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Issue Brief

Health Promotion for Maine’s Aging Population: A Legislative Roadmap

Maine has the distinction of being the oldest state in the nation based on the median age of its residents. The rapid aging of our citizenry has been accompanied by increases in rates of chronic disease, health care spending, and, in particular, the purchase of pharmaceuticals. This policy brief considers various strategies for promoting the health of aging Mainers with an emphasis on promising approaches that can be implemented with limited use of new resources through increased coordination and communication among providers and their consumers, enhanced integration of the health and human service networks, and reductions in health care service inefficiencies and duplication.

Inside the Numbers

For many Maine citizens the benefits of living in a rural state far outweigh the challenges. Yet, for those who decide to reside in Maine in their later years, those challenges can make it difficult to access services vital to their daily living; and as a state we are not alone in the challenge of providing rural services effectively and efficiently to older adults. As of 2005, 50 million people lived in rural America and approxi-

mately 7.5 million of those people were over the age of 65 (Jones, Kandel, & Parker, 2007). In Maine, approximately 14% of our population is age 65 or older, and that percentage will continue to increase due to the large number of young adults leaving the state and because our state continues to attract retirees, making our median age climb to 41.6, the highest in the country (The Henry J. Kaiser Foundation, 2007).

A recent report by the National Advisory Committee on Rural Health and Human Services (NACRHHS, 2008) outlined many of the challenges that rural elders face, including those in Maine. The report found that older adults in rural regions are more likely to be less educated, have worse health outcomes, and have incomes that fall below the poverty level compared to their urban counterparts (Cromartie & Gibbs, 2007). In Maine, we have the added demand created by a large proportion of our population that falls under the category “dual eligible.” As defined by the Center for Medicare and Medicaid Services, dual eligibles are individuals who are entitled to Medicare Part A and/or Part B and are also eligible for some form of Medicaid benefit (Center for Medicare, 2008). As

Fast Facts

- In 2008, approximately 15% of Maine’s population was over the age of 65. By 2025, one in five Mainers will be 65 years of age and older.
- Nearly 37% or \$1.2 billion of Maine’s increase in health spending from 1998 to 2005 is attributable to the leading chronic illnesses including cardiovascular disease, cancer, chronic lung disease and diabetes.
- Twenty-two percent of the total population and 63% of Medicare beneficiaries suffer from multiple chronic conditions.
- Older Americans with five or more chronic conditions have, on average, 14 doctors, see physicians 40 times a year, and fill almost 50 prescriptions.

Population Distribution by Age, Maine and U.S. (2007)

	ME #	ME %	US #	US %
Children 18 and under	300,961	23%	78,645,221	26%
Adults 19-64	816,714	62%	182,781,246	61%
65+	192,289	15%	36,788,888	12%
65-74	95,523	7%	19,587,238	7%
75+	96,766	7%	17,201,650	6%
Total	1,309,964	100%	298,215,355	100%

Sources: The Henry J. Kaiser Foundation’s Commission on Medicaid and the Uninsured (estimates based on the Census Bureau’s March 2007 and 2008 Current Population Survey).

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of 2003, there were approximately 82,000 dual eligibles in the state of Maine (The Henry J. Kaiser Foundation, 2007). Dual eligible beneficiaries influence greatly the state's annual fiscal budget expenditure. This budgetary obligation will only climb over the next few decades and states like Maine will have to make tough choices about how to offer services to this population. A recent article in the Bangor Daily News notes that incoming state legislators are charged with the task of deciding between eliminating services, reducing payment to physicians and hospitals, and/or increasing the out-of-pocket costs for beneficiaries to include higher co-pays and deductibles; there is no easy answer (Haskell, December 13, 2008).

Challenges of Rural Living

“Aging in place” for rural Mainers can be a difficult task, especially when access to health providers and services is limited. The 2008 NACRHHS report found that in non-metropolitan areas, the number of general practitioners has actually decreased by over 4% since 1985. The challenges of obtaining healthcare do not stop with the scarcity of Primary Care Physicians (and other health care professionals) in rural states like Maine. Emergency medical services (EMS) also play an unusual role in the lives of older Mainers. Due to the long distance to a hospital for many Maine residents, EMS is often times used as a primary means of medical support for older adults. The NACRHHS report found that due to limited access to preventive and primary care, EMS is often times utilized as a primary source of medical care. Maine also has a much higher than average rate of hospital emergency room (ER) visits. From 1996-2006, the rate of ER visits for the state of Maine was 576 visits per 1,000 population compared to the national average of 396 visits per 1,000 (The Henry J. Kaiser Foundation, 2007). One bright spot in healthcare access is that between 2002 and 2007 the President's Health Center Initiative funded over 1200 new health center sites. This enabled health centers to increase the number of patients that could be seen by 38% to 6.7 million individuals nationwide (HRSA Press Office, 2008). Federally Qualified Health Centers (FQHCs) have grown significantly in number and size in Maine during this time.

It is important to appreciate that the need for human (social) services is frequently just as great in rural areas as is the need for health services and it is difficult, if not impossible, to consider policies for one without simultaneously considering the other. Three out of the four factors that most influence demand for human services are present in rural America and in Maine: poverty, disability and advanced age (NACRHHS, 2008). Approximately, 24% of Maine citizens age 65 and older live at or below 150% of the federal poverty level (Purvis & Flowers, 2008). The need for human services is positively associated with the need for health and medical care.

Ask a Maine citizen over age 65 what his or her greatest challenge is in daily living and the majority will tell you lack of access to transportation. The lack of transportation options can and does make getting to the doctors office or picking up a prescription at the pharmacy difficult. The Older Americans Act (OAA) funds human services for the elderly through the

Administration on Aging (AoA); included in these services is assistance with transportation (O'Shaughnessy, 2008). In 2006, President Bush reauthorized the OAA for an additional five years. An underlying theme of the legislation is more flexibility given to the State Units on Aging (SUAs) and the Area Agencies on Aging (AAAs) in developing human services programs for older adults. However, the calculations used to distribute the funds are flawed because they put rural states at an extreme disadvantage because there are fewer providers that offer services and a larger geographic area to cover (NACRHHS, 2008).

Finding What Works

Finding answers to the challenges of access to health or human services by Maine's older citizens remains illusive. One reality appears clear in today's recessionary climate - an increase in funding from either the state or federal government is not an option that Maine citizens can count on. Policy makers, service providers and citizens must become more creative in finding ways to meet their needs without depending on additional dollars to make it happen.

Innovation and ingenuity is the key, and while there is no quick fix to this issue, it is up to Maine's aging network, including politicians, educators, practitioners and Maine's general populace, to come up with the answers. Several suggested strategies include:

- Utilize the additional and expanded Federally Qualified Health Centers that were created as part of the President's Health Center Initiative by encouraging those providers to reach out to greater numbers of older adults in Maine and provide those patients with efficient access to preventive and primary care health services.
- Encourage greater collaboration and cooperation across health and human service agencies, including AAAs, to strategically develop integrated or blended service delivery options for older adults that utilize existing services and do not reinvent programs that are already available.
- Reassess eligibility requirements for MaineCare to try and bring spending in line with other rural states and decrease health care costs to all Maine citizens.
- Find creative ways to educate Maine citizens about available health and human service programs by utilizing resources already in place including 2-1-1 Maine and the outreach programs offered by the AAAs, community action agencies, FQHCs, and others.

Chronic Disease and the Use of Prescription Medications

As chronic disease is common among older adults, this population is more likely to require the use of prescription medication, and often multiple medications, to manage these conditions. While use of medications has become essential to the health of many older adults, there are a number of risks associated

with the use of drugs, with those risks increasing as the number of medications used increases (Shepler et al, 2006; Fulton & Allen, 2005; Brager 2004; and Rollason & Vogt, 2003). The burden of medication management shouldered by older adults and their relatives is a major factor leading to heightened likelihood of premature and costly institutional placement.

The “concomitant ingestion of four or more medications” (Rollason & Vogt, 2003) or polypharmacy, has a number of consequences including nonadherence to the drug schedule resulting in under or over dosage, adverse drug reactions, drug-drug interactions, increased risk of hospitalization particularly as a result of adverse drug reactions and drug-drug interactions, medication errors often occurring due to inconsistencies between the patient’s medical report and the pharmacy prescription files, and increased costs due in part to the cost of the medications themselves but also due to the costs associated with the treatment of adverse effects (Rollason & Vogt, 2003).

Complicating the problem of polypharmacy is the fact that in addition to the use of prescription medications, many older adults self medicate with a combination of over-the-counter medications, and a variety of herbal remedies and supplements (Francis, Barnett, & Denham, 2005). While it is common for patients to discuss their prescription medication routine with their physician, it is less common for patients to disclose use of over-the-counter medications or herbal preparations to treat issues such as arthritis, constipation and allergies (Shepler et al, 2006; Francis et al, 2005). Just as multiple prescriptions can cause adverse reactions, over-the-counter drugs and herbal remedies can also result in negative drug interactions. Also important to this conversation is the misconception that natural ingredients make an herbal or alternative treatment safe. However, as these products are not regulated by the Food and Drug Administration, the safety and efficacy of these medications should be considered prior to use and especially prior to combination with other medications (Brager, 2004).

Another aspect of medication management and routine are the complications encountered by the addition of alcohol use while taking any medication. Alcohol can change how the body metabolizes medications which can lead to an adverse drug reaction. Consumers and physicians should be concerned especially with the interaction of alcohol with psychoactive medications such as barbiturates, benzodiazepines and antidepressants. While consumption of alcohol by older adults may follow different patterns than those of younger age groups, it is certainly an important part of the medication management discussion (Blow et al, n.d.). In addition, the accumulation of expired, unused, and unwanted prescription drugs in the households of older adults only serves to increase the possibility of drug misuse and abuse.

A promising method to combat discrepancies between multiple providers and pharmacy records is the use of e-prescribing, a type of electronic health record. Providers who utilize e-prescribing, have access to a patient’s prescription history and can eliminate medication error that is often caused due to medications being prescribed by more than one provider. Because this type of system can be in real-time, a physician can

bring up a patient’s complete medication record at the time of the interaction with the patient thus allowing for conversations about medication practices, change in dosage, use of over-the-counter or alternative therapies, and other medication concerns (Lapane, Dube, Schneider, & Quilliam, 2007). While use of e-prescribing could benefit the management of medication use by older adults, the integration of electronic health records in rural locations can prove challenging due to the lack of broadband access, and qualified IT assistance and maintenance needed to implement and sustain these programs (eHealth & CIMM, 2008). The Center for Improving Medication Management: (<http://www.thecimm.org/index.htm>) has a number of resources for providers and consumers to get the latest information on the use of e-prescribing.

Although the use of multiple medications to manage chronic conditions has become a necessity for many older adults, polypharmacy brings with it potentially severe consequences. While there is not one avenue to address this problem, there are a number of ways to help prevent the occurrence of negative consequences. Policies such as the following should be considered:

- Providers should review complete medication histories with their patients, including prescription, over-the-counter and herbal medications. Patients or caregivers need to be asked to bring in all medications on a regular schedule.
- Patients need to be educated about the administration, purpose and risks of their medications and the implications of multiple medication combinations.
- Providers should ask patients about their consumption of alcohol to screen for potential negative alcohol and drug interactions.
- Encourage the use of one pharmacy because it helps to eliminate discrepancies between patient medical records and pharmacy prescription files thus helping reduce potential adverse drug reactions and interactions.
- Improved consumer access is needed to product information through increased font size and design of medication packaging.
- Provider use of electronic health record tools like e-prescribing can help minimize medication error and provide continuity between physicians, specialists, and pharmacists.
- Honest and open communication between health providers and consumers is essential to safe use of prescription medication and appropriate integration of over-the-counter and herbal preparations into patient drug routine.
- Older adults should be encouraged to take advantage of available expired and unwanted prescription drug take-back programs such as the state-wide Safe Medicine Disposal for ME program.

Conclusions

The aging revolution remains an undeniable and highly influential demographic force influencing Maine's population profile and health care landscape in significant ways. There is little disagreement as to the harsh health care realities and challenges which serve to reduce quality of life for older Mainers. A commitment to enacting common sense policies and program practices which integrate existing services, use all available technology, make access to care less difficult, reduce service duplication, and encourage more cooperation and open communication between community providers and older adult consumers and their families is crucial and needed now.

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