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Maine's Rural Health Challenges

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Issue Brief

Maine's Rural Health Challenges

This brief describes the issues affecting access to health care in rural Maine. These issues include Maine's use of enhanced Medicare and Medicaid payments to support the rural health infrastructure, the adequacy of the provider workforce and the presence of training programs, the contribution of health care to the rural economy, and the high prevalence and unmet need for care for persons with substance use and mental health issues.

Rural Health Infrastructure

Maine's rural health infrastructure is composed of disconnected health and public health providers including independent provider offices, clinics, hospitals, nursing facilities, home health agencies, and others serving a relatively vulnerable populace with high rates of uninsurance and public coverage. In recognition, the Governor's State Health Plan established a Rural Health Working Group to develop rural-specific policy recommendations. A critical component of Maine's rural health infrastructure is the subsidy provided by three federal programs—Critical Access Hospitals, Federally Qualified Health Centers, and Rural Health Clinics—to ensure access to health care for rural areas.

Three federal programs subsidize the rural health infrastructure and contribute to health care access in Maine's rural areas. These programs include Critical Access Hospitals, Federally Qualified Health Centers, and Rural Health Clinics.

Critical Access Hospitals

Maine's 44 acute care and specialty hospitals provide traditional inpatient services and are increasingly providing outpatient, long term care, home health, primary care, and public health.^{1,2} The majority (31) of these hospitals are located in small towns or rural areas. More dependent on Medicare revenue than urban hospitals, rural hospitals have been financially vulnerable to fixed Medicare payment methods. Based on successful demonstrations of limited service hospitals in eight other states, Congress designed the Critical Access Hospital (CAH) designation in 1997.³ The designation is available to small hospitals with short patient stays that have an agreement or affiliation with a larger hospital. Importantly, CAHs receive higher payment for Medicare patients than usually received by rural hospitals.⁴ This higher reimbursement provides CAHs with a degree of financial stability that has allowed these hospitals to survive, and, in many cases, to make physical plant upgrades, service expansions, quality improvements, and to focus on community health needs.⁵ As of October 2006, 15 rural hospitals in Maine were designated as CAHs (Figure 1).⁶

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) provide preventive and primary care, dental services, mental health and substance abuse services, transportation, and specialty care in medically underserved areas. For uninsured and self-pay patients, cost of care is determined by a

Fast Facts

- Maine has 15 Critical Access Hospitals, 50 Federally Qualified Health Center sites, and 39 Rural Health Clinics.
- Maine has far fewer dentists than the nation as a whole, with 48 dentists per 100,000 residents in Maine compared with 64 dentists per 100,000 throughout the U.S.
- The health care industry accounted for 17% of the state's employment in 2004, up from 5% in 1969. Medicare and Medicaid account for much of this increase with 57% of funding for small, rural hospitals coming from these federal programs.

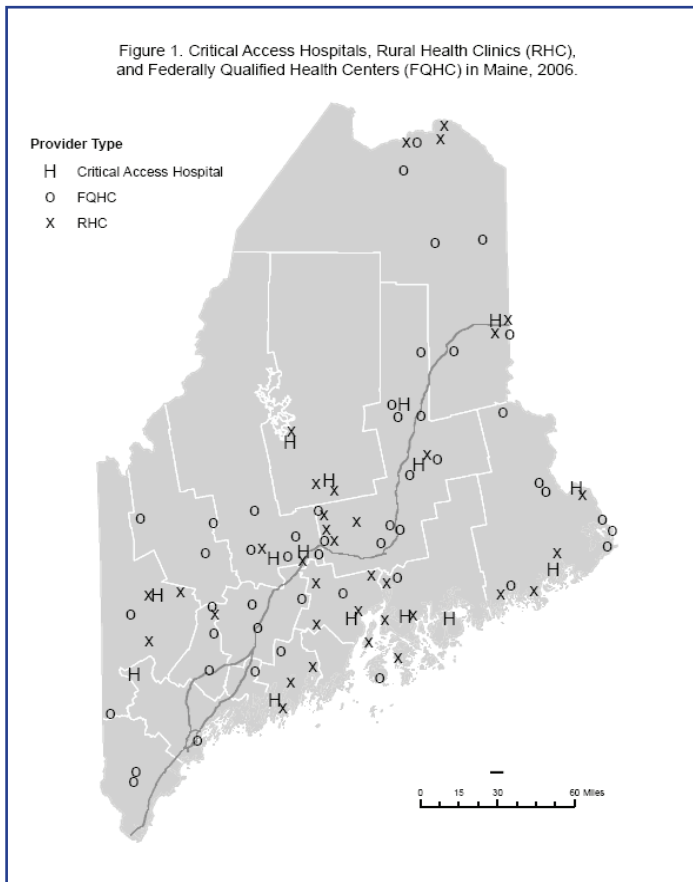
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Figure 1. Critical Access Hospitals, Rural Health Clinics (RHC), and Federally Qualified Health Centers (FQHC) in Maine, 2006.



patient's income and family size (known as a sliding fee scale). For Medicare and Medicaid patients, FQHCs receive enhanced reimbursement and may purchase prescription and non-prescription medications at reduced cost. Maine FQHCs include community health centers, migrant health centers, health care for the homeless programs, and public housing primary care programs. Sixteen FQHCs operate over 50 service delivery sites across Maine and serve an estimated 7 percent of Maine residents (Figure 1).^{1,7}

Rural Health Clinics

The Rural Health Clinic (RHC) designation allows clinics and physician practices located in rural areas with provider shortages to receive enhanced Medicaid and Medicare reimbursement for a set of core services. In addition to physicians, RHC status also allows enhanced reimbursement for care delivered by nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and clinical social workers. RHCs generally serve small towns and isolated rural areas characterized by poverty, reliance on public assistance, and low economic activity. The uninsured, self-pay, and free or reduced cost patients make up a significant portion of the RHC patient base, though they receive no specific reimbursement for care delivered to these populations.⁸ Most RHCs are smaller, and offer fewer services than FQHCs, although some RHCs are affiliated with hospitals. As of 2005, Maine had 39 RHCs (Figure 1.)¹

Workforce Issues

This section of the brief examines the adequacy of current health care providers and training programs to develop the future workforce.

Adequacy of Providers

- **Specialty providers: Physicians and mid-level providers in specialty practice are difficult to recruit to rural areas.**

Specialty providers. According to recruitment experts in Maine, physicians are difficult to recruit to rural areas, particularly specialists. Currently, the physicians most difficult to recruit include internal medicine physicians who practice outside of hospitals, OB/GYNs, and general surgeons. Mid-level providers, such as nurse practitioners and physician's assistants, are not as difficult to recruit generally; however, it is challenging to find mid-level providers to work within a specialty area (e.g., nephrology).⁹

- **Dentists: Maine's few dentists are concentrated in metropolitan areas.**

Dentists. Maine has far fewer dentists than the nation as a whole, with 48 dentists per 100,000 residents in Maine compared with 64 dentists per 100,000 throughout the U.S.¹⁰ This more limited supply of dentists is heavily concentrated within Maine's larger population centers. For example, Cumberland County has twice as many dentists per 100,000 residents as Aroostook, Oxford, Piscataquis, Somerset, Waldo, Washington, and York Counties (Table 1).¹¹

Table 1
Number of Dentists Per 100,000 County Residents, 2002

Cumberland	74	York	33
Knox	58	Aroostook	31
Kennebec	52	Franklin	31
Androscoggin	47	Washington	29
Hancock	46	Oxford	29
Lincoln	45	Piscataquis	29
Penobscot	41	Somerset	28
Sagadahoc	40	Waldo	22

Note: Rural counties indicated in blue.

Source: Office of Data, Research, and Vital Statistics, Maine Department of Health and Human Services: Maine Dentists: 2002. Fact Sheet, Series 11, Number 2.

The shortage of dentists is made worse by reimbursement problems. Nearly 50 percent of Maine residents lack dental insurance compared to 13 percent who lack health insurance.¹² While MaineCare covers dental care for children and emergency care for adults, many dentists refuse its coverage due to low reimbursement, paperwork burden, and patient no-shows.

- **Nurses: Nursing shortages are currently high and expected to grow.**

Nurses. Even though Maine has more nurses per population than the nation, the state still faces workforce shortages resulting from its growing elderly population and projected vacancies within hospitals, nursing facilities, and home health agencies. Among all occupations in 2004, nursing positions had the largest projected net job growth and the number of positions is projected to grow by 20 percent by 2014.¹³ The annual growth rate of nursing positions is more than twice the growth rate of all Maine occupations.¹⁴ Registered nurses are among the occupations with the most job vacancies in Maine's more rural regions (including the Aroostook and Washington region, the Hancock, Penobscot, and Piscataquis region, and the Androscoggin, Franklin, Kennebec, Oxford, and Somerset region), while the coastal region reports other occupations (Cumberland, Knox, Lincoln, Sagadahoc, Waldo, and York counties.)¹⁵ Hospitals report that shortages of nurses and other health care workers reduce their inpatient, outpatient, and emergency department capacity.¹⁶

- **Direct Care Workers: Access to long-term care is compromised by severe shortages of direct care workers, a demanding and low-pay occupation.**

Direct Care Workers. Direct care workers are the certified nursing assistants and personal care and support staff who provide assistance and health care for elders and adults with disabilities in hospitals, nursing homes, residential and assisted living facilities and in homes. These workers provide eight out of every ten hours of paid care received by long-term care clients.¹⁷ Demand for these workers is growing—by 2012, personal and home care aide positions are expected to increase by 55 percent; home health aides by 41 percent; and nursing aides, orderlies, and attendants by 16 percent.¹⁸ Recruiting and retaining people in these jobs is challenging; 25 percent leave nursing home positions each year and 150 percent leave home care agencies.¹⁹ Additionally, direct care employers provide no guarantee on workable hours, are unlikely to offer employer-sponsored health care or paid leave, and pay an hourly wage so low that many workers are eligible for food stamps and MaineCare.²⁰

Health Professional Training

Efforts are underway to build Maine's health professional workforce by exposing and preparing students in grades K-12 to enter health care professions and supporting and expanding college-level training programs. One potential pitfall is Maine's dependence on its Community College System to train mid-level professionals and the limited capacity of this System to respond to high numbers of applications for study.

- **Career pipeline: Maine's Department of Education and Maine Area Health Education Center Network expose secondary and post-secondary students to health care careers. The Network also places students in rural areas and provides continuing education for rural providers.**

Career pipeline. Through the Department of Education, Maine's Career and Technical Education (CTE) programs (formerly vocational education) expose high school and community college students to health care occupations. CTE prepares students to enter the community college system or the workforce in allied health occupations and nursing.²¹ Begun in 1989, the Maine Area Health Education Center (AHEC) Network aims to address health workforce needs through partnerships between training institutions and communities. Based at the University of New England's College of Osteopathic Medicine, the Maine AHEC Network supports awareness of health careers through elementary and high school programs and by publishing a directory of education programs. The Network places medical, physician assistant, and allied health professions students in rural and underserved areas for clinical training. It also provides continuing education for rural health care providers.²²

- **Scholarships and tuition reimbursement: The Health Care Workforce Alliance expands training programs and offers scholarships while the State Loan Repayment Program provides tuition reimbursement for providers working in areas with a shortage of medical personnel.**

Scholarships and tuition reimbursement. The Maine Hospital Association, Maine Community College System and Anthem Blue Cross and Blue Shield formed the Health Care Workforce Alliance in 2003 to address the state's health care workforce needs. These organizations provided an initial investment of \$400,000 to expand training programs in nursing and radiologic technology in underserved rural areas and 100 new scholarships for young adults pursuing health careers at the state's community colleges.²³

The Maine State Loan Repayment Program (SLRP) places recent health professional graduates in workforce shortage areas, reimbursing their educational loans in exchange for service. Federal

and state matching funds support the SLRP. The State Office of Rural Health and Primary Care has designated seven non-profit facilities to host a SLRP provider. The SLRP provider must offer free care or a sliding fee scale to those in need as well as accept MaineCare and Medicare.

- **The Maine Community College System has struggled to hire instructors and clinical training sites, which has backlogged applications to its nursing and other health professional programs.**

Maine Community College System. The Maine Community College System is witnessing a one to two year waiting list for programs in nursing and cardiovascular, radiological, and surgical technology. While small physical plants explain some of this bottleneck, limited availability of clinical training sites and supervisors and qualified instructors have also contributed to slowed enrollment. Clinical training sites are critical for health care training. For example, surgical technicians need supervised experience in the surgical suite. However, hospitals must carefully limit the number of students assigned to their staff to ensure quality patient care. In order to enroll more students, the Colleges need more facility staff members to perform these supervisory roles, but hospitals and other facilities do not have the resources available for this. Additionally, the Community Colleges offer low salaries in comparison to pay for clinical work, which has made it difficult to attract qualified instructors.²⁴

Impact of Health Care on the Local Economy

- **The health care industry accounted for 17 percent of the state's employment in 2004, up from 5 percent in 1969. Medicare and Medicaid account for much of this increase with 57 percent of funding for small, rural hospitals coming from these federal programs.**

The health care industry accounted for 17 percent of the state's employment in 2004, up from 5 percent in 1969. The growth rate in "rim" county employment (Oxford, Somerset, Piscataquis, Aroostook, and Washington Counties) exceeded the growth rate in Maine's hospital center counties (Cumberland, Androscoggin, Penobscot, and Kennebec Counties). Though the rate of wage growth in rim counties exceeds the rate in hospital center counties, actual wages are less in those more rural areas. The average health care wage in 2003 was \$34,010 in hospital center counties versus \$25,244 in rim counties. Some of this difference may be explained by greater use of paraprofessionals in rural counties, such as certified nursing assistants, who have lower wages.²⁵

Health care employment has grown despite declines in other industries. Given that Medicare payment and approximately 2 of every 3 Medicaid dollars comes from the federal government, about 57 percent of funding for small, rural hospitals comes from outside of Maine. In addition to bringing federal money to the state, health care generates indirect employment. For every person employed by a Maine hospital, two jobs are created within the community.²⁶

Substance Abuse and Mental Health Issues

Limited data provide an imperfect snapshot of substance use and presence of mental health issues throughout rural Maine. Currently, county-specific data describe substance use among young people and, while overall state estimates of mental health issues are available, only county-level suicide rates examine differences between rural and urban areas.

- **The highest use of illicit substances by children and teens is in Knox, Lincoln and Waldo counties.**

State data of substance use among 6th through 12th graders in 2004 show high use rates of multiple substances clustered among three neighboring rural counties. Among all Maine counties, Knox had the highest prevalence of lifetime and/or past month substance abuse for smokeless tobacco, cigarettes, marijuana, LSD, and cocaine. Lincoln County had the highest use rates of cigarettes, alcohol, binge drinking, marijuana, stimulants and heroin and was second to Knox in use of cocaine. Waldo County had the highest use of ecstasy, inhalants, stimulants, and heroin.²⁷

Over 10 percent of Maine adults over the age of 18 had a serious mental illness in 2002-2003, a rate that jumps to 16.6 percent among those aged 18-25.²⁸ An estimated 8-13 percent of Maine children and adolescents have an emotional or mental illness.^{29,30} The overall 5 year suicide rate in Maine was 12.3 per 100,000, with a range from 9.0 to 19.6 deaths per 100,000 population. For five urban counties, the suicide rate was 11.6, compared to 13.4 for eleven rural counties.³¹ Because suicide is a rare event, and the population of a county is relatively small, statistical estimates of suicide rates at the county level are not reliable indicators of the mental health of the population. However, population estimates at the national level have shown that rural suicide rates average 18 deaths per 100,000 in the smallest rural areas compared to 12.6 in suburban counties.³²

- **Children's mental health services are in short supply, and rural physicians report long waiting lists when they refer a child for services.**

In rural Maine, mental health services to children are particularly difficult to provide. Research has shown that shortages of mental health practitioners, such as social workers, psychologists, counselors, and psychiatrists are directly related to lower use of services, resulting in delayed or forgone treatment for depression, anxiety, and other mental health problems. Often, these problems can be addressed effectively by primary care physicians, who may or may not have access to a consulting psychiatrist. However, primary care practitioners are not trained in the treatment of children with serious emotional problems, and are often dismayed at the difficulties they have getting an appointment for their patient with a children's mental health specialist. Maine is fortunate to have a small number of rural community mental health centers that provide a full scope of services.

On the rare occasion when an adult or child requires psychiatric hospitalization, it is unlikely that one of Maine's rural hospitals can provide these services. However, inpatient psychiatric services are currently provided by the Aroostook Medical Center in Presque Isle, Northern Maine Medical Center in Fort Kent, and Penobscot Bay Medical Center in Rockport.

The Veterans' Administration (VA) Medical Center in Togus offers state-of-the-art care, but many rural veterans do not seek care for post traumatic stress disorder (PTSD). Often, problems are first reported by a spouse describing symptoms to a physician or social service provider. Even when PTSD is suspected, many veterans of Operation Desert Storm, Operation Enduring Freedom or Iraq are unable or unwilling to travel to Togus for services. In addition to veterans' centers at Bangor, Caribou, Lewiston, Portland and Sanford, the VA now offers community-based outpatient clinics in Bangor, Calais, Caribou, Rumford and Saco, some of which offer mental health services.

For More Information

Federal Office of Rural Health Policy:

<http://ruralhealth.hrsa.gov/>

Maine Rural Health Research Center:

<http://muskie.usm.maine.edu/ihp/ruralhealth/>

Maine State Office of Rural Health and Primary Care:

<http://www.maine.gov/dhhs/boh/orhpc/>

National Rural Health Association: <http://www.nrharural.org/>

Rural Assistance Center: <http://www.raconline.org/>

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