a psychiatric evaluation, bio-psychosocial assessment, or in-depth assessment has been completed by a qualified treating practitioner. Medicaid reimburses for brief behavioral health status exams a maximum of 10 quarter-hour units annually, per recipient, per state fiscal year (July 1 through June 30). Documentation for the brief behavioral health status exam must include the purpose of the exam, mental status of the recipient, summary of the findings, diagnostic formulation, and treatment recommendations or plan.

Clinicians who are not trained in infant mental health are most likely familiar with the Mental Status Exam (MSE) as the structured assessment for behavioral and cognitive functioning. The Infant and Toddler Mental Status Exam (ITMSE) is the infant mental health counterpart to this assessment. Although it is not an AHCA requirement, the ITMSE should be utilized when performing a brief behavioral status exam on infants and toddlers in order to compile a more thorough understanding of the child's development.

The ITMSE assesses the following clinical and developmental domains:

- Appearance
- Reaction to situation
- Adaptation
- Exploration and reaction to transitions
- Self regulation
- Sensory regulation
- Unusual behaviors
- Activity level
- Attention span
- Frustration tolerance
- Expression of aggression
- Muscle tone and strength
- Gross and fine motor coordination

H2019 HR: Individual or Family Therapy. Individual and family therapy services include the provision of insight-oriented, cognitive behavioral, or supportive therapy to an individual or family. Individual and family therapy may involve the recipient, the recipient's family (without the recipient present), or a combination of therapy with the recipient and the recipient's family. The focus or primary beneficiary of individual and family therapy services must always be the recipient. Individual and family therapy services must be provided by one of the following qualified practitioners:

- Physician
- Psychiatrist

- Psychiatric Physician's Assistant (PPA)
- Psychiatric ARNP
- Licensed Practitioner of the Health Arts (LPHA)
- Master's level Certified Addictions Professional (CAP)
- Master's level practitioner

Medicaid reimburses a maximum of 104 quarter-hour units of individual and family therapy services, per recipient, per state fiscal year (July 1 through June 30). Additionally, there is a maximum daily limit of 4 quarter-hour units.

Telemedicine. The Florida AHCA recently updated the *Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.* Telemedicine has been added as a billable service for selected codes. Telemedicine is defined as the practice of health care delivery using telecommunication equipment by the treating provider (at the spoke site) for the provision of approved covered services by the consulting provider (at the hub site) for the purpose of evaluation, diagnosis, or treatment. Services must be delivered from a facility that is enrolled in Medicaid as a community behavioral health services provider for Medicaid to reimburse for services delivered through telemedicine. Billable telemedicine services are listed in the Procedure Codes and Fee Schedule of the Handbook and have an additional modifier of GT. Telemedicine can be utilized for:

- In-depth assessment (H0031 HO GT);
- Limited functional assessment (H0031 GT);
- Brief behavioral health status exam (H2010 HO GT); and
- Individual and family therapy (H2019 HR GT).

These services were described in the previous section. Medicaid does not allow for the use of telemedicine for treatment plan development and reviews. The following interactions do not constitute reimbursable telemedicine services:

- Telephone conversations
- Video cell phone interactions
- E-mail messages
- Facsimile transmission
- "Store and forward" visits and consultations, which are transmitted after the recipient or psychiatrist is no longer available

Providers utilizing telemedicine must implement technical written policies and procedures for telemedicine systems that comply with the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations as well as applicable state and federal laws that pertain to patient privacy. Policies and procedures must also address the technical safeguards required by Title 45, Code of Federal Regulations, section 164.312, where applicable.

Reimbursable Early Intervention Services

The *Early Intervention Services Coverage and Limitations Handbook*[18] provides the guidelines for Medicaid services that fall under the umbrella of early intervention. The Handbook specifies that Medicaid eligible children receiving early intervention services must have verified developmental delay(s), or have established condition(s) that have a high probability of resulting in developmental delay(s), and that the services must be medically necessary. Reimbursable early intervention services are designed for early identification of developmental issues and to optimize the child's functioning capacity and capabilities. Medicaid early intervention services are designed to complement and enhance, not duplicate or replace other Medicaid services.

In addition to the general provider requirements and responsibilities that are contained in Chapter 2 of the *Florida Medicaid Provider General Handbook*, early intervention service providers are also responsible for complying with the provisions contained in *Early Intervention Services Coverage and Limitations*

Handbook. A Medicaid-enrolled early intervention services provider must enroll as a Medicaid Early Intervention Services (EIS) provider per Early Steps policy. Additionally, providers must, at a minimum:

- Participate in the development of the Individualized Family Support Plan (IFSP) based on the concerns of the family and needs of the child.
- Provide early intervention services as authorized in the child's IFSP and in the Early Intervention Plan of Care (POC).
- Review the IFSP and current Early Intervention Services POC as needed, but at least every six months.
- Report any changes to the child's service needs to the Local Early Steps Service Coordinator within five calendar days of the needed change.
- Maintain records that document the services provided, and accurately reflect client progress and effectiveness or the lack of progress and their ineffectiveness, and take actions to notify an Early Steps Service Coordinator and a parent, guardian or caretaker of progress or lack of progress.
- Bill and receive Medicaid reimbursement as payment-in-full.

Infant mental health falls under the auspices of both behavioral health and early intervention; however, the requirements to participate as a provider are not the same. Part C requires that services must be provided in natural environments or community settings, whereas behavioral health does not have any setting requirement for outpatient therapy; it can be provided in the natural environment, community setting or in the office. Second, under early intervention, the IFSP is the driving force and is necessary for treatment; however, it is not universally recognized as the basis for the "medical necessity" requirement under behavioral health.

The advantage of being enrolled as an Early Steps provider is that services that are not billable under Medicaid Behavioral Health procedural codes can be billed under Medicaid Early Intervention Services (EIS) codes. The Medicaid EIS codes were developed uniquely for Early Steps and cannot be used for children not currently enrolled in Early Steps, except for the initial evaluation. These EIS codes cannot be used for Applied Behavior Analysis (ABA) services. EIS procedural codes that apply to infant mental health service provision are as follows:

T1024 TL: Initial interdisciplinary psychosocial and developmental evaluation rendered by a licensed early intervention professional (maximum one per lifetime, per child; maximum of two hours)

T1024 TLTS: Follow-up psychosocial and developmental evaluation rendered by a licensed early intervention professional (maximum three per calendar year, per child; maximum of two hours)

T1027 SC: Early intervention individual session provided by an early intervention professional (maximum of one hour per day)

In addition to therapeutic services, the following are billable codes for consultation services.

T2024TL: IFSP Consultation, Professional Face-to-Face

99368: Face-to-Face Team Consultation

99368TL: Consultation, Phone

*Note: Because Early Steps is the payer of last resort, providers must first bill all other possible billing sources for infant mental health therapeutic services. The Health Insurance Claim Form 1550, also known as the CMS 1500 Claim Form, is required for Medicaid reimbursement of IMH therapeutic services (***Appendix F***). Additionally, if travel reimbursement is going to be billed under Early Steps, the Natural Environment Travel Log must be submitted (***Appendix G***). Each of these forms has requirements regarding completion and timeframes for submission.*

Accessing SAMH 100800 Funds

Substance Abuse and Mental Health (SAMH) 100800 funds are allocated to provide non-Medicaid reimbursable wraparound services to children with mental health or behavioral health needs who are victims of abuse or neglect and are in the physical custody of the Department of Children and Families, or are at high risk for out-of-home placement.

To be eligible to use these funds, **ALL** of the following criteria must be met:

- The child must be between the ages of 0-18 years old.
- There must be an open dependency case, or the child is receiving services through a community-based care program (CBC).
- The child is in out-of-home care or is at risk of placement in out-of-home care.
- The child has, or has had within the last year, a diagnosable Serious Emotional Disturbance (SED) sufficient to meet diagnostic criteria specified in the DC:0-3R, DSM-5 V, or ICD-10 Z equivalent (or the most recent editions). The following DSM-5 V codes and ICD-10 Z codes are excluded:
  - Problems Related to Access to Medical and Other Health Care: V63.9 (Z75.3), V63.8 (Z75.4);
  - Non-adherence to Medical Treatment: V15.81 (Z91.19), 278.00 (E66.9), V65.2 (Z76.5), V40.31 (Z91.83), V62.89 (R41.83);
- The child has a functional impairment which interferes with, or limits, their role or functioning in family, school, or community, or would have met the functional impairment criteria during the referenced year had they not had been provided services or supports.

The SAMH 100800 exclusion criteria include any child that meets any of the following:

- Has active Medicaid and the service is Medicaid reimbursable. If the child is Medicaid eligible but is not enrolled in a plan, the CBC must pursue Medicaid enrollment
- Is classified "at-risk" of emotional disturbance
- Does not have DSM-IV-R Axis I or II diagnoses, and only has V Codes (codes which are used to identify circumstances other than a disease or injury and report problems or factors that may influence present or future care)
- Has a primary substance use or developmental disorder, unless they co-occur with another primary diagnosable emotional disturbance
- Is 18 years old or over

Allowable expenditures are supports and services that are identified in the child's mental health treatment or service plan or case plan, but which are not Medicaid reimbursable. These services are typically non-traditional and are required to meet the treatment needs specified as part of the child's treatment goals. The categories of allowable SAMH 100800 expenditures include but are not limited to the following:

- Outings
- Recreational clubs
- Clothing
- Educational materials
- Use of innovative approaches for the child, including, but not limited to:
  - Multi-systemic therapy services
  - Integrated services for co-occurring disorders
  - Wrap-around services
  - Early childhood consultation (specific to identified child) in a child care center or school

The following categories are never reimbursable:

- Individual services for the identified child's parents, caregivers, family members, other person's residing in the child's home (e.g., parenting classes, adult mental health or substance abuse counseling)
- Medicaid or other third-party reimbursable services for the identified child

- Purchasing or improving land
- The purchase, construction or permanent improvement of a building or home
- Inpatient services (crisis units and psychiatric residential treatment facilities)
- Purchasing major medical equipment
- Using as match funding for other federal funds
- Grant award to a for-profit private entity (contracted services are acceptable)
- Making cash payments for health services

The documentation of services must be specified in the mental health treatment plan and case plan for the identified child. The community-based care agency has oversight responsibility and must monitor the use of funds through documentation review. At a minimum, documentation must include:

- The child's mental, behavioral or emotional diagnosis including:
  - The date of the evaluation
  - The evaluator's name and credentials
  - A brief description of the child's functional impairment in family, school, or community activities, or a list of treatments or other supports provided to prevent functional impairment
  - A brief statement indicating that the child is a victim of abuse or neglect, is in the physical care and custody of the state, or is at high risk for out-of-home placement
  - Documentation and verification that the service and supports are not Medicaid reimbursable
  - The child's mental health treatment plan and case plan must include the services and supports purchased with the Therapeutic Services for Children (100800) funding
  - Documentation that the funds were used for direct community-based services and supports addressing the child's mental health treatment needs

The documentation must be made available upon request for any monitoring or quality assurance activities of DCF. The documentation must show that each child served using these funds during a given fiscal year meets the SAMH requirements. Accessing SAMH 100800 funds requires that a provider is either providing a service as an employee of a contracted agency, has a contract with the CBC to provide services, or is subcontracted to provide services. The process to become eligible to provide services and supports through SAMH 100800 can be a competitive process with Requests for Proposals (RFP) or Requests for Applications (RFA). Providers can contact their local SAMH office or their CBC contract manager for information on how to access these funds.[19]

This paper addresses only Medicaid, CMS, and SAMH 100800 funding for IMH services.

How to Become Eligible to Provide Medicaid Early Intervention Services (EIS) for Early Steps

Accessing funding for early intervention services is only half of the equation for enhancing infant mental health services in Part C. The other half of the equation is that there must be qualified clinicians to provide the service. As the previous section illustrates, the magnitude and multitude of bureaucratic processes and requirements to become a Medicaid provider can be overwhelming and act as a disincentive.

There are many conditions that a provider must follow in order to be able to provide infant mental health services and receive payment. In addition to negotiating a contract with the local health plans as described earlier:

- A clinician must enroll as a provider in both Medicaid and the Children's Medical Services (CMS) network.
- Providers must abide by the Part C requirement that family-centered services are conducted in the natural environment and focused on helping the parents develop the skills necessary to meet the needs of their children. Therapists must be willing to provide services in the home.

To enroll as a Medicaid provider, go to the Medicaid fiscal agent's website at http://mymedicaid-florida.com/, select the *Public Information for Providers* then *Enrollment* tabs. Fingerprint cards must be obtained from the fiscal agent or the area Medicaid office. Applicants must submit the following forms and documentation for enrollment.

- Florida Medicaid Provider Enrollment Application, AHCA Form 2200-0003;
- Non-Institutional Medicaid Provider Agreement;
- Fingerprint Card or appropriate fingerprinting exemption (See Criminal History Check in this chapter for the specific fingerprinting exemption procedures);
- Electronic Data Interchange Agreement (included in AHCA Form 2200-0003);
- Medicaid Provider Surety Bond form (included in AHCA Form 2200-0003), if applicable;
- Physician Group Certification of Ownership Form (included in AHCA Form 2200-0003), if applicable; and
- Any other information that is requested in the enrollment package such as copies of required licenses, certifications, and other required documentation.

To enroll in CMS, go to their website https://www.cmskidsproviders.com/eis/. Use the checklists in **Appendix H** to ensure all the steps have been completed. In addition to these checklists, the following information is needed prior to enrolling at the CMS website.

- Medicaid number if applicable
- Copy of current license
- Copy of current professional liability policy

To become eligible to provide services for Early Steps:

Early intervention services providers must meet the general Medicaid provider enrollment requirements that are contained in Chapter 2 of the *Florida Medicaid Provider General Handbook*. To become a Medicaid early intervention services provider, an agency or individual must submit a completed Medicaid enrollment application package to the Department of Health, CMS Early Steps state office. The CMS Early Steps provider enrollment specialist will review the application package and, when complete, will forward it to the Medicaid fiscal agent for processing.

Early Steps contracts with therapists to provide necessary developmental services and requires that therapists direct bill if the child is covered by Medicaid, or become an approved provider for the child's health plan. It is the provider's responsibility to obtain payment for the services from the managed care plan if the child is enrolled in one.

To become eligible to provide behavioral health services to children in Early Steps who are Medicaid eligible but not under CMS:

Once enrolled as a Medicaid provider, the clinician must contract with the local managed care plans as described earlier. The enrollment process can take approximately six weeks. Although not required, having a contract with all local plans in the area is recommended for two reasons: 1) there is a 90-day window that allows for changing Medicaid plans; if a parent opts to change the child's plan, there will be a continuity of care plan in place; and 2) it allows for a more expansive client base.

The Opportunities

Opportunities exist to enhance infant mental health services within Florida's Part C program, Early Steps, including the following two which are each discussed in more detail below:

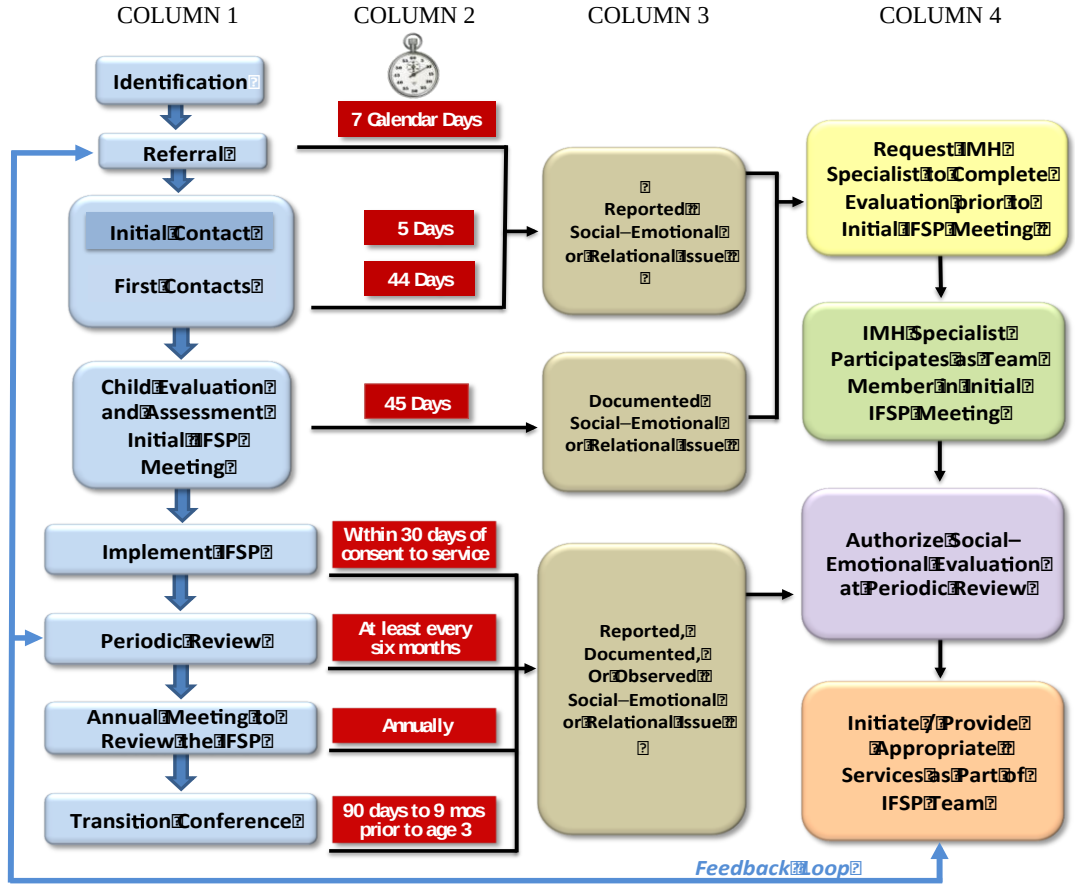
1. Capitalizing on The Multiple Opportunities in the Current Early Steps System for Making a Referral or Request for an Infant Mental Health Assessment and Services
2. Utilizing Social-Emotional Screening and Assessment

Opportunity #1: Capitalizing on the Multiple Opportunities in the Current Early Steps System for Making a Request for Infant Mental Health Assessment and Services

There are multiple opportunities for initiating infant mental health assessments and services in the Early Steps delivery model regardless of the eligibility status of the child. Identification of social-emotional and relationship issues requires an ongoing assessment process to ensure that the needs of the child and parents are met.

Infant and toddler development is dynamic; it changes over time. Assessment is static, a snapshot in time. It is important that Early Steps service providers recognize that infant mental health assessments and services can be initiated at any time in the process. Requesting an infant mental health assessment does not have to be dependent on the Early Steps eligibility determination. A request for an infant mental health assessment can be made at the time of referral or at initial/first contact by Early Steps if the parent/caregiver reports social-emotional issues. An infant mental health therapist can bill the assessment under Medicaid behavioral health code H0031 HO. During the Early Steps evaluation and assessment process, a request for an infant mental health assessment can be made if social-emotional issues are identified. Hopefully, by the time the IFSP has been developed and implemented, the child's social-emotional issues may have been identified but they may not have been. The key point for providers to recognize is that social-emotional issues need not be set aside because the child does not meet the behavioral health diagnostic criteria or Early Steps eligibility criteria at a single point in time during the process.

Figure 4. Enhanced Early Steps Service Delivery System



The model illustrated in Figure 4 depicts an "enhanced model" for integrating infant mental health services into the Early Steps process. This enhanced model service delivery system representation capitalizes on all of the opportunities for making a request for infant mental health assessment and services. Columns 1 and 2 reflect the current Early Steps delivery model offered in Figure 2. In column 3, notice the three opportunities for requesting an infant mental health assessment that fall under the auspices of reported, documented, and observed social-emotional or relational issues. Service providers should be cognizant of addressing the following examples of questions that can guide determination of the need for requesting an assessment:

1. Does the child have difficulty with self-regulation/self-soothing?
2. Does the child have difficulty with compliance?
3. Does the child have difficulty with communication?
4. Does the child have difficulty with interaction with others?
5. Have the parents expressed concerns about their child's behavior?
6. Has the child experienced a traumatic event?
7. Is the child currently in child welfare system and placed out of the home?
8. Does the child have a history of developmental delays?
9. Do the parents have a history of mental illness?
10. Do the parents have a history of substance abuse?
11. Do the parents have a history of domestic violence?
12. Have problematic behaviors been observed?

In Column 4, the Early Steps process is delineated from assessment to initiation of services. Since Part C is the payer of last resort, primary payment sources will be accessed for reimbursement for services by providers before billing Part C. The strengths of the "enhanced model" are: 1) it allows for early identification of and services for social-emotional issues prior to determining Early Steps eligibility; 2) it "frees up" Early Steps funding that was previously utilized for social-emotional services and consultation; and 3) the model provides additional information sources to inform and guide service delivery.

Opportunity #2: Utilizing Social-Emotional Screening and Assessment

The quality of social-emotional screening and assessment is further improved with the use of evidence-based tools that are designed to specifically assess social-emotional development. These tools can be used as free-standing tools or in conjunction with other developmental assessments.

Currently, the Early Steps program recommends the use of the *Ages and Stage Questionnaire* (ASQ) for screening for developmental delays. Medicaid does not reimburse screenings using ASQ or if an assessment is performed by an Early Steps Service Coordinator. Although Early Steps does not specify that the newest version, ASQ-3, is to be utilized, it is recommended that this new version is used across the state because of its expanded capability. The ASQ-3 includes a 2-month questionnaire, as well as open-ended questions about behavior and language development. The ASQ-3 screens the developmental areas of communication, fine motor, gross motor, problem solving, and personal social. The areas of "problem solving" and "personal social" are most often used to "screen in" or "screen out" the need for referring to Early Steps under the social-emotional domain; however, the series of six questions are not adequate to appropriately screen for social-emotional issues, especially when there are available screens specific to the social-emotional domain.

The *Ages and Stages Questionnaire-Social Emotional* (ASQ-SE) is intended for use in conjunction with other developmental screens, such as the ASQ, that assess physical, motor, language and cognitive development. Currently, Early Steps does not require the use of the ASQ-SE as a standard of practice. The ASQ-SE assesses social-emotional competence in infants and toddlers. The research is very clear that risk factors such as abuse, neglect, living in poverty, negative environmental influences, and diminished parental capacities have a significant impact on development—specifically brain development—which in turn influences all other domains of development. Additionally, children with disabilities not related to abuse or neglect should be routinely screened for social-emotional developmental issues that may be contributing to delays in other developmental areas as well as relational issues.

The barrier to adopting the ASQ-SE as part of the screening process comes down to time and money. It is understood that Early Steps Service Coordinators have high caseloads and programs have low operating budgets. However, the benefit of adopting the ASQ-SE as part of the assessment process far outweighs any cost or barrier that can be presented. The greatest feature of the ASQ-SE is its brevity and price-point: The ASQ-SE takes 10-15 minutes to complete and can be purchased at a minimal cost. Given the invaluable information that the questionnaire provides, the benefits of adopting this tool is worth the expense.

Another opportunity to enhance infant mental health in Early Steps that presents itself in the Service Delivery Model is the method in which the screens are actually completed. The model allows for face-to-face, mail, telephonic service delivery, or a combination of any of these formats. The ASQ and ASQ-SE are designed to be completed by the parent. However, the screening tools do not need to be completed *only* by the parent; they can be completed in conjunction with a therapist or Early Steps Service Coordinator. Screening and assessment are the two most important aspects of identifying developmental delays early. Working through the screens with parents/caregivers allows for two key benefits: 1) it ensures that the parent/caregiver is interpreting the items correctly; and 2) it permits dialogue about what the parents/caregivers are reporting or not reporting. Early intervention starts at the first contact with parents/caregivers and utilizing the screens as a partnership mechanism will enhance the relationship-based approach to practice and assist in identifying issues that were not apparent at the time of referral.

Lastly, the ASQ and ASQ-SE are typically used only at the time of screen and at the time of the IFSP review. The ASQ and ASQ-SE can be used as a means of measuring progress or lack thereof, as well as a means of determining a starting point for age appropriate services. For example, if a 14-month-old child's ASQ or ASQ-SE screen indicates that she needs further evaluation and the evaluation determines that she is 2 months delayed, the 12-month ASQ and or ASQ-SE can be used retrospectively to assist parents with relating to the child's current developmental level. It also describes the developmental skills that are needed to help her catch up. Service coordinators can use the ASQ and ASQ-SE periodically throughout the Early Steps process to monitor progression in all developmental areas, not just the identified delayed areas. Alternative screening and assessment tools that can be used in replacement or conjunction with the ASQ-SE can be found at http://www.nectac.org/~pdfs/pubs/screening.pdf.

Opportunity #3: Ensuring an Infant Mental Health Approach throughout the Early Steps Process

Through the infant mental health lens, early intervention supports and services are delivered in a manner that recognizes responsive and nurturing parent-child relationships and acknowledges that developmental delays and other conditions, such as parental capacity and environmental influences, may negatively impact the parent-child relationship and ultimately social-emotional developmental outcomes.

Ensuring an infant mental health approach means supporting the child within the context of his/her relationship with parents and other primary caregivers. An infant mental health approach is one in which relationship-based interventions are offered to parents/caregivers in an effort to optimize all of the developmental domains. The Early Steps service delivery model recognizes the importance of relationships and requires a team-based Primary Service Provider (PSP) approach to service delivery. This approach includes the identification of a lead provider in the interaction with the family and child with a disability or developmental delay. The team based approach is a family-centered, capacity building method to intervene with infants and toddlers with disabilities or developmental delays and their families. The IFSP identifies how each team member will share expertise through direct service provision, consultation and coaching with other providers to support and strengthen the family's confidence and competence in promoting their child's learning and development.

The team approach requires that all members of the team have an understanding and appreciation of the importance of parent-child relationships and social-emotional well-being. Continued and consistent use of relationship-based strategies ensures that the IFSP team utilizes an infant mental health approach throughout the service delivery process. Some examples of model relationship practices conducted by Early Steps staff include:

- Consulting with caregivers through a strength-based approach.
- Carefully listening to caregivers to help them identify, clarify, and address issues that may be affecting their developing relationship with their child.
- Discussing social and emotional milestones as part of developmental anticipatory guidance on all home visits.
- Teaching parents/caregivers to understand and sensitively respond to the behavioral cues of their child through modeling, role-play, and positive reinforcement.
- Supporting and encouraging families as they increase their knowledge of development and building resilience in their children.
- Using relationships as instruments of change.
- Making the parent-child relationship the focus of intervention.
- Seeking information about how the parents think and feel about their child's growth and development in relationship to their ability to effectively meet their needs.
- Bringing awareness to the infant's accomplishments and needs when parents don't see them.

Ensuring that there are opportunities for the parent to find joy and pleasure in parenting throughout the process.

Encouraging parents to take the lead in interacting with the child or determining the "agenda" or "topic for discussion."

Identifying and acknowledging the capacities that each parent brings to the care of the child.

Encouraging parents how to remain open, curious, and reflective.

Allowing parents to express their thoughts and feelings related to the presence and care of the child and the changing responsibilities of parenthood.

Attending and responding to parental histories of abandonment, separation, trauma, and unresolved loss that may affect the care of the infant, the early developing relationship, and the parent's emotional health.

Providing information about social-emotional development in the context of care-giving relationships to all family members not just the parents.[20]

Acknowledging what you don't know and requesting consultation when in doubt.

Making referrals or assisting families with access to appropriate mental health providers when there is concern about maternal depression, parental substance abuse, domestic violence and other family mental health disorders.

Opportunity #4: Serving Children who do not Qualify for Early Steps or Behavioral Health Services

Eligibility criteria can exclude children from receiving infant mental health therapeutic services through Early Steps but should not preclude them from receiving services through other programs.

Some children will be referred and assessed for social-emotional delays either through Early Steps or behavioral health services, but will not meet the standard deviation delay requirement for Early Steps, or they will not have the required diagnosis for reimbursement under behavioral health. These children are at a higher probability of falling through the cracks. In these instances, the parents or the CBC Lead Agency should be made aware of the delays and work with the pediatrician to determine if the child should be referred to speech and language, occupational, physical therapy or infant and early mental health services. If the delays are noted on the Child Well Check-up, the child may be eligible for the services through the Early Periodic Screening and Diagnostic and Treatment provisions of federal law. Not meeting eligibility criteria does not equate to not being "at risk." Risk may be addressed by referring families to infant mental health "Level 1" or "Level 2" resources discussed previously.

Additionally, there are children who have been referred for an infant mental health assessment, but do not meet the behavioral health diagnosis criteria, but do have a significantly low Parent-Infant Relationship Global Assessment Scale (PIR-GAS) on Axis II of the DC 0-3R. The Substance Abuse Mental Health Services Administration (SAMSHA) has acknowledged the need for services for these infants and toddlers who have a PIR-GAS of 40 or below which signifies a "disordered" relationship; however, AHCA has yet to allow for reimbursement for Axis II diagnosis on the DC0-3R scale. Community agencies should advocate amending the procedure coding structure to ensure that DC0-3R Axis II codes are recognized and reimbursable.

Opportunity #5: Meeting the Needs of Infants and Toddlers under CAPTA

Infants and toddlers who have a substantiated case of abuse and neglect have a unique set of needs. CAPTA ensures that these children are screened and assessed for social-emotional delays through a partnership between Early Steps and the Department of Children and Families.

Nationally, it is estimated that approximately 200,000 children between the ages of birth to three years old come into contact with the child welfare system annually. One-third of these children are placed in foster care. This represents the largest age group entering care.[21] Children in the child welfare system who require early intervention through Part C are in need of urgent attention due to their vulnerability and dependent status. Therefore, it is important that practitioners have an awareness of the impact of abuse and neglect on social-emotional development, as well as understanding the challenges of assessing and determining the Part C eligibility for these dependent children.

Infants and toddlers who are abused, neglected, exposed to family violence, or who have caregivers with mental health or substance abuse issues, have a higher probability of experiencing developmental delays than those not exposed to these risk factors. The occurrence of developmental problems for maltreated children between the ages of birth to three ranges from 20% to 65% depending on the developmental domain and the study parameters.[22] What is especially troubling about these statistics is the high rate of reported social-emotional, mental health or attachment problems directly attributed to the abuse or neglect. Studies indicate that up to 82% of infants in the system have attachment issues[23] and up to 61% of children under the age of three have social-emotional/mental health issues.[24]

Sadly, the youngest infants (three months or younger) typically remain in foster care 50% longer than older children and are less likely to be reunified with their parents. For those infants who do achieve reunification, almost one-third will re-enter the child welfare system. When comparing the child welfare data with developmental status and service use data, 33%-35% of children ages birth to three had developmental delays, yet were less likely to receive developmental services than older age groups.[25] What is more troubling is that less than 15% of the children eligible for services under Part C of the IDEA or CAPTA were receiving Individualized Service Plans.[26]

Although the child welfare system is in place to protect children, it can unintentionally exacerbate developmental issues by re-traumatizing children with removals, separations, or multiple placements. The traumatic event warranting the involvement of child welfare, compounded by the trauma of being in the child welfare system, can produce a stress overload or *toxic stress* for infants and toddlers, which can dramatically impair their ability to attach to people and ultimately their ability to stabilize or regulate their emotions. Fortunately, the long-term negative consequences of early exposure to abuse and neglect can be overcome with quality early intervention programs that address the unique circumstances of children in the child welfare system.

The importance of identifying and serving children in the child welfare system cannot be underrated or overlooked. The impact of living in an environment that is developmentally "*toxic"* can and will have life-long consequences if the system of care does not appropriately intervene. Early Steps and the Department of Children and Families (DCF) have a mandate through CAPTA to ensure that the developmental and social-emotional needs of children in the child welfare system are met. Early Steps and DCF have formed a partnership and have developed a referral protocol. Children in the welfare system are still not systematically referred to Early Steps as required by CAPTA. The research suggests that infants and toddlers often experience multiple transitions which may necessitate the need for social-emotional early intervention to strengthen the relationship that the child has with the parent as well as the placement caregiver(s). Systematic referral to Early Steps will ensure that children are screened for developmental disabilities in a timely manner.

Early Steps and DCF have created a Developmental Screening Checklist and Referral Form[27] that must be submitted within 48 hours of the abuse or neglect per interagency agreement. Currently, Section 1 of the checklist presents the list of certified medical conditions for Early Steps referral (i.e. hearing, vision, chromosomal, neurological, seizure and physical abnormality/abnormal movement). Section 2 of the checklist has a list of developmental delays:

- 3 months and child does not watch moving objects or respond to sounds
- 6 months and unable to roll over
- 9 months and unable to sit alone
- 12 months and unable to crawl (or crawls with great difficulty)
- 15 months unable to stand alone
- 15 months and unable to hold a cup
- 18 months and has no speech or only babbles
- 18 months and unable to walk
- 24 months and unable to use objects like crayons or spoons
- 24 months and does not engage in play or social interaction

Section 3 of the checklist presents the following "other concerns":

- Feeding/eating difficulty
- Shaken baby/head injury
- Chronic illness
- Child in hospital or recent hospitalization
- Child extremely underweight or appears malnourished
- Lack of eye contact or lack of interest in interaction with the parent/caregiver

The developmental checklist is attached to the referral form and submitted to Early Steps for review.

Lastly, Early Steps and DCF could work with AHCA to find ways to treat children who are in the child welfare system but do not meet criteria for an Axis I diagnosis or Early Steps criteria but have social-emotional issues related to parent-child interactions. The DSM-IVR utilizes the V-codes or 995.5 to signify a relational issue or physical abuse; however, there is not a billing mechanism in place to bill for children who are referred to Early Steps and/or having social-emotional issues based on the relationship they have or don't have with their parent. Nowhere in the system of care is this more important than child welfare. Children in the child welfare system often times have parents/caregivers who are substance abusing, mentally ill and/or in violent relationships. Children in these homes are not likely to experience the joyful and meaningful interactions that facilitate optimal social-emotional development and resiliency. The system should have safeguards in place to compensate for their parents' deficits.

Opportunity #6: Consulting and Collaborating with IMH Providers

A mental health system of care is an individualized comprehensive system that incorporates a broad array of services and supports to meet a child's multiple and changing mental health or social-emotional needs.

Collaboration and communication are the hallmarks of a system of care that is effective, efficient and evidence-based. The philosophy driving this system of care is that services should be child-centered, family-focused, and offered in the least restrictive, most appropriate setting. The mission of Early Steps meets this system of care definition and philosophy. There are opportunities for collaboration in the form of identifying additional partners and providers in the infant mental health movement. If more providers were identified and enrolled in the ES system, each LES could have a cadre of "go to providers" that support Early Steps mission and values as well as a system of care model. Providers should come from the primary care or pediatric community, mental health community, educational system and the legal system and have a role in establishing themselves as an Early Steps partner and provider. Partnerships should be established to integrate services and maximize efficiency while at the same time build the

knowledge base of each of the partners. Communication should occur from the time of referral to the time of discharge.

The communication or feedback loop should be continuous. *A Guide to Building Collaborative Mental Health Care Partnerships in Pediatric Primary Care* recommends three categories of collaborative models—referred to as the 3C's:[28]

- Consultation
- Co-location
- Collaborative or Integrative

Although these are presented as three separate models, they can be incorporated into one unified model and put into action by Early Steps State Office (ESSO) as well as at the local Early Steps (LES) level. The Early Steps service delivery model already has a consultation framework in place that can be enhanced to expand the social-emotional developmental focus by identifying and enrolling infant mental health trained therapists who can be assigned to a child's IFSP to provide direct service or consultation to the primary service provider. Those areas without access to IMH therapist enrolled in Children's Medical Services Provider Network can contract with "telephonic" consultants who are enrolled in another area and can assist the child's IFSP team through coaching and consultation. While co-locating a variety of early intervention professionals in the same office space is ideal, this model is often not feasible.

Collaborative or integrative models embrace partnerships that place a high value on case coordination and co-management of the treatment specialty types (i.e. OT, PT, SLP) that the child receives. This type of model can be achieved by integrating infant mental health into Early Steps program paperwork and procedures. All Early Steps forms should have a social-emotional or infant mental health component to ensure that collaboration and integration occurs. Additionally, infant mental health therapists serving on the child's team should be present for all IFSP Meetings.

Opportunity #7: Promoting Public Awareness and Cross-Training

Public awareness and cross-training is a critical component for ensuring sustainability of the Early Steps program and to ensure that stakeholders understand the importance of social-emotional development.

The 2010 *Early Steps Strategic Plan for Sustainability* cited three challenges to sustainability: funding, cost inefficiencies, and lack of knowledge and awareness. Funding and cost of services is directly correlated to public awareness and cross-training. Improving public relations and visibility can begin with mutual key systems' stakeholders, such as the court, legal, medical, and early childhood education systems. Additionally, outreach to other partners such as faith-based organizations and community recreation centers could be explored. Early Steps can partner with statewide infant mental health groups such as the Florida Association for Infant Mental Health (FAIMH) and it's local chapters to educate stakeholders on the impact of social-emotional developmental delays on the other domains of development. Additionally, FAIMH chapter representation can be included on the Florida Interagency Coordinating Council for Infants and Toddlers (FICCIT) or connected to regular consultative meetings at ES provider meetings. Cross-training on the signs and symptoms of social-emotional distress and the referral process can make Early Steps and the field of infant mental health more visible and is a "win-win" for both sides.

Opportunity #8: Identifying, Recruiting, and Enrolling Infant Mental Health Providers

There is a shortage of trained infant mental health providers enrolled as Medicaid providers. Identifying and overcoming the barriers to enrollment and retention should be addressed to increase the numbers of new provider enrollees and retain existing providers.

Medicaid funds most of the fundamental infant mental health services needed by Medicaid eligible children in Early Steps, however there must be qualified clinicians to provide the services. Currently, there are approximately 200 licensed therapists enrolled as CMS providers. What is unknown is: 1) how

many of these therapists are currently serving children between the ages of birth to three; 2) what percentage of their practice is devoted to children between birth and three; 3) whether or not they are credentialed through other Medicaid plans; 4) whether or not they are trained in infant mental health; and 5) whether they can be enticed to enroll in the Early Steps' provider network. As the previous section illustrates, the magnitude and multitude of processes and requirements to become a Medicaid provider can be overwhelming.

Florida has more than 200 trained licensed mental health therapists as a result primarily of the Harris Institute at Florida State University (FSU) Center for Prevention & Early Intervention Policy (FSU Center). Unfortunately, all of these graduates are not working in the field. To fill the ES provider enrollment gap, a 10-step process could be initiated to identify and enroll providers through collaboration of partnering agencies and licensed therapists:

Step 1: Commit to enhancing infant mental health services.

Step 2: Identify IMH trained providers who are enrolled in the Medicaid/CMS system. If they are not providing services, build relationships to promote enrollment and use on IFSP teams.

Step 3: Educate providers on the Medicaid/CMS enrollment requirements and offer assistance in maneuvering the system.

Step 4: Identify providers who are already enrolled in Medicaid to provide services to children under three and assist them with enrollment under CMS noting payment for consultation and travel as incentives.

Step 5: Utilize the DOH licensee and CMS provider databases to identify potential clinicians in those localities where Steps 2-4 do not produce a requisite number of infant mental health therapists. Have LES coordinators contact them to identify if they are providing services to children birth to three and assist them with enrollment, if interested.

Additionally, the 2010 *Early Steps Strategic Plan for Sustainability* outlined several provider enrollment strategies that are not specific to infant mental health but are essential to increasing the number of providers.

Step 6: Increase the level of reimbursement for Medicaid, Medicaid HMOs and Part C providers to better recruit and retain quality providers.

Step 7: Improve the enrollment process for the CMS provider group (Early Steps), Medicaid, and the LES offices.

Step 8: Utilize the cost analysis for employing versus contracting with providers and enact policies to support provider hiring/contracting practices based on evidence.

Step 9: Develop a statewide medical record and billing system to reduce paperwork and increase consistency of documentation while reducing redundancy.

Step 10: Work to systematically assess and improve the current data system, or investigate a new data system if funds can be identified and the current system cannot be improved on.

Opportunity #9: Creating a "Trauma-Informed" Early Intervention System that Recognizes and Responds to the Impact of Trauma

In a trauma-informed system, all staff are well trained in trauma-informed practices and utilize a trauma-sensitive lens in assessing risks to the child's development and the family relationships. Interventions come from a trauma-informed perspective.

Many of the children in Part C enter the program with either medical trauma or interpersonal trauma. Although early intervention providers are well-trained to address developmental disabilities and general developmental delay, they are not typically trained to consider trauma. For example, treating a language delay caused by a child who witnessed violence calls for very different approach than a language delay caused by a birth defect. A convergence of compelling evidence has linked traumatic early childhood

experiences with a lifetime trajectory of serious mental and physical health problems. Advances in the understanding of trauma, such as the landmark Adverse Childhood Experiences (ACE) Study, [29] compel us to re-think our early childhood systems and practices and bring an infant mental health perspective to the work with young children and families, especially those in the child welfare system. Although the child welfare system is in place to protect children, it can unintentionally exacerbate developmental issues by re-traumatizing children with removals, separations, or multiple placements. The traumatic event warranting the involvement of child welfare, compounded by the trauma of being in the child welfare system, can produce a stress overload or *toxic stress* for infants and toddlers, which can dramatically impair their ability to make attachments and ultimately their ability to stabilize or regulate their emotions. Fortunately, the long-term negative consequences of early exposure to abuse and neglect or extreme adversity can be overcome with quality early intervention programs that address infant mental health.

Nowhere is the need to re-examine trauma-informed services more apparent than in the Part C Early Intervention (EI) System. Part C already serves infants and toddlers who may have experienced medical trauma from repeated hospitalizations and painful procedures as well as children who are at elevated risk for abuse and neglect, such as substance exposed or premature infants.[30,31] Part C should routinely screen for trauma exposure and related symptoms at intake and throughout the process. Ideally, all part C providers whether hired or contracted should have trauma training and understand the impact of trauma upon development. Multidisciplinary teams with professionals who have trauma-specific expertise such as infant mental health specialists with trauma-training would enhance provision of services. These specialists can 1) provide trauma-informed evidence-based services to infants, toddlers and families; 2) consult with other EI providers to integrate trauma-related and developmental services; and 3) help develop the capacity of other providers to work from a trauma-informed perspective.

Opportunity #10: Increasing Evidence-Based Infant Mental Health Interventions for Children in the Child Welfare System

There are an increasing number of evidence-based relationship-based interventions to heal trauma and to promote infant mental health.

Child-Parent Psychotherapy (CPP) is the evidenced-based intervention to treat trauma and related social-emotional issues in young children. CPP or dyadic therapy, aims to expedite permanency and enhance child well-being for young children in the child welfare system. CPP is an evidence-based intervention for infants and toddlers who have been exposed to a traumatic event or events which have negatively impacted their development and ability to form secure attachments to their parents and/or caregivers. CPP is a relationship-based model that utilizes the parent-child relationship as the catalyst for healthy development. CPP interventions directly address the trauma that impacted the child and assists the parents with understanding their role in their child's developmental process. CPP can be provided in the home setting, which aligns with Early Steps mandate for services to be provided in the natural environment as well as an office setting.

Attachment and Bio-behavioral Catch-Up (ABC) is a treatment program based in attachment theory and neurobiology. ABC is a short-term intervention designed to improve attachment regulation and bio-behavioral regulation in children birth to 24 months who have experienced abuse and neglect.[32] The purpose of ABC is to help strengthen the parents' or caregivers' sensitivity and responsiveness to their child's cues and provide an environment that fosters the child's regulatory abilities.

Parent-Child Interaction Therapy (PCIT) is a dyadic behavioral intervention that focuses on decreasing externalizing child behavior problems, increasing child social skills and cooperation, and improving the parent-child attachment relationship. The target population is children ages 2-7 with behavior and parent-child relationship problems, and may also be done with foster parents, or caregivers.[33] PCIT utilizes a play-therapy approach to teach parents and their children behavior management skills to decrease negative child behavior.

Circle of Security (COS) is an attachment theory-based, home-based treatment program that targets high-risk families with children from birth to five years old.[34] The program is designed to increase caregiver responsiveness as well as increase the caregiver's capacity to reflect on how their own life experiences influences their perception of attachment and caregiving patterns of behavior. The goal of COS is to prevent insecure attachments and child mental health disorders.

Promoting First Relationships (PFR) is a manualized program that promotes the social-emotional development of children from birth to three years of age through responsive, nurturing caregiver-child relationships. The practitioner videotapes caregiver and child interactions to provide positive feedback to the caregiver to build competence and commitment to their children and promote a deeper emotional bond to deter the child's distress and problematic behaviors.

Watch, Wait, and Wonder (WWW) is a therapeutic approach focused on strengthening the attachment relationship between a caregiver and their child, in order to improve the child's self-regulating abilities and sense of efficacy and enhance the caregiver's sensitivity. The treatment is intended for parents/caregivers and their children birth to age 4 who are experiencing relational and developmental difficulties; however, the treatment has also been offered for use with older children.[35] The program is designed around using the child's natural spontaneous activity in a free play format to engage the parent and enhance sensitivity and responsiveness while building the child's sense of self and self-efficacy, emotion regulation, and the child-parent attachment.

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