



Behavioral Health Transformation in the District of Columbia: Perspectives and Recommendations from Children's National Hospital and the Early Childhood Innovation Network

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INTRODUCTION

The District has announced major changes to the public behavioral health system, including the transition of behavioral health services to the city's Medicaid managed care program in fiscal year 2023, and movement of fee-for-service beneficiaries to managed care.¹ These changes present a significant opportunity to improve the public behavioral health system for children and families in the District, particularly given the substantial number of children insured by Medicaid in DC.² As providers and advocates of services and programs to children and families in the District, Children's National Hospital and the Early Childhood Innovation Network (ECIN) are fully supportive of these efforts to implement an integrated, whole-person, population approach to behavioral health care, as it has the potential to significantly reduce the barriers families continue to face in accessing and utilizing high quality care and increase health equity. With these goals in mind, Children's National and ECIN offer the following recommendations and strategies to the Department of Behavioral Health (DBH) and the Department of Health Care Finance (DHCF) for consideration to achieve a fully comprehensive, equitable, inclusive, and high-quality behavioral health system.¹ We are appreciative of recent, early stage advancement of a discrete number of recommendations by DBH and DHCF that are contained in this paper, and look forward to further collaboration and progress to bring the full scope of proposals to fruition.

¹ The information provided herein was submitted to the Departments of Health Care Finance and Behavioral Health in September 2020, in response to their public *Request for Information: Medicaid Behavioral Health Transformation in the District of Columbia: A Roadmap to Integrated Care*.

FOUNDATIONAL ELEMENTS OF AN INTEGRATED CARE SYSTEM FOR CHILDREN³

The following section highlights key elements and principles on which any system change should be grounded to transform the child and adolescent behavioral health system.

Focus on Prevention and Early Intervention. A substantial body of scientific, research, and implementation evidence demonstrates that we can promote emotional wellbeing, prevent onset of mental health disorders, and/or mitigate their severity through a multitude of evidence-informed models, beginning in the perinatal period and through young adulthood. Yet, our system is oriented towards treatment and crisis care. System integration and service quality must go beyond treatment, and meaningfully include and focus on promotion, prevention and early intervention. Systems must also include quality behavioral health supports across the full range of family-serving systems including public education, child welfare, early intervention, and justice. Realizing a truly comprehensive and equitable behavioral health system demands that we foster preventive care through our financing, delivery, and workforce models.

Address Systemic Racism and Promote Inclusivity. As a core driver of child and adolescent health (physical, emotional, and behavioral), racism and the impact of trauma on health must be addressed as well as promoting inclusivity and equity (e.g., Black, Brown, non-English speaking, and immigrant families) through the building of a new system. To achieve a just, equitable and culturally responsive behavioral health system, the District must ensure that the strategies, policies, and services considered for implementation are evaluated through a racial equity lens.

Bolster Pediatric Primary Care. Pediatricians are a trusted source of care for families. They also play an extremely important role in the early identification of child and caregiver mental health concerns, given pediatricians' frequent contact and longitudinal relationships with families, as well as their nearly universal reach through well-child visits for children covered by Medicaid. With appropriate supports and consultation, care of patients with lower acuity concerns can be shifted to their primary care pediatrician or to mental health providers embedded within the pediatrician's office, allowing for patients with complex or serious mental health conditions to be seen in a timelier manner by specialty mental health providers.

Ensure Agreement & Accountability on Meaningful Measures. A significant opportunity during this transformation process is for all system stakeholders to agree on a discrete set of goals and outcomes, and to collectively hold themselves accountable for achievement, while centering the voices of those who use and are most impacted by the system in the discussions and decisions. Broad stakeholder agreement on a set of measures allows the District to benchmark its progress towards a responsive behavioral health care system that meets the needs of children, youth and families in a high-quality and timely manner. A

comprehensive, fully integrated system will meaningfully improve quality of life and functioning, and we must focus on measures that track essential system of care components in a manner that is distinct from the tracking of crisis utilization.

MANAGED CARE DELIVERY SYSTEM CONSIDERATIONS

As the District transitions the delivery and payment of behavioral health services to the Medicaid managed care system, we encourage deliberation on several key areas:

- **Existing DC Code and Regulations.** Certain parts of the existing DC code and regulations that did not anticipate a complete managed care environment may undermine the transition. Regulations need to be reframed for a fully managed care environment with Managed Care Organizations (MCOs) playing a greater role in care coordination, linkages, and paying for more care. One example of DC code that will need to be revisited, considering the transition, is certain sections of the Mental Health Information Act that limit health information exchange and data sharing. It may also be the time to consider restructuring the Core Service Agency (CSA) model. DC will need to ensure that relevant DC Code and Regulations are revised in a timely manner to support implementation.
- **Integrated Corporate Model.** Currently, Medicaid MCOs in DC have the ability to carve out behavioral services to another corporate entity. The benefits of an integrated delivery system may not be fully realized under this model, particularly if behavioral health services are carved out to an unrelated corporate entity.

RECOMMENDATIONS

This section outlines recommendations intended to strengthen core areas of the public behavioral health system for children and families: service delivery, considerations for special populations, workforce development, network adequacy, and financing. While these recommendations are not necessarily in order of priority, we believe early and sustained attention in these areas will have broad population impact. Implementation of policies designed to ensure timely access and quality service, such as integrated care, network adequacy, value-based payment, and a robust community-based continuum of care, will result in significant improvements in behavioral health outcomes for children and families in the District.

Service Delivery

Advance Models of Integrated Mental Health in Pediatric Primary Care. An effective and efficient integrated system ensures primary care is leveraged as a mechanism for delivery of mental health promotion, prevention, early intervention and treatment services (when clinically appropriate). DC has made strides in this area, but additional models, programs, and reimbursement and payment features should be considered:

- **Continue Expansion and Adequate Funding of HealthySteps.** HealthySteps is currently implemented within two Children’s National Hospital primary care clinics in Ward 8 (CHC–Anacostia and CHC–THEARC), with funding from the Department of Health and philanthropy. HealthySteps is a nationally recognized and evidence–based model of pediatric primary care that embeds a mental health clinician into the primary care practice to support the wellbeing of children from birth to age three and their families during their well–child visits. This model is also expanding to other health care centers in the District. We recommend that the Department of Health Care Finance (DHCF) and Department of Behavioral Health (DBH) advance improved coverage of HealthySteps providers and services under Medicaid, as it presents a significant opportunity to transform integrated behavioral health care for young children and families in the District and aligns with DC’s focus on prevention. Ohio and California are examples states that have implemented innovative policies that support HealthySteps.
- **Continue Adequate Funding of DC Mental Health Access in Pediatrics (DC MAP).** DC MAP is a rapidly growing, evidence–based consultation model that supports integrated mental health in primary care and is currently funded by DBH. This program successfully supports pediatricians in addressing the mental health needs of their patients through real–time access to child psychiatrists, psychologists, and care coordinators, which frees up DC’s specialized mental health resources to serve youth who generally need a higher level of care. DC should also explore opportunities for expansion of DC MAP services, such as the Adolescent Substance Use and Addiction Program at Boston Children’s Hospital–Massachusetts Child Psychiatry Access Program (ASAP–MCPAP) Consultation Line.⁴
- **Consider Establishing Certified Community Behavioral Health Clinics (CCBHCs).** CCBHCs are designed via federal legislation to provide a comprehensive range of mental health and substance use disorder services to under–resourced individuals. These clinics receive an enhanced Medicaid reimbursement rate based on the anticipated costs of expanding services to meet the needs of complex populations. Recent data from states that have implemented CCBHCs

demonstrate drastic reduction or elimination of waitlists for services within a few years of initiating the model. Additionally, each state was able to leverage the model to reach key populations, with improvements in children's services frequently mentioned as a key advancement.⁵

- **Enable Psychiatric Collaborative Care Management (PCCM) through Current Procedural Terminology (CPT) Codes 99492- 99494.** The Psychiatric Collaborative Care Management model is an evidence-based framework that integrates a behavioral care manager (typically a social worker, counselor, nurse, or psychologist) and a psychiatric consultant (a trained medical professional who can prescribe a full range of medications) into the primary care team.⁶ This model utilizes a patient-centered, population-based, measurement-based, treatment-to-target, evidence-based, and accountable-care approach to help support treatment of patients' behavioral health conditions within the primary care setting. The PCCM model utilizes a set of CPT codes (99492-99494) to bill for services monthly. Research on the implementation of this model shows that at least 15 states currently allow for Medicaid reimbursement, including Massachusetts, New York, Oregon and Washington. We suggest that DHCF and DBH adopt the PCCM model's CPT codes as part of the District's Medicaid fee schedule.⁷

Continue Appropriate Screening, Assessment and Referral Practices. Medicaid Managed Care Organizations should be following, and continue to follow, behavioral health screening requirements as mandated by the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit and the Department of Health Care Finance. While every child (0-21) should be screened through their pediatric primary care provider annually with a validated tool, we recommend a degree of continued flexibility in order to allow health care providers to implement screening tools that fit their particular practice demographics, infrastructure and workflow. Ethical screening practice requires that referrals made for further assessment, diagnosis, and treatment be rapidly available, further underscoring the need for robust referral networks. For screening related to trauma or adverse childhood experiences, ample training and referral mechanisms must be in place, as well as staff buy-in for the screening process, in order to attend to needs that arise from the screening.

Flexibility and Decentralization of Care Coordination. Clinicians engage in hours of unreimbursed time in their efforts to coordinate care and advocate for their patients across systems. The current system of care coordination, which is broadly centralized through the MCOs, would benefit from additional flexibility, decentralization to pediatric primary care or other locations families frequent or feel most comfortable, and reimbursement to fund and sustain clinical staff positions on site. Collaboration and shared care would also reduce overutilization of services as families would not need to enlist the

aid of multiple professionals to help them navigate across multiple sectors and organizations, in which they are receiving care.

Coverage of Dialectical Behavior Therapy (DBT).⁸ Dialectical Behavior Therapy (DBT) is an evidence-based treatment for individuals with chronic suicidality, self-injury, and mood dysregulation. A full DBT program consists of individual therapy, a weekly skills group for the child/teen and ideally the parent as well and coaching via telephone. Children's National successfully uses DBT in their inpatient unit and many of these patients respond well to the skill-focus and structure of the treatment. However, there are many barriers to DBT, including a lack of programs in the District, a lack of adequate referral sources for discharge that accept Medicaid, and the referral of DC Medicaid patients to therapists who are not equipped to work with the patients with the most severe symptoms, such as suicidality. We recommend that the District provide reimbursement for all clinical components of DBT, including time spent in groups and in coaching via telephone, as well as increased funding for outpatient services and trained DBT clinicians.

Improve Assessment, Diagnostic and Treatment Services for Children At-Risk or Diagnosed with Autism Spectrum Disorder (ASD). District children in need of assessment, diagnostic and treatment services for ASD, especially those with additional co-occurring behavioral health conditions, face numerous challenges accessing high-quality and timely care. As providers of these services, we recommend that the District prioritize comprehensive policy solutions, such as implementation of an ASD Medicaid benefit; development and enforcement of strategies to achieve parity and network adequacy; and collaboration with the newly formed DC Autism Collaborative (a public-private partnership that includes representation from DHCF and DBH) on other specific strategies to employ.

Establish a Full Continuum of Psychiatric Care for Children and Youth including Acute Care, Crisis Stabilization, and Intensive Outpatient Care. The District currently does not have a full range of services for children and youth in need of acute psychiatric care. We recommend DHCF, DBH, and the MCOs work towards establishing these types of programs so District families do not need to travel to Virginia, Maryland or farther distances to access medically necessary services: 1) **Intensive Outpatient Supports** such as an Intensive Outpatient Program and/or a Partial Hospitalization Program (IOP/PHP); 2) **Crisis Stabilization Unit** such as a youth crisis stabilization unit or pediatric comprehensive psychiatric emergency program; and 3) **Bridging Clinic** for youth who are being discharged from inpatient psychiatric units without established outpatient therapy and medication providers. While these services are not expressly prohibited or unauthorized under DC Medicaid, other factors, likely due to financing and reimbursement, have served as barriers to implementation.

Improve Treatment Options for Youth At-Risk of, or Diagnosed with, Substance Use Disorders (SUD). While the District has some SUD treatment options available, anecdotal evidence suggests that there are limited options for substance use treatment (e.g., rehabilitation,

residential or group therapy) in the District and low engagement in treatment among youth. We recommend the District place special emphasis on working with youth, families and providers to explore solutions to improve screening, assessment, referral and treatment, and options for improved integration of SUD prevention and treatment services into easily accessible locations, such as primary care and schools, and that the District invest in more robust workforce development positions and capacities, such as addiction counselors and coaching.

Continue Expansion of Early Childhood Mental Health Consultation. Early childhood mental health consultation (ECMHC) promotes enhanced capacity to address social-emotional development and mental health in early learning centers and other education settings. This model provides support to both teachers and staff as well as early learners and their caregivers. The highly successful implementation of ECMHC models in DC should continue to be supported and expanded.

Special Populations

Pregnant and Postpartum Women. Healthy child development starts during preconception. A mother's health (physical, behavioral, and emotional), during and after pregnancy, greatly impacts the health outcomes of the child. Perinatal mood and anxiety disorders (PMADs) such as postpartum depression disproportionately affect low-income women and can lead to increased costs of medical care, inappropriate medical care, child abuse and neglect, discontinuation of breastfeeding, and adverse effects on a child's early brain development.⁹ We recommend DHCF and MCOs continue to work with community-based organizations and other stakeholders to increase access to PMAD screenings and easily accessible integrated care treatment options in obstetrics/gynecology and pediatric primary care settings, and to include the 2020 perinatal Healthcare Effectiveness Data and Information Set (HEDIS) measures in quality-of-care metrics and reporting, which cover prenatal and postpartum depression screening and follow-up.¹⁰

Infants and Toddlers. Infant and early childhood mental health (IECMH) focuses on improving the social and emotional development of children from birth to age five and incorporates multigenerational models of care. Addressing the social and emotional development of infants and toddlers is critical in the prevention of mental health disorders during adulthood. Despite the overwhelming science that supports early intervention to foster resilience, there are still many barriers to supporting infant and early childhood mental health, including lack of knowledge about this field among policymakers, reimbursement and billing challenges, and lack of specialized training and education supports for practitioners.

Based on lessons learned from the Early Childhood Innovation Network,¹¹ we recommend DBH and DHCF actively explore the following: 1) increase IECMH-specific programming in early learning centers; 2) expand the availability and scope of IECMH services; and 3) expand public funding for peer-delivered supports in IECMH.

The DC IECMH Financing Policy Workgroup, comprised of representation from DHCF, DBH, the Office of the State Superintendent of Education (OSSE), ECIN, and Children's National Hospital, is currently examining best practices, innovative models being implemented in other states, and opportunities in the District to advance the IECMH system.¹² We also recommend that the District and MCOs work with this group to implement IECMH recommendations.

Parents, Caregivers, and Families. The mental health of the family is equally important as that of the child. Children are directly impacted by the mental health of their parents and caregivers and therefore, it is essential that the District take a multigenerational, family-centered approach to care that fully addresses the needs and improve the outcomes of the whole family. This approach includes ensuring adequate reimbursement of treatment services received by a parent and child simultaneously, as well as ensuring that parents' and their children's records/charts are included in the same health record when clinically indicated. The District has already taken steps in this direction with the support and monitoring of Child-Parent Psychotherapy (CPP) and Parent-Child Interaction Therapy (PCIT). We also recommend that the District further integrate parenting supports (e.g., parenting classes, training, and peer support groups) in pediatric primary care and community settings and consider certain evidence-based parenting supports as reimbursable services under Medicaid.

Workforce Development and Network Adequacy

Integrate Non-Traditional Behavioral Health Practitioners into Primary Care and Hospital-Based Settings. A truly integrated system of care requires a culturally responsive, humble, team-based approach to care that not only includes "traditional" providers, but also takes into consideration other community resources that are needed for effective care coordination and improving the health of the whole person. DC should create additional career pathways for peer specialists, family navigators, and/or community health workers in integrated care settings such as primary care, early learning and childcare facilities, and/or community-based and family-run organizations. These pathways should include clear scopes of practice, training, and appropriate levels of supervision. The addition of non-traditional providers is not intended to replace receipt of clinical care from a licensed provider or to displace workforce development efforts that increase the availability of psychiatrists, psychologists, and other mental health professionals, but instead serve as a critical complement to the existing workforce, especially given the long-standing

behavioral health workforce shortage. In addition to strengthening the behavioral health workforce, peer support and community health workers could also be used in the primary care space to support families in understanding the full range of the EPSDT benefit, and ultimately increase access to, and uptake of, screenings, assessments, referrals and treatment.

Include Psychologists, LICSWs, LPCs, LMFTs as Covered Providers in the State Medicaid Plan.

Although the 1115 waiver addresses Medicaid reimbursement for psychologists, LICSWs, and other licensed providers, it is imperative that these providers are included as part of the State Medicaid Plan to ensure access to comprehensive behavioral health services in all qualified settings.

Invest in Workforce Development. We recommend increasing or establishing funds to support behavioral health training of high school, undergraduate, and graduate level students to increase interest and preparedness for working in an integrated care setting. Currently, there is robust federal funding for medical trainees, but such funding is not available in allied professions such as psychology and social work. Providing dedicated funding and loan-repayment incentives would enable students who are currently unable to take unpaid or low-paying training opportunities to avail themselves of this training.

Fund Quality Improvement Learning Collaboratives for Pediatric Primary Care. The District has previously provided financial support for Quality Improvement Learning Collaboratives, resulting in substantial improvement of integrated behavioral health care and screening. Further partnership through these collaboratives and collaboration could support additional enhancements of integrated care.¹³

Improve Network Adequacy for Behavioral Health Services. Provider networks are already inadequate, and this may continue to be a challenge without strong oversight and enforcement. There is a scarcity of behavioral health care providers that are able to provide services for children and youth in DC, particularly for very young children (under 5 years), families whose first language is not English, and children with Autism Spectrum Disorder or developmental delays. Providers for children and youth require specialized training, training in specific evidence-based practices, and prior experience in order to serve these specific populations. Currently, the shortage of child-serving providers in DC results in long wait times for initial appointments and significant delays in obtaining treatment. Addressing network adequacy will be paramount to a successful transition to managed care and to meeting the needs of DC's children and families.

Require Universal Contracting for Critical Providers to Ensure Initial Network Adequacy. DHCF and DBH should first require universal contracting for critical providers to ensure network adequacy. This means that any provider who is licensed, credentialed, and willing to accept the plan's contract terms would initially be offered a contract. DBH-certified providers, in addition to other types of providers (i.e., Adolescent Community Reinforcement Approach [ACRA] providers, Adolescent Substance Abuse Treatment

[ASTEP] providers, Federally Qualified Health Centers [FQHCs], Psychiatric Residential Treatment Facilities [PRTFs], and hospitals) are included as critical providers. MCOs should be required to offer at least an initial contract to all other child-serving providers, to ensure there is an adequate network for children immediately following the transition.

Financing

Address Historically Low Reimbursement Rates for Behavioral Health Care Services. According to the Blue Ridge Academic Group, reimbursement for behavioral health services nationally has been significantly lower than reimbursement for physical health services. One study found that behavioral health professionals are reimbursed at fee-for-service rates that are 20% below the rate for primary care physicians when the time required to evaluate behavioral health is often longer than a basic primary care visit. In addition, reimbursement is often more limited for preventative services and/or behavioral health rehabilitation services.¹⁴ A critical feature of an effective, integrated system is ensuring behavioral health reimbursement rates are sufficient and on par with reimbursement for physical health conditions. Additionally, it is imperative that reimbursement be adequate for assessment and diagnosis (including medically necessary psychological and neuropsychological testing), which has been historically limited.

Pay for Same-Day Services. DHCF and MCOs should ensure that when children have to see both a medical and behavioral health provider at the same location on the same day (e.g., seeing both an endocrinologist and psychiatrist on the same day), payment is rendered to both providers. This would substantially reduce the burden on parents in having to make multiple visits, reduce the time out of school for children, and advance the District's goals of successfully integrating physical and behavioral health care.

Phase-In Payment Changes. During the transition of behavioral health services from the purview of DBH to managed care organizations (MCOs), changes to payment terms should be phased in gradually, with initial payment rates at least matching the Medicaid fee-for-service fee schedule.

Cover Discrete Z-codes to Promote Mental Health and Prevent Mental Health Disorders. Health care providers often see children who do not meet the full criteria for a mental health diagnosis but who are experiencing conditions and family circumstances that place them at high risk for the development of significant mental health disorders. Health care providers and families should not have to wait until a child has a full-blown psychiatric diagnosis before effective interventions can be delivered. Further, given the stigma still associated with mental health diagnoses, we should equip providers with reimbursable codes and services that bolster the promotion and prevention end of the care continuum.

California and Oregon are example states that incorporate coverage of Z-codes via Medicaid.

Develop Value-Based Payment Initiatives That Prioritize Children’s Social And Emotional Development.¹⁵ As the District considers value-based payment models, we encourage a focus on advancing value-based or alternative payment models that incorporate a focus on child and family behavioral health, including early childhood social and emotional development. These might take the form of bundled payments, episodes of care, or other models. In particular, we recommend the recent paper, [Alternative Payment Models to Support Child Health & Development: How to Design and Implement New Models](#) as a starting point for design considerations.¹⁶

Technology

Increase Access to Telehealth Services. Telehealth is a critically important component in improving access to behavioral health care for children and families. The District has made remarkable progress in the past year in increasing access to these services through permanent changes to regulatory guidance made during the Public Health Emergency. However, ensuring that families with Medicaid have sufficient access to Wi-Fi, devices, and adequate broadband support would further help to increase access to behavioral health care services.

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² Department of Health Care Finance, “Presentation to Medical Care Advisory Committee on DC Medicaid Reform,” October 23, 2019, https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/MCAC%20Reform%20Final_0.pdf

³ For a full list of guiding principles from, Children’s Law Center, Children’s National Hospital, DC Behavioral Health Association, the Early Childhood Innovation Network, & MedStar Georgetown University Hospital Division of Child and Adolescent Psychiatry, “The Principles and Values to Guide Child and Adolescent Public Behavioral Health Care System Transformation in the District of Columbia,” 2019,

<https://www.childrenslawcenter.org/resource/principles-and-values-guide-child-and-adolescent-public-behavioral-health-care-system>.

⁴ For more information on the ASAP-MCPAP Consultation Line, see

<https://www.mcpap.com/pdf/ASAP.MCPAP.Announcement.pdf>.

⁵ National Council for Behavioral Health and NASMHPD, Behavioral Health Commissioners Summit, September 10, 2020.

⁶ For more information, see "AIMS Center Advancing Integrated Mental Health Solutions in Integrated Care," 2020, accessed September 14, 2020, <https://aims.uw.edu/>.

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⁸ For more information on DBT, see <https://behavioraltech.org/resources/faqs/dialectical-behavior-therapy-dbt/>.

⁹ See, "Perinatal Toolkit," DC Collaborative for Mental Health in Pediatric Primary Care.

<https://www.dchealthcheck.net/resources/healthcheck/mental-health-tools.html>.

¹⁰ Center for Medicare and Medicaid Services. "2020 Core Set of Maternal and Perinatal Health Measures for Medicaid and CHIP," accessed December 23, 2019, <https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-maternity-core-set.pdf>.

¹¹ For further information on ECIN innovations, please visit <https://www.ecin.org/innovations>.

¹² For more information, see Smith, S., Granja, M.R., Nguyen, U., Rajana, K., "How States Use Medicaid to Cover Key Infant and Early Childhood Mental Health Services: Results of a 50-State Survey (2018 Update)," New York: National Center for Children in Poverty, Mailman School of Public Health, Columbia University, http://www.nccp.org/publications/pdf/text_1211.pdf.

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¹⁴ The Blue Ridge Academic Group, "The Behavioral Health Crisis: A Road Map for Academic Health Center Leadership in Healing Our Nation," Winter 2019-2020. Report 24. <http://whsc.emory.edu/blueridge/publications/archive/Blue%20Ridge%202019-2020-FINAL.pdf>.

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