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

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Et al.

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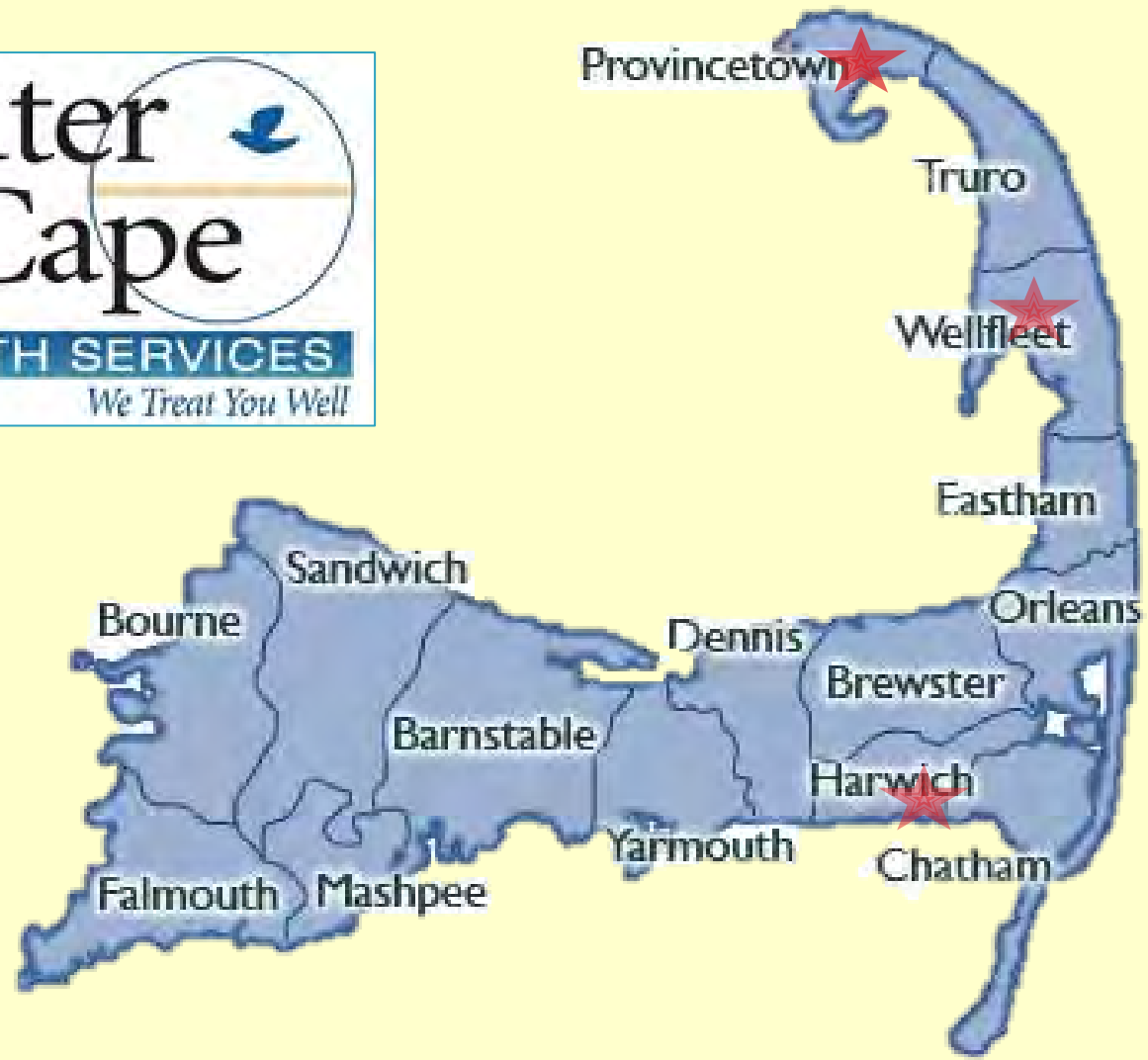


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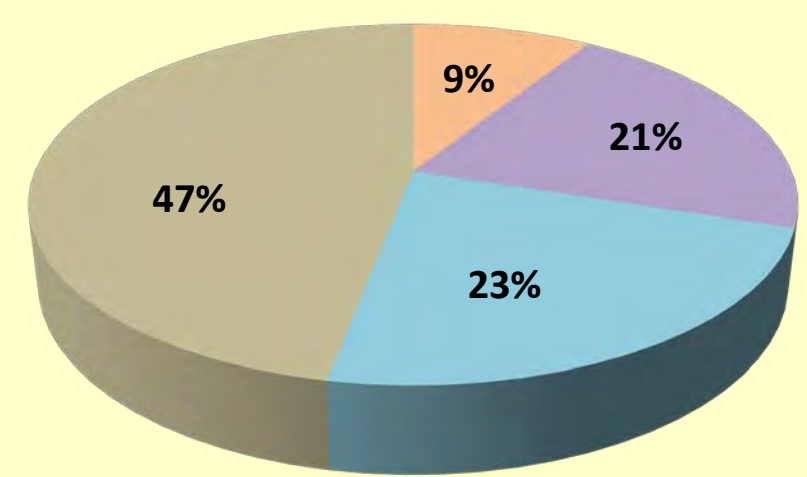
Rural Elder Care Coordination on Cape Cod: A Community-Based Approach to Closing the Gaps

Kazmira Nedeau (Grants Submission & Compliance Analyst) & Andy Lowe (Director of Program Management Resources)
Outer Cape Health Services, Wellfleet, MA

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

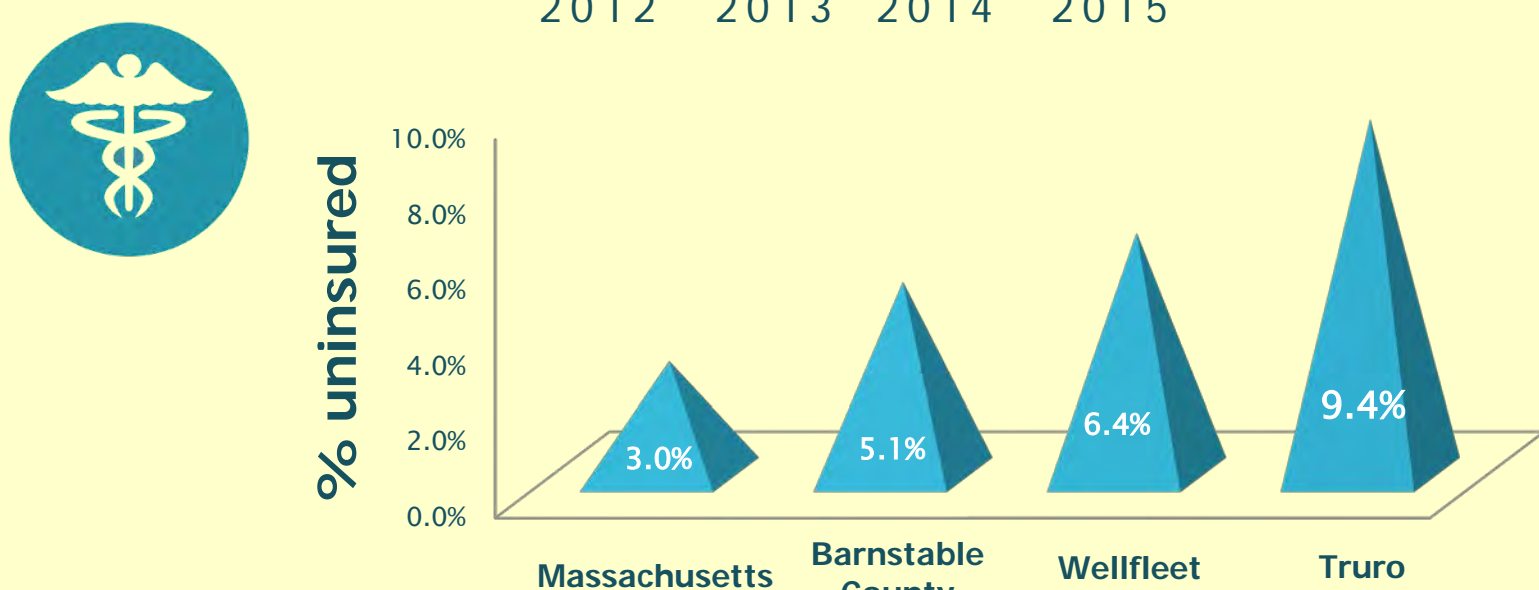
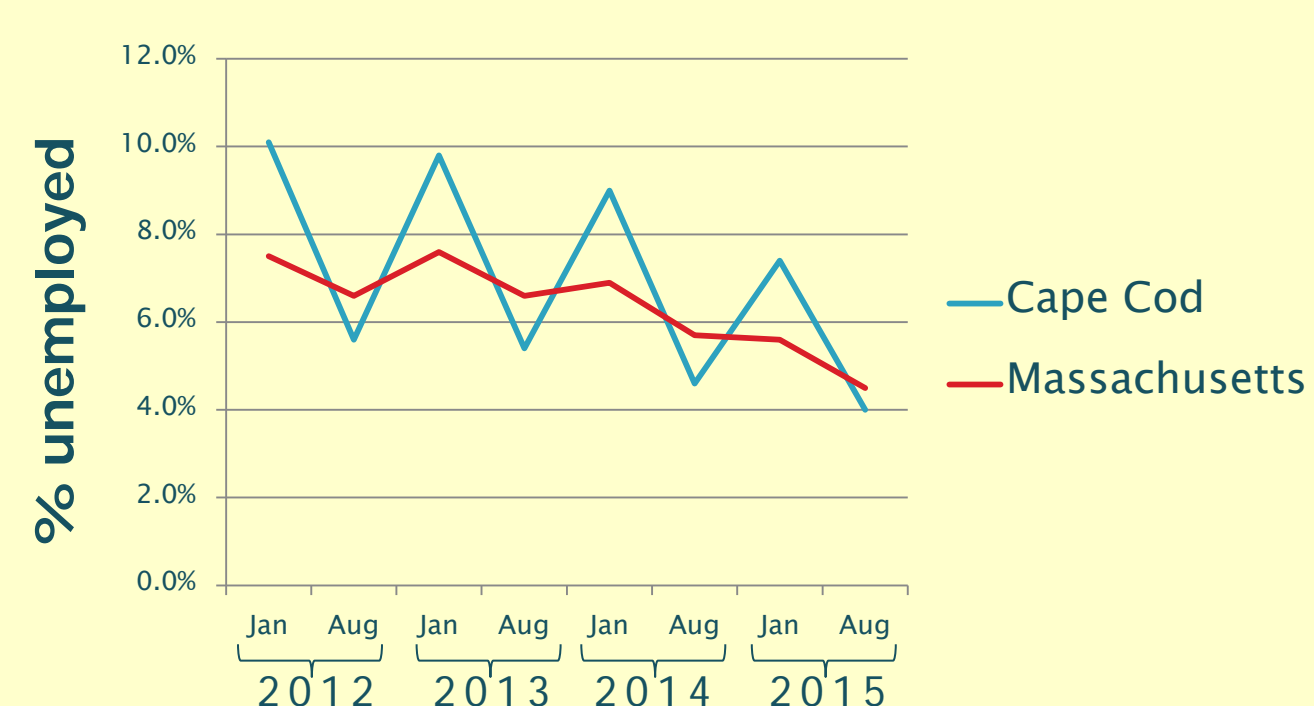
Population characteristics

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

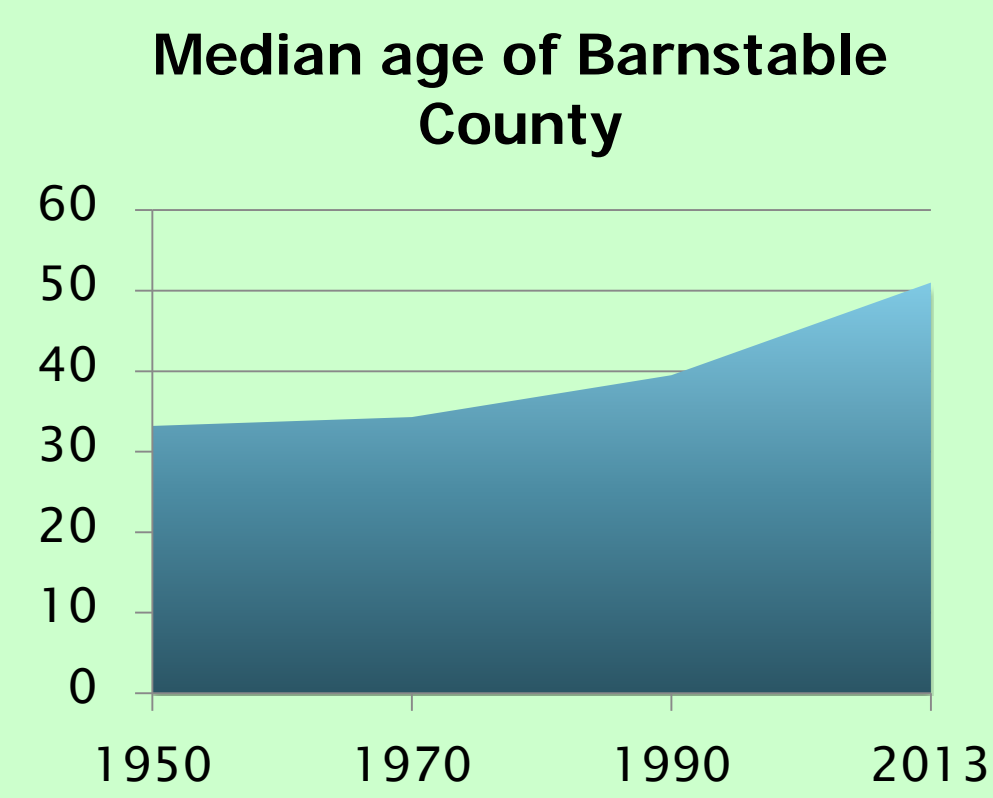
House Less housing is available; highest number of units for seasonal use (35.5%) compared with all other Mass. counties

Bed Rents are expensive
48.9% Renters spending >30% of income on housing
60.0%

Briefcase Seasonal employment, higher unemployment



AN AGING POPULATION

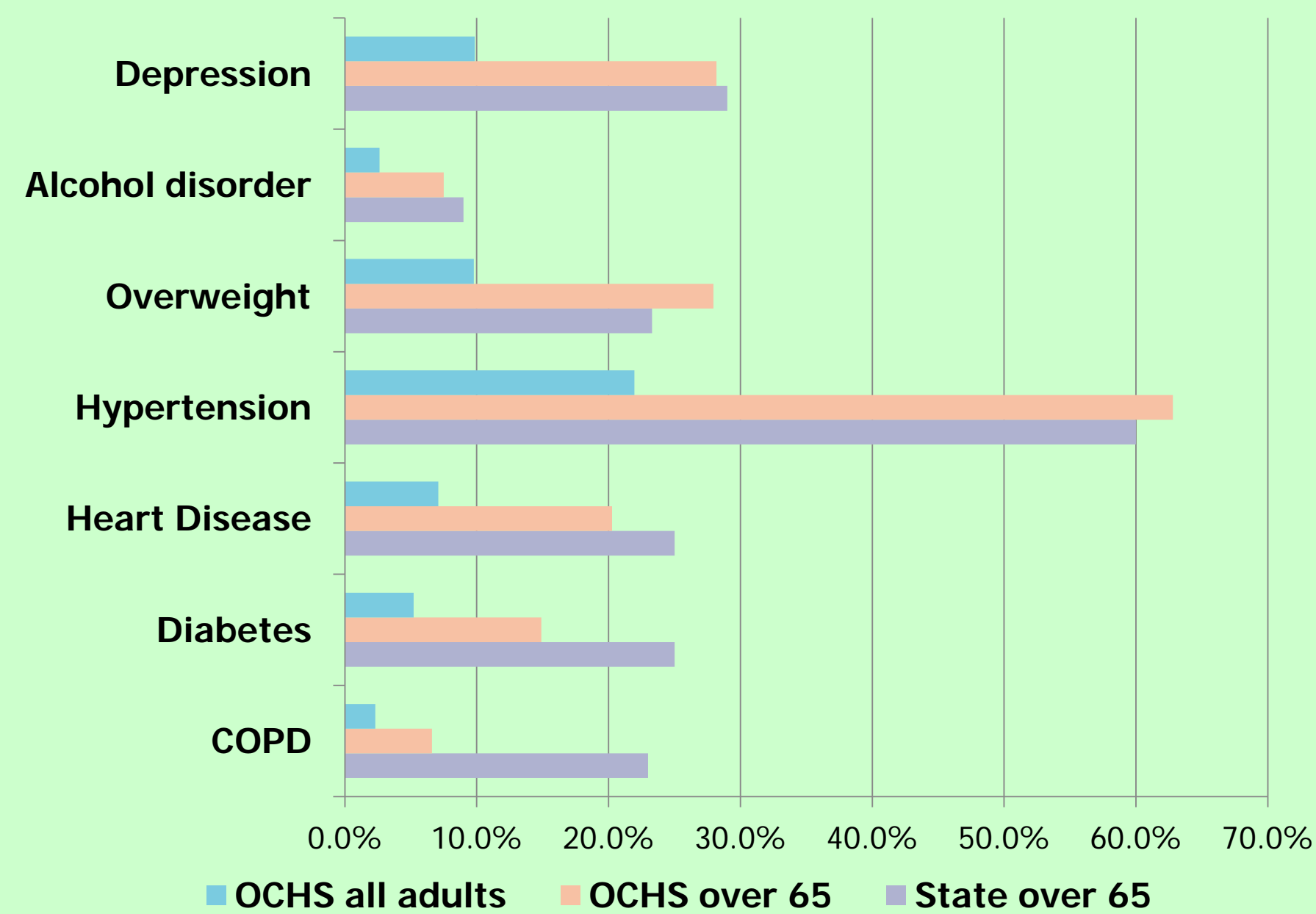


CAPE COD TIMES
Oct. 8, 2011

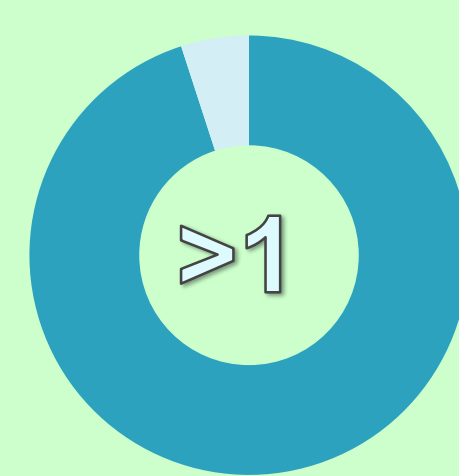
80+ population growing on Cape Cod

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

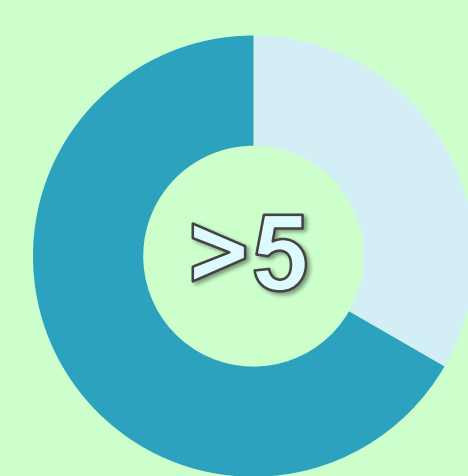
Health conditions



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

Barriers to care

Finding a doctor

Barnstable County designated by HRSA as **Medically Underserved Area** for primary care, mental health and dental health

Fewer physicians accepting MassHealth

68% Mass. 43% Cape Cod

Transportation

60% Of Cape Cod seniors have lost their driver's license

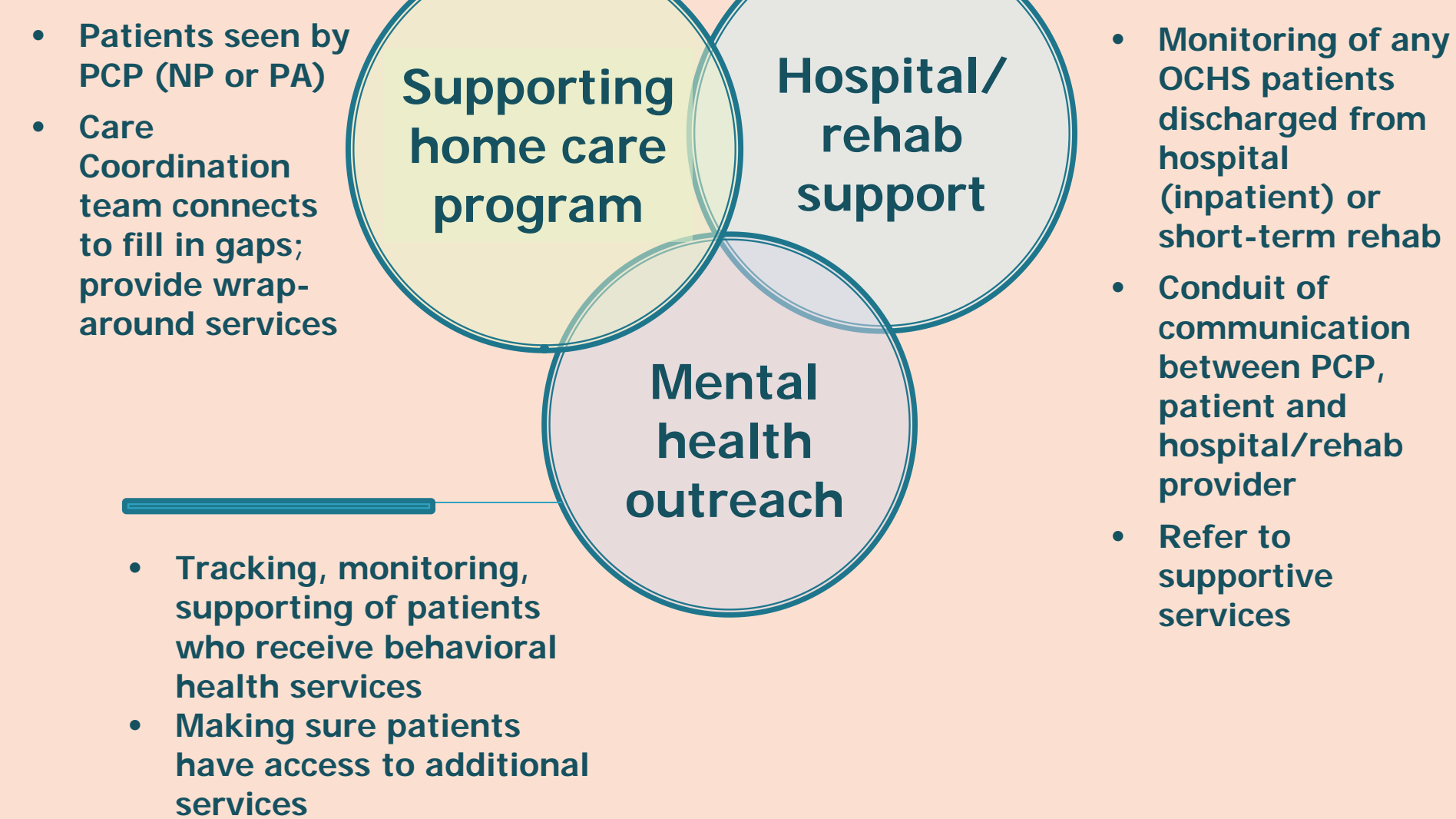
63% Find particular locations difficult to access on public transit

High costs

42% Of Cape Cod seniors have difficulty paying insurance deductibles/co-pays

36% Could not afford fees for service

CARE COORDINATION PROGRAM

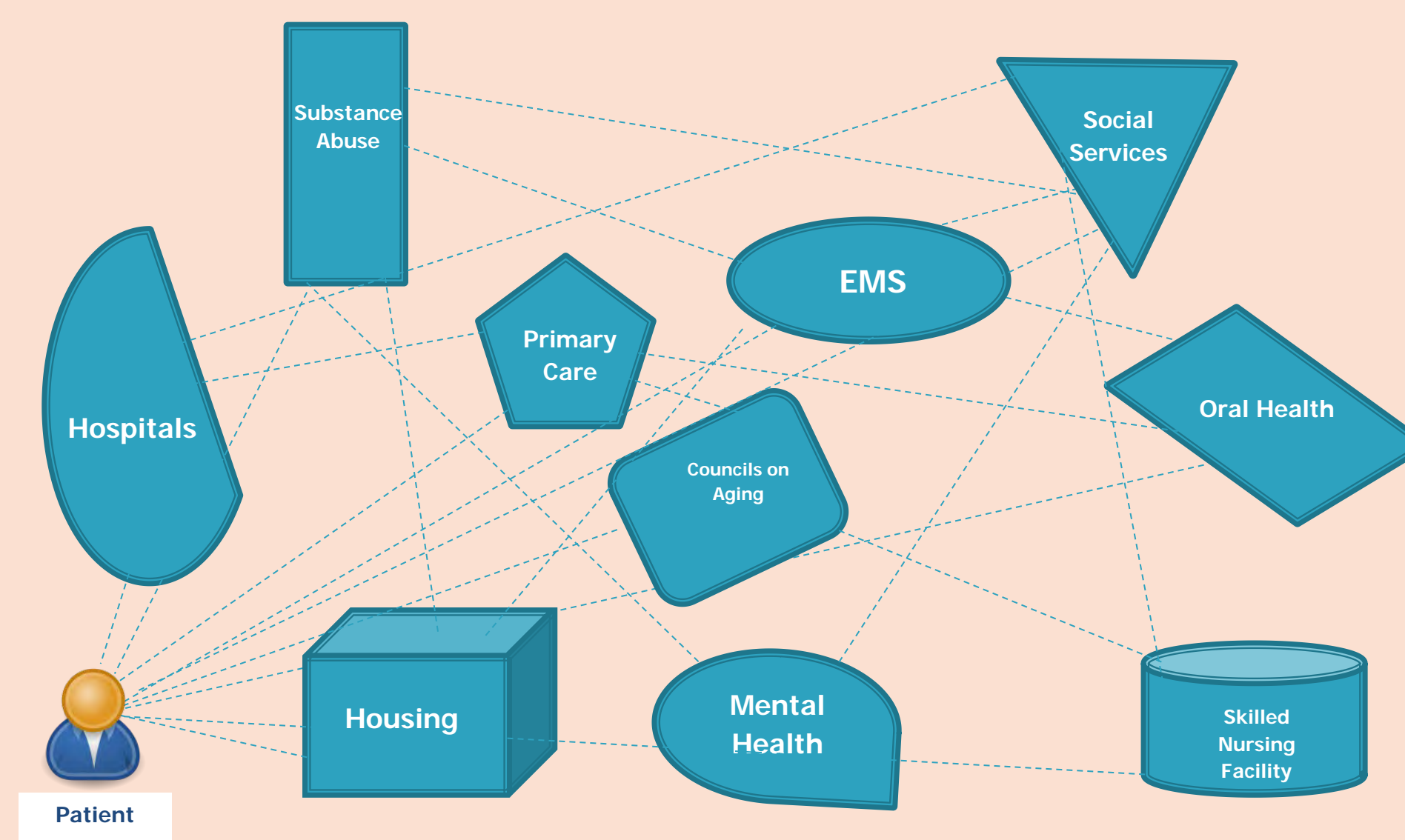


Observed benefits

- 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

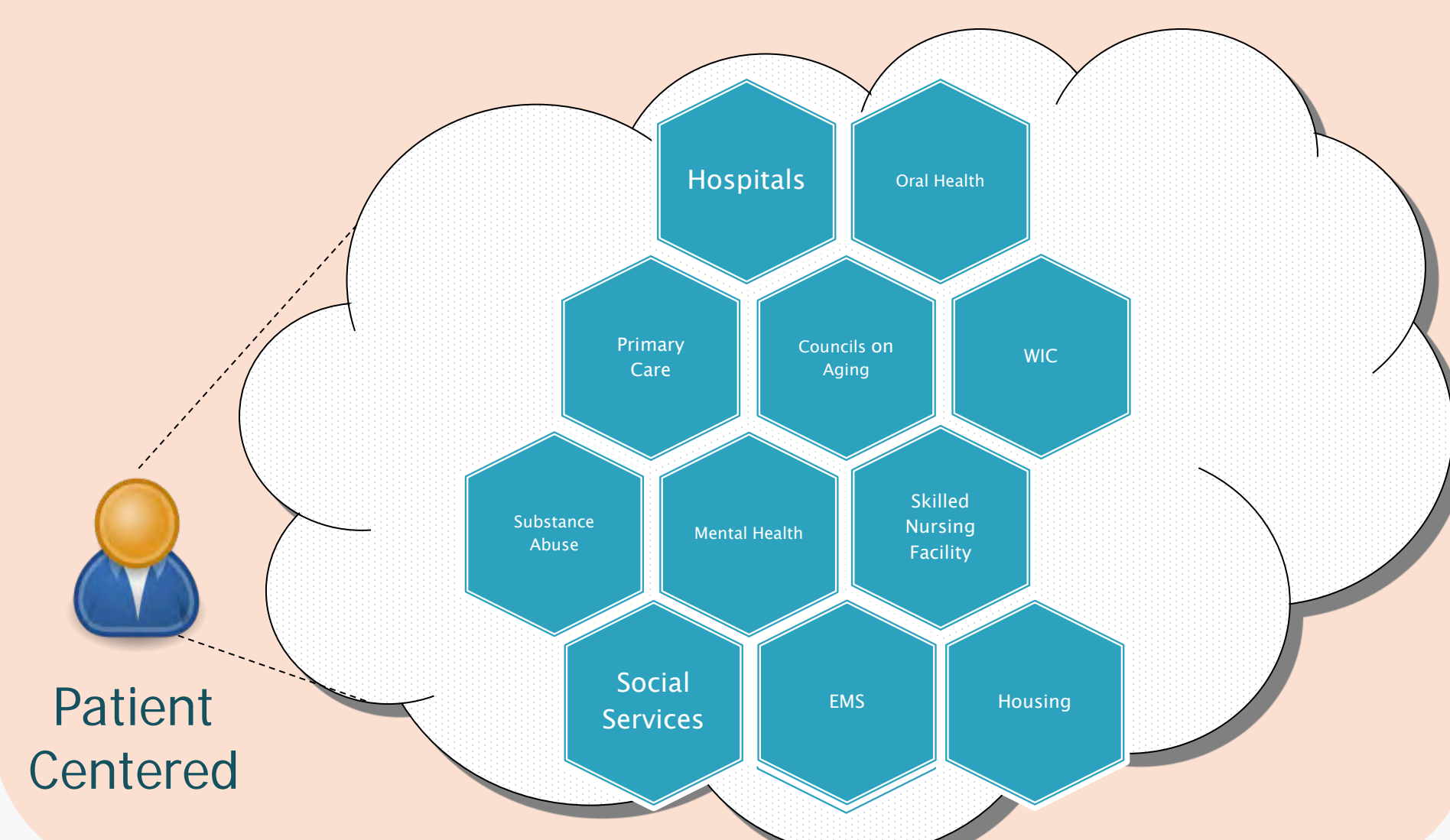
Challenges

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



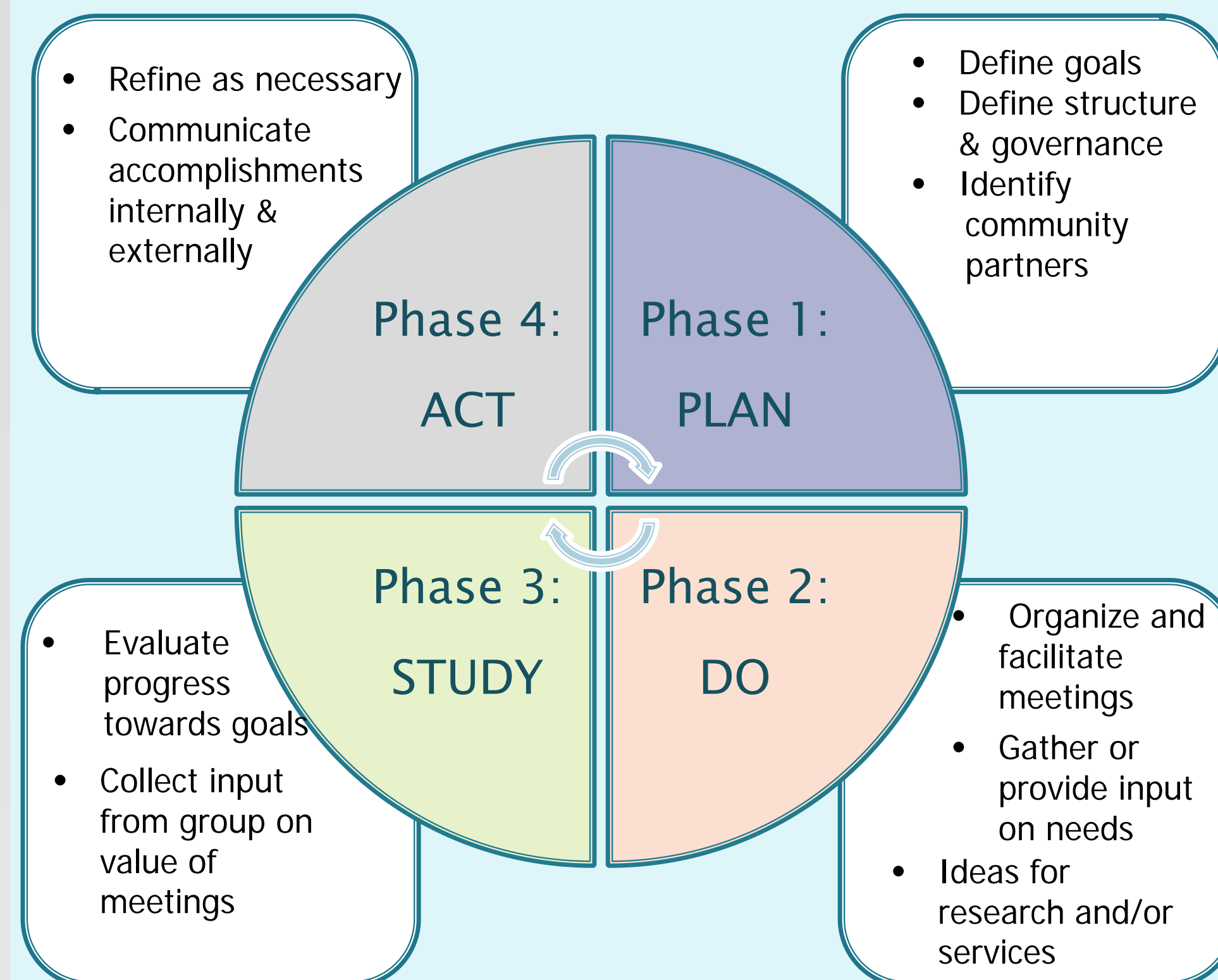
The goal

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

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

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