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Rural Elder Care Coordination on Cape Cod: A Community-Based Approach to Closing the Gaps
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WHO WE ARE

- Federally-qualified health center
- Three locations on Outer Cape Cod
- Provide primary and specialty care to 16,500 patients (2015)
- Specialty care: Behavioral health, dermatology, dental, vision
- Over half of patients on public insurance or uninsured:
  - None/Uninsured
  - Medicaid
  - Medicare
  - Private insurance

Population characteristics

10% lower per capita income than Massachusetts (2010-2014)

Less housing is available; highest number of units for seasonal use (35.5%) compared with all other Mass. counties

Rents are expensive

Seasonal employment, higher unemployment

HIGH RISK = HIGH COST

Health conditions

- Depression
- Alcohol disorder
- Overweight
- Hypertension
- Heart Disease
- Diabetes
- COPD

- OCHS adults
- OCHS over 65
- State over 65

Barriers to care

Finding a doctor
Barnstable County designated by HHS as Medically Underserved Area for primary care, mental health and dental health

Fewer physicians accepting MassHealth
68% MassHealth

Transportation
60% of Cape Cod seniors have lost their driver’s license
Find particular locations difficult to access on public transit

High costs
24% Cape Cod seniors have difficulty paying insurance deductible/co-pays
Could not afford fees for services

CARE COORDINATION PROGRAM

Supporting home care program
Hospital/Rehab support
Mental health outreach

- Patients seen by PCP (NP or PA)
- Care Coordination team connects to 86 in 2015
- Provide wrap-around services
- Monitoring of any OCHS patient discharged from hospital (inpatient) or short-term rehab
- Conduct of communication between PCP, patient and referral provider
- Refer to supportive services

Observed benefits

- Lower rates of hospital readmissions
- Reduction in hospital days
- Reduction in days at skilled nursing facility
- Reduced cost to individual, system
- Increased time at home, quality of life

Challenges

- Sporadic or inconsistent communication among agencies involved in patients’ care
- Difficult to close loop on referrals
- Fractured continuum of care places burden on patient

The goal

Communication is consistent among agencies, resulting in greater focus on the patient’s needs and provision of wrap-around services.

BUILDING A NETWORK

A critical success factor in improving the Care Coordination program will be building a network of partners in the community to provide input and share resources

Key considerations

- Marathon, not a sprint
- Iterative process; will take shape over time
- Participation of consumers needed for validity, efficacy
- Solution should be responsive, not prescriptive

Challenges & questions

- How to get people excited about something that’s inherently difficult to define
- Creating a self-governing body with shared goals
- Empowering participants, particularly consumers, to take leadership roles
- What are the measures of efficacy of care coordination?
- Does care coordination increase quality of life? Sense of connection to community?

Support & potential funding

- UIMMS CCTS: Drs. Ockene & Cashman
- Patient Centered Outcomes Research Institute
- Town grants, Cape & Islands United Way

Phase 4: ACT
- Refine as necessary
- Communicate accomplishments internally & externally

Phase 3: PLAN
- Evaluate progress towards goals
- Collect input from group on value of meetings

Phase 2: DO
- Organize and facilitate meetings
- Gather or provide input on needs
- Ideas for research and/or services

Phase 1: STUDY
- Highlights from the Massachusetts Healthy Aging Data Report: Community profiles 2014

References

4. Barnstable County. Barnstable County strategic plan. 2015