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

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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:

![Population characteristics](image)

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

![Health conditions](image)

High risk = High cost

Patients with >1 chronic condition account for 95% of all Medicare spending
Patients with >5 conditions account for two thirds of Medicare spending

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

Fewer physicians accepting MassHealth

Transportation
Off Cape Cod seniors have lost their driver's license
Find particular locations difficult to access on public transit

High costs
60% of Cape Cod seniors have difficulty paying insurance deductible/cos pays
Could not afford fees for service

CARE COORDINATION PROGRAM

- 80+ population growing on Cape Cod
- The number of men in their 80s is rapidly outpacing other senior citizens on Cape Cod, but reason is unclear

![Cape Cod Times](image)

Oct. 8, 2011

80+ population growing on Cape Cod

Supporting home care program
- Monitoring of any OCHS patients discharged from hospital (inpatient) or short-term rehab
- Consult of communication between PCP, patient and rehab provider
- Refer to supportive services

Hospital/rehab support
- Tracking, monitoring, supporting of patients who receive behavioral health services
- Making sure patients have access to additional services

Mental health outreach

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

- Refine as necessary
- Communicate accomplishments internally & externally

- Evaluate progress towards goals
- Collect input from group on value of meetings

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

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