Rural Health Listening Session: Caribou

Meeting Report

August 12, 2019

What matters most?

- **Services**
  - Primary care – services to keep people healthy, including
    - Wellness visits
    - Oral health care
    - Behavioral health care
  - Treatment for substance use disorder (SUD), including
    - Medication
    - Counseling
  - Specialty care
  - Unscheduled/after-hours care, including
    - Emergency services
    - Pharmacy
  - Coordination of services, including
    - Assessments
    - Referrals
    - Communications
    - Social services

- **Systems**
  - Aging *graciously* in place
  - Home-based prevention, screenings, and care
  - Alignment of patient needs and care settings (i.e. reducing/eliminating "patients in the wrong beds")

- **Social determinants and other supports**
  - Transportation
  - Housing security for all ages and needs
  - Food security
  - Child care
  - Health literacy
  - Caregiver supports

Community assets

- Resilience
- Active promotion of healthy lifestyles
- Partnerships and enthusiastic partners
  - Partnerships strengthen all organizations
  - Aroostook County Health Network: new and exciting partnership between FQHCs and social services
- Resource guide/hub (Aroostook Health Network)
- Age-friendly communities
- VA Community Based Outpatient Clinic & Veterans' Center – keeping people close to home
- Medicaid Home and Community Based Service waiver

- Home transitions to prevent readmissions: visits and meals (hospital-AAA partnership)
- Collaboration across Aroostook County hospitals - have avoided "cut-throat" competition
- Dedicated workforce
- Recovery centers

Challenges

- Aging population
- Population loss, including from people moving and substance use disorder
- Large geographic area – many live great distances from service center towns
- Weather
- Shortage of ambulance service
- Transportation options
- Pride (people hate to ask for help or plug into available supports)
- Staffing/workforce shortages – challenges to recruit and retain
- Un/under insurance and high co-pays
- Community collaborations often must rely on volunteers for coordination
- Regulatory challenges, including scope of practice and hospital/FQHC collaborations
- Children with trauma
- Housing shortages
- Not enough capacity for psychiatric patients
- Not enough long-term care beds – in general and especially for the un/under insured

How can things work better: what's the ideal; what solutions can we pursue?

- **Services we need:**
    - Resilience-building for kids with trauma
    - Community based psychiatric care and support (to fulfill the plan from the 1960's)
        - *Report from Commissioner Lambrew:*
            - *Maine DHHS is very interested in this and is mapping the need by population and setting, then matching patients and services (by Fall 2019)*
            - *Dorothea Dix is expanding*
    - A system of care and services that "start and end at the kitchen table"

- **Systems and/or infrastructure we need:**
    - A longer-term SUD recovery center, including a culturally appropriate Wabanaki recovery center
    - More local infrastructure/housing for long-term care and mental health care that can accept un/under insured
    - More school-based health services, including an expanded model/definition to broaden scope and reach of care provided
    - Workforce recruitment and retention program
        - Fix federal definitions of "rural" and "health professional shortage areas" to bring more resources into Maine
        - Allow health professionals in loan repayment programs to build private practices so they will stay in rural communities after their service period ends

- **Supports we need:**
    - Transportation, including
        - Promotion of transportation options
        - Encouragement, especially among seniors, to utilize transportation options
    - More support for older adults & their caregivers, particularly for new & creative workforce approaches for home-based care services
    - Parent education and supports, parenting skill training
    - Community-based SUD recovery supports, recovery centers
    - Support & payment for new models of care – e.g. community paramedicine, use of paramedics in EDs

- **Information we need:**
    - Are patients receiving care via telemedicine satisfied with their care?
    - Data collection to quantify the problem of "patients in the wrong beds" and support the design and funding of region-wide solutions

- **Other things we need:**
    - Sustainable funding
        - We need all organizations in the system to get paid for everything they do
        - We need funding that doesn't end (vs. time-limited grants) – i.e. to support staffing and programs that aren't time-limited
    - Remove regulatory barriers to collaboration and innovation – e.g. collaboration across hospitals and other providers re: who offers which services
    - More options for appropriate housing options particularly for traditionally hard-to-place individuals (e.g. geriatric psych patients, youth in crisis, morbidly obese needing home care)
    - Leadership and priority-setting
        - The County has three distinct regions (and sometimes four) – we need more public health planning and priority-setting in local communities
        - Leadership and backbone support from hospitals and public health District Coordinating Councils (which don't always have enough resources)