Statewide Rational Service Areas Listening Session

Prepared by

Rural Health and Primary Care Program

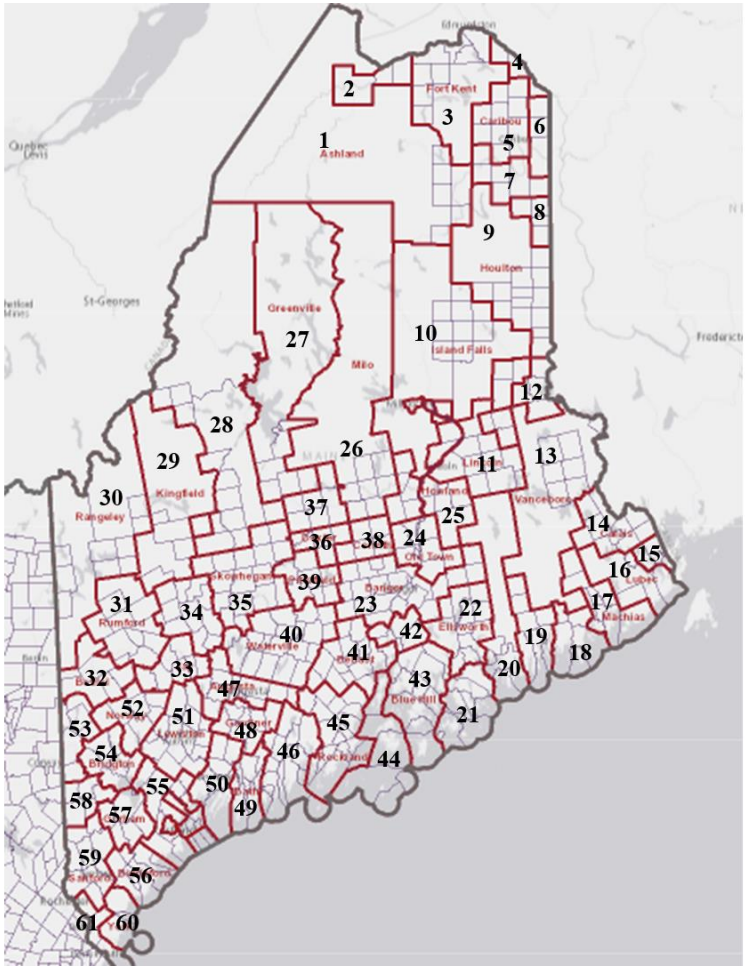
JSI

The Rural Health and Primary Care Program is a Program within the Division of Public Health Systems of the Maine Center for Disease Control and Prevention which is an Office of the Maine Department of Health and Human Services.

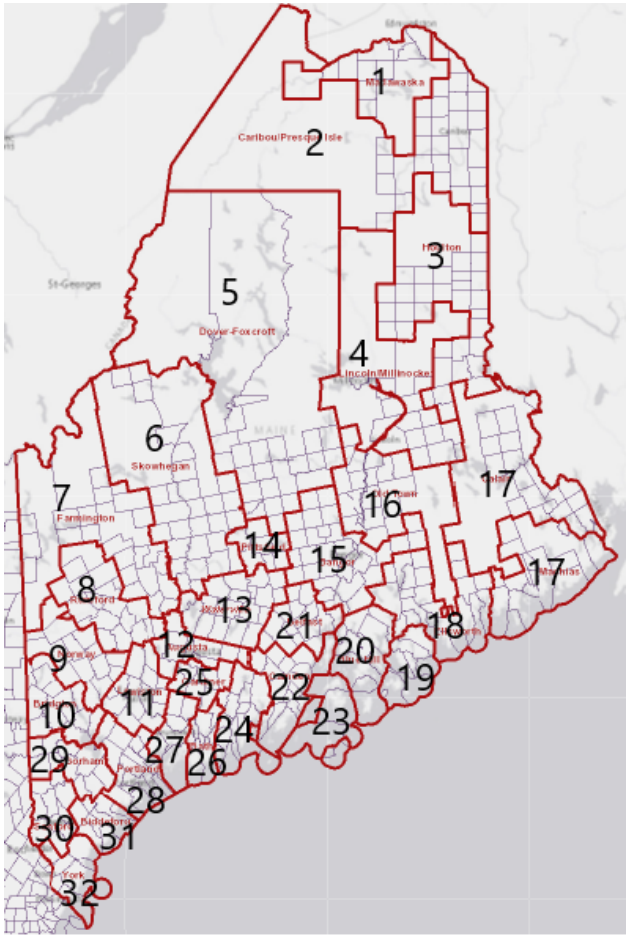
Background

- Maine is one of a handful of states that currently has an approved SRSA plan
- Enacted decades ago

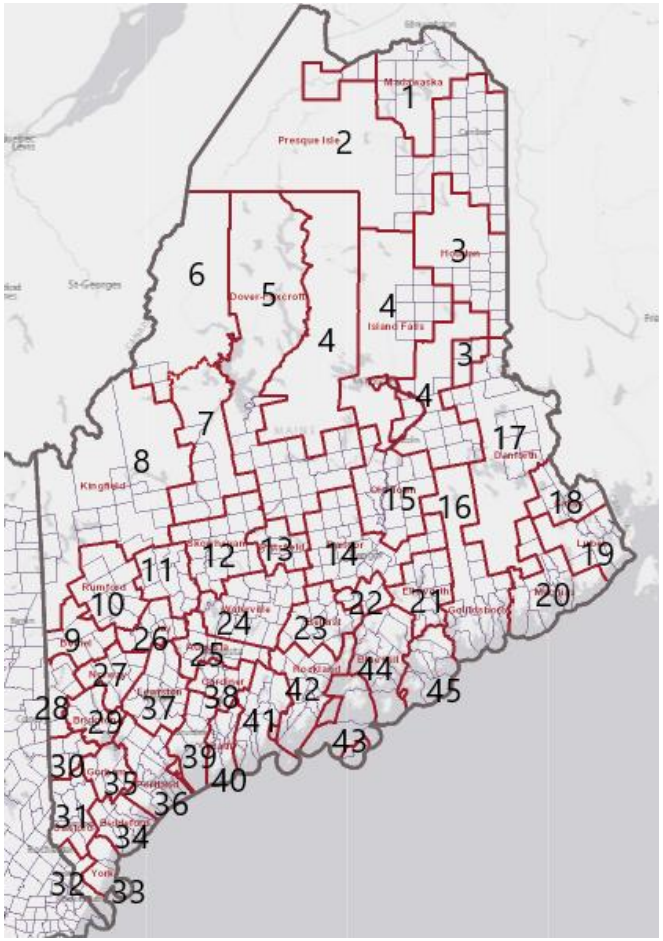
Primary Care



Mental Health



Dental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SRSA Updates

- Review required per Primary Care Office grant
- Provides the opportunity to analyze current capacity at the provider and community level to inform the validity of Maine's previously established Rational Service Areas

SRSA JSI Team

- Eric Turer
- Diane Lewis
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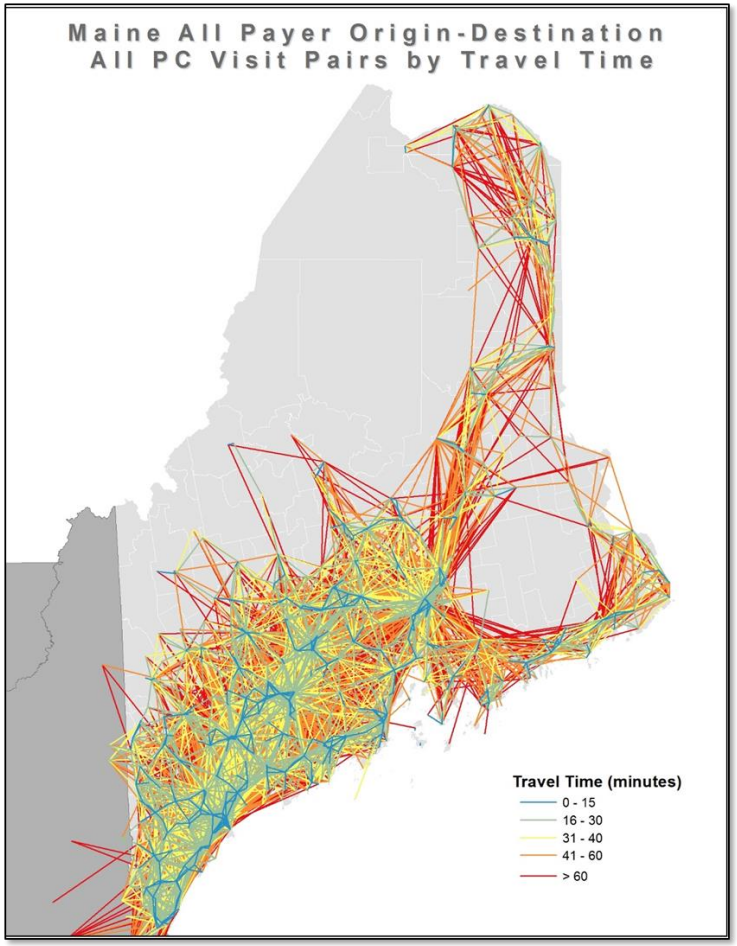
Goals

- Identify pockets of unmet need. Rational Service Areas should not simply reflect the current patterns of patient access and existing ‘hubs’ of medical capacity
- Capture and reflect the different underlying barriers to access and capacity experienced by different sub-population groups within the state (income/insurance, language/culture, etc.)
- Sequentially assess population needs from Geographic to Population level and cover areas with no apparent need in Rational Service Areas last
- Rely on objective data driven methods to examine current patterns of access and quantify metrics of access difficulties
- Relate provider distribution and access to population-level indicators of underservice and lack of capacity.

Origin-Destination (O-D) Access Analysis

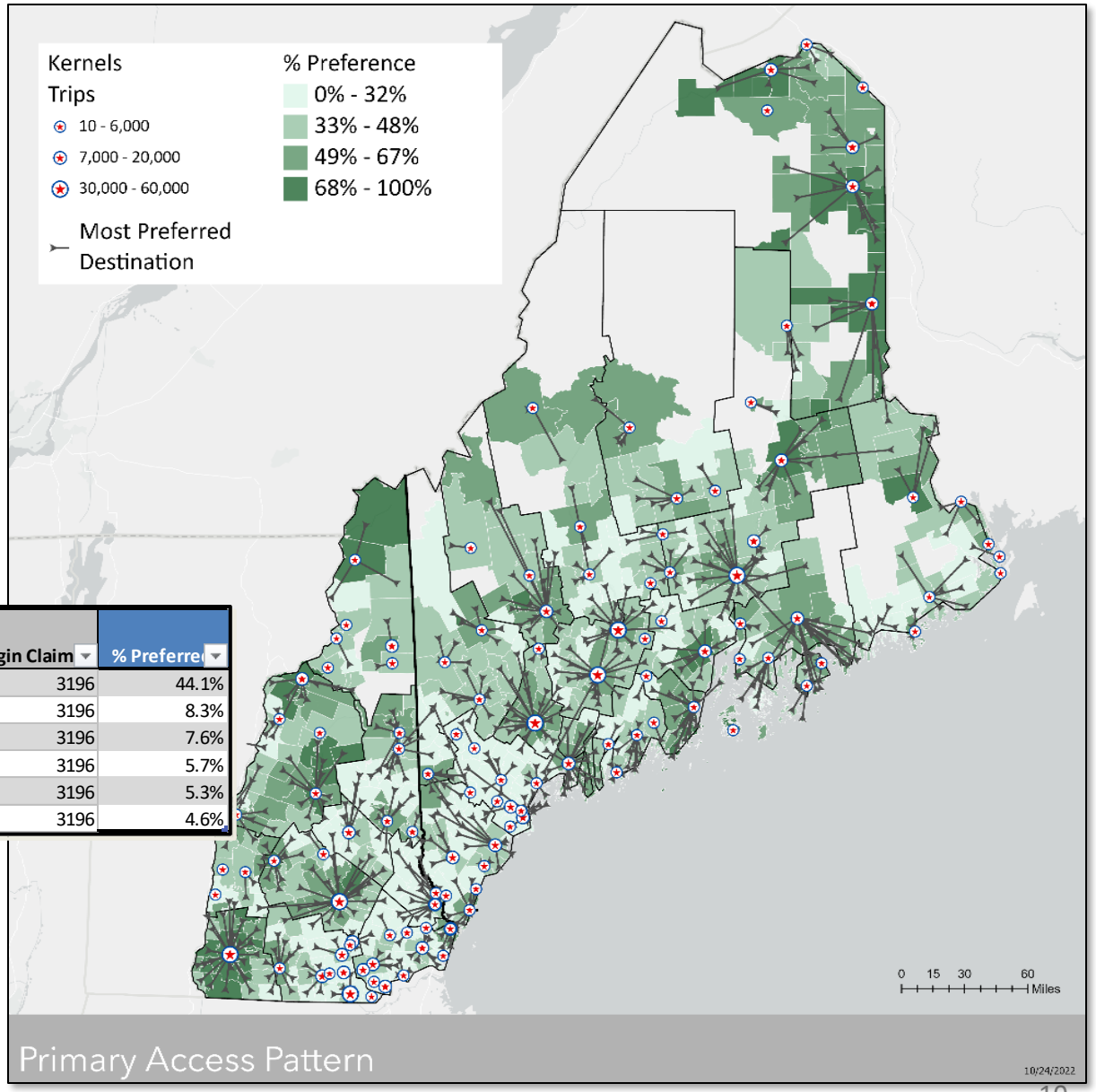


- Data Source: Maine All-Payer Claims Dataset
  - PC visits defined by CPT codes and Provider Taxonomy
- Origin-Destination for each PC visit
  - Origin: Patient Zip Code
  - Destination: Provider Service Location Zip Code
- Non-Physician primary care providers included
- Limits imposed to eliminate extraneous patterns
  - Destinations with <11 claims from origin zip excluded
  - 90 minute drive time limit
- O-D Patterns mapped *(Primary vs All)*
  - Preference percent by destination zip calculated
- Drive time between O-D zip pairs calculated
  - Mean Travel Time to care
    - Volume weighted by # of claims per pair
  - Fractional Travel Time exceeding threshold
    - Percent of population traveling > 30 Minutes, >40 Minutes, etc.
  - Visit Frequency
    - PC Visits per 'member-year'

Primary Destination Patterns

- Shows dominant pattern for PC visits
- Kernel = Dominant destination is same zip
- Destination = Dominant destination is other zip
- Percent Preference = Portion of visits that follow primary pattern
  - May not represent majority of care

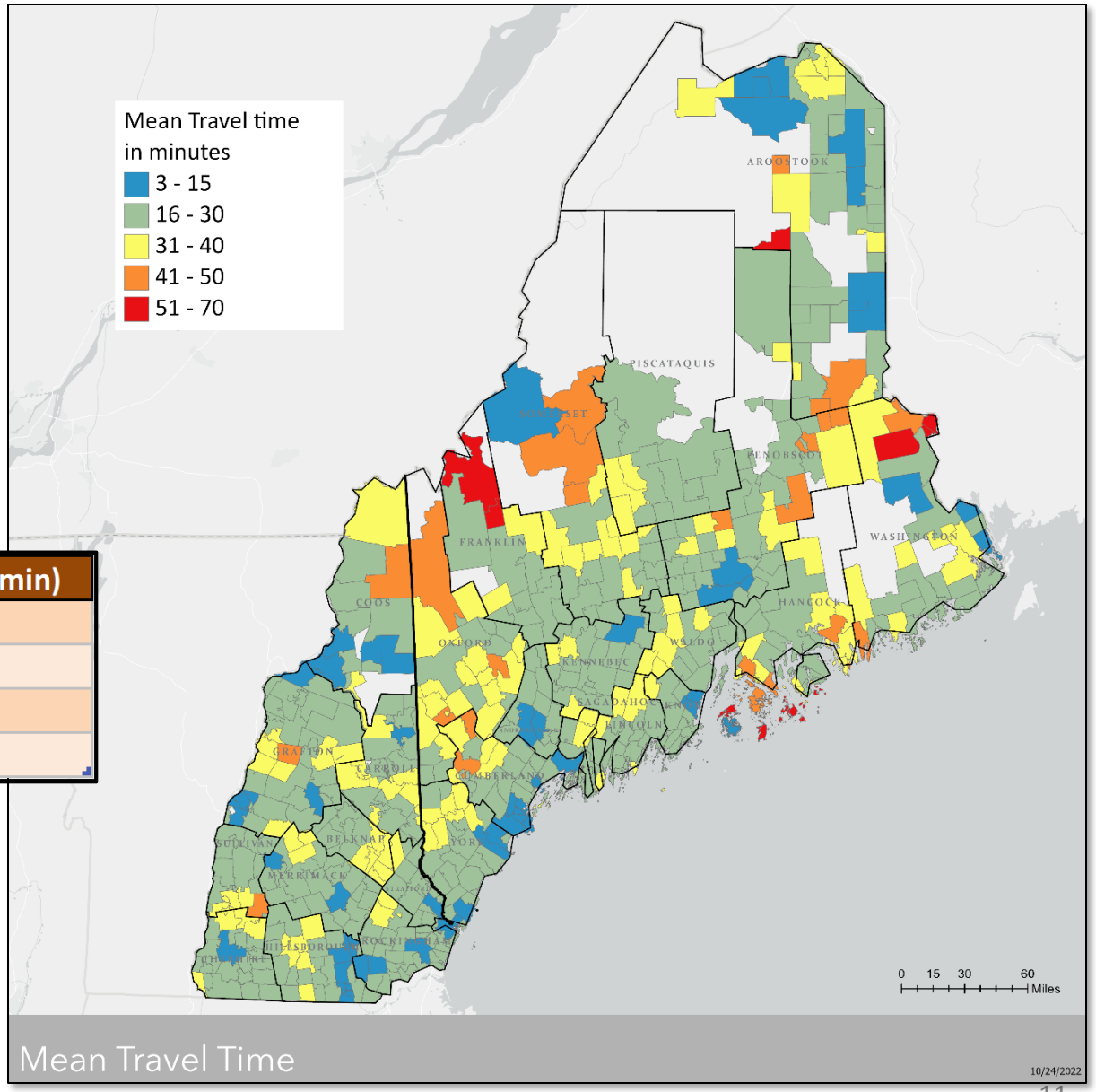
Origin_Zip	Destination_Zi	Claims	Total Origin Claim	% Preferre
01001	01107	1410	3196	44.1%
01001	01001	265	3196	8.3%
01001	01089	243	3196	7.6%
01001	01085	182	3196	5.7%
01001	01103	168	3196	5.3%
01001	01109	147	3196	4.6%



Mean Travel Time to PC Visit

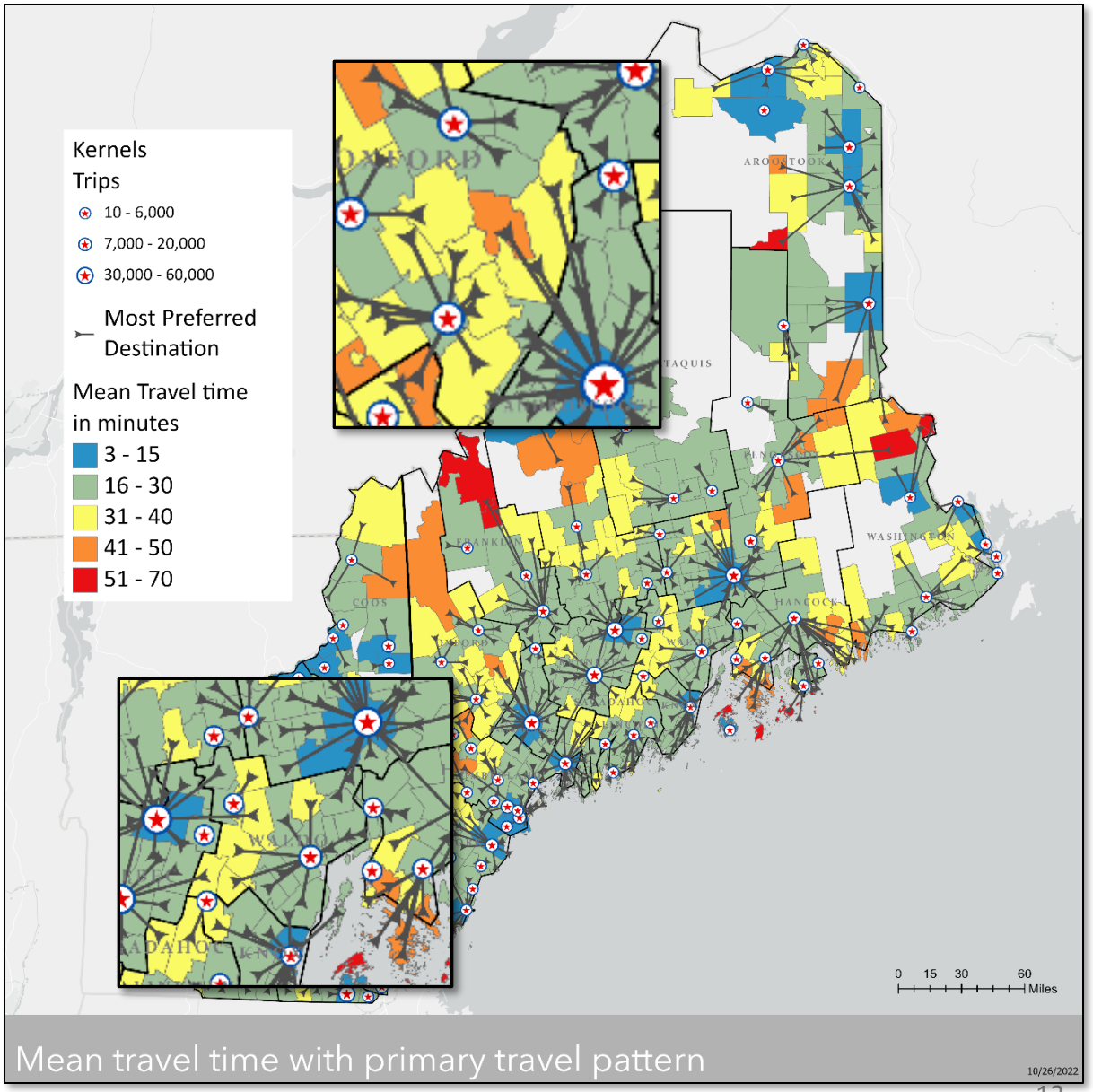
- Uses all visits from each zip *(not just primary)*
  - After exclusions for small counts and excessive time
- Applies O-D drive time between zips to visit count
  - Drive time based on actual road network, speed limits, etc.

O/D Zip Codes	Drivetime (min)
03031-03031	0
03031-03101	19.5
03031-03053	29.7
03031-01854	40.1



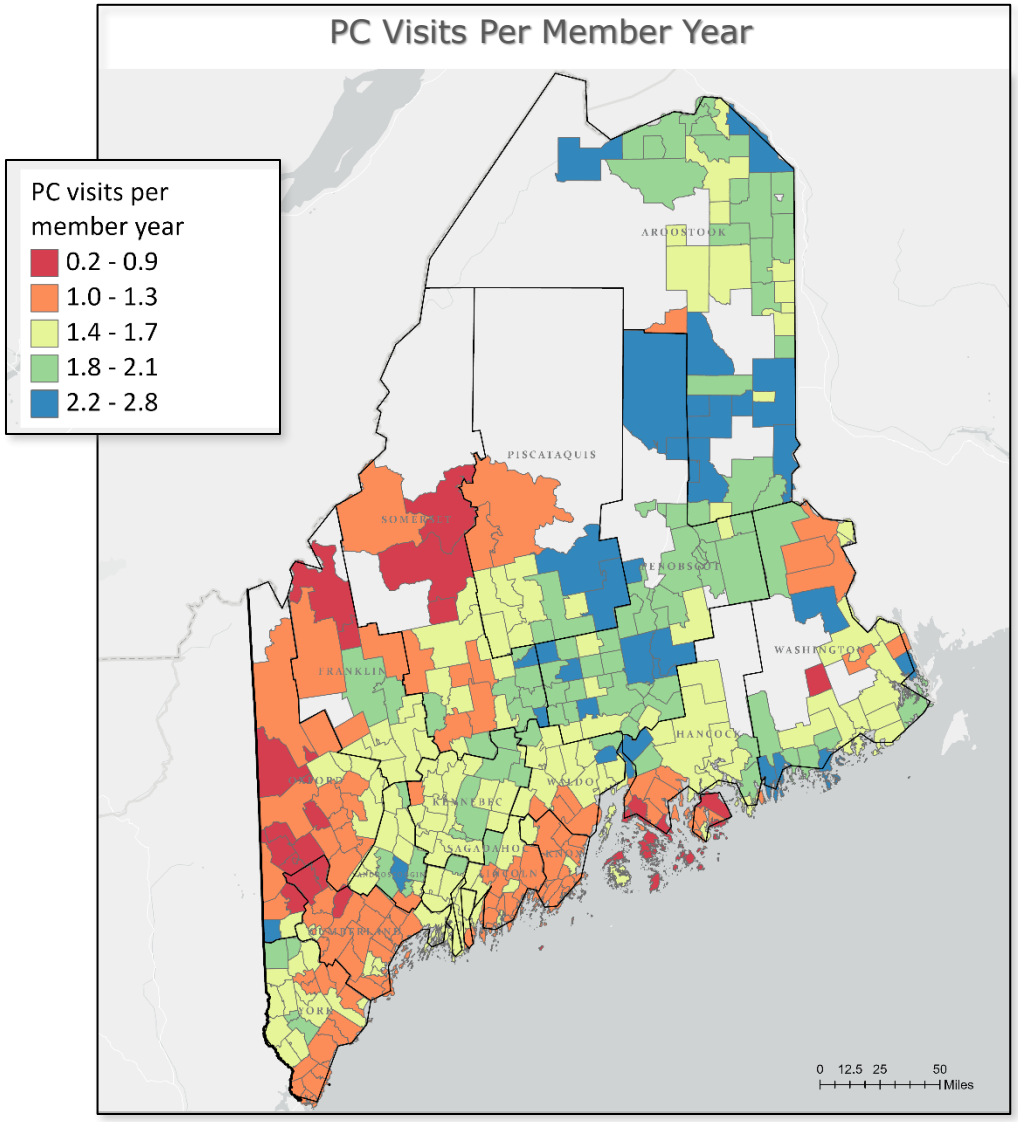
Comparison of Travel Time and Primary Pattern

- Mean travel time shortest around ‘kernel’ communities
- Areas with greatest travel time also often lack strong preference
  - Pulled apart towards different destinations



Mean travel time with primary travel pattern

Claims-based Utilization per Member Year



Other Elements Considered

- Medicaid vs Private access patterns
- Underlying community demographics (poverty, age distribution)
- Roads, bridges/ferries, topography
- Location of existing resources serving the areas
- School Districts and other existing community relationships
- Medical access pattern factored into other designation disciplines

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