

# Early Childhood Intervention



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# INTRODUCTION



Welcome to **Early Childhood Intervention (ECI) of North Central Texas**. We are pleased to recognize you as part of the ECI team and look forward to a mutually successful relationship with you.

## Definitions

In this Provider Manual,

1. **Provider** - refers to any professional who has been approved to provide services to ECI children and their families, under a contractual agreement.
2. **Part C** - refers to Part C of the Individuals with Disabilities Education Act (IDEA); more information: <https://sites.ed.gov/idea/statute-chapter-33/subchapter-IV/part-C>
3. **Covered individual, client, infant, baby, toddler and family** are all terms to be considered interchangeable.
4. A list of [ECI definitions](#) is available, as established by the Texas Administrative Code (TAC) §350.103.
5. **ACTION** = actions you are required to perform to complete the application process
6. **TRAINING** = training required to be completed before you can begin delivering ECI services

The information contained in this manual applies as of the date it was published and may be modified by ECI at any time.

## Federal and State Statutes, Rules, and Regulations

The ECI program is governed by and is compliant with the following [statutes, rules and regulations](#):

### Statutes

- United States Code, Title 20, Chapter 33, [Individuals with Disabilities Education Act \(IDEA\)](#)
- Human Resources Code, Chapter 73, [Interagency Council on Early Childhood Intervention Services](#)
- United States Code, Title 20, Section 1232(g), [Family Educational Rights and Privacy Act of 1974 \(FERPA\)](#)

### Regulations

- Code of Federal Regulations, Title 34, Part 99, [Family Educational Rights and Privacy](#)
- Code of Federal Regulations, Title 34, Part 303, [Early Intervention Program for Infants and Toddlers with Disabilities](#)

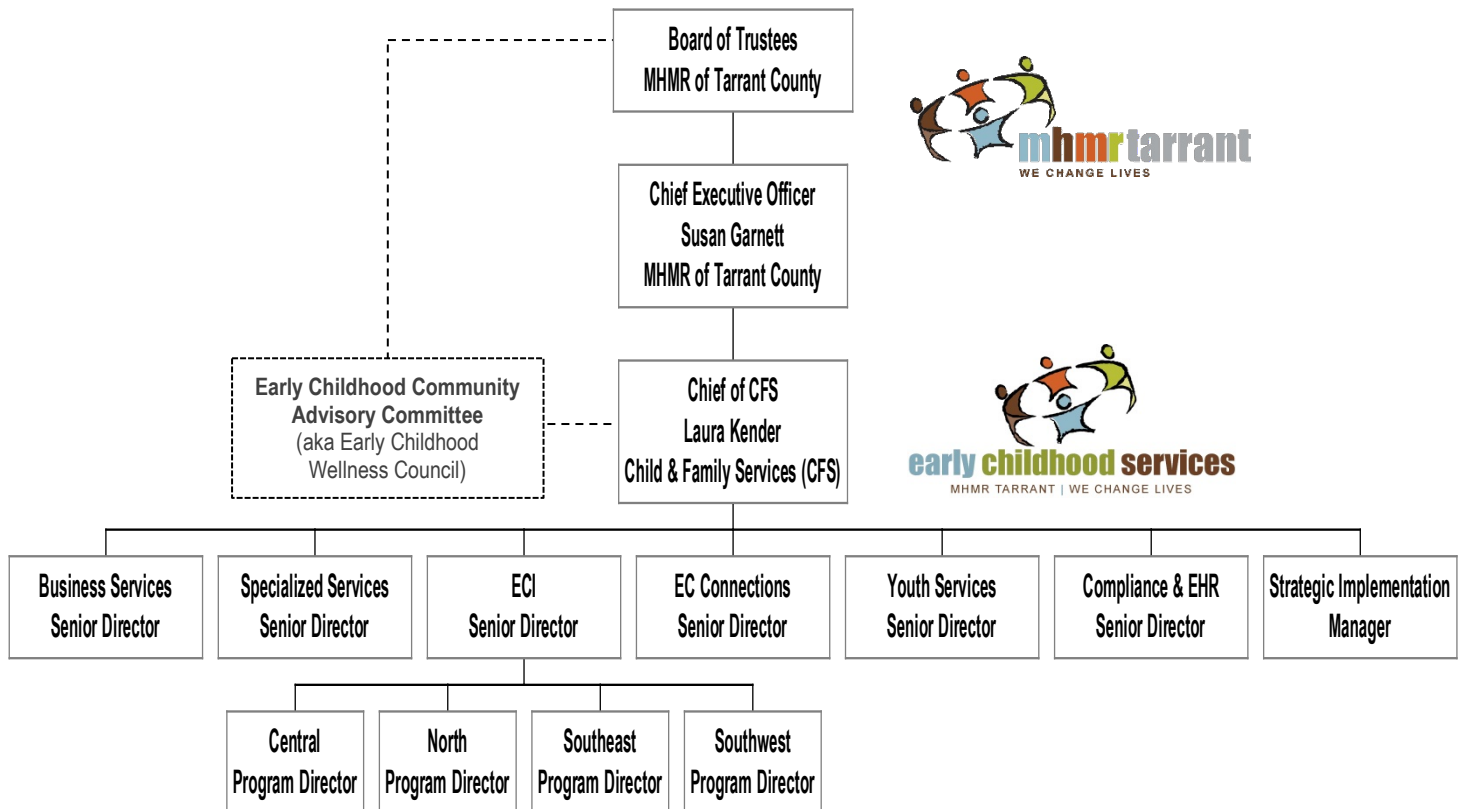
### Rules

- Texas Administrative Code, Title 26, Part 1, Chapter 350, [Early Childhood Intervention Services](#)
- Texas Administrative Code, Title 1, Part 15, Chapter 355, Subchapter J, Division 22, [Reimbursement Methodology For the Early Childhood Intervention Program](#)

# ORGANIZATIONAL STRUCTURE

**E**CI of North Central Texas is a program within the Early Childhood Services Division of **My Health My Resources of Tarrant County (MHMR)** <https://www.mhmrtarrant.org> and is an affiliate of the Texas Early Childhood Intervention under the Texas Health and Human Services (HHS) <https://hhs.texas.gov/>

## Organizational Chart



## ECI Contact Information

Central Administration  
3840 Hulen Street, Suite 100  
Fort Worth, Texas 76107

Title	Name	Phone
Early Childhood Services (ECS) Chief	Laura Kender	817-569-5301
Early Childhood Intervention - Senior Director	Anisha Philips	817-718-4823
Specialized Services - Sr. Director	Meghan Glovier	817-569-5303
Early Childhood Connections - Sr. Director	Marnie Stone	682-287-5100
ECS Business Services - Sr. Director	Candace Andrade	817-569-5311
Compliance & Electronic Health Record (EHR) - Sr. Director	Sarah Nagle	817-343-4871
Strategic Implementation Manager	Debbie Lindsey	817-692-4834
ECI Central Division - Program Director <i>Serving the Northern portion of Tarrant County</i>	Margie Jones	682-309-7648
ECI North Division - Program Director <i>Serving Tarrant, Denton, Wise and Cooke Counties</i>	Sarah Bernhagen	817-223-2406
Southeast Division - Program Director <i>Serving Ellis, Navarro, and the Southeast portion of Tarrant County</i>	Veshia Bowen	214-949-2867
Southwest Division - Program Director <i>Serving Parker, Johnson, Erath, Palo Pinto, Somervell and the Southwest portion of Tarrant County</i>	Molly Wheeler	682-478-7786

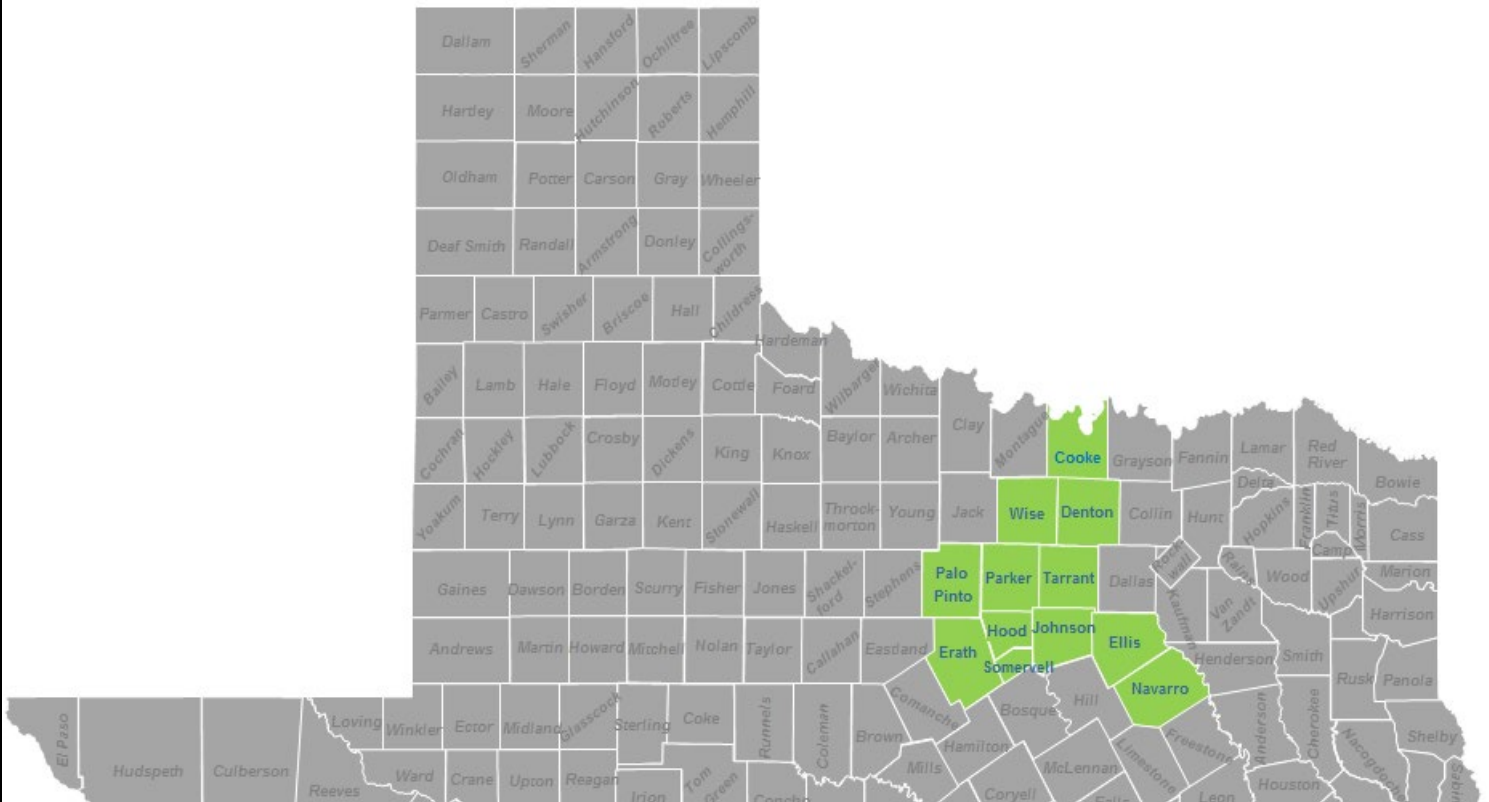
Each ECI division has 4 Team Coordinators, who are assigned children based upon the family's residential zip code. The children assigned to the Provider will be listed on a caseload list.

**ECI Referral Line**  
**1-888-754-0524** (toll free) or **817-446-8000**  
817-569-4492 fax

# SERVICE AREA



CI of North Central Texas provides services in the following 12 counties:



1. Cooke County
2. Denton County
3. Ellis County
4. Erath County
5. Hood County
6. Johnson County
7. Navarro County
8. Palo Pinto County
9. Parker County
10. Somervell County
11. Tarrant County
12. Wise County

# ECI PUBLICATIONS & VIDEO

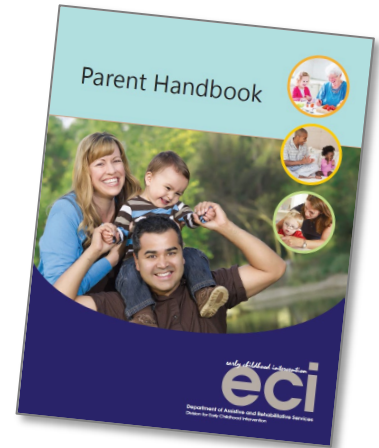
**P**ublications and videos have been produced to help educate and inform families and professionals about ECI's service delivery system and parental rights (procedural safeguards).

## Publications

ECI publications listed below are available on MHMR's website.

- How's Your Baby?
- Beyond ECI: Transition Handbook
- Paying for ECI Services
- What Healthcare Professionals Need to Know About ECI
- Parent Handbook

**TRAINING**



## ACTION

*Read the Parent Handbook (located on [ECI's webpage](#)), which explains ECI services from the parent's perspective and their legal rights in accordance with the Family Educational Rights and Privacy Act (FERPA).*

## Video

A video about the local Early Childhood Intervention program is available on YouTube at <https://www.youtube.com/watch?v=sc6RjbxBzJM>



# SERVICE GUIDELINES

It is the provider's responsibility to render services to ECI children and their families in accordance with the terms of the contract and this Provider Manual. The provider is required to render services in the same manner, adhering to the same standards, and within the same time availability as offered to all other children and families. There is no guarantee that any ECI family will utilize any particular provider.



## Age of Children

ECI services are provided for children ages birth to 36 months. Services may not be provided to a child on or after their third (3<sup>rd</sup>) birthday.

## Toys

ECI philosophy dictates use of the families' toys. Providers must **NOT** bring toys into the family's home.

## Transportation

Provider may **NEVER** transport an ECI client or family member in their personal vehicle.

## Equipment

Provider is responsible for all equipment and supplies needed to carry out the treatment/services whether, in the child's home, or in other settings; including testing tools.

Provider is responsible for first discussing with the Service Coordinator any recommendations for equipment.

## Case Transfers

Provider is expected to fully cooperate with cases that transfer to another provider.

## Subpoenas

If Provider receives a subpoena for a client's records or a subpoena by attorney summons to testify in court or by deposition, Provider must contact their assigned Program Director immediately.

No records may be released without a subpoena or a Release of Information (ROI), unless it is a Child Protective Service (CPS) investigation, and in this instance, the Provider must notify their Program Director immediately of any requests or subpoena. Coordination of a subpoena is handled through MHMR's Health Information Management (HIM) Department by contacting:

Director of Health Information Management  
MHMR Tarrant, RU #1044  
3840 Hulen Street - North Tower  
Fort Worth, TX 76107  
817-569-4382  
[Health.Information@mhmrtc.org](mailto:Health.Information@mhmrtc.org)



# SERVICE DELIVERY

**T**he primary contact person for any ECI child and family is the ECI Primary Service Provider (PSP), also called the Service Coordinator. The ECI Service Coordinator is responsible for the overall coordination of services to the child. All issues regarding a child must be brought to the attention of the ECI Service Coordinator for assistance in resolution.

ECI of North Central Texas recognizes that a team effort is needed to successfully provide services to ECI families. For this reason, the Provider is seen as a valuable member of the team, having insight into successes or problems as they occur. Providers are encouraged to ask questions of the ECI Service Coordinator as **Individualized Family Service Plans (IFSPs)** and other plans are developed to ensure those specific areas most important to the child and family are addressed at that time.

It is expected that regular communication will occur between the Provider, family, ECI Service Coordinator, and other team members, as indicated to ensure roles and responsibilities are tailored to meet the child and family's needs.

## Activities to Achieve Child & Family Outcomes

Any Provider that delivers services will be expected to address specific written outcomes and procedures/activities, in conjunction with the ECI child, family and other team members. Specific procedures / activities will need to be written as part of the IFSP. The minimum requirements for an IFSP team are the ECI service coordinator, the ECI parent or legal guardian and a second discipline. Second disciplines include:

- Infant Mental Health Specialist: LPC, LCSW, or LMFT
- Physical Therapist
- Occupational Therapist
- Speech Therapist
- Registered Nurse
- Registered Dietitian
- Early Intervention Specialist



For children with Auditory and/or Visual Impairments (AI/VI), the AI or VI teacher from the Independent School District (ISD) is required to participate.

## Coaching *also see Training Section*

ECI uses a coaching approach, which allows the parent/caregiver to feel confident and competent. Coaching provides support, suggestions for improvement, and encouragement in parents' ability to:

- Reflect on interactions with the child;
- Develop a plan for future interactions; and
- Support the child in all areas of development.

## Visits

- Provider must ensure that all visits assigned to them are completed, as stated in the child's IFSP.
- Any requests to change frequency or duration of service must be directed to the appropriate Service Coordinator immediately. Changes cannot occur until an IFSP revision has been completed.
- Progress notes must be completed at each therapy visit; a copy must be left with the parent/caregiver.

## Father Engagement

The father's involvement is essential for young children's development and learning. The Provider can play an important role by encouraging the father to become engaged in their child's life and should operate from an approach that every child has two parents (even if one is not living in the home). From the first contact with family, Provider should use "invite dad" strategies to encourage father's participation, such as:

- Schedule visits when dad can attend.
- If dad cannot be physically present, arrange for him to participate virtually (e.g. [Doxy.me](https://doxy.me)).
- Use active listening skills to acknowledge dad's needs and opinions.
- Involve the dad in an activity with the child and point out how responsive the child is to him.
- Affirm the dad's interests and skills and describe ways those can be shared with his child.
- Include the dad in goal setting (don't just ask him about financial matters).
- Share information with dad if he cannot attend.

## No Shows or Cancellations

Any "no show", client cancellation, or cancellation by Provider must be documented on a progress note.

## Outside Referrals

In accordance with ECI best practices, Provider may not make a medical referral/recommendation for the family to see an outside company that are medical or that would require authorization by the family's primary care physician (PCP), managed care organization (MCO), or private insurance case manager. Examples are:

- Private therapy
- Diagnostic testing
- Audiological testing
- Ophthalmology testing

If a family requests a recommendation for a private therapy company, Provider will refer the family to their PCP, MCO, or private insurance case manager and notify the Service Coordinator. A list of referral sources should not be given to the family.

## Interpretation / Translation

Provider must make ensure that interpretation or translation services in the child's native language or other communication assistance necessary for a parent or child with limited English proficiency or with communication impairments to participate in early childhood services. Interpretation, translation, and communication assistance is provided at no cost to the family ([TAC Title 26, Part 1, Chapter 350, Subchapter B, Rule §350.203](#)).

The ECI program has contractual agreements with interpretation companies, which ECI staff and Providers may utilize for interpretation, translation, and sign language assistance. To arrange for the appropriate interpretation source prior to meeting with the family, Provider should contact the child's assigned Team Coordinator for instructions.

# COMMUNICABLE DISEASES

## Provider

Any Provider who routinely performs any job duty in proximity to any child served must practice universal precautions to safeguard others against infectious and communicable diseases. Before Provider begins service delivery, evidence of a negative TB test must be given.

### ACTION

*Provide proof of negative TB test lab results.  
(as required in the Provider Application for an Individual packet)*

## Child

With written parental consent, for identified children with infectious diseases (e.g., HIV, AIDS, Hepatitis B, Cytomegalovirus), the Service Coordinator will communicate with the physician responsible for medical care and must involve the physician in programmatic decisions about treatment. Communication with the physician must occur prior to assessment and on an ongoing basis as needed. The Service Coordinator will communicate status with Provider.

Contact the appropriate Team Coordinator immediately if a communicable disease is suspected.

## Notifiable Conditions

The following table lists notifiable conditions in Texas. In addition to these conditions, any outbreaks, exotic diseases, and unusual group expressions of disease must be reported. Children with notifiable conditions must be reported to the Team Coordinator by name, age, sex, race/ethnicity, date of birth, address, telephone number, disease, date of onset, method of diagnosis, and name, address, and telephone number of physician.



The [Notifiable Conditions](#) indicates when to report each condition. Cases or suspected cases of illness considered being **public health emergencies, outbreaks, exotic diseases**, and unusual group expressions of disease must be reported to the local health department or DSHS **immediately**. Other diseases for which there must be a quick public health response must be reported **within one working day**. All other conditions must be reported to the local health department or DSHS **within one week**. Provider will coordinate reporting with appropriate Team Coordinator.

Most notifiable conditions, or other illnesses that may be of public health significance, should be reported directly to the [local or health service regions](#). Paper reporting forms can be obtained by calling your local or health service region or by download from [here](#) (by using either the EPI-1 or EPI-2 form). If needed, cases may be reported to the Department of State Health Services at **1-800-252-8239**. After hours, this number will reach physician / epidemiologist-on-call. Contact information for your local or regional health department can be found at: <http://www.dshs.state.tx.us/idcu/investigation/conditions/contacts/>.



## Texas Notifiable Conditions

Report all Confirmed and Suspected cases

24/7 Number of Immediately Reportable - 1-800-705-8868

Unless noted by\*, report to your local or regional health department using number above or find contact information at <https://www.dshs.texas.gov/idcu/investigation/conditions/contacts/>

Contact Information



A – L	When to Report	L – Y	When to Report
*Acquired immune deficiency syndrome (AIDS) <sup>1</sup>	Within 1 week	Legionellosis <sup>2</sup>	Within 1 week
Amebic meningitis and encephalitis <sup>2</sup>	Within 1 week	Leishmaniasis <sup>2</sup>	Within 1 week
Anaplasmosis <sup>2</sup>	Within 1 week	Listeriosis <sup>2, 3</sup>	Within 1 week
<b>Anthrax</b> <sup>2, 3, 25</sup>	<b>Call Immediately</b>	Lyme disease <sup>2</sup>	Within 1 week
Arboviral infections <sup>2, 4, 5</sup>	Within 1 week	Malaria <sup>2</sup>	Within 1 week
*Asbestosis <sup>6</sup>	Within 1 week	<b>Measles (rubeola)</b> <sup>2</sup>	<b>Call Immediately</b>
Ascariasis <sup>2</sup>	Within 1 week	<b>Meningococcal infection, invasive (Neisseria meningitidis)</b> <sup>2, 3</sup>	<b>Call Immediately</b>
Babesiosis <sup>2,5</sup>	Within 1 week	<b>Mumps</b> <sup>2</sup>	<b>Within 1 work day</b>
<b>Botulism (adult and infant)</b> <sup>2, 3, 7, 25</sup>	<b>Call Immediately</b> <sup>7</sup>	Paragonimiasis <sup>2</sup>	Within 1 week
<b>Brucellosis</b> <sup>2, 3, 25</sup>	<b>Within 1 work day</b>	<b>Pertussis</b> <sup>2</sup>	<b>Within 1 work day</b>
Campylobacteriosis <sup>2</sup>	Within 1 week	*Pesticide poisoning, acute occupational <sup>8</sup>	Within 1 week
*Cancer <sup>9</sup>	See rules <sup>9</sup>	<b>Plague (Yersinia pestis)</b> <sup>2, 3, 25</sup>	<b>Call Immediately</b>
<b>Candida auris</b> <sup>2, 3, 10</sup>	<b>Within 1 work day</b>	<b>Poliomyelitis, acute paralytic</b> <sup>2</sup>	<b>Call Immediately</b>
<b>Carbapenem-resistant Enterobacteriaceae (CRE)</b> <sup>2, 11</sup>	<b>Within 1 work day</b>	<b>Poliovirus infection, non-paralytic</b> <sup>2</sup>	<b>Within 1 work day</b>
Chagas disease <sup>2, 5</sup>	Within 1 week	Prion disease such as Creutzfeldt-Jakob disease (CJD) <sup>2, 12</sup>	Within 1 week
*Chancroid <sup>1</sup>	Within 1 week	<b>Q fever</b> <sup>2</sup>	<b>Within 1 work day</b>
*Chickenpox (varicella) <sup>13</sup>	Within 1 week	<b>Rabies, human</b> <sup>2</sup>	<b>Call Immediately</b>
*Chlamydia trachomatis infection <sup>1</sup>	Within 1 week	<b>Rubella (including congenital)</b> <sup>2</sup>	<b>Within 1 work day</b>
*Contaminated sharps injury <sup>14</sup>	Within 1 month	Salmonellosis, including typhoid fever <sup>2, 3</sup>	Within 1 week
<b>*Controlled substance overdose</b> <sup>15</sup>	<b>Report Immediately</b>	Shiga toxin-producing <i>Escherichia coli</i> <sup>2, 3</sup>	Within 1 week
<b>Coronavirus, novel</b> <sup>2, 16</sup>	<b>Call Immediately</b>	Shigellosis <sup>2</sup>	Within 1 week
Cryptosporidiosis <sup>2</sup>	Within 1 week	*Silicosis <sup>17</sup>	Within 1 week
Cyclosporiasis <sup>2</sup>	Within 1 week	<b>Smallpox</b> <sup>2, 25</sup>	<b>Call Immediately</b>
Cysticercosis <sup>2</sup>	Within 1 week	*Spinal cord injury <sup>18</sup>	Within 10 work days
<b>Diphtheria</b> <sup>2, 3</sup>	<b>Call Immediately</b>	Spotted fever rickettsiosis <sup>2</sup>	Within 1 week
*Drowning/near drowning <sup>18</sup>	Within 10 work days	Streptococcal disease ( <i>S. pneumoniae</i> <sup>2, 3</sup> ), invasive	Within 1 week
Echinococcosis <sup>2</sup>	Within 1 week	<b>*Syphilis – primary and secondary stages</b> <sup>1, 19</sup>	<b>Within 1 work day</b>
Ehrlichiosis <sup>2</sup>	Within 1 week	*Syphilis – all other stages <sup>1, 19</sup>	Within 1 week
Fascioliasis <sup>2</sup>	Within 1 week	<i>Taenia solium</i> and undifferentiated <i>Taenia</i> infection <sup>2</sup>	Within 1 week
*Gonorrhea <sup>1</sup>	Within 1 week	Tetanus <sup>2</sup>	Within 1 week
<i>Haemophilus influenzae</i> , invasive <sup>2, 3</sup>	Within 1 week	Tick-borne relapsing fever (TBRF) <sup>2</sup>	Within 1 week
Hansen's disease (leprosy) <sup>20</sup>	Within 1 week	*Traumatic brain injury <sup>18</sup>	Within 10 work days
Hantavirus infection <sup>2</sup>	Within 1 week	Trichinosis <sup>2</sup>	Within 1 week
Hemolytic uremic syndrome (HUS) <sup>2</sup>	Within 1 week	Trichuriasis <sup>2</sup>	Within 1 week
<b>Hepatitis A</b> <sup>2</sup>	<b>Within 1 work day</b>	<b>Tuberculosis (<i>Mycobacterium tuberculosis</i> complex)</b> <sup>3, 21</sup>	<b>Within 1 work day</b>
Hepatitis B, C, and E (acute) <sup>2</sup>	Within 1 week	Tuberculosis infection <sup>22</sup>	Within 1 week
Hepatitis B infection identified prenatally or at delivery (mother) <sup>2</sup>	Within 1 week	<b>Tularemia</b> <sup>2, 3, 25</sup>	<b>Call Immediately</b>
<b>Hepatitis B, perinatal (HBsAg+ &lt; 24 months old) (child)</b> <sup>2</sup>	<b>Within 1 work day</b>	Typhus <sup>2</sup>	Within 1 week
Hookworm (ancylostomiasis) <sup>2</sup>	Within 1 week	<b>Vancomycin-intermediate <i>Staph aureus</i> (VISA)</b> <sup>2, 3</sup>	<b>Call Immediately</b>
<b>*Human immunodeficiency virus (HIV), acute infection</b> <sup>1, 23</sup>	<b>Within 1 work day</b>	<b>Vancomycin-resistant <i>Staph aureus</i> (VRSA)</b> <sup>2, 3</sup>	<b>Call Immediately</b>
*Human immunodeficiency virus (HIV), non-acute infection <sup>1, 23</sup>	Within 1 week	<b><i>Vibrio</i> infection, including cholera</b> <sup>2, 3</sup>	<b>Within 1 work day</b>
<b>Influenza-associated pediatric mortality</b> <sup>2</sup>	<b>Within 1 work day</b>	<b>Viral hemorrhagic fever (including Ebola)</b> <sup>2, 25</sup>	<b>Call Immediately</b>
<b>Influenza, novel</b> <sup>2</sup>	<b>Call Immediately</b>	<b>Yellow fever</b> <sup>2</sup>	<b>Call Immediately</b>
<b>*Lead, child blood, any level &amp; adult blood, any level</b> <sup>24</sup>	<b>Call/Fax Immediately</b>	Yersiniosis <sup>2</sup>	Within 1 week

In addition to specified reportable conditions, **any outbreak, exotic disease, or unusual group expression of disease that may be of public health concern should be reported by the most expeditious means available. This includes any case of a select agent** <sup>25</sup>

See select agent list at <https://www.selectagents.gov/selectagentsandtoxinslist.html>

\*See condition-specific footnotes for reporting contact information



## Texas Notifiable Conditions Footnotes - 2021

- 1 Please refer to specific rules and regulations for HIV/STD reporting and who to report to at: <http://www.dshs.texas.gov/hivstd/healthcare/reporting.shtm>.
- 2 Reporting forms are available at <http://www.dshs.texas.gov/idcu/investigation/forms/> and investigation forms at <http://www.dshs.texas.gov/idcu/investigation/>. Call as indicated for immediately reportable conditions.
- 3 Lab samples of the following must be sent to the Department of State Health Services, Laboratory Services Section, 1100 West 49th Street, Austin, Texas 78756-3199 or other public health laboratory as designated by the Department of State Health Services: Bacillus anthracis isolates (also requested- Bacillus cereus isolates that may contain anthrax toxin genes from patients with severe disease or death), Clostridium botulinum isolates, Brucella species isolates, Candida auris isolates, Corynebacterium diphtheriae isolates, Haemophilus influenzae isolates from normally sterile sites in children under five years old, Listeria monocytogenes isolates, Neisseria meningitidis isolates from normally sterile sites or purpuric lesions, Yersinia pestis isolates, Salmonella species isolates (also requested - specimens positive for Salmonella by culture-independent diagnostic testing (CIDT) methods), Shiga toxin-producing Escherichia coli (all E.coli O157:H7 isolates and any E.coli isolates or specimens in which Shiga toxin activity has been demonstrated), isolates of all members of the Mycobacterium tuberculosis complex, Staphylococcus aureus with a vancomycin MIC greater than 2 µg/mL (VISA and VRSA), Streptococcus pneumoniae isolates from normally sterile sites in children under five years old, Francisella tularensis isolates, and Vibrio species isolates (also requested - specimens positive for Vibrio by culture-independent diagnostic testing (CIDT) methods). Pure cultures (or specimens) should be submitted as they become available accompanied by a current department Specimen Submission Form. See the Texas [Administrative Code \(TAC\) Chapter 97](#): §97.3(a)(4), §97.4(a)(6), and §97.5(a)(2)(C). Call 512-776-7598 for specimen submission information.
- 4 Arboviral infections including, but not limited to, those caused by California serogroup viruses, chikungunya virus, dengue virus, Eastern equine encephalitis (EEE) virus, St. Louis encephalitis (SLE) virus, Western equine encephalitis (WEE) virus, West Nile (WN) virus, and Zika virus.
- 5 All blood collection centers should report all donors with reactive tests for West Nile virus, Zika virus, Babesia species, and Trypanosoma cruzi (Chagas disease) to the DSHS Zoonosis Control Branch. If your center uses a screening assay under an IND protocol, please include results of follow-up testing as well. To report, simply send a secure email to [WNV@dshs.texas.gov](mailto:WNV@dshs.texas.gov) or fax the report to 512-776-7454. Providing the following data points will suffice: Collection Agency; Unique BUI #; Test Name, Collection Date; Last Name, First Name, Donor Phone Number, Donor Address, Date of Birth, Age, Sex, Race, and Hispanic Ethnicity (Y/N). If your location has a city or county health department, we recommend that you also share this same information with them. Contact information for the health department(s) serving the county where you are located can be found at [www.dshs.texas.gov/idcu/investigation/conditions/contacts/](http://www.dshs.texas.gov/idcu/investigation/conditions/contacts/).
- 6 For asbestos reporting information see <http://www.dshs.texas.gov/epitox/Asbestosis-and-Silicosis-Surveillance/>.
- 7 Report suspected botulism immediately by phone to 888-963-7111.
- 8 For pesticide reporting information see <http://www.dshs.texas.gov/epitox/Pesticide-Exposure>.
- 9 For more information on cancer reporting rules and requirements go to <http://www.dshs.texas.gov/tcr/reporting.shtm>.
- 10 See additional Candida auris reporting information at [https://www.dshs.texas.gov/IDCU/health/antibiotic\\_resistance/Cauris-Home.aspx](https://www.dshs.texas.gov/IDCU/health/antibiotic_resistance/Cauris-Home.aspx).
- 11 See additional CRE reporting information at [http://www.dshs.texas.gov/IDCU/health/antibiotic\\_resistance/Reporting-CRE.doc](http://www.dshs.texas.gov/IDCU/health/antibiotic_resistance/Reporting-CRE.doc).
- 12 For purposes of surveillance, CJD notification also includes Kuru, Gerstmann-Sträussler-Scheinker (GSS) disease, fatal familial insomnia (FFI), sporadic fatal insomnia (sFI), Variably Protease-Sensitive Prionopathy (VPSPr), and any novel prion disease affecting humans.
- 13 Call your local health department for a copy of the Varicella Reporting Form with their fax number. The [Varicella \(Chickenpox\) Reporting Form](#) should be used instead of an Epi-1 or Epi-2 morbidity report.
- 14 Applicable for governmental entities. Not applicable to private facilities. ([TAC §96.201](#)) Initial reporting forms for Contaminated Sharps at [http://www.dshs.texas.gov/idcu/health/infection\\_control/bloodborne\\_pathogens/reporting/](http://www.dshs.texas.gov/idcu/health/infection_control/bloodborne_pathogens/reporting/).
- 15 To report a Controlled Substance Overdose, go to <https://odreport.dshs.texas.gov/>.
- 16 Novel coronavirus causing severe acute respiratory disease includes Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS).
- 17 For silicosis reporting information see <http://www.dshs.texas.gov/epitox/Asbestosis-and-Silicosis-Surveillance/>.
- 18 Please refer to specific rules and regulations for injury reporting and who to report to at <http://www.dshs.texas.gov/injury/rules.shtm>.
- 19 Laboratories should report syphilis test results within 3 work days of the testing outcome.
- 20 Reporting forms are available at <https://www.dshs.texas.gov/idcu/disease/hansens/forms.shtm>.
- 21 Reportable tuberculosis disease includes the following: suspected tuberculosis disease pending final laboratory results; positive nucleic acid amplification tests; clinically or laboratory-confirmed tuberculosis disease; and all Mycobacterium tuberculosis (M. tb) complex including M. tuberculosis, M. bovis, M. africanum, M. canettii, M. microti, M. caprae, and M. pinnipedii. See rules and reporting information at <http://www.dshs.texas.gov/idcu/disease/tb/reporting/>.
- 22 TB infection is determined by a positive result from an FDA-approved Interferon-Gamma Release Assay (IGRA) test such as T-Spot TB or QuantiFERON® - TB GOLD In-Tube Test or a tuberculin skin test, and a normal chest radiograph with no presenting symptoms of TB disease. See rules and reporting information at <http://www.dshs.texas.gov/idcu/disease/tb/reporting/>. Please report skin test results in millimeters.
- 23 Any person suspected of having HIV should be reported, including HIV exposed infants.
- 24 For lead reporting information see <http://www.dshs.texas.gov/lead/Reporting-Laws-Administrative-Code.aspx>.
- 25 Please secure select agent isolates and specimens in accordance with the guidance in the [Select Agent Regulation](#), and immediately initiate a consultation with public health regarding need for further testing or sequencing. Notify any transfer facilities of any test results of high consequence/interest.

# INCIDENT REPORTING

## Critical Incidents

Providers are required to contact the appropriate Team Coordinator **immediately** with information regarding an event with potential impact to life, safety, or the agency that requires attention:

- 9-1-1 called
- Abuse, Neglect or Exploitation *\*including "suspected" cases - see below*
- Catastrophic Events (i.e. bomb threats, explosions, major fire, etc.)
- Client Death - Suicide/Homicide
- Critical event requiring sheltering, evacuation, lock-out or lock-down
- Death
- Homicide (including an Attempt or Threat with a Plan)
- Illness or Injury requiring Emergency Room or hospital admission
- Litigation Threat
- Missing Person (police report filed)
- News Media Coverage (likely or mentioned)

If unable to reach Team Coordinator, Provider may call a Program Director or Senior Director to complete an incident report.

## Suspected Abuse, Neglect or Exploitation *also see Training Section*

Any Provider having cause to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse or neglect, must report this in accordance with state law to the Texas Department of Family and Protective Services (DFPS) and/or a local or state law enforcement agency.

- Call **9-1-1** immediately if you are witnessing an emergency or life-threatening situation

**Urgent** - When the situation is urgent, call the Texas Abuse Hotline **immediately** at **1-800-252-5400** upon witnessing a person faces immediate risk of abuse or neglect **that could result in death or serious harm** for situations, such as:

- Serious injury
- Any injury to a child 5 years or younger
- Immediate need for medical treatment
- Sexual abuse where the abuser has or will have access to the victim within the next 24 hours
- Children age 5 or younger are alone or are likely to be left alone within the next 24 hours
- Anytime you believe your situation requires action in less than 24 hours

**Non-Urgent** - If Provider becomes aware of possible situation that is non-urgent, a report must be made via the Texas Abuse website at [www.txabusehotline.org](http://www.txabusehotline.org)

Provider must also notify the ECI Senior Director.

**Failure to report suspected abuse or neglect is a Class B misdemeanor.**



## Non-Critical Incidents

Provider is required to contact their Team Coordinator **as soon as possible** with information regarding non-critical events that **do NOT pose potential impact to life or safety**, upon learning of an incident, such as:

- Agency Property Damage
- Criminal Activity
- Forceful or hostile actions
- Illegal Substances
- Infectious Diseases
- Injury
- Physical Aggression (forceful or hostile actions with intent to harm self/others)

# FAMILY COMPLAINTS

## Parent Handbook

Serving as the family and child's Service Coordinator, ECI of North Central Texas staff members are required to provide each family with the ECI Parent Handbook (a publication, pursuant to Texas Administrative Code (TAC) [Title 26, Part 1, Chapter 350, Subchapter B §203](#)). The handbook explains ways to resolve a disagreement related to ECI service provision.

If the family mentions a concern or complaint, the Provider may inquire if the family still has their copy of the Parent Handbook, which was issued to them during their first ECI visit.

If the family is unable to locate their originally issued Parent Handbook, Provider will provide a second Parent Handbook and make note of giving the handbook in a progress note. In addition, Provider may offer the family the web link to the Parent Handbook:

- English & Spanish versions are available on ECI's webpage: <https://www.mhmrtarrant.org/eci/>

## Local Contact

Most disagreements may be resolved at the local level without a formal complaint. Provider will direct the family to the appropriate personnel (listed below) to help resolve any issues or concerns:

<b>Contact Name:</b>	<b>Contact Info</b>
1. ECI Service Coordinator .....	info provided to family during the first ECI visit
2. ECI Program Director .....	written on the inside cover of the Parent Handbook, or see the ECI Contact Information (page 3 of this Provider Manual)
3. ECI Senior Director, Anisha Philips.....	817-718-4823 - <a href="mailto:Anisha.Philips@mhmrtc.org">Anisha.Philips@mhmrtc.org</a>
4. ECS Clinical Sr. Director, Meghan Glovier.....	817-569-5303 - <a href="mailto:Meghan.Glovier@mhmrtc.org">Meghan.Glovier@mhmrtc.org</a>
5. CFS Chief, Laura Kender .....	817-569-5301 - <a href="mailto:Laura.Kender@mhmrtc.org">Laura.Kender@mhmrtc.org</a>
6. MHMR Client Rights Officer, Paul Duncan.....	817-569-4367 - <a href="mailto:Paul.Duncan@mhmrtc.org">Paul.Duncan@mhmrtc.org</a> <i>to report violation of rights, abuse, or neglect</i>

## State Contact

If disagreements are not able to be resolved at the local level, the family has the right to file a complaint with the Texas Health and Human Services (HHS) at the state level. In such instances, Provider will inform the family of the directions described in the Parent Handbook (page 13-14) on filing a complaint and inform the family that they may call the HHS Office of the Ombudsman at **1-877-787-8999** to ask to speak with someone at the ECI State Office who will help resolve a problem or concern.

More details are available online: <https://hhs.texas.gov/services/disability/early-childhood-intervention-services/eci-how-file-a-complaint>

# HOME VISIT SAFETY

**W**hile delivering services at a family's home, Provider should take necessary safety precautions to protect yourself and be prepared in any situation. The tips below provide general guidelines for situations that may arise while out in the community.



## Before Going to the Home

- 1) Contact the people you plan to visit and obtain as much information as possible, such as: the meeting location, their full name, their address, and phone.
- 2) If possible, attempt to verify that the information is correct.
- 3) Check the home visit address to determine if it is a potentially dangerous location, by visiting crime reporting websites, such as <https://www.crimemapping.com> , <https://spotcrime.com/> , or [www.mylocalcrime.com](http://www.mylocalcrime.com).
- 4) Before your visit, ask questions about pets, children, potential visitors or risk factors, such as: drug/chemical abuse, domestic violence, criminal involvement, or mental illness.
- 5) If needed for safety, Provider may request to have an ECI staff attend the visit with you. If a 2-person team is not feasible:
  - a. Ensure someone always knows of the date, time, and location of your home visits, or
  - b. Notify someone of your arrival time, the address, phone numbers, and approximate length of visit.
  - c. Arrange for someone to call you on your mobile phone near the end of your visit to confirm that you are okay.
  - d. Establish a predetermined duress "code word" or "phrase" to use in an emergency to alert others you are in danger and should call **9-1-1**.

## Personal Safety

- 1) If you carry bags, keep your car keys and mobile phone on you. In an emergency, you'll have those readily available, where you can flee or barricade yourself in another room and use your phone.
- 2) Survey the premises for exits and ways out in an emergency. Also think about fire escape routes.
- 3) If the person you are visiting locks the front door (particularly deadlocks), ask them to please leave the key in the lock.
- 4) Be wary of trip hazards that are both external and internal to the home, such as: steps, lifted floor coverings, electrical wires, or clutter.
- 5) If there are dogs or other pets that concern you, ask the family to put the animals in a locked kennel or room.
- 6) Limit the amount of cash you carry.
- 7) Avoid carrying credit cards.
- 8) Don't wear expensive jewelry.
- 9) Don't carry a purse.
- 10) Carry essential identification only.
- 11) Dress conservatively.

## Travel Safety

- 1) Always keep car doors locked .
- 2) Don't park in the driveway; you could get blocked in. If not possible, consider reverse parking, so you can drive away quickly.
- 3) In a cul-de-sac, park in the direction of the cul-de-sac exit.
- 4) Avoid parking next to vans or trucks.
- 5) Avoid parking in isolated areas.
- 6) Park in well-lit areas.
- 7) Hide your purse, bags, packages and valuables, so they are not visible.
- 8) Approach your car with keys in-hand.
- 9) Check the car interior before entering.
- 10) Lock your car doors as soon as you get in.



## Aggressive or Dangerous Activity

- 1) Never enter a house if there is yelling, screaming, breaking glass, or sounds that cause concern coming from within; instead, call the police (**9-1-1**).
- 2) Don't enter a home with someone who is under the influence of alcohol or drugs.
- 3) Don't enter a home with someone who is inappropriately dressed.
- 4) If an aggressive incident occurs, remain as calm as possible, speaking slowly and calmly.
- 5) Stay out of types of rooms where weapons might be stored, such as the knives in the kitchen.
- 6) Try to keep a barrier between you and the aggressor, such as a table.
- 7) Don't stand face-to-face to the aggressor; this makes you vulnerable to attack.
- 8) Try to move slowly toward an exit or consider a room you can barricade yourself in and use your cell phone to call the police (**9-1-1**).
- 9) Don't walk backwards, as you risk tripping over something unseen.
- 10) Even if it is only the threat of assault, call the police (**9-1-1**) at the earliest opportunity, and report the incident to the ECI Program Director or ECI Senior Director.
- 11) You must inform the police if firearms are produced or implied.

# DRESS CODE

**E**CI providers are expected to be suitably attired and groomed during working hours or when representing the ECI program. These standards are established as guidelines for a professional appearance while providing services with dignity, maturity and respect.

## Preferred Attire

Preferred attire is ECI shirt with casual pants or scrub pants.



## Appropriate & Inappropriate Attire

Category	Appropriate Attire	Inappropriate / DO NOT WEAR
Shirts	<ul style="list-style-type: none"> <li>✓ Business casual shirt</li> <li>✓ ECI/ECS shirt</li> <li>✓ Holiday t-shirt or sweatshirt (be respectful of families religious and cultural beliefs)</li> <li>✓ Sleeveless shirt</li> </ul>	<ul style="list-style-type: none"> <li>✗ Worn out or sloppy shirt</li> <li>✗ Sweat shirts</li> <li>✗ Tank tops</li> <li>✗ T-shirt with any advertising or logo (other than ECI)</li> <li>✗ College, school or sports team t-shirts, jerseys or athletic wear</li> <li>✗ Spaghetti straps</li> <li>✗ Low cut shirts that expose or reveal cleavage</li> <li>✗ Short shirts (if midriff shows when the arms are raised)</li> </ul>
Pants	<ul style="list-style-type: none"> <li>✓ Business casual pants, jeans or khakis</li> <li>✓ Scrub pants</li> <li>✓ Walking shorts (knee length; no more than 2" above the knee)</li> </ul>	<ul style="list-style-type: none"> <li>✗ Worn out or sloppy pants/jeans (not frayed; no holes)</li> <li>✗ Exercise or sweat pants</li> <li>✗ Low-ride pants/jeans</li> <li>✗ Short shorts</li> <li>✗ Bib overalls</li> </ul>
Dresses/Skirts	<ul style="list-style-type: none"> <li>✓ Business casual dress or skirt (knee length; no more than 2" above the knee)</li> <li>✓ Short dresses or skirts above the knee are permissible if worn with tights or leggings</li> </ul>	
Shoes	<ul style="list-style-type: none"> <li>✓ Clean shoes, boots, sandals or tennis shoes</li> <li>✓ <b>NOTE:</b> Ask permission before taking off shoes in the home or child care center. If shoes are removed, socks or booties must be worn.</li> </ul>	<ul style="list-style-type: none"> <li>✗ Dirty shoes</li> <li>✗ Flip flops (beach)</li> </ul>
General	<ul style="list-style-type: none"> <li>✓ All items of attire should be clean and nice in appearance</li> <li>✓ Be respectful of families' religious and cultural beliefs</li> <li>✓ Be respectful of people (especially babies) who might be allergic or are intolerant to smells and fragrances</li> <li>✓ Good hygiene</li> <li>✓ Well-kept hair</li> <li>✓ ECI/ECS badge</li> </ul>	<ul style="list-style-type: none"> <li>✗ Tight fitting clothes</li> <li>✗ Clothing that reveals too much cleavage, back, chest, stomach or underwear</li> <li>✗ No sheer or see-through clothing</li> <li>✗ Abundant accessories</li> <li>✗ Caps</li> <li>✗ Excessive make-up</li> <li>✗ Inappropriate tattoos or piercings that would be considered unprofessional or considered a distraction (tattoos may be covered)</li> <li>✗ Perfume, cologne, aftershave, or scented lotions</li> </ul>

# CHILD ELIGIBILITY

A

child is eligible for ECI services if he or she is under 36 months of age and has a:

- **Medically Diagnosed Condition** - a child who has a medically diagnosed condition that has a high probability of resulting in developmental delay qualifies for ECI services. Diagnoses that are deemed automatic qualifiers can be found by searching the name of the condition or diagnosis code at: <https://diagsearch.hhsc.state.tx.us/>
- **Developmental Delay** - a child who has a developmental delay of at least 25% in one or more areas of development, or a 33% if the delay occurs only in the area of communication.

When a child is referred for developmental delay, the ECI program administers the Battelle Developmental Inventory-Second Edition (BDI-2) a standardized, norm-referenced tool that evaluates all developmental domain areas including cognitive, social interactions, gross and fine motor skills, adaptive skills and communication. This establishes your child's percent of delay for eligibility.

- **Auditory or Visual Impairment** - a child who has a vision or hearing impairment as defined by the Texas Education Agency rule at [19 TAC Section 89.1040](#) qualifies for ECI. This determination is made by a team led by certified staff from the local independent school district.

Rules for eligibility for ECI services are found in the Texas Administrative Code (TAC):  
[Title 26, Part 1, Chapter 350, Subchapter H.](#)

Additional information for families:  
<https://hhs.texas.gov/services/disability/early-childhood-intervention-services/information-families>



# SERVICE DESCRIPTIONS

**S**ervices are provided utilizing a coaching approach with the parent/caregiver as the primary interventionists. Services are delivered primarily in the child's home or child care. Services are provided to accommodate the parent/caregiver's schedule and evening visits may be considered an option.



Providers shall provide the ECI services identified below, as assigned, in accordance with the Individualized Family Service Plan (IFSP) through qualified service providers. To provide ECI services, the Provider must be knowledgeable in child development and developmentally appropriate behavior, as well as possess the requisite education, demonstrated competence and/or experience identified below.

Provider must provide services to address the development of the whole child in the context of the family, and in the context of natural learning activities to strengthen the capacity of the family to meet the unique needs of their child. ECI services must be delivered in accordance with [IDEA Part C](#), Federal Regulation [Title 34, Part 303](#), Texas Government Code [Chapter 531](#), and Texas Administrative Code (TAC) [Title 26, Part 1, Chapter 350](#), as outlined in the HHS/ECI contract.

ECI provides a wide array of services:

- Audiology/Hearing
- Assistive Technology
- Behavioral Intervention
- Service Coordination/Case Management
- Counseling
- Family Education & Training
- Health Services
- Infant Massage
- Nursing
- Nutrition and Feeding
- Occupational Therapy
- Physical Therapy
- Social Work
- Specialized Skills Training
- Speech & Language Therapy
- Transition to Services after Age 3
- Translation/Interpretation
- Vision

**Primary services delivered by contract providers are:**

## 1. Occupational Therapy (OT)

- a. Services to address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development.
- b. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings, and include:
  - i. Identification, assessment, and intervention;
  - ii. Adaptation of the environment, and selection, design, and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and
  - iii. Prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability.
- c. Occupational therapy may be provided through:
  - i. direct one-to-one intervention with the child and their parent or routine caregiver; or
  - ii. direct group intervention with children and their parents or routine caregivers.

- d. Occupational therapy (OT) must be provided by an:
  - i. OT licensed by the Texas Board of Occupational Therapy Examiners; or
  - ii. OT Assistant licensed by the Texas Board of Occupational Therapy Examiners, working under the direction of a Licensed OT.

## **2. Physical Therapy (PT)**

- a. Services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status and effective environmental adaptations.
- b. These services include:
  - i. Screening, evaluation, and assessment of infants and toddlers to identify movement dysfunction;
  - ii. Obtaining, interpreting, and integrating information appropriate to program planning to prevent, alleviate, or compensate for movement dysfunction and related functional problems;
  - iii. Providing individual or group services or treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems; and
  - iv. Services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation.
- c. Physical therapy may be provided through:
  - i. direct one-to-one intervention with the child and their parent or routine caregiver; or
  - ii. direct group intervention with children and their parents or routine caregivers.
- d. Physical therapy must be provided by a:
  - i. Licensed PT licensed by the Texas State Board of Physical Therapy Examiners; or
  - ii. PT Assistant licensed by the Texas State Board of Physical Therapy Examiners, working under the direction of a Licensed PT.

## **3. Speech-Language Pathology (SLP)**

- a. Identification of children with communicative or oropharyngeal disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills; referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communicative or oropharyngeal disorders and delays in development of communication skills; and provision of services for the habilitation, rehabilitation, or prevention of communicative or oropharyngeal disorders and delays in development of communication skills.
- b. Speech-language pathology may be provided through:
  - i. direct one-to-one intervention with the child and their parent or routine caregiver; or
  - ii. direct group intervention with children and their parents or routine caregivers.
- c. Speech-language pathology must be provided by a:
  - i. A SLP licensed by the Texas State Board of Examiners for Speech-Language Pathology and Audiology;
  - ii. An Intern in Speech-Language Pathology licensed by the Texas State Board of Examiners for Speech-Language Pathology and Audiology; or
  - iii. A Licensed Assistant in Speech-Language Pathology (SLPA) licensed by the Texas State Board of Examiners for Speech-Language Pathology and Audiology, working under the direction of a licensed SLP.

## 4. Behavior Intervention

- a. Behavioral Intervention services are delivered through a structured plan to strengthen developmental skills while specifically addressing severely challenging behaviors as determined by the IFSP team.
- b. A behavior plan is developed by the IFSP team (that includes the plan supervisor) to:
  - i. identify goals;
  - ii. conduct a functional assessment to determine the motivation for the behavior;
  - iii. develop a hypothesis;
  - iv. design support plans; and
  - v. implement, monitor, and evaluate goals.
- c. Behavioral intervention is provided through direct one-to-one intervention with the child combined with direct intervention with the child and the parent or routine caregiver.
- d. Behavioral intervention must be provided by individuals with:
  - i. knowledge of child development;
  - ii. knowledge of developmentally appropriate behavior; and
  - iii. skills to utilize behavior analysis techniques and intervention in ways that help achieve the desired behavior change.
- e. Behavioral intervention must be provided according to a structured plan supervised by one of the following:
  - i. Licensed Behavior Analyst (“LBA”); or
  - ii. one of the following who is trained in Positive Behavior Supports or Applied Behavior Analysis:
    - 1) Licensed Psychologist (“LP”) licensed by the Texas State Board of Examiners of Psychologists.
    - 2) Licensed Psychological Associate (“LPA”) licensed by the Texas State Board of Examiners of Psychologists.
    - 3) Licensed Professional Counselor (“LPC”) licensed by the Texas State Board of Examiners of Professional Counselors.
    - 4) Licensed Clinical Social Worker (“LCSW”) licensed by the Texas State Board of Social Work Examiners.
    - 5) Licensed Marriage and Family Therapist (“LMFT”) licensed by the Texas State Board of Examiners of Marriage and Family Therapists.
    - 6) Certified Autism Specialist.
- f. The team and the parent may specify a provider who has the requisite knowledge, skills and training.

## 4. Specialized Skills Training (SST)

- a. Specialized Skills Training may be provided through:
  - i. direct one-to-one intervention with the child and their parent or routine caregiver; or
  - ii. direct group intervention with children and their parents or routine caregivers.
- b. Providers of SST must be knowledgeable in:
  - i. implementing strategies across developmental domains; and
  - ii. basic behavior intervention strategies (including rewards and consequences).
- c. Providers of SST must have knowledge and training in the domain in which the child has an identified developmental need.
- d. SST must be provided by an Early Intervention Specialist (“EIS”).
- e. Grantee must ensure an EIS who are in the process of completing their IPDP receive at least four hours of supervision per month from a qualified supervisor. Supervisors of EISs must meet the qualifications listed in [TAC Title 26, Part 1, Chapter 350, Subchapter C, §350.313](#).

# DOCUMENTATION & BILLING

**T**he Provider must provide detailed records of all ECI services delivered. During the home visit, Provider will be delivering the service that was determined in the Individualized Family Services Plan (IFSP) establishes



## Documentation

Progress notes are written in partnership between Provider and the child's parents/caregivers, which provides evidence of the work you have done and what required your professional expertise, such as:

- What you did and why it was done (using your skilled intervention)
- What you taught the parents (applying your professional knowledge while coaching)
- Your professional suggestions for parent to implement strategies throughout the day
- The child's progress

Provider is responsible for accuracy in all documentation and must not indiscriminately copy, paste, or clone statements from other progress notes or documents.

## Billing for Services Provided to a Child/Family

To document and to bill for services provided to an ECI child/family, MHMR's Provider Relations Department will grant Provider access to use MHMR's **ProviderConnect** system.

### ◆ ProviderConnect

MHMR's Provider Relations Department will send you the **ProviderConnect User Guide**, which contains step-by-steps instructions on how to:

- change your password;
- navigate through the system;
- look up assigned client's information;
- check authorizations;
- enter data;
- attach documents;
- submit bills, and
- run reports.

### ◆ Documentation of Services Delivered

For each service performed, Provider must enter data in ProviderConnect as required (e.g. date of service, start time, end time, location, and service code).

### ◆ Submission of Progress Notes

For each service performed, Provider must submit a corresponding progress note that matches the date of service, start time, end time, location, and service code - submitted in two locations:

- 1) **For Billing records:** attach the progress note in ProviderConnect  
and
- 2) **For inclusion in the child's Electronic Health Record (EHR):** submit the progress note via email to [ECI4Contractors@mhmrtc.org](mailto:ECI4Contractors@mhmrtc.org)

### ◆ **Billing for Services**

The ProviderConnect User Guide allows Provider to generate, edit, and submit a bill to MHMR. Provider will be able to view the status of each bill and run reports.

If authorized contract work is performed, which is not related to an ECI child (e.g. consultation, attend team meeting), Provider will send documentation and invoice to [ECI4Contractors@mhmrtc.org](mailto:ECI4Contractors@mhmrtc.org)

### ◆ **Training & Assistance**

For training and assistance with ProviderConnect, contact [Provider.Relations@mhmrtc.org](mailto:Provider.Relations@mhmrtc.org)  
To make changes after a bill has been submitted, contact [Accounts.Payable@mhmrtc.org](mailto:Accounts.Payable@mhmrtc.org)

## **Verification**

Provider must maintain records necessary to verify services delivered and billed to ECI. Progress notes must be completed for all services rendered. These notes must reflect the service that took place and the individual's progress or lack of progress towards the anticipated service outcome.

Provider must additionally maintain records including the following:

- Names of all covered individuals seen by Provider
- Evidence of licensure, certification or accreditation, as required
- Evidence of insurance coverage
- Evidence of required training
- If covered individuals are paid by Provider, evidence of compliance with Department of Labor (DOL) regulations regarding salaries and pay

# PRE-REQUISITES

## Credentialing

Before providing ECI services, each Provider must be credentialed through MHMR. Once Provider begins the individual application process, you will receive the appropriate **credentialing application** from MHMR's Patient Financial Services. Once completed, Provider should submit the credentialing application to:

**Tracey Walton, Credentialing Specialist**

Contracts Department RU#1012

MHMR of Tarrant County

3840 Hulen Street

Fort Worth, TX 76107

[Tracey.Walton@mhmrtc.org](mailto:Tracey.Walton@mhmrtc.org)

817-569-5027 Office | 817-810-3042 Fax

### ACTION

*After receiving the Credentialing Application, please complete and submit it to MHMR's Credentialing Department, as shown above.*

## TPI & NPI Numbers

### ◆ TPI Number

Even if Provider already has a TPI number, each Provider is required to obtain a Medicaid **Texas Provider Identifier (TPI)** number to allow Provider's services to be billed to under MHMR. Once credentialed, MHMR's Patient Financial Services will send to Provider the appropriate packet/forms. Upon completion, Provider should submit the to:

**Ashley Edwards, Provider Enrollment Specialist**

Patient Financial Services RU#1024

MHMR of Tarrant County

3840 Hulen Street

Fort Worth, TX 76107

[Ashley.Edwards2@mhmrtc.org](mailto:Ashley.Edwards2@mhmrtc.org)

817-569-4786 Office | 817-810-3042 Fax

### ACTION

*After receiving and completing the packet, please submit to MHMR's Patient Financial Services Department, as shown above.*

### ◆ NPI Number

Each Provider is required to have a **National Provider Identifier (NPI)** number. If Provider has not previously obtained an NPI #, MHMR's Patient Financial Services Department will assist. Provider will make arrangements accordingly with:

**Ashley Edwards, Provider Enrollment Specialist**

Patient Financial Services RU#1024

MHMR of Tarrant County

3840 Hulen Street

Fort Worth, TX 76107

[Ashley.Edwards2@mhmrtc.org](mailto:Ashley.Edwards2@mhmrtc.org)

817-569-4786 Office | 817-810-3042 Fax



## Fingerprint-Based Background Check

Anyone working under ECI must be cleared initially by a federal fingerprint-based criminal background check prior to that person's direct contact with children or families (Texas Administrative Code [Title 26, Part 1, §350.310](#)).

The background check consists of fingerprint-based searches of state and FBI Criminal History Record Information databases and name index searches of computerized databases. These databases contain criminal arrest and conviction information.

The [Health and Safety Code 250.007\(c\)](#) requires that results of criminal background records may not be released to another organization; therefore, fingerprint checks must be performed for **each** organization the Provider works with (e.g. past employers, licensing boards, school district, or hospital).



### ◆ Steps

#### ACTION

*Follow these steps:*

1. To obtain a fingerprint background check, go to **IdentoGo** online at <https://uenroll.identogo.com/>
2. Enter the Service Code for MHMR of Tarrant County: **11FNKZ**
3. Select “**Schedule or Manage an Appointment**” then finish the online form and make an appointment at a location convenient for you.
4. When you go to the Fingerprint Appointment:
  - Bring a valid state-issued identification card or driver's license
  - Smile - a photograph will be taken
  - Pay an on-site fee\* (approximately \$13)

\*By entering MHMR's Service Code, MHMR/ECS will pay approximately \$45 fee for each fingerprinting session. MHMR/ECS will reimburse you for the on-site fee that is required to be paid at the time of the appointment. Bring the original receipt to your ECI Program Director or designee for reimbursement.

Federal fingerprint-based background checks are required only once for your work through MHMR. Subsequent background checks will be conducted annually through the Texas Department of Public Safety.

## DPS Background Checks

In Texas, annual criminal history checks are run by the Department of Public Safety (DPS). Provider must sign a **Computerized Criminal History (CCH) Verification** form to acknowledge that they are aware that a background check will be performed each year, beginning the following year after the initial fingerprint-based background check.

#### ACTION

*Complete the DPS form, which is found on page 3 of the Provider Application for an Individual packet.*

# SANCTIONS, APPEALS & TERMINATION

**E**CI of North Central Texas will take punitive action against Provider for any acts that pose a hazard to ECI children and families or potentially violate service guidelines.

## Sanctions

Sanctions will be imposed if:

- ✗ Provider does not maintain quality services in compliance with state and federal standards and ECI philosophy, policies, standards, or procedures.
- ✗ Provider submits inaccurate documentation (e.g. invoices, progress notes) or is late making deadlines as outlined in this Provider Manual. Late or inaccurate documentation affects ECI's ability to render payment. These practices are unacceptable and jeopardize Provider's status as a preferred vendor.
- ✗ Provider engages in behavior that is classified as a conflict of interest, including, but not limited to, soliciting families to change to Provider's contract for services or to purchase equipment directly from the Provider.



Sanctions may include, but are not limited to:

- Immediate termination of contract;
- Withholding of new referrals;
- Withholding of outstanding payments, in whole or in part;
- Request for recoupment of funds paid to Provider for services;
- Fines, charge backs or offsets against future payments; or
- Suspension of contract and referral of existing ECI clients, pending appeal.

## Appeals

If Provider wishes to appeal a sanction decision, Provider must notify the Director of Contracts in writing within seven (7) days of receipt of a Notice of Default or Notice of Termination of the request for appeal. If Provider has additional information, not taken into consideration at the time the sanction was imposed, documentation must be submitted with the request for appeal. Correspondence must be sent to:

**Kevin McClean**, Senior Director of Contract Administration  
MHMR of Tarrant County, RU#1012  
3840 Hulen Street  
Fort Worth, TX 76107  
[Kevin.McClean@mhmrtc.org](mailto:Kevin.McClean@mhmrtc.org)

## Termination

Notice of Default or Notice of Termination will be sent by certified mail to the Provider. If the contract is terminated, Provider is expected to cooperate with ECI in the transfer of clients to other providers.

# TRAINING

**P**rovider must complete required training prior to working directly with ECI children and families and must demonstrate the ability to provide quality and billable services.



## Training Matrix

#	Course	Requirements	Source / Details	Frequency		
1	<b>Pediatric First Aid / CPR / AED</b>	Class must cover first-aid and cardiopulmonary resuscitation for children and infants <a href="#">TAC 26, Part 1, Chapter 350, Subchapter C §309 (b)(2) &amp; (c) - Min. Requirements</a>	MHMRTC Training Dept. (MHMR CPR-ECS Pediatric) - 6 hours -or- Submit a current CRP certification for review/approval; trainings such as: <ul style="list-style-type: none"><li>American Heart Association “Heartsaver® Pediatric First Aid / CPR / AED; or</li><li>American Health Care Academy “CPR / AED &amp; First Aid Combo”</li></ul>	every 2 years		
2	<b>Infection Prevention</b> (aka Universal Precautions) Part 1 and Part 2	Must sign attestation that course was read and understood <a href="#">TAC 26, Part 1, Chapter 350, Subchapter C §309 (b)(3) - Min. Requirements</a>	Course is included in this Provider Manual Self-paced	Annually		
3	<b>Procedural Safeguards for Confidentiality</b> <ul style="list-style-type: none"><li>FERPA</li><li>HIPAA</li></ul>	Must sign attestation that course was read and understood Code of Federal Regulations, Title 34, Part 99: <a href="#">FERPA</a> Family Educational Rights and Privacy Act of 1974); <a href="#">TAC 26, Part 1, Chapter 350, Subchapter C §309 - Min. Requirements</a>	Course is included in this Provider Manual Self-paced	Annually		
4	<b>Client Rights, Abuse, and Neglect</b>	Must sign attestation that course was read and understood	Course is included in this Provider Manual Self-paced	Annually		
<b>Making it Work (MIW) -or- Making It Work for Therapists (MIWT)</b>						
	<b>Part 1</b>	Sign attestation that each section was read and understood; and Submit certificates along with individual application <a href="#">TAC 26, Part 1, Chapter 350, Subchapter C §309 (b)(1) - Min. Requirements</a>	All links needed are provided in this Provider Manual  All sections are self-paced Estimated time to complete: <ul style="list-style-type: none"><li>Licensed staff = 4.5 hours</li><li>Non-Licensed = 12 hours</li></ul>  The self-assessment will be graded by ECI Senior Director  IPDP will be developed by ECI’s Senior Director (or designee), utilizing the form for “Licensed Practitioners of the Healing Arts (LPHA) & other providers”	Once		
5	• Section 1 - Introduction					
6	• Section 2 - Referral & Initial Contact					
7	• Section 3 - Evaluation & Assessment					
8	• Section 4 - Individualized Family Services Plan (IFSP)					
9	• Section 5 - Service Delivery					
10	• Section 6 - Case Management					
11	• Section 7 - Transition					
12	• Section 8 - Conclusion					
	<b>Part 2</b>					
13	• Self-Assessment	Complete the <b>Staff Self-Assessment</b> form				
	<b>Part 3</b>	Contractor will review and sign the IPDP				
14	• Individual Professional Development Plan (IPDP)					

#	Course	Requirements	Source / Details	Frequency
15	<b>Videos / Observation - Service Delivery Visit</b> - watch 6 videos to observe examples of ECI service delivery visits	a. Watch all 6 of the " <a href="#">Just Being Kids</a> " videos, and b. Complete an Observation form and Progress Note for each of the 6 videos	<p>The link and instructions for the videos is explained on pages 38-39 of this Provider Manual</p> <p>The "Observation" form is found on pages 7-8 of the <u>Provider Application for an Individual</u>. Complete an observation for each of the 6 videos.</p> <p>The observation also requires a progress note to be completed. The "Intervention Progress Note" is found on page 9 of the <u>Provider Application for an Individual</u>.</p> <p>Self-paced</p>	Once
16	<b>Coaching</b>	Read the coaching material	See training pages 40-49 of this Provider Manual	Once
17	<b>Demonstration of Service Delivery</b>	The first in-home service delivered by Provider will be observed by an ECI staff member.	ECI Senior Director, or designee, as described in this Provider Manual	Once
18	<b>Forms</b>	Instruction will be given regarding the use of ECI forms.	ECI Senior Director, or designee	Once

## 1. Pediatric First Aid / CPR / AED

### TRAINING

Provider must complete a **First Aid**, **CPR** (Cardiopulmonary Resuscitation), and **AED** (Automated External Defibrillator) training for children and infants.

### ACTION

#### If Currently Certified:

If Provider has already completed **First Aid / CPR / AED** training, *make a copy of your current certification and submit along with the Provider Application for an Individual packet*. Provider's existing certification will be reviewed / approved by the ECI Senior Director or designee.

-or-

### ACTION

#### If Not Certified:

If Provider has **NOT** completed a **First Aid / CPR / AED** training:

**In-Person Training:** through MHMR's Training Department (if available):

- 1) Register for the **Pediatric First Aid / CPR / AED** training class at [Training.Requests@mhmrtc.org](mailto:Training.Requests@mhmrtc.org) or 817-569-4342.

This 6-hour instruction is normally taught in a classroom setting and is offered at **no cost** to Provider. Certification will be awarded after successful completion.

or

**Virtual Training:** If a 100% virtual environment is necessary:

- 2) *Contact the American Health Care Academy at 1-888-277-7865* and ask for Lilly Hall. Inform them you are an ECI contractor with MHMR Tarrant and you need the online "**Healthcare CPR/AED & First Aid Combo**" certification, located at <https://CPRaedcourse.com> - conducted via ZOOM (approximately 3 hours; no reimbursement).

or

**American Heart Association:**

- 3) *Completed the "Heartsaver® Pediatric First Aid / CPR / AED" class at a training center of your choice* (no reimbursement).

## 2. Infection Prevention

### TRAINING

Read and study the following **Infection Prevention** training.

This training will provide information and procedures that will promote the health and safety of Provider, ECI clients, and family members and reduce the possibility of disease transmission during service delivery. These actions are good basic hygiene, which should be observed with every client regardless of diagnosis.

### Hand Washing

Hand washing techniques are designed to prevent cross-contamination:

- Hands and other skin surfaces should be washed with soap and warm water immediately and thoroughly:
  - a) before and after client contact,
  - b) if contaminated with body substances,
  - c) before and after gloves are worn, and
  - d) before preparing or eating food.
- Use soap, warm water, and friction for hand washing.
- Lather and scrub for 15-30 seconds.
- Rinse well.
- Dry hands on a paper towel.
- Use paper towels to turn off faucets.
- If facilities are not available in the home, use a waterless hand washing product immediately, such as: Purell or other anti-bacterial solution.



### Disposable Gloves

The use of disposable gloves (latex or vinyl) is important to prevent transmission of any infection.

- Gloves are to be worn by the Provider when direct contact is anticipated with:
  - a) non-intact skin (openings in the skin) caused by various reasons, such as: cuts, abrasions, dermatitis, chapped skin, surgery, ports, tubes
  - b) bodily substance, such as: blood, urine, pus, feces, saliva, drainage of any kind
- Remove gloves by pulling down over the hands, so that the soiled surface is inside.
- Dispose of gloves immediately.
- Gloves should not be washed or disinfected for re-use.

### Toy Washing

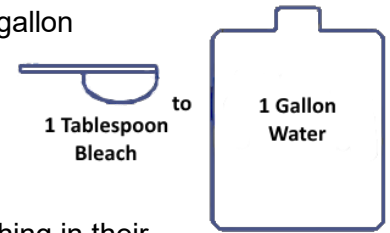
It is best to use only toys and equipment found in the home environment as this limits exposure to germs and encourages families to utilize toys readily available to the child.

If impracticable to use an item from the child's home, it must be sterilized if used by another person prior to the therapy session, by using one of these sterilization methods:

- Cleaned in the dishwasher (recommended)



- Submerge toy in a mixture of 1 tablespoon liquid household bleach to 1 gallon of water (neither hot nor cold); rinse thoroughly under running water; and air dry.
- Use of Clorox Disinfecting Wipes (or similar non-toxic wipes) are acceptable; however, the toy should also be rinsed with water after cleaning it with the wipe, because ingredients in these cleaning wipes should not be ingested, and small children have a habit of putting everything in their mouths.

**ACTION**

*After completion, you may check ✓ affirmative in the **Attestation** section of the [Provider Application for an Individual \(page 6\)](#) that you have read and understand this **Infection Prevention** training.*

### 3. Procedural Safeguards for Confidentiality

#### TRAINING

Read and study the following **ECI Procedural Safeguards for Confidentiality** training.

#### FERPA Training

(Family Educational Rights and Privacy Act of 1974)

- For Contract Employees -



#### Section 1 - Child & Parent Rights

The child's and parent's rights begin immediately when the ECI program receives the referral or is otherwise contacted about the child or family. The parent has the right to:

- Expect confidentiality of **Personally Identifiable Information (PII)** (*such as: name, address, social security number, personal characteristics or other information that would make it possible to identify or trace the child, parent, or family member*);
- Review and inspect their child's records;
- Request information in their child's record be corrected, if incorrect or violates the child/family's privacy; and
- Report concerns to HHS/ECI.

#### Section 2 - Maintaining Confidentiality

1. **Custody/Guardianship** - ECI may presume that the parents have authority to inspect their child's records, unless advised that the parent does not have the authority. If there is a question regarding guardianship, ECI will request court papers to determine which parent has the authority to make decisions.
2. **FERPA** - ECI must ensure that FERPA (Family Educational Rights and Privacy Act of 1974) and IDEA (Individuals with Disabilities Education Act) requirements for confidentiality are met.

##### a) Parental Rights to Child/Family Records

The parent has the right to receive a description of what PII is maintained, the types of information sought, the methods used in gathering information, and how the information will be used.

##### b) ECI's Responsibility

ECI employees and contractors must protect the confidentiality of PII at the collection, storage, disclosure, and destruction stages.

##### c) Disputed Records

A parent who believes that information in the child's record is inaccurate, misleading, or violates the privacy or other rights, may request that the record be amended.

##### d) Changes to Records

- **Paper Note:** Any changes to any information documented in a child's record must be lined through with a single line, initialed, and dated by the individual making the changes. The use of correction fluid or any other method to make a correction is not allowed.
- **Draft Electronic Record:** Any changes or corrections made to any note MUST be done by the ECI staff or contractor themselves and cannot be done for them by any person.
- **Completed Electronic Record:** The completed note may not be changed by the staff/contractor. Only the Team Coordinator (supervisor) can make a correction to a final note.

e) **Release of Information With Parental Consent**

With written parental consent, their child's record may be released to a designated party. Documentation will be maintained in the child's record of all disclosures of confidential information made. Unless authorized to do so under FERPA, 34 CFR §99.31, informed written consent must be obtained **before** PII is disclosed to anyone other than officials, employees, or subcontractors of ECI-contracted agencies and public school child-find personnel.

f) **Release of Information Without Consent**

In some circumstances, PII may be shared without parental consent. The ECI staff/contractor is responsible for following policy and procedures in these circumstances. This may include:

- Compliance with judicial orders;
- Health or safety emergencies (i.e. child protective situations); and
- Other reasons allowed by law.

g) **Release of Information to School Districts for Transition**

When a child is making the transition from an ECI program to a public school setting, informed parental consent must be obtained before confidential records are released to a school district.

If the parent refuses consent, confidential records must not be intermingled with public school records, including records relating to special education. This consent is not required for PII that must be shared with school district child-find personnel, when the child is between 27-33 months of age.

h) **Exchange of Information with Other Agencies**

Exchange of information with entities outside ECI may occur only for legitimate reasons. The parent must provide prior written consent to release their child's records. If ECI staff/contractor is requested to release or disclose information to another entity, ensure a MHMR Tarrant Consent for Release of Information form has been completed, it is current, and it is signed by the parent.

i) **Records Retention**

ECI must retain records for five (5) years after the child exits the ECI program. The parent is provided written notice. The parent is provided written notice during both the pre-enrollment and exit processes that the child's records will be destroyed five (5) years after the child exits.

### **Section 3 - Written Notice & Informed Consent**

1. **Written Notice** - The family must be given adequate notice to participate in assessments, evaluations, and the planning and development of early intervention services. Prior written notice must be provided before the following events:
  - Evaluating the child
  - Scheduling IFSP meetings
  - Initiating/Changing Child's Eligibility Status
  - Initiating/Changing ECI services
  - Proposing to discontinue ECI services
2. **Consent** - ECI staff/contractors must ensure that the parent is fully informed and has agreed in writing to all activities before the child participates. Written parental consent must be obtained before any of these events take place:
  - Conducting a screening, assessment, or evaluation
  - Providing services as stated on the IFSP
  - Making changes to services listed on the IFSP (*e.g. frequency, intensity, location, adding or discontinuing services, or payment arrangements*)

- Releasing or exchanging PII with other entities
- Billing family's private insurance

#### Section 4 - Appointment of Surrogate Parent

After reasonable efforts are taken, ECI ensures that all rights of an eligible child are protected if:

- No parent can be identified;
- Unable to discover the whereabouts of a parent; or
- The child is a ward of the state, under the laws of Texas

ECI will ensure the child's rights are protected by assigning a surrogate parent to represent the child's interests in matters pertaining to assessment, evaluation, IFSP development, and early intervention services.

### HIPAA Training

(Health Insurance Portability and Accountability Act of 1996)

#### For Contract Employees



#### HIPAA Privacy and Security Rules

The Privacy Rule under HIPAA is a federal law that requires health care providers to protect privacy of medical records and identifies certain rights of persons served to control use and disclosure of and access their medical records.

*Failure to keep adequate records or to keep records in a secure manner may lead to a malpractice claim or accusation of negligence. It also breaches the standard of care of the profession.*

*HIPAA violation fines can range from \$100 to \$50,000 per instance.*

To protect client electronic **protected health information (PHI)** under the HIPAA Security Rule, follow these guidelines:

1. **Password Protection:** It is imperative that passwords are sufficiently complex; do not share them with anyone.
2. **Physical Security:** Tilt your computer screen away from public areas; keep electronic devices and hardware locked up when not in use; log off when away from your work area; ensure doors and desks are locked appropriately.
3. **Destruction of PHI:** Paper records must be shredded, burned, pulped so that it is unreadable and cannot be reconstructed. For PHI that is stored electronically, consult with your supervisor to arrange for MHMR's IT Department to clear, purge, and/or destroy the data from the device.
4. **Encryption:** Do not send PHI electronically without encryption.
5. **Privacy/Security Violations:** Report any violations to the ECI Senior Director or Chief of ECS. All violations should also be reported to MHMR's Privacy/Security Officer at 817-569-4382.

### ACTION

*After completion, you may check ✓ affirmative in the **Attestation** section of the **Provider Application for an Individual (page 6)** that you have read and understand this **Procedural Safeguards for Confidentiality** training.*

## 4. Client Rights, Abuse, and Neglect

### TRAINING

Read and study the following **Client Rights, Abuse, and Neglect** training.

By law, everyone in Texas is a mandated reporter of abuse, neglect or exploitation. Mandatory child abuse and neglect reporting laws were passed in the Child Abuse Prevention and Treatment Act (**CAPTA**). Professionals have a responsibility under federal and state laws to report any potential abuse, neglect or exploitation of children. Child Protective Services (**CPS**) operates under the Texas Department of Family and Protective Services (**DFPS**).



The following guidelines should assist when faced with those instances.

### Suspected Abuse, Neglect or Exploitation

If Provider suspects that a child is being abused, neglected, or exploited, the following guidelines should be followed:

- 1) In emergency or life-threatening situations, call **9-1-1** immediately.
- 2) If suspected abuse, neglect or exploitation, Provider must make a report **within 48-hours** from the time they first suspect. Call CPS at **1-800-252-5400** (toll-free 24 hours a day/7 days a week).
- 3) In all instances, Provider should also consult with the ECI Senior Director, Team Coordinator, Clinical Director, or Chief of ECS for further assistance development of an action plan.
- 4) In general, it is recommended to discuss with the family ahead of time about making a CPS report. However, for safety reasons or flight risks, the Provider may choose not to inform the family at the time of the visit.
- 5) Provider may identify risk factors regarding the family's inability to do what is needed or to choose not to do what is needed. If so, Provider may need to:
  - Speak with family about the Provider's concerns;
  - Develop and get an agreement on a plan;
  - Talk to them about what the Provider expects; and
  - Call CPS if situations/conditions do not change or if the plan is not followed.
- 6) The Provider must document the event in a brief progress note.
- 7) Provider must inform an ECI team member (e.g. Program Director; Team Coordinator; Service Coordinator) so that an Incident Report can be documented with MHMR.

### Minor Child Left Alone

If it seems a minor child has been left alone at home unattended, discovered through a phone call or when arriving for a home visit, these guidelines must be followed:

- 1) **Do Not Leave!** Call the non-emergency telephone number for the local police department (e.g. Fort Worth Police Department is **817-335-4222**). However, if there is a medical or other emergency call **9-1-1**.
- 2) Notify the ECI Program Director immediately to report the situation and develop an action plan. In most situations, the Program Director will instruct the Provider to attempt to contact the parent or caregiver.
- 3) Call Child Protective Services at **1-800-252-5400** (toll-free 24 hours a day/7 days a week). Providers need to make the report, even if a police officer indicates they will be notifying Child Protective Services.
- 4) If a foster child is involved, call the foster agency.

- 5) The Provider may need to be available by a phone, as the police, CPS, foster agency, and/or MHMR's Emergency Management Department may make follow-up calls for additional information.
- 6) Wait until an appropriate adult arrives before you leave.
- 7) Write a progress note detailing the events.
- 8) Provider will inform an appropriate ECI team member (e.g. Program Director; Team Coordinator; Service Coordinator) so that an Incident Report can be documented with MHMR.
- 9) Discuss the next steps with the ECI Program Director and/or Clinical Director.

*Failure to report child abuse or neglect is against the law and could result in a Class A misdemeanor or state jail felony.*

### **Making a Report**

A person making a report to DFPS in good faith is immune from civil or criminal liability. The name of the person making the report is kept confidential by the DFPS; however, the name can be released in certain circumstances, such as: order of the court, or request of law enforcement if they are conducting a criminal investigation.

- ◆ **Abuse Hotline: 1-800-252-5400** toll-free 24 hours a day, 7 days a week
- ◆ **Online:** [www.txabusehotline.org](http://www.txabusehotline.org)
- ◆ **More info:** [http://www.dfps.state.tx.us/Contact Us/report\\_abuse.asp](http://www.dfps.state.tx.us/ContactUs/report_abuse.asp)

### **ACTION**

*After completion, you may check ✓ affirmative on the **Attestation** section of the *Provider Application for an Individual* (page 6) that you have read and understand this **Client Rights, Abuse and Neglect** training.*

*Requirements under the law can be found in the Texas Family Code 261.101 through 261.110, Texas Human Resources Code Chapter 48.101(2), 42 United States Code 5106a(b)(2)(B)(i), and 45 Code of Federal Regulations Section 164.512(b)(1)(ii).*

## TRAINING

New Providers are required to take the state's ECI orientation training, called **Making it Work (MIW)** to understand the basics of the ECI process. This self-paced training is located on the HHS website under "ECI Training and Technical Assistance" at <https://hhs.texas.gov/doing-business-hhs/provider-portals/assistive-services-providers/early-childhood-intervention-programs/eci-training-and-technical-assistance>.

## For Therapists

**Licensed Therapists** take the **Making It Work for Therapists** course:

**Go to** <https://txeci.articulate-online.com/0466595159>

**-or-**

## For Non-Therapist

Early Intervention Specialist and other non-licensed contractors will take standard **Making It Work** course:

Go to <http://txeci.articulate-online.com/0466515684>

## ACTION

**►Part 1-** *Print your certificate after completing each section*

- ◆ **Section 1 - Introduction**
- ◆ **Section 2 - Referral & Initial Contact**
- ◆ **Section 3 - Evaluation & Assessment**
- ◆ **Section 4 - Individualized Family Services Plan (IFSP)**
- ◆ **Section 5 - Service Delivery**
- ◆ **Section 6 - Case Management**
- ◆ **Section 7 - Transition**

## Part 2

- ## ◆ Self-Assessment

## ACTION

**Go to [http://admin.abcsignup.com/files/%7B07D0901F-86B6-4CD0-B7A2-908BF5F49EB0%7D\\_59/AllStaffSelfAssessment.pdf](http://admin.abcsignup.com/files/%7B07D0901F-86B6-4CD0-B7A2-908BF5F49EB0%7D_59/AllStaffSelfAssessment.pdf) and complete the Self-Assessment form.**

## ACTION

*Submit the certificates and self-assessment to*

Kathy Duer, Administrative Assistant  
3840 Hulen Street, Suite 602  
Fort Worth, Texas 76107  
817-569-5302  
[Kathy.Duer@mhmrtc.org](mailto:Kathy.Duer@mhmrtc.org)

## Part 3

- ## ◆ Individualized Professional Development Plan (IPDP)

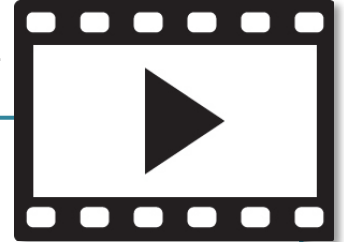
After the Self-Assessment is graded, the Provider's IPDP will be developed by ECI's Training Department Director (or designee) to identify any specific training requirements or supplementary activities.



## 15. Videos / Observation of Service Delivery Visit

### TRAINING

View all 6 of the “Just Being Kids” videos, located at [http://www.cde.state.co.us/resultsmatter/rmvideoseriess\\_justbeingkids](http://www.cde.state.co.us/resultsmatter/rmvideoseriess_justbeingkids) and answer questions on the Observation form (described below), refer to the outcomes listed below that correspond to each video.



### Outcomes

#### Blake’s Story:

- Blake will be able to stay engaged on a shopping trip by helping mom locate needed groceries, instead of pulling things off the shelf and throwing them in the floor at least 1 time per week for 1 month.

#### Evan’s Story:

- Evan will be able to feed himself with a spoon during snack time and mealtimes by getting half of the food in his mouth at each meal 3 times per week.
- During play time Evan will be able to use 5 or more meaningful words to request toys or activities at least one time daily for 2 weeks.

#### Jacob’s Story:

- During playtime Jacob will be able to sit with minimal support for 5 minutes to play with a toy or do another enjoyable activity at least 3 times per week.

#### Janella’s Story

- During playtime and bedtime, Janella will be able to communicate her choices to her parents or other caregivers at least 5 times a day for 2 weeks.

#### Jenni’s Story

- During family outings, Jenni will be able to walk from the house to the car at least 3 times a day for 2 weeks.
- During playtime, Jenni will participate in a family activity for 5 minutes at least 3 times a day for 2 weeks.

#### Nolan’s Story

- During bath time, Nolan will be able to sit in the bathtub for at least 10 minutes without crying and play with his toys once a day for 2 weeks.

### ACTION

1. Locate the “Observation” form that is located in the Provider Application for an Individual packet (pages 7 & 8) and the “Intervention Progress Note” form (page 9).
2. Complete an Observation form and Progress Note (as described in the observation form) for each of the 6 videos.

- 3.** *Submit the completed forms along with your Provider Application for an Individual, or you may submit (by print & deliver - or scan & e-mail) the 6 observation forms and 6 progress notes to:*

Anisha Philips, Senior Director  
3840 Hulen Street, Suite 602  
Fort Worth, Texas 76107  
[Anisha.Philips@mhmrhc.org](mailto:Anisha.Philips@mhmrhc.org)

## 16. Coaching

### TRAINING

#### Evidence-based definition of coaching:

An adult learning strategy in which the coach promotes the learner's (coachee's) ability to reflect on his or her actions as a means to determine the effectiveness of an action or practice and develop a plan for refinement and use of the action in immediate and future situations.

- Dunst, Trivette, & Cutspec, 2002

Coaching is an effective strategy for supporting the learning of parents of young children and teachers in early childhood programs

- Hendrickson, Gardner, Kaiser, & Riley, 1993; Kohler et al., 1995; Marchant & Young, 2001; Miller, 1994; Peterson, Luze, Eshbaugh, Jeon, & Kantz, 2007; Shanley & Niec, 2010

### 10 Key Elements of Coaching

#### #1 Consistent With Principles of Adult Learning

For the learner to gain knowledge of an area he/she must develop an understanding of how the knowledge may be used in both specific times and generic times.

- Bransford, Brown, & Cocking, 2000

#### #2 Capacity Building

Building the knowledge, skills, and abilities of the coachee without the ongoing support of the coach

- Wilson, Holbert, & Sexton, 2006

#### #3 Non-Directive

Not telling people what to do but giving them a chance to examine what they are doing in light of their intentions.

- Whitmore, 2002; Goldsmith, 2000

#### #4 Goal Oriented

Coaching in an interaction style used to achieve outcomes that are identified by the coachee and are related to desired knowledge.

- Ives, 2008; Reiss, 2007

#### #5 Solution Focused

Determine the present and creating the future rather than on analyzing the past.

- Ives, 2008

#### #6 Performance-Based

Developing people on purpose, improving the coachee's performance, applying knowledge gained, and demonstrating of skills resulting from coaching

- Doyle, 1999; Flaherty, 1999; Kinlaw, 1999; Reiss, 2007

#### #7 Reflective

Looking back in order to look forward, it is a means of reaching a deeper understanding of what a person already knows. As a result, the person's confidence is enhanced, causing him or her to continue to do what works, to try new possibilities, and to evaluate the effectiveness of all these actions.

- Jackson, 2004; Daniels, 2002; Showers & Joyce, 1996

#### #8 Collaborative

It is a partnership and reciprocal process in which both coach and coachee bring knowledge and abilities to the relationship. Coaching cannot be a hierarchical relationship in which the coachee implements actions due to directives.



**#9 Context-Driven**

It is a relationship that is built on achievement of goals related to functional activities, beginning with the current concern by the coachee.

**#10 As Hands-On As It Needs To Be**

The role of the coach may need to be more hands-on. The coach may assist in identifying possible options, external resources, and share information to build deeper knowledge of the topic. Over time, feedback by the coach becomes more affirmative and less informational.

- Berg & Karlsen, 2007; Ives, 2008



## 5 Coaching Characteristics

1. Joint Planning
2. Observation
3. Action/Practice
4. Reflection
5. Feedback

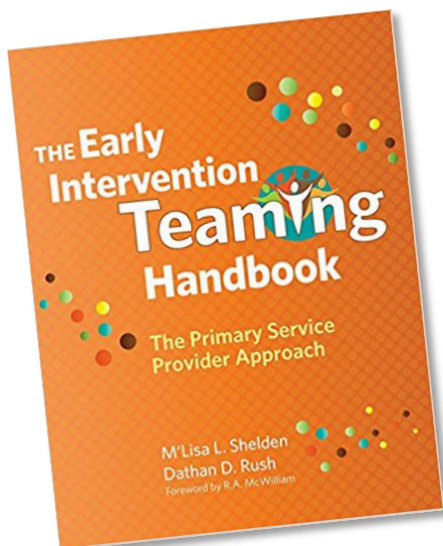
## Coaching Misperceptions

- ✗ Coaching only works with certain families.
- ✗ Coaching is only useful for certain children.
- ✗ Coaching is a watered-down approach.
- ✗ Coaching doesn't allow the therapist to touch the child.
- ✗ Coaching is not a billable service.
- ✗ Some parents want to be told what to do, not coached.
- ✗ Coaching implies a hierarchical relationship between the practitioner and parent.
- ✗ Coaching is a technique to get people to do what you want them to do.
- ✗ Coaching does not allow a practitioner to share expertise with the parent or caregiver.
- ✗ Coaching is the same as consultation.

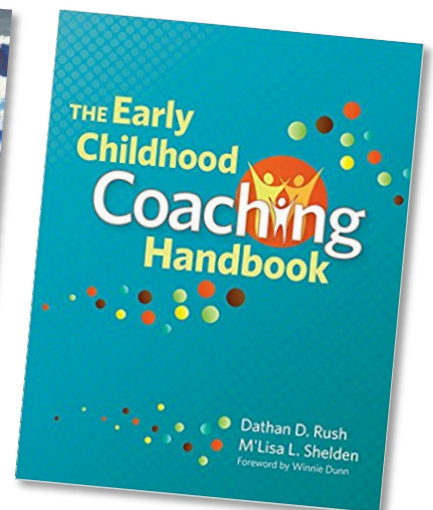
## Ways to Build Your Coaching Knowledge

- Role playing
- Someone observing you
- You observe someone
- Roadmaps (include in this Provider Manual)
- At-A-Glance Coaching Questions (included in this Coaching training section)

## Coaching Roadmaps



Books by  
M'Lisa Sheldon, PT Ph.D.  
and  
Dathan Rush, Ed.D. CCC-SLP



## At-a-Glance Coaching

### Capacity-Building Process

Practitioners support

- Parents' strengths and abilities to achieve desired results
- Parents to recognize and use current and new abilities to achieve preferred outcomes
- Parents to identify opportunities and embrace responsibility for actively working toward their desired outcomes

### Relational Helpinggiving

Practices and characteristics that promote positive relationships with parents.

- Trust
- Respect
- Empathy
- Caring

*Sources for Effective Helpinggiving (Dunst & Trivette, 2009; Trivette & Dunst, 2007)*

### Participatory Helpinggiving

Practices and characteristics that promote active participation on the part of parents (choice & action).

- Parents
- Develop their own goals
- Develop their own plans with support
- Implement the plans with support
- Evaluate the effectiveness of their actions
- Develop new plans as needed
- Recognize the results of their actions (self-attribution)

### Previous Plan

- At the beginning of the visit, review the previous plan related to what the person was going to do between coaching conversations
- Ask the parent/teacher to reflect on the success or lack thereof regarding the previous plan
- After a thorough review of the previous plan and actions taken by the parent/teacher, move to observations and actions related to the activity/routine or topic planned for the current visit

### Observation

- Observe the parent/teacher and child engaged in the typical activity setting or routine occurring during the time of your visit as it relates to the parent/teacher priorities
  - If necessary, intentionally model how to support the child's participation within the current activity or routine while parent/teacher observes
  - Explain what will be modeled and why
  - Give the parent/teacher something to observe/do
- Conduct the model
- Reflect on the model with parent/teacher
- Invite the parent/teacher to try
- Reflect on/debrief parent/teacher return demonstration
- Plan how the parent/teacher will do this when coach is not present

### Action/Practice

- Ask the parent/teacher to demonstrate what worked or did not work from the previous plan during the current visit if appropriate
- Provide opportunities within the present activity settings or routines for the parent/teacher to demonstrate/practice new knowledge, skills, and/or strategies based on discussion/reflection and/or your modeling
- Use verbal prompting or direct teaching when necessary to support parent/teacher success in promoting child participation within the activity setting/routine
- Identify how the parent/teacher will continue to use the newly learned knowledge, skills, and/or strategies in the current and future activities/routines



### Reflection

- Ask *awareness* questions to find out what the parent/teacher already knows and/or is doing within the activity/routine from the previous joint plan and in the current activity setting/routine serving as the context for the visit
- Ask *analysis* questions to assist the parent/teacher to think more deeply about child participation and parent responsiveness in past, current, and new or future activities and routines and to promote self-attribution
- Ask *alternatives* questions to generate new ideas
- Ask *action* questions to support the parent/teacher to create a new joint plan
- Avoid yes/no questions except when asking permission or avoiding making an assumption

### Feedback

- Provide affirmative feedback to acknowledge what the parent/teacher is sharing with you and demonstrate you are listening and understand
- Provide positive evaluative feedback to let the parent/teacher know when you agree or need to reinforce the parent's/teacher's thought or idea
- Follow evaluative feedback with an explanation of why you agree or what you are reinforcing (i.e., informative feedback)
- Provide informative feedback to share necessary information or provide ideas after the parent/teacher has the opportunity to reflect
- Follow informative feedback with an analysis question for the parent/teacher to assess the information and/or idea and plan how it might work in the present and future
- Provide directive feedback only in situations of clear, present, imminent danger

### New Joint Planning

- Assist the parent/teacher to develop a new joint plan throughout and/or at the conclusion of the visit
- Develop a two-part plan with the parent/teacher
  - What the parent/teacher will be doing to support child participation within and across specific activity settings/routines
  - What activity setting(s)/routine(s) will serve as the context for the next visit and when it would be necessary for you to return and be part of that activity/routine
- Use the new joint plan to start your next conversation

### Self-Assessment

- What did the parent/teacher learn and/or change as a result of this conversation?
- How did this interaction build the other person's knowledge and skills for the current and future situations?
- How did this interaction compare to others with this parent/teacher?
- What will I do similarly in future coaching interactions?
- What will I do differently in future coaching interactions?

### Your Plan

- What is my plan related to the continued use of coaching practices in terms of what I want to continue to improve or do differently?
- What additional supports do I need?
- When should I revisit my plan?

**At-a-Glance****Reflective Coaching Questions****Awareness**

- What do you know?
  - What have you tried?
- Tell me about that.  
Tell me more.  
What else do you know/did you try?*

**Alternatives**

- What ideas do you have?
  - What do you need to know?
  - What do you need to find out?
  - What could you do/try?
  - What can/will you do differently?
- What else could you do?  
What are other options/ideas?  
What is missing?*

**Action**

- What is your plan/decision?
  - What do you plan to do?
  - What is your first step?
- What is your back-up plan?  
When will you do this?  
What supports will you need?  
When do you think we should revisit this plan?*

**Analysis**

- How (well) did/does that work?
- How (well) do you think that will work?
- How did you know to do that?
- How did/does that compare to what you want to happen?
- What would the ideal situation look like?
- How will you know?
- Why do you think that happened?
- What have you done in a similar situation?
- What do you think you *could* have done differently?
- What could/should happen?
- What do you think about that?
- What did you do to make that happen?
- What are your thoughts (do you think) about what I have shared?

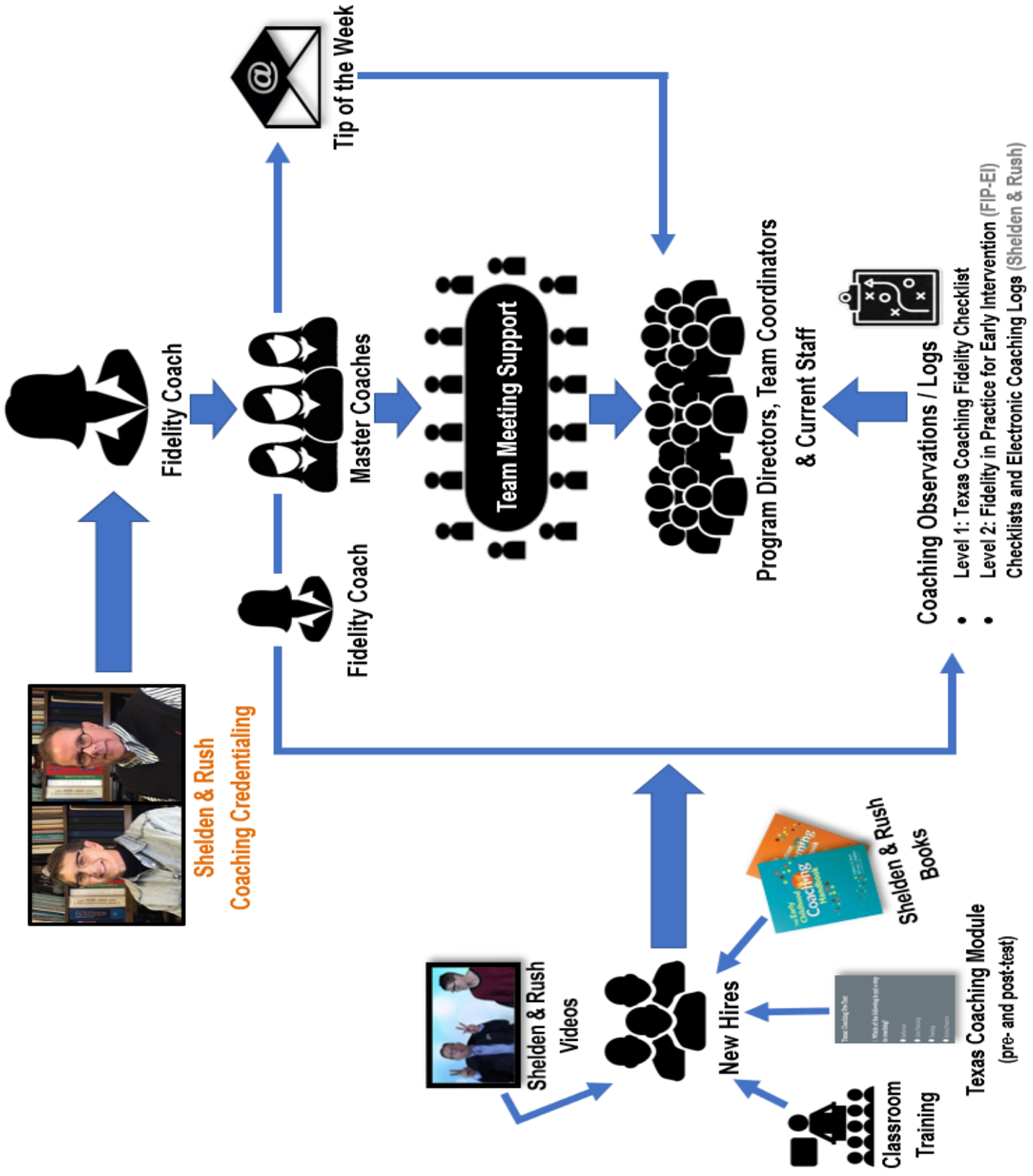
**Why?**

*What are the advantages and disadvantages of that idea?  
What is or will be the most or least helpful?*

**At-a-Glance****Tips for Reflective Coaching Questions**

- Ask only one reflective question at a time.
- Be comfortable with silence while waiting for the person to think about his/her response.
- Avoid asking "grand tour" questions to revisit the previous joint plan (i.e., "How are things going?").
- An awareness, analysis, or alternatives question always precedes informative feedback.
- An analysis question always follows informative feedback (i.e., "What are your thoughts about that idea?" "How would that work for you?").
- A self-attribution question is "What did you do to make that happen/cause that progress?"
- A yes/no question should only be used to ask permission or not make an assumption (i.e., "Would you like to try it?").
- When you ask a reflective question and the person says, "I don't know,"
  - rephrase the question to ensure he/she understands, or
  - provide affirmative feedback about an observation you made in the past that confirms he/she knows, or
  - provide informative feedback, and then ask the person an analysis question.
- When a person says, "Just tell me,"
  - assure the person that you have some ideas to share;
  - ask the person a few awareness questions to ensure that the information/idea you have matches the needs/priorities; and
  - provide informative feedback, and then ask the person an analysis question.
- Avoid asking questions with the answer embedded (i.e., "I wonder what would happen if...?" "What would you think about...?" "How about you try...?").
- Avoid asking questions to get the person you are coaching to agree with what you are thinking (i.e., coaxing).

# Fidelity Coaching



# Roadmap for Reflection: "I need help...."

A Service Coordination Coaching Guide for Reflective Questions & Feedback



I need help with....

What has happened since the last visit, including any family or household challenges?

Tell me more about the situation.

What have you done so far?

Tried something, but it's not working

Tried something; it worked

Haven't tried anything

What other ideas do you have? -or- Let's think about other options. (brainstorm & provide informative feedback)

What have you done before that worked or didn't work?

Based on your experience, what do you know about this? How could you get started?

How can you use that? -or- Let's think about other options. (brainstorm & provide informative feedback)

What are your thoughts about those ideas? What are the advantages / disadvantages?

What are your next steps?

When will you do that?

What other things would you need to do or consider or are required?

When should we revisit this plan?

What supports do you need / want?

What is your plan?

What are your thoughts about those ideas?

Provide informative feedback, if needed.



## Fidelity in Practice-Early Intervention (FIP-EI) Indicator Descriptions

### Coaching Practices Checklist

	Selected "Observed" when the practices look like this:	Selected "Not Observed During the Visit" when the practices look like this:
Joint Planning	<p><b>1a.</b> Practitioner and parent review the between visit plan by asking questions such as, "You were planning to ... how did that go?" They discuss in enough detail to identify what worked (i.e., what worked?), barriers to implementing the plan (i.e., why do you think that happened?) and/or determining modifications needed in the plan (i.e., what would make it work better?), or create a new plan to achieve the desired outcomes.</p>	<p>Practitioner does not engage parent in conversation about the previous joint plan OR It appears that no previous joint plan was developed.</p> <p>OR</p> <p>Practitioner and parent discuss the previous plan, but don't follow up on the effectiveness of the plan AND/OR discuss modifications needed in the plan to achieve desired outcomes.</p>
	<p><b>1b.</b> Practitioner engages the parent in a discussion of the previously developed plan for the current visit.</p> <p>Practitioner and parent review the plan that was developed for the current visit, including the activity that was to be the focus of the current visit and whether this activity still fits with the child's routines (when providing child learning support) by asking questions such as, "Today we planned to... will that still work for you?"</p> <p>OR</p> <p>Practitioner and parent review the plan that was developed for the current visit including the topic that was to be the focus of the current visit and whether the topic is still a parent priority (when providing family support) by asking a question such as, "Today we planned to... will that still work for you?"</p>	<p>Practitioner assumes the planned activity will happen without asking.</p> <p>OR</p> <p>Practitioner joins in the child's play or other ongoing activity without discussing the previously planned activity that was to be the focus of the visit.</p> <p>OR</p> <p>Practitioner and parent have no plan for what would occur at the current visit.</p> <p>OR</p> <p>Practitioner tells the parent what the agenda for the visit is without parent input.</p>
Action	<p><b>2</b> Practitioner recognizes that the parent completed part or all of the previous plan between visits.</p> <p>OR</p> <p>Practitioner learns that the parent revised the plan and completed part or all of the revised plan.</p>	<p>Practitioner discovers parent did not implement plan or does not remember plan.</p> <p>OR</p> <p>Practitioner does not engage the parent in a discussion of the previous joint plan.</p>
Observation	<p><b>3</b> Practitioner creates/encourages opportunities for the parent and practitioner to observe desired strategies within the context of a) everyday activities or b) family support activities.</p> <p>Practitioner asks the parent to try interacting with his/her child during an interest-based everyday activity or routine using a questions such as, "How would you like to try it?"</p> <p>OR</p> <p>Practitioner observes the parent practice a skill or strategy needed to address a parent priority; AND Practitioner models a strategy for the parent; AND Practitioner invites the parent to try the strategy.</p> <p>OR</p> <p>The practitioner and the parent intentionally observe the environment or the child interacting with the environment.</p>	<p>Practitioner does not observe the parent practicing a desired strategy while engaged in an interest-based everyday activity.</p> <p>OR</p> <p>Practitioner does not observe the parent practice a strategy to address a family support goal.</p> <p>OR</p> <p>Practitioner lacks flexibility in capitalizing on serendipitous opportunities to observe the parent in action.</p>
	<p><b>4</b> Practitioner intentionally models an evidence-based strategy/technique to promote a) the child's participation in an everyday learning activity, or b) the parent's action toward a goal.</p> <p>If the practitioner modeled for the parent, the practitioner used the following steps (implicitly or explicitly):</p> <ul style="list-style-type: none"> <li>Practitioner explained what will be modeled and why or what is being modeled if the opportunity would be lost if the practitioner waited.</li> <li>Practitioner ensures parent is observing (i.e., by prompting, getting the parent's attention, giving the parent a job, etc.).</li> <li>Practitioner models.</li> <li>Practitioner prompts the parent to reflect on the model.</li> <li>Practitioner invites the parent to try.</li> <li>Practitioner prompts the parent to reflect on his/her attempt.</li> <li>Practitioner prompts the parent to plan how the parent will do it when the coach is not present.</li> </ul>	<p>Practitioner does not model for the parent, prompt the parent to demonstrate while the practitioner observes, or prompt the parent to observe the child and/or the environment for the purpose of enhancing the learning opportunity for the child or a parent skill.</p> <p>OR</p> <p>Practitioner asks before modeling strategy but does not wait for permission from the parent or is overly pushy without being sensitive to parent response.</p> <p>OR</p> <p>Practitioner uses hopeful modeling rather than intentional modeling</p> <p>OR</p> <p>Practitioner models a non-evidence-based strategy or is not intentional in modeling.</p>

	Select "Observed" when the practices look like this:	Select "Not Observed During the Visit" when the practices look like this:
<b>5</b> Practitioner promotes the parent's reflection on the knowledge, abilities, and actions related to the skills or outcomes desired and evidence-based practice standards.	Practitioner promotes reflection using a variety of open-ended questions including awareness, analysis and/or alternatives, questions before sharing information or suggestions, and action questions. <b>AND</b> Practitioner uses "yes/no" questions intentionally to avoid assumptions and/or ask for permission. <b>AND</b> Practitioner asks questions in a conversational manner that evolves the parent's level of understanding and/or skill and builds the parent's capacity to develop a new plan of action.	Practitioner uses too many "yes/no" questions (more than 20% of the total questions asked) that do not ask permission or avoid assumptions or the number of "yes/no" questions limits the learner's ability to analyze, consider alternatives, and/or develop his/her own plan. <b>OR</b> Practitioner asks mostly awareness questions with very few, if any, other types of questions. <b>OR</b> Practitioner asks questions in a way that disrupts the flow of progress of the conversation (i.e., asking too many questions, jumping topics, asking questions unrelated to the parent's priority).
<b>6</b> Practitioner provides information and feedback to the parent that is accurate and shared in a way that builds the parent's knowledge and understanding.	Practitioner provides a variety of types of feedback, limiting directive feedback to instances of immediate danger. <b>AND</b> Practitioner uses informative feedback after the practitioner provides an opportunity for the parent to reflect (if informative feedback is used). For example, the practitioner asks, "what do you already know about..." and provides information that builds on the parent's preexisting knowledge. <b>AND</b> Practitioner prompts parent reflection after informative feedback is shared (if informative feedback is used) (i.e., "What are your thoughts about that?") <b>AND</b> Practitioner matches the context and the amount of feedback to the parent's expressed needs and response.	Practitioner does not provide any feedback. <b>OR</b> Practitioner uses any amount of directive feedback (outside of a situation with immediate danger to the child). <b>OR</b> Practitioner uses an overabundance of or a lack of informative feedback. <b>OR</b> Practitioner provides incorrect informative feedback <b>OR</b> gives informative feedback prior to prompting parent reflection. <b>OR</b> Practitioner primarily uses evaluative feedback.
<b>7a</b> Practitioner engages the parent in developing a two-part plan that includes a new between-visit plan.	Practitioner uses action questions to help the parent develop a between-visit plan that includes one or more real-life activities and parent responsive strategies when the focus of the visit is promoting child learning (i.e., "What would you like to work on between visits?"). <b>OR</b> Practitioner uses action questions to help the parent develop a between-visit plan that includes actions the parent will take to mobilize needed resources and supports, when the focus is on parent support (i.e., "What are your next steps?").	Practitioner does not make a between-visit plan. <b>OR</b> Practitioner develops the plan for the parent. <b>OR</b> Practitioner does not develop a joint plan with enough specificity for the parent to be able to act on the plan between visits (i.e., joint plan does not include responsive strategies parent will use or everyday activity settings or routines).
<b>7b</b> Practitioner engages the parent in developing a two-part plan that includes a next visit plan identifying what will happen and scheduling the visit at a time when that activity would naturally occur.	Practitioner uses action questions to help the parent develop a plan that includes a focus activity and a time of day when the activity naturally occurs when the focus of the visit is on promoting child learning (i.e., "What activity or routine would you like us to focus on at our next visit?") <b>OR</b> Practitioner uses action questions to help the parent develop a plan that includes how each person at the visit will prepare for the next visit and a time of day convenient for the discussion when the focus of the visit is parent support (i.e., "When would you like to follow up?")	Practitioner does not facilitate the development of a plan for what will occur at the next visit. <b>OR</b> Practitioner and parent develop a vague plan and do not include an activity setting or a time of day when the activity setting naturally occurs or what each party will do to prepare for the visit. <b>OR</b> Practitioner and parent do not schedule the visit at a time and place convenient for the parent or for the discussion. <b>OR</b> Practitioner develops the plan for the parent. <b>OR</b> Practitioner has determined the frequency prior to planning the next visit with the family.

Adapted from: Rush D. & Shelden, M. (2006). Coaching practices rating scale for assessing adherence to evidence-based early childhood intervention practices. CASEtools 2(2), 1-7. Available at [http://fipp.org/static/media/uploads/casetools/casetools\\_vol2\\_no2.pdf](http://fipp.org/static/media/uploads/casetools/casetools_vol2_no2.pdf).



## 17. Demonstration of Service Delivery

Provider's first ECI in-home service delivered will be observed by an ECI staff member.

### ACTION

*After all individual application requirements are cleared and all trainings (in this Provider Manual have been completed, the **ECI Senior Director** will contact you to schedule a clinical demonstration during your first in-home visit:*

Anisha Philips, ECI Senior Director  
MHMR Tarrant / ECS RU#3100  
3840 Hulen Street, Suite 602  
Fort Worth, TX 76107  
[Anisha.Philips@mhmrtc.org](mailto:Anisha.Philips@mhmrtc.org)

## 18. Forms

ECI's Senior Director or designee will provide instruction regarding the proper use and completion of ECI forms. If at any time you have questions about a form, your assigned Program Director, Team Coordinator, or Records Manager can assist.

## NEXT STEPS

### ACTION

*Fill out the **Provider Application for an Individual form**, which contains an **Attestation** section (page 6) that affirms you understood this Provider Manual and the trainings specified within. Submit to the Chief of Child & Family Services, as directed in the application.*

*If you have already submitted your **Provider Application for an Individual** but did not finish the trainings or **Attestation** section (page 6), submit the Attestation page to:*

Kathy Duer, Administrative Assistant  
3840 Hulen Street, Suite 602  
Fort Worth, Texas 76107  
817-569-5302  
[Kathy.Duer@mhmrtc.org](mailto:Kathy.Duer@mhmrtc.org)