



Exploring State Strategies for Financing Infant and Early Childhood Mental Health Assessment, Diagnosis, and Treatment

Executive Summary

This paper summarizes key themes from a recent convening and describes approaches to financing Infant and Early Childhood Mental Health (IECMH) assessment, diagnosis, and treatment.

In the sections that follow, state examples illustrate core areas that can be employed to improve IECMH. There are interrelated activities that need to be addressed in order to increase access to high-quality mental health services for pregnant women and young children and families. To do this, states need to align practice, policy, and systems integration with developmental science. Investments need to be made that:

- grow, train, and support the workforce;
- secure and sustain financing for services;
- build systems that support integration; and
- cultivate leadership inside and outside government.



The paper concludes with 10 tips for advancing state IECMH policy, suggested by the first cohort of states participating in the ZERO TO THREE IECMH-Financing Policy Project (IECMH-FPP).

1. Meet with Medicaid staff early and often.
2. Remember that relationships are essential.
3. Share the leadership.
4. Be as inclusive as possible.
5. Be strategic.
6. Be persistent.
7. Be aware of unconscious assumptions.
8. Try different forms of communication.
9. Don't get discouraged by what you do not know.
10. Recognize that paying for a process and paying for a product are not the same thing.



Introduction

The earliest years are a period of special opportunity and vulnerability. Epigenetics teaches us that early brain development is shaped by the interaction between genetics and early experiences. Beginning in utero, the environment has a profound impact on children's long-term health and well-being. Sensitive and responsive relationships with primary caregivers contribute to a strong foundation that boosts psychological health, builds protective factors, and supports cognitive development. Malnutrition during pregnancy, premature birth, toxic stress, and other adverse conditions impede development, resulting in altered neuronal development. For infants and toddlers, this may manifest in regulation, attachment, and early emotional challenges characteristic of an anxious and fearful brain. These have a lasting impact on cognitive, social, and emotional capacities, since in the earliest years all areas of development are interrelated.

Health and mental health practitioners, researchers, and policymakers are increasingly aware of the importance of the prenatal-to-age-5 period. The internationally known developmental researcher Megan Gunnar opines, "It is easier to develop a healthier brain than to repair a damaged one. There are no do-overs in neuroscience, only work-arounds." Glenace Edwall adds from a state administrator perspective, "Failure to intervene too often condemns children to system involvement. Being expelled from child care is a lifelong marker you do not want to have."

The growing but still nascent field of Infant and Early Childhood Mental Health (IECMH) is focused on just this—supporting the early relationships between very young children with their parents and other caregivers so children can have the early experiences that enable them to flourish. That means creating stimulating early opportunities, reducing the amount of toxic stress, and increasing protective factors for both children and families. IECMH services run the

Definitions

Infant and Early Childhood Mental Health: Infant and early childhood mental health (IECMH), sometimes referred to as social and emotional development, is the developing capacity of the child from birth to 5 years of age to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn—all in the context of family, community, and culture.

DC:0-5™: *DC:0-5: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* was created to provide developmentally specific diagnostic criteria and information about mental health disorders in infants and young children. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)* and World Health Organization's *International Classification of Diseases (ICD)* are comparable classification systems for older children, adolescents, and adults. DC:0-5, published in December 2016, revised and updated DC:0-3R by expanding the age range from 3 years old to 5 years old, extending criteria to younger ages, and including all disorders relevant for young children.

continuum from promotion to prevention, to developmentally appropriate assessment and diagnosis, to treatment. When something goes awry, with the right interventions, IECMH treatment can help to minimize future adverse outcomes during childhood and into adulthood.

Delivering the “right intervention” is dependent on several factors that are still evolving. One important factor is a proper **assessment and diagnosis**, which greatly influences intervention. *DC:0-5™: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC:0-5) is a developmentally based nosology of infancy and early childhood disorders. It is the most appropriate diagnostic tool to accurately assess children, inform interventions, and align with Medicaid billing. **Health care policy and financing** is only beginning to recognize IECMH, with just a few states leading the way to ensure the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is used to its fullest and Medicaid managed care contracts and accountable care organizations cover IECMH screening, assessment, and treatment. The **workforce** of IECMH practitioners is small but growing. Informed and engaged **leadership inside and outside government** is still needed to help raise awareness and bring about policy change. And better **coordination across service delivery systems** is essential. Fortunately, over the past decade, several states have begun to take steps in each of these areas. “Two decades ago I would go to a conference and there was no understanding of IECMH. Now I go and everyone has heard of IECMH and they want to learn more,” said Edwall.

IECMH State Leader Policy Convening

With support from the Robert Wood Johnson Foundation, the Irving Harris Foundation, the Alliance for Early Success, and the University of Minnesota, ZERO TO THREE launched the IECMH Financing Policy Project (IECMH-FPP) in 2016. The purpose was to support states’ advancement of IECMH assessment, diagnosis, and treatment policies that will contribute to the healthy development of young children.

The first cohort of states participating in the IECMH-FPP included Alaska, Colorado, Illinois, Indiana, Louisiana, Massachusetts, North Carolina, Oklahoma, Oregon, and Virginia. Diverse teams from each of these states consisted of a high-level representative from Medicaid and a practicing

Cohort 1 Accomplishments

The work of the Cohort 1 states took many dimensions. Some states had a laser focus on just one aspect of IECMH; others took on multiple projects. What follows is just one example of each of their accomplishments.

Alaska: An 1115 Medicaid waiver application was written to specifically include a focus on IECMH.

Colorado: An Early Childhood Mental Health Risk, Reach, and Resources mapping project was commissioned.

Illinois: DC:0-5 training was brought to the state.

Indiana: Time was devoted to exploration of IECMH consultation opportunities.

Louisiana: Focused energy was directed toward creating a draft of a state strategy for expanding and sustaining vital IECMH supports and services, and partnering with the Governor’s Children’s Cabinet Advisory Board to work toward advancing these priorities.

Massachusetts: An inside-outside government strategy included the convening of more than 100 stakeholders at an IECMH Summit to set an agenda and action steps.

North Carolina: Mental health services are now integrated into primary care and a focus throughout is on the social determinants of health.

Oklahoma: The Department of Health and the Department of Mental Health partnered with Oklahoma State University’s Institute for Building Early Relationships (IBEaR) to increase workforce capacity through the provision of formal coursework in IECMH assessment, reflective consultation and mentoring, and training in evidence-based practice.

Oregon: A diagnostic crosswalk aligning DC:0-5 with DSM-V and ICD-10 codes was created and widely disseminated to support IECMH providers in billing Medicaid.

Virginia: Virginia has a full-time state ECMH Coordinator funded by three state agencies to develop a comprehensive IECMH system. Efforts include support for the workforce through the IMH Endorsement and a series of IECMH trainings provided by the state infant mental health association, ECMH Virginia Initiative, and Virginia Commonwealth University’s Office of Continuing and Professional Education.

IECMH clinician. Other members included but were not limited to representatives from the state infant mental health association, advocacy organizations, and divisions of state government including Part C, child welfare, public health, behavioral health, and early care and education. Teams attended a national policy convening at the University of Minnesota in October 2016 and then received nine months of individualized technical assistance, participated in group calls and webinars, and engaged in an online learning community.

The second cohort was launched in May 2018, again with a meeting at the University of Minnesota and supported by the original funders. States participating included Alabama, the District of Columbia, Maryland, Nevada, New Hampshire, New Mexico, New York, South Carolina, Tennessee, and Washington. Five-person teams from each state convened for two days of intense learning. Some team members had a long history of working together; others met for the first time. All used the opportunity to share their experiences, surface challenges and questions, and learn from one another as well as from experts in the field. Teams were given time to identify an area of IECMH that they would address during the year-long project, and to begin developing action plans. According to one state official, "It's hard to decide to be out of the office, but this meeting was a very good use of my time."

This report summarizes highlights from the May 2018 meeting. It draws on the experiences of the states that participated in the first cohort, as well as the states that are now joining the IECMH-FPP. The appendices includes the state participants and the resource contributors.

Core Areas to Advance IECMH

States participating in the IECMH-FPP recognize that there are interrelated activities that need to be addressed to increase access to high-quality mental health services for pregnant women and young children and families. To do this, states need to align practice, policy, and systems integration with developmental science. Investments need to be made that:

- grow, train, and support the workforce;
- secure and sustain financing for services;
- build systems that support integration; and
- cultivate leadership inside and outside government.



"It is not enough to love babies or to understand the conceptual foundations of infant mental health. We have to be able to translate what we know into what we do and what our policies direct others to do. And that is the hard part. To figure out what language allows you to sustain and advance your work, how to get it paid for, etc. Our goal is to help you advance IECMH policies that reflect the evidence base behind the work and result in more infants, toddlers, and their parents receiving the support they need for strong, secure attachments."

– Cindy Oser, ZERO TO THREE

The states participating in the IECMH-FPP are working in one or more of these areas, and their experiences are highlighted below.

Grow, Train, and Support the IECMH Workforce

States recognize the importance of growing, training, and supporting the workforce. However, as a young field, the challenges to achieving this are many. Too many people are still unaware and uninformed about IECMH. There are too few college-level IECMH certification programs. Even within the mental health professional community, there is scant understanding of the unique issues of infant and toddler mental health. There is also a lack of understanding about basic development in the earliest years, which is a necessary prelude to having the skills to accurately screen and assess. Though there are diagnostic tools that could help to guide assessment and treatment decisions, they have not been widely adopted. And while there is growing commitment to reflective supervision and consultation as integral to IECMH practice, it is difficult to provide to all professionals in the field. There are a limited number of professionals qualified to provide reflective supervision and consultation, many communities are struggling with increasing capacity, and there is difficulty paying for it. However, glimmers of hope exist, as well as growing clarity on what is needed.

Discussions at the policy convening emphasized the need to:

- grow the number of IECMH providers;
- ensure IECMH providers have the DC:0-5 training needed for developmentally appropriate assessment and diagnosis;
- develop a cadre of IECMH consultants who can work at a systems level to inform practices in related fields such as early intervention, child welfare, home visiting, and child care; and
- build capacity to provide reflective supervision.

Action from states in the IECMH-FPP illustrates that they are addressing workforce challenges on a number of fronts.

Grow the number of IECMH providers with the support of IECMH Associations and Credentials.

Most states have established associations to support IECMH, and some have created endorsement, credentialing, and certification systems. Thirteen of the 20 states participating in Cohorts 1 and 2 are members of the Alliance for the Advancement of Infant Mental Health and have purchased the license for Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant & Early Childhood Mental Health.[®] Three of the participating states (Illinois, New Hampshire, and North Carolina) that are not part of the Alliance for the Advancement of Infant Mental Health have developed their own competencies, and Illinois also created a Masters credential.

A few examples include:

- Virginia funds three state agencies to develop a system for the IECMH workforce. A large portion of this work is focused on professionals who work with young children across disciplines obtaining infant mental health endorsement. There are 52 providers who are endorsed, and a fourth cohort of professionals is starting the endorsement process. The state is also offering IECMH training as part of collaboration between the infant mental health association and Virginia Commonwealth University.
- Tennessee's efforts are focused on increasing the number of professionals knowledgeable about infant mental health. They had more than 200 applicants for Infant Mental Health Endorsement[®] in the first six months, representing a broad range of sectors and disciplines across the IECMH workforce.

- New Hampshire is offering a cross-disciplinary IECMH credential at the intermediate and advanced level. Eight providers have graduated thus far.
- Maryland is launching a ninth cohort of their state infant mental health certification program.
- North Carolina is building an infrastructure for the state infant mental health association to be able to provide a roster of certified providers. The state also undertook a workforce study to document the training needed by pediatricians, mental health providers, early intervention, and the early childhood community to identify and respond to social determinants of health.
- Oklahoma worked with the university system to develop a course on infant assessment and development. While taking the course, students are assigned a reflective consultant who supports them as they begin working with clients. The hope is that by providing the course along with reflective consultation, the practitioners will have the baseline understanding needed to effectively serve infants, toddlers, and their families. The course is aligned with the university's effort to launch an infant mental health graduate certificate offering additional formal education to a multidisciplinary workforce.



Using DC:0-5 for Training and Diagnosis. IECMH providers need to be trained to use evidence-based diagnostic tools for screening, diagnosis, and treatment. Initial training should be supplemented with ongoing coaching or consultation groups. Several states are moving in this direction, as evidenced by the following:

- Minnesota recognized that university faculty had deep knowledge related to DSM, but they often lacked training and exposure to appropriate diagnostic methods for the youngest children. Because of this, the state launched an effort to train university faculty on DC:0-5. Faculty participating in the training came from 11 different universities across the state and represented the fields of psychology, psychiatry, developmental pediatrics, social work, clinical counseling, and marriage and family.
- New Mexico supports DC:0-5 training for all state-funded IECMH teams working with children in foster care. Skill development is focused on clinical case formation, treatment objectives, and discharge planning, all in the context of DC:0-5.
- Approximately 200 clinicians and early intervention leaders in New York participated in a two-day DC:0-5 training provided by ZERO TO THREE. The training was supported by the New York City Department of Health and Mental Hygiene, the New York City Bureau of Early Intervention, and the New York City Early Childhood Training and Technical Assistance Center. An intensive one-day training was provided through the New York University Langone Child Study Center for 50 advanced practitioners, including psychiatrists, psychologists, licensed mental health clinicians, and nurses. In addition, to build sustainability and fidelity to the curriculum, a two-day Training of Trainers (ToT) was piloted for 14 clinicians previously trained in DC:0-5.

Participating in approved DC:0-5 training is also helpful for professionals working with young children but who do not diagnose, so they are able to recognize signs that a child needs additional supports or assessment.

- Colorado has trained more than 150 professionals, including all early childhood mental health consultants across the state, so they understand IECMH disorders and can work collaboratively with clinicians providing services to children and families.
- Minnesota offers foundational infant mental health training to child care providers as part of qualifying for the child care quality rating and improvement STAR system. This is tied to the state's early childhood mental health consultation effort. Participation helps child care providers accrue continuing education units (CEUs), and it also helps them to climb the child care career lattice.

IECMH Consultation. States also recognize the value of IECMH consultation for extending the reach of services. Examples from the states include:

- Colorado has 34 state-funded IECMH consultation positions filled by 44 professionals. Approximately 20 additional mental health consultants are funded with philanthropic dollars. All consultants have access to trainings and resources, participate in learning collaborative activities, and use common tools to measure outcomes.
- Minnesota saw that clinicians burn out if they are in the clinic 100 percent of the time. Because of this, the state encourages clinicians to divide their time between clinical work and consultation. Being a consultant, though, requires a higher skill set, as one has to be fully competent in clinical work first, and be able to teach, guide, and mentor other providers.
- Illinois is partway through a five-year initiative focused on systematizing implementation of IECMH consultation across child-serving systems. The state developed a unified model for IECMH consultation and is currently piloting it in home visiting, child care centers, and preschool in four communities.
- Oklahoma has a network of IECMH consultants available to early care and education programs in about half of its counties. This is accomplished through braided funding efforts using Child Care Development Fund, state, and federal grants. State and private partners participate in the network sharing a common training and mentoring process. Through Oklahoma Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), the state piloted consultation in pre-K settings.

What is IECMH Consultation?

IECMH consultation is a preventive intervention to improve children's social, emotional, and behavioral health and development. A mental health professional partners with an early childhood professional or program staff to infuse activities and interactions that promote healthy social and emotional development, prevent the development of problem behaviors, and intervene to reduce the occurrence of challenging behaviors.

One team cautioned that consultation is helpful, but states also need to build a comprehensive IECMH workforce. As consultation and other systems improvements increase identification and referral of children in need, there needs to be a provider community ready to receive the children and provide treatment.

Building Capacity for Reflective Supervision. Training providers on DC:0-5 needs to be coupled with reflective supervision. Intentional efforts are needed to build capacity for reflective supervision to occur. Some examples include:

- Through a collaboration between the Early Childhood Mental Health Virginia Initiative and Early Impact Virginia (a consortium of all home visiting programs in the state), supervisors in home visiting programs have been participating in reflective supervision training provided by two infant mental health–endorsed clinicians. The training also includes key principles and practices of infant mental health to link knowledge with practice. The goal is to embed reflective practice and reflective supervision into home visiting programs as part of a home visitor's ongoing supervision. This collaboration also ensures reflective supervision is received from a trained and endorsed home visiting program supervisor and meets the requirements for Virginia's Infant Mental Health Endorsement for Categories I and II.

- Tennessee is developing a system for regional reflective supervision. Currently more than 40 supervisors from home visiting programs are participating in regional reflective supervision groups.
- Alabama is piloting a learning collaborative aimed at building capacity to add reflective supervision to IECMH consultation and training. From the first collaborative, a workgroup was formed to explore existing resources from which to grow the capacity of reflective supervision providers.

Secure and Sustain Financing for Services

If the first core area for advancing IECMH relates to building a skilled workforce, the second area must focus on establishing financing policies that will cover reimbursement for the services those workers provide.

Challenges to securing and sustaining financing are many. There is a lack of awareness among those who establish financing policy about IECMH. The policies common for adult mental health cannot be extended downward to infants and toddlers. There are not yet many studies that demonstrate a return on investment specifically for IECMH consultation and treatment, or the speedy return that policymakers desire. Many states are not fully maximizing the potential for IECMH coverage through the Medicaid children's benefit, EPSDT. And states that are beginning to cover behavioral health as part of managed care and accountable care organizations still need to be educated about services for infants and toddlers. Even when states establish policies for covering IECMH services, the workforce needs to be educated on how to bill for those services. According to a state administrator, "One piece of this is helping providers understand how to do the assessments correctly, and the other piece is helping them understand how to bill for and document the services they provide."

Discussions at the policy convening emphasized the need to:

- develop and use return on investment (ROI) data to generate support for IECMH;

Minnesota: The Golden Thread

"We had a wake-up call in Minnesota several years ago when we realized that 35 to 50 percent of children on psychotropic medication did not have a diagnosis. The Medicaid director at the time said this had to stop," reflects Edwall. The state turned to research to gain a better understanding of the foundations of child development, and how mental health is interwoven and cannot be separated out in a pragmatic way. This helped the state to focus on early intervention as the key to ameliorating the effects of adverse early experiences.

Policy changes at the Minnesota Mental Health Division expanded Medicaid benefits allowing providers to deliver a full continuum of care while billing Medicaid rather than counties. With this came recognition that more needed to be done to provide basic training for practitioners on child development and then more focused training on assessment and diagnosis, as well as training and certification on evidence-based interventions.¹ It reinforced the need to use data to guide and inform both practice and policy. And it provided an impetus to align policy to support payment of these service components.

In 2003, the state adopted the Medicaid Rehabilitation Option that opened the door for mental health services to be delivered outside the clinical setting. The state was flooded with providers who wanted to offer services and bill Medicaid. It exposed the fact that there were real capacity issues that needed to be addressed. This led to conversations about the need for documentation of medical necessity and the related course of treatment and discharge planning. What emerged was an approach coined *The Golden Thread*.

The Golden Thread is a systems approach that focuses on helping provider groups understand the links between assessment, diagnosis, medical necessity, treatment, review, and discharge. It involves training clinicians, ensuring they are certified; providing consultation to support compliance with Medicaid documentation standards; offering an ongoing diagnostic support group where clinicians are required to present six cases over time to receive feedback and build capacity to effectively use the DC:0-3R/DC:0-5; and aligning Medicaid policy in order to support payment of services.

Since 2004, the state has trained more than 3,000 clinicians at no cost to the clinicians.

1. Minnesota supports research-informed IECMH assessments and treatments including: (1) DC:0-3R/DC:0-5 for diagnosing young children ages birth to 5; (2) Attachment Bio-Behavioral Catch-up (ABC) for children ages 6 months to 4 years and their parents with early stressful histories including trauma; (3) Parent-Child Interaction Therapy (PCIT) for children ages 3 to 7 who present with behavioral dysregulation; and (4) Trauma Informed-Child Parent Psychotherapy (TI-CPP) for children birth to 6 with trauma histories.

- use DC:0-5 to standardize developmentally appropriate eligibility determination and billing; and
- maximize use of Medicaid and the EPSDT benefit, and embed language on IECMH in managed care and accountable care organization contracts.

Examples of work underway in the states illustrate promise for addressing the challenge of financing IECMH.

Developing and Using Return on Investment.

IECMH-FPP participants spoke about the importance of being able to demonstrate the cost effectiveness of IECMH services. Legitimizing and convincing policymakers of the critical importance are both big barriers. They suggest that having ROI data available would be very helpful for when they need to push back against claims that the services are too costly or not effective. A few states are working on this:

- Alaska used an epidemiological measure to look at the percentage of adults who would not be on Medicaid if they were to eliminate adverse early childhood experiences (ACEs). The study pegged this at 42 percent. Such a high number caught the attention of legislators who realized the tremendous potential savings to Medicaid. Now conversations are more frequent with legislators and they are interested in talking about topics like self-regulation and ACEs. They seem to understand that even a modest chip away at ACEs will save the state a lot of money in the long run.
- Oregon has been collecting data for more than 10 years on Parent-Child Interaction Therapy (PCIT). State staff review every treatment record and provide feedback. Data is used for fidelity reviews and also to influence broader goals of the agency. The data indicates that 85 percent of families that participate in four or more sessions show improvement. While this is promising, state staff refrain from saying PCIT will save money because they do not have the data to make that claim. Instead, when asked about the cost, they refer to an article published on the cost-benefit of the PCIT intervention.
- New Mexico is considering a cost study of what it might mean to treat the babies at highest risk, including those in the child welfare system.



“There are short-term and longer-term returns on investment with IECMH. Everyone should be armed with saying we don’t need years of treatment to have success. Twenty to 26 sessions can make a real difference. You can also note it is a ‘two-for-one’ when treating the child and parent at the same time.”

– Resource contributor

Using DC:0-5 for Developmentally Appropriate Eligibility Determination and Billing. Several of the states that are early adopters of DC:0-5 are also working to ensure that it can be used for Medicaid billing.

- Nevada’s Division of Child and Family Services and some private clinicians created a crosswalk between DC:0-5 and ICD-10 for eligibility and billing purposes.
- Minnesota supports providers in the use of DC:0-5 for diagnostic assessment with a state-provided billing crosswalk. The state currently is consolidating its Medicaid authority to incent or require the use of DC:0-5. The state also allows reimbursement for three diagnostic visits and reimbursement for dyadic therapy.

- Oregon developed a crosswalk between DC:0-5, DSM, and ICD-10. To encourage use of the crosswalk, they added information specific to Oregon's Medicaid plan, posted the crosswalk to the official Oregon Health Authority website, and created companion documents outlining how and why it should be used. They are working to get the word out through multiple statewide presentations so more providers will take advantage of this opportunity to bill for eligible IECMH services.
- Alabama Medicaid has agreed to support the IMH and ECMH Endorsement® of mental health professionals by requiring those who treat children and families, birth through age 5, to be endorsed in order to bill for services. This plan will be phased in over a three-year period, giving the state time to build reflective supervision capacity. Additionally, Alabama is working to develop a guidance document to be used by any professional working with children birth through age 5. The document will help professionals understand how to bill for mental health services, not just through Medicaid, but through private insurance and Alabama's children's health insurance program as well. It will also crosswalk the DC:0-5 with DSM-5, ICD-10, and CPT codes.
- Minnesota, New Mexico, and North Carolina allow providers to conduct multiple visits with a child before establishing a diagnosis. Maryland allows one session before conducting an evaluation to establish a diagnosis.

Maximizing Reimbursement by Medicaid EPSDT, Managed Care, and Accountable Care Organizations.

A survey by the National Center for Children in Poverty indicates that a number of states are adding maternal depression screening requirements and child social-emotional screening to their EPSDT periodicity schedules, along with guidelines from Medicaid explaining this change and what to do. Importantly, 22 states are now allowing Medicaid to reimburse for maternal depression under the child's eligibility in a well-child visit during the first year of an infant's life. In addition to maternal depression, states are also inserting requirements related to dyadic treatment and developmentally appropriate diagnosis. These and other advances illustrate that states are beginning to find ways to maximize reimbursement by making use of existing policy or working to advance policy change. Some examples include:

- Minnesota provides reimbursement for three diagnostic visits with children or adults with complicated presentations before making a diagnosis, called an extended diagnostic assessment. The state also covers reimbursement for parent-child dyadic therapy.
- Illinois allows for billing of maternal depression screenings as well as dyadic therapies.
- North Carolina changed Medicaid policy in 2001 to allow up to 16 mental health visits using non-specific V (now Z) codes. The state also provides a small payment incentive for completion of maternal depression screens. The state is working to identify resources for follow-up referrals, including to community-based nurses who can help connect families to resources. They are also referring to mental health professionals, with the primary care provider offering additional follow-up as appropriate.
- Colorado changed its accountable care system allowing for six episodic behavioral health visits in either primary care or mental health settings without a qualifying mental health diagnosis. Legislative changes in 2018 resulted in three allowable maternal depression screenings during the infant's first year of life.
- The District of Columbia allows pediatric primary care providers to conduct a maternal depression screening as part of a well-child visit during the first year of the infant's life. In addition, a major focus by the District of Columbia Collaborative for Mental Health in Pediatric Primary Care is to increase social-emotional and mental health screenings in well-child visits. A quality improvement learning collaborative worked with nearly every major provider practice to improve mental health screening, and the Department of Behavioral Health funded the DCMAP program (District of Columbia Mental Health Access in Pediatrics). DCMAP allows pediatricians to use a hotline to get immediate access to a team of child mental health professionals who are on

call and can help with medication management questions, care coordination, and other issues. Currently, another learning collaborative with pediatric providers and early childhood providers is trying to determine how child development and social-emotional screening information could be shared among providers (e.g., medical and child care) to avoid duplication and to track referrals and follow-through rates.

- Oregon Medicaid policy codes abuse and neglect as a primary diagnosis, and therefore all children in the child welfare system are eligible for behavioral health services. Parent-child relational problems are now a primary diagnosis, too, as well as other stressors to the primary support group. Leaders were successful in making the case that social determinants of health (e.g., homelessness, substance abuse) are stressors on the primary support group and therefore should qualify the parent and child for services.
- Washington began the process of integrating medical and behavioral health services (mental health and substance use disorder services) into the Apple Health Managed Care Organizations in two counties in April 2016. The Integrated Managed Care program is expected to be implemented statewide by January 2020. The state has developed a “Common Measure Set” of performance measures that focus on a broad spectrum of medical and behavioral health services.

“If you wanted to do it right, you would up-end the system and create a centralized intake to assess all the child and family needs and then triage to services. Workers would not be trained in silos but rather there would be core knowledge across fields that work with infants and toddlers.”

– Cohort 2 participant

Build Systems That Support Integration

Effective IECMH approaches encompass the full continuum of promotion, prevention, developmentally appropriate assessment and diagnosis, and treatment. Therefore, it is important that the many providers families come in contact with have some awareness of IECMH so that they can do their part to facilitate healthy social and emotional development in children, and recognize when additional support is needed. Given that IECMH is still a relatively young field, many challenges exist to accomplishing this. More attention is needed to build systems that support IECMH integration and alignment across related areas of practice, including but not limited to health and behavioral health clinics, primary care, home visiting, early learning systems such as Head Start and child care, early intervention, and child welfare.

Discussions at the policy convening emphasized the need to:

- support cross-agency work; and
- integrate IECMH within primary care, home visiting, child care, early intervention, child welfare, and related fields.

Examples of state activities to embed IECMH practices into early childhood service delivery follow.

Supporting Cross-Agency Work. States are at different stages in the process of cross-agency work. For some, they are simply providing a forum for conversation. Others are bringing systems together to support better collaboration and alignment of policies and practices.

- New Mexico supports a collaborative on clinical policy that includes the Department of Children, Youth and Families, Medicaid, Behavioral Health, and the University of New Mexico. They all come together in order to form policy. “It’s the best thing ever!” said a member of the New Mexico team. They also are creating strategic plans for infants and young children within and across all departments. This work builds upon previous successful collaboration that integrated behavioral health with human services.

- South Carolina created an interdisciplinary, cross-agency IECMH committee in 2016 with representatives from all major child-serving agencies, institutions of higher education, health systems, and community partners. Together they focus on IECMH workforce competencies. In January 2018, the committee partnered with the South Carolina Infant Mental Health Association to launch an IECMH endorsement system. The committee has created momentum for broader systems-change to support IECMH.
- Washington State’s Medicaid program covers nearly 50 percent of all children. The state brought Medicaid and behavioral health together to create a more integrated system.
- Alabama is working to develop a system of IECMH within the state by leading collaboration efforts with the state’s Departments of Mental Health, Early Childhood Education, and others.
- Under Project LAUNCH, Maryland developed IECMH core competencies for home visitors and collaborated with home visiting programs to design and deliver an IECMH home visiting curriculum.
- Illinois developed the *Illinois Action Plan to Integrate Early Childhood Mental Health into Child- and Family-Serving Systems, Prenatal through Age Five*. This plan inspired cross-systems work and projects including the IECMH consultation initiative that reaches home visiting, child care, and preschool in four pilot communities, and participation in IECMH-FPP.
- New York is undergoing a Medicaid redesign, which presents an opportunity for agencies, practitioners, and nonprofits to talk with each other and determine services for the 2 million children enrolled in the state’s Medicaid program. The state’s focus on the first 1,000 days provides a jumping-off place for prioritization of cross-agency projects.

Integrating IECMH Within Primary Care, Home Visiting, Child Care, Early Intervention, Child Welfare, and Related Fields. Integrating IECMH concepts within related fields will increase the chance that those interacting with families will have the basic knowledge needed to support mental health promotion and prevention. Actually embedding IECMH providers within these fields can be even more effective.

Efforts underway in the states include:

- Illinois is implementing an action plan that supports the intentional integration of prevention, intervention, and treatment services and support into child- and family-serving systems, prenatal through age 5.
- Louisiana is building upon existing structures to provide extensive IECMH

New York: First 1,000 Days on Medicaid

The New York Medicaid director recognized that the first three years are the most crucial for children’s development, that Medicaid covers nearly 60 percent of children in the state during their first 1,000 days, and that the early years of life present great opportunity for Medicaid to have lifelong impact and generate savings across all sectors. Those things prompted the director to call for an intentional focus on young children in the context of New York’s Medicaid system redesign. A cross-sector stakeholder workgroup met four times and developed and prioritized a 10-point agenda focused on improving outcomes—health, development, education, family—for New York’s youngest children.

1. Braided Funding for Early Childhood Mental Health Consultations
2. Statewide Home Visiting
3. Create a Preventive Pediatric Care Clinical Advisory Group
4. Expand Centering Pregnancy
5. Promote Early Literacy through Local Strategies
6. Require Managed Care Plans to have a Kids Quality Agenda
7. New York State Developmental Inventory Upon Kindergarten Entry
8. Pilot and Evaluate Peer Family Navigators in Multiple Settings
9. Parent/Caregiver Diagnosis as Eligibility Criteria for Dyadic Therapy
10. Data System Development for Cross-Sector Referrals

For more information, visit: https://www.health.ny.gov/health_care/medicaid/redesign/first_1000.htm

consultation through child care, home visiting, primary care, early intervention, and perinatal health providers. This is informed by earlier work as a Project LAUNCH grantee.

- As part of the Project LAUNCH grant, Alabama began a pilot project in 2018 that involves the integration of an IECMH consultant within one pediatric practice one to two days a week for nine to 12 months.
- The District of Columbia includes developmental and mental health screening in pediatric primary care. A challenge is connecting families to follow-up care when needed, as there is a lack of IECMH providers. A local collaborative is also piloting an effort to embed a mental health clinician into an obstetric practice at the largest delivery hospital that serves women who are at high risk of poor pregnancy outcomes, including maternal depression.
- Virginia's IECMH leaders are working closely with Early Impact Virginia (a consortium of all home visiting programs in the state). They are putting energy, support, and training into increasing understanding of IECMH among home visiting providers.
- New York offers DC:0-5 training for Part C early intervention staff. Some states are challenged by not being able to use a mental health diagnosis for Part C service eligibility, even though these disorders, if untreated, are likely to affect development. The state provides Part C eligibility with two specific DC:0-5 diagnoses—autism spectrum disorder and attention deficit hyperactivity disorder. Other disorders can provide evidence toward eligibility. Further, New York's Part C program developed a paper with case examples using DC:0-5 and guidance on supporting young children with early intervention.



Cultivate Leadership Inside and Outside Government

A final core area that surfaced at the policy convening related to the importance of building IECMH awareness and support both inside and outside government.

Growing Leadership Inside the Government. Participants highlighted the need to grow strong state leadership for IECMH. Many states have found it helpful to have a position of leadership in state government that is focused on IECMH. Such a “point-person” can look for opportunities and take initiative to weave IECMH into other state efforts. There can be downsides to this approach, though, if the leader has a portfolio of other responsibilities, or if others become so dependent on the leader that they show little initiative on their own. Some states have IECMH workgroups; other states do not have workgroups specific to IECMH but rather invite IECMH to the tables of other groups and planning efforts.

Growing Leadership Outside the Government. It is just as important to build a cadre of informed spokespeople and advocates who can educate policymakers and influence decision-making from outside the government. Often state leaders have a very full agenda and understanding the specifics of a topic is a luxury. Especially in the case of IECMH, which is a developing field, having knowledgeable and trustworthy people outside who can be called on for opinion, testimony, and advice can be tremendously helpful.

Examples of state work in this area include:

- Colorado has a director-level state government position dedicated to IECMH within the Office of Early Childhood in the Department of Human Services. The role of the position is to institutionalize policy and practice around IECMH, create and execute an IECMH strategic plan, and provide internal and external IECMH expertise to state agencies and community-based organizations. Projects accomplished to date by the IECMH director include doubling the size of the IECMH consultation program from 17 to 34 state-funded, full-time equivalents; developing an IECMH training, reflective supervision and endorsement initiative for early intervention providers; and developing e-learning course material on understanding the impacts of implicit bias in child care.
- Oklahoma's state Departments of Health and Mental Health have invested in a co-leadership role for the state's IECMH efforts. This has greatly influenced coordination around a shared state plan and related activities within state and federally funded projects.
- Washington has a Children's Mental Health Work Group that includes a mix of legislators and advocates. The Work Group focuses broadly on children from birth through transition-aged youth and has successfully advanced legislation that ensures depression screening for new mothers, and created a state-level planning position to develop IECMH services.
- Illinois has a Children's Mental Health Partnership, which was established in statute. The Partnership is a statewide public/private group of policymakers and advocates committed to improving the scope and access of mental health programs, services, and supports.

"We are at a tipping point with adverse childhood experiences (ACEs) and toxic stress language. People are listening more. This is a good time. You don't have to be in human services to hear about ACEs. Even if policymakers have not heard of IECMH, they have probably heard about ACEs and trauma."
– Cohort 2 participant

Massachusetts: A Strong Inside-Outside Strategy

Interest in advancing an IECMH agenda was front and center for many stakeholders in Massachusetts during the past decade. There was a lot of excitement and opportunity related to the Race to the Top – Early Learning Challenge, but a long-term coherent strategy for capturing and coordinating this goodwill was missing. Fortunately, because of strong and growing relationships and collaboration, multiple state agencies and a statewide coalition of parents, advocates, mental health providers, and educators have been able to work across public and private sectors to coordinate and align efforts.

As a member of the first cohort of the IECMH-FPP, the Massachusetts team prioritized convening an IECMH Summit that could build a "coalition of coalitions" and reach consensus on actionable steps to move the IECMH field ahead. With coordination provided by the Children's Mental Health Campaign (the principal "outside" partner), the IECMH Summit was held in June 2017 with nearly 100 participants. Together they developed a shared framework acknowledging disparities and inequities, particularly for immigrants and people of color. They divided into groups to explore key challenges and develop action steps.

Throughout this process, the leaders were intentional in thinking about who needed to be included to provide the right balance of those who could set a state agenda, those who could implement the agenda, and those who could extend the work and hold the state accountable.

Top 10 Tips – Lessons Learned From Cohort 1

During the May 2018 policy convening, Cohort 1 team leads shared their tips for advancing IECMH policy.

1. **Meet with Medicaid staff early and often.** Bring your colleagues (e.g., early childhood providers, home visitors, early interventionists, and child welfare workers) together to demonstrate that partnerships are in place. Come with data that is consumable for the Medicaid director and staff. Have an ask that is coordinated and supported across programs (e.g., behavioral health, pediatrics, early intervention, child welfare), and don't make it just about money.
2. **Remember that relationships are essential.** Build in time for those who are trying to advance an IECMH agenda to have conversations, get to know one another, and understand what each can contribute. Sometimes this works best one-on-one; other times it is best as a group effort.
3. **Share the leadership.** When IECMH coordination in the state is layered onto other primary job responsibilities, it can be overwhelming and difficult to stay on top of all tasks. Find ways to share the leadership with others so that it does not fall to just one person. Know that leadership does not always have to come from a state agency. Sometimes it is best to have leadership come from a nonprofit.
4. **Be as inclusive as possible.** Bring everyone to the table who might have interest, because you never know when someone will have a conversation with another person that may evolve into an opportunity. Recognize that there is value in having the leaders and middle-level managers at the table. Sometimes other issues consume all the energy of the leaders and it is the middle managers who are better able to move the process forward.
5. **Be strategic.** An inside/outside of government partnership can elevate issues that might not be discussed otherwise and can make use of each contributor's strengths and position to move an agenda. Also, look for opportunities to ride on the tail of other efforts that might be happening in the state. For example, if the state is focused on return on investment, take that track to demonstrate the value of IECMH. Or if the state is focused on social determinants of health, use the ACEs research to drive home the importance of early intervention.
6. **Be persistent.** Change takes time. Keep meeting and talking about IECMH even if you feel that the process is not moving forward.
7. **Be aware of unconscious assumptions.** The same words may have different meanings in different settings, such as the meaning of prevention or what it means to serve all children.
8. **Try different forms of communication.** For some, regular meetings of key stakeholders and decision makers are effective; for others regular email communication sharing resources and information is the better approach. Some states have found summits to be helpful in bringing together public and private partners and parents to educate all stakeholders, identify goals, and set action steps to move IECMH forward.
9. **Don't get discouraged by what you do not know.** Take in the conversations about billing and procedural codes, value-based payment, accountable care organizations, and the like. Educate yourself by reaching out to the people who really understand these concepts, practices, rules, and guidelines, and explain IECMH to them. Use them as a resource to help you identify the changes that are needed in policy.
10. **Recognize that paying for a "process" and paying for the "product" are two different things.** Spend a lot of energy up front to make sure that the process of assessment and screening is grounded in developmental science. Invest in training and establish tools, resources, and procedures to make assessment and screening effective. Establishing policies that facilitate payment is necessary, but not enough if the process does not reflect best practice.

Next Steps

The Cohort 2 states departed the convening with a renewed sense of energy and a commitment to working with their state teams to clarify a goal and related action steps that will guide their work during the course of the year-long IECMH-FPP and beyond.

Nearly every state mentioned that they intend to prioritize workforce development. For those states without an endorsement, credential, or certificate program, creating these were high on the list. Others mentioned the desire to build an IECMH consultation network and a workforce inventory to identify who is in the field and what skills and training they have. States seemed “on fire” about DC:0-5 and talked about plans for training mental health clinicians as well as providers in related fields. Some mentioned the need to prepare adult mental health providers to be more aware of IECMH. Collaborating with higher education to embed IECMH in many disciplines was also suggested. Some were inspired by the examples from Cohort 1, in which states are targeting training on specific evidence-based practices.

States seemed equally passionate about finding ways to address financing for IECMH services. Some talked about developing Medicaid state plan amendments that recognize the importance of trauma-informed care for infants and toddlers, while others talked more generally about the need to educate each other about what is already reimbursable by Medicaid through EPSDT and not being billed. Several focused on the need to embed DC:0-5 in insurance billing codes. For those with managed care, there was interest in taking time to make sure that a behavioral health carve-out encompasses IECMH.

Finally, there was discussion about the importance of stronger communication and messaging about the importance of IECMH to the general public and policymakers, and across the related fields and systems, especially between health and education.

Cindy Oser closed the meeting encouraging all to “Go in peace, but set the world on fire!” And that, these teams will surely do. They have the knowledge, passion, inside and outside expertise, and technical support available that will enable them to address challenges and advance IECMH policy and practice.

Acknowledgments

We are grateful to the many individuals who made the IECMH-FPP possible. First, we would like to thank the state teams from Cohorts 1 and 2 for their curiosity and commitment to finding ways to better meet the needs of our youngest children and their families. We would also like to thank our funders—the Robert Wood Johnson Foundation, the Irving Harris Foundation, the Alliance for Early Success, and the University of Minnesota—for their persistence in lifting up the need to address IECMH from both practice and policy dimensions. Third, we would like to recognize the staff at ZERO TO THREE for their content and facilitation expertise, especially project manager Lindsay Usry, and also Myra Jones-Taylor, Cindy Oser, Julie Cohen, Therese Ahlers, Jamie Colvard, Kathleen Mulrooney, and Johanna Lister. We appreciate the work of Deborah Roderick Stark who wrote this report.

About Us

The ZERO TO THREE Policy Center is a nonpartisan, research-based resource for federal and state policymakers and advocates on the unique developmental needs of infants and toddlers. To learn more about this topic or about the ZERO TO THREE Policy Center, please visit our website at www.zerotothree.org/policy-and-advocacy.

Appendix A

State Representatives

Cohort 1

Jordana Ash	Early Childhood Mental Health Director, Office of Early Childhood, Colorado Department of Human Services
Marian Earls	Director of Pediatric Programs and Deputy Chief Medical Officer, Community Care of North Carolina
Bonnie Grifa	State Early Childhood Mental Health Coordinator and Virginia Infant Mental Health Endorsement Coordinator, Virginia Commonwealth University
Sarah Hinshaw-Fuselier	Infant Mental Health Manager, Louisiana Office of Public Health–Bureau of Family Health; Assistant Professor of Psychiatry and Behavioral Sciences, Tulane University School of Medicine
Amy Huffer	Early Childhood Trainer/Consultant, Oklahoma Department of Mental Health and Substance Abuse Services
Allison Lowe-Fotos	Policy Manager–Illinois Policy, Ounce of Prevention Fund
Kate Roper	Assistant Director of Early Childhood Services, Massachusetts Department of Public Health
Patrick Sidmore	Health and Social Services Planner, Alaska Mental Health Board, Advisory Board on Alcoholism and Drug Abuse
Laurie Theodorou	Early Childhood Mental Health Policy Specialist, Oregon Health Authority
Nancy Ward	Chief Nurse Consultant, Indiana Office of Early Childhood and Out of School Learning

Cohort 2

ALABAMA	Jane Duer	Early Intervention Coordinator and Project LAUNCH Principal Investigator, Department of Mental Health
	Kathy Hall	Deputy Commissioner of Program Administration, Alabama Medicaid Agency
	Dallas Rabig	State Coordinator for Infant and Early Childhood Mental Health, Department of Early Childhood Education
	Sarah-Ellen Thompson	Project LAUNCH Director, Alabama Partnership for Children
	Ada Katherine van Wyhe	Administrative Manager and Legislative Liaison, Department of Early Childhood Education

DISTRICT OF COLUMBIA	Leandra Godoy	Assistant Professor of Pediatrics, Children’s National Health System
	Elizabeth Groginsky	Assistant Superintendent of Early Learning, Office of the State Superintendent of Education
	Sarah Barclay Hoffman	Assistant Director, Early Childhood Innovation Network; Program Manager, Early Childhood Mental Health, Children’s National Health System
	Colleen Sonosky	Associate Director, Division of Children’s Health Services, Health Care Delivery Management Administration, Department of Health Care Finance
	Meghan Sullivan	Project Director, DC Social Emotional and Early Development Project, Department of Behavioral Health

MARYLAND	Kay Connors	Co-Director, Center of Excellence for Infant and Early Childhood Mental Health; Program Director, Center for Infant Study; Instructor, University of Maryland School of Medicine
	Elaine Hall	Health Policy Analyst Advanced, Behavioral Health Division, Offices of Health Services and Health Care Financing
	Kim Malat	Deputy Director, Chair, Children’s Cabinet Implementation Team, Governor’s Office for Children
	Melissa Rock	Director, 0-3 Strategic Initiative in Baltimore City, Advocates for Children and Youth
	D’Lisa Worthy	LAUNCH State Young Child Wellness Expert/Project Director, Division of Child and Adolescent Services, Behavioral Health Administration, Department of Health; Co-Director, Center of Excellence for Infant and Early Childhood Mental Health

Cohort 2

NEVADA	Terri Golish	Developmental Specialist IV, Supervisor, Early Intervention Services, Division of Aging and Disability Services
	Rhonda Lawrence	Clinical Program Manager I, Northern Nevada Child and Adolescent Services, Division of Child and Family Services
	Ann Polakowski	Clinical Program Manager II, Division of Child and Family Services
	Tricia Woodliff	Private Infant and Early Childhood Mental Health Practitioner
	Jack Zenteno	Chief of Children’s Services, Division of Health Care Financing and Policy

NEW HAMPSHIRE	Elizabeth Collins	Director, Special Medical Services, Children and Youth with Special Health Care Needs
	Henry Lipman	Director, New Hampshire Medicaid
	Ellyn Schreiber	Children’s Director, Riverbend Community Mental Health Center; President of New Hampshire Association for Infant Mental Health
	Patricia Tilley	Deputy Director, New Hampshire Public Health
	Erica Ungarelli	Director, Bureau for Children’s Behavioral Health, Division for Behavioral Health

NEW MEXICO	Jeanette Baca	Director of Mental Health, YDI Early/Head Start
	Wayne Lindstrom	Director and CEO, Behavioral Health Services Department, Human Services Department
	Soledad Martinez	Infant and Early Childhood Mental Health Services Director, Children, Youth & Families Department
	Pamela Segel	Endorsement Committee Member, New Mexico Association for Infant Mental Health
	Sally Wait	Behavioral Health Manager, Medicaid Division, Human Services Department

NEW YORK	Evelyn Blanck	Associate Executive Director, New York Center for Child Development
	Donna Bradbury	Associate Commissioner, Division of Integrated Community Services for Children and Families, Office of Mental Health
	Kate Breslin	President and CEO, Schuyler Center for Analysis and Advocacy
	Sarah Fitzgibbons	Clinical Director, The Society for the Protection and Care of Children
	Kalin Scott	Director, Medicaid Redesign Team Project Management Office, Office of Health Insurance Programs, Department of Health

Cohort 2

SOUTH CAROLINA	Ann-Marie Dwyer	Director of Behavioral Health, Department of Health and Human Services, Medicaid Authority
	Melanie Gambrell	Executive Director, Beckman Center for Mental Health Services, Department of Mental Health
	Gwynne Goodlett	Child Health and Well-Being Medical Director, Department of Social Services
	Kerrie Schnake	Program Director, Medical University of South Carolina/South Carolina Program for Infant and Toddler Care
	Mary Ellen Warren	Associate Professor, University of South Carolina School of Medicine, Department of Neuropsychiatry and Behavioral Science

TENNESSEE	Heather Taylor Griffith	Director, Office of Children and Youth Mental Health, Department of Mental Health and Substance Abuse Services
	Mindy Kronenberg	Private Practice Consultation; Project LAUNCH Young Child Wellness Partner
	Crystal Parker	Director of Child Programs, Department of Health Care Finance and Administration, in the Division of TennCare
	Lisa Pellegrin	Executive Director, Office of Child Health, Department of Children’s Services
	Angela Webster	Executive Director, AIMHiTN - Association of Infant Mental Health in Tennessee

WASHINGTON	Jamie Elzea	Executive Director, Washington Association for Infant Mental Health
	Janet Fraatz	Child Care and Early Learning Mental Health Consultation Manager, Department of Early Learning
	MaryAnne Lindeblad	Deputy Director, Health Care Authority
	Sharon Shadwell	Mental Health Integration Coordinator/Universal Developmental Screening Systems Consultant, Department of Health
	Erin Wentz	Clinical Supervisor, Navos Community Mental Health Services

Appendix B

Resource Contributors

Sue Abderholden, MPH, is the Executive Director for the National Alliance on Mental Illness (NAMI) in Minnesota. She has devoted her career to changing laws and attitudes that affect people with disabilities and their families. Abderholden has been the executive director for NAMI Minnesota the past 16 years. Under her leadership the organization has grown from being in the shadows to becoming the state's most effective mental health advocacy organization. Abderholden has also held positions with the Arc of Minnesota, U.S. Senator Paul D. Wellstone, and PACER Center (Minnesota's Parent Training and Information Center). She has a BA in political science from Macalester College and a master's degree in public health administration from the University of Minnesota. Abderholden has received numerous awards for her advocacy including the 2013 Gaylord Anderson Leadership Award from the University of Minnesota, School of Public Health, and the 2013 National Council for Behavioral Health Advocacy Leadership Award.

Therese Ahlers, MS, MPA, IMH-E® (IV), is a Senior Technical Assistance Specialist working on Infant and Early Childhood Mental Health policy at ZERO TO THREE. Ahlers started with ZERO TO THREE as a Resource Specialist for Project LAUNCH – Linking Actions for Unmet Needs in Child Health. In this role, she provided technical assistance on state and community early childhood wellness promotion strategies, including early childhood mental health consultation, to LAUNCH grantees. Prior to joining ZERO TO THREE, Ahlers served as the founding Executive Director for Wisconsin Alliance for Infant Mental Health (WI-AIMH). She also convened two previous national infant mental health summits in 2005 and 2007. Prior to WI-AIMH, while working for Wisconsin Medicaid, Ahlers wrote the first contract establishing WrapAround Milwaukee. She has 10 years of experience working with adults with disabilities and more than 20 years of experience working on mental health policy. Ahlers is endorsed at Category IV as an Infant Mental Health Policy Mentor and is a 2003 ZERO TO THREE Graduate Fellow. She received a Master of Arts – Public Administration from the University of Wisconsin LaFollette Institute of Public Affairs and a Master of Science in Behavioral Disabilities and Rehabilitation Psychology.

Elisabeth Wright Burak, MPP, MSW, is a Senior Fellow at the Georgetown University's McCourt School of Public Policy's Center for Children and Families (CCF), where she directs projects focused on young children's development and supports CCF's work with national and state partners. She has more than 15 years of experience in public policy to support low-income children and families at the national and state levels. As Director of Health Policy and Legislative Affairs for Arkansas Advocates for Children & Families, Burak led successful coalition efforts to expand access to ARKids First (Medicaid and CHIP for Arkansas children). In addition to improvements in Arkansas's Medicaid program, she helped achieve other victories for families at the state capitol, including tax relief for families living in poverty and increased access to school-based health, substance abuse, and afterschool programs. Burak originally returned to her home state of Arkansas to lead the Department of Human Services Office of Policy and Planning, where she guided a number of cross-system initiatives, including the agency's priority agenda to reform the children's behavioral health system. Burak previously worked with state leaders on after-school and early childhood programs at the National Governors Association (NGA) Center for Best Practices and The Finance Project. She received Master of Public Policy and Master of Social Work degrees from the University of Michigan and a Bachelor of Arts in social psychology with honors from Smith College.

Elizabeth Carlson, PhD, LP, is a Senior Researcher, Affiliate Graduate Faculty, and Director of the Irving Harris Program at the Institute of Child Development, University of Minnesota. Carlson conducts research on the Minnesota Longitudinal Study of Risk and Adaptation, focusing on the effects of early experience on social/emotional development and psychopathology. She is coauthor of the book *The Development of the Person: The Minnesota Study of Risk and Adaptation from Birth to Adulthood*. Carlson also directs the University of Minnesota training program in Infant and Early Childhood Mental Health and its application to policy and practice. She works directly with young children and families at risk in clinical practice.

Julie Cohen, MSW, is Associate Director of the ZERO TO THREE Policy Center. During her 19-year career at ZERO TO THREE, Cohen has worked on a wide range of policy issues impacting infants and toddlers, including Infant and Early Childhood Mental Health (IECMH). She was a member of the international expert workgroup that wrote DC:0-5™: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. Cohen also just led the development of an IECMH Policy Series with briefing papers on a variety of IECMH topics. She is the author of numerous publications. Prior to joining ZERO TO THREE, Cohen worked at the National Association of Child Advocates. She earned her bachelor's degree from the American University in Washington, D.C., and her Master of Science in Social Work from Columbia University.

Jamie Colvard, MPP, is a Senior Technical Assistance Specialist with the ZERO TO THREE Policy Center. Her work focuses on issues such as home visiting, infant and early childhood mental health (IECMH), state advocacy, cross-agency collaboration, and other aspects of creating comprehensive early childhood systems that support infants, toddlers, and their families. She supports states through technical assistance, research and analysis, and the development of written products and tools. In addition to supporting states involved in the IECMH financing policy project, her current projects include supporting state advocacy organizations to implement Think Babies™ campaigns to advance policies supporting infants and toddlers, and co-facilitation of a cross-state community of practice focused on home visiting. She formerly served as a Resource Specialist with the Project LAUNCH Resource Center at ZERO TO THREE. Prior to joining ZERO TO THREE, Colvard worked on the program and policy staff at Grantmakers for Children, Youth & Families, and held several managerial and marketing positions with a regional law firm in California. She earned her MPP from the McCourt School of Public Policy at Georgetown University and her BA from Linfield College.

Abigail (Abbi) Coursolle, JD, MPP, is a Senior Attorney in the Los Angeles office of the National Health Law Program. She provides technical assistance, advocate training, and litigation support on a range of issues, with a special focus on access to care for low-income populations, Medicaid managed care, prescription drug access, behavioral health access, and children's health issues. Before joining NHeLP, Coursolle was the Greenberg Traurig Equal Justice Works staff attorney at the Western Center on Law & Poverty. At Western Center, she led a 58-county project to enforce safety-net laws for low-income Californians and worked to implement policy changes within administrative agencies in order to fully implement health programs for low-income individuals not eligible for Medicaid. Coursolle's legal and policy experience includes summer law clerkships with the Legal Aid Society of Minneapolis; the law offices of Hadsell, Stormer, Keeny, Richardson & Rennick; and the Legal Aid Foundation of Los Angeles. Coursolle received a BA from Yale University, a JD from the UCLA School of Law, and a master's degree in public policy from the UCLA School of Public Affairs.

Denise Castillo Dell Isola, JD, is a Senior Program Officer at the Irving Harris Foundation where she advances the Foundation's early childhood public policy agenda at the state and federal levels. She manages grants and special initiatives around infant and early childhood mental health, early learning, family support, and early childhood advocacy, policy, and systems building. Dell Isola spearheaded the Foundation's efforts, in partnership with the public and private sectors, to develop an action plan to better integrate early childhood mental health into Illinois' child- and family-serving systems. She currently leads the Foundation's work with the state's Children's Mental Health Partnership to advance a public/private partnership with state agency leaders, advocates, foundations, and other stakeholders to advance a mental health consultation initiative in Illinois. Before joining the Foundation, Dell Isola served as the Executive Director of an early childhood center in Chicago and practiced law at DLA Piper LLP.

Glenace Edwall, PhD, PsyD, is the former Acting Assistant Commissioner for Chemical and Mental Health Services at the Minnesota Department of Human Services. In addition to this role, beginning in May 2000, she was Director of the Children's Mental Health Division, where she was responsible for oversight of the state's tribal and county-administered children's mental health service system; technical assistance and support to the state's 95 children's mental health and family service collaboratives; and the policy component of the state's children's mental health benefits provided through Medicaid. In December 2013, she also became Director of DHS' Adult Mental Health Division, with similar responsibilities for tribal and county-administered services and Medicaid adult mental health benefits. Edwall has earned doctorates from the University of Minnesota (PhD, educational psychology) and from the University of Denver (PsyD, clinical psychology). Her interest in public policy in relationship to children's mental health led her to also pursue a master's degree in public policy from the Humphrey Institute at the University of Minnesota. Her clinical and scholarly interests have focused on lifelong trajectories in socioemotional development and their implications for children's and families' mental health status and service needs.

Becca Graves is Director of Strategic Investments for Perigee Fund. She is based in Seattle. Since early 2017 she has worked with Perigee Fund's founder Lisa Mennet to articulate a vision and goals for Perigee's work, establish operations, and develop an initial portfolio of local, state, and national partnerships. Prior to Perigee, Graves was a Managing Director at FSG, and a leader in FSG's philanthropy practice area. She was a founding member of FSG's team in 2001 and has worked in many different types of communities on strategy development, collective impact, and evaluation projects. Her clients have included foundations of all sizes focused on providing leadership across many issues facing their community as well as those who develop long-term systems-change strategies focused on advancing issues such as education or health. Graves' career began in finance, corporate strategy, and community economic development. She also served as an AmeriCorps*VISTA volunteer at a community-based organization operating programs to address family homelessness. She holds a BA from Dartmouth College in Economics and Applied Mathematics.

Megan Gunnar, PhD, is a Regents Professor and Distinguished McKnight University Professor at the University of Minnesota. She is the Director and Chair of the Institute of Child Development, the Interim Director of the Center for Early Education and Development, and the Associate Director of the Center for Neurobehavioral Development. She received her PhD in Developmental Psychology from Stanford University and then completed a post-doctoral fellowship in stress neurobiology at Stanford Medical School. In 1979, she came to the University of Minnesota as an assistant professor, moving through the ranks to full professor by 1990. Gunnar has spent her career studying how stress affects human brain and behavioral development and the processes that help children regulate stress. She is the recipient of lifetime achievement awards from the American Psychological Association, Division 7

Developmental Psychology, and the Society for Research in Child Development, and a lifetime mentor award from the Association for Psychological Science. Nationally she is a member of the Harvard National Scientific Council on the Developing Child that translates developmental science into language that communicates with policymakers. Internationally she is a member of the Canadian Institute for Advanced Research's Program on Child and Brain Development, a group working on how early experiences "gets under the skin" to influence lifelong health and well-being. In addition, she chairs the Research Advisory Council for the Minnesota Children's Museum and is a consultant on stress and development for the Greater Minneapolis Crisis Nursery.

Carrie Hanlon, MPP, is Project Director at the National Academy for State Health Policy (NASHP), where she analyzes state policies designed to improve population health and advance health equity, particularly for women and young children. She leads research about state Medicaid payment and care-delivery strategies to support healthy child development, address social determinants of children's health, and promote women's access to high-quality perinatal care. Prior to joining NASHP in 2007, Hanlon coordinated statewide quality improvement initiatives for Maine's Dirigo Health Agency. A Phi Beta Kappa graduate of Elmira College, Hanlon holds a master's degree in public policy from the George Washington University.

Myra Jones-Taylor, PhD, is the Chief Policy Officer at ZERO TO THREE, the national leader on infant-toddler policy and program development. She leads the development and implementation of the organization's policy agenda, priorities and strategies; oversees the Policy Center; and serves as the principal spokesperson for the organization on public policy matters with policymakers, the media, funders and partner organizations. Prior to this role, Jones-Taylor served as the founding Commissioner of the Connecticut Office of Early Childhood, a cabinet-level state agency responsible for early care and education, home visiting, early intervention, and child care licensing in the state, serving more than 50,000 children from birth through age five. Jones-Taylor received her doctorate in American studies and anthropology from Yale University. She is a cultural anthropologist with expertise in early care and education policy. She has the honor of being both an Ascend Fellow and a Pahara Fellow at the Aspen Institute. She is a board member of All Our Kin and an advisory committee member to the Irving Harris Foundation's Early Childhood and Reproductive Health Justice Committee. Jones-Taylor lives in Washington, D.C., with her husband and two children.

Johanna Lister, JD, MPH, is a Senior Policy Specialist with the Policy and Finance team at the HealthySteps National Office. In this role, Lister pursues sustainable funding for HealthySteps sites across the nations. She works with stakeholders, including providers, payers, and states, to promote favorable reimbursement policies to help deliver critical services to children and their families in the pediatric and family medicine setting. Prior to joining ZERO TO THREE, Lister was a Consultant with the Advisory Board Company. In that role, she advised large health systems on strategies for growth, expansion and market differentiation. Johanna's career has largely centered around the intersection of Medicaid and children's systems, including the role Medicaid plays in child welfare, special education and school-based health services, and juvenile justice. Lister has a Bachelor of Arts degree in Philosophy and Global Public Health and a Master of Public Health from George Washington University. She also has a law degree, specializing in health law, from the University of Maryland.

Alexandra Maul, MPH, is a program officer at the Center for Health Care Strategies (CHCS) supporting initiatives related to child health quality and populations with complex needs. With a focus on upstream prevention and improving the health of low-income children and families, she leads the Medicaid Early Childhood Innovation Lab and Innovations in Childhood Obesity initiatives. Maul also

supports the technical assistance and implementation needs of the Advancing Trauma-Informed Care multi-site demonstration. Prior to joining CHCS, Maul worked with the University of California, Los Angeles/Johnson & Johnson Health Care Institute, where she researched and developed health education programs for Head Start agencies around the country. She also conducted a needs assessment with the Maternal, Child, and Adolescent division of the Los Angeles County Department of Public Health to improve the health of adolescents in Los Angeles County. Maul began her career in public health with a health education nonprofit in Washington, D.C., where she planned and executed national provider education programs in nutrition, oncology, and mind-body medicine. She also served as an account manager with a global business strategy consulting firm in Washington, D.C. Maul holds a master's degree in public health from the University of California, Los Angeles, and a bachelor's degree in human and organizational development from Vanderbilt University.

Carey McCann, MA, is Assistant Director of State Services for the BUILD Initiative. She provides consultation to state leaders who are advancing early childhood systems, setting policy, and advocating for young children and their families. She also co-leads BUILD's health equity project, which works with states to advance progress toward equitable outcomes for children prenatal to age five and their families. The project aims to build the capacity of state leaders and cross-sector teams to prevent social adversities in early childhood and promote child well-being through access and the reduction of disparities. McCann partners with the State Capacity Building Center on supporting states' efforts to reduce and prevent expulsion and suspension in early childhood by developing a multi-pronged strategy. McCann came to BUILD from more than 12 years at the Ounce of Prevention Fund, where she led the consultation practice and peer learning with 18 states on early childhood policy and advocacy. She was a board member of the Illinois Association for Infant Mental Health for eight years. McCann started her career in child welfare in Rochester, N.Y. She has a bachelor's degree in psychology from the University of Rochester, and a master's degree from the University of Chicago's School of Social Service Administration with a concentration in policy and a fellowship in family support.

Tara Oakman, PhD, is a senior program officer at the Robert Wood Johnson Foundation, which works to improve the value of our investments in health and health care and also to help ensure that all young children—supported by their families and communities—have the building blocks for lifelong health and well-being. Prior to joining the Foundation in 2013, Oakman served as director of the Quality Team in the Exchange Policy and Operations Group at the Center for Consumer Information and Insurance Oversight (CCIIO) in the Centers for Medicare and Medicaid Services (CMS). In this role, she oversaw implementation of the sections of the Affordable Care Act (ACA) that set the quality-related requirements for the new Health Insurance Marketplaces and participating issuers. She also helped to write some of the first market reform regulations under the ACA. Earlier, she was an international health officer with the U.S. Department of Health and Human Services (HHS) Office of Global Health Affairs implementing the President's Emergency Plan for AIDS Relief. She also served as a program analyst in the HHS Budget Office with responsibility for evaluating the Centers for Disease Control and Prevention (CDC) budget. Oakman received a BA in political science from Brown University, a Master of Public Policy from Harvard University's John F. Kennedy School of Government, and a PhD in Health Care Policy from Harvard University. She has written and lectured on the uninsured, Medicare, health care reform, and a host of other issues.

Cindy Oser, MSN, is Director of Infant Early Childhood Mental Health (IECMH) Strategy in the ZERO TO THREE Policy Center. Oser is an experienced pediatric nurse with a focus on building comprehensive early childhood systems, early intervention for infants and toddlers with disabilities, and IECMH policy. Oser leads ZERO TO THREE's state and federal IECMH policy work, including overseeing development and publication of DC:0-5™, Diagnostic Classification of Mental Health and Developmental Disorders

of Infancy and Early Childhood. From 2004 to 2009, she was the first director and founder of the ZERO TO THREE Western Office in Los Angeles and prior to that, directed state policy initiatives and provided technical assistance to states at ZERO TO THREE. Oser previously held positions in state government and higher education. She served as the first president and founding board member of the IDEA Infant Toddler Coordinators Association and is currently a board member of the Ohio Association for Infant Mental Health. Oser has a Bachelor of Science and a Master of Science in Nursing from The Ohio State University. She is also a registered nurse in the State of Ohio, and recently achieved grandmother status.

Sheila Smith, PhD, is Director of Early Childhood at the National Center for Children in Poverty, Mailman School of Public Health, Columbia University. Smith is a psychologist whose research has focused on interventions and policies that promote the healthy development of young children in poverty. At NCCP she leads an ongoing project that profiles state policies affecting young children; projects to promote quality improvement in preschool programs; and a range of activities to help states strengthen parent engagement and early childhood mental health policies. Before joining NCCP, Smith directed the Forum on Children and Families, and two Early Reading First initiatives at New York University. She earned her doctorate in Educational Psychology at the University of Chicago, completed a post-doctoral fellowship in Child Development and Social Policy at the University of Michigan, and served as a Society for Research in Child Development Congressional Science Fellow.

Deborah Roderick Stark, MSW, is a nationally recognized expert in child, family, and social policy, programs, and research. Stark's work addresses the intersections between early childhood and systems including K-12 education, maternal and child health, mental health, substance abuse, and family well-being. She has three decades of experience working with foundations, public agencies, the nonprofit community, and federal legislators. Stark is author of many publications, including *Equity Starts Early* (2016), a policy statement of the Council for Chief State School Officers (CCSSO); *Investing in Infants, Toddlers, and their Families* (2015), a policy paper for the California First 5 Association; *Supporting Every Young Learner* (2014), Maryland's early childhood pedagogy; and *Nurturing Change* (2013), policy strategies for improving infant and early childhood mental health. She is co-founder and Secretary of the Board of the National Association for Family, School and Community Engagement, and past President of the Board of the Institute for Community Peace. She serves on the Board of Montford Hall, a nonprofit residential recovery program for adolescent boys. Stark received her BA from Wellesley College and her MSW from the University of California at Berkeley. She is the mother of three and lives in Maryland.

Lindsay Usry is a Senior Policy Analyst in the Policy Center at ZERO TO THREE, focusing on Infant and Early Childhood Mental Health. She formerly served as Director of Special Projects for the Institute of Infant and Early Childhood Mental Health at Tulane University School of Medicine, where she is on faculty and continues to host the Early Childhood Policy Leadership Institute. She also served as the Louisiana Early Childhood Comprehensive Systems Coordinator for the Louisiana Department of Health and Hospitals, Office of Public Health. Her work focuses primarily on the translation and dissemination of research on early childhood mental health and development to inform policy and programming decisions. Usry received her Bachelor of Science in neuroscience from the College of William and Mary and her Master of Public Health in global maternal and child health from Tulane University. She has previously worked with the U.S. Government Secretariat for Children in Adversity at the U.S. Agency for International Development (USAID) as well as The World Bank, and served on the Louisiana Governor's Children's Cabinet Advisory Board. She has worked on international and domestic public health initiatives and also taught elementary special education.

Claire Wilson is Assistant Commissioner for the Community Supports Administration of the Minnesota Department of Human Services (DHS). Community Supports includes all DHS behavioral health policy areas, including the divisions of Mental Health, Alcohol and Drug Abuse, Disability Services, Deaf and Hard of Hearing Services, and Housing and Support Services. Wilson has more than two decades of experience in public policy and related issues. Wilson came to DHS in June 2016 from the Minnesota Association of Community Mental Health Programs, where she served as executive director. In that role, she provided strategic and administrative leadership, creating coalitions of stakeholders to advance improvements in mental health. She has also served in a leadership role for the Office of the Minnesota Secretary of State, where her work included outreach to underserved communities. In addition, she was a 2013 Humphrey Policy Fellow at the University of Minnesota Humphrey School of Public Affairs.

Catherine Wright has a doctorate in Counseling Psychology from the University of St. Thomas. She has more than 20 years of experience providing direct children's mental health services and managing children's mental health programs and systems. She is a licensed professional clinical counselor (LPCC) and the Early Childhood Mental Health System Coordinator within the Mental Health Division of the Department of Human Services for the State of Minnesota. At the State of Minnesota, Wright is responsible for developing the early childhood mental health system of care, including arranging for and managing trainings in evidence-based practices for early childhood mental health clinicians, supporting policy development around early childhood mental health, and integrating clinical services within family-serving systems such as child care, Head Start, schools, primary care clinics and the adult mental health system. She is interested in developing an evidence-based treatment for parents with serious mental illness who are parenting their young children.

Marie Zimmerman was appointed Minnesota's Medicaid director in 2014, and oversees the strategic policy direction and the core business functions of Medicaid and the Basic Health Program (BHP), called MinnesotaCare. During her tenure, the state has saved more than \$1.5 billion through managed care reform and purchasing innovations. Savings include \$213 million related to improved health outcomes for Medicaid enrollees through an accountable care model called Integrated Health Partnerships, a collaborative, patient-focused approach to delivering care while lowering cost. In addition, Zimmerman has managed a successful Basic Health Program that provides affordable and comprehensive coverage for lower-income Minnesotans who do not qualify for Medicaid. Prior to her service as Medicaid director, she acted as health care policy director for the Minnesota Department of Human Services, where she led early efforts to reform health care purchasing for Medicaid, moving the state toward a pay-for-value model. Zimmerman is a recipient of the Women in Health Care Leadership Award from Women's Health Leadership TRUST. She serves on the boards of the National Academy for State Health Policy and the National Association of Medicaid Directors. Zimmerman lives in Minneapolis with her family. She holds a Master of Public Policy from the University of Minnesota's Humphrey School of Public Affairs and earned a bachelor's degree in economics and political science from the University of St. Thomas in Minnesota.