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:

  ![](image)

AN AGING POPULATION

Median age of Barnstable County

- 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

CARE COORDINATION PROGRAM

- Patients seen by PCP (NP or PA)
- Care Coordination team connects to 80% in gaps; provide wrap-around services
- Monitoring of any OCHS patients discharged from hospital (inpatient) or short-term rehab
- Disworld of communication between PCP, patient and the rehab provider
- Refer to supportive services

HEALTH CONDITIONS

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

- OCHS all adults
- OCHS over 65
- State over 65

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

Barrier to care

- Finding a doctor
- Barnstable County designated by HMO as medically underserved area for primary care, mental health and dental health

Fewer physicians accepting MassHealth

- 68% Mass

BUIDLING 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

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

REFERENCES


High costs

- 68% of Cape Cod seniors have lost their driving license
- Find particular locations difficult to access on public transit
- Could not afford fees for service

Transportation

- 40% Cape Cod seniors have lost their driving license

High costs

- 35% Cape Cod seniors have difficulty paying insurance deductibles/co-pays

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

Barrier to care

- Finding a doctor
- Barnstable County designated by HMO as medically underserved area for primary care, mental health and dental health

Fewer physicians accepting MassHealth

- 68% Mass

The goal

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