The Interprofessional Care Access Network: Coming to a Neighborhood Near You!

Oregon Health & Science University, Portland, OR
Presenters

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1 | PROJECT OVERVIEW
2 | CASE STUDIES – ROUND 1
3 | INTRODUCING ZOOM
4 | CASE STUDIES – ROUND 2
5 | FULL GROUP DISCUSSION
6 | OUTCOMES AND IMPLICATIONS
Workshop Format

Please keep the following in mind in order to get the most out of today’s workshop:

- **Spread Out!** Make sure that there are at least three different professions represented at each table.

- **Identify Roles!** Each table will need a scribe, a reporter, and a discussion facilitator.

- **Don’t Peek!** Please wait to open the case study envelopes until instructed to do so. There will be two rounds, each with a separate envelope. Each table has 1 of 3 different cases.
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Oregon Health & Science University
OHSU’s Interprofessional Initiative (IPI)

Updated the institutional strategic plan to include “interprofessional” and “collaboration.”

Created an IPECP infrastructure including steering and advisory committees, taskforces, core faculty, and curriculum changes.

Established Core Graduation Competencies shared across all academic programs.

Developed a University Curriculum Committee to grow and expand interprofessional courses.
Facilitating IPECP Culture

- Common academic calendar
- Designated, shared time for IPE learning
- University-wide tuition model
- Interprofessional simulation
- IP team-based care in the OHSU Health System
- Return on investment
The Collaborative Life Sciences Building
Enhancing IPECP Culture

Be Inclusive – dentistry, medicine, nursing, nutrition, pharmacy, physician assistant, public health, radiation therapy.

Interprofessional Rural Health Campus rotations integrated into all academic schools.

“Value-Added Curriculum” rather than add-on curriculum.

Interprofessional courses

Collaborative practice training sites
Nexus Innovation Incubator

National Center for Interprofessional Education and Practice designated OHSU as a Nexus Innovation Incubator site.

3 Nexus Innovation Incubator Projects at OHSU including I-CAN.
I-CAN Goals

- **Expand partnerships** between OHSU, neighborhood clinics, and community service agencies.
- **Create a collaborative model** for clinical practice and interprofessional education.
- **Improve access** to local health care services for the uninsured, isolated, or medically vulnerable.
- **Address the Triple Aim goals** of increasing satisfaction with the healthcare experience, improving population health outcomes, and reducing or containing per capita costs.
Academic Partners within OHSU

I-CAN brings together students and faculty from the:

- School of Nursing
  3rd and 4th Year Students

- School of Dentistry
  4th Year Students

- School of Medicine
  2nd and 3rd Year Students

- College of Pharmacy
  4th Year Students
Three Neighborhoods, Three Populations

Old Town Portland
Homelessness, mental health, disability, low-income, veterans, seniors.

Southeast Portland
Immigrants and refugees from Sub-Saharan Africa, the Middle East, and Southeast Asia.

West Medford
Low-income, families, homelessness, seasonal and migrant farm workers.
Care Coordination Process

Neighborhood Collaboratives for Academic-Practice Partnership

- People in the neighborhood
- Health care organization
- Community service agency
- Community service agency
- I-CAN student teams
- Other local resources
Community partners identify their most vulnerable clients.

- 2+ non-acute EMS calls in the past 6 months.
- >3 missed appointments in the past 6 months.
- No primary care home.
- No health care insurance.
- More than 10 medications.
- Older than 60 or families with children without stable housing.
- Signs of child negligence.
- >1 family member with a disabling chronic illness.
- Developmentally delayed parent(s).
Care Coordination

Nursing faculty-in-residence (FIR) coordinate interprofessional student teams.

- Have established history in the neighborhood.
- Are committed to community-based practice role.
- Support student learning and safety through mentoring.
- Provide consistent point of contact for clients.
- Form link between academia and community.
Intake Assessment

Churn: in the past six months, how often have you…
• Seen/called a healthcare provider?
• Been involved in an EMS/police call?
• Visited the emergency room?
• Been hospitalized?
• Had a change in insurance?
• Had a change in housing?

Stabilization: describe, in the past six months, your…
• Employment and/or other source of income.
• Level of social support.
• Food security/nutrition.
• Healthcare appointment adherence.
Students work collaboratively with clients and partners.

- Establish relationship built on trust.
- Partner with client and community service agency to identify and prioritize goals.
- Develop client-centered care plans for achieving goals.
- Visit weekly over multiple academic terms.
- Connect clients with local resources and services in the neighborhood.
- Work intensively with small caseloads.
- Identify population-level health issues and potential student projects.
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Case #1: “Lucy”

A 34 year old single mother with five children, referred to I-CAN because she has missed multiple appointments. She has recently come from the Congo to Oregon, speaks only Swahili, and has no formal education.

- She has recently been diagnosed with hepatitis B.
- She has underlying sickle cell anemia.
Case #2: “Mark”

A 40 year old male from the mid-west who has been blind since birth, reads Braille, and has highly developed cell phone skills.

He is referred by the community service agency because of his health needs and a very strong unpleasant body odor.

He has an underlying seizure disorder and depression.
Case #3: “Kian”

A 38 year old male refugee from Burma who speaks Cantonese and has 12 years of education.

He presents with painful facial swelling and a foul odor from his mouth.

He has underlying hypertension and his mother died at a young age from “high blood pressure.”
Round 1 Discussions

Please open the envelope marked “Round 1” and read over the full case summary assigned to your table.

Discuss among yourselves the case summary and consider the following questions:

1. What are the issues related to lifestyle and social determinants of health?

2. What would you bring to the case based on your professional perspective/lens?
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Learning to Zoom
Mr. Taumata Tafaia
Tribal Chief

VIA AIR MAIL

Solomon Island
Australia
Using Zoom

Find a partner and zoom out on the case assigned to your table. Zoom as far as you can!

What new insights does this bring to the case? Discuss with the others at your table.

Share with the full group what you discussed and what you learned from your discussion.
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Open the “Round 2” envelope and read the additional information about your case.

1. Are there any surprises in the case that you didn’t anticipate?

2. How does the level of “zoom” refocus your intervention and practice at each level?

3. What resources do you need or require at each level?

4. What community and professional partners did you include as you zoomed in/out?
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Take 5 minutes to discuss the questions below at your table and prepare to share with the full group.

1. What was the value of the zoom model in identifying the context of health care?

2. How could this perspective affect the interprofessional function of healthcare teams?

3. How might this perspective influence your own professional practice in your community?
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A Second Look at I-CAN

I-CAN addresses social determinants of health that are barriers to appropriate healthcare use and health self-management.

I-CAN serves vulnerable and disadvantaged people who have fallen through gaps in the system and are not typically seen in primary care.

I-CAN clients experience chaos and complexity that traditional community service agencies and health clinics aren’t always able to support.
When clients start working with I-CAN:

- 37% Of clients lack a primary care home
- 23% Of clients lack stable housing
- 20% Of clients lack health insurance
In the six-month period prior to working with I-CAN:

- **48%** of clients visited the emergency department at least once.
- **24%** of clients who visited the ED visited **three or more times** in six months.
- **33%** of clients were admitted to the hospital at least once.
- **33%** of clients called emergency medical services at least once.

High Utilization of Healthcare
Aggregate Health Outcome Measures

Short-Term Client Outcome Measures

- Increase the number of clients with access to primary care homes
- Increase the number of clients living in stable housing
- Increase the number of clients with healthcare insurance
Aggregate Health Outcome Measures

Long-Term Client Outcome Measures

- Reduce non-acute EMS calls
- Reduce number of ED visits
- Reduce hospital admissions
- Increase healthcare satisfaction
Achieving Client Goals

First-year data from April 1, 2013 through May 15, 2014.

- **63%** \(\uparrow\) Increase in clients with access to primary care \((N = 30)\)
- **39%** \(\uparrow\) Increase in clients living in stable housing \((N = 19)\)
- **53%** \(\uparrow\) Increase in clients with access to health insurance \((N = 30)\)
Healthcare utilization decreased significantly after twelve I-CAN visits when compared to the six month period prior to I-CAN.
Healthcare utilization decreased significantly after twelve I-CAN visits when compared to the six month period prior to I-CAN.

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<thead>
<tr>
<th>Reducing System Utilization (N = 15)</th>
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<tr>
<th></th>
<th>ED Visits</th>
<th>EMS Calls</th>
<th>Admissions</th>
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<tbody>
<tr>
<td>Pre-I-CAN</td>
<td>31</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>Post-I-CAN</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
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In estimated cost avoidance for just 15 clients.

$183,114
Health Delivery System Transformation

Acute Care System 1.0
- Episodic healthcare
- Lack of integrated care networks
- Lack of quality & cost performance transparency
- Poorly coordinated chronic care management

Coordinated Seamless Healthcare System 2.0
- Patient/person centered
- Transparent cost and quality performance
- Accountable provider networks designed around the patient
- Shared financial risk
- Health information technology-integrated
- Focus on care management and preventive care

Community Integrated Healthcare System 3.0
- Healthy population-centered, population health-focused strategies
- Integrated networks linked to community resources capable of addressing psycho-social/economic needs
- Population-based reimbursement
- Learning organization: capable of rapid deployment of best practices
- Community health integrated
- E-health and telehealth capable

(Halfon et al., 2014)
I-CAN Team Members

Project Director: Peggy Wros, PhD, RN
Project Manager - Portland: Launa Rae Mathews, MS, RN, COHN-S
Project Co-Manager - Medford: Heather Voss, MSN, RN
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Liaison to School of Dentistry: Jill Mason, MPH, RDH, EPP
Liaison to College of Pharmacy: Juancho Ramirez, PharmD
Faculty in Residence – Old Town: Beth Doyle, MSN, WHCNP, ANP, RN
Faculty in Residence – Medford: Fran Voss, MSN, RN
Faculty in Residence - Southeast: Kristen Beiers-Jones, MN, RN
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<tr>
<th>Organization</th>
<th>Liaison</th>
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<tbody>
<tr>
<td>Central City Concern</td>
<td>Chuck Sve, LAc</td>
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<tr>
<td>Macdonald Center</td>
<td>Kristrun Grondal</td>
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<td>Neighborhood House</td>
<td>Janice Jones</td>
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<tr>
<td>La Clinica</td>
<td>Alma Elder, RN</td>
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<tr>
<td>Family Nurturing Center</td>
<td>Beth Jaffee-Stafford</td>
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<td>St. Vincent de Paul</td>
<td>Berry Birmingham</td>
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<tr>
<td>Family Medicine at Richmond</td>
<td>Erin Kirk</td>
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<tr>
<td>Asian Health &amp; Service Center</td>
<td>Christine Lau</td>
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<tr>
<td>Lutheran Community Services NW</td>
<td>Jacinda Paschoal</td>
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<tr>
<td>Russell Street Dental</td>
<td>Alisha Brazzle</td>
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Disclaimer
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Thank You

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Roanoke, Virginia
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