Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

Alternative or "in Lieu of" Service Description Child First®

Service Name and Description:

Service Name:

Child First®

Definitions

- **Child First National Program Office (NPO):** Located in Fairfield, Connecticut. The role of the NPO includes: Overseeing the accreditation of Child First affiliate sites; providing Child First Learning Collaboratives and trainings; providing clinical reflective consultation and technical assistance; monitoring of fidelity; and providing data analytics and reporting on outcomes to the affiliate sites, state office and the LME-MCO.
- **Clinical Teams:** Two (2) person Child First Clinical Team (Master's level, licensed Mental Health(MH)/Developmental Clinician and Bachelor's Level (BA/BS) Family Resource Partner that carry an assigned Child First caseload.
- **Child First Developmental Mental Health Clinician:** A licensed Master's level mental health clinician who is being or has been trained in Child First. This individual is most often referred to as "Clinician" professionally. When working with families, s/he is referred to as a "Child Development Specialist." This individual implements the treatment interventions of the Child First model with the child (prenatal through 6 years at intake) and the primary caregiver(s).
- **Child First Family Resource Partner:** This individual is an expert in the community resources of the county (ies) assigned and is a partner of a MH licensed Clinician. This partnership is called a Child First Clinical Team.
- **Child First affiliate agencies:** These are the provider agencies contracted with the LME-MCO, Child First State Office, and Child First NPO to provide Child First model.
- **Affiliate Clinical Supervisors:** Child First Clinical Supervisors located within the provider agencies at the affiliate sites that are contracted to provide Child First Model. Each Clinical Supervisor will have up to 4 Clinical Teams to supervise.
- **Affiliate Site:** An assigned group of four (4) Child First Clinical Teams to one (1) Affiliate Clinical Supervisor. An affiliate site is a contracted provider agency to deliver services in a specific catchment area using the Child First evidence-based model.
- **NC Clinical Supervisor Network:** The affiliate sites' Child First Clinical Supervisors in NC.

- **Child First Community Advisory Board:** A group of key community partners/stakeholders who serve in an advisory capacity to Child First affiliate agency serving a specified geographic catchment area.
- **NC Child First State Program Office (SPO):** NC Council of Community Programs serves as State Program officer for Child First in North Carolina. The Council's role is to oversee the installation and implantation stages of the Child First model in North Carolina. It will also ensure that Child First is well integrated into NC's early childhood and mental health systems. The Child First State office employs the NC Child First Program Director and houses the NC Child First Regional Director (s).
- **NC Child First State Program Director:** Oversees the implementation and administration of Child First in NC. The Program Director also engages with and educates community stakeholders and LME/MCOs about the Child First model with the goal of extending implementation of Child First across the state.
- **Child First Regional Clinical Director**: Employed by the Child First National Program Office. Is responsible for overseeing the clinical operations of Child First through reflective clinical consultation, technical assistance, and training to ensure model fidelity with affiliate agencies within a region.
- **Child First State Advisory Board:** A group of key community partners/stakeholders who serve in an advisory capacity to Child First NPO and the Child First State Office.

Description:

Child First® is an innovative, home-based, early childhood intervention, embedded in a system of care that works to decrease the incidence of serious emotional disturbance, developmental and learning problems, and abuse and neglect among the most vulnerable young children and families. Child First has been evaluated in a randomized, controlled trial with statistically significant findings showing Child First children were less likely to have aggressive and defiant behavior and less likely to have language problems; Mothers had lower levels of depression and mental health problems; Families were less likely to be involved with child protective services and more likely to access community services and supports. Child First has been designated one of the national evidence-based home visiting models eligible for replication funding under the federal Maternal, Infant and Early Childhood Home Visiting Program (MIECHV). Child First currently has 15 sites throughout Connecticut. It is also being replicated in Palm Beach county Florida. North Carolina has been chosen out of 25 states by Board of the Child First National Program Office to be the first for statewide replication. The 24-county catchment of Trillium Health Resources will be the first site within NC to provide Child First.

Information about Population to be Served:

Population	Age Ranges	Projected Numbers	Characteristics
Infants and young children with behavioral/ emotional, and/or developmental/ learning problems **or** at risk for such conditions due to parental mental illness, maladaptive parenting practices, discordant parent-child temperamental styles, **and/or** adverse life circumstances (e.g. extreme poverty, domestic violence, substance use homelessness, abuse and neglect, incarceration, and isolation) in which there is considerable risk to the health and development of the child.	0 through 6yrs, 0 months at the onset of services	As of 9/7/15 the population age 0-6 for the Trillium catchment was 111,813. As of 6/30/15 the Medicaid eligible population for 0-6 was 24,152 for the Trillium catchment. The prevalence rate for Child MH ages 0-6 is 4,830 for the Trillium Catchment. Trillium expects each Child Frist Clinical team to maintain a case load of 11-15 families at any one time. Child First Clinical Supervisors should maintain at least one active at any one time but may carry a small caseload during transitional periods among teams (e.g. vacancy, maternity/paternity or medical leave) It is anticipated with 36 clinical teams and 10 supervisors, the approx. capacity for providing Child First to children 0-6yo and their families would be 432 families at a time.	**1.** DSM 5 (or the most current DSM) diagnosis assessed or v-code identified based on developmental delays or behavioral concern identified by a medical professional, therapist or caregiver. **2.** Child has experienced adverse life circumstances or has been exposed to potentially traumatic events (recent or acute) **3.** Evidence that the child is being negatively impacted by the behavioral health issues of the primary caregiver (though caregiver is not currently at risk of hurting self or others). **4.** Ability of the primary caregiver to be sensitive to and respond to infant's signals **5.** DSS involvement or at risk for out of home placement **6.** Other environmental risks identified (e.g. expulsion from early care or education setting, eviction/homeless)

a. **Population Data: NC Office of State Budget and Management** (OSMB). http://www.osbm.nc.gov/demog/county-estimates Accessed 9/7/2015

b. **MH Child Prevalence Rate Source:** Merikangas, K.R., He, J., Burstein, M., Swanson, S.A., Avenevoli, S., Cui, L., benjet, C., Gerogiades, K., & Swendsen, J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Study-Adolescent supplement (NCS-A). *Journal of the American academy of Child and Adolescent Psychiatry, 49, 90-989.*

c. **National Institute of Mental Health**. What is Prevalence? Any Disorder Among Children. (Accessed 10/27/2015) Retrieved from the National Institute of Mental Health

d. North Carolina Medicaid Eligible Resource: North Carolina Division of Medical Assistance Medicaid Eligible – June 30, 2015. Accessed 10/10/15.

Eligibility criteria for Child First include the following:

- Children aged 0 to 3yo who have been assessed and referred by a Children's Developmental Services Agency or NC Infant Toddler Program who are considered to have
  - a cognitive or communication developmental delay that impacts or is related to their social-emotional well-being

OR

- Children aged 0 to 6 years, 0 months assessed who met the DSM 5 criteria (or any subsequent editions of this reference material) for one or more of the following:
  - Neurodevelopmental disorders
  - Autism Spectrum Disorders
  - Attention Deficit/Hyperactivity Disorder
  - Global Developmental Delay
  - Motor Disorders
  - Major Depressive Disorder or Unspecified Depressive Disorder
  - Disruptive Mood Dysregulation Disorder
  - Anxiety Disorders
  - Trauma and Stressor Related Disorders
  - Language Disorder
  - Developmental coordination Disorder
  - Feeding and Eating Disorders
  - Elimination Disorders
  - Oppositional Defiant Disorder
  - Obsessive-Compulsive and Related Disorders

OR

- Other Conditions (Relational, Child Abuse & Neglect, Exposure to Parental Abuse, Housing an Economic Problems) that are impacting or will be impacting the child's social and emotional wellbeing without intervention.

Child First's Treatment Program Philosophy, Goals and Objectives:

Philosophy

Child First Vision: All young children and their families will have the nurturing, support, and services that they need to promote optimal social-emotional, cognitive, and physical health and development.

Child First Mission: Child First helps to heal and protect children and families from the devastating effects of trauma and chronic stress by fostering the development of strong, nurturing, caregiver-child relationships, promoting adult capacity, and connecting families with needed services.

Child First Guiding Principle: To help a child we must help the family.

- Development of a responsive, nurturing parent-child relationship to buffer the child from high levels of stress and promote healthy functioning and resilience.
- Enhancing the parent's capacity to provide sensitive, age-appropriate care, and protection, with mutual pleasure in the parent-child relationship.
- Assisting parents in recognizing and addressing their behavioral or mental health issues or basic needs that may be negatively impacting their ability to attend to the needs of their child.
- Planning and treatment is based upon the wishes, values, culture, and strengths of the family.

Assessment Tools Used by Child First Teams:

In order to understand and measure both problems and strengths at baseline, structured clinical interviews, validated age-appropriate standardized assessments and inventories are used to collect clinical information on all identified children and their primary caregivers.

Child First clinicians are trained on specific standardized assessments. The tools used are approved by the Child First NPO and are able to be used by master's level Child First clinicians.

Data measured:

a. Monthly data metrics collected include: Referral Rates and Referral Sources; Enrollment status; Number of Active Enrollees; Gender, Age at enrollment, Ethnicity and Race of Child; Caregiver(s) race; Caregiver(s) relationship status to child; Number of Children enrolled that require interpreters and the primary Language spoken; County of Medicaid eligibility and residence; Retention rates; Reason for early termination; and Number of completed cases (full of Child First).

b. Baseline, 6 month and discharge measures are collected on the following:

Required			Opt	Assessment Measures	Age-range at baseline	Purpose
Base	6 mo	Term				
				Child Development:		
X	X[1]	X[1]		Ages and Stages Developmental Questionnaire (ASQ)	1-66 mos.	Measures child functioning in the areas of language, cognition, gross and fine motor skills, and personal-social skills.
X				Modified Checklist for Autism in Toddlers – Revised with Follow-Up Interview (M-CHAT-R/F)	16-30 mos.	Autism screen with follow-up interview.
			o	*Dunn – Infant/Toddler Sensory Profile*	< 36 mos.	Measures sensory processing/integration difficulties.
			o	*Dunn – Short Sensory Profile*	> 36 mos.	Measures sensory processing/integration difficulties.
				Social-Emotional and Behavioral Concerns:		
X	X	X		Ages and Stages - Social Emotional, 2nd edition (ASQ: SE–2)	1-11 mos.	Measures social-emotional development.
X	X	X		Brief Infant-Toddler Social & Emotional Assessment (BITSEA)	12-35 mos.	Measures both emotional/behavioral problems and competence. Completed by the parent.
			o	*Infant-Toddler Social & Emotional Assessment (ITSEA)*	12-35 mos.	Provides a more in-depth clinical assessment of behavioral problems and emotional functioning.
X	X	X		Preschool and Kindergarten Behavior Scales-Second Edition (PKBS-2) – teacher and parent	36-72 mos.	Measures both emotional/behavioral problems and social competence. Separate forms completed by the parent and the teacher.
X		X		Traumatic Events Screening Inventory-Parent Report Revised (TESI-PRR)	All	Documents traumatic events in the life of a child.

Required			Opt	Assessment Measures	Age-range at baseline	Purpose
				Caregiver-Child Relationships:		
X	X	X		Caregiver-Child Interaction Scale (CCIS) *	All	Measures important aspects of the caregiver-child relationship.
				Caregiver Strengths and Challenges:		
X				Parent Questionnaire (PQ) *	All	Measures psycho-social risk factors for the child and family.
X	X	X		Parenting Stress Index–4th Edition Short Form (PSI-4-SF)	All	Measures the stress that parents experience from the parenting role.
X	X	X		Center for Epidemiology Scale-Depression (CESD-R)	All	Measures parental depressive symptoms.
			o	*Edinburgh Postnatal Depression Scale (EPDS)*	prenatal-12 mos.	Measures maternal depression in the prenatal and post-partum period.
X		X		Life Stressor Checklist – Revised (LSC-R)	All	Documents traumatic events in the life of a parent or caregiver.
X		X		PTSD Checklist – Civilian Version (PCL-C)	All	Measures parental PTSD symptoms.
				Child and Family Health:		
X				See: Guide to Child and Family Clinical History - Health	All	Documents the health status of the child and family.
		X		See: Termination Data - Health	All	Documents the health status of the child and family at discharge.
X	X	X		Home Observation of Physical Environment (HOPE)*	All	Documents the conditions of the home environment..
				Service Needs:		
X	Ongoing			Family Service Tracking Form (STF) *	All	Information from Intake Part 2: Service Needs Inventory for Families (SNIFF) is transferred to the Family Service Tracking Form.

Termination Information	Age-range	Purpose
Youth Service Satisfaction for Families (YSSF)	All	Documents the caregivers' satisfaction with the Child First intervention.
Termination Data	All	Indicators of change in demographics, health, etc.

Key:

X1: At 6 months and termination, complete ASQ Communications and any assessment domain where there was a concern

Base: Baseline measures that are done with every child in designated age range. These should be completed in the first 30 days.

6 mos.: 6 month follow up measures that should be completed 6 months after the first visit. Results should inform the development of the Child and Family Plan of Care at 7 months. (If family terminates before 7 months, this may replace the termination outcomes measures.)

Term: Termination measures that are done with every child in designated age range.

Opt: Optional measures (*italicized*) that may be used to gather information under specific circumstances or at the discretion of the Clinician

***** : Measure created by Child First

Expected Outcomes:

By the end of treatment, expected outcomes include:

- Decrease in child emotional/behavioral problems
- Improvement in child social skills/ social competence
- Improvement in child language development
- Strengthening of the parent-child relationship
- Decrease in identified mental health issues of caregiver (if present at baseline) that were negatively impacting the child (e.g. maternal depression, parental stress)

Staffing Qualifications, Credentialing Process, and Levels of Supervision Administrative and Clinical) Required:

Each family accepted for Child First will be matched to a Child First clinical team. Each clinical team is comprised of a Master's level mental health/developmental clinician and a Bachelor's level community expert known as the Family Resource Partner. The qualifications for each role of the Clinical team are summarized below.

Child First Developmental Mental Health Clinician will meet all of the following qualifications:

- Fully Licensed Master's or Doctoral level mental health provider (LCSW, LMFT, Licensed Psychologist, LPA, and LPC) licensed in North Carolina. Individuals only licensed as Licensed Clinical Addiction Specialist (LCAS) are not included as eligible to deliver Child First services.

- Experience working psychotherapeutically with culturally diverse children and families, including parent-child therapeutic work and play therapy with very young children (0-5 years), for a minimum of three years. Past Child Parent Psychotherapy (CPP) training is highly valued.
- Knowledge of relationship-based, psychodynamic intervention and early child development; parent-child relationships and attachment theory; effects of trauma and environmental risks on early childhood brain development, especially violence exposure, maternal depression, and substance abuse; and community-level risk factors (e.g., poverty, homelessness).
- Experience providing mental health assessments and consultations.
- Knowledge and experience working with adults with mental health, substance use, and cognitive challenges.
- Experience providing intervention within diverse home and community settings.

Family Resource Partner

Family Resource Partner must meet all of the following qualifications:

- Bachelor's degree in child development, psychology, nursing, human services, or related human services field or equivalent combination of higher education and experience.
- A minimum of three years working with culturally diverse families and young children under the age of six years.
- Openness to learning, capacity for self-reflection, and eagerness to participate in reflective clinical supervision.
- Knowledge of early childhood development, parent education, parent-child relationships, and individual, family, and community-level risk factors (e.g., poverty, homelessness, maternal depression, domestic violence, substance abuse, teen parenthood).
- Knowledge of and experience with community-based services and supports in service area, highly valued.
- Experience working in home and community-based settings with vulnerable populations of diverse cultures and ethnicities.

Clinical Director/Supervisor

Clinical Director/Supervisor must meet all of the following qualifications:

- Licensed mental health clinician with Masters or Doctoral degree in social work, psychology, APRN-child psychiatry, marriage and family therapy, or related field.
- Knowledge of early childhood development and disability, especially emotional/behavioral health; parent-child relationships and attachment theory; effects of environmental risks on

early childhood brain development, especially violence exposure and maternal depression; family systems; adult psychopathology, especially depression, personality disorders, and effects of trauma; psychopharmacology; and diagnostic classification of young children and adults.

- Minimum of five years' experience working psychotherapeutically with young children (0-5 years) and their families using a relationally-based model. Specific experience with dyadic parent-child psychotherapy preferred.
- Significant experience working in home and community based settings.
- Knowledge and experience working with adults with mental health and cognitive challenges.
- Knowledge and experience working with diverse cultures and ethnicities.
- Minimum of 3 years' experience conducting reflective supervision with Master's level clinicians.

Duties/responsibilities of the Clinical Director/Supervisor

- Supervise all components of clinical operations and set program policy and procedures for Child First teams of Masters and Bachelors level staff.
- Provide Child First group reflective supervision and case conference meetings on a weekly basis, using videotape as appropriate.
- Provide weekly reflective supervision with each Clinician, Family Resource Partner, and Clinical Team.
- Review progress notes, formulations, and clinical diagnoses for all children and families.
- Review and sign all Child and Family Plans of Care (Treatment Plans).
- Build and maintain cohesive, supportive, reflective, respectful relationships among staff.
- Review all process and outcome data on a regular basis with staff and discuss areas for improvement, and respond to clinical areas of need with specific training for staff.
- Use the Child First Fidelity Framework with all staff to maintain fidelity to the Child First model.
- Lead all site-based quality enhancement activities including supervision of data entry of all data by staff and ensure accuracy and completion of chart reviews to ensure all necessary clinical components and consents are in place.
- Assure that the Child First program and staff are integrated into the affiliate agency, with ongoing communication with the agency Clinical Director and/or CEO.

- Actively participate in all Child First training, including Child First Learning Collaborative, distance learning, and specialty training, and assist staff in mastering program components to ensure fidelity to the Child First model.
- Attend the monthly clinical and administrative Child First Clinical Supervisors' Meeting.
- Supervise entry of all data by staff and ensure accuracy.
- Build relationships and work collaboratively with local non-profit agencies, public social services, and state policy makers to enhance their understanding and utilization of Child First services.
- Represent Child First within the local early childhood council or collaborative meetings and other local, state, and national meetings, as appropriate.
- Serve as the Child First liaison with all community partners including child welfare, health providers, early care and education, early intervention (IDEA-Part C), courts, etc.
- Maintain at least one active Child First case, in partnership with a Family Resource Partner to maintain skills in delivering and supervising on Child First program.
- The Clinical Director/Supervisor provides all clinical, reflective supervision to staff. She/he must maintain an "open-door" policy in case of acute clinical needs.
- The Clinical Director/Supervisor receives weekly individual, clinical supervision by a senior clinician in the agency implementing Child First (or an outside consultant).
- The Clinical Director/Supervisor must participate in biweekly, individual, clinical, reflective consultation with the Child First state Clinical Director or other senior clinical Child First consultant.
- Individual reflective supervision: 1 hour/week of individual clinical, reflective supervision is required for both Clinician and Family Resource Partner.
- Team reflective supervision: 1 hour/week of clinical team reflective, clinical supervision is required.
- Group reflective and clinical case supervision: 1 ½ hours/week of group, reflective supervision is required.
- Administrative supervision: A minimum of 1 hour/month of programmatic or administrative supervision in a group setting is required.

Supervision of staff is covered as an indirect cost and therefore must not be billed separately as a Child First service.

Duties/responsibilities of the Developmental Mental Health Clinician

- Engage with the Child First family and the Family Resource Partner in the collaborative family assessment process (i.e., gather information from interviews, observations of interactions and play, reviewed records, collateral sources, and standardized measures).
- Use all available information to develop a thoughtful, well-integrated clinical formulation and Child and Family Plan of Care, in partnership with the Family Resource Partner and family.
- Provide Child First home-based psychotherapeutic intervention with young children and their caregivers using relational, dyadic psychotherapy (CPP) and other modalities.
- Help the caregiver gain insight regarding personal history (including trauma history), feelings for the child, and current parenting practices.
- Avert crisis situations by assisting the family in times of urgent need (e.g., risk of harm to child or caregiver, pending child removal), in consultation with the Family Resource Partner and Clinical Director.
- Provide mental health and developmental assessment and consultation within early care and education settings and to other early childhood providers.
- Embrace use of videotaping to enhance both therapeutic work with families and reflective supervision.
- Engage in weekly individual, Team, and group reflective clinical supervision with Clinical Director.
- Engage actively in all aspects of the Child First Learning Collaborative, including in-person trainings, distance learning curriculum, and specialty trainings.
- Keep all appropriate documentation for clinical accountability and reimbursement.
- Participate in other clinical and administrative activities as appropriate.
- Attend all required face to face collaborative learning sessions held over the course of the first 12 months.

Duties/responsibilities of the Family Resource Partner

- Provide community resource expertise to Child First team and families, including identifying and collaborating with community-based service providers and supports.
- Engage with the Child First family and the Clinician in the collaborative family assessment process (i.e., use data from interviews, observations, interactions, and standardized measures to identify family strengths, needs, and challenges).

- Promote family stabilization by identifying all needed and desired services, integrating service needs into the Child and Family Plan of Care, and addressing barriers to services as they arise.
- Avert crisis situations by assisting Child First family in times of urgent need (e.g., eviction).
- Enhance caregiver executive functioning skills (e.g., planning, organizing, managing time, focusing attention, regulating emotions, reflecting on progress) as needed and in consultation with the Clinician and Clinical Director.
- Maintain a reflective lens when engaging with the caregiver, in order to understand his/her motivation, needs, and possible barriers to new services and supports.
- Collaborate closely with Child First Clinician to meet the needs of Child First families.
- Embrace use of videotaping to enhance both therapeutic work with families and reflective clinical supervision.
- Provide identified child and/or other children in the family with an interactive, growth-promoting play experience.
- Engage in weekly individual, Team, and group reflective clinical supervision with Clinical Director.
- Engage actively in all aspects of the Child First Learning Collaborative, including in-person trainings, distance learning curriculum, and specialty trainings.
- Track completion of all assessments and enter into the appropriate database.
- Keep all appropriate documentation for clinical accountability and reimbursement.
- Participate in other clinical and administrative activities as appropriate.

Program Requirements

Services are delivered face-to-face with the beneficiary, family, and caregivers primarily in the home but could be held in other locations such as a clinical office, church, private room in a community facility, etc. Every Child First Affiliate Site must have a minimum of two active clinical teams (four preferred). Clinical teams and Clinical Supervisors must participate in and adhere to the weekly individual, team and group reflective supervision schedules of the Child First program and clinical case supervision. All required assessment measures are to be completed at baseline, 6 month and at discharge for each beneficiary. At any point while the beneficiary is receiving Child First services, the Child First Clinical Team shall link the beneficiary to an alternative service when clinically indicated and functionally appropriate for the needs of the beneficiary and family.

Unit of Service

per diem

Anticipated Units of Service per Person and Team Caseload:

The Developmental Mental Health Clinician should have a minimum number of 1 contact per week with each family actively engaged in Child First.

The Family Resource Partner should have a minimum of 1 contact per week for each family actively engaged in Child First. The length of the contacts and associated activities by the Family Resource Partner will vary with the treatment plan designed. Increased travel time could impact the number of visits per week.

Typical visits can last an average of 60-90 minutes in duration but could be longer. Families with crisis event may also require longer contact with the clinical team to resolve the situation.

The required caseload size for each Child First Clinical Team may be impacted by several important factors: Frequency/intensity of service needed, success of planned visits, travel distances and environmental conditions within their assigned sections of counties or regions. In general, each Child First team should have a caseload size of no less than 8 families with a maximum caseload size of 16 families. Estimated home visits per 40 hour work week should be between 8-16 visits by the clinician.

Targeted Length of Service:

Families are served for an average of 9 months. Services may continue beyond 12 months with preapproval from Trillium Health Resources (Trillium) services and the Child First Regional Clinical Director and/or the Affiliate Site Clinical Supervisor.

Note: Any private insurance covering the beneficiary should be explored first and claims filed by the provider. For Child First services that are not covered under Medicaid, such as Case Management, the provider can file the EPSDT Prior Approval Request Form, *Non-covered State Medicaid Plan Services Request Form for Recipients under 21 Years Old*. This form can be found on the Trillium website under Provider Documents and Forms.

Utilization Management

Beneficiaries, covered under the waiver, may be seen for the initial 60 calendar days of treatment without a prior authorization to complete the comprehensive battery of assessments. Services provided after this initial 60 day "pass-through" period require authorization from the Medicaid or NCHC approved vendor. This pass-through is available only once per fiscal year. Utilization management for Medicaid population 0-3 is subject to Medicaid prior authorization requirements.

Describe why this service is needed and is different than any State Plan or alternative service already defined. If implemented in other states, describe successful outcomes.

Currently in North Carolina, there is limited capacity for evidence based services for providing early childhood intervention treatment programs for our most vulnerable children. Medicaid services for children birth up to age 3 years old are currently managed by a statewide vendor;

while Medicaid services for children ages 3 years old and up are managed by the LME-MCOs. Thus, creating a fragmented system of care and making it difficult to effectively coordinate and plan for a continuum of care that best meets the needs of the child and his/her family. Additionally, the current Medicaid Plan structure does not adequately support the use of evidence-based treatment models or prevention models. For instance, the NC Medicaid Plan does not have a reimbursement rate structure that supports the design of research/evidence-based models such as Child First, which have been shown to be effective when delivered with fidelity to the model. The NC Medicaid Plan does not currently cover intensive case management services, more than one service delivered to a beneficiary in the same day by the same provider, or service contacts longer than 90 minute increments.

North Carolina also has a workforce deficit in the availability of licensed mental health professionals with early childhood development training. It is even more problematic in the rural areas of North Carolina. Children's Developmental Services Agency (CDSAs) in Eastern North Carolina is finding it difficult to find treatment providers for the birth to 3 year old. There is currently no behavioral service defined in the Medicaid State plan or existing alternative services that focuses on the birth to 6 year old population and offers to treat the dyadic relationship of the child and his/her primary caregiver while also addressing the environmental risk factors/determinants that can negatively impact a child's health and development.

Prevalence Rates

- The prevalence rate for children with diagnosable mental illness is now 1 in 5 or 20% nationally. [1]

Poverty

- Poverty is the cause of compounded stress within families, resulting in children that suffer compromised health, academic and overall wellness outcomes.[2]
- The median income for North Carolina citizens in 2013 was $45,195. Sixteen Trillium counties fall below the North Carolina level, with Washington County the lowest at $31,596 and Camden County the highest at $60,537.
- The North Carolina Department of Commerce annually ranks the state's 100 counties based on economic well-being, and assigns each county a Tier designation. The 24-county catchment includes 14 Tier 1 (58%)- the most economically distressed in the state, six Tier 2 (25%) and four Tier 3 (17%) designations in the 2015 report.[3]
- Eighteen (75%) of Trillium's 24 counties had a higher percentage of poverty than the North Carolina benchmark of 17.8%. The poverty rate in the United States for the same time period was 15.8%. The combined poverty rate for all people in the Trillium catchment (20.1%) is over 2 percentage points higher than the North Carolina 17.8%. [3]

Trauma

- As many as one in four infants and toddlers are estimated to experience potentially traumatic events. The impact of these stressors causes major disruption in self-regulation, executive functioning, cognition, and social-emotional development, critical for school readiness and academic success.[4]

Maternal Depression

- About 12% of all women report depressive symptoms annually. For low-income women, it is estimated to be at least 25%. Low-income mothers of young children and pregnant and parenting teens report depressive symptoms in the 40 to 60% range. This rate is consistent across ethnic and linguistic communities.[5]

Teen Pregnancy

- Six of 24 Trillium counties are at or above the 2014 state rate of 32.6% for Teen Pregnancy (Beaufort, Bertie, Brunswick, Crave, Hertford, Martin, Northampton, Onslow, Pasquotank, and Washington) [5].

Domestic Violence

- The North Carolina rate of Domestic Violence decreased from 58.7 in 2013 to 56.3 in 2014. Fifteen (63%) of the 24 Trillium counties reported rates higher than the State rate, including Beaufort (62.8), Bertie (220.9), Camden (195.6), Chowan (216.0), Currituck (166.1), Dare (91.3), Gates (124.6), Hertford (275.0), Hyde (234.2), New Hanover (89.5), Northampton (195.3), Pasquotank (224.5), Pender (64.1), Perquimans (135.8), and Tyrrell (65.2) [5].

Abuse and Neglect

- "Research indicates that half of children involved with the child welfare system have clinically significant behavioral or emotional problems, *but only about a quarter are getting mental health services.*"[6]
- In 2012, U.S. state and local child protective services (CPS), estimated that 686,000 children (9.2 per 1,000) were victims of maltreatment.[7]
- 27% of victims were younger than 3 years, 20% of victims were age 3-5 years, with children younger than 1 year having the highest rate of victimization (21.9 per 1,000 children).[8]

Homelessness

- The impact of homelessness on children often leads to chronic stress and trauma from frequent moves, inconsistent relationships, lack of places to play, and witnessing domestic violence and substance abuse. This stress and trauma can be emotionally and cognitively damaging.[9]

- One in 30 children experience homelessness in America each year. That's 2,483,539 equals children who experienced homelessness in the U.S. in 2013.[10]

Citations

- [1] The National Institute of Mental Health (2012.
- [2] Yang, J., Ekono, M., & Skinner, C.(2015, January) . Basic Facts About Low-Income Children: Children under 6 Years, 2013. *National Center for Children in Poverty*. Retrieved from *http://www.nccp.org/publications/pub_1097.html*,
- [3] ECBH Gaps & Needs Analysis reports, 2015
- [4] Briggs-Gowan, M., Ford, J., Fraleigh, L., McCarthy, K., & Carter, A. (2010, December). Prevalence of exposure to potentially traumatic events in a healthy birth cohort of very young children in the northeastern United States. *Journal of Traumatic Stress*, 23:6, 725-733.
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Description of Monitoring Activities:

- All sites are required to meet benchmarks and demonstrate model fidelity in order to obtain yearly Accreditation as a Child First affiliate site.
- All sites must participate in the Accreditation review, which includes: Metrics and Assessment outcomes, Program Fidelity Checklist, clinical chart, video, Fidelity

Framework, training participation, Child First Community Advisory Board, agency compliance, etc.

- Sites may receive: Accreditation, Provisional Accreditation, or Probation based on their fidelity to the Child First model, including process measures and outcomes.
- Any affiliate site receiving Provisional Accreditation must agree to participate in the development of a Quality Enhancement Plan, and meet timelines in achieving stated results.
- Any affiliate site on Probation must agree to participate in the development of a Performance Improvement Plan (with DCF in CT) and meet timelines in achieving stated results.

Child First NPO oversees and consistently performs program evaluation through data analysis. Each clinical team directly uploads the data (service activity, assessments, progress notes, supervision, and other activity) to the Carelogic Electronic Health Record system managed by NPO and Qualifacts. This is a contractual requirement between each affiliate site and Child First NPO. The LME-MCO is provided monthly and quarterly reports by the NPO and has the capability to run unique reports, as needed. The affiliate sites are able to pull the needed data elements for their reporting requirements to the state and LME-MCO.