Maine Medical Education Trust
P.O. Box 190
Manchester, ME 04351

June 13, 2017

Suzanne Emmer
Director
Division of Chapter Quality Improvement
American Academy of Pediatrics

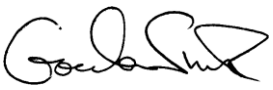
Dear Reviewers,

We are pleased to submit a grant application to the Pfizer Foundation to fund a one-year initiative to improve care for children with Attention Deficit and Hyperactivity Disorder (ADHD) called the "CALM Project: Collaborative ADHD Learning in Maine" with our partners at Maine Quality Counts, and the Maine Chapter of the American Academy of Pediatrics.

The amount of our grant request for the one year project is $150,000. The money will fund a one-year learning collaborative for eight to ten practices with 15-25 providers that includes a two-month planning period and one-month wrap-up period for evaluation and spreading lessons learned from the project.

Thank you for the opportunity to submit a proposal. We look forward to hearing from you and hope that you will agree that our proven experience in collaborating with medical practices and the greater health care community merits the awarding of this grant. Please don't hesitate to contact me with any questions.

Sincerely,



Gordon Smith, Esq.
Executive Vice President, Maine Medical Association
On behalf of the Trustees of the Maine Medical Education Trust

A. Cover Page

A.1 Title: "CALM Project: Collaborative ADHD Learning in Maine:" Maine Medical Education Trust, Maine Quality Counts, and the Maine Chapter of the American Academy of Pediatrics

A.2 Abstract

The overall aim of the CALM Project is to elevate the health of children by measurably improving the screening, diagnosis, and treatment for Attention Deficit and Hyperactivity Disorder (ADHD). By July 2018, the goal is to increase practice compliance up to 80% in the following domains: improve proper ADHD diagnosis and management so that patients are assessed for ADHD using a validated instrument across multiple major settings; parents of patients diagnosed with ADHD are given an educational ADHD booklet; and patients diagnosed with ADHD are prescribed behavior therapy.

This project will strongly align with the ADHD guidelines issued by the American Academy of Pediatrics (AAP). It also fits into the broader efforts of the AAP Task Force on Mental Health to build alliances between primary care and families to prevent and identify mental health conditions and provide early intervention.

The Maine Medical Education Trust, Maine Quality Counts (QC), and the Maine Chapter of the AAP (MAAP) propose to bring together up to 10 practice teams to work with school personnel and families in a year-long learning collaborative to improve care for ADHD. QC brings its demonstrated capacity to reach and engage health care providers and practice teams, utilize science-based quality improvement processes, and promote awareness and adoption of evidence-based best practices by clinicians, policymakers, and other stakeholders in order to improve population-based health metrics. MAAP's experience in effectively reaching and educating pediatric providers on expert content developed by the AAP makes this an ideal partnership to improve ADHD care.

B. Table of Contents

C. CALM Proposal

C.1. Goal and Objectives:

The overall aim of "CALM Project: Collaborative ADHD Learning in Maine" is to improve the health of children by measurably improving the screening, diagnosis and treatment for ADHD. By July 2018, the goal is to increase practice compliance up to 80% in the following domains for proper ADHD management: improve proper ADHD Diagnosis and management so that patients are assessed for ADHD using a validated instrument (i.e., Vanderbilt assessment scale) across multiple major settings; parents of patients diagnosed with ADHD are given an educational ADHD Booklet; and patients diagnosed with ADHD are prescribed behavior therapy. The Maine Medical Education Trust (MMET), Maine Quality Counts (QC) and the Maine Chapter of the American Academy of Pediatrics (MAAP) propose to bring together practice teams from across the state who will work together with school personnel and parents/families year-long learning collaborative to improve care for children diagnosed with ADHD.

This project will strongly align with the AAP ADHD guideline and also fits into the broader AAP Task Force on Mental Health and its efforts to build alliances between primary care and families to work to prevent and identify mental health conditions and provide early intervention (Bibliography: AAP Guidelines). The project will focus on the AAP ADHD action statements:

1) Action statement 1: The primary care clinician should initiate an evaluation for ADHD for any child 4 through age 18 years of age who presents (Bibliography: Centers for Disease Control Report) with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity. (Bibliography: AAP Guidelines)
2) Action statement 2: To make a diagnosis of ADHD, the primary care clinician should determine that DSM-IV-TR criteria have been met and information should be obtained primarily from reports from parents or guardians, teachers, and other school and mental health clinicians involved in the child's care. (Bibliography: AAP Guidelines)

The objectives for the project, noted in Model 1, are:

1) Engage a minimum of eight and up to ten primary care practices in a year-long learning collaborative that builds QI infrastructure, representing as many as 15-30 physicians and practice staff. Teams will be asked to invite a member from local schools and a parent to participate in the QI team.
2) Expose participating practices to a variety of interventions and educational strategies that highlight best practices and ADHD guidelines that have been shown to positively influence ADHD measures via the learning collaborative model.
3) Educate families around the usage of standardized tools for diagnosis and management. Improve parent education by creating an ADHD notebook that will be offered to every family when an initial diagnosis is made. This notebook will include the National Institute of Mental Health 2012 ADHD guide and other elements available in the AAP ADHD toolkit.
4) Identify parent resources for behavioral interventions and determine availability and how often behavioral therapy is recommended as the first line of treatment.
5) Provide quality improvement support and develop office workflows using standardized tools for screening and follow-up.
6) Utilize a standardized consent to share information with schools.
7) Identify sources of reimbursement for utilizing and reviewing standard tools.
8) Work with practices and health systems to reach targets for ADHD care and to promote the adoption of consistent metrics and practice guidelines.

The MMET, QC, and the MAAP are part of a strong partnership in the state of Maine that work together to improve child health quality. The MMET is the accredited provider accountable for upholding the ACCME standards. Maine Quality Counts is the home of the Maine Child Health Improvement Partnership (ME CHIP) which has informally developed into the quality improvement arm of the MAAP. QC brings its demonstrated capacity to reach and engage health care providers and practice teams, utilize science-based QI processes, and promote awareness and adoption of evidence-based best practices by clinicians, policymakers, and other stakeholders. The MAAP brings experience in effectively reaching and educating pediatric providers. This project builds on key lessons learned from recent successful child health quality initiatives in Maine between 2009 and 2017. In 2009-2010, The MAAP was part of the first AAP CQN Asthma Pilot which helped improve asthma care rates at the practice and state level. This helped jumpstart QI work in Maine with its physician leader starting MECHIP at QC so that one of Maine's leading QI organization would also have a child health focus. From 2010-2014, QC worked closely with the MAAP to implement the First STEPS Learning Collaborative (Strengthening Together Early Preventive Services) that focused on immunizations as part of Federal CHIPRA grant in Maine and Vermont. The project significantly improved the quality of care delivered by 24 primary care practices across the state of Maine and impacted the health status of more than an estimated 20,000 children between the ages of 0-5 years, and 84,000 children between the ages of 0-21 years.

Currently, QC is leading the Developmental Systems Integration (DSI), to developmental screening rates and coordination of early intervention services for children ages 0-3. Over the last four years, developmental screening rates have improved over 20% in Maine Medicaid claims data. As part of this work, QC is piloting quality improvement projects in four Maine communities working across early childhood sectors with primary care practices to improve developmental screening and close the loop on referrals to early intervention services. Lessons learned around quality improvement will be adapted for the CALM Project to improve ADHD care in order to build relationships in the community to improve access to behavioral health and parenting classes in order to support families with the management of ADHD symptoms.

C.2. Current Assessment of Need for the Project:

The partnership between QC and the MAAP brings the knowledge, experience and leadership skills needed to successfully complete this project and deliver outcomes that can be helpful to providers throughout the state who seek to improve care for patients diagnosed with ADHD. Providers in Maine have seen a dramatic increase in the number of children identified as having ADHD. According to the 2007 National Survey of Children's Health 6.5% of parents of children in Maine were told by their doctor that their child had ADHD (Bibliography: www.nschdata.org). The subsequent 2011/2012 National Survey of Children's Health reported that in Maine 11% of children aged 6 to 11 years and 11.6% of teens aged 12 to 17 currently have ADHD (Bibliography: childhealthdata.org). The Maine Children's Alliance produced the Children's Mental Health Report 2010 (Bibliography: mekids.org) and the Maine Kids Count 2017 (Bibliography: mekids.org). Data from Kids Count 2017 shows that in 2014 there were 194,198 children in Maine between the ages of 6 and 18. Extrapolating from this data suggests that there are over 21,000 children in Maine ages 6 to 18 with ADHD.

Several existing challenges to improve care for patients with ADHD in Maine include: meeting the diverse needs and characteristics of children; social, geographic and economic barriers to accessing health care; and a lack of formally-trained, board-certified developmental and behavioral health specialists in Maine. Currently, there are only six Developmental-Behavioral Pediatricians practicing in Maine. A lack of providers and the large geographic distances in Maine relative to our limited population results in variations and gaps in ADHD resulting in children not receiving the most up-to-date evidence-based care. Education for providers on basic behavioral health screening and treatment is an area of recurring need; there has not been any structured training in ADHD provided within Maine to practicing providers and primary care offices since the release of the updated AAP ADHD guidelines in 2011.

The primary care clinician should recognize ADHD as a chronic condition and, therefore, consider children and adolescents with ADHD as children and youth with special health care needs. First described by Sir George Still in 1902 (Bibliography: cdc.gov) Attention Deficit Hyperactivity Disorder is the most common neurobehavioral disorder, affecting 11% of children ages 4 to 17 in the United States which is consistent with the numbers in Maine. Children have been treated effectively with psychotropic medications for this disorder since 1936, but the treatment decisions were often based on little or no objective information. Evidence-based psychometric tools for evaluating and following children diagnosed with ADHD have been available for more than 20 years, yet their use by physicians and other providers is variable. There is concern that too many young children are being diagnosed with ADHD and subsequently being treated with medication without using appropriate screening tools.

In addition, recommendations for treatment of children with ADHD vary with age. The preschool ADHD treatment study and other research have shown that parent management training should be the first line of treatment for children with ADHD identified before age 6. Unfortunately, in Maine there is limited availability of therapists or physicians trained in evidence based parenting interventions. In this grant, the hope is to identify resources and increased availability of evidence-based behavior therapy. One of the goals of the project will be to build relationships between primary care providers and behavioral health providers within the community, so that referrals can be more seamless for families. In Central Maine, families will be connected to Triple P parent management training that is being piloted with several practices. This grant proposal advances the national ALF resolution on parenting that was proposed by Maine, abiding by current AAP guidelines on ADHD management. In 2016, at the AAP Annual Leadership Forum (ALF), the Maine Chapter submitted a resolution on parenting that was passed and set the stage for future focus by the AAP. This resolution, entitled “Evidence-Based Parent Management Training,” called for: “Be it RESOLVED that the Academy promotes and supports development and availability of evidence-based parent management training programs.” This project will raise the bar for diagnosing and treating children with ADHD and work to build infrastructure for parenting resources. QC and the MAAP want to ensure that children and families in our state get the care they need, when they need it, and where they need it.

C.3.Target Population and Recruitment

Maine has an active and committed pediatric community and we have had great success engaging our primary care providers in quality improvement activities. This project will be open

to all Pediatric practices in the state and with a specific focus on recruiting practices in Central, Northern, Midcoast, and Southern Maine. These areas are chosen because they have a large number of children with ADHD, strong AAP Physician Champions who are guiding this project, and each has access to a Pediatric Rapid Evaluation Program (PREP) so that providers can also work to improve ADHD care for children who are in foster care. PREP has four components: review medical and mental health record, assess developmental progress, psychosocial functioning and coping strategies, and make recommendations regarding foster care, mental health therapy, educational needs and further assessment.

As noted in the MaineCare 2016 Improving Health Outcomes for Children (IHOC) Measure report, "The percentage of children estimated to have attention deficit hyperactivity disorder (ADHD) continues to grow, up from 3% in 2003 to 11% in 2011 (Bibliography: Centers for Disease Control Report). This translates into more than 1 in 10 children ages 4 – 17 having been diagnosed with ADHD in 2011 (Bibliography: Centers for Disease Control Report). Estimates show that approximately 6% of children nationally take medication for ADHD. In 2011, 10.1% of children in Maine had a current diagnosis of ADHD, and 6.6% of those children were currently taking a medication for the disorder (Bibliography: Centers for Disease Control Report).

Since medications affect children differently, follow-up care for medicated children is critical for their health and well-being, as well as the treatment of their ADHD (Bibliography: IHOC). As shown in the Appendix table labeled Figure 12, children in Maine do better than the national average in getting follow-up care for ADHD: 67% are seen in follow-up at one month, and 64% at 9 months. However, Maine practices struggle to secure appropriate behavioral health and parenting interventions for children.

Using the Kids Count 2017 report, it can be estimated the burden of ADHD in different counties of the state from which to recruit pediatric practices for this project. These practices are varied in their access to behavioral health supports and will likely have a range of approaches to evaluation and management of ADHD. For example, in Kennebec County there are approximately 1815 children with ADHD. The region is supported by the Edmund N. Ervin Pediatric Center (EEPC), a Behavioral and Developmental Pediatric program staffed by a Developmental Behavioral Pediatrician, Child Psychiatrist and a team of Clinical Psychologists and social workers that provide integrated behavioral health services including parent management training to two of the three practices. The Kennebec Behavioral Health (KBH) program has a staff of three Child Psychiatrists and three Psychiatric Nurse Practitioners providing mental health services to children in the region. This organization is able to supply in-home mental health (LCSW) and case management services to parents and children with severe mental health problems. Many of these children also have ADHD.

In the Midcoast area, Sagadahoc County there are two pediatric practices that care for about 550 children with ADHD. Providers in Sagadahoc County and Southern Maine have access to Developmental–Behavioral Pediatricians in Portland but they have limited access to children's specialized behavioral health services in their region and the specialists often have long wait lists.

Finally, in Northern Maine, Penobscot County has the city of Bangor, the Eastern Maine Medical Center and the Acadia Hospital for mental health disorders. This community has a population of

nearly 21,000 children ages 6 to 18, and an estimated 2,300 with ADHD. There are two Pediatric practices supplemented by many Family Medicine physicians in this community in addition to the Key Clinic, a specialty clinic caring for children who enter into foster care. This region also has access to child psychiatry and developmental behavioral pediatrics, but the current Developmental Pediatrician is retiring, leaving a gap in specialty care. In most areas of the state, it is unfeasible to expect that these providers will be available to deliver parenting services for the area's children who are diagnosed with ADHD. There is a dire need for more psych/developmental/trained mental health providers or for more creative means to fill present gaps in the services for parenting and behavioral health. It is a much more dramatic problem in the more rural areas, but remains a systemic challenge for most of the state. All this provides justification for adding on-line resources and local resources that promote parenting and behavioral health interventions to help advance management of ADHD in children living in rural areas.

For recruitment, 15-30 physicians will be recruited to participate in 8-10 practices across the state to participate in the CALM Project. This is realistic, because although Maine is a small state with around 40 pediatric practices, between QC and MAAP, quality improvement projects typically attract 8-25 practices. Maintenance of Certification (MOC) credit and CME will be offered as an incentive. Each practice team will need to complete a pre and post office systems assessment. Practices will submit a monthly PDSA cycle and data from either chart review or from their electronic medical record. Practice teams will attend two learning sessions in October 2017 and May 2018. Practice teams will attend four educational and quality improvement webinars between learning sessions. A physician leader will be identified in each practice to be on the practice team. They will work with all providers in the practice seeking MOC to participate in monthly QI meetings in the practices, complete PDSA cycles, review monthly data, and to set aims and goals for the practice project. Practices will be expected to complete at least 80% of each requirement for physicians to quality for MOC.

C 4. Project Design and Measurement Strategy

Project Design

The first part of the project will focus on planning for the project including establishing leadership and operations staff teams and connecting with the National AAP technical assistance team. The project will engage 8 to 10 primary care practices. In order to participate, practices will be required to identify a leadership team that includes a lead provider, clinical staff, and administrative staff who serve as champions for change in the practice. QC and the AAP are very sensitive to the time restraints on providers in practice and will work to develop ways in the CALM Project to engage them that are fun, meaningful, and not overly burdensome on a providers' time. Participating practice teams will be asked to recruit a school nurse or representative from their local school-based health center, as well as a parent to participate as part of their improvement team. Including these representatives will ensure that community and family voices are present throughout the project design and implementation phases, ultimately resulting in improvements that are optimal for families.

We will use the learning collaborative model as a framework for the project. The model, adapted from the Institute for Healthcare Improvement's (IHI) Breakthrough Series model, (Bibliography: Kilo CM) is successfully used by improvement organizations across the country and around the globe and has withstood the test of time. QC and the MAAP have extensive experience using the learning collaborative model to improve child health care, including efforts to improve care for asthma, healthy weight, oral health, immunizations, and developmental screening. Practices and health systems in Maine have found this to be a useful model for change that produces results that are measurable and sustainable at the population-based level. In addition, learning collaborates are valuable to providers because they present a framework for structured learning. In the rural state of Maine where providers are geographically isolated, they have helped create a peer learning network for practices and providers that has the ability to get clinical guidelines into practices more rapidly.

The learning collaborative will convene practice teams, clinical experts and QI specialists to support practices through both in-person and virtual trainings, QI coaching, technical assistance, and monthly feedback on measures and testing. A learning work plan will be developed that combines QI and ADHD topics. Leaders from the MAAP will help develop and deliver educational content for the learning collaborative which will be guided by the work of leaders at the National AAP**.**

Areas such as how social determinants of health can affect care, parenting, and family resilience will also be highlighted. Special attention will be made on how to improve ADHD management for children in foster care. "Best practices" from the previous First STEPS learning collaborative will be applied to the work. At the beginning and the end of the learning collaborative, practices will complete an office system survey related to measure their progress. The Model for Improvement, which highlights the importance of having a clear aim, the value of using measures to track changes and testing using Plan-Do-Study-Act cycles will be used to accelerate the improvement work. Each team will have a copy of their individual and aggregate data results to review on a monthly basis. QC staff will adapt the current AAP ADHD change package for the Maine project. We will assist practices with QI technical support with phone calls, on-site visits, and electronic communications.

The project will also build on the lessons learned from the previous AAP ADHD project referenced in the RFP: "The CQN ADHD pilot project improved upon the rates found in Epstein, et al., but still found many barriers to high-quality care. Obtaining rating scales from parents and, particularly, teachers can be labor-intensive and may fall to the wayside in busy pediatric practices. Community connections with schools and behavior therapy providers are often weak. In many areas, behavior therapy is not available and, where it is available, access may be limited due to long wait-lists. Furthermore, many providers are unaware of what constitutes evidence-based behavior therapy. Pilot leaders also found that providers required significant clinical education to raise their confidence in their ability to diagnose ADHD and comorbidities, titrate medication and manage the condition long-term." (Bibliography: ADHD RFP) QC and the AAP have experience doing QI with community organizations and primary care providers through the Developmental Systems Integration Project and will work to build connections between schools and behavioral health providers in order to assist families and primary care providers and improve care coordination and early intervention.

As one of the suggested interventions, practices will work to increase their connections with behavioral health providers in order to improve outcomes for children and their families. The changes that will take place may be sustained by building quality improvement into the change process including developing workflows, training plans, and a change package. At least one targeted practice has developed a process to send Vanderbilt forms to the school and to recover them and could share this process with other teams.

As a unique part of the project, practices in Central Maine will have access to the Positive Parenting Program (Triple P) parenting model at the Edmund N. Ervin Pediatric Center at MaineGeneral Medical Center. This is a local demonstration project to implement the Triple P for patients and families. This evidence-based program has extensive literature to support its use as an effective intervention for young children with poor self-regulation and aggressive, disruptive behaviors. Triple P has been proven to decrease behavioral and emotional problems in children, and parents report feeling less stressed and less depressed in response to the program. Furthermore, the implementation of Triple P is associated with decreased rates of child abuse and foster care placement. The program equips parents with the skills and confidence to raise their children in a more nurturing and encouraging environment.

Because evidenced-based parenting programs, like Triple P, are not readily available in rural regions of Maine, the other practices will be able to take advantage on-line resources. In order to increase coaching by primary care providers to assist parents in managing some of the challenging behaviors associated with ADHD, they will have access to the tools on the *Lives in the Balance* website by Dr. Ross Greene. *Lives in the Balance* is a nonprofit organization located in Maine that is committed to helping families and communities work with children with behavioral challenges. *Lives in the Balance* has developed a website full of parent resources and is working to help pediatric providers: coach parents to better understand factors driving a child's behavior and provide tools that may influence a child's behavior in the context of a busy pediatric practice. Dr. Greene speaks and teaches all over the world and recently addressed the MAAP's spring conference.

In order to make this work sustainable, the project team will work with practices and insurers around the billing and coding of the screening tests. Currently, Maine's Medicaid provider allows billing for Vanderbilt under the 96127 code and in this project the team would investigate payment by 3rd party payers to reimburse the providers for administering and scoring the psychometric tests.

Measurement Strategy

The evaluation design will incorporate the use of mixed methodologies, including both qualitative and quantitative data guided by a composite of metrics. The project will use the measures in the RFP including and ask practices to focus on achieving an 80% rate on at least three of the five following measures:

1. Proper ADHD Diagnosis Process measure percent of patients who were assessed for ADHD using a validated instrument (i.e., Vanderbilt assessment scale) across multiple major settings.
2. Parent Diagnosis Education Process measure percent of patients diagnosed with ADHD whose physician documented giving the parent an educational ADHD Booklet.

3. Medication Titration Follow-Up Process measure percent of patients whose medication initiation is followed up by Vanderbilt assessment scales from multiple sources within 30 days.
4. Medication Maintenance Process measure percent of patients whose medication maintenance is properly monitored by multiple sets of Vanderbilt assessment scales across multiple settings.
5. Appropriate Treatment (Behavior Therapy) Process measure percent of diagnosed patients who are prescribed behavior therapy.
6. Number of families referred to Triple P program that have completed program work.

At the start of the project, some baseline ADHD data can be collected from practice Medicaid billing data from semi-annual Utilization Review Reports to see baseline claims data on medication titration and maintenance. For the project, "just in time" data on ADHD rates will be gathered at baseline and then monthly until the conclusion of the project. Practices can submit monthly data collected from measures either from their electronic medical record or from a chart review of five charts per provider and up to 20 charts per month per practice. In addition to data from medical records, monthly Plan Do Study Act cycles detailing their tests of change to improve ADHD management rates will be submitted via an online data collection system, QI Team Space, managed by the QC staff. QI Team Space is an online tool developed by partners in Utah. QC has used it to collect data on QI projects over the last three years. Once data is submitted, practices will be able to immediately view monthly metrics and run charts. QC's QI specialist will provide feedback to practices on their data and PDSA cycles. Other data to be examined will include: practices' involvement in training, learning sessions, webinars, and check-ins with the QI Coach. For the analysis, QC staff will monitor the data including office system assessments, PDSA cycles, run charts, interview results and satisfaction surveys.

C.5. Existing Projects

The Developmental Systems Integration (DSI) Project: QC leads the DSI Project whose goals is to bring together partners across early childhood sectors to focus on systems integration as a method to increase developmental screening rates for children ages 0-3. Since 2013, the DSI Steering Committee has worked to develop a strategy and plan to coordinate efforts and share results among different organizations, working toward the goals of increasing screening rates; reducing duplicate screening; ensuring that children who require further evaluation and services receive appropriate and timely follow-up care; and completing the communication loop to make sure that screening and evaluation results are communicated back to both child health care providers and referring organizations that work with children and their families. As mentioned early, in four communities, quality improvement work has been piloted across early childhood sectors to improve screening and coordination. Efforts in 2017 are focusing on exploring opportunities to use the "Help Me Grow" model of enhancing community linkages to ensure that children are connected to services early after being screened.

MAAP Foster Care Grant: This grant fortifies and sustains the recent, relevant, and successful advocacy grant track records in Maine that have sought to improve foster care (FC) services and to build resilience. This grant history adds experiential background strength to this grant, as it dovetails with specific aims to sustain and expand the scope of progress made in those two areas of pediatric care. Specifically, it helps children in FC who are at higher risk for ADHD than is the general population. The grant also furthers the theme of "Building Resilience," by incorporating services for parenting that attend to mindfulness, distress tolerance, and healthy relationships.

Triple P: The Edmund N. Ervin Pediatric Center at MaineGeneral Medical Center has a demonstration project to implement the Positive Parenting Program (Triple P) for patients and families. Triple P is an evidenced based parent management program that has been extensively researched and is applicable across cultures. Through more than 200 clinical trials, Triple P has been shown to be an effective method in managing young children with impulsive, hyperactive and disruptive behavior. Triple P has been proven to decrease behavioral and emotional problems in children, and parents report feeling less stressed and less depressed in response to the program. Children ages 2 to 12 years referred to the Edmund N. Ervin Pediatric Center for behavior therapy that present with impulsive, hyperactive, and/or disruptive behavior have the option of being enrolled in the Triple P program. If the pilot is effective, the hope is to have widespread expansion of Triple P throughout Maine.

Resilience: In 2016, the MAAP was awarded the AAP Healthy People 2020 grant from *Friends of Children* that funded a project called, "Building Intergenerational Resilience." This community collaborative engaged the MAAP, University of Maine, Eastern Maine Medical Center, Orono High School, and Gateway Seniors. Resilience was fostered in three generations of participants, by utilizing a mentoring model and by practicing techniques that promote resilience. Efforts aimed to develop mindfulness, improve distress tolerance, cultivate healthy relationships, generate gratitude, and pursue purpose. Participants were surveyed, both initially and at the conclusion, to highlight progress.

C.6. Anticipated Project Timeline (July 2017 to June 2018):

July- September 2017: Planning and Recruitment

The planning phase of the grant will focus on planning for the project including establishing a leadership team and operations staff team as well as oversight of the project convened by the partner's advisory groups. QC and MAAP staff will work closely with the National AAP and attend project calls as well as the August 4th training. The first phase (July-Sept) of the learning collaborative will focus on engaging practice teams, practices recruiting family and school representatives for their improvement teams, and introducing them to the project. QC staff will plan for and organize the learning collaborative and complete applications for CME and a Maintenance of Certification (MOC) Project for the American Board of Pediatrics. QC staff will work with the MAAP to recruit peer mentors and develop a work plan for content trainings, learning sessions, and webinars. The recruited practices will collect baseline data, complete and office system survey, and attend an introductory webinar hosted by QC. Practices will begin to submit monthly PDSA cycles and data through QI Team Space with assistance from the QI Specialist. Practices will perform a "Strengths, Weaknesses, Opportunities, and Threats (SWOT)" analysis using baseline data, the office systems survey results and team assessment results. The aim of the OSS and SWOT is to create a "big picture" of the system revealing new improvement and redesign opportunities to inform the collaborative.

October-May 2018: Learning Collaborative

In October, there will be a face to face learning session which will focus on assembling practice teams, school nurses, and families to talk about improving ADHD care. Practices will participate in four webinars that highlight different learning objectives. During this time practices will work on screenings for ADHD and messaging/scripting for providers and staff. They will also be working closely with project staff and QC's quality improvement coach to set goals for Quality Improvement within their practice and team. The MAAP will launch the peer learning network

to provide support to primary care providers around ADHD. In the beginning, a parent education guide will be developed that can be used across the practices in the state that is based on what some of the MAAP Physician leaders are using in their office. Once this is completed, practices will work to build relationships with behavioral health providers in their community. Practices will also be connected to parenting resources: those in Central Maine to *Triple P* and others to *Lives in the Balance*, an online resource.

May 2017-June 2018: Wrap Up and Spreading Lessons Learned

The last two months, will be dedicated to finalizing the project, evaluation and sustainability. The final learning session will be hosted in May where information on successes, continued challenges and plans for sustainability will be discussed. Practices will complete a post Office System Survey in May and finalize data collection. Throughout the project, QC will be working with MAAP Physician Leaders to develop a virtual CME module that will be added to the QC Learning Management system so that providers statewide can access information on best practices around ADHD "on demand." A final report with best practices for spread will be completed and presentations will discuss lessons learned as well as recommendations for best practices in the future. The QC QI specialist will work with the National AAP technical assistance team to update a change package on ADHD that will be disseminated widely.

C.7. Dissemination of Project Outcomes

Best practice information will be disseminated at the conclusion of the initiative through a final report, executive summary, a series of fact sheets and presentations highlighting the initiatives major findings. We will disseminate the results widely throughout the state and with national audiences by leveraging strong partnerships with provider organizations, community partners, and other regional health improvement initiatives across the country. Information will be disseminated through the leadership and wide array of existing education and communication channels available via QC, the MAAP, the Maine Child Health Improvement Partnership (ME CHIP) Advisory Council, leveraging our role as trusted quality leaders in the State of Maine. Materials and final reports produced from this initiative will be available just in time for the MAAP's annual conference and the results will be featured in a session presented at the conference. Information will also be available for download from QC's web site.

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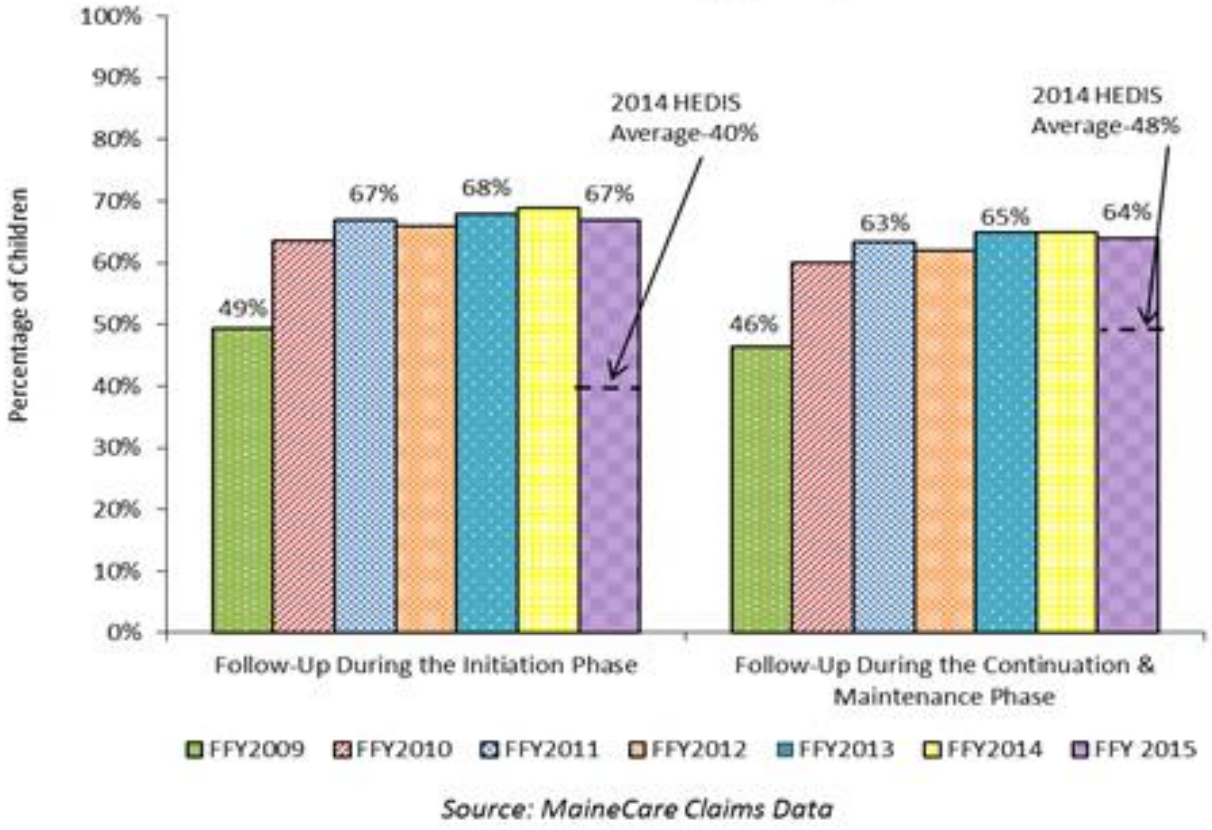
Improving Health Outcomes for Children (IHOC) Summary of Pediatric Quality Measures for Children Enrolled in MaineCare. FFY 2009 – FFY 2015, October 2016, Muskie School of Public Service, USM p. 20.

Improving Health Outcomes for Children (IHOC) Summary of Pediatric Quality Measures for Children Enrolled in MaineCare. FFY 2009 – FFY 2015, October 2016, Muskie School of Public Service, USM p. 21.

H. Appendices

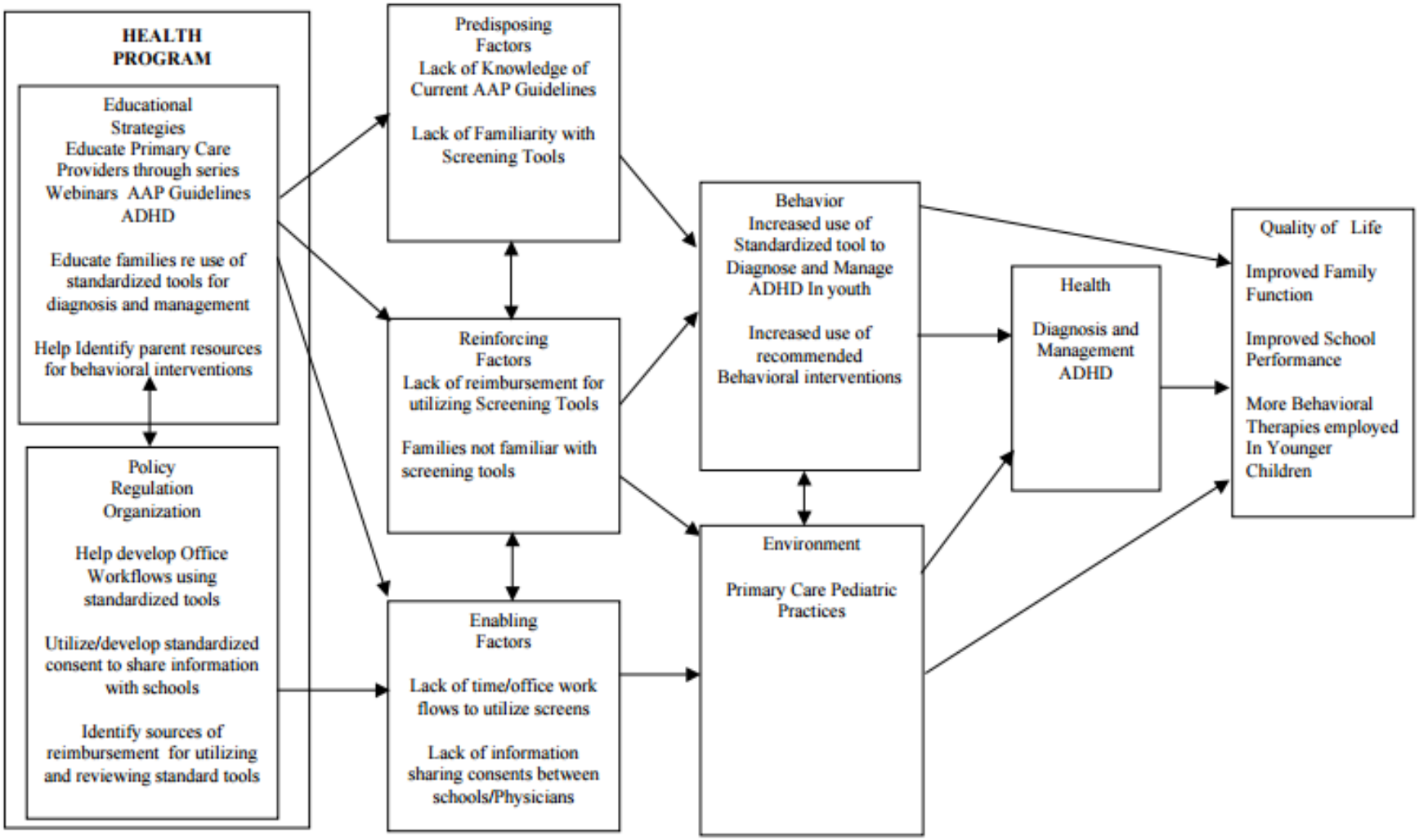
Figure 12
Follow-Up Care for Children Prescribed
ADHD medication (Ages 6-12)



Source: MaineCare Claims Data

Model 1

Table 12


HEALTH PROGRAM
Educational Strategies
Educate Primary Care Providers through series Webinars AAP Guidelines ADHD
Educate families re use of standardized tools for diagnosis and management
Help Identify parent resources for behavioral interventions
Policy Regulation Organization
Help develop Office Workflows using standardized tools
Utilize/develop standardized consent to share information with schools
Identify sources of reimbursement for utilizing and reviewing standard tools
Predisposing Factors
Lack of Knowledge of Current AAP Guidelines
Lack of Familiarity with Screening Tools
Reinforcing Factors
Lack of reimbursement for utilizing Screening Tools
Families not familiar with screening tools
Enabling Factors
Lack of time/office work flows to utilize screens
Lack of information sharing consents between schools/Physicians
Behavior
Increased use of Standardized tool to Diagnose and Manage ADHD In youth
Increased use of recommended Behavioral interventions
Environment
Primary Care Pediatric Practices
Health
Diagnosis and Management ADHD
Quality of Life
Improved Family Function
Improved School Performance
More Behavioral Therapies employed In Younger Children