UNIVERSITY of MARYLAND
SCHOOL OF SOCIAL WORK

THE INSTITUTE FOR INNOVATION & IMPLEMENTATION

Southern Maryland BRIDGE

Building a System of Care




Southern Maryland BRIDGE
Finance Plan Executive Report

September 2017 [1]

An Introduction to Southern Maryland BRIDGE:

The Charles County Local Management Board (LMB) is the recipient, on behalf of the Southern Maryland counties of Charles, Calvert, and St. Mary's, of a four-year (9/30/2015 – 9/29/2019) system of care (SOC) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). This grant, known as Southern Maryland BRIDGE (Building Resiliency from Infancy through Development, Growth and Empowerment) focuses on strengthening the Southern Maryland's early childhood SOC by developing, financing, and piloting an evidenced-based service array for young children ages birth-five with behavioral health issues and their families and caregivers. As a collaborative initiative, BRIDGE is led by the Charles County LMB with The Institute for Innovation & Implementation at the University of Maryland School of Social Work and is set out to achieve the following:

- Create a tiered model of early childhood services including parenting groups, support for children in early care and education settings, and clinic and home based mental health treatment,
- Fund evidence-based direct services aimed at addressing mental health concerns in young children age to birth to 5 and their families,
- Create a replicable early childhood training and workforce development model,
- Create a social marketing campaign to engage families in services,
- Create a replicable and sustainable financing model for delivering services.

The emotional and behavioral needs of vulnerable infants, toddlers, and preschoolers are best met through coordinated services that focus on their full environment of relationships, including parents, extended family members, home visitors, providers of early care and education, and/or mental health professionals. This project is designed to address the needs of young children across jurisdictions and to develop a seamless SOC that

[1] Prepared by Kate Wasserman, Jennifer Lowther, Margo Candelaria, and Deborah Harburger at The Institute for Innovation & Implementation, University of Maryland School of Social Work (UMB), with the BRIDGE Executive Leadership Team.

Funded through the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Grant #1U79SM062471. The contents of this publication do not necessarily reflect the views or policies of the funder, nor does the mention of trade names, commercial products or organizations imply endorsement by the U.S. Department of Health and Human Services. This information is in the public domain. Readers are encouraged to copy and share it.

includes a coordinated, accessible array of effective home- and community-based services that are culturally and linguistically responsive and individualized to the strengths and needs of Southern Maryland families.

Financing Plan Requirements:

SAMHSA requires all SOC grants complete a financing plan by the end of the second year of the grant period to support sustainability of the interventions and services developed and implemented through the grant mechanism. The financing plan should include financial links and/or coordination with other child- and family-serving systems, use of Medicaid funds, and integration with Mental Health/Substance Abuse Block Grant activities and the implementation of the Affordable Care Act. The financing plan is expected to address the role of commercial/private insurance in the sustainability of the grant services. Implementation of the plan should begin by the beginning of the third year of the grant.

Process to Develop the Southern Maryland BRIDGE Finance Plan:

BRIDGE staff conducted key **informant interviews to better understand the current billing mechanisms and practices within the Southern Maryland region.** Interviews were conducted with the following stakeholders and partners:[2]

1. Maryland Department of Health
    - Office of Health Services, Health Care Financing (Elaine Frances Hall, MPH, Health Policy Analyst, Behavioral Health Division)
    - Maternal, Infant, & Early Childhood Home Visiting (MIECHV) Program, Maryland Department of Health (Mary LaCasse, M.S., Ed, Chief of Early Childhood and Family Services, Office of Family and Community Health Services) and (Dona Ponn, M.S., Ed, Program Coordinator, Early Childhood, Office of Family and Community Health Services)
2. TRICARE, Defense Health Agency, U.S. Department of Defense (Patricia G. Moseley, Ph.D., LCSW, ACSW, DCSW, Military Child and Family Behavioral Health Senior Policy Analyst, Clinical Communities Support Clinical Support Division)
3. Local Core Service Agencies (local mental health authorities):
    - Core Service Agency, Calvert County Health Department (Cynthia Middelton, Child & Adolescent Coordinator)
    - Local Behavioral Health Authority, Charles County Department of Health (Karyn Black, Director & Candice Nelson, Child & Adolescent Coordinator)
    - St. Mary's County Local Behavioral Health Authority, Tammy Loewe (Director) formerly at St. Mary's Department of Social Services
    - Carroll County Core Service Agency (Dawn Brown, Director Quality Improvement and Prevention until 9/2017)
4. Beacon Health Options Maryland (Administrative Service Organization) (Maria Rodowski-Stanco, Associate Medical Director until 8/2017)
5. Local Service Providers
    a. Center for Children, Inc. (Cathy Meyers, LCPC, CCMHC, Executive Director)
    b. The Promise Resource Center (Kelly Hutter, MSW, Executive Director)
    c. Tri-County Youth Services Bureau (Laurel James, MSW, Executive Director)

Service Array and Finance Committees for BRIDGE were formed with a group of local and state leaders to discuss the sustainability of both the services and early childhood system this grant is designing and implementing. Additionally, UMB met with state leadership to initiate financing discussions, including: the Director of Child and Adolescent Services for Maryland's Behavioral Health Administration, the Hilltop

[2] Titles are noted as they were at the time of the interview. Key informants may have left the position or organization since the time of the interview. Information provided is presumed to remain accurate.

Institute, and Maryland Medicaid officials. Through the National Technical Assistance Network, UMB staff also spoke with key leaders from other states (including Colorado and Massachusetts) to hear about their successes and barriers related to financing and sustainability planning for their early childhood initiatives.

Accountable Care Act (ACA) Impact on Maryland

On March 23, 2010, the Patient Protection and Affordable Care Act, also known as the ACA, was signed into law by President Barack Obama. Maryland's Children's Health Insurance Program had extended coverage to over 300% of the federal poverty level prior to the ACA (https://mmcp.health.maryland.gov/chp/Pages/Home.asp) however, since its implementation, the ACA has enabled 291,000 individuals to gain coverage through Medicaid and another 142,872 to gain coverage through the Maryland Health Benefit Exchange, as reported in the Mental Health Association of Maryland (MHAMD[3]) 2017 Legislative Wrap-up Document. Subsequent to the initial implementation of the ACA, Maryland merged its mental health and substance abuse authority with a new Medicaid financing and behavioral health integration model. Shortly after initial implementation of the ACA, the Maryland Department of Health (MDH)[4] received a SAMHSA-funded SOC grant focused on Baltimore County that was known as LIFT. LIFT utilized lessons learned and infrastructure established through Maryland's extensive history of SOC initiatives:

> *"Even prior to the passage of the ACA, CMS and SAMHSA were providing federal funds to states and communities, including Maryland, to improve the quality, cost, and effectiveness of behavioral health services for children and families. Findings from over thirty years of System of Care work at the client- and system-level have given states a launching point to implement quality programming and oversight for children's behavioral health care. As the recipient of many such grants, Maryland has been well-positioned to leverage these grant mechanisms to strategically implement and sustain systems of care. Since 2007, federal funding from CMS (including the Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant and the 1915(c) PRTF Demonstration Waiver), and SAMHSA (including System of Care grants - MD CARES, Rural CARES, and LIFT), have provided for the capture of detailed information about the impact of intensive home- and community-based services" (McGarrie, Harburger, Sulzbach & Estep, 2015, p.4).*

LIFT focused on Medicaid-eligible adolescents with serious emotional disorders and co-occurring substance abuse needs who were receiving services through Maryland's public behavioral health system. Under LIFT, Baltimore County implemented a new intensive case management service tailored for children with behavioral health needs. LIFT served as a pilot for the larger Targeted Case Management (TCM) and 1915(i) State Plan Amendment (SPA) that was implemented beginning in 2014.

For more than 20 years, Maryland has demonstrated experience and expertise in approaching federal- and state-funded initiatives from a systemic perspective by leveraging different resources and combining implementation efforts across similarly focused initiatives to link cross-system transformation and maximize statewide impact. This BRIDGE follows suit by using initiatives and services designed under prior grants to move the needle on improving the service array in Maryland. Intensive Care Coordination is an essential service in the continuum of behavioral health services offered as part of Southern Maryland's home- and community-based service (HCBS) array.

Many advocates are fighting to preserve the successes Maryland gained through ACA, and are relentlessly tracking the impact that potential repeal of the ACA could have on this state. Although there is great ambiguity of state of healthcare in this country, Maryland has some advantages which could minimize the impact for

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[3] Mental Health Association of Maryland (MHAMD[3]) is a volunteer, non-profit citizen's organization that brings together consumers, families, professional, advocate and concerned citizens to address mental health and mental illness issues.

[4] Known as the Maryland Department of Health and Mental Hygiene (DHMH) until July 1, 2017 when the name changed to the Maryland Department of Health (MDH).

Maryland. Many of Maryland's healthcare costs are mandated through existing legislation, which could save coverage currently available to many special populations or those with certain conditions. Additionally, SB 571 was passed and enacted into law as the Health Insurance Coverage Protection Act in the 2017 Maryland General Assembly session; this statute established the Maryland Health Insurance Coverage Protection Commission, which will assess and monitor the impact of any possible changes to the ACA, Medicare, Medicaid and other affordable health programs. Per the MHAMD Legislative Wrap-up Document, the bill was amended to at the request of Mental Health Association of Maryland (MHAMD) to include a behavioral health representative on this Commission to ensure mental health and substance use disorder coverage was addressed.

Financing Plan Strategies:

1. ***Align with state and national early childhood initiatives and funding priorities.*** The grant provides a unique opportunity to leverage early childhood funding across three counties while aligning the work with initiatives occurring at the federal and state levels. The BRIDGE staff and Executive Leadership Team will continue to engage with:
    a. **The Maryland Department of Health,** including Maryland Medicaid and the Behavioral Health Administration, on early childhood systems and finance activities;
    b. **The Carroll County Health Department**, on the newly awarded early childhood System of Care Grant, E-SMART, beginning October 2017;
    c. **The State Early Childhood Mental Health Steering Committee,** on opportunities to explore new financing mechanisms and leverage policy and training opportunities;
    d. **The Maryland Department of Human Services (DHS) and Calvert, Charles and St. Mary's Local Departments of Social Services (LDSS) ,** on the implementation of its Title IV-E Waiver/ Families Blossom, particularly regarding services and interventions in Southern Maryland as well as evidence-based and promising practices across Maryland related to parenting programs, substance-exposed newborns, behavioral health services, trauma informed services initiatives underway at DHS and LDSS; and,
    e. **The Maryland State Department of Education,** on opportunities to leverage federal financing to support early childhood initiatives, including through Infants & Toddlers and Early Care and Education programming.

2. ***FY2018 Behavioral Health Legislative Priorities.*** This legislative cycle there were two initiatives that track most closely with BRIDGE Financing mechanisms, both focusing on adult mental health needs with significant implications for the infants and young children in their lives:
    a. ***Maternal Mental Health:*** MHAMD advocated successfully for implementation of several key recommendations of the previously established Task Force To Study Maternal Mental Health, including increased screening and referral for mental health concerns for new mothers in the postpartum year. The provisions (SB 600/HB 775) work to address this unmet need by developing a mental health system within the state, to identify, screen and refer caregivers in need during visits with pediatric primary care and OBGYN care. Postpartum mental health remains a quiet, private epidemic, despite glaring statistics that inform us that one in eight women silently suffer during their postpartum period. It should be noted that we have made advancements over the course of the past decade. Yet, diagnosis and treatment of depression and anxiety in the pregnancy and postpartum period are often overlooked. Targeting support for these caregivers, and linking early childhood interventions for these families provides tremendous prevention opportunities.
    b. ***Opioid Crisis:*** MHAMD advocated for and tracked the efforts and outcomes of legislative bills introduced to the 437th legislative session of the Maryland General Assembly in response to

rising suicides and opioid-related deaths in Maryland. In their *Legislative Wrap-Up Document,* MHAMD noted several legislative victories addressing unmet maternal mental health needs and individuals with severe mental illnesses who have been identified as "hard to engage." The Keep the Door Open Act (SB 476/HB 580), a campaign to support and resource community behavioral health providers in Maryland, was reintroduced this past session to ensure increased funding for the workforce serving children and adults to reflect rise in cost of healthcare, demand for increased services and promotion of high quality services to treat mental health and substance use disorders. This legislation gained momentum because it was included in the Heroin and Opioid Prevention Effort (HOPE) and Treatment Act of 2017 (SB 967/HB 1329), which is a comprehensive plan to address Maryland's Behavioral Health Crisis. Governor Hogan signed HOPE Treatment Act of 2017 via a bipartisan omnibus bill that contains provisions to improve patient education, increase treatment services, and includes the administrations Overdose Prevention Act.

Young children, the target of our BRIDGE work, are impacted greatly when caregivers and family members are impacted by this epidemic. The opioid epidemic in the United States claimed more than 33,000 deaths in 2015 (CDC, 2016), as public health officials call it the worst drug crisis in the nation's history. Yet, perhaps more disturbing is the number of children being affected by the increase of opioid use in all 50 states. The images of parents passed out in cars from drugs while their children are sitting in back seats have gone viral through social media. There is significant implication for early childhood workforce development here to serve the specific needs of these infants and young children. Overall, current home visiting application to caregivers with substance use struggles is limited. These caregivers can be more difficult to engage in services and are more likely to drop out or have inconsistent participation due to the conflicting needs of substance use and parenting. Typically, treatment for substance use problems does not focus on parenting concerns in particular, which may overlook a primary source of stress for caregivers with substance use problems (Parolin & Simonelli, 2016). Review studies have indicated that traditional caregiver interventions focused on improving parenting behaviors may not be sufficient for caregivers with substance use problems (Azzi-Lessing, 2013); but an approach that delves into caregiver mental representations in a reflective manner (focusing on attachment and trauma history and how it impact current relationships) may be more relevant for this population (Suchman, et. al., 2006).

Some of the highlights of the Keep the Door Open Act included in the HOPE and Treatment Act of 2017 that should impact Southern Maryland children and families include the following:

- establish behavioral health crisis treatment centers consistent with future recommendations from the Maryland Behavioral Health Advisory Council;
- expand and promote statewide 24/7 crisis hotlines; and,
- require a report from the MDH on potential outcomes measures for behavioral health providers and how reimbursement can best be tied to outcomes.

Additionally, the fiscal note for FY 2018 included monies that could favorably fund and boost the County's system for children and families and involve:

- costs of merging local mental health authority/core service agencies with local addictions authorities;
- behavioral health accreditation processes;
- integration of behavioral and somatic health services; and,
- agency coordination in determining appropriate community placements of children with mental illness, complex medical needs and developmental disabilities.

3. ***Conduct a comprehensive assessment of current financing for early childhood initiatives in Southern Maryland.***
    a. BRIDGE staff will request **Medicaid expenditure and claims data** on children Southern Maryland ages 0-8 to identify current utilization of the public mental health system (primary and specialty), providers serving these children and families, diagnosis codes utilized, and ages of children served, as well as any patterns of service utilization. Data will be requested from The Hilltop Institute at UMBC, Beacon Health Options Maryland, and/or the Health Services and Cost Review Commission.
    b. BRIDGE staff will reach out to **TRICARE and commercial insurers** to obtain additional information on covered benefits for young children with behavioral health needs and their families as well as the percentage of covered families that access these benefits.
    c. A **fund map** will be completed by a contracted expert, David McNear, to include a children's budget matrix and detailed behavioral health fiscal analysis of Southern Maryland. The budget matrix will include information from key stakeholders and partners including local core service agencies, Medicaid, and child welfare agencies.
    d. Key **informant interviews** will be conducted with Southern Maryland Local Management Boards to explore current funding and opportunities for expanding funding.

4. ***Encourage Medicaid billing for BRIDGE services.*** Support BRIDGE providers to **bill Medicaid for evidence-based practices (EBPs)** provided under BRIDGE. The BRIDGE Executive Leadership Team and staff are committed to billing Medicaid, as allowable, appropriate, and to the extent possible, for services contracted under BRIDGE. Providers whose services have implementation costs that exceed the Public Behavioral Health System rate that is available may be given supplemental funds from BRIDGE to cover the cost of services. Supplemental rates should be considered based on documentation of actual costs or, if such documentation does not exist initially, on an assumption than an evidence-based practice costs an additional 10-20% (depending on whether it is provided in an office or in-home). Data will be collected from providers to determine if it is necessary to advocate for an enhanced rate for the EBPs under the Medicaid State Plan.
    a. **Support providers to utilize diagnostic and functional assessment tools that align with requirements for Medicaid and commercial insurance billing.**
        i. Zero to Three will be providing a DC 0-5 Diagnostic Assessment training to providers to support the workforce to utilize appropriate diagnoses with young children with behavioral health needs.
        ii. Providers (having participated in a training provided by the American Academy of Child and Adolescent Providers in May 2017) will be piloting the use of the Early Childhood Service Intensity Instrument (ECSII) during the first quarter of Year 3, to assist with conducting functional assessments in support of service planning and, as appropriate, case formulation and diagnoses.

5. ***Explore opportunities to maximize funding through Part C and Child Find of the Individuals with Disabilities Education Act (IDEA).*** Part C and Child Find (within Part B) funding have been utilized in other states to support improved assessment tools, provide training, and improve coordination among service providers. The BRIDGE Executive Leadership Team will work with the Maryland State Department of Education and the local school systems to identify opportunities to utilize these funds to sustain the work of BRIDGE.

6. ***Explore Medicaid reimbursement opportunities for Early Childhood Mental Health Consultation (ECHMC) and Enhanced Early Childhood Mental Health Consultation (E-ECMHC).*** BRIDGE staff will

work with Medicaid finance experts within The Technical Assistance Network for Children's Behavioral Health as well as with Maryland Medicaid and Zero to Three to identify mechanisms for Medicaid billing for components of ECMHC and E-ECMHC. Based on the findings, the BRIDGE Executive Leadership Team will make recommendations regarding next steps for financing these interventions.

7. ***Partner with the Maryland Department of Health and Beacon Health Options Maryland to issue policy guidance regarding the eligibility regulations for Mental Health Case Management: Care Coordination for Children and Youth (COMAR 10.09.90.03).*** The State Plan Amendment and the associated regulations require that the child requires community treatment and support in order to prevent or address inpatient psychiatric or substance use treatment; treatment in a Residential Treatment Center (RTC) or residential substance use treatment facility; an out-of-home placement; emergency room utilization due to multiple behavioral health stressors; homelessness or housing instability, or otherwise lacking in permanent, safe housing; or arrest or incarceration due to multiple behavioral health stressors. Policy guidance should be reviewed and customized to determined what risk factors look like in young children ages 0 to 8 with serious behavioral health needs so that more children are able to access this service. Furthermore, partnership with the pending Carroll County E-SMART grant will explore this further as a primary component of that grant is to develop an early childhood care coordination model and determine corresponding reimbursement mechanisms.

8. ***Support the Maryland Department of Health to draft modifications to the 1915(i) State Plan Amendment for Children and Youth to make the medical necessity criteria for children under age six less restrictive.*** The current Medicaid State Plan Amendment requires that children under six with an ECSII score of 4 must either must be referred directly from an inpatient hospital unit or, if living in the community, have two or more psychiatric inpatient hospitalizations in the past 12 months. This creates a very high barrier to services for young children with serious behavioral health needs, requiring inpatient hospitalizations for children with a score of 4 or for these children to have a score of 5, which is the highest score and one that would correlate to needing an inpatient hospitalization. SOC is focused on improving access to effective home- and community-based services; BRIDGE is focused on ensuring that young children with intensive behavioral health needs have access to effective services in the least restrictive setting.

9. ***Collect satisfaction and performance data on services funded by BRIDGE, including new services like the warm line, to support efforts to solicit private, local, and state funds for sustainability in grant years three and four.*** The BRIDGE Executive Leadership Team recognizes that there are competing priorities for limited resources; as such, it will use the data from its national and local evaluations and contract performance data to support focused requests for sustained funding from private philanthropic entities as well as state and local partners.

10. ***Leveraging Behavioral Health Screens Through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT).*** Maryland should ensure that behavioral health screens occur through the Early Periodic Screening, Diagnosis, and Treatment program in Medicaid. Behavioral health screens should be occurring through EPSDT and tracking of these screens and the referral outcomes would be valuable to undertake in the Southern Maryland regions to better understand how EPSDT is administered and implemented.

BRIDGE Service Array:

Although recognized that mental health services for very young children and their families are a necessary and important the quality of service and access to them remains a barrier. Additional issues include problems

associated with stigma, timely community referrals, diagnosis of mental health concerns in infants and toddlers, differences in the family engagement and involvement process, and the scarcity of well-trained infant-family mental health professionals. Infants and toddlers do not enter the mental health system through traditional portals, as families typically do not usually seek mental health treatment services for their very young children on their own. Recognizing the disparity for young children needing to access services and supports to address behavioral health, this collaborative SOC work focuses on strengthening the Southern Maryland early childhood system of care by developing, financing, and piloting an evidenced-based service array for young children ages birth to 5 with behavioral health issues and their families and caregivers.

The EBPs implemented under BRIDGE include:

- **Tier 1: Circle of Security Parenting Program (COS-P)**—An attachment-based intervention that can be implemented in individual or group sessions. COS-P teaches parents about children's key needs for both intimate connection and autonomy about parenting behaviors that support these needs and promotes parents' reflection on their own histories and current parenting behaviors (serving ages birth-5).
- **Tier 2:**
    - **Attachment BioBehavioral Catch-up (ABC)**—A dyadic, attachment-based intervention that is delivered through 10 home visits provided by a trained parent coach. ABC promotes attachment security and biological regulation in children who have experienced adversity (serving children under 2).
    - **Parent Child Interaction Therapy (PCIT)**—12-20 session intervention that focuses on improving the quality of the parent-child relationship and changing parent-child interaction patterns; typically conducted in an office but BRIDGE will also try implementing in a home-based setting. PCIT was available in SOMD before the initiation of this grant, but BRIDGE funds have successfully expanded its availability for families and increased the number of trained providers (serving ages 2 to 5).
- **Tier 3: Child Parent Psychotherapy (CPP)**—A 12-month dyadic intervention addressing parents' perceptions and behaviors and child's mental health symptoms, this program supports attachment security to promote children's mental health and explicitly addresses both parents' and children's traumatic experiences (serving ages birth to 5).

In addition to the above described EBP's embedded within clinical practices and other child-serving settings, BRIDGE is working to augment the current early childhood SOC in Southern Maryland by leveraging existing Medicaid funded services in place in Maryland. Care Coordination (known as Targeted Case Management in COMAR) aligns with the system of care efforts and is being implemented with a younger population as part of this grant. Intensive Care Coordination can be authorized by Beacon Health and bill Medicaid if meets medical necessity criteria. This grant will cover those that need care coordination but are commercially-insured children since private insurance does not cover this service. This Tri-County, Southern Maryland early childhood focused SAMSHA grant follows suit by using initiatives and services designed under prior grants to move the needle on improving the system of services in Maryland. Intensive Care Coordination is an essential service in the continuum of behavioral health services offered as part of BRIDGE's early childhood system of care. Additionally, the grant covers discretionary funds to pay for services or supports identified in the plan of care to meet a goal, but are not reimbursable. These additional dollars give financial flexibility to help treat young children and support families.

Grant funds also cover the administrative costs of providing specific EBPs (discussed above) as well as establishing a model of enhanced Early Childhood Mental Health Consultation (E-ECMHC) services that augment childcare setting consultation to include a family-focused home visiting offered by a mental health clinician. Funds have also been dedicated to partner with Maryland Family Network who offer Parent Cafes

and Parent Café Facilitator Trainings across the three counties. These are two-hour, structured gatherings that engage parents and other adults in meaningful conversations about what matters most to families with young children and how to build protective factors at home and in early childhood settings. At Parent Cafés, caregivers of young children share information and ideas that can help them to take care of themselves, develop strong relationships with children, and strengthen families.

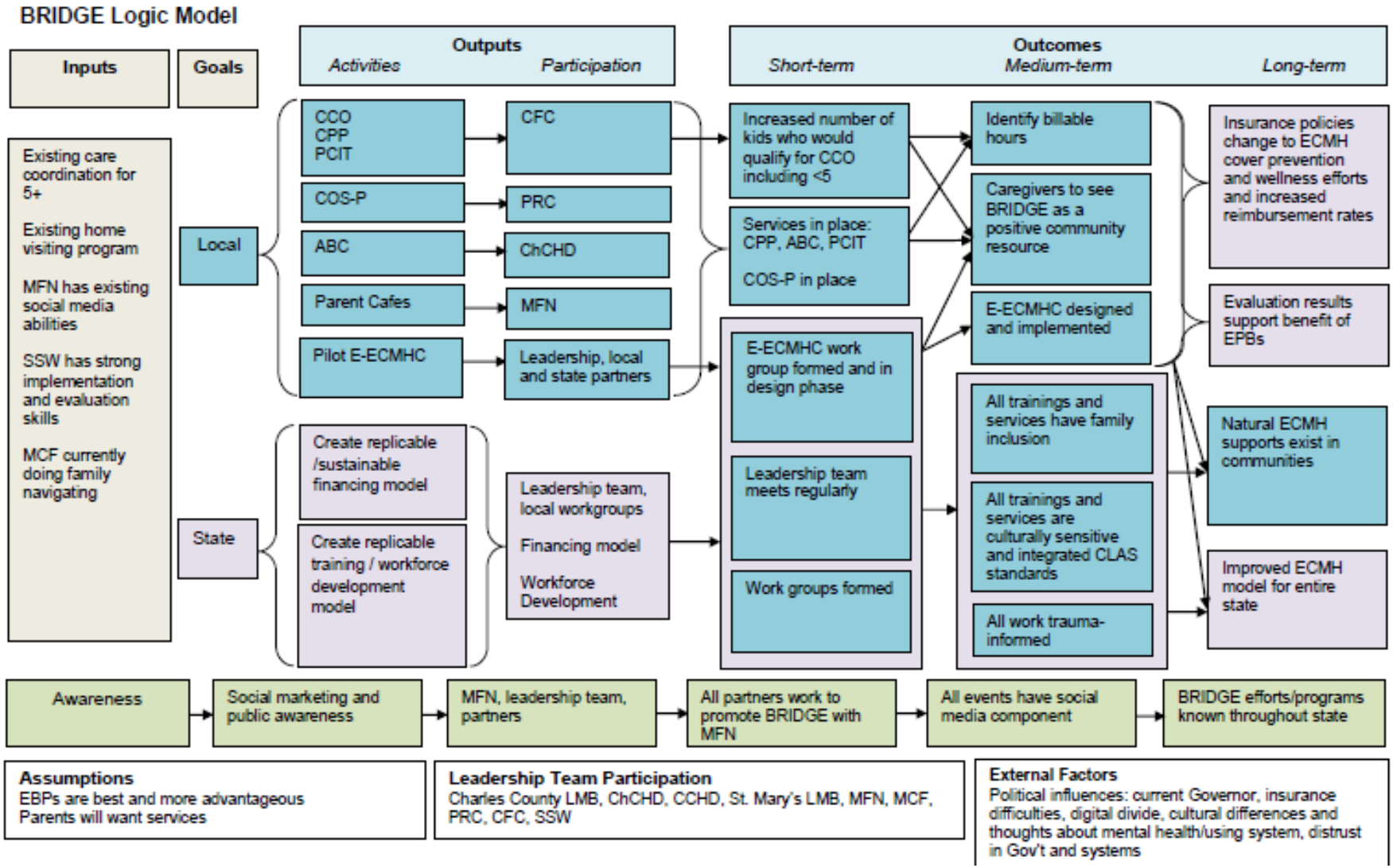
A primary lesson learned is the importance of recruiting an engaged cohort of providers representing agencies that illustrate more fully the broad service array that works to serve young children and their families and holds true to the values of system of care. For that reason, The BRIDGE Executive Leadership Team (Team) is working to solicit and engage additional community partners including representatives from the Departments of Social Service, Infants and Toddlers early intervention programs, the school systems, pediatric primary care providers and others. The Team continues to address the issue of engaging families at each meeting and continue to look for innovative ways do so. The Team is implementing a collective impact framework for theory of change and believe that this approach will serve both providers and families in bridging the current disconnect between demonstrated need in children and families, and lack of engagement in available and age-appropriate mental health services and supports.

The Team has begun to show initial success in recruiting children and families and serving this population with a unique tiered system of support, and are learning more about needed trainings to support the early childhood workforce in the area, including plans for an overview of early childhood mental health for the CCO team and DC 0 – 5 for diagnostic codes. The hope is that this and other trainings will increase the competencies of the workforce with respect to mental health needs and diagnoses. As a result, many of the local service staff have completed the training necessary to be providing highly skilled services related to their specific contracted EBPs. The Team will continue to strive for further partnership and increased service delivery and address financial sustainability efforts across the Southern Maryland region.

About the Institute for Innovation & Implementation, University of Maryland School of Social Work:

The Institute for Innovation & Implementation at the University of Maryland, Baltimore School of Social Work serves as a national training, technical assistance, evaluation, policy, systems design, and finance center focused on children's behavioral health. The Institute supports state and local governments and organizations to implement effective systems and practices to best meet the needs of children and youth with complex behavioral needs and their families. The Institute integrates its policy and finance; training, technical assistance, and implementation; and, research and evaluation activities to assist governmental and other organizational entities to achieve better outcomes for children, youth, and their families. The Institute is the coordinating entity and centralized contact for the Technical Assistance Network for Children's Behavioral Health.

APPENDIX A: BRIDGE LOGIC MODEL



APPENDIX B: BRIDGE Finance Chart

BRIDGE Finance Planning

Services to Promote, Prevent and Address Mental Health Concerns in the 0-7 Population in Southern Maryland

Service Category	*Service*	*Funding Source/ Billing Mechanism* (Block Grant, Health Codes, MH Codes, MSDE, other)	*Billable Providers/Staff*	*Identified Patient*		*Insurance Coverage*		
				Caregiver	*Child*	*Medicaid*	*Private*	*Tri-Care*
Identification	EPSDT Screening	Additional E/M code added to well child visit in primary care setting. *(Can this also be done through other mechanisms in the health department? Home visiting? OMHC?)*	Medical Providers	Yes *(can bill during prenatal and postpartum visits)*	Yes	Yes	Yes	Yes
Promotion	Parent Cafes	- SOC Grant Funded - How does MFN fund these across the state?		Yes	No	No	No	No
Promotion/ Prevention/ Treatment	Parent Groups (Eg: COS-P or Chicago Parent Program)	Can be provided in schools, OMHCs, other settings – if OMHC location of staff, and parents/child is enrolled in TX can be billable service through insurance.	Depends on setting – can be medical providers, licensed mental health clinicians and/or paraprofessionals	Yes	Yes	Yes	Limited	Limited
Prevention *(if universal)* **Intervention** *(if targeted)*	Developmental screening with interpretation and referral	96110 – ASQ, PEDS, other screener	Medical providers and/or licensed mental health clinicians (PhD, PsyD, MSW, LCPC, etc.) (what about OTs, Nurses, others)	No	Yes	Yes	Yes	Yes
Intervention	Early Intervention,	96101, 96111 and 90791	Licensed psychologist	No	Yes	Yes	Yes	Yes

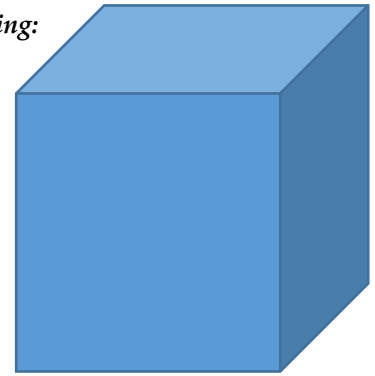
	psychological testing	Can occur within early intervention ITP program, or OMHC or school setting						
Intervention	Mental Health Consultation	- Consultants grant funded through MSDE - Enhanced model funded through SOC funds - Licensed MH Clinician with ability to bill for assessment, individual and family sessions.	- Licensed mental health providers (graduate level social work, counseling) - Some are not licensed (traditional MSDE funded model, not enhanced model funded through SOC dollars)	Limited, if documenting that parent is the focus of consultation	Yes	No	No	No
Care Coordination	CCO	Current SOC Grant Funds (other mechanisms?)	No license required. COMAR Regulations.	Yes	Yes	Yes	No	No
Case Management	Home Visiting	Title 5 Block Grant funded (other MSDE grant funding) Local foundation grants (United Way, etc.)	Nurses or other public health professionals, no license required. Models like Healthy Families hires paraprofessionals.	Yes	Yes	No	No	No
Medical Case Management	Medical Case Management	Health Codes	Nurse or paraprofessional within health care setting/entity	No	Yes	Yes, if medically indicated and approved.	If medically indicated, child qualifies for Medicare or Medicaid	
Treatment	Individual, Family & Group Treatment (Standard)	MH Codes: - 90847 (45 minute family therapy with patient present) - 90843 (60 minute family therapy with patient present) - 90867 (family therapy w/o patient) - 90846 (Multi-family group treatment)	Licensed mental health clinicians (Psychiatrist, PhD, PsyD, MSW, LCPC, etc.)	Yes	Yes	Yes, if patient is enrolled and given DX	Limited	Limited
Treatment	ECMH EBPs (PCIT, CPP,	MH Codes: - See above…	Licensed mental health clinicians (Psychiatrist, PhD, PsyD, MSW, LCPC, etc.)	Yes	Yes	Yes, if patient is enrolled and given DX		

APPENDIX C: EXCII Overview for Service Array Committee

ECSII Overview for Service Array Committee

Overview: The Early Childhood Service Intensity Instrument (ECSII) developed by the American Academic of Child and Adolescent Psychiatrists (AACAP), determines intensity of service need for infants, toddlers, and children from ages 0-5 years. The ECSII is a tool for providers and others involved in the care of young children with emotional, behavioral, and/or developmental needs, and their families, including those children who are experiencing environmental stressors that may put them at risk for such problems. ***Domains of the ECSII:*** I: Degree of Safety; II. Caregiver-Child Relationships; III. Caregiving Environment; IV. Functional/Developmental Status; V. Impact of Medical, Developmental, or Emotional/Behavioral Problems; VI. Services Profile

Dimensions of Service Planning:



Service Settings:

E.g. Home, child care, clinic, head start, etc.

Focus of Services:

E.g. Child, dyad, family, community, system of care

Service Categories:

Types of Services: E.g. Evaluative, medical, developmental/early education, social service, mental health, community and natural supports.

Level of Service Intensity	*Service Category: Evaluation*	*Service Category: Medical*	*Service Category: Developmental/Educational Services*	*Service Category: Mental Health Services*	*Service Category: Social Services/Child Welfare*	*Service Category: Care Coordination/Child Family Team*	*Service Category: Community and Natural Supports*
0	• Primary Care Check Up	• Well Child Care • Standard preschool health monitoring	• Childcare, head start, preschool	• Mental Health Screening in preschool or	• Public Health Education	• Caregiver(s) coordinates services as needed	• Support from family, kin, community

	• Health Screening in preschool settings			primary care settings			
1	• Evaluation in a single service area	• Primary care management of acute common childhood illnesses (ear infection, GI issues) • Preschool monitoring of specific health issue (dental, nutrition)	• Regular kindergarten or Montessori class	• Parental guidance and support e.g. training/education	• Basic financial education (WIC, food stamps, SCHIP)	• Caregiver(s) coordinates services as needed in collaboration with primary service provider (PCP, therapist)	• Child (day) care
2	• Evaluation from one or more service areas	• Chronic medical conditions managed by PCP • Medications for chronic conditions given in preschool or childcare setting	• Play groups	• Mental Health Consultation in childcare setting	• Community home visiting	• Primary service provider performs care coordination as needed in collaboration with caregivers(s)	• Informal parent peer support
3	• Evaluation from multiple service areas, with repeated visits	• Chronic medical conditions managed by primary care provider with occasional specialists consultation • Time-limited home-based health care (e.g. completion of course of IV antibiotics)	• Single developmental therapy but below Early Intervention eligibility(e.g. speech clinic, home visiting with 0-3 specialist, OT consult)	• Outpatient MH Services once per week or less by MH professional	• Public assistance (cash assistance) with assigned caseworker	• Separate care coordinator if multiple providers are involved	• Faith-based community
4	• Complex, integrated, multidisciplinary evaluation	• Chronic medical problems requiring management by specialists or multiple	• Early Intervention developmental services provided in home with	• MH Diagnosis and psychotropic medication by PCP	• Periodic home mentoring for identified area of concern (e.g. home health nurse)	• Development of child and family team with active family involvement. CFT may meet	• Parent support group or parenting education class

		specialist consultations • Intermittent hospitalizations for chronic condition • Ongoing home-based or school-based health care	caregiver skills training			on as-needed basis or be time-limited	
5	• Evaluation in inpatient or other 24-hour setting	• Frequent hospital admissions, secure nursing facility or medical foster care • Intensive, home-based care	• Supports or modifications to typical classroom setting	• Intensive outpatient (> 1 session per week) of individual, dyadic, family or parental TX	• Parenting education classes for identified concern	• Formal care coordination with a child and family team that meets regularly	• Increased involvement of extended family, kin, community

APPENDIX D: Illustration of Single Point of Entry Warm Line for Southern Maryland With Family Navigation