



ZERO TO THREE
Early connections last a lifetime

ZERO TO THREE Infant and Early Childhood Mental Health Policy Convening

Aligning Policy and Practice: Mental Health Assessment and Treatment of Infants,
Young Children, and Families



Executive Summary

Overview

On October 13–14, 2016, ZERO TO THREE, with support from the Irving Harris Foundation, the Robert Wood Johnson Foundation, and the University of Minnesota, convened 10 diverse state teams (see Appendix A) in Minneapolis, Minnesota, to launch a year-long technical assistance program to support states' advancement of their infant and early childhood mental health (IECMH) policies. The goal of the IECMH Policy Convening was to identify state strategies for aligning health care financing policy, specifically Medicaid policy, with IECMH practice, while also providing a unique and valuable opportunity for expert and peer learning and collaboration. During the 2-day convening, state teams heard presentations from IECMH experts (see Appendix B), shared their own experiences developing and implementing IECMH policies, and began developing team action plans.

"This opportunity has opened doors not possible before."—Policy Convening attendee

Key Themes

Over the course of the 2-day convening, several key themes emerged related both to substantive issues that must be addressed to advance IECMH and to the strategic challenges and opportunities confronting states.

- **The research is unequivocal that IECMH is critical to lifelong health and well-being, but state decision-makers often are not familiar with the research.**

The convening featured a powerful review of the research on the impact of the relationship between a young child and his caretaker by Dr. Megan Gunnar, Regents Professor and Distinguished McKnight University Professor, University of Minnesota. While much of the information was familiar to audience participants, they reported that their leadership "back home" is not always aware of the strong evidence base for family-based IECMH interventions. The session left participants thinking about how to more broadly disseminate the research and make the case for investment in IECMH. By the end of the convening, one state already had decided to sponsor its own conference on IECMH in 2017 where the research could be presented.

- **States with the most advanced IECMH policies have strong, coordinated leadership that elevates IECMH issues and ensures that these issues receive attention and resources on a sustained basis.**

The participating states varied widely in the extent to which IECMH already is a part of their states' policy agendas and priorities. The states that are furthest along could readily identify key

individuals within the state who have spearheaded the focus on IECMH, highlighting the importance of continuing to identify, train, and support such leaders in the months and years ahead. One related theme that emerged over the course of the 2 days was that an effective IECMH strategy requires the engagement of multiple state agencies (e.g., department of health, child welfare agency, department of education), making it critical to engage a state's governor if possible.

- **A strong consensus emerged on the importance of consistent, reliable diagnosis of IECMH conditions using the DC:0–3R (and DC:0–5™, which was released in December 2016).**

As discussed in detail during the convening, a critical first step in ensuring that children receive appropriate services is to accurately diagnose their conditions. *The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood—Revised* (DC:0–3R) offers a tool that, unlike the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5®), is specifically tailored to infants and young children and accounts for the importance of multiple assessments (three to five) in various settings and over time. The states at the convening that already had adopted the tool were able to explain to their counterparts in other states how they had gone about implementing it. For example, they shared how they integrated it into their regulations; used a “crosswalk” to serve as a bridge between the diagnosable disorders in the DC:0–3R and the codes needed for Medicaid billing purposes in the state; and established a training series for providers, medical billing specialists, and other parties on DC:0–3R to ensure it is used as intended.

- **A significant portion of the meeting was dedicated to how best to provide and finance the services needed to treat IECMH disorders.**

This topic encompassed a range of issues, including:

- **Dyadic services for parents and caretakers who are uninsured.** For IECMH, a major issue is what to do when parents and caretakers lack coverage and are not eligible on their own for therapy or other services that would improve IECMH. One of the expert contributor states (Minnesota) had found a way to secure Medicaid reimbursement for some evidence-based dyadic services (two-generational treatment), even when the parent is treated separately from the child, by justifying how this treatment approach is necessary in addressing the child's mental health needs. Other states, however, were eager for additional clarification and confirmation from the Centers for Medicare and Medicaid Services (CMS) that they can indeed provide dyadic services without running afoul of CMS regulations.
- **Addressing the social and economic issues that contribute to IECMH issues.** The convening highlighted the importance of working together with social service agencies to address unstable housing, job loss, food insecurity, community and domestic violence, low education levels, and legal issues that can directly impact IECMH. To address these “social determinants of health,” participants discussed the importance of working across silos at the state level and engaging with social support agencies and community-based organizations. Some states (and providers within states) have started to add social needs assessments to their developmental screenings.
- **Role of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) in ensuring access to IECMH services.** Many participants were well-versed in the intricacies of EPSDT requirements, but others had not fully appreciated the role that it could play in supporting their IECMH agendas. Given that EPSDT is designed to ensure that children enrolled in Medicaid receive all medically necessary services, many participants were interested in more information on how it could be used to support IECMH.

- **Workforce development is essential, and some states have established innovative ways to train and expand their IECMH workforce.**

A number of states highlighted the importance of training their workforce, including early childhood education and mental health professionals, in the unique issues raised by IECMH. They discussed training topics including the importance of a family-based approach, working with other social service agencies, and treating children and their families in a variety of settings. The examples given by states included an initiative to pay for some of the IECMH training costs that participating providers incur; developing formal endorsement programs; and establishing ongoing training, oversight, and support for the IECMH workforce.

- **IECMH is not yet a part of larger Medicaid discussions about moving to greater use of value-based payment strategies.**

To date, IECMH services, and children more broadly, largely have been left out of state efforts to move to greater use of value-based payment strategies in Medicaid. This exclusion of IECMH occurs because children are not major drivers of Medicaid spending; the fiscal benefits of IECMH services generally accrue over a multiyear time horizon; and there is a dearth of quality metrics aimed at IECMH that could be used to support value-based payment. The participants at the convening were interested in learning more about value-based payment and how to become more active participants in larger state discussions about broader delivery system reform.

Next Steps and Future Opportunities

The convening yielded numerous new ideas and opportunities for state-level action and cross-state collaboration. Participants spent the 2 days sharing ideas and mapping out paths forward.

Future Convenings

Throughout the convening, participants remarked that just being in the same room together and exchanging ideas offered an extraordinarily valuable and unique opportunity for state teams to learn from one another. They appreciated the meeting format—a mix of presentations, organized small group discussions, team-specific meeting time, and informal conversation with other state teams and expert contributors—that allowed state teams to hear from other states and experts. As important, it gave many state officials the opportunity to meet with colleagues from their own states, some of whom they had never met before, and to begin mapping out a plan for advancing IECMH. It was clear that they would greatly appreciate the opportunity for further convening, such as a chance to share updates and further develop and refine states' action plans, in the fall of 2017. Some also highlighted that they would like to have regular, day-long individual state team planning sessions on team action plans to sustain and build on the momentum created by the October convening.

“Our team was very energized by the convening – it was helpful to hear real stories of policy change, to sit together and hash out next-steps, and build relationships for future work.”—Policy Convening attendee

Practical State Tools and Technical Assistance

The meeting also highlighted the importance of several highly practical tools and strategies that could facilitate state progress on IECMH in the near term. The specific tools and resources that were requested include:

- **Talking points on the importance of IECMH** and strategies for improving it, including key data and “return on investment” arguments, that states can customize for use with different stakeholders.
- **A tool to review Medicaid managed care (MMC) contracts through the lens of IECMH.** Among other things, the tool could include a review of key questions to ask when reviewing an MMC contract, as well as sample language from states that are furthest along in promoting IECMH.
- **Training on key issues** that arose during the convening, including strategies for adopting DC:0–5; the role of EPSDT in IECMH; training and certification standards for IECMH workforce development; and creative financing strategies available to support IECMH services.

National Advocacy Efforts

Throughout the meeting, a number of recommendations were made for working with national policy-makers to improve IECMH.

- **Developing IECMH quality metrics.** Participants flagged the importance of creating and validating quality measures relevant to IECMH, such as family-oriented metrics (rather than child only) and metrics that address social determinants for families with young children. In order to engage MMC plans more directly in IECMH issues, it will be important to have metrics by which they can be measured.
- **Building IECMH into delivery system reform efforts.** Participants were interested in working with CMS and the Center for Medicare and Medicaid Innovation to encourage the federal government to incorporate IECMH into more delivery system reform efforts, including State Innovation Model grants and the Medicaid Innovation Accelerator Program, an initiative aimed at providing technical assistance to states on Medicaid and delivery system reform.
- **Clarifying IECMH options and payment policies.** Participants suggested that CMS could be asked to directly address the question of when and how Medicaid can provide services to parents (even if they are not Medicaid-eligible) that directly benefit the mental health and well-being of their infants and young children. They also suggested asking CMS to do more to educate Medicaid officials around the country on how Medicaid can be used to support IECMH and on best practices through an informational bulletin or convenings.

“Our team got the ‘how-to’s’ to keep working on this issue when we get back home.”—Policy Convening attendee

In sum, the convening was a robust discussion that highlighted the extensive work that already is underway on IECMH and the promising practices emerging around the country. It not only gave states the opportunity to hear from their counterparts in other jurisdictions, but also to begin to build an IECMH agenda and team within their own states or to bolster and energize the work of preexisting teams. Several substantive ideas and challenges were raised, pointing the way toward a series of promising next steps for continuing to advance the agenda of IECMH.

Detailed Summary of the IECMH Policy Convening

Background

Children’s earliest experiences—both positive and negative—impact their brain formation and in turn, their social and emotional, physical, cognitive, communication, and sensory and motor skills development. Promoting an optimal environment for brain growth is paramount to influencing healthy development. Conversely, certain negative early experiences (often referred to as adverse childhood experiences) have long-lasting and consequential impacts on health outcomes (e.g., chronic illness, substance abuse), educational performance (e.g., absenteeism, dropout rates), and even criminal justice involvement (e.g., juvenile arrests, felony charges) throughout children’s lives.

Recognizing the tremendous opportunities—and risks—associated with this critical time, policymakers are increasingly investing in IECMH. Today, more than ever, states are well-positioned to implement strategies to promote positive IECMH development and intervene when a child’s environment or experiences threaten her healthy development. Making such investments and advancing IECMH policies, though, are not without challenges, requiring states to address a range of issues related to leadership, financing, and workforce development, among others. As a national leader and advocate of healthy child development, ZERO TO THREE has been at the forefront of supporting states to develop and implement IECMH policies.

IECMH is defined as the capacity of a child from birth to 5 years old to:

- (1) experience, express, and regulate emotions;
- (2) form close, secure interpersonal relationships; and
- (3) explore his or her environment and learn, within the context of family and cultural expectations.

Overview of the IECMH Policy Convening

On October 13–14, 2016, ZERO TO THREE, with support from the Irving Harris Foundation, the Robert Wood Johnson Foundation, and the University of Minnesota, convened 10, diverse state teams (see Appendix A)—selected from among 25 state teams—in Minneapolis, Minnesota, launching a year-long technical assistance program to support states’ advancement of their IECMH policies and support the healthy development of young children. The convening was structured as three main sessions—assessment and diagnosis, treatment, and translating to policy action. During each of the three main sessions, state teams heard a presentation from IECMH experts; broke into small groups, led by one state team member, to discuss a specific topic area in further depth (see “Tabletop discussions” summaries), share their own states’ experiences, and ask relevant questions of the lead content contributor

and other state attendees; and then, reconvened as state teams to reflect on the session's learnings. At the end of the convening, states had an opportunity to initiate development of team action plans, which outline the policy priorities and opportunities the teams have agreed to focus on in the coming months, and to identify the concrete actions they will take in this collaborative work. The state teams will participate in conference calls and webinars with the ZERO TO THREE Technical Assistance team to encourage movement and tracking of progress on the plans.

This proceedings report provides a summary of the events and key learnings from the 2-day IECMH Policy Convening.

Summary of Keynote Presentation

Presentation: Toxic Stress and Brain Development: Closing the Gap Between What We Know and What We Do for Children

Presenter: Megan Gunnar

Dr. Gunnar opened the IECMH Policy Convening with a keynote presentation on the impact of toxic stress on brain development, reviewing the biological and epigenetic underpinnings of early experiences on lifelong development and outcomes, educational attainment, economic prosperity, responsible citizenship, and health. Her keynote focused on the critical importance of early relationships—of consistent call and response—on brain development. Although secure attachment helps build resilience, Dr. Gunnar cited studies showing that less supportive parenting; chronic early deprivation; and exposure to frequent, stressful experiences have serious consequences for young children's developing brains and stress systems. To ensure healthy development, science points toward a three-tiered approach: (1) universally available basic health services and early care and education; (2) broadly targeted interventions for children in poverty or with other broad risks (e.g., immigrants); and (3) narrowly targeted, specialized services for 10–15% of children who experience toxic stress levels to prevent the development of later problems.

Three Levels of Stress

1. Positive: Brief increases in heart rate, mild elevations in stress levels
2. Tolerable: Serious, temporary stress responses, buffered by supportive relationships
3. Toxic: Prolonged activation of stress response systems in the absence of protective relationships

*"The foundation of a successful society is built in early childhood."
—Dr. Megan Gunnar*

Session 1: Assessment & Diagnosis

Summary of Session Presentation

Presentation: Making Appropriate Diagnoses and Establishing Eligibility for IECMH Services: DC:0–5

Presenters: Cindy Oser and Therese Ahlers

Ms. Oser and Ms. Ahlers presented on the revised and updated edition of ZERO TO THREE's *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC:0–5™), emphasizing the importance of ensuring that clinicians have developmentally appropriate tools to assess and diagnose infant and young children's atypical behaviors to increase their access to evidence-based treatments. Originally published as a companion to the widely used, but more adult-focused, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5®), the DC:0–5™ (which was published after this convening, in December 2016) makes the following updates from the current edition (DC:0–3R): (1) includes disorders occurring in infants and young children through 5 years old; (2) extends criteria to younger ages when appropriate, including in some cases the first year of life; (3) includes all disorders relevant to young children; (4) requires functional impairment criteria for every disorder; (5) introduces several new disorders including Relationship Specific Disorder of Infancy/Early Childhood; and (6) eliminates a few disorders that do not have a sufficient evidence base (e.g., Mixed Disorder of Emotional Expressiveness). To assist states, ZERO TO THREE developed a [DC:0–5 crosswalk](#) that links DC:0–5 disorders to DSM-5 disorders and to *International Classification of Diseases, Tenth Revision* (ICD-10) codes to ensure appropriate coding and billing.

Summary of Tabletop Conversations

Following the group assessment and diagnosis presentation, state teams had the opportunity to attend one of six breakout discussions. Each tabletop discussion was led by a state team member or members who provided an overview of a specific assessment and diagnosis practice in their state and answered other states' questions about implementation challenges, financing, and other topics. State team members split up to allow each state team to attend as many different tabletop conversations as possible.

Assessment and Diagnosis Tabletop 1: DC:0–5™ in Policy and Practice (Discussion led by Cindy Oser and Catherine Wright [MN])

Minnesota encourages the use of DC:0–3R (then the current edition of the DC:0–5) for children under 5 years old by including it in its Mental Health Outpatient Rule and providing ongoing training on

Updated DC:0–5™ Multi-Axial System

Axis I: Clinical Disorders

Axis II: Relational Context

Axis III: Physical Health Conditions and Considerations

Axis IV: Psychosocial Stressors

Axis V: Developmental Competence

Select State Examples

NC: Permits provider reimbursement for up to six visits billed under its "Z code."

MN: The Minnesota Mental Health Outpatient Rule encourages the use of DC:0–3R for children under 5 years old.

OR: Uses ICD-10 code Z63.8 as a secondary diagnosis to "Other Specified Reactions to Severe Stress," which permits documentation of risk, rather than only a child's symptomology, to be used as criteria when a child requires further treatment. OR also made abuse and neglect codes (Z69.010 & Z69.020) billable as a primary diagnosis, even without posttraumatic stress disorder, depression, etc.

DC:0–3R. To date, Minnesota has trained 1,500 clinicians in DC:0–3R via monthly consultation and case study opportunities across the state. These trainings are financed with money from state general revenue funds and Minnesota’s Mental Health Block Grant. All licensed mental health providers who are trained in DC:0–3R also have the opportunity to attend clinical advanced studies. The state has established a strong link between DC:0–3R and services by setting it up so that a DC:0–3R diagnosis qualifies a child for Part C services (early intervention). Prior to making a diagnosis, clinicians are permitted up to three visits with a child, if necessary, reflecting that for infants and young children, it often is necessary to assess them on multiple occasions to gain a full portrait of their circumstances.

Assessment and Diagnosis Tabletop 2: Using Data to Drive IECMH Policy: Minnesota’s Experience With Mining Medicaid Data (Discussion led by Jeff Schiff)

Minnesota has used Medicaid data to drive collaboration across agencies, using its Medicaid and Statistical Information System (MSIS) data to identify risk factors. (“MSIS” is the name given to the database and IT infrastructure that each state uses to pay claims. Depending on the state, MSIS contains data on Medicaid eligibility, enrollment, expenditures, and usage patterns.) The tabletop discussion was far ranging and raised many questions including: how to establish data use agreements between health and social service agencies, strategies for linking data across agencies, the best sources of data for identifying at-risk children, and the extent to which states can use Medicaid to provide housing and social services when children’s health is at stake. Finally, there was an extensive discussion of how best to serve parents of children in the child welfare system in states that have not expanded Medicaid, leaving the parents uninsured when their children enter the child welfare system.

Assessment and Diagnosis Tabletop 3: When a Child Doesn’t Qualify for a Diagnosis but Needs Treatment: Oregon’s “At-Risk” Code Z63.8 (Discussion led by Laurie Theodorou)

In response to the common problem that some children whose health and development appear to be at-risk do not fit neatly into a diagnosis category, beginning in January 2016, Oregon permitted reimbursement for Z63.8 (Other Specified Stressor Related to the Primary Support Group), secondary to F43.8 (Other Specified Reactions to Severe Stressor). It is assigned to children who do not meet criteria for any specific disorder but who need some form of family or dyadic services to reduce risk factors which could lead to a mental health or developmental disorder. The group’s discussion centered on whether the code is needed to capture a narrow subset of children who do not receive a diagnosis or for use as an umbrella code to capture all those children who are “at-risk” for developing a mental health diagnosis. The discussion also raised questions about stigmatization and practitioners’ reluctance to diagnose children from birth to 3 years old because of concerns around labeling; the group concluded that using this code does not eliminate those concerns and that it is critical to reassess a child’s early mental health diagnosis over time. For Oregon, the use of Z63.8 allows practitioners to treat children’s symptoms early (before a full diagnosis is available) and to provide services to reduce overall family stress.

Assessment and Diagnosis Tabletop 4: Making Social-Emotional Screening Happen: North Carolina’s ABCD Project and Beyond (Discussion led by Marian Earls)

In 2000, practitioners in North Carolina began an effort to provide universal developmental screening, including social-emotional development, as well as autism and maternal depression screens. Today, North Carolina has a 91% developmental screening rate. Ms. Earls attributes North Carolina’s success to a number of factors, including:

- engaging all primary care doctors from the beginning;
- developing a state advisory group, inclusive of external stakeholders, consumers, and Community Care of North Carolina (CCNC)—North Carolina’s statewide Medicaid management initiative—with quarterly meetings;
- hosting a corresponding quarterly meeting of quality improvement professionals to identify operational barriers;
- providing practitioners with data on their performance on a quarterly basis;

- limiting major Medicaid policy changes until providers were accepting of screenings;
- hosting “mixers” to bring mental health and primary care providers together to build relationships to ensure a common understanding of available community-level supports and services;
- developing a standardized referral system to Part B (Assistance for Education of All Children With Disabilities) and Part C (early intervention) programs so primary care providers know what becomes of their referrals;
- using Title V funding for public health nurses to identify children from birth to 5 years old in families exposed to toxic stress and make community referrals; and
- paying for screening as an add-on to a child’s well care visit (a more recent policy change).

States discussed how CCNC provided the state with crucial infrastructure to implement a robust screening program. One challenge North Carolina has faced is the ability to refer people with positive screens to the appropriate services; even though the state’s screening rate is high, the referral rate is about 60%.

Assessment and Diagnosis Tabletop 5: Streamlining and Coordinating Assessment and Diagnosis: Indiana’s Early Evaluation Hub Initiative (Discussion led by Meghan Smith)

To facilitate a discussion of practical strategies for promoting early assessment and diagnosis, this tabletop discussion featured Meghan Smith, who described an Indiana initiative to facilitate earlier diagnosis of autism. Under the initiative, the Indiana University School of Medicine, in partnership with Riley Children’s Foundation, opened Early Evaluation Hubs for autism spectrum disorder and developmental delays in nine locations across Indiana in order to reduce the average age of diagnosis (currently at 5.3 years in Indiana). To meet the growing need for early diagnosis, diagnostic services are now available for children 18 months to 42 months old who have been identified in early screenings as showing signs of developmental delay or autism. The Hub’s criteria for evaluation appointments are: (1) the child must be 18–42 months old; (2) the child must have a primary care physician; and (3) that physician must identify a concern based on the use of a standardized screening tool (e.g., Ages and Stages Questionnaire, ASQ, and/or Modified Checklist for Autism in Toddlers, M-CHAT). With a new round of funding from Kiwanis expected soon, the Initiative plans to establish additional locations and focus on outreach to families and providers. The Hubs refer children to early intervention, as appropriate. In addition to discussing Indiana’s Hubs, the group grappled with the challenges that states face with providing endorsement for mental health providers, balancing the concern that diagnosing mental health disorders in young children takes specialization with the reality that endorsement is not appropriate for every workforce professional.

The Michigan Association for Infant Mental Health (MI-AIMH) created a 4-level workforce development process, the Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health (IMH-E®), to recognize all infant and family professionals within the diverse and rapidly expanding infant mental health field. IMH-E® verifies an individual’s attainment of a specific level of education, service provision to infants and families, participation in specialized in-service trainings, receipt of guidance and reflective supervision or consultation, and the ability to deliver high-quality, culturally sensitive IECMH services. To date, more than 20 states have adopted the IMH-E® through their infant mental health associations.

Assessment and Diagnosis Tabletop 6: Financing Care Coordination/Case Management: Minnesota’s Benefits (Discussion led by Glenace Edwall and Karry Udvig)

Dr. Edwall and Ms. Udvig reviewed four strategies for financing care coordination and case management that Minnesota has used: (1) clinical core consultation, (2) mental health targeted case management embedded in Managed Care Organization (MCO) contracts, (3) psychiatric consultation for primary care, and (4) behavioral health homes for children. The group discussed the related billing process, provider communication strategies, MCO policy development strategies, and advocacy

strategies to garner legislative support. The largest portion of the session was devoted to the question of whether Medicaid can be used to finance the cost of providing therapy or other services to a parent who is not eligible for Medicaid when it would benefit her child. Participants explained their strategies for providing such services, discussed a recent CMS informational bulletin on the issue, and identified the need for further clarification from the federal government from when and how Medicaid can be used to provide such care.

Team Reflections

Following the group assessment and diagnosis presentation and tabletop discussions, state teams had the opportunity to regroup, share learnings from each of the tabletops that team members attended, and reflect and generate ideas for the team's action plan.

Session 2: Treatment

Summary of Session Presentation

Presentation: Shaping Policy to Support IECMH Best Practice: Considering Appropriate Place, Provider, and Components of Treatment for Infants and Toddlers

Presenters: Catherine Wright and Glenace Edwall

Dr. Wright and Dr. Edwall opened the second day of the convening with a presentation highlighting the actions Minnesota has taken to shape its policies to support IECMH best practices. The State of Minnesota Children's Mental Health Division has integrated research, outcomes data, grant funding, and Medicaid policy to develop a comprehensive early childhood clinical mental health system of care. As part of this, the Children's Mental Health Division mapped all the early childhood mental health services available across the continuum of care, identifying prevention, early intervention, intervention, and intensive intervention services. The state also built a workforce equipped to address IECMH issues by offering training in evidence-based practices and establishing a robust certification process. Critically, the Minnesota Legislature authorized \$1 million per year for early childhood mental health training and infrastructure. Coupled with another \$400,000 from the Community Mental Health federal block grant, the State supports clinician training and certification in Attachment Bio-Behavioral Catch-up (ABC), Parent Child Interaction Therapy (PCIT), and Trauma Informed-Child Parent Psychotherapy (TI-CPP). Because clinicians are unable to bill for services while participating in training, clinicians are reimbursed for time to attend the trainings. If clinicians do not complete the certification or leave the state, they must return the funds spent on their training and certification. Further, the state permits flexibility under EPSDT¹ and the mental health benefit to allow

Clinician Training in Minnesota

- 1,500 clinicians trained in DC:0–3R; verified fidelity of the DC:0–3R with 500 clinicians
- 18 Level 1 PCIT trainers either certified or in the process of certification; more than 100 clinicians have been trained in PCIT
- 150 rostered clinicians in TI-CPP
- 25 clinicians either currently certified or in the process of certification for ABC

"Paying for clinicians' training and time has been critical to building the state's IECMH infrastructure."

—Catherine Wright

¹ The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under 21 years old who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services. States are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines.

children to access the best intervention available at the earliest time, aligning the state rules with evidence-based research and practice. Dr. Wright and Dr. Edwall also highlighted Minnesota's new pilot program for mental health clinical care consultation in early child care settings, which permits mental health professionals or trainees to provide consultation to other professionals about a child's needs. Finally, they presented on legislation from 2015 requiring a study of rate-setting methodology for community based services, which is currently underway.

Summary of Tabletop Conversations

Following the Minnesota presentation, state teams once again had the opportunity to attend breakout discussions. On this morning, there were two rounds of tabletop discussions. Like the assessment and diagnosis tabletop discussions, each of these was led by a state team member or members who provided an overview of a specific topic related to treatment in their state. Attendees had the opportunity to discuss the state's practices, pose questions, and discuss their own experiences.

Treatment Tabletop 1: *Shaping Policy to Support IECMH Best Practice, Conversation Continued*
(Discussion led by Glenace Edwall & Sue Abderholden)

During this tabletop, the group reflected on the important role that language plays when discussing children and mental health, noting the need to avoid labeling children with mental health issues as children with behavior issues. Further, the group discussed the importance of educating teachers about the early warning signs of mental health issues. Ms. Abderholden, a leader with the National Alliance for the Mentally Ill (NAMI), highlighted NAMI's advocacy efforts to: (1) engage families to share their stories, (2) educate providers on mental health, and (3) collaborate with states and providers.

Treatment Tabletop 2: *Delivering Services in Diverse Settings: North Carolina's Child First Program*
(Discussion led by Hope Jones Newsome)

Ms. Newsome, North Carolina's Child First State Program Director at the North Carolina Council of Community Programs, provided an overview of North Carolina's Child First Program, an evidence-based, intensive, home-based early childhood model that works with the most vulnerable young children and their families to help them recover from the effects of stress and trauma. This two-generation model, focusing on children prenatally through 5 years old and their families, uses a professional team of master's level mental health/developmental clinicians and a care coordinator. Key components of the model include:

- psychotherapeutic, two-generation intervention;
- care coordination; and
- facilitation of executive functioning.

Since July 2015, North Carolina has trained close to 70 people (30 teams), using a combination of intensive learning collaboratives and distance learning opportunities with their regional clinical director. Participants also are trained in Child-Parent Psychotherapy. Once the program is running at capacity, North Carolina will serve 400 families at any given time.

Treatment Tabletop 3: *Integration of IECMH Into Primary Care: Colorado's Early Childhood Activities and Initiative* (Discussion led by Ayelet Talmi)

Dr. Talmi, a pediatric psychologist at the Children's Hospital Colorado, led a discussion about the critical importance of integrating IECMH into primary care and using well-child visits as a way to reach nearly all children. Children's Hospital Colorado provides a full continuum of activities to address children's needs: (1) screening (with triage and referral as necessary); (2) prevention and health promotion (e.g., parenting groups, Baby & Me); (3) case consultation and intervention; and (4) case management and care coordination, connecting children and families to formal and informal supports. Dr. Talmi also noted that the hospital is training its residents to handle routine issues confronting families and

"A willingness to try new things helps!"
– Ayelet Talmi

that it has found that having translators available has been critical to minimize the barriers faced by non-English proficient patients and their families. Beyond Children’s Hospital Colorado, the state more generally has sought to support IECMH by integrating physical and behavioral health services; expanding [HealthySteps](#) across the state; and providing behavioral health coverage including psychiatry in outpatient primary care clinics, although notably, because of challenges in accessing Medicaid financing for these services, this work is privately funded.

Treatment Tabletop 4: Service Financing and Systems Design: Massachusetts’ Children’s Behavioral Health Initiative (Discussion led Emily Sherwood)

In response to the class action lawsuit *Rosie D. v. Romney*, which maintained that Massachusetts was failing to provide children with adequate mental health services as required by EPSDT, the state implemented six home- and community-based mental health services for all Medicaid-enrolled children under 21 years old with a focus on children with serious emotional disturbance (SED). The six services are:

- enhanced mobile crisis team for children available 7 days a week,
- high-fidelity wraparound (e.g., targeted case management for children with SED),
- in-home therapy,
- in-home behavioral therapy,
- therapeutic mentors (e.g., paraprofessionals working under the supervision of mental health clinicians to help build children’s social skills), and
- family partners (e.g., peer parents who also have children with SED who are supervised by senior family partners).

Notably, care coordination is the underpinning of all six services and is tied to a regional hub and implemented by the state’s six Medicaid MCOs. They jointly manage the network, relying on periodic technical assistance calls to coordinate their activities. During the group discussion, attendees discussed the recruitment process for family partners, noting that training and supervision is key to successful family partnership, and how the family partners service is billed under EPSDT in 15-minute increments. Discussion also included the credentials of therapeutic mentors (i.e., high school diploma), how families find out about the services, the integration of multiple levels of care coordination, and the need to provide more intensive supports in the prevention space for earlier identification of young children in need. Ms. Sherwood described the enhanced rate that the Medicaid state plans pays to mental health therapists providing services “in-home,” and emphasized that the state, not MCOs, wrote the medical necessity guidelines, the service definitions and authorization procedures, and provided training to the MCOs on the wraparound service. Issues that arose during implementation—such as variability in oversight between child welfare and mental health, variability in quality, onerous billing requirements, and concerns about network sufficiency—were also discussed. As a result of the settlement, Massachusetts continues to be subject to court monitoring, which has had the effect of requiring Massachusetts leaders to continue to focus on sustaining and improving mental health services for children, including young children.

Treatment Tabletop 5: Building and Maintaining a Qualified Workforce: The Oklahoma Collaborative Project (Discussion led by Amy Huffer and Ashleigh Kraft)

During this tabletop, representatives from Oklahoma discussed their efforts to build a workforce equipped to address IECMH. As a first step, the Oklahoma Association for Infant Mental Health (OKAIMH) purchased the MI-AIMH’s IMH-E[®] (described on p. 10). One of the IMH-E[®]’s requirements is for reflective supervision. However, once Oklahoma purchased the IMH-E[®], it realized it did not have the capacity to provide reflective supervision. As a result, the state developed the OK Collaborative Project in partnership with OKAIMH, The Institute for Building Early Relationships (IBEaR) at Oklahoma State University, Oklahoma Project LAUNCH grant, and Oklahoma Systems of Care 2 grant to train two cohorts on infant mental health practices including a graduate course in infant mental health assessment. These two cohorts will receive on-going reflective supervision as they integrate infant mental health concepts into their work and will have the opportunity to participate in a Child Parent Psychotherapy collaborative over the next 2 years. In addition, the Project also provided training to

judges and attorneys who are involved in child welfare system about infant and toddler assessments, trauma, and Trauma Informed-Child Parent Psychotherapy (TI-CPP). One critical lesson gained by Oklahoma from this experience is the importance of supporting people who get trained in TI-CPP and other evidence-based practices in actually implementing the new practices in their specific organizational settings, such as by offering supervision and by providing people with time to learn how to conduct the new work.

Treatment Tabletop 6: *Maximizing the Use of EPSDT: Minnesota’s Approach to Making the Most of Benefits (Discussion led by Karry Udvig)*

To illustrate how EPSDT can be used to improve coverage of services important to IECMH, Ms. Udvig, a former Minnesota state official, reviewed Minnesota’s approach to structuring its benefits for children, which include individual, family, and group psychotherapy, individual and group skills training, mental health behavioral aide service, and service plan development to maximize clinicians’ abilities to provide children with needed and appropriate services. In 2011, Minnesota submitted a State Plan Amendment (SPA) to provide reimbursement for doctoral-level clinical trainees and master’s-level clinical trainees to be paid at 100% and 80%, respectively of the usual Medicaid rates even though they remain under supervision; tribal agencies were also permitted to be paid at 100%. To accomplish this, the state formed an advisory committee of consumers, advocates, providers, and licensing boards, among others, who met for 6 months to develop the SPA, ensuring buy-in from all stakeholders. Once the SPA was approved, the state wrote bulletins and provided training and technical assistance with the assistance of community licensing boards.

Treatment Tabletop 7: *Ensuring Services for Families in Need: Defining Medical Necessity (Discussion led by Catherine Wright and Casey Ladd)*

During this discussion, tabletop attendees discussed the definition of medical necessity and the critical importance of documentation to make a good diagnosis and inform the treatment plan. The discussion also centered on: (1) how to scale up evidence-based approaches and decrease ineffective practices; (2) how to define medical necessity in a political climate where there are significant concerns about Medicaid costs; (3) how to treat uninsured parents without unnecessarily diagnosing a child; (4) how medical necessity differs between Medicaid, managed care, and commercial insurance; and (5) the administrative burden of documenting medical necessity.

Due to Alaska’s vast size, the state has developed creative solutions to home visiting by relying on airplanes and telehealth, developed in partnership with tribal nations.

In Minnesota, the rehab option includes psychotherapy, and providers must prove why they did not do psychotherapy if they provided skills training.

Session 3: Translating to Policy Action

Summary of Session Panel Presentation

Panel: Trends and Opportunities to Connect IECMH With Health Care Reform

Panelists: Elisabeth Burak and Jocelyn Guyer

Ms. Oser led a panel discussion with Ms. Burak and Ms. Guyer discussing the trends and opportunities to connect IECMH assessment and treatment with health care reform. Ms. Burak and Ms. Guyer discussed the current trends in managed care and delivery system reform, noting that children are not

central to many of the discussions because they are the least expensive population with limited short-term savings. As a result, and given the intense pressures of Affordable Care Act implementation, most states have focused on identifying savings opportunities related to their adult population. Panelists emphasized the importance of child advocates keeping children included in delivery system reform conversations, noting that 44% of children under 6 years old are on Medicaid. Panelists also discussed how to maximize EPSDT, noting that the statutory structure of Medicaid requires Medicaid to cover all medically necessary services for children. To do this, they recommended that states: (1) consider the linkages between screening and provision of treatment; (2) ensure Medicaid MCO contracts require developmental screening for children under 6 years old and mental health intervention, when warranted; and (3) consider using the option to target enhanced services to a subset of children through the flexibility available to create an “alternative benefit plan” for selected children. Finally, panelists discussed the quality provisions of the final Medicaid Managed Care rule, which increase the importance of quality metrics in overseeing Medicaid managed care and, from an IECMH perspective, of ensuring that states have appropriate quality metrics for measuring high-quality care for children, including those at risk of IECMH.

During the question and answer period, Massachusetts asked about the development of CMS’s May 2016 [post-partum depression guidance](#). Ms. Burak and Ms. Guyer responded that they were encouraged by CMS’s support for two-generational treatment but believed that gaps still existed for parents who lack Medicaid coverage, such as in states that have not expanded Medicaid. In response to questions about how to introduce IECMH issues into delivery system and Medicaid managed care discussions, Ms. Burak and Ms. Guyer recommended that states (1) review their existing Medicaid managed care contracts closely, (2) research any value-based payment or broader delivery system reform discussions underway and advocate to be included, and (3) review the quality metrics under use in their states and assess whether they could be improved from an IECMH perspective.

Summary of Tabletop Conversations

Following the panel discussion, teams once again broke out into small group discussions to have further conversation about trends and opportunities to connect IECMH with health care reform.

Translating to Policy Action Tabletop 1: Medicaid Managed Care, Conversation Continued (Discussion led by Elisabeth Burak and Jocelyn Guyer)

During this tabletop, the group discussed that many behavioral health services are still carved out of Medicaid managed care and, even in states where this is no longer the case, integrated care is still not yet the norm at a practice level. Participants noted that providers face challenges under managed care, including the ability to meet productivity requirements and complete paperwork; they also noted a shortage of mental health professionals in rural areas and lack of understanding about early childhood among primary care providers. The group discussed using managed care contract provisions to incentivize the use of evidence-based practices with experience in IECMH and dis-incentivize the use of non-evidence-based practices and non-preferred providers.

Translating to Policy Action Tabletop 2: Designing Mental Health Benefits for Young Children: How Minnesota’s Benefits Were Created (Discussion led by Glenace Edwall and Karry Udvig)

Dr. Edwall and Ms. Udvig reviewed the history of Minnesota’s IECMH planning and policy changes including: (1) new payment mechanisms and inclusion in managed care contracts, (2) revised Part C eligibility, (3) implementation of Children’s Therapeutic Services and Supports benefit for children under 21 years old, and (4) piloting of mental health consultation in Head Start. Minnesota faced the challenge of ensuing adequate payment for the group therapy structure. One of the keys to Minnesota’s success was hiring a clinician leader with deep passion and knowledge of IECMH and using the Minnesota Legislative Network to reach consensus and avoid internal and public disagreements.

Translating to Policy Action Tabletop 3: Program Financing and Systems Design in Rural Settings: Louisiana's Early Childhood Supports and Services (Discussion led by Cheryll Bowers-Stephens)

Dr. Bowers-Stephens, Medical Director of Behavioral Health for Amerigroup LA, described Louisiana's early childhood supports and services (a now de-funded, but promising program) as a "franchise model," where counties have ownership of the supports and services, which are focused on at-risk, young children (from birth to 6 years old) and range from prevention to treatment services. The program was funded with \$4 million from Temporary Assistance to Needy Families (TANF), as well as a blend of the Department of Child and Family Services, Mental Health Block Grant, and state funds. Local consortiums identified children to be screened; based on the screening results, a referral was made to an Infant Mental Health team for treatment. Critical to the program's success was support services for parents who receive Temporary Assistance to Needy Families. Another lesson learned is the need for flexibility across different communities, including how to build sustainable capacity locally, rather than on the basis of academic best practices. Although Louisiana's goal was a franchise model, the state needed more of a critical mass. The state also identified the importance of non-traditional champions and social marketing, including videos of children "before" and "after" to use with legislators. In retrospect, Dr. Bowers-Stephens would have launched the program in more parishes initially, worked with Medicaid from the beginning, and undertaken more rulemaking.

Translating to Policy Action Tabletop 4: Lessons Learned During Medicaid Reform: Alaska's Experience With Medicaid Transformation (Discussion led by Margaret Brodie and Terry Hamm)

Ms. Brodie, Alaska's Medicaid Director, and Ms. Hamm, a behavioral health policy analyst for the state, reviewed Alaska's 16 Medicaid reform projects underway as mandated by the State Legislature, focusing on one project specifically that seeks to redesign the state's behavioral health system under an 1115 waiver. As part of this, the state is in the process of deciding whether there is interest in pursuing an Administrative Services Organization model for paying for care. Though still in the early stages, Alaska has been successful in making advances by including tribal nations in the planning process. Due to the state's geography, managed care is not a feasible structure and as such, Alaska is considering developing a "semi-managed care" structure. Within the comprehensive overhaul of the state's health care system, the greatest opportunities for IECMH will be through the State's 1115 waiver,² because all behavioral health services are likely to be handled by the proposed Administrative Services Organization.

Translating to Policy Action Tabletop 5: Legislative Solutions to Barriers in IECMH: Massachusetts' Children's Mental Health Campaign and Omnibus Bill (Discussion led by Nancy Allen Scannell)

Ms. Scannell, a longtime children's advocate, described Massachusetts' [Children's Mental Health Campaign](#), a statewide coalition of families and youth, advocates, health care providers, and educators dedicated to comprehensive reform of the children's mental health system. Key factors for success have included the collaborative nature of the Campaign, which is driven by diverse stakeholders as opposed to a singular trade organization. The Campaign's multidisciplinary leadership team is comprised of five organizations and backed by 160 supporting groups, divided into workgroups and projects. Further, budget advocacy is broad-based and this system, built over 10 years, has allowed for the cultivation of deep and trusted relationships. Ms. Scannell described how thoughtful messaging has been especially important in discussing IECMH with legislators. The Campaign is privately funded and the five lead partner organizations dedicate staff time.

² Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children's Health Insurance Program programs. Under this authority, the Secretary may waive certain provisions of the Medicaid law to give states additional flexibility to design and improve their programs.

Translating to Policy Action Tabletop 6: *Using Case Examples to Make the Case: Virginia’s Approach to Securing Medicaid Coverage for Dyadic Treatment (Discussion led by Bonnie Grifa)*

To increase knowledge of what is needed by young children for reimbursable services, Virginia collected case studies as a way to involve providers across the state and to use in messaging with Medicaid leadership and help providers learn about billing. To select the case studies, the team asked providers to submit their most challenging cases and were cognizant of provider and geographical diversity.

Translating to Policy Action Tabletop 7: *How to Effectively Sell IECMH: Shaping Messages That Connect With People (Discussion led by Cindy Oser)*

Ms. Oser led a discussion on how to “sell” IECMH. Most critically, she emphasized the need to understand one’s audience and what resonates with different stakeholders—advocates, legislators, parents, business community, and health care professionals, among others. One challenge that was raised is the different terminology currently being used to describe the same concepts and need to build uniformity. Examples of specific states’ techniques include developing succinct briefing papers or infographics with case examples to educate legislators and including data such as preschool expulsion rates to illustrate the need for IECMH services.

Team Action Planning

The convening concluded with a session dedicated to state team action planning. During this final session, states reflected on the convening learnings and brainstormed their action plans, based on an assessment of their current priorities and opportunities. During the report out, states presented their top three IECMH priorities to focus on in the months ahead. States will provide action plan progress updates to ZERO TO THREE every other month.

Acknowledgments

ZERO TO THREE would like to thank Arielle Traub from Manatt Health for drafting this proceedings report.

Special thanks to the state teams, the expert contributors, the Irving Harris Foundation, and the Robert Wood Johnson Foundation who made the ZERO TO THREE IECMH Policy Convening possible.

Support for this report was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

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 Teams

Alaska

Gennifer Moreau	Early Childhood Comprehensive Systems Impact, Team Lead
Margaret Brodie	Medicaid Director, Director of Health Care Services
Terry Hamm	Policy Analyst, AK Division of Behavioral Health
Christy McMurren	Program Services Manager, Program for Infants and Children
Trevor Storrs	Executive Director, AK Children's Trust

Colorado

Jordana Ash	ECMH Director Colorado Office of Early Childhood (OEC), CO Department of Human Services, Team Lead
Anne-Marie Braga	Population and Community Health Section Manager, CO Department of Public Health and Environment
Lisa Montagu	Investment Director, Health and Education, The Piton Foundation
Susanna Snyder	Women's Health Policy Specialist, CO Health Programs Office
Ayelet Talmi	Associate Professor of Psychiatry and Pediatrics, University of CO School of Medicine; Pediatric Psychologist at Children's Hospital CO

Illinois

Linda Delimata	Consultation Coordinator, IL Children's Mental Health Partnership, Team Lead
Lisa Betz	Deputy Director-Child and Adolescent Services, IDHS, IL Division of Mental Health
Teresa Hursey	Acting Medicaid Director at the IL Department of Healthcare and Family Services
Jenna Kelly	I-ECMH clinician, Chestnut Health Systems
Andrea Palmer	Chief, Division of Maternal, Child and Family Health Services; Title V Director

Indiana

Meghan Smith	Professional Development Director, IN Office of Early Childhood and Out of School Learning, Team Lead
Laura Chavez	Guide Consultant, Nurse Family Partnership
Gina Doyle	Assistant Deputy Director, Youth Services, IN Division of Mental Health & Addiction
Jan Katz	Mental Health Consultant and President, The Child Care Consortium; Professor of Child Psychology, Purdue University North Central
Gary Parker	Director, CHIP and Hoosier Healthwise, IN Medicaid

Louisiana

Sarah Hinshaw-Fuselier	Infant Mental Health Manager, LA Office of Public Health-Bureau of Family Health; Assistant Professor of Psychiatry and Behavioral Sciences, Tulane University School of Medicine, Team Lead
Cheryll Bowers-Stephens	Managing Medical Director of Behavioral Health, Amerigroup LA
Richard Dalton	Behavioral Health Medical Director, LA Healthcare Connections
SreyRam Kuy	Chief Medical Officer, State of LA Medicaid
Kristin Savicki	Lead for the Child Clinical Systems Team, Office of Behavioral Health

Massachusetts

Kate Roper	Assistant Director of Early Childhood Services, MA Department of Public Health, Team Lead
Mathieu Bermingham	Child and Adolescent Psychiatrist, Medical Director for Children's Services of Roxbury
Christina Fluet	Director of Planning and Policy Development, Division of Child and Adolescent Services, Department of Mental Health
Nancy Allen Scannell	Director of Policy and Planning at the MA Society for the Prevention of Cruelty to Children, Lead for Children's Mental Health Campaign
Emily Sherwood	Director, MA Medicaid Office of Behavioral Health

North Carolina

Marian Earls	Director of Pediatric Programs, Community Care of NC, Team Co-Lead
Catharine Goldsmith	Children's Behavioral Health Services Manager, Clinical Policy Section, NC Division of Medical Assistance, Team Co-Lead
Melissa R. Johnson	NC Infant Mental Health Association Immediate Past President
Hope Jones Newsome	NC Child First State Program Director, NC Council of Community Program
Jill Singer	Early Intervention Branch Head, Division of Public Health, NC Department of Health and Human Services

Oklahoma

Melissa Griffin	Infant and Early Childhood Wellness Specialist, OK Department of Health—IECMH Co-Lead, Team Lead
Amy Huffer	President of the OK Association of Infant Mental Health
Ashleigh Kraft	Clinical Director, Parent Child Center of Tulsa
Traylor Rains-Simms	Director of Policy and Planning, OK Department of Mental Health and Substance Abuse Services
Jackie Shipp	Director, Children’s Behavioral Health Services, OK Department of Mental Health and Substance Abuse Services

Oregon

Laurie Theodorou	Early Childhood Mental Health Policy Specialist, Health Systems (formerly AMH and DMAP), Team Lead
Benjamin Hazelton	Home Visiting Policy & Systems Coordinator, Maternal Infant & Early Childhood Home Visiting State Lead, OR Public Health Division
Ajit Jetmalani	Director, Division of Child and Adolescent Psychiatry, OR Health Sciences University; Consultant to the OR Health Authority and Department of Human Services and Child Welfare
Don Ross	Principal Executive Manager, OR Health Authority Operations and Policy
Erin Sewell	Program Manager, Lifeworks Northwest

Virginia

Ashley Everette	Policy Analyst and Coordinator, Campaign for Children’s Mental Health, Voices for VA’s Children, Team Co-Lead
Bonnie Grifa	State Early Childhood Mental Health Coordinator, VA Infant Mental Health Endorsement Coordinator, Virginia Commonwealth University, Team Co-Lead
Adrienne Fegans	Senior Program Administrator, VA Department of Medical Assistance Services
Daniela Lewy	Executive Director of the VA Governor’s Children’s Cabinet
Janet Lung	VA Department of Behavioral Health & Developmental Services

Appendix B: Expert Contributor Bios

Sue Abderholden

Sue Abderholden, has been the executive director for the National Alliance on Mental Illness (NAMI) in Minnesota for the past 15 years. She has devoted her career to changing laws and attitudes that affect people with disabilities and their families. Ms. 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). Ms. 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

Therese Ahlers is a resource specialist for Project LAUNCH—Linking Actions for Unmet Needs in Child Health—at ZERO TO THREE. ZERO TO THREE co-leads the LAUNCH Resource team, part of the National Resource Center on Mental Health Promotion and Youth Violence Prevention. Prior to joining ZERO TO THREE, Ms. Ahlers served as the founding executive director for Wisconsin Alliance for Infant Mental Health (WI-AIMH). Prior to WI-AIMH, while working for Wisconsin Medicaid, Ms. Ahlers wrote the first contract establishing WrapAround Milwaukee. Ms. Ahlers is endorsed at Level IV as an Infant Mental Health Policy Mentor and is a 2003 ZERO TO THREE Graduate Fellow.

Elisabeth Wright Burak

Elisabeth Wright Burak is the senior program director 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, tracks federal legislative developments, and supports CCF's work with national partners. As director of Health Policy and Legislative Affairs for Arkansas Advocates for Children & Families, Ms. Burak led successful coalition efforts to expand access to ARKids First (Medicaid and CHIP for Arkansas children). Ms. Burak previously worked with state leaders on afterschool and early childhood programs at the National Governors Association Center for Best Practices and The Finance Project.

Elizabeth Carlson

Elizabeth Carlson is a senior researcher, affiliate graduate faculty, and director of the Irving Harris Training Programs at the Institute of Child Development, University of Minnesota. For more than 20 years, Dr. Carlson has conducted research on the Minnesota Longitudinal Study of Risk and Adaptation. She is co-author of the book, *The Development of the Person, The Minnesota Study of Risk and Adaptation From Birth to Adulthood*. Dr. Carlson also directs the Infant and Early Childhood Mental Health Certificate program that provides training in early childhood development and its application to policy and practice, and she is an internationally recognized trainer in infant attachment. Dr. Carlson works directly with young children and families at risk in clinical practice.

Jamie Colvard

Jamie Colvard is a technical assistance specialist with the ZERO TO THREE Policy Center and a resource specialist with the Project LAUNCH Resource Center at ZERO TO THREE. Her work focuses on issues such as home visiting, family engagement, cross-agency collaboration, and other aspects

of creating comprehensive early childhood systems that support infants, toddlers, and their families. Prior to joining ZERO TO THREE, Ms. 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 located in California.

Julie Cohen

Julie Cohen is associate director of the ZERO TO THREE Policy Center. Ms. Cohen specializes in early childhood policy, specifically infant-early childhood mental health (I-ECMH). She worked on *DC:0–5™: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (the revised and updated DC:0–3R). She is also overseeing the development of an I-ECMH Policy Toolkit with briefing sheets on a variety of I-ECMH topics. Ms. Cohen is the author of numerous publications, including *America's Babies: The ZERO TO THREE Policy Center Data Book*. Recent publications include: *Nurturing Change: State Strategies for Improving Infant and Early Childhood Mental Health* (2013); *Supporting Infants, Toddlers, and Families Impacted by Caregiver's Mental Health Problems, Substance Abuse, and Trauma, A Community Action Guide* (2012); and *Making it Happen: Overcoming Barriers to Providing Infant-Early Childhood Mental Health* (2012).

Denise Dell Isola

Denise Castillo Dell Isola is a 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 initiatives around early childhood mental health, early learning, family support, and early childhood advocacy, public policy and systems-building. Denise recently spearheaded the Foundation's efforts to develop an action plan to better integrate early childhood mental health into Illinois' child- and family-serving systems. Before joining the Foundation, Denise served as the executive director of an early childhood center in Chicago and practiced law at DLA Piper LLP.

Glenace Edwall

Glenace Edwall recently retired as the acting assistant commissioner for Chemical and Mental Health Services at the Minnesota Department of Human Services. In addition to this role, she was director of the Children's Mental Health Division beginning in May 2000, where she was responsible for oversight of the state's tribal and county-administered children's mental health service system, for technical assistance and support to the state's 95 children's mental health and family service collaboratives, and for the policy component of the state's children's mental health benefits provided through Medicaid. 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.

Megan Gunnar

Megan R. Gunnar 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. Professor 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. She received her doctorate from Stanford University.

Jocelyn Guyer

Jocelyn Guyer is a managing director with Manatt Health, an interdisciplinary policy and business advisory division of Manatt, Phelps & Phillips, LLP. Ms. Guyer provides policy expertise, strategic advice, and technical support to states, foundations, and a broad array of other clients on implementation of

the Affordable Care Act, Medicaid, and the Children's Health Insurance Program. With more than 20 years of experience in health policy, she has particularly deep knowledge of eligibility issues and IT systems and has served as an advisor to organizations such as the National Academy for State Health Policy and the American Academy of Pediatrics, and to major foundations. Prior to joining Manatt, Ms. Guyer was a founding member and co-executive director of the Center for Children and Families (CCF), a health policy center at Georgetown University. Previous leadership roles include associate director with the Kaiser Commission on Medicaid and the Uninsured, and senior health policy analyst on health and welfare policy at the Center on Budget and Policy Priorities.

Carrie Hanlon

Carrie Hanlon 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 oversees research about state Medicaid/CHIP performance measures and incentives for preventive services for women and children. She has directed, evaluated, or contributed to multi-sector, multi-state learning collaboratives about healthy child development, health equity, and primary care practice transformation. Prior to joining NASHP in 2007, Carrie was a planning and research associate at the Maine Quality Forum, a division of Maine's Dirigo Health Agency devoted to health care quality improvement.

Mary Casey Ladd

Mary Casey Ladd is a family therapist with 40 years of experience working with chronically stressed families. She has expertise in working multigenerationally with families beginning in 1972 with runaway adolescents and their families, and in the past 11 years with families parenting birth to 5-year-olds. Ms. Ladd at present is the director of Staff Development at The Human Development Center, a community mental health center.

Carey McCann

Carey McCann is assistant director of state services for the BUILD Initiative. She supports state leaders to develop effective early childhood systems, set policy that guides implementation of services, and advocate for children birth to 5 years old. Carey came to BUILD from more than 12 years at the Ounce of Prevention Fund, where she led the National Policy Team's consultation practice and peer learning with 18 states on early childhood policy and advocacy. Prior to her national work, Carey coordinated the Ounce's Birth to Five Project, a statewide effort to identify system gaps, develop solutions, and link the many efforts that were underway for young children in Illinois. She developed an expertise in early childhood mental health policy and was a board member of the Illinois Association for Infant Mental Health for 8 years.

Justine Nelson

Justine Nelson is a research scientist at the Minnesota Department of Human Services, and has spent the last few years compiling and reporting data on the social risk factors experienced by participants in Minnesota's Medicaid program. Her most recent work describes children's risk factors such as poverty, homelessness, and parental chemical dependency: <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7079-ENG> She holds a doctorate from the University of Minnesota (Family Social Science).

Becky Normile

Becky Normile is a policy associate on the Child and Family Team at National Academy for State Health Policy (NASHP), where she focuses on issues related to children and youth with special health care needs, children's developmental and behavioral health, and women's health. Prior to joining NASHP, Becky served as a research associate for AcademyHealth's State Policy and Technical Assistance team. In this role, she worked on a range of projects dedicated to advancing health care reform and quality improvement, including assisting states with the implementation of the coverage-related provisions of the Affordable Care Act and supporting the national evaluation of the CHIPRA Quality Demonstration Grant Program.

Cindy Oser

Cindy Oser is a registered nurse and director of Infant Early Childhood Mental Health (IECMH) Strategy in the ZERO TO THREE Policy Center and co-director of the Project LAUNCH Resource Center, part of the National Resource Center on Mental Health Promotion and Youth Violence Prevention. Ms. Oser leads ZERO TO THREE's state and federal IECMH policy work, including overseeing the revision of *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood—Revised (DC:0-3R)*. From 2004–2009, she was the first director and founder of the ZERO TO THREE Western Office in Los Angeles, California. Ms. 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.

Helene Stebbins

Helene Stebbins is senior policy director for the Alliance for Early Success, a pooled private fund that brings state, national, and funding partners together to improve state policies for young children. She provides strategic oversight for the knowledge development grants, with a focus on making the research more accessible to policymakers. Ms. Stebbins also manages her own consulting firm, specializing in the coordination of the health, education, and care of children from birth through 5 years old. From 1996–2002 Ms. Stebbins worked in the Center for Best Practices at the National Governors Association. As the program director for children and youth policy, she served as a resource to governors and their senior advisors on child and family policy issues.

Amanda Szekely

Amanda Szekely is senior technical assistance specialist at ZERO TO THREE, where she supports state policymakers in building systems of support for young children and their families, including: early care and education, health and mental health initiatives, and family support services. In addition to carrying out foundation-funded projects at ZERO TO THREE, Ms. Szekely is part of the national resource team supporting federal Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) grantees in carrying out children's mental health prevention and promotion strategies. Prior to joining ZERO TO THREE, Ms. Szekely worked at the National Governors Association Center for Best Practices, where she designed and carried out policy consultation projects to inform governors' early childhood policy agendas. Ms. Szekely was also a senior program associate at The Finance Project.

Jennifer Tracey

Jennifer Tracey is the Director of Policy and Finance for Healthy Steps at ZERO TO THREE. She leads efforts to identify potential financing strategies to support the expansion and long-term program sustainability of Healthy Steps. Prior to joining ZERO TO THREE, Ms. Tracey was the Medicare-Medicaid Federal Policy Director for UnitedHealthcare Community & State where she influenced state and federal health policy related to Medicaid, CHIP, and Medicare-Medicaid enrollees, assisted internal business segments with product development, and collaborated with external entities on advancement of care integration and coverage expansions. Ms. Tracey also worked at the Medicaid and CHIP Payment and Access Commission where she focused on managed care health policy issues and served as the Quality Lead for the Commission's Medicaid work.

Arielle Traub

Arielle Traub is a manager at Manatt Health, the interdisciplinary health policy and business strategy advisory division of Manatt, Phelps and Phillips, LLP. She provides research, policy analysis, project support, and other business services to health care providers, payers, pharmaceutical manufacturers, foundations, and other health care stakeholders. Arielle's primary areas of focus include health care reform, public insurance programs, and delivery system and payment reform issues, with a specialty around children's health issues. Prior to joining Manatt, Arielle worked in the Office of Managed Care at New York City Health and Hospitals and in the Department of Population Management at the Harvard Pilgrim Health Care Institute/Harvard School of Medicine.

Karry Udvig

Karry Udvig recently retired from the State of Minnesota, where she spent the past 25 years working in the Children's Mental Health and the Health Care administrations. During her tenure Karry supported development and implementation of the current children's mental health system. Karry's experience includes policy development, rule making, parent support, provider technical assistance and training, and collaboration with MCOs on policy change implementation and system development.

Lindsay Usry

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. She also served as the Louisiana Early Childhood Comprehensive Systems Coordinator for the LA Department of Health and Hospitals, Office of Public Health. 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

Claire Wilson is the Minnesota Department of Human Service's Community Supports Administration's Assistant Commissioner. She provides statewide policy direction for the state's mental health, disability services, alcohol and drug abuse, housing and supports, and deaf and hard of hearing services divisions. Prior to working for the State of Minnesota, Claire served as the executive director of the Minnesota Association of Community Mental Health Programs. 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.

Catherine Wright

Catherine has a doctorate in Counseling Psychology from the University of St. Thomas. 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, Catherine 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.

Appendix C: Resource List

Centers for Medicare and Medicaid Services Guidance

- Center for Medicaid and State Operations. (2007, August 15). *State Medicaid Director letter #07-011*. Available at www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD081507A.pdf
- Joint CMCS and SAMHSA Information Bulletin. (2013, May 7). *Coverage of behavioral health services for children, youth and young adults with significant mental health conditions*. Available at www.medicaid.gov/federal-policy-guidance/downloads/CIB-05-07-2013.pdf
- CMCS Informational Bulletin, Center for Medicaid and CHIP Services. (2016, May 11). *Maternal depression screening and treatment: A critical role for Medicaid in the care of mothers and children*. Available at www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf

IECMH Best Practice Websites

- National Registry of Evidence-Based Programs and Practices, www.samhsa.gov/nrepp
- California Evidence-Based Clearinghouse for Child Welfare, www.cebc4cw.org
- Center for Neurobehavioral Development, University of Minnesota, <https://cnbd.umn.edu>
- Institute of Child Development, University of Minnesota, www.cehd.umn.edu/icd
- National Scientific Council on the Developing Child, Center on the Developing Child, <http://developingchild.harvard.edu/science/national-scientific-council-on-the-developing-child>
- The National Child Traumatic Stress Network, www.nctsn.org
- ZERO TO THREE, www.zerotothree.org
- ZERO TO THREE Safe Babies Court Teams, www.zerotothree.org/our-work/safe-babies-court-teams

Organizations

- Project ECHO, <http://echo.unm.edu>
- Roots of Empathy, www.rootsofempathy.org/

Publications

- Bailit Health. (2016, July 13). *Value-based payment models for Medicaid child health services: Report to the Schuyler Center for Analysis and Advocacy and the United Hospital Fund*. www.uhfnyc.org/assets/1503
- Mention, N. & Heider, F. (2016). *The nuts and bolts of Medicaid reimbursement for developmental screening: Insights from George, Minnesota, and North Carolina*. National Academy of State Health Policy. Available at <http://nashp.org/wp-content/uploads/2016/09/Screening-Brief.pdf>
- American Academy of Pediatrics. (2016). *Addressing early childhood emotional and behavioral problems*. Available at <http://pediatrics.aappublications.org/content/pediatrics/early/2016/11/17/peds.2016-3023.full.pdf>
- Center on the Developing Child. (2016). *Applying the science of child development in child welfare systems*. http://developingchild.harvard.edu/wp-content/uploads/2016/10/HCDC_ChildWelfareSystems.pdf
- Briggs, R. (Ed.). (2016). *Integrated early childhood behavioral health in primary care*. Available at www.springer.com/us/book/9783319318134