Maine SIM Initiative

Award
$33 million

Period of performance
October 1, 2013 – September 30, 2017

Pre-SIM Landscape

Patient-Centered Medical Home Model
Piloted a PCMH model with Medicaid and commercial payers in 2010; Medicare joined in 2012 through the Multi-Payer Advanced Primary Care Practice demonstration.

Health Information Exchange
HealthInfoNet, a nonprofit statewide HIE, established by executive order in 2010.

Quality Measure Public Reporting Programs
The Maine Health Management Coalition led public reporting of quality measures, including a website launched in 2011.

Plans for Delivery System Reform
Began planning Medicaid ACOs and Section 2703 HHs and BHHs prior to the SIM Initiative.

Strategies

Symbols represent strategies that build on efforts that pre-date SIM.

Expand delivery system models
Maine developed and expanded three MaineCare delivery and payment reform models: Accountable Communities, BHHs, and HHs.

Support practice transformation
Maine supported primary care and behavioral health providers with in-person learning sessions, site visits, telephone assistance, webinars, and a newsletter.

Expand and develop workforce
Maine expanded the number of diabetes prevention lifestyle coaches, trained providers on the needs of individuals with development disabilities, and piloted a community health worker initiative.

Connect BHHs to the HIE
Maine helped connect behavioral health providers to the HIE to facilitate the exchange of physical and behavioral health data between providers.

Employ data analytics for care management
Maine supported development of event notifications, clinical data dashboards, and risk prediction tools for MaineCare care managers.

Reach

Maine's BHH model reached 4% of the state's total Medicaid population, and the Accountable Communities model reached 20% of this population.

BHHs/HHs
as of September 2017

4% BHHs

18% HHs

Medicaid
21% of state population

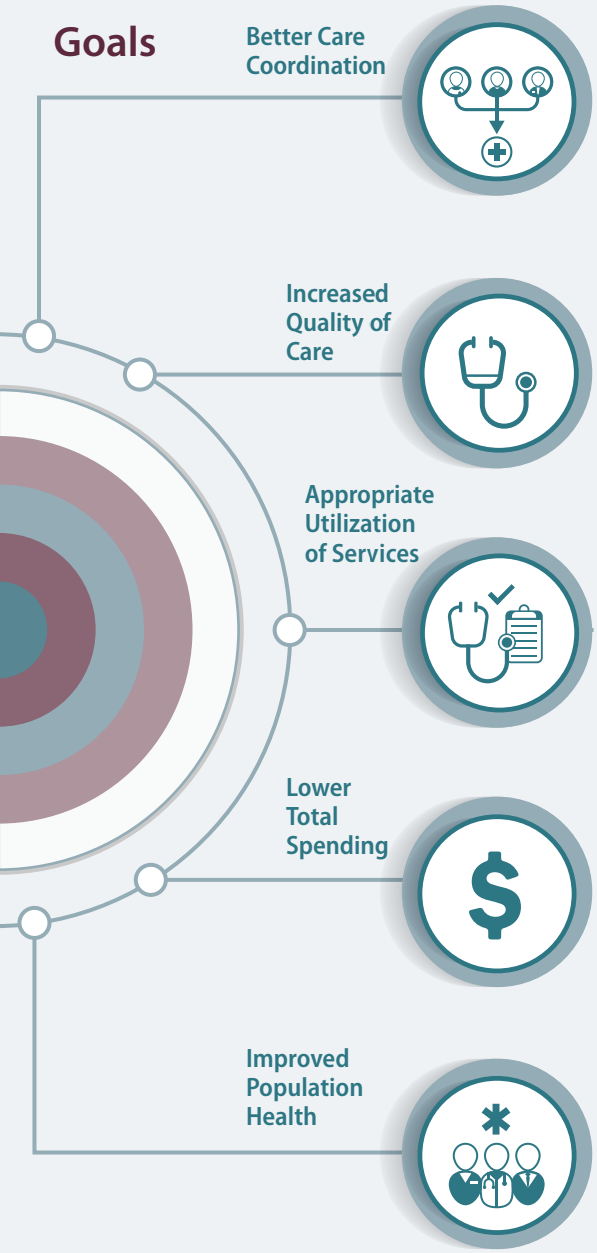
Accountable Communities
as of July 2017

20%

ACO = Accountable Care Organization; BHH = behavioral health home; HH = health home; HIE = health information exchange; PCMH = patient-centered medical home

Impact on Medicaid Population

✅ = Improved from pre- to post-period (BHH) / performed better than the CG (AC)
❌ = Worsened from pre- to post-period (BHH) / performed worse than the CG (AC)
⚫ = No statistically significant change



Goals	BHH	Accountable Communities
Better Care Coordination	✅ Primary care provider visits ✅ Specialty provider visits ⚫ 30-day follow after mental illness hospitalization Increased visits aligned with expectations around care coordination and connecting patients to appropriate resources.	❌ Primary care provider visits The decreased physician visit rate may indicate that AC providers reduced unnecessary outpatient care, but some increases were expected due to AC preventive care measures. ❌ Specialty provider visits ⚫ 30-day follow after mental illness hospitalization
Increased Quality of Care	✅ Antidepressant medication management ❌ Hba1c testing	⚫ Antidepressant medication management ⚫ Hba1c testing
Appropriate Utilization of Services	⚫ ED visits ⚫ Inpatient admissions Efforts to connect patients to timely, needed mental health services may have necessitated inpatient hospital care. ⚫ 30-day readmissions	✅ ED visits ✅ Inpatient admissions ⚫ 30-day readmissions
Lower Total Spending	❌ Inpatient PBPM spending ❌ Total PBPM spending Expenditures may increase as patients connect with needed services. ⚫ Professional PBPM spending	⚫ Inpatient PBPM spending ⚫ Professional PBPM spending ⚫ Total PBPM spending Year Two results were generally more positive than Year One results, suggesting that the AC model may become more effective over time.
Improved Population Health	Under the SIM initative, Maine expanded the National Diabetes Prevention Program by funding the training of 133 lifestyle coaches. Maine also piloted community health workers within primary care practices and health systems at four project sites.	

Limitations

Because the BHH pre-post analysis does not have a CG, results may be impacted by factors other than true changes in outcomes for the BHH population (e.g., secular trends, unobserved changes in the population, the tendency for values to go towards the mean).

Lessons Learned

- ☑ Technical assistance and access to health IT and data analytics tools helped primary care and behavioral health providers transform care in HH and BHH models.
- ☑ Primary care and behavioral health providers relied on real-time EHR and HIE data for care management.
- ☑ Continuous quality improvement was a guiding principle that shaped Maine's SIM activities.
- ☑ Maine refocused SIM Initiative priorities when necessary to ensure efficient and effective use of SIM funding.

AC = Accountable Communities; BHH = behavioral health home; CG = comparison group; ED = emergency department; EHR = electronic health record; HH = health home; HIE = health information exchange; PBPM = per beneficiary per month