Nurture Connection

State Leadership and Policy Action to Advance Early Relational Health

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October 2023

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Introduction

Early relational health (ERH) is the state of emotional well-being that grows from the positive emotional connection that babies and toddlers and their parents experience with each other through everyday moments of caregiving and nurturing. ERH is foundational to children's healthy growth, development, and overall well-being, as well as to promoting family resilience and protecting children and adults from the harmful effects of stress. Both science and cultural wisdom clearly tell us that strong, positive, and nurturing relationships within supportive communities create the state of ERH.

While ERH is anchored in a two-generational and family-based concept, ERH equally emphasizes the critical influences of the social, economic, racial, and cultural contexts within which families live. ERH is influenced and may be disrupted by living in communities that are under-resourced. The foundational relationships that anchor ERH require safe and supportive environments for the family within the larger social context. Racist and discriminatory policies and practices continue to generate persistent maternal and child health disparities in both access and outcomes for families of color.

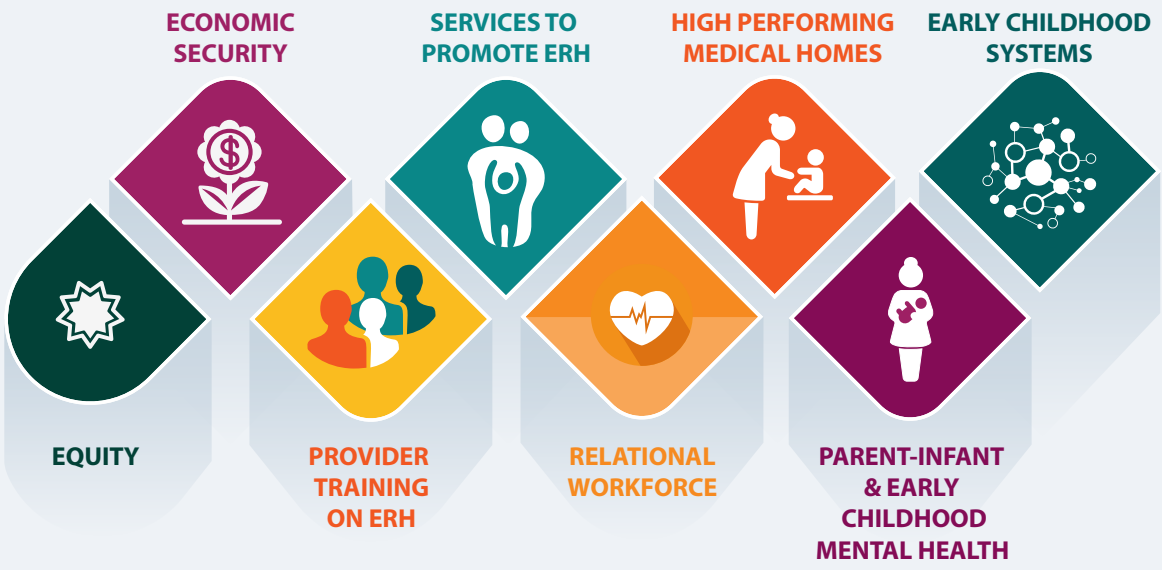
For far too long, our nation has perpetuated health, economic, human services, and early childhood policies that do not attend to the critical need for supporting and developing foundational early relationships between babies and parents. Deeply entrenched structural racism has resulted in inequities, including the policies and service delivery systems that segregate and marginalize families of color from opportunities that support optimal health and development for their children. Specifically, limits on policies designed to end child poverty also have a negative impact on families' ability to ensure ERH, resulting in a lack of stable housing, persistent food insecurity, and limited access to other basic needs. This socioeconomic hardship contributes to increased caregiver stress and may impede positive early relationships and optimal child development.

Our nation needs an array of policy, structural, and systemic changes to meet the needs of children and families of color, and ultimately all families. Policies and programs can be designed to reduce the stressors and remove the structural barriers (e.g., insufficient income, racism, lack of safety, limited time at home with children) that affect parents' capacities and resources to develop strong nurturing connections and early relationships with their infants and toddlers and, in turn, ERH.

To promote ERH, governmental policies must support child and family well-being, particularly in the first three years of a child's life. Using an ERH framework, we can work toward a more equitable society by advancing policies and practices that promote healthy parent/caregiver-child relationships and the contexts for overall family well-being.

The work of Nurture Connection, a networked and engaged movement to advance ERH, is focused on policy solutions that not only advance relational practice transformations within public and private child health and development systems, but that also promote the economic and social well-being of families with young children. The Nurture Connection policy goals for ERH also include an array of policies and programs to support family economic security and early childhood systems in communities that link and coordinate health, mental health, early care and education, family support, home visiting, housing, child welfare, and other services. As put forth by Nurture Connection, these ERH policy goals are shown in Figure 1.

Figure 1: Early Relational Health Policy Goals



- **EQUITY –** Aim to advance equity in the design and implementation of all policies.
- **ECONOMIC SECURITY –** Support family economic security and mobility for two-generational success, including paid family leave, child tax credit, and assistance to address food insecurity, housing, income, and other concrete needs. Policy solutions can improve the economic well-being of families of color and those living with below-poverty income.
- **PROVIDER TRAINING ON ERH –** Many policies and programs provide funds for training. One aim should be to train all providers serving families with young children in ERH principles and best practices, including those that are strengths-based, family-driven, culturally and linguistically affirming, and anti-biased. Providers may include physicians, nurses, community health workers, doulas, family support specialists, mental health professionals, child development specialists, early care and education teachers, and others. Policy and program strategies can also support cross-system training.
- **SERVICES TO PROMOTE ERH –** Public financing is needed to scale up and sustain evidence-based and evidence-informed interventions and community system innovations that promote ERH. A range of promotion, prevention, and intervention services have been shown to be effective for improving early relational health; however, the translation from research demonstration projects to widespread implementation of these services is emergent and ready to scale.
- **RELATIONAL WORKFORCE –** Policies to advance ERH require attention to the capacities and relational focus of an expanded workforce. The focus is on developing a diverse and well-trained relational workforce, including community health workers, doulas, home visitors, and others, especially focused on people who come from the communities they serve and have experience navigating child- and family-serving systems. For example, an increasing number of states are using various mechanisms in Medicaid to finance community health worker services, sometimes with emphasis on child and family health. In addition, some states have added Medicaid coverage of community-based doula services. Other finance streams support training and workforce development of community- and practice-based workforce.
- **HIGH PERFORMING MEDICAL HOMES –** Increased financing and child health practice transformation are needed to accelerate the use of high performing medical homes, which use team-based, family-driven approaches, have relational care coordination staff, and integrate models and services designed to promote optimal ERH, child development, and the long-term health and well-being of children and families. Since half of all children and a disproportionate share of

young children of color are enrolled, Medicaid plays a central role in financing these best practices. More incentives for pediatric primary care providers to become high performing medical homes may come from Medicaid-managed care plans that serve 80 percent of children in Medicaid.

- **PARENT, INFANT, AND EARLY CHILDHOOD MENTAL HEALTH –** Investments are needed to improve access to parental, infant, and early childhood mental health, beginning prenatally and including promotion, prevention, screening, and treatment for parents and children together. Infant and early childhood mental health (IECMH) and maternal mental health services are being funded with Medicaid and mental health dollars but still fall short of need in many states.
- **EARLY CHILDHOOD SYSTEMS –** More federal and state policy support is needed to strengthen early childhood systems in communities, with linkages and coordination among child- and family-serving systems. This system of systems in early childhood would include health, mental health, family support, early care and education, home visiting, early intervention, housing, child welfare, economic, environmental, and other services and informal supports. Efforts by state agencies to advance early childhood systems can be a lever for change and sustainability.

This issue brief highlights action in select states that are advancing policies that support and are aligned with the above policy goals for advancing ERH. Based on a review of state-level policy action and interviews with key state leaders, policy and systems developments in six states**—New Jersey, Oregon, Washington, California, Michigan, and Vermont—**are described here. In addition, policies that support ERH (implicitly or explicitly) are being advanced in numerous other states across the country. (See Table 1: State Action on ERH Policy Goals.) It is clear that state-level policies that are designed to improve the lives of families prenatal to three and promote ERH are advancing from coast to coast. In some states and communities, intentional efforts are underway to advance equity and make fundamental systems change through policy.

Progress Across the Country Toward ERH Policy Goals

Table 1 shows the status of 14 policy and program areas for all 50 states across four clusters of ERH policy goals. This brief selected four effective policies and two key strategies identified by the Prenatal-to-3 Policy Impact Center that are aligned with the ERH policy goals. The Prenatal-to-3 State Policy Roadmap is grounded in reviews of science and is designed to provide guidance to state leaders on the most effective investments states can make to ensure all children thrive from the start. The table also shows six state Medicaid policies related to early childhood health, mental health, and relational workforce, as well as two categories of early childhood system investment. (Citations for data sources accompany the table.)

ERH POLICY GOALS: Economic Security and Equity

While economic security does not ensure equity and ERH, gaps in income and wealth are major drivers of inequitable outcomes for children and families. Recent surveys of young families make clear the impacts of economic hardship on their family's stress and well-being. Public policy can improve the economic well-being of families of color and those living with below-poverty income. For example, a study using Census data revealed that the expansion of the federal Child Tax Credit (by increasing its value and making it fully refundable) in 2021 resulted in an historic reduction in child poverty, with 2.1 million children being lifted out of poverty, one-third of whom were under age 6. A rigorous, randomized study of the impact of income support and poverty reduction on infant brain development found significant benefits among those who received unconditional cash transfers.

State-level policies that support family economic security and mobility for two-generational success have been identified by a number of national organizations and policy centers. As shown in Table 1, the policies that can support family economic security, and thereby promote early relational health, include the following:

- Paid Family Leave of at Least 6 Weeks (9 states)
- State Minimum Wage of $10 or Greater (29 states)

- Refundable State Earned Income Tax Credit at Least 10 percent (28 states)
- Child Tax Credits (8 states)
- Reduced Administrative Burden for SNAP (33 states)

ERH POLICY GOALS: Services to Promote ERH, Relational Workforce, and High Performing Medical Homes

The ERH policy goals call for increased investments in order to scale and spread a range of promotion, prevention, and intervention services that have been shown to be effective in supporting families' foundational relationships and in improving ERH. As shown in Table 1, this includes program models such as Reach Out and Read, DULCE, Family Connects, and Healthy Steps, and approaches such as group care for pregnant and parenting families (e.g., Centering). Another goal is to adopt policies that support the development of a diverse and well-trained relational workforce, including community health workers, doulas, home visitors, and others, especially people who come from the communities they serve and have experience navigating child- and family-serving systems and helping families engage with their communities. Increased financing is needed to accelerate the use of high performing medical homes, which use team-based, family-driven approaches, relational care coordination staff, and integrate models and services designed to promote optimal ERH, child development, and the long-term health and well-being of children and families.

At the state-level, Medicaid must play a central role in funding services to promote ERH, pay for the services of the relational workforce, and adequately finance high performing medical homes for young children. Medicaid covers at least 40 percent of births, half of all children, and a disproportionate share of Black, Hispanic, and Indigenous infants and toddlers. Given the breadth of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) child health benefit, its role in financing services to promote health, well-being, and ERH is undeniable. As shown in Table 1, these include the following:

- Extended Postpartum Medicaid Eligibility (37 states)
- Developmental Health and Connection Programs (26 states)
- Group Prenatal and Parenting Care Programs (44 states)
- Medicaid Financing for Doulas (10 states)
- Medicaid Financing for Community Health Workers (29 states)

ERH POLICY GOAL: Parent, Infant, and Early Childhood Mental Health

One key ERH policy goal is to increase public investment in services that support parental, infant, and early childhood mental health, beginning prenatally, and include promotion, prevention, screening, and treatment for parents and children together. Infant and early childhood mental health (IECMH) and maternal/perinatal mental health services are being funded with federal and state dollars via Medicaid and mental health programs but still fall short of meeting the current and growing needs.

As discussed above, Medicaid must play a central role in financing services for young children. Table 1 features examples of supplemental payments as incentives for health providers to conduct recommended screening related to young children's social-emotional development, parental/perinatal depression, and social risk factors.

- Supplemental Payment for Child Social-Emotional Screenings (17 states)
- Supplemental Payment for Maternal and/or Parental Depression Screening (25 states)
- Supplemental Payment for Social Determinants of Health Screenings (4 states)

This ERH Policy Goal supports, aligns with, and complements more comprehensive Infant Mental Health policy agendas.

ERH POLICY GOAL: Early Childhood Systems

While some investments have been made in recent years, more federal and state policy support is needed to advance and strengthen early childhood systems in communities. As discussed in this brief, this system of systems in early childhood would include health, mental health, family support, early care and education, home visiting, early intervention, housing, child welfare, economic, environmental, and other services and informal supports.

Two types of early childhood system-building grants to states from the Health Resources and Services Administration (HRSA) related to early childhood systems development are highlighted in the table.

- HRSA Early Childhood Comprehensive Systems (ECCS) Grants (20 states)
- HRSA Transforming Pediatrics for Early Childhood (TPEC) Grants (8 states)

Table 1: State Action on ERH Policy Goals

Economic Security and Equity & High Performing Medical Homes, Relational Workforce and Services to Promote ERH

	ERH Policy Goal: Economic Security and Equity					ERH Policy Goal: High Performing Medical Homes, Relational Workforce and Services to Promote ERH				
	Paid Family Leave of at Least 6 Weeks[1]	State Minimum Wage of $10 or Greater[1]	Refundable State Earned Income Tax Credit[2]	Child Tax Credits[3]	Reduced Administrative Burden for SNAP[1]	Extended Postpartum Medicaid Eligibility[4]	Development, Health, and Connection Programs (includes DULCE, Family Connects, HealthySteps)[1]	Group prenatal and parenting care[1]	Medicaid Financing for Doulas[5]	Medicaid Financing for Community Health Workers[6]
Alabama					X	X	X	X		X
Alaska		X				P		X		
Arizona		X			X	X	X	X		
Arkansas		X			X	--		X		
California	X	X	X	X	X	X	X	X	X	X
Colorado		X	X	X		X	X	X		X
Connecticut	X	X	X		X	X	X			X
Delaware		X	X		X	X				
District of Columbia	X	X	X		X	X	X	X	X	X
Florida		X				X	X	X		
Georgia						X		X		
Hawaii		X	X			X	X	X		
Idaho				NR						
Illinois		X	X		X	X	X	X		X
Indiana			X		X	X		X		X
Iowa			X			--		X		
Kansas			X		X	X		X		
Kentucky					X	X	X	X		X
Louisiana			X		X	X		X		X
Maine		X	X	NR	X	X		X		X
Maryland		X	X	X	X	X	X	X	X	
Massachusetts	X	X	X	X	X	X	X	X		X
Michigan		X	X		X	X		X	X	X
Minnesota		X	X		X	X	X	X	X	X
Mississippi						P	X	X		

	ERH Policy Goal: Economic Security and Equity					ERH Policy Goal: High Performing Medical Homes, Relational Workforce and Services to Promote ERH				
	Paid Family Leave of at Least 6 Weeks[1]	State Minimum Wage of $10 or Greater[1]	Refundable State Earned Income Tax Credit[2]	Child Tax Credits[3]	Reduced Administrative Burden for SNAP[1]	Extended Postpartum Medicaid Eligibility[4]	Development, Health, and Connection Programs (includes DULCE, Family Connects, HealthySteps)[1]	Group prenatal and parenting care[1]	Medicaid Financing for Doulas[5]	Medicaid Financing for Community Health Workers[6]
Missouri		X	NR		X	P	X	X		
Montana			X		X	P		X		
Nebraska		X	X			P		X		
Nevada		X				P		X	X	X
New Hampshire						P		X		
New Jersey	X	X	X	X	X	X	X	X	X	X
New Mexico		X	X	X	X	X		X		X
New York	X	X	X	X		X	X	X		X
North Carolina						X	X	X		X
North Dakota						X		X		X
Ohio		X	NR		X	X	X	X		X
Oklahoma			X	NR	X	X	X	X		
Oregon	X	X	X		X	X	X	X	X	X
Pennsylvania					X	X	X	X		X
Rhode Island	X	X	X		X	X			X	X
South Carolina			NR			X	X	X		
South Dakota		X			X	X				X
Tennessee					X	X		X		
Texas						P	X	X		
Utah			NR			limited				X
Vermont		X	X	X	X	X	X	X		
Virginia		X	X		X	X		X	X	X
Washington	X	X	X		X	X	X	X		X
West Virginia					X	X		X		X
Wisconsin			X		X	limited		X		X
Wyoming						P				
Total	**9**	**29**	**28**	**8**	**33**	**37**	**26**	**44**	**10**	**29**

Table 1: State Action on ERH Policy Goals, continued

Parent, Infant, and Early Childhood Health & Mental Health and Early Childhood Systems

	ERH Policy Goal: Parent, Infant, and Early Childhood Health and Mental Health			ERH Policy Goal: Early Childhood Systems	
	Supplemental Payment for Child Social-Emotional Screening[7]	Supplemental Payment for Maternal and/or Parental Depression Screening[7]	Supplemental Payment for Social Determinants of Health Screening[7]	HRSA Early Childhood Comprehensive Systems (ECCS) Grants[8]	HRSA Transforming Pediatrics for Early Childhood (TPEC) Grants[8]
Alabama		X			
Alaska					
Arizona	X	X			
Arkansas					X
California	X				X
Colorado	X	X	X	X	
Connecticut	X	X			
Delaware					
District of Columbia		X			
Florida				X	
Georgia	X	X			
Hawaii				X	
Idaho		X			
Illinois				X	
Indiana	X	X			
Iowa			X		
Kansas	X	X			
Kentucky					
Louisiana		X		X	
Maine	X	X	X	X	
Maryland	X	X			X
Massachusetts	X	X			X
Michigan	X	X		X	
Minnesota				X	
Mississippi		X			
Missouri		X		X	
Montana					
Nebraska					
Nevada				X	

	ERH Policy Goal: Parent, Infant, and Early Childhood Health and Mental Health			ERH Policy Goal: Early Childhood Systems	
	Supplemental Payment for Child Social-Emotional Screening[7]	Supplemental Payment for Maternal and/or Parental Depression Screening[7]	Supplemental Payment for Social Determinants of Health Screening[7]	HRSA Early Childhood Comprehensive Systems (ECCS) Grants[8]	HRSA Transforming Pediatrics for Early Childhood (TPEC) Grants[8]
New Hampshire					
New Jersey				X	X
New Mexico				X	
New York		X		X	
North Carolina					
North Dakota	X	X			
Ohio	X				
Oklahoma	X	X			X
Oregon		X			X
Pennsylvania		X		X	
Rhode Island				X	
South Carolina	X	X	X		
South Dakota	X	X		X	
Tennessee					
Texas		X			
Utah				X	
Vermont				X	X
Virginia				X	
Washington	X	X		X	
West Virginia					
Wisconsin					
Wyoming					
Total	**17**	**25**	**4**	**20**	**8**

NOTES ON DATA SOURCES

[1] Prenatal-to-3 State Policy Roadmap 2023. Available at: https://pn3policy.org. Policies adopted and implemented as of October 11, 2022.

[2] From Urban Institute. Available at: https://www.urban.org/policy-centers/cross-center-initiatives/state-and-local-finance-initiative/state-and-local-backgrounders/state-earned-income-tax-credits. Data from 2023. NR means non-refundable credits which are not included in the total.

[3] Center on Budget and Policy Priorities. Available at: https://www.cbpp.org/blog/movement-for-state-child-tax-credits-continues-to-grow. Data as of April 3, 2023. NR means non-refundable credits which are not included in the total.

[4] Kaiser Family Foundation Medicaid Postpartum Coverage Extension Tracker as of September 7, 2023. Available at: https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/. P for states still in planning phase, coverage not implemented.

[5] National Academy for State Health Policy. Updated April 10, 2023. Available at: https://nashp.org/state-medicaid-approaches-to-doula-service-benefits/

[6] Kaiser Family Foundation. States that authorize state plan coverage for Community Health Workers as of July 1, 2022. Available at: https://www.kff.org/medicaid/issue-brief/state-policies-for-expanding-medicaid-coverage-of-community-health-worker-chw-services/

[7] National Center for Children in Poverty and Georgetown Center for Children and Families. Medicaid Policies to Help Young Children Access Key Infant-Early Childhood Mental Health Services: Results from a 50-State Survey. Available at: https://ccf.georgetown.edu/2023/06/09/medicaid-policies-to-help-young-children-access-infant-early-childhood-mental-health-services-results-from-a-50-state-survey/

[8] Health Care Resources and Services Administration. Available at: https://mchb.hrsa.gov/programs-impact/early-childhood-systems

Learning from Policy and Program Innovation in Six States

New Jersey: Multifaceted Initiative to Strengthen and Promote ERH, Strengthen the Early Childhood System, and Advance Equity

FOCUSING ON SYSTEMS CHANGE AND EQUITY

In New Jersey, work on ERH is happening through a broad-based public and private collaboration. This partnership includes the Office of the First Lady, the New Jersey Department of Children and Families and multiple departments in state government, the Burke Foundation, and the New Jersey Chapter of the American Academy of Pediatrics (NJAAP). New Jersey is exemplary in having numerous policy and program efforts focused on supporting ERH, and leaders have been intentional about working at a systems level, across many of the ERH policy goals, and with a focus on equity. New Jersey leadership and partnerships have positioned the state among those who have adopted the most change in policy to promote maternal and infant health, early relational health, and family well-being.

Nurture NJ is the state's signature effort to become the safest and most equitable place in the nation to give birth and raise a baby. This initiative was launched in 2019 and is being spearheaded by New Jersey First Lady Tammy Snyder Murphy, and is a campaign to improve maternal and infant health outcomes for women of color, reduce maternal and infant mortality, and ensure equitable care among women and children of all races and ethnicities. Nurture NJ has three primary objectives: 1) ensure all women are healthy and have access to care before pregnancy; 2) build a safe, high quality, equitable system of care and services for all women during prenatal, labor and delivery, and postpartum care; and 3) ensure supportive community environments and contexts during every other period of a woman's life so that the conditions and opportunities for health are always available.

Through the extraordinary efforts of public-private leadership, more than 44 pieces of legislation that support Nurture NJ have been signed into law in recent years. Reflecting what has been learned and the initiative's goals and strategies, the National Governors Association (NGA) released the Maternal & Infant Health Playbook, which was stewarded

by First Lady Tammy Murphy as 2022-2023 chair of the NGA Spouse Program. The Playbook makes 32 policy recommendations already in practice and feasible for other states to implement, including a focus on strategic planning and systems building, access to care, disparities and non-medical root causes, and workforce.

Nurture NJ developed a strategic plan that included input from state departments and agencies, health systems, physicians, midwives, doulas, community organizations, and, most importantly, families. This strategic plan is designed to make transformational change in a system that has historically failed mothers and babies of color. Notably, this strategic plan focuses on: 1) dismantling structural racism, advancing community power-building, and promoting engagement to support all aspects of planning and implementation; 2) multi-sector collaboration to address root causes outside the realm of influence of public health

Box 1: Action Areas for the Nurture NJ Strategic Plan

- **Build racial equity infrastructure and capacity.**
- **Support community infrastructures for power-building and consistent engagement in decision-making.**
- **Engage multiple sectors to achieve collective impact on health.**
- **Shift ideology and mindsets to increase support for transformative action.**
- **Strengthen and expand public policy to support conditions for health in New Jersey.**
- **Generate and more widely disseminate data and information for improved decision-making.**
- **Change institutional structures to accommodate innovation and transformative action.**
- **Address the social determinants of health.**
- **Improve the quality of care and service delivery to individuals.**

and medicine, and 3) a commitment to systematically transform systems, particularly in communities with low resources/high needs. The nine action steps of the strategic plan are highlighted in Box 1. The plan is now in an implementation phase where stakeholders are convening and creating workgroups to translate the plan into action.

The systems transformation work in New Jersey goes beyond maternal and infant health care to include a focus on promoting ERH. For example, in May 2022, a statewide ERH Summit was held, entitled *Joining Hands to Promote Foundational Relationships for Every Child*. This summit was hosted by the New Jersey Department of Children and Family Services and Families, the NJAAP, and the Burke Foundation, with sponsorship of the SPAN Parent Advocacy Network and the Turrell Fund. The audience included families, as well as pediatricians, child care providers, nurses, social workers, community health workers, doulas, home visitors, and a wide range of other professionals who work with young children and families. In all, nearly 200 attended and shared resources and showcased efforts to promote strong and nurturing early relationships, with a focus on establishing common language to discuss ERH, and on gaps in services across the state. This cross-system engagement is part of system building.

ECONOMIC SECURITY

Economic security is foundational for the well-being of families, and its absence, as in persistent poverty, can overload families and impact ERH. To help address economic security, New Jersey has paid family leave, a child tax credit, and a pilot guaranteed income initiative.

New Jersey's paid family leave program is through Family Leave Insurance (FLI). Under New Jersey policy, FLI provides workers paid time off to be with a new child (birth, foster, or adopted), to care for a seriously ill loved one, or to deal with issues related to domestic or sexual violence. FLI allows for 12 continuous weeks (or 56 intermittent days over a 12-month period) of paid leave and is available to both parents. FLI pays workers 85 percent of their weekly wage up to a maximum weekly benefit of $1,025 per week. The program is 100 percent financed by employee payroll deductions, which are a maximum of $94.08 in 2023.

New Jersey's child tax credit provides eligible families up to $500 for each child under the age of six. This credit has been in effect since the 2022 tax year. The credit is for $500 per child if earning less than $30,000 per year, and the credit is reduced based on income until completely phasing out for families earning over $80,000 annually. The credit is refundable so families will receive the credit even if the amount of credit exceeds their tax liability.

New Jersey also has an emerging guaranteed income initiative to promote economic security among residents of Newark, the largest city in the state, which is majority Black

and Hispanic and has wide disparities in income and wealth. In 2021, Newark launched a guaranteed income pilot program for 400 residents. Known as the Newark Movement for Economic Equity, these residents were randomly assigned to one of two groups: the first group will receive bi-weekly payments of $250 for two years, and the second group will receive semi-annual payments of $3,000 over two years. In all, each group will receive a total of $6000. Different from a universal basic income, this program targets specific communities to address income inequality and focuses on providing income to people living below the poverty line or with inconsistent or no income. After the two-year test period, the city of Newark can use the data and lessons learned to improve the social safety net and make it more inclusive.

PROVIDER TRAINING AND RELATIONAL WORKFORCE

New Jersey is investing in provider training and has dramatically expanded the role of Medicaid in supporting a community-based, relational workforce. As part of ongoing efforts under Nurture NJ, in January 2023, First Lady Murphy and Human Services Commissioner Sarah Adelman announced that New Jersey Medicaid (known as FamilyCare) increased reimbursement rates for perinatal, midwifery, and community doula care, with approval of a State Plan Amendment by the federal Centers for Medicare and Medicaid Services (CMS). Community-based doula care is early relational health care at its core, with trusted and intimate relational supports from the community focused on perinatal and postnatal maternal and infant well-being.

In 2019, New Jersey approved a policy to add doula care to its list of Medicaid-covered comprehensive maternity care services. The state received federal approval to use the optional preventive services benefit, which became effective on January 1, 2021. The New Jersey Department of Human Services facilitated a process for doulas to enroll as fee-for-service (FFS) Medicaid providers, and Medicaid-managed care plans have each identified a doula liaison. By 2022, while a small number of doulas had been trained, enrolled, and contracted with health plans, the enrollment process remained challenging. As part of the effort to expand the relational workforce, in 2021, the New Jersey Department of Health convened the New Jersey Doula Learning Collaborative, which engages HealthConnect One in providing training, workforce development, technical assistance, and sustainability planning for community doulas and doula organizations throughout the state. Doulas may practice and bill independently, or they can be hired by an entity (for example, a community-based doula organization or a hospital) that bills payors on their behalf. Despite these efforts, New Jersey and other states continue to face implementation challenges in workforce development.

In 2021, policy to support Universal Newborn Home Visiting was signed into law by Gov. Murphy to make it statewide (only the second state to do so, following Oregon). New Jersey will use the Family Connects model. The implementation of a universal home visiting program available at birth aligns with the Nurture NJ 2021 Strategic Plan. The goal of providing a short-term, nurse-staffed home visiting model to all families in select areas is to reduce maternal and infant morbidity and mortality by assessing the health needs of parents and infants, assessing the behavioral health and social needs of families, and connecting families with appropriate community services. The state released an RFP in 2023, targeting 5 high-priority counties for Phase 1 implementation. Funding will come from both Medicaid and private insurance company newborn coverage requirements by the state. The Burke Foundation and NJ Department of Children and Families jointly funded a Family Connects pilot project in Mercer County, which laid the groundwork for the statewide effort. The Burke Foundation is also supporting state implementation of this policy with support for: 1) a communications campaign, 2) nurse recruitment, and 3) building the nurse training pipeline.

To promote ERH, the state created the Professional Formation Center for the Early Relational Health Workforce at Montclair State University's Center for Autism and Early Childhood Mental Health. The Professional Formation Center is funded through the federal Preschool Development Grant Birth through Five, as well as contracts with other state agencies. The Professional Formation Center has developed a training, *Keeping Babies and Children in Mind*, which provides professional education in evidence-based practices, including topics on promoting ERH and infant and early childhood mental health (IECMH), supporting child and family strengths, and responding to trauma. Multidisciplinary trainings have been provided to more than 20,000 professionals from a range of public services and systems and are designed to foster better cross-system collaboration and strengthen referral pathways. Training people from different systems together helps to ensure that families encounter professionals who use a similar relationship-based approach to supporting the family. This training is available to other states and has currently been shared with Texas and Pennsylvania.

HIGH PERFORMING MEDICAL HOMES

A high performing medical home includes approaches that are team-based, family-driven, community-connected, and anti-bias, and embeds or links to models that promote ERH and child development. The August 2021 statement from the American Academy of Pediatrics, *Preventing Childhood Toxic Stress: Partnering with Families and Communities to Promote Relational Health*, calls for translating the relational health framework into clinical practice, research, and public policy, and for adopting a public health approach that

builds relational health by partnering with families and communities. NJAAP has ERH at the center of its strategy to support and build high performing medical homes in the state and ERH is featured on NJAAPs website.

In 2019-2021, the Burke Foundation, New Jersey Department of Health, Henry and Marilyn Taub Foundation, and The Nicholson Foundation supported a five-site pilot program for Centering, a group-based, relationship-based model to deliver prenatal and pediatric health care. Then, in 2022, the Burke Foundation and NJAAP partnered to launch the New Jersey Centering Alliance to support the expansion and sustainability of Centering to 50 sites throughout the state by 2026. So far, 20 sites have been awarded implementation grants through this initiative. NJAAP oversees the New Jersey Centering Alliance with support from the Centering Healthcare Institute and in partnership with the New Jersey Health Care Quality Institute.

Under the federal Health Resources and Services Administration (HRSA)'s Transforming Pediatrics for Early Childhood (TPEC) program, NJAAP was awarded a four-year cooperative agreement to support primary care transformation for prenatal-to-five populations who are covered by Medicaid (New Jersey FamilyCare) or who are uninsured. New Jersey is one of eight states selected to receive this funding. Federal TPEC awards are aimed at placing early childhood development experts in pediatric primary care, providing training and technical assistance to practices, engaging family and community leaders in systems-building efforts, and addressing financial and policy barriers to equitable service delivery. In New Jersey, the TPEC initiative will bring together a diverse group of leaders in pediatrics and obstetrics, parent advocates, and child development to improve outcomes in early development, social-emotional health, school readiness, family well-being, and health equity.

The TPEC resources in New Jersey will, in part, be used to expand HealthySteps—an evidence-based model based at ZERO TO THREE—which integrates a child-development professional (called a HealthySteps specialist) into the pediatric primary care team of a young child's medical home. This specialist connects families with additional services and community resources according to the needs and comfort of the families. HealthySteps has been shown to improve child health and well-being by supporting early development, strengthening early relationships and social-emotional development, supporting parents, and promoting timely and continued care.

In addition, New Jersey's recently approved FY 2024 budget includes $500,000 in state funds to finance expansion of the evidence-based HealthySteps program. Consistent with recommendations to increase rates for high performing medical homes, New Jersey will increase payments for providers that use HealthySteps to improve performance. The legislative language for the budget increase requires that Medicaid managed care

organizations provide an enhanced payment for well-child visit and sick-visit claims submitted for children under four years of age at provider sites using HealthySteps that measure and document meeting or being on track to meet HealthySteps model components.

Reach Out and Read New Jersey (ROR) is another evidence-based program designed to augment pediatric primary care for young children, with more than 100 program sites at clinics and doctor's offices across the state and nearly 75,000 children and their families receiving free books and other resources that promote early childhood literacy. ROR helps to promote ERH by increasing parent knowledge of how reading aloud supports brain development, reduces stress, and helps build strong foundational relationships. Conversations on this topic also help build relationships between the provider and the parent. ROR is also embedded in all the state's medical education programs for physicians in residency training. While ROR was originally designed to start at 6 months of age, New Jersey is a part of the first cohort of states now moving to launch a "Back to Birth" approach to ROR.

New Jersey is also one of the six states to receive grants under the federal Centers for Medicare and Medicaid Integrated Care for Kids (InCK) initiative launched in 2020 and continuing for seven years. New Jersey InCK is changing health care systems for families with children birth to 21 who live in Monmouth County or Ocean County and are enrolled in New Jersey Medicaid FamilyCare. It is a partnership engaging parents, local organizations, health care providers, and many others committed to building stronger, healthier communities for all. Lead organizations include: Hackensack Meridian Health (grantee), Visiting Nurse Association of Central Jersey (co-lead), New Jersey Health Care Quality Institute (co-lead), NJAAP, and Central Jersey Family Health Consortium. The co-leads have brought together a Partnership Council with a charter signed by 14 entities, including local health departments, stakeholder representatives (e.g., Family Support Organizations and the Statewide Parent Advocacy Network), Medicaid payers (e.g., New Jersey Medicaid and Amerigroup), and providers responsible for core child services. These services include physical and behavioral clinical care, schools, housing authorities, nutrition services, early care and education, child welfare, and mobile crisis response services. Community-based case management and care planning, as well as use of community health workers and varied clinical interventions are highlights of the New Jersey InCK approach. An array of programs and providers are involved in a process that brings together core child health services in a "circle of care" designed to keep children healthy and thriving.

New Jersey also uses Help Me Grow (HMG) as a free, confidential, 211 telephone access point that connects families with young children (birth to 5) with local health care and family support services. HMG works with partners to improve the quality and availability of services at the state and local level, and eliminate disparities through early childhood systems

integration. Connecting NJ is another network of partners that uses a county-based, single point-of-entry system that simplifies and streamlines the referral process for maternal and infant care providers, agencies, and families.

The state also extended postpartum coverage, meaning mother-baby pairs will both have guaranteed coverage for a full year after the end of pregnancy. This policy change permits more financing of dyadic services, beginning in primary care with screening and referrals and continuing to interventions for health and mental health needs. New Jersey's Medicaid FamilyCare covers 30 percent of births in the state.

To accelerate child health transformation and help to embed ERH principles in pediatric practices, NJAAP, New Jersey Department of Children and Families, and the Burke Foundation brought the Keystones of Development online curriculum to all nine residency programs and 12 family medicine residency programs in the state. This curriculum helps pediatricians learn to support positive parenting and promote brain development within routine well-child visits. As part of NJAAPs Healthy Spaces: Promoting ERH program, the Keystones of Development curriculum is now available to additional pediatric practices across the state through a learning collaboration that is part of NJAAPs Project ECHO (Extension of Community Health Outcomes) program. Developed at the Mount Sinai Parenting Center, research on Keystones of Development shows how it can promote children's cognitive and emotional growth by training pediatricians to provide parents and caregivers with confidence, skills, and satisfaction in parenting.

PARENT, INFANT, AND EARLY CHILDHOOD MENTAL HEALTH

The ERH policy agenda also seeks to advance and expand access to parent and infant and early childhood mental health (IECMH) services. Over the past decade New Jersey has promoted IECMH, including the support of workforce development and the use of several evidence-based models across the continuum of care. As in some other states, this work included the federally funded Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) at the state and local levels, which has been managed by the Office of Early Childhood Services in the state Department of Children and Families. As discussed above, *Keeping Babies and Children in Mind* is one example of training efforts. The Montclair Center also provides IECMH consultation services to early care and education programs across the state.

To further increase the number of IECMH professionals, the Professional Formation Center at Montclair State started a 2-year training program for community clinicians to become infant-mental-health-endorsed. This IMH endorsement is specific for ages 0-3. There are currently 22 mental health professionals in the first cohort, while cohort two has just started

with 54 clinicians. A third cohort will begin shortly and have another 60 clinicians. The Center is training mental health professionals, both infant mental health clinicians and clinicians who are part of the state's mobile response teams that respond to crises as part of their Systems of Care initiative. Previously these teams did not serve children under age 6 but now receive their own training modules and therefore are prepared to serve younger children. New Jersey is also a recipient of a federal Infant and Early Childhood Mental Health grant (authorized under the 21st Century Cures Act).

New Jersey has embraced the ERH framework and each of the eight ERH policy agendas across all sectors of its early childhood system, including a private-public strategy to advance equity, social justice, and child and family well-being.

Oregon: Leveraging Medicaid and Health Care System Innovation

Oregon has long been a leader in health care transformation, child health and development improvement efforts, and other innovations in pediatric care and early childhood system coordination. One of the latest policy improvements was to secure approval from the Centers for Medicare and Medicaid Services (CMS) to provide continuous Medicaid coverage for all children birth through age 5 (sixth birthday), using Section 1115 waiver authority. This will provide stable health coverage to 146,000 young children in Oregon during their early years of life and offers new opportunities for preventive and primary care to promote ERH.

RELATIONAL WORKFORCE: EXPANDING DOULA SERVICES

Doula services are culturally and relationally-based, healing-centered, and offer meaningful opportunities to advance early relational health. In 2011, the Oregon state legislature passed a bill to require the Oregon Health Authority to explore Medicaid coverage of doula services and by 2014, the state began coverage. While payments were initially low (e.g., reimbursing $75 for presence at labor and delivery), in 2017, the payment was raised to a $350 global payment that includes two prenatal visits, birth services, and two postpartum visits. In addition, some Medicaid coordinated care organizations (CCOs) were paying doulas more than the fee-for-service rate, and some doulas successfully negotiated higher rates (e.g., nine CCOs provided reimbursement rates between $700 and $900). In 2022, following years of advocacy, the Oregon Health Authority submitted and got approval for a State Plan Amendment to increase its Medicaid fee-for-service rate from $350 to $1500. This increased reimbursement has already resulted in an expanding doula network of providers. As an

enrolled Medicaid provider, Oregon doulas may practice and bill independently or work within an organization or clinic that bills on their behalf. In either case, under this state's approach, a licensed obstetric provider must request the services.

SERVICES TO PROMOTE ERH: INCENTIVIZING QUALITY

Oregon also has been a leader in pursuing data-driven change through a committed focus on population data and quality metrics, due to the understanding that "what you measure is what you focus on," or "what gets measured gets done." Oregon's unique and innovative Oregon Integrated Data Platform further helps inform decision making by policy makers and the public from this meaningful and longitudinal data.

Quality metrics paired with population data are driving a focus on the role that the health care system plays in ensuring children are ready for kindergarten. A key partner leading these data and change efforts in Oregon is the Oregon Pediatric Improvement Partnership (OPIP), one of the nation's 20+ child health or pediatric improvement projects. Operated from within the Department of Pediatrics at Oregon Health & Science University Doernbecher Children's Hospital, OPIP works closely with the Oregon Health Authority (OHA and the home of Medicaid) and the Children's Institute (a private non-profit advocacy organization), as well as families. By statute, the OHA contracts with 16 CCOs across the state. These 16 CCOs serve nearly 1.3 million people on the Oregon Health Plan (Oregon's Medicaid and CHIP Program), representing approximately 30 percent of the state's population. Also, the CCOs by statute are required to develop an approach for improved kindergarten readiness at a population and community level. This overarching vision has been a significant policy lever to advance innovations for upstream child and family well-being, and has galvanized state, regional, and local community initiatives, often led by CCOs.

Recognizing that a substantial share of children has health coverage within the Oregon Health Plan, OPIP has focused on data used by the state Medicaid system about children, especially data that meets the intended goal of the CCOs, which is to ensure that the children's physical, behavioral, and oral health needs, including kindergarten readiness, are met and that care is coordinated. OPIP has developed multiple measures that have been adopted into state quality metrics to improve the health and development of children at the population level: the Developmental Screening in the First Three Years of Life, the System-Level Social Emotional Health (co-developed with Children's Institute) incentive metrics for CCOs, and the Child Health Complexity measure that OHA began disseminating in 2019.

Achieving kindergarten readiness by supporting the social-emotional-mental health and development of young children, built upon the framework of ERH and the relationships in the child's life, is at the core of the work in Oregon. OPIP is leading a number of efforts

focused on family-centered, population- and community-based approaches to build health, development and resilience in young children. Their leadership has informed the development of these metrics and their use meant to improve the services that children receive. These include incentivizing screening for social-emotional development, tracking follow-up for developmental screening, promoting dyadic behavioral approaches for young children and their parents, and making visible health complexity data for children birth to 5 to design community-level solutions.

OPIP and the Children's Institute, with collaboration support from OHA, partnered with families, providers, and communities to develop the System-Level Social-Emotional Health Metric, which focused on the health care system's role in addressing social-emotional health as an essential element for achieving kindergarten readiness. This first-of-its kind metric is included in the CCO Incentive metrics. The metric intentionally focuses on the connection between social-emotional development and kindergarten readiness and requires the health care system to look at what services are being provided through the system that address early identification and issue-focused services addressing a young child's social-emotional health. This metric also gives intentional focus to advancing equity and the process includes requirements to engage populations who have been historically marginalized as a result of racism and systemic bias. As a result, the state's Medicaid financing and the CCOs who deliver care to families will be challenged and incentivized to increase prevention and services to support social-emotional development and ERH. Currently, less than 7 percent of young children aged 5 and younger who are covered by Medicaid's Oregon Health Plan receive any type of social-emotional services, despite far greater need.

The new metric was successfully piloted and then, as of January 1, 2022, the 16 CCOs started using this metric to better understand the unmet social and emotional needs of children under age 5. Working with local providers and families, CCOs are using the findings to understand and address gaps in services to support social and emotional development. The result is the development of yearly action plans that started in 2022. Financial incentives will be set in place for the CCOs who successfully complete the required activities. The CCO Action Plans developed as a result of the 2022 activities describe transformative, community-informed actions that are beginning to enhance the number of behavioral health providers that focus on children birth to five, increase family-centered closed loop pathways to these providers, and increase early identification through screening and assessments conducted in primary care.

As part of the incentive measure, the CCO must execute a number of activities and attest that these have been completed. These activities include data analysis, asset (resource) mapping, reviewing current service provision, and obtaining deliberate feedback from community partners and parents of young children that can guide and inform the planning

to improve, or enhance, available social-emotional services for young children. CCOs must also examine the services that have been provided to understand the number of children with complexity factors and adverse childhood experiences who have received social-emotional assessments and intervention. OPIP developed the **social-emotional services reach metric** which describes the proportion and number of children who receive any type of social-emotional services–from EPSDT recommended screenings and assessments to issue-focused services addressing social-emotional delays. CCOs receive a report from the OHA that provides their overall findings, and then shows the findings specific to children with health complexity. This feedback informs potential targeted areas of improvement for children with known experiences where clinical recommendations would recommend a social-emotional assessment. A key learning in the first year of implementation of this social-emotional service metric is that a majority of children with known adverse childhood experiences have not received a recommended social-emotional service. For example, only 9 percent of children from whom one or more parents have been incarcerated in a state-level prison have received any kind of social-emotional service.

The System-Level Social-Emotional metric is one piece of the four-part measurement strategy recommended by the Health Aspects of Kindergarten Readiness Workgroup for staggered adoption into the CCO Incentive Metric set. In all, three of these metrics have been included in the measures to incentivize CCOs to improve the quality of health care and outcomes for young children. The first two were adopted in 2020 to monitor and incentivize oral health visits for children 1-5 years old and well-child visits for children 3-4 years old. The System-Level Social-Emotional Health is a third incentive measure, with a fourth proposed that focuses on follow-up to developmental screening. CCOs are financially incentivized to show progress on all measures, including the social-emotional metric. As this work proceeds, Oregon's Department of Early Learning and Care continue in parallel to advance their kindergarten entry assessment (KEA) tool. Recent efforts are exploring a family/child interview, rather than a multi-domain measurement tool, as Oregon's emerging equity and family-led approach to KEA.

HIGH PERFORMING MEDICAL HOMES: MEASUREMENT TO IMPROVE PERFORMANCE

Oregon uses the **health complexity data** to support payments that encourage and advance the high performing medical homes. The measure of health complexity is the combination of measures of medical complexity and social complexity. Social complexity, as operationalized in the Oregon model, has 12 factors, which include an array of social drivers of health and adverse childhood experiences (e.g., poverty, child maltreatment, foster care, parental mental health or substance use).

Young children need advanced, team-based, high performing medical homes–especially children with elevated risks and complex conditions. Based on Oregon's Child Health Complexity data, for 134,291 children birth through age 5 enrolled in Oregon Medicaid or CHIP, only 21 percent had neither medical nor social complexity identified. For the group, 19 percent had a medical complexity and 28 percent had three or more indicators of social complexity. In all, 15 percent of these children had a combination of medical and social risks that would require additional responses in health care settings. However, based on 2021 claims data, only 4 percent of children received a social-emotional assessment, only 3 percent received a social-emotional service, and only 5 percent received an assessment and/or service.

These data are being used by CCOs and communities to guide and inform improvement efforts. For example, some CCOs have examined the data by attributed medical home and by zip code to ensure that children enrolled in Medicaid/CHIP have access to a Patient-Centered Primary Care Home (PCPCH). Measurement is a key aspect of assuring that enrolled people are receiving services that meet the PCPCH standards. Such standards, accompanied by measurement, include timely access and communication, involving patients and families as advisors, team-based care, family-centered approaches, recommended preventive services, mental/behavioral health strategies, assessment of health-related social needs, effective referral processes, and so forth. Payments from the CCOs to the PCPCH are based on a methodology that supports quality care, and a clinic/practice can achieve five different tiers of recognition. PCPCHs can use data about individual child enrollees to build enhanced care coordination, an element of a high performing medical home. By examining the data by zip code, the CCOs can also determine if they can reduce health complexity by placing more community supports and services in locations to better address the child or family needs.

These data can drive additional investments in care coordination and supports that may factor into the full array of services, needs, and barriers for children with health complexity and their families. In addition, availability of the data at a population level can inform how payment rates are set and provide an opportunity to include medical and social complexity factors in the rate-setting process. Importantly, identifying and supporting children with health complexity directly aligns with efforts to eliminate health disparities by putting the most vulnerable in the center of system redesign.

Oregon's leadership in child health transformation, driven by health complexity population data, identified risk, and need, along with its commitment to improving kindergarten readiness represents a clear understanding of the early relational health framework and the importance of driving Medicaid/CHIP policies to address ERH, social-emotional and developmental outcomes.

Washington State: Public-Private Partnerships to Leverage Medicaid's Role in Advancing ERH and IECMH

In Washington State, Medicaid is managed by the Health Care Authority (HCA), which has adopted a number of Medicaid policies that support the optimal health, development, and well-being of young children. This year, the state began extending continuous Medicaid eligibility for children from the point they become eligible (e.g., at birth) until they reach age six, regardless of income fluctuations that would affect eligibility. This change was included in their five-year Medicaid Transformation Project 1115 waiver renewal that was recently approved by CMS. The continuous enrollment is being implemented currently so when children ages birth to 6 are up for redetermination of eligibility, they will be continuously enrolled until the last day of the month before their sixth birthday.

The state of Washington has also demonstrated the impact that private philanthropy can have on moving high-level state agendas with strategic intentionality. The Perigee Fund has funded dedicated positions in the state Medicaid agency to advance ERH. These subject matter experts in ERH and IECMH have participated in the co-development and implementation of a variety of initiatives that are advancing ERH and IECMH to support positive outcomes during pregnancy/postpartum, infancy, and early childhood. This public-private initiative between the Medicaid agency and private philanthropy has proven to be a unique and powerful lever to advance ERH.

RELATIONAL WORKFORCE AND HIGH PERFORMING MEDICAL HOMES

Partnerships between child and family advocates, philanthropy, the Washington State Chapter of the American Academy of Pediatrics (WCAAP), Seattle Children's Hospital, other early childhood providers, and families have been essential to advancing an aligned policy change. In particular, the WCAAP's First Year Families, a broad, cross-stakeholder and -agency project, advanced the role of expanding the high performing medical homes for ERH and family well-being. These advocacy efforts have resulted in important legislative policy change in recent years.

In 2022, aiming to advance high performing medical homes, ERH, and children's mental health in Washington State, the WCAAP First Year Families steering committee worked with the state's Children and Youth Behavioral Health Workgroup's Behavioral Health Integration into Primary Care subgroup to make recommendations to the Legislature for Medicaid financing for **community health workers (CHWs) in pediatric primary care**. This advocacy meaningfully contributed to the Legislature passing Engrossed Substitute Senate Bill 5693, Section 211 (103). This statute directs the Medicaid agency to create a two-year grant program

to embed CHWs in primary care as an integrated part of the care team working with children and families, and to explore ongoing Medicaid reimbursement options for CHWs in primary care to support the health-related social needs of families. The legislatively supported CHW grant runs from January 2023 through January 2025. Under this grant, competitively selected primary care clinics now have CHWs within their clinics focused on the following target populations and areas of need: 1) ERH for young children birth through age 5, or 2) mental health for school aged children 5-18 in grades K-12. Half of the new ERH CHWs are designated to address the needs and supports for families with children birth to age 5, a uniquely transformative effort to promote ERH within emerging high performing medical homes.

This new cohort of ERH CHWs for pediatric primary care practices also has ongoing training in the development of their role for providing relational care coordination and family engagement. From this view, CHWs within the clinics can provide personalized and sensitive navigation support to access needed social services and provide the guidance and outreach for needed referrals and follow-up. CHWs also play a role in addressing health-related social needs through support accessing housing, transportation, food, and other services deemed as "gap-filling services." This type of relational care coordination worker is one key component of high performing medical homes. ERH CHWs are also able to provide health education to families on the importance of the various recommended screenings, including newborn screenings and other developmental screenings in the first years of life. Often the ERH CHW may actually conduct these screenings with families (i.e., development screening, Social Determinants of Health, and Adverse Childhood Experiences screens) as an important contribution to the medical home's quality services. With the lived experience and expertise that CHWs bring to their role, they can advance health equity within the practices by bringing greater and transformative cultural and linguistic understanding into the primary care team. Unique also to this initiative has been the commitment by WA Department of Health and WCAAP to offer ongoing meetings for the ERH CHWs for training and role development, including reflective practices. It is well understood that this new role in the medical home is evolving, complex, and has many demands. These facilitated meetings provide the peer support and reflective practices to ensure the success and development of this new ERH workforce that is transformative enough to achieve a high performing medical home.

Community-based doulas are another group of providers who are considered a part of the relational workforce. In 2020, the Washington State legislature instructed the Department of Health to consult with stakeholders and seek approval for Medicaid reimbursement of doula services, which resulted in the report "Methods to Secure Doula Reimbursement Approval from CMS." While Washington State passed legislation in 2022 to create a new health professional category for birth doulas, the state has not yet adopted new law implementing Medicaid coverage for doula services. In January 2023, an appropriations bill that addresses Medicaid coverage for doulas was adopted but funding has not yet been appropriated

for this benefit. State Medicaid agency staff continue to partner with doulas in WA (e.g., Doulas4all) and other stakeholders/partners with the goal of a sustainable and successful Medicaid benefit.

PARENT, INFANT, AND EARLY CHILDHOOD MENTAL HEALTH

Medicaid leaders have also been actively engaged in improving financing in recent years for a continuum of services that promote ERH and expand optimal IECMH. Current leaders and staff in the agency have both a deep commitment and knowledge about the role of Medicaid in promoting the health and well-being of young children and their families. The IECMH experts hired into the Medicaid agency with private philanthropic funding from the Perigee Fund work to design and implement a continuum of effective Medicaid financing strategies. In addition, public-private partnerships and collaboration bring ERH and IECMH representation and influence to the state's Children and Behavioral Health Workgroup.

A key piece of this work is legislation passed in 2021 that spelled out several policy changes to advance for young children enrolled in Washington's Medicaid program, known as Apple Health. The final legislation (2021 c 126 § 2) directs Medicaid to: 1) reimburse up to five sessions for child mental health assessment, 2) reimburse the travel costs of the clinician when conducting mental health assessments in the home or community sites, and 3) require mental health providers to use the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5™). In addition to mental health assessment, the state's Medicaid program also reimburses for infant and early childhood mental health treatment, including dyadic parent-child treatment. (The state also is implementing a Medicaid postpartum coverage extension to one full year, thereby creating more opportunities to finance dyadic services that promote ERH.)

The Medicaid agency recently surveyed mental health providers to better understand how they were adopting the new assessment of young children and what else needs to be done to implement the new policy. Of the providers who responded, 80 percent were implementing or planning to implement multi-session assessments, and 90 percent were implementing or planning to implement use of the DC: 0-5. Less utilized is the ability to travel to complete the mental health assessment, with only 45 percent indicating they were planning to implement this option. Overall, providers reported that these policies have made billing for IECMH services easier, increased provider competence in serving young children, and improved access to developmentally appropriate mental health services. Public-private efforts are also underway to support pediatric primary providers in their role as the anchor for the implementation of these new policies. This advanced IECMH policy adds to the continuum within the ERH policy framework for child health and mental health care in Washington.

California: Moving Upstream to Finance Services that Promote ERH

In recent years, the California Department of Health Care Services (DHCS), which administers Medi-Cal (Medicaid), has adopted new policies that improve financing for the community-based relational workforce, high performing medical homes, and the continuum of promotion, early intervention, and treatment services related to ERH and social-emotional-mental health. In addition, the state has issued new and much improved guidance for its EPSDT child health benefit, with increased attention to developmental and social-emotional concerns, and is consistent with federal EPSDT guidance calling for coverage of services that prevent, maintain, or ameliorate mental health conditions. These changes are the result of strong advocacy, technical assistance, and leadership for this Medi-Cal vision.

RELATIONAL WORKFORCE

At the same time, California has made other Medi-Cal policy changes that can improve the relational workforce. Specifically, the state added new provider categories: community health workers, doulas, and behavioral health coaches. Adopting policies that permit Medi-Cal billing by these groups of providers will help to grow and diversify the workforce available to serve families with young children in community and clinical settings.

Effective January 1, 2023, California has included doulas as providers under Medi-Cal. The state used the Medicaid-optional preventive services benefit and freestanding birth center benefit to include **doulas** as reimbursable providers (who may practice independently, as part of a group, or under a managed care plan). Consistent with the preventive services benefit, doulas must have a written recommendation from a physician or other licensed practitioner to have services covered. Prenatal, abortion-related, birth, and postpartum services are covered.

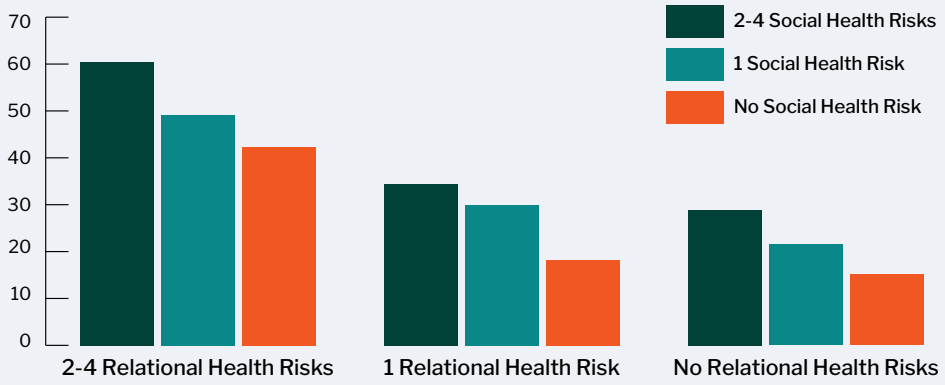
Beginning in July 2022, the Department of Health Care Services (DHCS) added **community health worker (CHW)** services as a Medi-Cal benefit. The federal Centers for Medicare and Medicaid Services (CMS) approved State Plan Amendment (SPA) 22-0001, which added CHW services as a Medi-Cal benefit. The process for design of this new benefit engaged stakeholders and secured input from providers, families, and local leaders. California used the Medicaid state option to cover CHWs as providers of preventive services with the written recommendation of a physician or other licensed practitioner of the healing arts within their scope of practice under state law. Under Medi-Cal, CHW services may address beneficiary issues that include but are not limited to: need for preventive services, perinatal health conditions, child health and development, sexual and reproductive health, control

and prevention of chronic conditions or infectious diseases, mental health conditions and substance use disorders, environmental and climate-sensitive health issues, oral health, aging, injury, domestic violence, and violence prevention. The Medi-Cal Provider Manual for the community health worker benefit has been published.

Box 2: Relational Health Risks and Social Health Risks Both Matter

As shown in Figure 2, a study using data from the National Survey of Children's Health reveals the interaction of social health risks (e.g., economic hardship, food insufficiency, neighborhood violence, and racial discrimination) and relational health risks (e.g., ACEs, poor or fair parent mental health, and high parental stress) on the mental-social-emotional-behavioral health of children ages 3-17. Nearly 7 in 10 US children ages 3-17 with mental-social-emotional-behavioral health conditions had experienced significant social or relational health risks. The prevalence of mental health conditions among US children varies fourfold, from 15 percent to 60 percent, based on their experience of social or relational risks. At the same time, children whose families had greater resilience and parent-child positive relationships were less likely to have mental health conditions. These results point to the need for more promotion, prevention, and early interventions for both social and relational risks to protect and improve the mental health of children.

Figure 2: Mental-Emotional and Behavioral Conditions Among Children 3-17, by Relational and Social Health Risks



Bethell et al. Social and Relational Health Risks and Common Mental Health Problems Among US Children. *Child Adolesc Psychiatric Clin N Am.* 2022;31: 45–70. https://doi.org/10.1016/j.chc.2021.08.001

HIGH PERFORMING MEDICAL HOME: MORE PREVENTION OF MENTAL HEALTH CONCERNS

In addition, starting in January 2023, Medi-Cal began coverage of parent-child "dyadic" preventive behavioral health care to promote child and family well-being. The design of a preventive dyadic services benefit sets a high bar for other states to follow in support of ERH. The addition of this coverage for primary care can help move toward more high performing medical homes, and improved ERH. The preventive behavioral health care is a family-focused

> *"model of care intended to address developmental and behavioral health conditions of children as soon as they are identified, and that fosters access to preventive care for children, rates of immunization completion, coordination of care, child social-emotional health and safety, developmentally appropriate parenting, and maternal mental health."*

The coverage is dyadic–for both children (aged birth to 21 years) and their parents/caregivers–and it may be billed using the child's beneficiary number. The benefit is designed to promote and prevent problems and includes but is not limited to screening for behavioral health, Adverse Childhood Experiences (ACEs), parental depression or substance use, and social determinants of health (e.g., food insecurity and housing instability). Furthermore, these promotive and preventive dyadic services may be anchored in well-child visits. This benefit also permits providers to bill for services delivered under evidence-based models in embedded primary care such as the HealthySteps model.

California is using this policy approach to promote ERH and prevent and intervene early for mental health concerns.

PARENT, INFANT, AND EARLY CHILDHOOD MENTAL HEALTH

An equally important revision to state guidance clarified that family therapy is a covered Medi-Cal benefit, including for children who are at risk for behavioral health concerns but do not have a mental health diagnosis. In California, family therapy is defined as at least two family members together receiving family therapy from a mental health provider to improve parent-child relationships and bonding, resolve conflicts, and create a safe and nurturing home environment. In addition, the state permits children to receive up to five family therapy sessions before a mental health diagnosis is required. These visits prior to a diagnosis are permitted for children and parents with risk factors for mental health disorders (e.g., separation from a parent/caregiver due to incarceration, immigration, or

death; foster care placement; food insecurity; housing instability; exposure to domestic violence; and maltreatment).

The combination of advances in Medicaid financing for the continuum of the relational workforce, advancing the elements for the high performing medical home, and intentional focus on children's mental health offers an opportunity for substantial change toward ERH services for children. The ERH policy advancements in California offer novel and breakthrough approaches that other state policy leaders can learn from.

Michigan: Relational Workforce and Provider Training on ERH

RELATIONAL WORKFORCE

The state of Michigan has had a long-standing commitment to infant and early childhood mental health (IECMH). It has one of the oldest IECMH consultation programs in the nation that supports child care programs. Medicaid financing for IECMH services also has a long history in Michigan, beginning in the 1980s, when child health leaders began to focus on IECMH with prevention dollars. The Infant Mental Health Home Visiting (IMH-HV) model has been known as an exemplar Medicaid-covered prevention model that is delivered to at-risk parents and their young children by community mental health service providers across the state.

With funding from the Michigan Health Endowment Fund, the state Department of Health and Human Services (MDHHS) has adopted an ERH framework as part of their next-generation early childhood systems efforts, using a stronger emphasis on antiracist approaches and co-creation with families. The development of an **ERH Curriculum** is intended to broaden the communication and framing to ensure that IECMH consultation services are more family-focused, culturally responsive, strengths-based, and evidence-based. Specifically, a broader focus for all families on ERH is intended to expand family engagement and rectify inequities in access to resources and opportunities created by racism, ableism, and low-income bias.

The addition of an ERH Curriculum is intended to equip mental health consultants with critical skills to recognize and address, together with families, the social, racial, cultural, and economic injustices and challenges that often take a toll on parents, young children, and their relational health. This training seeks to align ERH competencies with existing requirements across the early childhood field such as Early Head Start performance measures, Part C Child Outcomes Summary requirements, and the Infant Mental Health

Endorsement. The intention is to test this new curriculum in MI, but to eventually offer this training nationally.

The work in Michigan for ERH workforce development and support is based on a systems-level, cross-departmental collaboration that continues with a commitment to young children and families. This is perhaps best illustrated by the current performance agreement between the Michigan Department of Education (MDE, through their Office of Great Start) and the MDHHS. This interagency agreement facilitates the use of Child Care Development Fund dollars, which are administered by MDE, to MDHHS in support of a continuum of care that assists child care providers in supporting their own social and emotional well-being, as well as that of the infants, young children, and families that they serve. These funds are used to support IECMHC services, training, and coaching that supports staff well-being, as well as professional development and coaching to promote providers in implementation of social-emotional practices. In addition, all professional development opportunities are aligned with the state's infant mental health competencies and entered into a registry to support the growth of providers in attaining credit and professional endorsement in social-emotional health.

In addition, in January 2023, Governor Gretchen Whitmer announced that Michigan became one of the first states to extend supports to mothers by covering **doula services**. Michigan's Department of Health and Human Services opted to use the preventive services benefit and began implementing doula Medicaid coverage. Medicaid will finance various types of doula services, including community-based, prenatal, labor and delivery, and postpartum services when recommended by a licensed health care provider. Dr. Natasha Bagdasarian, Chief Medical Executive for the State of Michigan, took a unique and positive step by making a standing recommendation, which addresses a federal requirement by the Centers for Medicare and Medicaid Services that doula services are recommended by a licensed health care provider. She "…hereby recommend[ed] that doula services be offered immediately and on an ongoing basis to Medicaid recipients until such time as determined no longer necessary." Doulas may practice and bill independently or practice within a Medicaid managed care organization or clinic that bills on their behalf. The new policy aims to improve birth outcomes, address social determinants of health, and decrease health and racial disparities for Medicaid beneficiaries.

PARENT, INFANT, AND EARLY CHILDHOOD MENTAL HEALTH

To ensure access to a continuum of mental health services and supports for young children and their families, Michigan has developed criteria that ensures the age of the child, and their developmental issues, are understood as decisions are made. These criteria are implemented through contracts with Community Mental Health Service Providers that provide services to

children 0-3 and 4-7, and their families. These criteria include diagnosis, functional limitations, and duration symptomatology. In addition, observational tools have been identified to assess the capacity of the caregiver to provide the nurturing required for development.

Specific models for young children are supported, including home-based services, child and family therapy, respite services, wraparound services, parent support, psychiatric evaluation and medication management, and infant mental health services that are specifically prevention focused. These prevention efforts, which include direct services, are designed to reduce the need for individuals to seek treatment through the public mental health system by preventing the incidence of behavioral, emotional, or cognitive dysfunction. It should be noted that Michigan's Medicaid policy requires that providers of IMH home-based and specialty services are master's- prepared mental health professionals with specific training (Level 2 by the Michigan Association of Infant Mental Health, Level 3 preferred; and Reflective Supervision provided by endorsed individuals).

Furthermore, the needs of young children whose parent(s) may have a mental health issue are also recognized. For these children, services are available to prevent emotional-behavioral disorders if their parent is receiving services from the public mental health system. Evidence-based models to improve parenting attitudes and skills, educate parents on developmental stages of childhood (including social-emotional developmental stages), and teach positive approaches to child behavior and interventions are also utilized to support healthy social and emotional development and to remediate problem behaviors.

Michigan's systems-level work, with a focus on prevention, building the overall knowledge of the early childhood workforce in ERH and IMH, and the availability of infant mental health treatment using clinicians who have the IMH endorsement, is an exemplar in supporting young children and families. These cross-department efforts, combined with the explicit focus on equity in the system, including ongoing support from the Michigan Health Endowment Fund that supports an Early Relational Health framework with a strong emphasis on antiracist and co-created design, have enabled Michigan to make great strides in advancing multiple elements of the Early Relational Health policy agenda.

Box 3: High Performing Medical Home

For decades, the concept of a medical home has been advanced as an approach for delivery of comprehensive primary care that facilitates partnerships between patients, providers, and families. The American Academy of Pediatrics (AAP), as well as the US Department of

Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB), and the HHS Centers for Medicare and Medicaid Services (CMS) all recommend that each child–birth to age 2–have a patient/family-centered medical home. As defined by the AAP and MCHB, a pediatric medical home must be accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. While not consistently included in lists of the characteristics of a medical home, equity was identified as one of the six core dimensions of a high performing, high-quality health care system in the landmark Institute of Medicine/National Academy of Sciences report *Crossing the Quality Chasm*.

While all children should have access to a medical home, only half of children and just over one third of those in Medicaid have even a basic medical home. At the same time, low-income families with young children in Medicaid need additional support through what has recently been called a "high performing medical home" or an "advanced medical home." The high performing medical home for young children would aim to: a) provide comprehensive primary care, with well-child visits based on standards such as *Bright Futures*, b) engage families to promote ERH and optimal development, and c) support parents in responding to social determinants of health and other needs (see Figure 3).

Figure 3: High Performing Medical Homes to Advance Early Relational Health

Redesigned Well-Child Visits

- Holistic, **team-based care**
- Comprehensive **well-child visits** based on *Bright Futures* guidelines and EPSDT
- Family-centered, **strengths-based, relational**, holistic approaches
- **Recommended screening** for development, social-emotional health, maternal depression and social determinants of health (SDOH)
- Reach Out and Read as universal promotion

Relational Care Coordination

- **Routine** care coordination as part of medical home
- **Intensive care coordination** for more complex medical conditions or social risks
- **Relational care coordination staff** (e.g., community health workers, peer navigators)
- More **effective responses, completed referrals,** and **linkages** to community

Other Services and Enhanced Supports

- **Co-located programs in primary care** to promote ERH and development (e.g., DULCE, Healthy Steps, VIP)
- **Integrate mental health**
- **Families engaged** as advisors and partners
- **Referrals and/or linkages** to other services (e.g., home visiting, early intervention, dental care, early care and education, parent-child mental health therapy, nutrition programs)

Adapted from: Willis DW, Paradis N, Johnson K. The paradigm shift to early relational health: A network movement. *Zero to Three*. 2022;42(4):22-30.
Johnson K, Bruner C. *A Sourcebook on Medicaid's Role in Early Childhood: Advancing high performing medical homes and improving lifelong health*. Child and Family Policy Center. 2018.
https://www.inckmarks.org/docs/pdfs_for_Medicaid_and_EPSDT_page/SourcebookMEDICAIDYOUNGCHILDRENALL.pdf

Vermont: Accelerating ERH and High Performing Medical Homes

Vermont has had a long commitment to improving child health. It was among the first states to use its option to expand coverage to low-income children living above the poverty line. It is unique in activating a partnership between a Department of Health and Medicaid agency to maximize the coverage under the EPSDT child health benefit. And as a result, it is also the home of the Vermont Child Health Improvement Program (VCHIP), which focuses on population-based maternal and child health quality improvement and practice support programs. and is based at the University of Vermont with the support of state agencies, including the Department of Health and Medicaid agency.

HIGH PERFORMING MEDICAL HOME: USING DULCE TO PROVIDE SUPPORT TO FAMILIES WITH INFANTS

One model designed to be embedded in the medical home is Developmental Understanding and Legal Collaboration for Everyone (DULCE), a strengths-based approach to support parents of infants in the first six months of life. In a randomized controlled trial conducted at Boston Medical Center in 2010-13, DULCE demonstrated successful outcomes, including increased likelihood of completing well-child visits, reduced likelihood of visiting the emergency department, and accelerated access to concrete resources when needed. DULCE sites and practice quality improvement efforts show high levels of family engagement and effectiveness in assisting families in completing well-child visits, gaining parenting skills to promote ERH, and receiving support for concrete needs. Furthermore, family acceptance has been shown to be high, and visits with DULCE are more family-centered and more likely to result in families visiting a referral site. The Center for the Study of Social Policy considers DULCE as a model to support and promote ERH in the first six months.

Set in the pediatric practice, a DULCE Family Specialist (often a community health worker) builds a trusting relationship with families to provide parents with the help they need to promote ERH and optimal health and development. The Family Specialist is a part of an Interdisciplinary Team which also includes a medical provider, a legal partner, an early childhood system representative, a mental health representative, a project lead, and a clinic administrator. The team engages and supports the family in securing resources by reducing family stress, in turn supporting strong foundational relationships.

Vermont has made a commitment to and invested in DULCE since 2017, aiming to spread the model statewide. The effort is administered by the state's Family and Child Health

Program and currently has six pediatric practices that are implementing the DULCE model around the state. In Vermont, the Family Specialist is employed by one of 15 Parent Child Centers and is then deployed into a pediatric practice. As Parent Child Centers are community-based hubs for early childhood services, they serve as a strong anchor for DULCE teams.

Various public and private funds have been used to support these efforts. This includes state health dollars and philanthropic investments. Most of the current funding for the existing six sites has been provided through a blend of funds from the Vermont Department of Health and OneCare Vermont, the state's accountability care organization, using Medicaid financing. This funding was set to end after four years. Vermont's legislature and state leaders are supportive of the universal approach of DULCE and continue to work toward sustainable funding for DULCE and other investments in prevention.

Other State and Local Policy and Program Initiatives Designed to Enhance ERH through Economic Security

There are multiple efforts across the country that are supporting ERH through **guaranteed income programs** that support the economic security of young mothers. While there are now numerous guaranteed income initiatives across the United States, a few of these have been designed to specifically support pregnant women. The first of these efforts in the country is the Abundant Birth Project (ABP) in San Francisco. The ABP provides unconditional cash supplements to Black and Pacific Islander mothers to reduce preterm birth and improve economic outcomes for those communities. The goal of ABP is to improve maternal health and birthing outcomes by addressing material needs and providing monthly income supplements during the pregnancy and postpartum periods. The pilot launched in 2020 with public and private funds. Since the summer of 2021, participating women have been receiving $1000 each month. In December 2022, it was announced that ABP would receive $6.5 million in state and city funds to expand to four additional counties in the state (Alameda, Contra Costa, Los Angeles, and Riverside).

Similarly, in 2021, the Bridge Project launched in New York City, with 100 pregnant women in Washington Heights, Harlem, and Inwood set to receive $500-1000, unconditionally, for 36 months. This 16-million-dollar effort was funded by a private foundation. In April 2022, the program expanded to serve an additional 500 pregnant women and included East Harlem and parts of the Bronx. For the women participating in the Bridge Project, approximately half were Black and half Hispanic, and more than 70 percent had less than $100 in savings.

Philadelphia is planning to launch a guaranteed income support program for pregnant women in 2024. Known as the Philly Joy Bank, the pilot program will offer pregnant women a total of $18,000 paid out $1,000 a month during six months of pregnancy and then for a year after childbirth. The initial pilot will target 250 women living in Cobbs Creek, Strawberry Mansion, and Nicetown-Tioga, areas of the city with the highest rates of very low birth weights. The city is working to raise $6 million to launch the program and has initial commitments from private philanthropy.

A formal study funded by the National Institutes of Health and private foundations, designed to look at the causal relationship between guaranteed income supports and child development, was launched in 2018. Known as the Baby's First Years, 1000 mothers were recruited at the time of their child's birth in New York City, New Orleans, the Twin Cities, and the Omaha metropolitan area. Mothers were randomly assigned to receive a monthly cash amount of either $333 per month, or $20 per month, for the first 52 months of their child's life. Recruitment of the 1000 participants was completed in June 2019. Data on the child and family are being collected after birth and at 12, 24, 36, and 48 months of age. Very early findings, when the child reached 12 months of age, showed that the infants of mothers who had received $333 per month were more likely to show faster brain activity, in a pattern associated with learning and development.

All of these guaranteed income programs adopt a core belief that reducing the economic stress and hardship on young families decreases parental stress and thereby improves parent-child relationships, engagement, and ERH.

Conclusion

With clear evidence of the importance of strong, supportive, and nurturing relationships from the first days, weeks, and months of life, states are implementing policies to ensure their systems and programs promote the foundations for ERH and the well-being of families with young children. The use of this broad ERH policy framework with multiple and simultaneous approaches can further accelerate the pace of progress while partnering with families and communities to build a more equitable society.

Working to support these efforts and to ensure that learning from each state is shared across the country, Nurture Connection has defined a broad policy agenda that is focused on advancing equity, economic, health, and social well-being of families with young children. This agenda is not one piece of legislation nor a single program, but rather many policies and programs that collectively support families and promote ERH.

This policy agenda can serve as an ongoing guide to states that desire to increase their efforts to improve ERH through a systemic approach and with smart and informed policies. Lessons and learning from other states will surely help increase the pace of change and lead to smarter and more insightful policies in support of young children and their caregivers.

Notably, state policy and program strategies that promote ERH are not necessarily labeled as ERH. While this issue brief highlights the efforts and progress in six specific states, every state in the nation is actively engaged in supporting ERH. (See Table 1). The state-specific examples here are certainly illustrative but do not represent the totality of the work taking place to support strong relationships between young children and their families. For example, many states' efforts to transform child health care, upend child welfare services, and create a more diverse and relational workforce are not included in the table.

Whether it is broad and systemwide efforts (New Jersey), applying measurement to leverage health systems innovation (Oregon), using Medicaid to improve ERH and IECMH through public-private partnerships (Washington), moving upstream to finance services that promote ERH and IECMH such as HealthySteps (California), designing provider training and competencies related to ERH (Michigan), or accelerating ERH and high performing medical homes by implementing DULCE (Vermont), it is clear that state-level policy change that can advance ERH has momentum. Each of these examples can be used to guide similar efforts in other states and their lessons, metrics, and impacts will have far-reaching value for child health and child and family advocates across our nation.

It is expected that by this articulated baseline of progress with the ERH Policy Agenda, future policy scans will confirm progress in advancing policies that support ERH and family well-being. As usual in our US federalist system, states lead the way for innovation in child and family policy development, within broad federal guidelines.

Appendix A: State Leader Interviews

The following state leaders from the public and private sectors provided interviews that inform this work and reviewed draft summaries for their respective states. The responsibility for all content is solely that of the authors.

California

The summary of California policy in this brief is adapted from a forthcoming issue brief of the Georgetown University Center for Children and Families, entitled *Medicaid Support for Infant and Early Childhood Mental Health: Lessons from Five States*. Co-authors: Kay Johnson and Elisabeth Wright Burak. People interviewed for that process include:

- Alex Briscoe, Principal, California Children's Trust
- Sarah Crow, Managing Director, First 5 Center for Children's Policy
- Karen Moran Finello, Project Director, WestEd
- Alexandra Parma, Senior Policy Research Associate, First 5 Center for Children's Policy
- Pamela Riley, Chief Equity Officer & Assistant Deputy Director, Quality and Population Health Management, California Department of Health Care Services

Michigan

- Mary Mackrain, Director of Maternal and Child Health Programs, Education Development Center, IECMH State Consultant, Michigan Department of Health and Human Services
- Bryn Fortune, Coordinator, ERH Family Network Collaborative, Nurture Connection; and former Director, Family and Parent Leadership, Early Childhood Investment Corporation, Michigan

New Jersey

- Kim Byam, Executive Director, Reach Out and Reach New Jersey and Delaware
- Ericka Dickerson, ECCS P-3/Help Me Grow Manager, Office of Early Childhood Services, New Jersey Department of Children and Families
- Brittany Johnson, Program Director, New Jersey Chapter, American Academy of Pediatrics

- Kaitlin Mulcahy, Director, Center for Autism and Early Childhood Mental Health, Montclair State University
- Renee Nogales, Senior Program Officer, The Burke Foundation
- Atiya Weiss, Executive Director, The Burke Foundation

Oregon

- Tyson Barker, Chief Science and Innovation Officer, Institute for Child Success
- Peg King, Portfolio Manager, Child and Family Partnerships, Health Share of Oregon
- Colleen Reuland, Director, Oregon Pediatric Improvement Partnership (OPIP)
- Maureen Seferovich, Program Manager, Health Systems Integration, Health Share of Oregon

Vermont

- Breena Holmes, Vermont Child Health Improvement Program, Professor of Pediatrics, University of Vermont Larner College of Medicine
- Scott Johnson, Nonprofit Consultant, Former DULCE Statewide Coordinator; former Executive Director of the Lamoille Family Center; past chair of the Vermont Parent Child Center Network
- Ilisa Steinberg, Maternal and Child Health Director, Vermont Department of Health

Washington State

- Nikki Banks, Community Health Integration Program Manager, Clinical Quality and Care Transformation, Washington State Health Care Authority
- Christine Cole, Infant-Early Childhood Mental Health Program Manager, Washington State Health Care Authority

Nurture Connection

Johnson K, Nagle G, Willis D. *State Leadership and Policy Action to Advance Early Relational Health*. Nurture Connection. October 2023.