Pediatric Mental Health Care Access program – HRSA -19-096
Maine Project Narrative

INTRODUCTION

1. The purpose of the proposed project is to implement a standard of care change to health care providers in Maine. It will:

1. Increase access to behavioral health care by expanding the ability of pediatric primary and specialty care providers to detect, assess, treat and refer children with behavioral health disorders;
2. Improve access to behavioral health care and other support services for children and their families;
3. Provide training for the utilization of a standardized validated screening tools to screen children and adolescents for behavioral health conditions and on referral and treatment; and
4. Create a method for ensuring that real-time psychiatric consultation and care coordination is available to pediatric primary and specialty care providers.

2.a. Maine will build on a standard of care change model that has been successfully implemented by a practice in Southern Maine. Its funding ended in 2015 and the work was not sustainable without outside funding. This opportunity allows for more consistent implementation, including strong foundational provider training and a feasible plan to maintain and expand this model after the grant funding has ended.

2.b. HRSA funding for this project will be used to complement, without duplicating other state activities with similar goals. The funding used on those activities is the Maternal and Child Health Block Grant. Maine receives $3,316,776 annually. The Title V Program is the applicant for this project. The Title V MCH Block grant supports population-level strategies focused on twelve priority areas. See **Attachment 8** for the full set of priorities. Four of the 2016–2020 MCH priorities support behavioral health for children and youth: developmental screening; bullying and youth suicide prevention; improving access to treatment for adolescents with unmet mental health needs and medical home for children and youth with special needs. HRSA-19-096 funds will help fill the behavioral health consultation and service gaps in rural and underserved communities and complement the population health policy and systems change strategies being implemented through each of the MCH priority action plans.

The Maternal and Child Health Block Grant (MCH BG) will provide 0.15 FTE of the Project Director's time. The sustainability plan will include the use of Title V funds and the required maintenance of effort funds as well as other strategies as outlined in the sustainability planning section of this proposal.

NEEDS ASSESSMENT

1. The need for behavioral health services in Maine, particularly for children and adolescents is well documented. Almost half of children/adolescents who need services do not get them, which may be attributed to limited access to providers, most specifically in rural and underserved areas. According to the American Academy of Child and Adolescent Psychiatry (AACAP) Maine had 24 child and adolescent psychiatrists per 100,000 children age 0-17 in 2018. These 24 providers

are not evenly distributed throughout the State. Child and adolescent psychiatry providers (inclusive of psychiatrists, psychiatric nurse practitioners and psychiatric physician assistants trained and working in this specialty service area) are concentrated in the southern part of the State making accessibility to people living in other parts of Maine difficult. These limitations show the need for improved care coordination and more timely access to treatment which is a reasonable distance from the client.

According to America's Health Rankings (AHR), the overall health of women and children in Maine has been worsening. In their 2016 report, the health of Maine's women and children was the 11th best in the U.S. In the 2018 report, Maine had dropped to 21st place.

The National Survey of Children's Health National Outcome Measure for the MCH Block Grant showed that 47.8% of children, ages 3 through 17, with a mental/behavioral condition needed treatment, but did not receive it. In addition, the State-level prevalence of at least one mental health disorder for Maine was 27.2% according to a recent letter published by JAMA Pediatrics.

2.a. Maine's data shows that the areas of need exist across the entire State. As mentioned above, one out of four children/adolescents in Maine has at least one behavioral health condition, yet half of them never receive services. This project will build networks of providers Statewide to increase accessibility of services either face to face or through telehealth to Maine families.

Building upon a model that was successful in one community will enable Maine to tap into existing resources, including mini-networks that have already been built. The two proposed partners, Maine Medical Center and Northern Light Acadia Hospital, will allow for the greatest reach across the State to ensure participation from any practice or provider. The proposed plan will expand the model previously used to include telehealth options both for providers and to increase access to services for clients.

2.b. The project's intended audience includes all primary and specialty care practices that serve children, including pediatric and family medicine practices across the State, with a focus on rural areas. The lead networks, Maine Medical Center and Northern Light Acadia Hospital, will recruit physicians, physician assistants and nurse practitioners to participate. In addition, psychiatrists (with specialty nurse practitioners and physician assistants) and other behavioral health providers, such as psychologists and master's level clinicians, will be linked into the project to increase awareness of the opportunities being presented through the networks to partner with primary and specialty care providers.

2.c. The proposed project will meet the unmet needs of Maine families by increasing access to behavioral health providers statewide. This will be accomplished by ensuring primary and specialty care providers are trained in screening for behavioral health disorders and feel comfortable with working with a patient who is diagnosed with one. This allows for the client to continue to receive services within their community instead of having to refer them to a provider who may be and hour or more away.

3. The two main categories of socio-cultural determinants of health and health disparities that impact the populations and communities served are 1) income/social status, which includes

transportation, food security, housing, employment, education, drug use including alcohol and tobacco and 2) access to health services relating to the prevention and treatment of disease.

Socioeconomic Status

Socioeconomic status (SES) is measured by data on income, poverty, employment, education. The extent to which one lives in areas of economic disadvantage is closely linked to overall health status. Low income status is highly correlated to a lower than average life expectancy.[i] Lack of gainful employment is linked to several barriers to care, such as lack of health insurance, inability to pay for health care services, and inability to pay for transportation to receive services. Higher education is associated with improved health outcomes and social development at individual and community levels.[ii] The health benefits of higher education typically include better access to resources, safer and more stable housing, and better engagement with providers. Proximate factors associated with low education that affect health outcomes include the inability to navigate the healthcare system, educational disparities in personal health behaviors, and exposure to chronic stress.[iii] It is important to note that, while education affects health, poor health status may also be a barrier to education. Additionally, in Maine:

- The estimated high school graduation rate increased between 2011 and 2017 from 83.8% to 86.9%
- The percent of the population over 25 with an associate's degree or higher increased between 2011 and 2016 from 35.3% to 39.9%

Table 4: Socioeconomic Status Maine, 2012–2016

	MAINE
Median household income	$50,826
Unemployment rate	3.8%
Individuals living in poverty	13.5%
Children living in poverty	17.2%
65+ living alone	45.3%

Data Source: US Census Bureau, 2012-2016

Access to health services relating to the prevention and treatment of disease is the second socio-cultural determinant at health to be discussed. People understand that when they are sick or have been diagnosed with a chronic disease they need to seek assistance from their healthcare provider or have continuous monitoring to ensure stability of their condition. However, people don't always understand or see the value in seeking preventative healthcare such as annual physicals, immunizations and screening and treatment for behavioral health conditions. Many times, seeking preventative care is too difficult because of transportation issues. Removing these barriers through telehealth services or other creative solutions can create opportunities for access and affordability to healthcare and behavioral health services.

In Maine all the previously described socio-cultural determinants of health and health disparities apply to the targeted population. Ensuring screenings are completed and referrals to accessible treatment is available are critical to the health of children and adolescents and are equally critical for creating healthy environments for them to grow up in. The end result of being a decrease in the number of adverse childhood events a person experiences in their lifetime. This project will

consider children and adolescents with private insurance, individuals served by Medicaid, as well as the underinsured and individuals without insurance.

4. Relevant barriers are described in the following table.

Relevant Barriers	**Possible Solutions**
Providers currently report that there are limited options for referring a child or adolescent who needs further evaluation from a behavioral health care provider	Care coordinators will build and maintain a list of providers who can take referrals for children or adolescents. In addition, care coordinators will connect the referring provider to a psychiatrist or other behavioral health provider for consultation when necessary.
It is reported that provider's use of depression assessment tools across the State vary.	A critical piece of this project is to provide and train participating providers on approved screening tools and provide guidance on where to refer clients in need of further evaluation. We will also work with practices to fit screening and treatment into the existing clinic workflow.
Access to psychiatric services, particularly for children and adolescents, in more remote geographic areas can be challenging for both providers and patients.	Proposed partners have already begun to implement telehealth services and MaineCare (Maine's Medicaid) already has a mechanism to reimburse providers for this service. This project will expand and enhance the infrastructure and payment models to ensure this service is sustainable after the grant period.
MaineCare's current payment model does not allow two providers to be paid at the same time for one client.	This project will support payment for providers while this issue is worked through with MaineCare to find a payment model that works.
Some behavioral health providers will not accept private insurance.	This requires further exploration.
Numerous practices across Maine serve children and adolescents and although this project proposes to serve the entire state, it will be challenging to reach all providers.	The proposed partners in this project have far reaching relationships and the mechanisms are already in place to ensure connections to a majority, if not all providers.
Access to and use of telehealth services varies among providers.	Some primary, specialty care and behavioral healthcare providers have begun incorporating telehealth into their methods of providing care. The two network leads have policies and protocols in place which they will utilize in assisting other providers who

	have not implemented telehealth capabilities in their practices.

5. Telehealth services are being utilized throughout Maine. However, not all providers in all hospital systems are using the services. MaineCare will reimburse for telehealth as long as the service meets criteria outlined in MaineCare rules. Part of the sustainability plan is to work with private and public health insurance companies to create a system in which all providers can bill for telehealth services regardless of the payor. Please note that broadband in Maine is underdeveloped. It is a priority of this administration to make broadband internet accessible to all. This initiative's success will affect the accessibility of telehealth statewide.

METHODOLGY

1.a. Maine proposes to use a framework with four major components:

1. Provide training for primary and specialty care providers so they can screen and refer clients as well as feel comfortable maintaining a child with behavioral health conditions within their practice;
2. Create a network of behavioral health providers who can take referrals and see clients in a timely manner;
3. Create a system that provides consultation and support for behavioral health concerns to primary and specialty care providers from behavioral health providers through telephone, asynchronous e-consultation (secure email and record-sharing), and telehealth video conferencing; and
4. Develop the telehealth infrastructure to make it easily available for providers who need to integrate it into their service delivery model.

Maine expects that by successfully using this model, the project will be integrated and sustained by the participating systems by the end of the four-year funding period. The methodology for achieving the goals of this project are outlined below.

- **1.b. Conduct a needs assessment.** As one of the first activities, we will assess the current landscape of behavioral health care in Maine, the specific needs among pediatric providers and their preferred mechanisms for receiving consultation, training and technical assistance. This will inform the development and implementation of both the telehealth consultation service and provider education efforts. The needs assessment will be conducted during the first six months of the project using the following methods:
    - Conduct an environmental scan of current professional development initiatives for Maine's pediatric primary and specialty care providers;
    - Conduct key informant interviews with partners currently working on pediatric behavioral health delivery; and
    - Survey pediatric primary and specialty care providers, using the professional associations as a distributor.

- **1.b. Establish mental health teams within each proposed network.** The goal of this project is to establish telehealth services for pediatric behavioral health consultation. To

do this, we will create mental health teams to ensure adequate capacity to respond to the consultation needs of Maine's pediatric primary and specialty care providers. Each mental health team will consist of a case coordinator, a child and adolescent psychiatrist, and a licensed clinical behavioral health professional with expertise in the pediatric population. Two network teams will be established to provide statewide coverage.

- **1.b. Develop and implement teleconsultation services**. During the second half of Year 1, we will develop a teleconsultation program that allows pediatric primary and specialty care providers to get real-time consultation with a specialist in pediatric behavioral health care. Teleconsultation would include the following services: telephone or video conference consultation with a child psychiatrist; consultation through asynchronous methods such as secure email and shared electronic health record; and referrals to behavioral health services and community resources through a case coordinator. The consultation will provide support on diagnosis, treatment planning and evidence-based medication treatment and medication adjustments for children and adolescents. Pediatric primary and specialty care providers will request a consultation by calling the network's care coordinator. Services will be tracked with a database that will capture information about the provider requesting services, the nature of the request, the outcome and recommended next steps. We will establish a protocol and locations for providing a direct one-time consultation with patients, either in person or through telehealth, to guide primary and specialty care provider delivery of services.

  The care coordinators in each network will be responsible for developing and maintaining a resource and referral list. The referral list will be kept up to ensure there is an accurate list of behavioral health providers who are available to provide services to referred clients.

- **1.e. Develop an online resource hub for clinical guidance.** During Year 1, we will develop a website to serve as both the project hub and an online resource library of clinical guidance, information and protocols for screening, assessing and treating pediatric behavioral health disorders. This library will include both existing evidence-based protocols and guidance (with permission to use them) and new guidance created by the project team to fill any gaps or meet specific needs of Maine pediatric providers.

- **1.d. and 1.e. Connect and collaborate with partners and providers**. We plan to do proactive vigorous outreach to providers and partners to facilitate program adoption and implementation. Below are the collaboration, outreach and partnership methods we will use:
    - **Provider outreach**. The two network leads will be responsible for reaching out to providers in the catchment area where they are assigned. We will contact professional and support organizations such as the American Academy of Pediatrics Maine chapter, the Maine Child and Adolescent Psychiatry

Association, and the Maine Primary Care Association. We will begin to promote the telehealth service and enroll practices during the second half of Year 1.

- **Payer and health plan collaborations**. We will work together with key partners MaineCare (Maine's Medicaid program) and other organizations involved in behavioral health integration. We will establish and expand partnerships that allow us to participate in health policy discussions and decisions, particularly those that concern payment models and reimbursement for behavioral health services.

- **1.f. Conduct training and provide technical assistance to pediatric primary and specialty care providers to support the early identification, diagnosis, treatment and referral of children with behavioral health conditions.** The proposed plan for ongoing training and technical assistance to pediatric primary and specialty care providers includes these elements:
  - **Training on detection, diagnosis, treatment and referral of behavioral health conditions in children**. At least quarterly, the networks will host learning opportunities face-to-face or via webinar (using a platform such as GoToMeeting or Adobe Connect). These meetings will focus general topics in pediatric behavioral health, such as how to work effectively with behavioral health providers; common behavioral health issues in the pediatric population; screening protocols and tools; talking with patients, parents and guardians about mental health; using available resources to diagnose behavioral health conditions; and creating treatment plans.
  - **Training by specialists on specific topics in pediatric behavioral health**. The project will explore using the Project Extension for Community Healthcare Outcomes (ECHO) Maine format and service for this purpose, and will determine the frequency and topics after the needs assessment. We anticipate doing 1–2 of these per year. The faculty will be specialists in the area that is the topic of the training.
  - **Peer support and learning collaboratives**.
    Twice per year, defined cohorts of participating primary and specialty care providers will come together in person or via interactive web meeting to talk about challenges and solutions. The network leads will facilitate these opportunities.
  - **Screening and diagnostic resources**
    These resources, along with other information for pediatric primary and specialty care providers, will allow engagement in self-directed and just-in-time learning about the detection, diagnosis and treatment of pediatric behavioral health conditions. We will provide access to materials and links and to other diagnostic tools specific to Maine through a website that will be developed as part of this project.

- **1.g. Advisory Committee**. We will create an advisory committee that includes staff from the Maine CDC, Office of MaineCare Services (Maine's Medicaid provider),

Office of Child and Family Services (OCFS) and Substance Abuse and Mental Health Services (SAMHS). Maine CDC partners include the Title V Director, WIC, Public Health Nursing and the Substance Abuse and Tobacco Prevention team. External partners include Maine Association of Child and Adolescent Psychiatrists, Maine Quality Counts, Maine American Academy of Pediatrics, the Maine Osteopathic Association, Maine American College of Obstetricians and Gynecologists, nurse practitioners, the Maine Medical Association, Maine Academy of Family Practices, and representatives from the two networks (Maine Medical Center and Northern Light Acadia Hospital). The Maine CDC will continue to recruit members to the Advisory Board as they are identified to be appropriate. The Advisory Committee will meet monthly and will be led by the Project Director.

- **1.h. Evaluate the project and disseminate results.** We plan to track all performance, outcome and OMB reporting metrics as required (see the Evaluation and Technical Support Capacity section and **Attachment 9** of this proposal for a detailed explanation of the evaluation plan). We will disseminate the results of the needs assessment as soon as it is compiled (approximately 6–8 months after the start of the project) and issue quarterly data reports once the telehealth service is implemented. All reports will be easily understandable and published in generally acceptable formats such as Word and PDF. Project results will be available on the website as they become available, as well as posted, when appropriate, on social media.

  To contribute our learning and knowledge to the wider community, the Maine CDC will share updates regularly with HRSA and the other grantees in the cohort. We also plan to share any clinical guidance or pathways developed as part of this project with the grant cohort as opportunities are available through HRSA's guidance. In addition, we will look for opportunities to learn from what other states have already done and what states in our cohort are doing.

2. The Maine CDC has secured State general funds to fulfill the 1:5 non-federal program matching requirement discussed in the Section III. 2., Eligibility Cost Sharing/Matching using State general fund dollars. Match dollars will be used to procure services at the network level and will be distributed in the contract. Match funds at the State level will procure items such as print materials, supplies and other educational materials in addition to federal funds. See the **budget narrative** for additional details.

3. Maine CDC, with their partners, will help to build an infrastructure in which pediatric primary and specialty care providers have access to training and technical assistance to assist them in providing the best care they can to their clients. This includes behavioral health screening, referral and treatment. In order to sustain this project after the grant funds end, Maine proposes the following strategies:

1. Work with insurance companies, including MaineCare, to examine payment structures to determine if there are opportunities to make adjustments which would allow for collaborative care billing. This could help sustain the care coordination that will be built during this project.

2. Work with MaineCare to determine a strategy that would allow more than one provider to bill for the same code for the same patient at the same time. Currently only one provider can bill for the service, however, when they are consulting with each another about the same case, they both should be able to bill.
3. Work on creating a structure which has minimal costs associated with it that can be sustained. In addition, we will examine restructuring current funding sources to absorb any associated maintenance costs.

WORK PLAN
The work plan is included in this application in table format as **Attachment 1**. Below is a summary of activities and a description of meaningful support, collaboration and coordination with key stakeholders.

1. Summary of activities
The goals of the project focus on increasing access to behavioral health care by expanding the ability of pediatric primary and specialty care providers to detect, assess, treat and refer children with behavioral health disorders; improving access to behavioral health care and other support services for children and their families; and sustaining successful interventions. The 4-Year timeline for the project can be found in **Attachment 12** and below is a summary of objectives and steps to achieve each objective of the project.

Objectives
- Objective 1.1: Increase the number of pediatric primary and specialty care providers who are aware and implement standard processes for screening and referral.
- Objective 1.2: Increase the number of children and adolescents screened for behavioral health disorders in primary care settings.
- Objective 1.3: Increase the number of referrals provided to children and adolescents who screen positive for a behavioral health disorder to the pediatric mental health team (including by telehealth).
- Objective 1.4: Increase the number of pediatric primary and specialty care providers who utilize consultations with behavioral health providers.

In partnership with the Maine CDC, the two networks will develop and disseminate training for pediatric primary and specialty care providers on how to screen, assess, treat and refer children and adolescents for behavioral health disorders. The networks will recruit providers to participate in the project, including providing technical assistance on how the clinical workflow can be tracked. Training evaluation surveys will be administered immediately after the training and again 3–6 months after training, to gain insight into barriers to implementing the training and level of comfort with implementing the protocols. In addition, yearly surveys will be administered to providers to learn about what is working and where the training gaps exist. Electronic Health Records (EHRs), claims data or other data source identified by the practices will be used to track screening; practice data sources and the teleconsultation log to track referrals and consultations will also be used.

- Objective 1.5: Increase the number of resources on the website.
- Objective 1.6: Increase the number of pediatric primary and specialty care

providers who access resources to support diagnosis and treatment planning for children and youth with behavioral health disorders.

To achieve these objectives, a website will be developed to provide resources and information to providers 24/7. The goal is to create an open access library of practice guidance and protocols for pediatric behavioral health care that can be used by all pediatric primary care and specialty providers. We will collect resources that currently exist that can be openly shared and conduct a scan to determine what gaps exists where resources would need to be developed. We will use website metrics to track use of the website and materials.

- Objective 2.1: Increase the number of children and adolescents served by providers who referred to and consulted with network behavioral health providers (including by telehealth).
- Objective 2.2: Increase the number of children and adolescents living in rural and underserved counties served by providers who referred to and consulted with network behavioral health providers (including by telehealth).
- Objective 2.3: Increase the number children in need of behavioral health treatment in a rural or underserved area who access treatment, including telehealth treatment when needed.

To achieve these objectives, the networks will work together to develop a training, communication and promotion plan for the teleconsultation service. The two networks will recruit and enroll providers into the program. In addition, the networks will recruit, hire and train care coordinators to provide the teleconsultation service, which can include referrals to behavioral health providers who can accept the patient and/or connecting the primary pediatric primary or specialty care provider to consultation as needed. Maine CDC will work with the networks to ensure security/privacy requirements for all teleconsultation methods (telephone, email and telehealth/videoconference) are in place and develop data collection tool for tracking teleconsultation encounters. Data collected will include demographic information about the patient as well as the type of service provided, how long it took to provide the service, the outcome, the diagnosis and any recommended medication. These data will be used in the evaluation of the project and meet the requirements of this grant.

- Objective 3.1: Complete all evaluation activities by 2023.
- Objective 3.2: Develop and implement a program sustainability plan by 2023.

To achieve these objectives, we are establishing a comprehensive and achievable data and evaluation plan for years two through four of this grant. The first six months of year one will be spent competitively bidding for the evaluation work which will once the contract is encumbered. The evaluation plan will be flexible enough to be able to accommodate for changes that need to happen throughout the project.

In addition, we will work with key stakeholders on the Advisory Board, and others as appropriate, to create pathways for the financial sustainability of the teleconsultation service. Possible pathways include investigating currently payment structures to identify changes that can be made to enhance sustainability or identifying alternative payment

models that create incentives for better access to behavioral health care.

3. Key Stakeholder Support and Collaboration

As the lead agency for Maine's Maternal and Child Health (MCH) Title V Block Grant, we are well-positioned to lead this project and create the necessary linkages between providers in Maine's communities. Maryann Harakall holds a key leadership role for this project as she is the Title V Director, the Children with Special Health Needs (CSHN) Director, the Principal Investigator on the Home Visiting Grant and oversees other MCH programming. She has connections both at the state level with organizations, such as American Academy of Pediatrics, Maine Chapter, and at the community level. Letters of support for this project can be found in **Attachment 7.**

Two key collaborators on this project will serve as the Network Leads. They are Maine Medical Center and Northern Light Acadia Hospital. These two agencies have assisted the Maine CDC in designing the project, either through drawing on their own experiences or working with various consultants in other states, such as Colorado. They have agreed to be project partners throughout the grant period.

The Maine Medical Center program has over 60 clinicians working in more than 70 primary care and specialty medical care practices across the MaineHealth system. BHI clinicians are placed in practices to offer focused assessment, individual and family therapy, prevention and educational services and consultation to primary care providers, office staff, and other members of the care coordination team. The Behavioral Health Clinicians (BHC's) are fully integrated into the practice systems and processes, working directly in the electronic medical record, delivering reimbursable behavioral health services, offering consultation to providers and staff re: behavioral health concerns, links patients and families to community resources including specialty mental health, and participating as a member of the care coordination team as it addresses the needs of complex and high-utilizing patients.

Referrals to the BHC can be for:

- Mental health
- Substance use treatment and
- Behavioral change around medical conditions

Psychiatry connection: BHC's receive case consultation from MMC and MBH psychiatrists and work to actively link psychiatry resources with primary care providers and their patients. This triangular connection between BHC, PCP and psychiatry partner works to strengthen the behavioral health service delivery within primary care and ensure that patients are accessing treatment at the right level of care,

Goals include: Improved behavioral health care and access to mental health care, implementation of and support for standardized screening for behavioral health conditions and clinical pathways for common conditions i.e. anxiety, depression, and help improving outcomes for patients with chronic medical conditions.

Northern Light Acadia Hospital has an Integrated Behavioral Health program which is consultative and designed to maximize patient and provider access to behavioral health expertise within outpatient medical practices. An evidence-based model of collaborative care is adapted to

most effectively serve the population of each individual practice, provider and patient. As integrated providers, principles of team based care that include shared goals, clear roles, mutual trust, and effective communication are used as guidance.

Northern Light Acadia Hospital uses on-site/telehealth experts and whose primary functions include Licensed Clinical Social Workers (LCSW) that provide mental health diagnostic clarification, evidence-based behavioral therapy for mental health and substance use, individual and group therapy, advance directives educational sessions and Psychiatric Mental Health Nurse Practitioners (PMHNP's) who provide mental health diagnostic clarification, psychiatric assessment, prescribing and monitoring psychiatric medications, treating behavioral complications of medical diagnoses and treatment.

The Northern Light Acadia Hospital team provides program implementation, guidance and operational support and works with each medical practice's information systems, legal and compliance departments to develop effective work flow and documentation. They collaborate with medical practices to innovate practical real-world solutions to bridge the care gap between behavioral health and medical care. They are trained in brief, evidence based interventions and have the capacity to provide administrative and clinical supervision and training.

Northern Light Acadia Hospital plays an important role in policy and administration by providing education to providers, administrators and the public about impact of co-occurring and underlying behavioral health and substance misuse issues, advocating for policies that educate and support patients and improve workflow for practices to provide whole patient care and effectively engaging in community, state and national conversations about public health and the role of Integrated Behavioral Health.

For the reasons mentioned above, Maine Medical Center and Northern Light Acadia Hospital are strong partners and collaborators on this project. The Maine CDC is confident that they will be able to successfully implement the project and achieve the desired outcomes. Both organizations have the infrastructure in place to begin implementing the activities as outlined in the timeline. Letters of agreement from each of the partners are in **Attachment 4**.

In addition to Maine Medical Center and Northern Light Acadia Hospital, the Maine CDC anticipates working with many community and state level organizations. We will be working with other Maine CDC programs such as Public Health Nursing and WIC to increase the number of screenings done and referred to the networks. Maine CDC also plans to include MaineCare, Substance Abuse and Mental Health Services (SAMHS) and Office of Child and Family representatives on the Advisory Board. The Maine Association of Child and Adolescent Psychiatrists, Maine American Academy of Pediatrics, Maine American College of Obstetricians and Gynecologists, nurse practitioners, the Maine Osteopathic Association, the Maine Medical Association, Maine Academy of Family Practices will be invited to participate. Letters of support are in **Attachment 7.**

4. See **Attachment 1** for a detailed work plan. See **Attachment 10** for the project logic model.

RESOLUTION OF CHALLENGES

Maine has a solid foundation on which to build this project due to the work that has already been done by partners, however, we anticipate challenges to arise along the way with implementing statewide telehealth services for pediatric mental health care and working out the logistics of creating sustainable networks. Expected challenges and proposed approaches for addressing them are discussed below.

Challenges in designing and implementing the work plan

1. The following challenges are anticipated in designing and implementing the activities:

- **Recruitment and buy-in from pediatric primary and specialty care providers.** Pediatric primary and specialty care providers provide services to over 250,000 children and adolescents in the State. Although these initiatives are meant to strengthen and equip providers to better serve their patients, sometimes it can be overwhelming as providers try to include yet one more thing into their workflows. We plan to address this challenge by ensuring that solid training is developed and disseminated through multiple mediums. This will provide greater access to all providers. During this process we intend to survey the recipients of the training to evaluate its effectiveness to identify any gaps.
- **Documentation of screening and telehealth in the Electronic Health Record (EHR)**. Mental health screening must be recorded in the EHR for both clinical and program evaluation purposes, but some practices may not have an EHR with capacity to record and store this information. We will learn from practitioners and researchers who have already addressed this challenge, and include guidance to enrolled practices about how to use the EHR for mental health screening and available billing codes. Regarding telehealth, the networks will provide guidance about documenting telehealth in the EHR, including payment structures, policies and procedures and billing codes.
- **Stigma about discussing mental health issues**. Some parents/guardians will welcome the opportunity to talk about their child's mental health challenges with a primary and specialty care provider, but some may feel shame, stigma and fear of judgment. Some may believe that mental health should not be addressed by a pediatrician. To overcome this challenge, we plan to train pediatric primary and specialty care providers not only on clinical guidance for screening, assessment and treatment, but communication skills for initiating and conducting this conversation skillfully and with sensitivity.
- **Working across healthcare systems.** Maine has four major healthcare systems, each with their own set of hospitals and providers under their respective umbrellas. Maine has a population of about only 1.3 million people. It is inevitable that the healthcare systems will compete for patients. This project intends to break through that barrier by requiring providers, regardless of which healthcare system they are affiliated with, to work together to provide services in the best interest of the client. To do this, contracts with the two networks will require them to provide network services to all providers within their assigned area. They will also be required to work with FQHCs and to take referrals for clients regardless of where the client lives. The nature of this project will require the two network leads to collaborate with one another and share resources so the referring providers receive similar care coordination from both networks. It is vital that there is a standard of care utilized statewide to ensure credibly and trust between the providers.

2. Addressing lack of behavioral health and recovery support providers

It is difficult for Mainers to access behavioral health care according to the American Academy

of Child and Adolescent Psychiatry (AACAP) as there were only 24 child and adolescent psychiatrists per 100,000 children age 0-17 in 2018. The most recent data on Maine's child and adolescent psychiatry workforce shows 5 of Maine's 16 counties have no practicing child and adolescent psychiatrist, 5 counties have a severe shortage, 5 have a high shortage and only one has a mostly sufficient supply. See **Attachment 11** for the map provided by the American Academy of Child and Adolescent Psychiatry. (http://www.aacap.org/app_themes/aacap/docs/Advocacy/federal_and_state_initiatives/workforce/individual_state_maps/Maine%20workforce%20map.pdf)

We plan to address this with two tools: teleconsultation between psychiatric specialists and local pediatric primary and specialty care providers and telehealth for direct behavioral health services for patients who cannot find appropriate care locally. This will allow access to psychiatric specialists regardless of where the client lives. It also enables the networks to balance the workload within the limited number of psychiatric providers to ensure the resources are being used to the highest and most efficient level possible.

3. Resolving organizational readiness and leadership challenges

The network leads involved in this work have already demonstrated a strong commitment to telehealth for behavioral health services. We anticipate challenges with the readiness of some of the pediatric primary and specialty care providers, however, we recognize that many of them have been implementing some of the model already. This project presents the opportunity for Maine to connect, expand and enhance the current work being done.

The Maine CDC does not anticipate any leadership challenges at the State level because there has been direct support from the Division of Disease Prevention (where this program sits within the larger organization), the Maine CDC Director and the Commissioner to apply for and implement this program. We anticipate needing to work through some challenges with the network leadership while working out logistics, as mentioned in the challenges and resolutions section, but we believe we will be able to work through whatever arises due to the strong relationships that already exist.

4. Challenges regarding liability for telehealth services

As with any health care matter, liability is also a concern for services provided by telehealth. There have long been concerns that telehealth would result in greater liability risk, but this has not been the case thus far. However, it is still important to address the unique potential liability risks for telehealth. Below are potential risks and solutions.

- **Liability insurance that does not cover telehealth**. It will be important for all providers involved in this project to have liability insurance that covers telehealth services. We will provide guidance to enrolled practices about checking and updating their liability insurance.
- **Communication issues**. Miscommunication is often at the heart of provider liability cases, including those involving incorrect diagnosis or incorrect treatment. At times, communication can be more challenging without face-to-face contact. We plan to train both the mental health teams and the health care providers on how to communicate effectively with each other using the telehealth tools so there is clear communication

of the signs and symptoms, screening results, treatment plans, medication recommendations and other information. We will also ensure that any providers who are delivering direct telehealth services are trained in how to communicate effectively with patients and overcome the potential limitations of telehealth.

- **Privacy concerns**. Any technology used in telehealth must be HIPAA compliant. We plan to address this concern by using existing tools (for example, encrypted email) that allows for HIPAA-compliant communication.

Challenges for long-term sustainability

One of the most pressing challenges for long-term sustainability of telehealth is reimbursement or payment for services. Maine has a foundation for sustaining telehealth services because Medicaid already reimburses for behavioral health services provided via telehealth. Some of our health systems and payers are already set up to facilitate telehealth services; the telehealth infrastructure continues to grow but is not yet consistently sufficient. Broadband coverage in the State continues to be an issue, however, it is one of the new administration's priorities.

The greater challenge is payment for teleconsultation services. Multiple providers cannot bill for the same service at the same time for the same client. In other words, the providers cannot bill on a fee-for-service model. We intend to investigate ways in which we can create alternative payment models that incentivize access to behavioral health care. We plan to track the number of children and adolescents served and overlay those data with the number of consultations provided to try to estimate the amount of dollars saved by using this model to show it is a worthwhile investment for MaineCare and private insurance companies.

EVALUATION AND TECHNICAL SUPPORT CAPACITY

The complete evaluation plan and project logic model are included as **Attachments 9 (Evaluation Plan) and 10 (Logic Model)**, respectively. Highlights of the plan are shown below which demonstrate our proposed methods for evaluation and capacity to collect the data required for HRSA's Pediatric Mental Health Care Access Program. The Maine team will work with HRSA on all the performance and outcome measures as outlined in the NOFO. We look forward to participating on all the evaluation activities and learning from those states who are currently working on the project and those who are funded through this opportunity.

2, 3, 4. Evaluation Plan (Goals, Activities, Measures, Data Sources)

Below is the evaluation plan for the Maine Mental Health Care Assess Program (ME MHCAP). It is organized by the three major goals of the program. Under each goal are the related activities and a table that shows the performance and outcome measures and how the data will be collected.

Goal 1: Increased timely detection, assessment, treatment and referral of children with behavioral health disorders in pediatric primary and specialty care settings.

Activities for Goal 1:

1.A: Develop and disseminate training for pediatric primary and specialty care providers on how to screen, assess, treat and refer children and adolescents for behavioral health disorders.

1.B: Administer training evaluation surveys immediately after the training and again 3–6 months after training to gain insight into barriers to implementing the training and level of comfort with implementing the protocols.

1.C: Administer surveys annually to providers to learn about what is working and where the training gaps exist.

1.D: Recruit providers to participate in the networks and provide technical assistance on how the clinical workflow can be tracked.

1.E: Utilize EHRs, claims data or other data sources identified by the practices to track screening.

1.F: Use data sources identified by the practices in conjunction with the teleconsultation log to track referrals and consultations.

1.G: Develop a website to provide resources and information to providers which is easily accessible and available 24/7.

1.H: Collect and share resources that currently exist and conduct a scan to determine what gaps exists where resources would need to be developed.

Table 1: Project Measures and Data Collection Methods and Schedule for Goal 1

ID	**Measure**	**Data Source or Collection Method**	**Time Point(s) for Data Collection**
PM-1	Number and type of training materials (e.g., case studies, diagnostic and treatment protocols) and training mechanism used (e.g., in-person, web-based).	Program records – developed from quarterly reports from the network leads	At time of info or training materials being used
PM-2	Number of trainings held, by topic and mechanism used (e.g., in-person, web-based)	Program records – developed from quarterly reports from the network leads	Upon implementation of info or training sessions
PM-3	Number and types of providers trained	Training surveys	Upon implementation of info or training sessions

PM-4	Number of consultations and referrals received by the pediatric mental health teams, by provider discipline type and telehealth mechanism.	Tele consult log	At time of communication
PM-6	Number and types of practitioners enrolled with the pediatric mental health teams.	Enrollment records	At the time of enrollment

Goal 2: Improved access for children and adolescents to behavioral health providers, including rural and medically underserved areas.

Activities for Goal 2:

2.A: The two network leads will develop a training, communication and promotion plan for the teleconsultation service.

2.B: The two network leads will recruit and enroll providers into the program.

2.C: The two network leads will recruit, hire and train care coordinators to provide the teleconsultation service, which can include referrals to behavioral health providers who can accept the patient and/or connecting the primary pediatric primary or specialty care provider to consultation as needed.

2.D: Maine CDC will work with the two network leads to ensure security/privacy requirements for all teleconsultation methods (telephone, email and telehealth/videoconference) are in place and develop data collection tool for tracking teleconsultation encounters.

2.E: Investigate current payment structures to identify changes that can be made to enhance sustainability or identify alternative payment models that create incentives for better access to behavioral health care.

Table 2: Project Measures and Data Collection Methods and Schedule for Goal 2

ID	**Measure**	**Data Source or Collection Method**	**Time Point(s) for Data Collection**
PM-5	Number of consultations and referrals provided by each member of the pediatric mental health team.	Tele consult log	At time of communication

PM-7	Reasons for provider contact with the pediatric mental health team ● Psychiatric consultation, and for what condition(s) ● Care coordination	Tele consult log	At time of communication
PM-8	Types of referrals provided by the pediatric mental health team and the extent to which such referrals are provided through telehealth (teleconsultation).	Tele consult log; EHR or claims database	At time of referral; at time of telehealth service
PM-9	Course of action to be taken by provider following contact with the pediatric mental health team.	Tele consult log	At time of communication
PM-10	Number and types of community-based mental health and support service providers in the telehealth referral database.	Report from two network leads' care coordinators' databases	Baseline within the first six months of the project, and annual measures at the end of each project year.
OM-1	Number and types of referrals provided to children and adolescents who screen positive for a behavioral health disorder [to the pediatric mental health team].	EHR or claims database	Baseline at the time of enrollment; subsequent data collected at the time the referral is made
OM-2	Number of children and adolescents served by providers who contacted the pediatric mental health teams (including by telehealth)	Provider enrollment records and tele consult logs by zip code	- Upon enrollment (# of children and adolescents served by provider) - At time of tele consult (providers who contacted program)
OM-3	Number of children and adolescents living in rural and underserved counties served by providers who contacted the pediatric mental health teams (including by telehealth)	Provider enrollment records and tele consult logs by zip code	- Upon enrollment (# of children and adolescents served by provider) - At time of tele consult (providers who contacted program)

Goal 3: Sustained strategies and interventions that are effective in improving behavioral health care access and practice.

Activities for Goal 3:
3.A: Lead the Advisory Board and facilitate monthly meetings.

3.B: Establish a comprehensive and achievable data and evaluation plan for years two through four of this grant.

3.C: Competitively bid the evaluation component.

This evaluation plan represents the efforts to measure, monitor, evaluate and sustain the Maine Mental Health Care Assess Program (ME MHCAP). See **Attachment 1** for a detailed work plan. See **Attachment 10** for the project logic model.

5. Project's anticipated value to increase mental health care access using telephone and teleconsultations

The project will add value to health care by leveraging evaluation results to: 1) increase the acceptability of telehealth and teleconsultation services among pediatric primary and specialty practices to meet the mental health care needs of children and youth; 2) identify critical components for the effective integration of psychiatric telehealth/teleconsultation and primary and specialty care to inform similar interventions; 3) establish a protocol for folding telehealth into the workflow at provider practices; 4) provide recommendations for overcoming the challenges of practice uptake of psychiatric telehealth; 5) discuss the merit of a multi-level approach for triaging and providing access to needed mental health resources; 6) provide payment structure models that can create sustainability for this and similar interventions and 6) provide evidence of how this model addresses critical gaps in psychiatric care.

ORGANIZATIONAL INFORMATION

1. Applicant organization

a. The Maine Department of Health and Human Services (DHHS) serves approximately one-third of the people of Maine, providing health care and social service support to children, families, the elderly, the disabled, people with mental illness or substance abuse issues, and the poor. The Department operates two State psychiatric hospitals; provides public health information, guidance and management through the Maine Center for Disease Control and Prevention; and provides oversight to hospitals, nursing homes and other health care entities through the Division of Licensing and Regulatory Services.

b. One staff member will be assigned to this project at the State level and multiple staff will be assigned within the network leads. The network positions include care coordinators, child and adolescent psychiatrists and licensed clinical behavioral health professionals. See the staffing plan in **Attachment 2** for full details.

Maine CDC Staff:

Project Director: Maryann Harakall, MPPM, State of Maine Title V Director and Maternal and Child Health Program Director, will be the Project Director for this project. Harakall has managed multiple federal grants including grants from HRSA, U.S. CDC and the Department of Justice. Harakall has over twelve years' experience managing public health programs as well as experience working with the Maine's procurement and accounting systems.

Maine Medical Center Staff:

Co-Project Directors (.20 FTE In-Kind): Mary Jean Mork, LCSW, VP of Integrated Programming and Heather Young, Program Manager for Child, Adolescent and Geriatric Services

The Co-Project Directors will oversee the Maine Medical Center engagement with this initiative. They will ensure rapid project launch, efficient use of federal funds and accountable monitoring of project performance. The Co-Project Directors will supervise the Project Manager and ensure collaborative and productive relationships with network stakeholders, Maine CDC and HRSA program officers. Mary Jean Mork with take the lead on project development in relation to telehealth infrastructure and link to pediatric and primary care sites. Heather Young will oversee the programmatic functions related to pediatric consultation, provider recruitment, care coordination, and the delivery of training curriculum. Throughout the project, the Co-Directors will engage with other Maine Medical Center leaders and network partners to sustain the use of telehealth technologies and care models which improve care access for children and adolescents with identified behavioral disorders. Biographical Sketches are included in Attachment 3.

Project Manager (.25 FTE): TBD

The Project Manager will coordinate project start-up and implementation activities with the MaineHealth network. The Project Manager will manage recruitment, orientation and supervision of the Care Coordinator and oversee the day to day operational engagement with network sites. S/he will ensure operational integration and integrity, consistent with project activities outlined in this proposal and best practice standards of care. The Project Manager ensures the administrative and operational needs of the project are met on-time, and as outlined in the proposal. Additional responsibilities include working with the Co-Project Directors to ensure gaps and barriers to care are identified and addressed. S/he will facilitate communication and coordination among key internal team members. In addition, the Project Manager will establish mechanisms to ensure timely data capture, performance monitoring and reporting of program indicators to assess increased access to pediatric mental health care services.

Care Coordinator (.50 FTE): TBD

The Care Coordinator will work with participating sites to establish a sustainable workflow and ensure all referrals are delivered within set parameters. The care coordinator fosters strong working relationships with key personnel at the partner sites to ensure satisfaction and creates process improvement actions as needed. The care coordinator is also responsible for creating and maintaining a resource list of available community-based mental health and support service providers, and will ensure the proper collection and reporting of referral and service utilization data.

Medical Director (.05 FTE): Robyn Ostrander

The Medical Director develops the clinical service delivery model and oversees quality and process improvement. Dr. Ostrander. will provide strategic input and thought leadership to foster enhanced clinical-community linkages which expand access to quality behavioral health care for children and their families. She will also represent Maine Medical Center on the MeCPAP Advisory Board. Dr. Ostrander's Biographical Sketch is included in Attachment 3.

Child and Adolescent Psychiatrist (.20 FTE): Amy Mayhew, M.D.,

The Child and Adolescent Psychiatrist will participate in the development of the clinical service delivery model and ensure supervision of pediatric psychiatry consults delivered through this cooperative agreement. Dr. Mayhew will contribute to the pediatric and primary care training curriculum and serve as faculty delivering best practice provider training and technical assistance.
Dr. Mayhew's Biographical Sketch is included in Attachment 3.

Director, Behavioral Health Integration (.10 FTE): Stacey Ouellette, LCSW:
The Director of Behavioral Health Integration will serve as faculty to the project, assisting with the development and delivery of training curriculum to primary care and pediatric sites. And provide technical assistance to new primary care sites, assisting with workflows, screening and assessment tools and supporting front line providers and practice managers. She will participate in the development of clinical service delivery model and ensure the assignment, supervision and support of behavioral health practitioners who will expand capacity of pediatric and primary care providers to identify, treat, and refer children. Stacey Ouellette's Biographical Sketch is included in Attachment 3.

Northern Light Acadia Hospital Staff:
Co-Project Directors: (.20 FTE In-Kind): **Richard Redmond, LCSW, AVP - Community Partnerships and Service Line Development and Chris McLaughlin, LCSW, AVP - Community and Pediatric Services**
The Co-Project Directors will oversee the Acadia Network engagement with this initiative. They will ensure rapid project launch, efficient use of federal funds and accountable monitoring of project performance. The Co-Project Directors will supervise the Project Manager and ensure collaborative and productive relationships with network stakeholders, Maine CDC and HRSA program officers. Richard Redmond will lead the telehealth infrastructure expansion, network growth and service delivery to pediatric and primary care sites. Chris McLaughlin will oversee pediatric consultation, provider recruitment, care coordination, and the delivery of training curriculum. Throughout the project, the Co-Directors will engage with other Northern Light Acadia Hospital leaders and network partners to sustain the use of telehealth technologies and care models which improve care access for children and adolescents with identified behavioral disorders. Biographical Sketches are included in **Attachment 3.**

Care Coordinator: The care coordinator will work with participating sites to establish a sustainable workflow and ensure all referrals are delivered within set parameters. The care coordinator fosters strong working relationships with key personnel at the partner sites to ensure satisfaction and creates process improvement actions as needed. The care coordinator is also responsible for creating and maintaining a resource list of available community-based mental health and support service providers, and will ensure the proper collection and reporting of referral and service utilization data.

Medical Director: (.05 FTE): **John Campbell, M.D., Chief Medical Informatics Officer and Medical Director of Community Service Lines**
The Medical Director will develop the clinical service delivery model and oversee quality and process improvement. Dr. Campbell will provide strategic input and thought leadership to foster enhanced clinical-community linkages which expand access to quality behavioral health care for

children and their families. He will also represent the Acadia Network on the MeCPAP Advisory Board. Dr. Campbell's Biographical Sketch is included in **Attachment 3.**

Child and Adolescent Psychiatrist: (.20 FTE): **Joshua Newman, M.D., Acting Medical Director, Inpatient Pediatric Psychiatry**
The Child and Adolescent Psychiatrist will participate in the development of the clinical service delivery model and ensure supervision of pediatric psychiatry consults delivered through this cooperative agreement. Dr. Newman will contribute to the pediatric and primary care training curriculum and serve as faculty delivering best practice provider training and technical assistance. Dr. Newman's Biographical Sketch is included in **Attachment 3.**

Director, Behavioral Health Integration: (.10 FTE): **Jesse Higgins, PMH-NP, Director, Integrated Behavioral Health.** The Director of Behavioral Health Integration will serve as faculty to the project, assisting with the development and delivery of training curriculum to primary care and pediatric sites. Jesse Higgins will also provide technical assistance to new primary care sites, assisting with workflows, screening and assessment tools and supporting front line providers and practice managers. She will participate in the development of clinical service delivery model and ensure the assignment, supervision and support of behavioral health practitioners who will expand capacity of pediatric and primary care providers to identify, treat, and refer children. Jesse Higgins' Biographical Sketch is included in **Attachment 3.**

c. The Title V Program resides within the Maine Center for Disease Control and Prevention (Maine CDC). Me CDC's mission is to provide the leadership, expertise, information and tools to assure conditions in which all Maine people can be healthy. Maine CDC has seven divisions which span across Disease Prevention, Disease Surveillance, Environmental and Community Health, Public Health Nursing, Public Health Operations, Public Health Systems and Epidemiology. The goals for SFY 19 are to support health care quality and safety, enforce laws and regulations, demonstrate responsible utilization of public resources, monitor health surveillance through data and engage in collaborative efforts with internal and external constituencies. See **Attachment 5:** Organization Chart.

Three of Maine CDC's seven divisions will be involved in some way in this project. Maternal and Child Health sits within the Division of Disease Prevention, as does WIC and the Substance and Tobacco Use Prevention Team. Public Health Nursing will assist with the screenings. The public health Operations Team will provide the financial management for the grant.

This project fits under four of the five goals for Maine CDC as it aims to improve health care quality and safety as a primary goal. At its core, the proposed project engages in collaborative efforts with internal and external partners and monitors health surveillance through data. Without these two activities, the project will not be successful. In the end, this project will demonstrate responsible utilization of public resources by being effective and efficient.

d. MaineCare, Maine's Medicaid program, has been utilizing telehealth in other programs and has made rule changes that provide the flexibility to providers that sustains the program. We anticipate the same thing happening throughout this project as we look at changing payment

structures that will enable this program to continue after the grant ends and to continue to improve the efficiency and effectiveness of telehealth in Maine.

e. Maine has pockets of culturally diverse populations throughout the state. This project will allow for localized and culturally competent adaptation of informational materials and education. The Maine CDC has a workgroup that focuses on health disparities which can inform these adaptations.

f. Although Maine is predominantly white, there are many communities across the state that have diverse populations, both ethnic and racial. For example, 5.1 percent of the population in Washington County is American Indian and in urban areas such as the cities of Lewiston and Portland, there is a high density of resettled refugees and immigrants from a number of countries around the world. To best serve the needs of these communities, we will rely on the local healthcare providers to assess and tailor the implementation of this project into their practices.

The Maine CDC is committed to ensuring that all Mainers have access to services. Materials and messages will be adapted to be responsive to specific populations to ensure they can be understood by any reading/education level.

g. Maine CDC will use the approved plan as guidance on what to implement and when. Program staff have a proven history of being successful in following and implementing work plans and working closely with providers to discuss any proposed changes to the plan. The Department of Health and Human Services has a Division of Contract Management (DCM) whose responsibilities include managing all contracts and procurement processes. DCM manages a database which records information about the contract and tracks payments to the providers as well as any financial reports that are required. They are also responsible for ensuring all required FFATA reporting is completed.

In addition to contract management, DHHS also utilizes a service center whose responsibility is to do the drawdowns from the federal government, track all expenses related to the grant and submit financial reports.

Both the Service Center and DCM work closely with Maine CDC but the separation of duties provides an opportunity to ensure everything is managed, tracked and reported accurately to avoid audit findings.

Maine CDC has a long history of developing, implementing and managing a statewide provider consultation, care coordination, and/or provider training programs. One successful project has been implemented by a contracted clinical professional to provide training and consultation to Maine birthing hospitals. An outreach coordinator position was created with the contracted provider and it is this positions role to provide technical assistance to any birthing hospital in Maine on topics including policies for standards of care, transports from smaller hospitals to level 2 and 3 hospitals (Maine has 2 of these), breastfeeding initiatives, safe sleep guidelines etc. When possible, this position conducts face to face meetings and trainings. These trainings and technical assistance opportunities focus on health care providers.

In addition, DHHS has implemented a performance based contracting system which enables program staff to choose performance measures that will be tracked quarterly to ensure providers are making progress towards goals. Tools are available to provide contracted partners technical assistance on reaching goals and allow program managers to effectively manage the contracts.

2. Project partner organizations

a. The Maine CDC will serve as the lead on this project. The paths of oversight and communication will include email and conference calls to ensure there is direct communication to all partners statewide. Face to face communication will take place at Advisory Board meetings and trainings. Subcontractors will be required to submit monthly progress reports and/or data as required by the grant.

b. Not applicable because the Title V MCH Program is the applicant.

c. Maine's Department of Health and Human Services has oversight of Maine CDC, MaineCare (Maine's Medicaid), the Office of Child and Family Services (OCFS), the Office of Family Independence (OFI), Substance Abuse and Mental Health Services (SAMHS), two psychiatric hospitals and the Office of Aging and Disability (OADS). The Department is managed by the Commissioner, Jeanne M. Lambrew, Ph.D. Lambrew relies on the Deputy Commissioner of Finance (Bethany Hamm) to oversee the offices as shown on the organization chart. Nancy Beardsley is the Acting Director of Maine CDC and she directly supervises the Division Director for the Disease Prevention. Maternal and Child Health falls within Disease Prevention.

The structure of DHHS is important as it is set up to function as a team. Each of the separate offices work together on various programs. One aspect that is not depicted in the organization chart is the Department's connection with the Department of Education (DOE). There are two employees at DOE, paid for by the MCH Block Grant, whose role it is to act as the liaisons between public health and education. The two positions ensure that public health messaging, specific to maternal and child health, are incorporated into health education programming. They also take advantage of educational and in-service opportunities to train school health nurses and other appropriate staff within the school systems.

d. Maine CDC has a close working relationship with the Office of MaineCare Services (OMS). This is due, in part, to the care coordination work done with children with special healthcare needs and the fact that the Medical Officer for OMS is also the Medical Officer for the MCH BG. This close relationship has enabled Maine CDC to accomplish tasks that would otherwise not be possible. For example, for many years OMS did not pay for low protein foods for their members with PKU. This past year, Maine CDC made a strong argument as to why this was important and with the help of the Medical Officer translating the public health need into a medical need, OMS has now opened a code that will allow suppliers of the low protein foods to bill OMS directly.

Maine CDC also has working relationships statewide with various agencies. Examples of those agencies include the American Academy of Pediatrics whose vision is to improve the lives of children and adolescents in Maine. They are a strong partner for Maine CDC as they are involved in an advisory capacity as well as providing connections and access to pediatricians

statewide. They have a strong interest in this project as the outcome of it will affect the lives of Maine's children. The Maine Association of Child and Adolescent Psychiatrists has submitted a letter of support and will also be participating on the Advisory Board.

Two of the main healthcare systems in Maine are also partners in this project. Their support and willingness to participate in this project is critical to its success. They have provided letters of agreement as they will be the two network leads.

e. The Project Manager will be working directly with the team who will be developing the training materials and the tool kit for providers. This work will be intense for the first 3 to 6 months of the project; however, it is the backbone for the work that will follow. Much of this work will be done virtually through conference calls and zoom meetings as the partners are spread across the state.

The project manager, network leads and the care coordinators will be in frequent contact with the psychiatrists on the project as well to ensure the trainings are happening and to implement the referral system/consulting. This contact will happen through email, conference calls and/or Advisory Board meetings.

The Advisory Board will meet monthly face to face with the option to call into a conference line. Pertinent emails will be shared with the Advisory Board as appropriate between meetings. In addition, the Advisory Board will continue to add members as appropriate to the project and create sub-committees when necessary.

In general, communications to the health care community will be shared through association newsletters and conferences. Messages will provide partners the opportunity to learn more about what the project is doing and to participate in trainings offered. In addition to working through the associations, communications will also be shared through the Department's regular communication channels, including social media, as appropriate.

---

[i] Chetty, R., Stepner, M., Abraham, S. et al. (2016). The association between income and life expectancy in the United States, 2001-2014. *Journal of the American Medical Association, 315*(16), 1750-1766.

[ii] Zimmerman, B., Woolf, S.H., & Haley, A. (2015). Population health: Behavioral and social science insights – Understanding the relationship between education and health. Retrieved from https://www.ahrq.gov/ professionals/education/curriculum-tools/ population-health/ zimmerman.html, September 2015

[iii] Zimmerman, *Population Health*