



Collaborating Across
Borders V

Roanoke, Virginia

October 2, 2015

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

Oregon Health & Science University, Portland, OR

Presenters

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Molly Osborne, MD, PhD Liaison to the Interprofessional Initiative

- 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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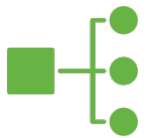
Oregon Health & Science University



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



Interprofessional
simulation



Designated,
shared time for
IPE learning



IP team-based
care in the OHSU
Health System



University-wide
tuition model



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



Care Coordination

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.

Interprofessional Student Team Visits

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.

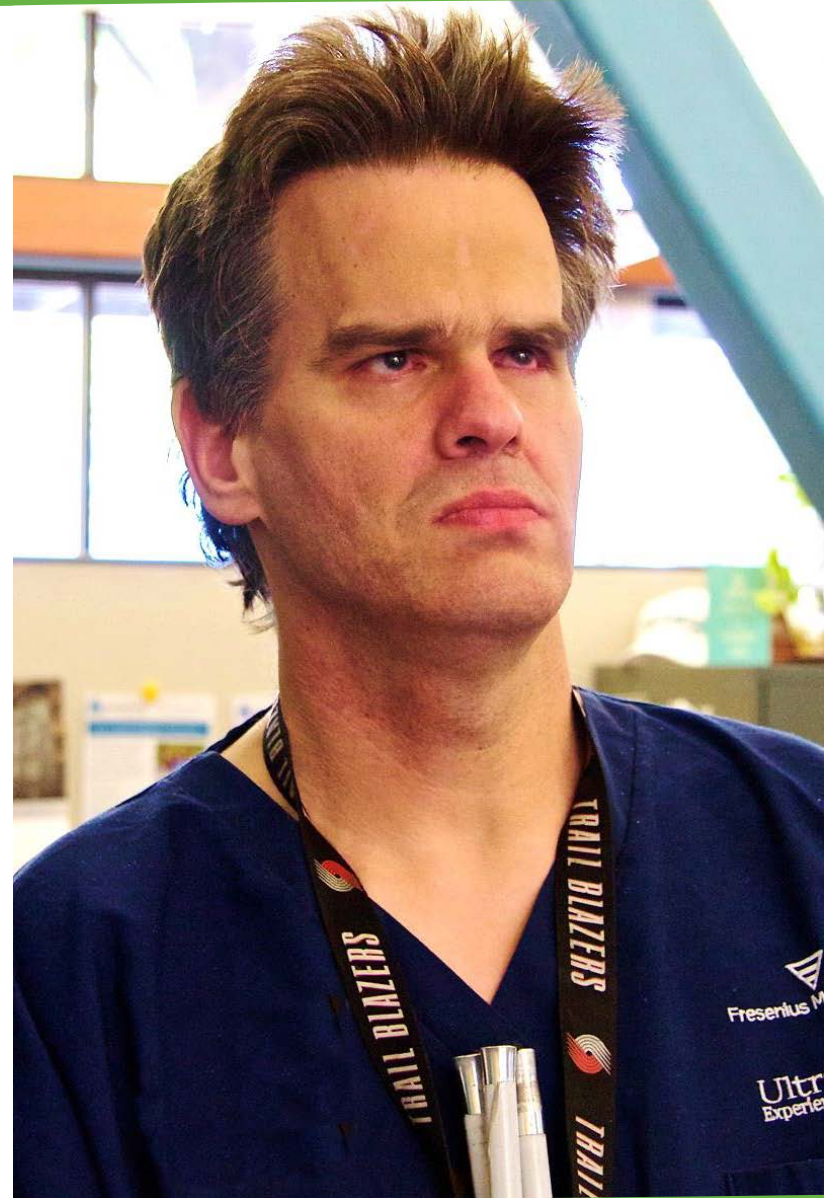


Case #2: “Mark”

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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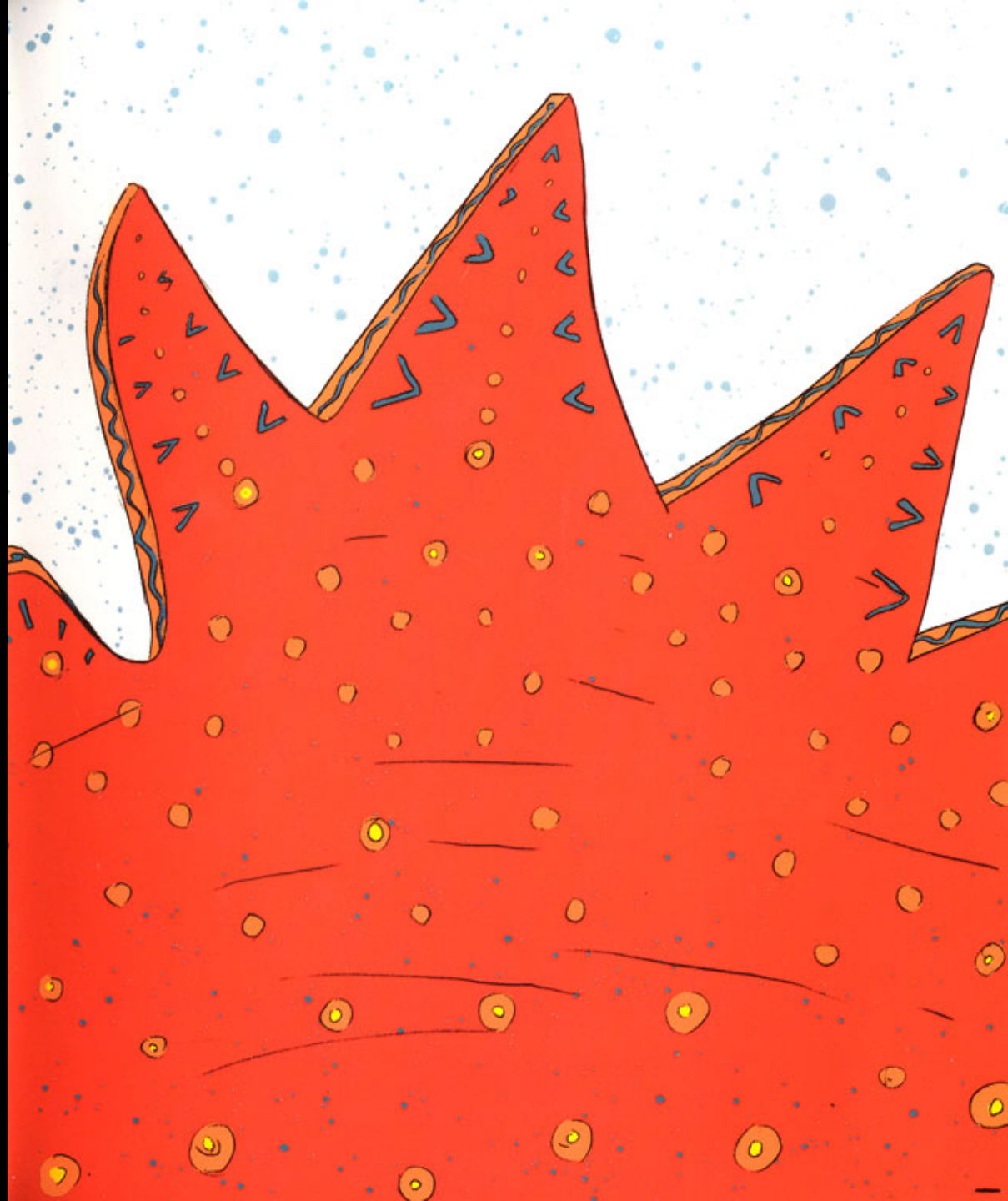
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Learning to Zoom













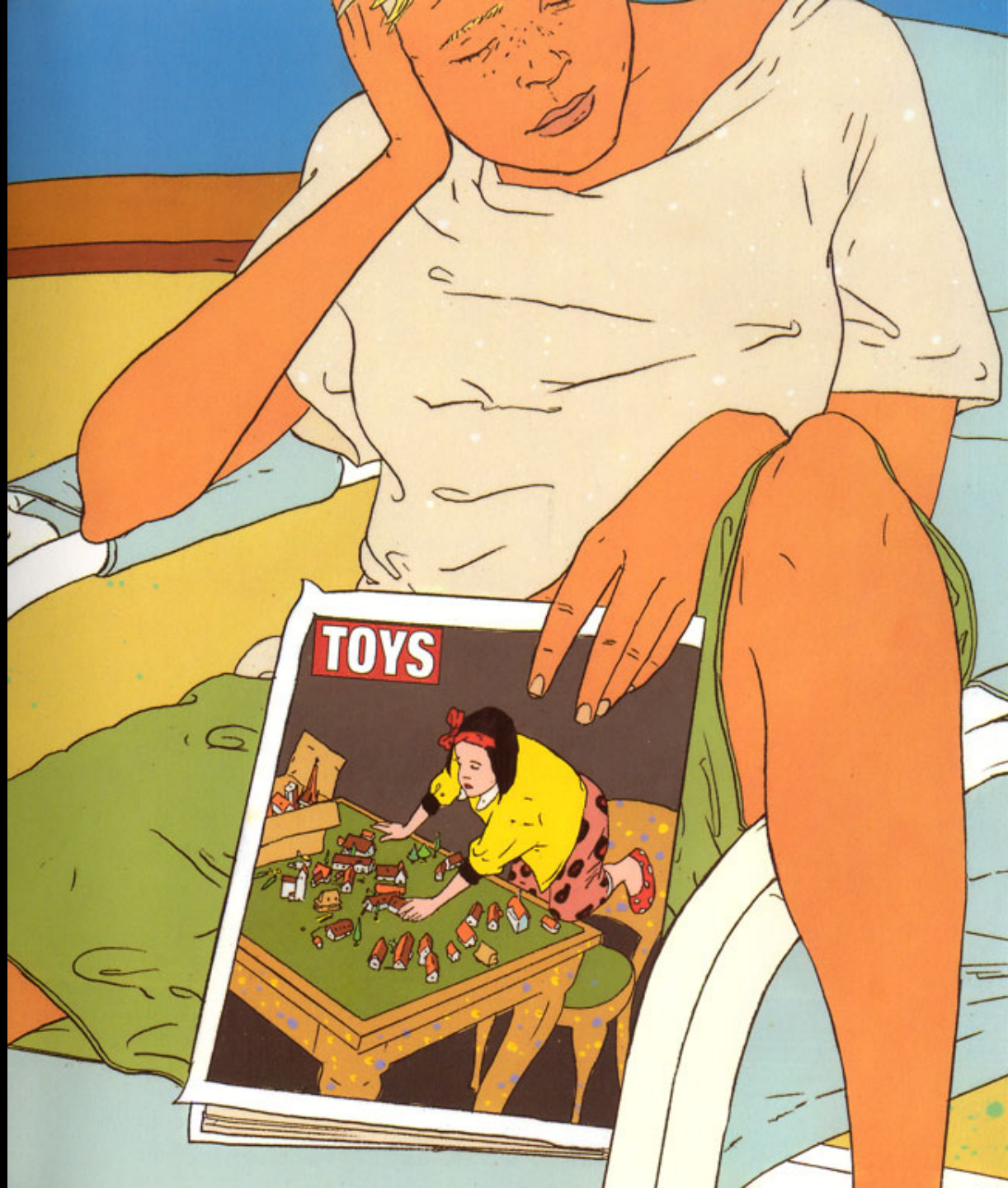




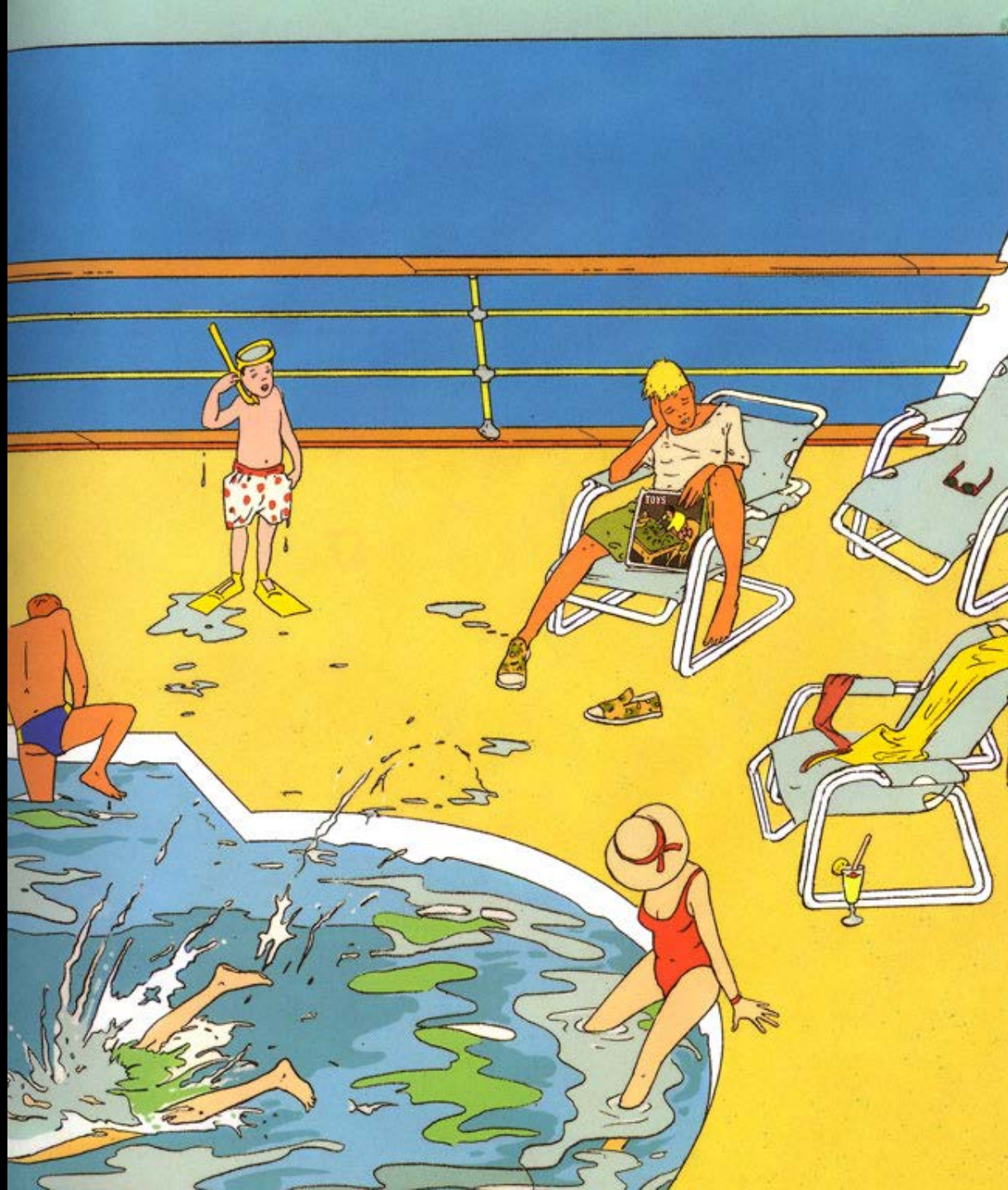


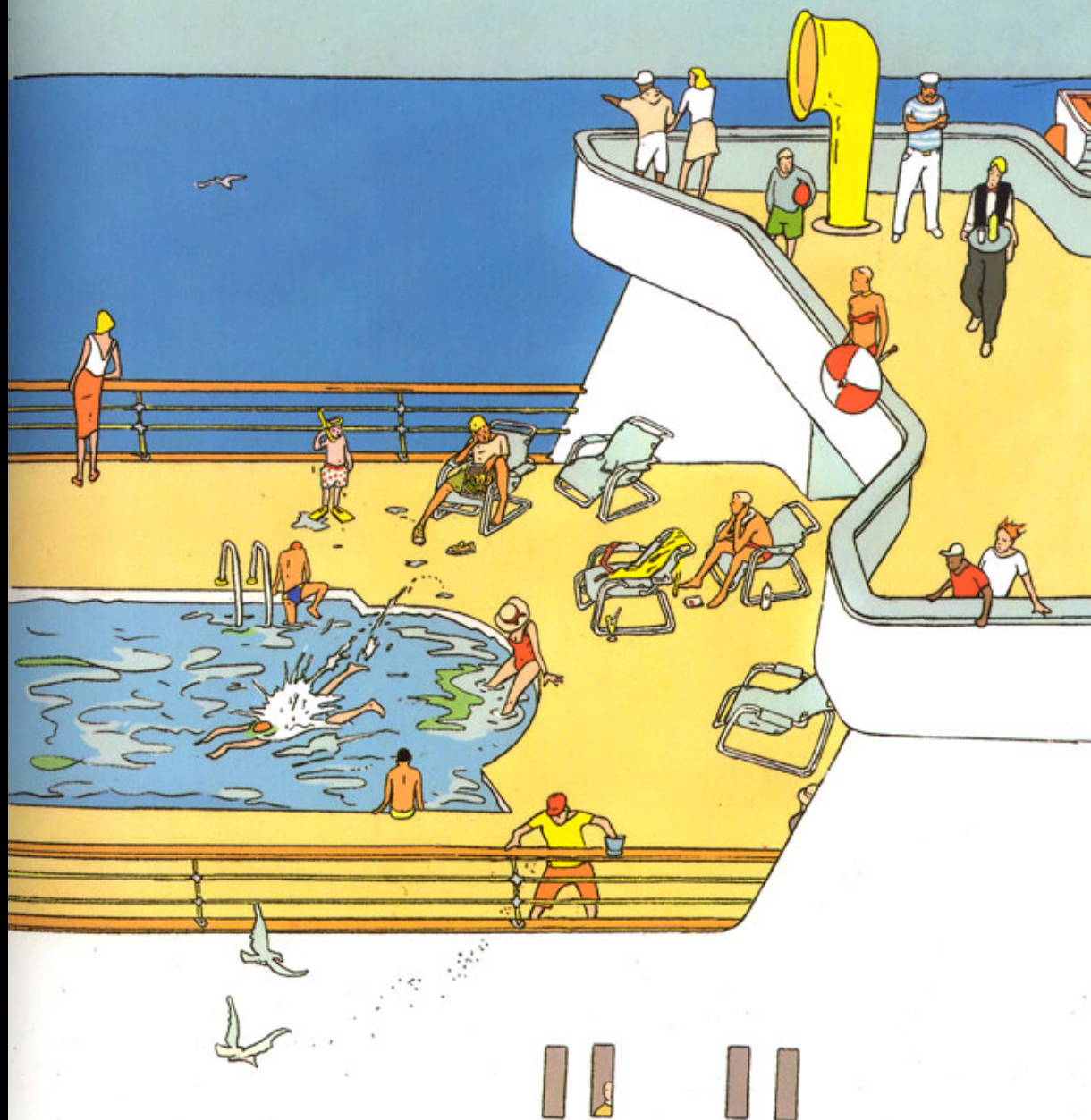
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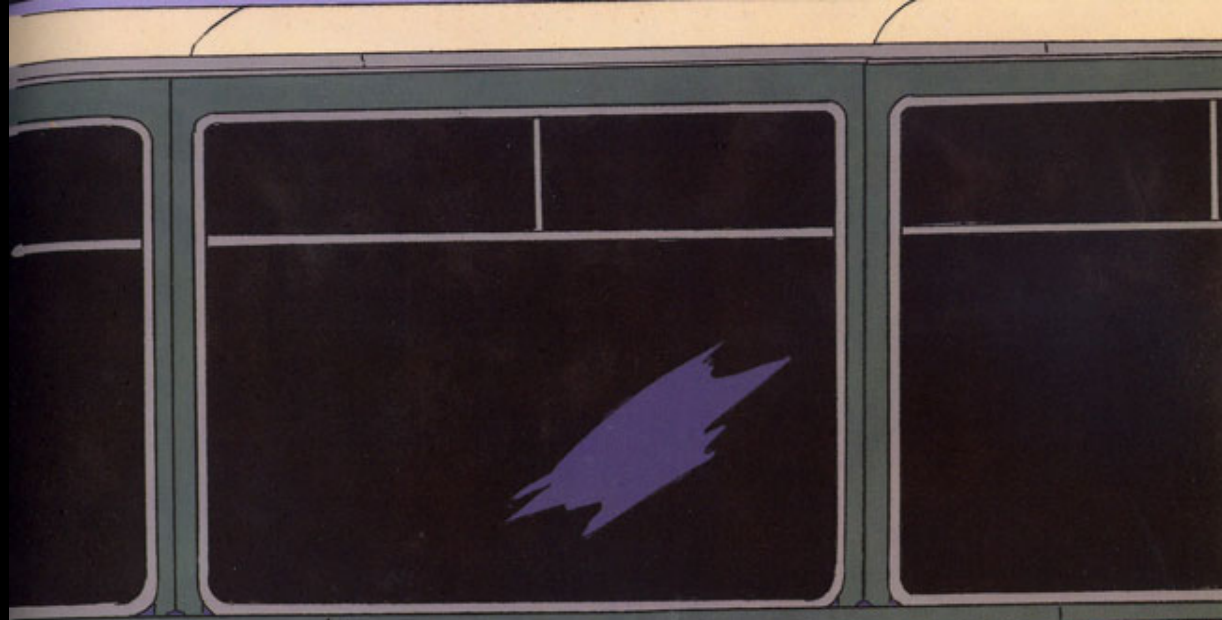




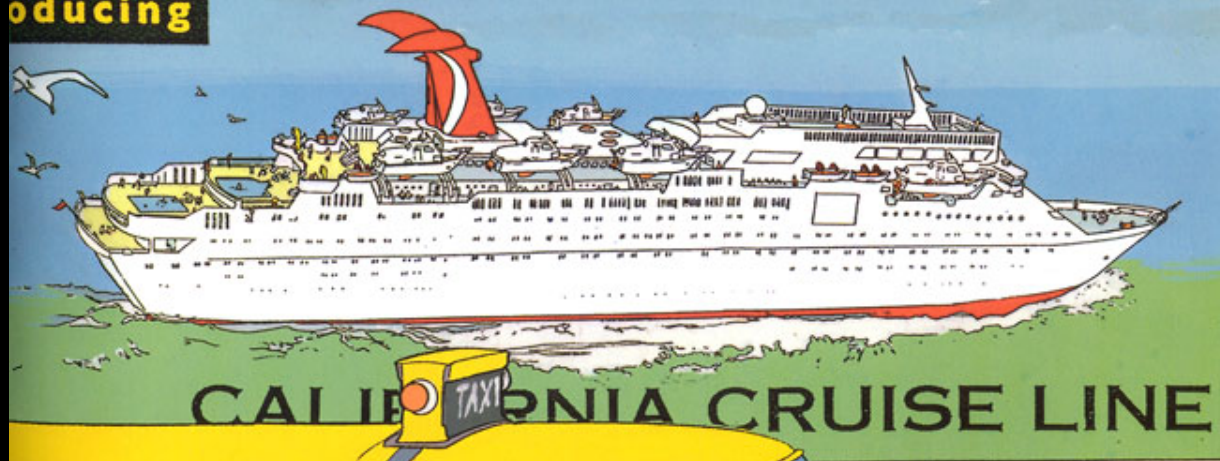


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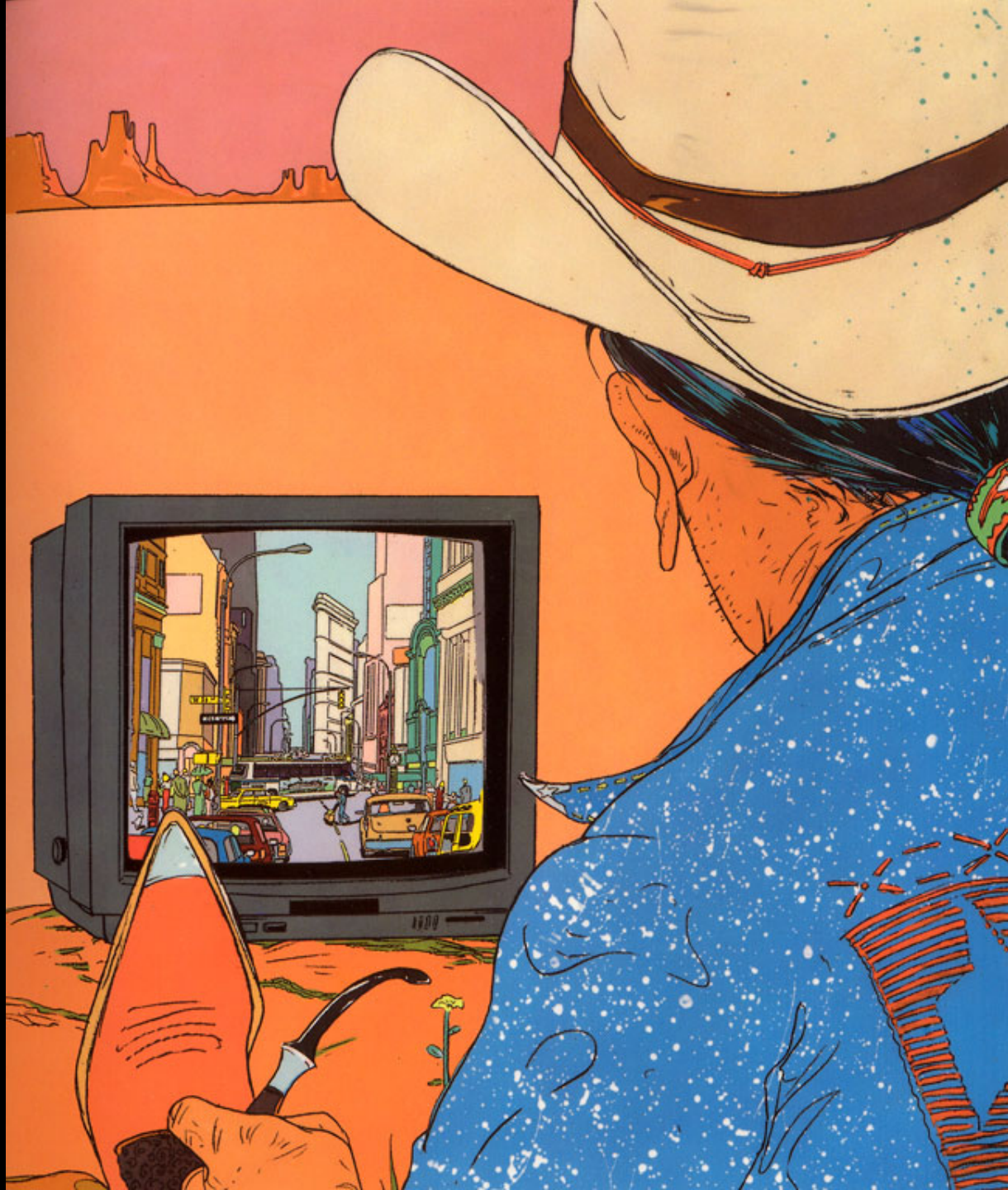


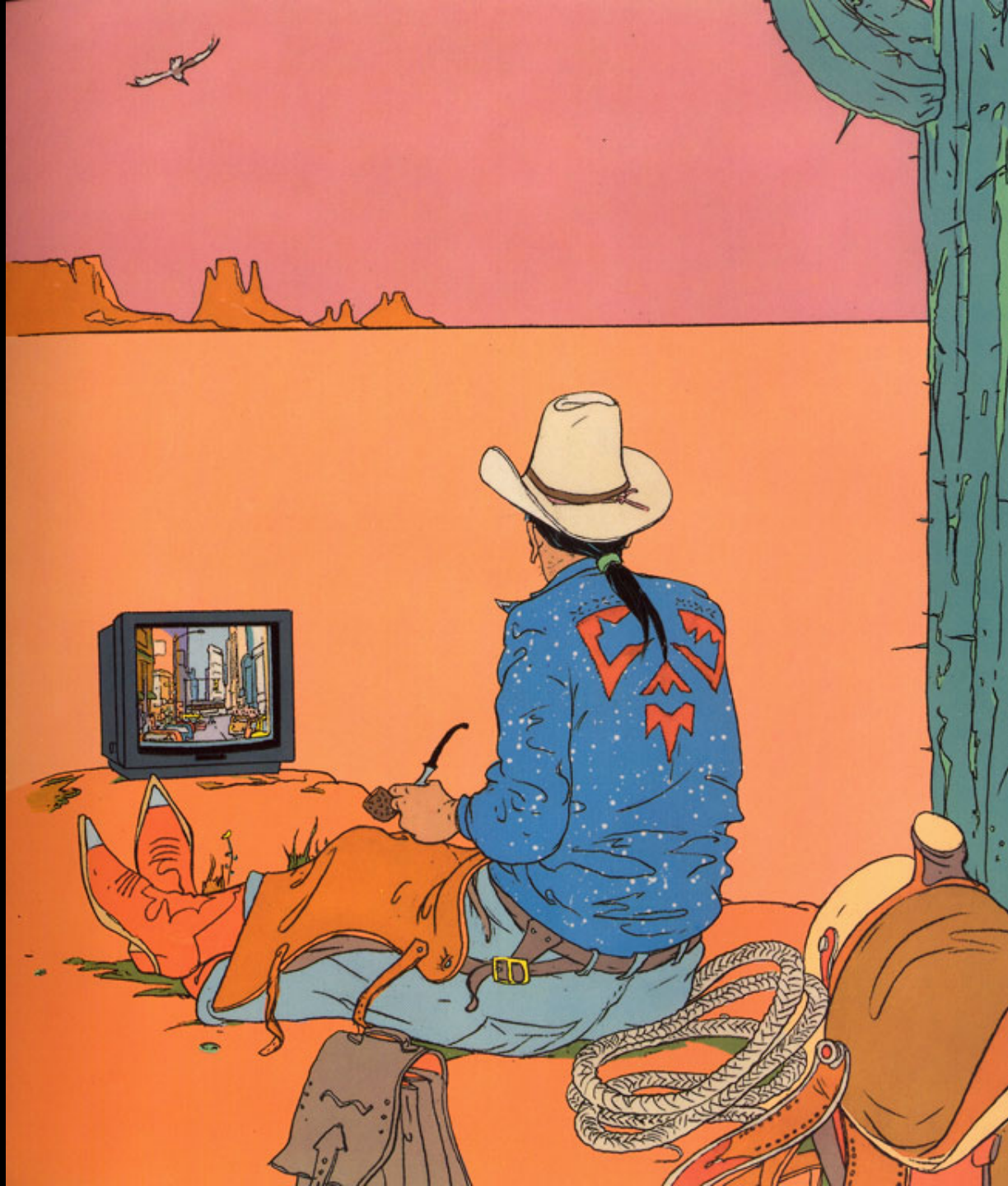
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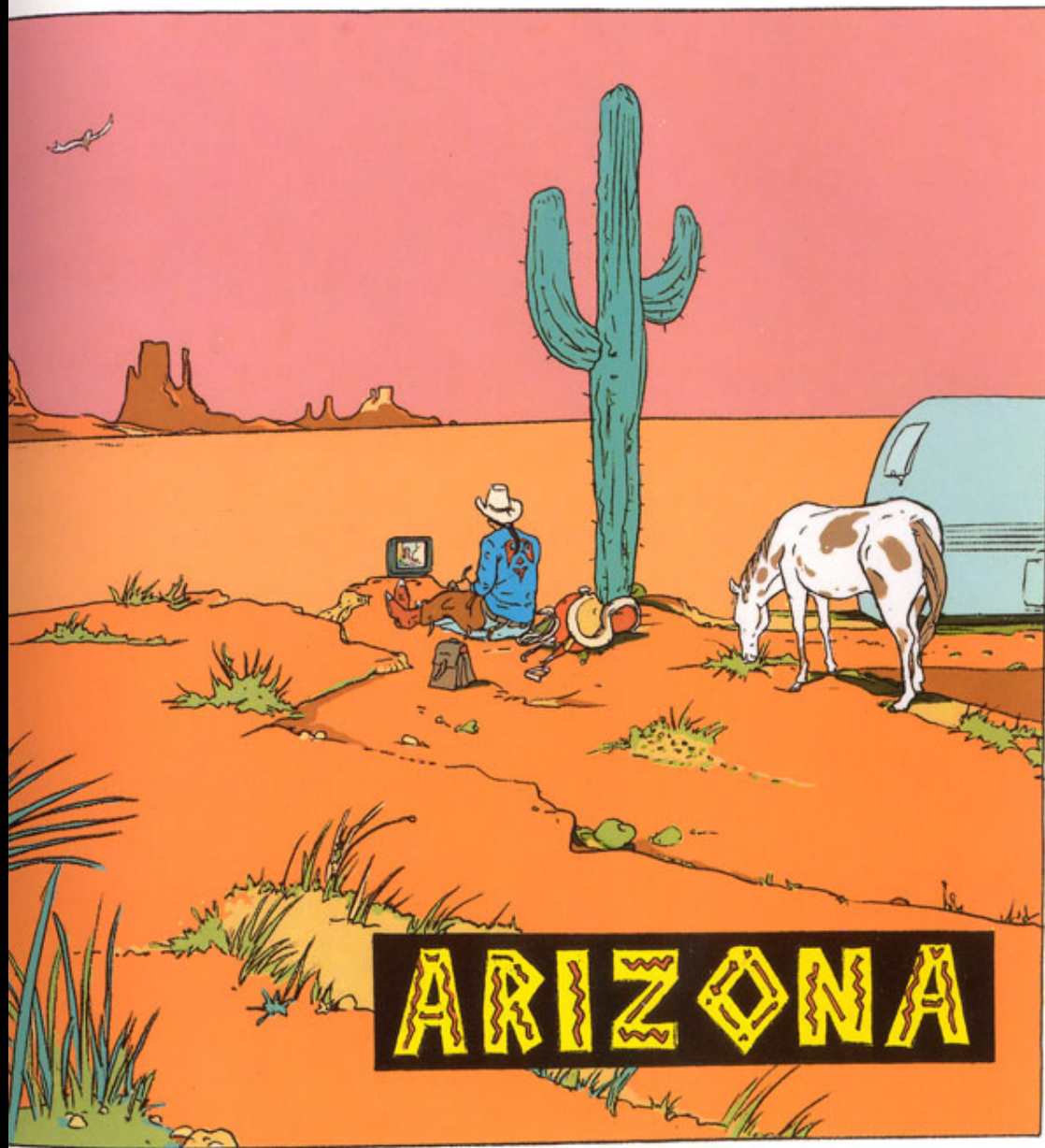


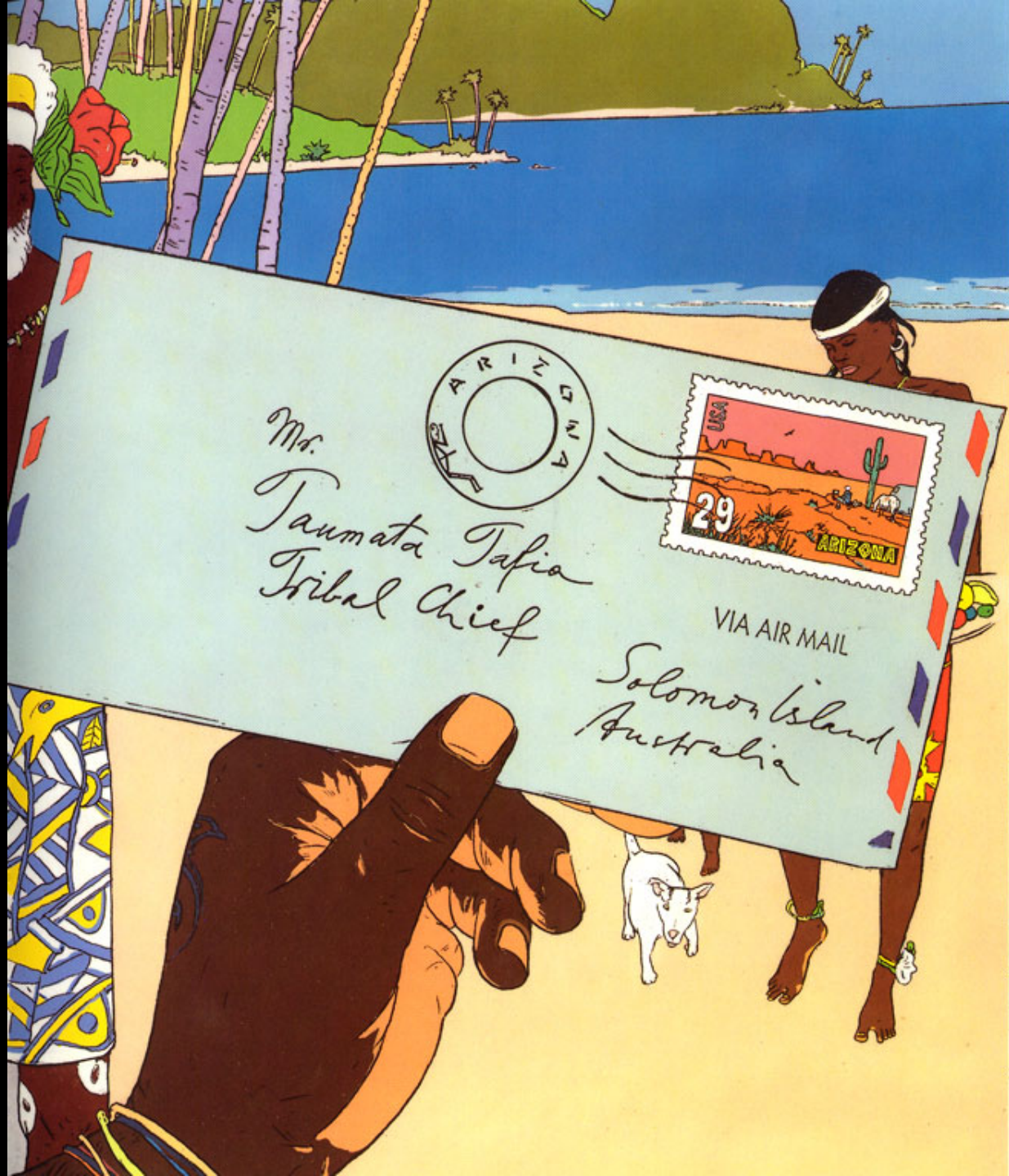


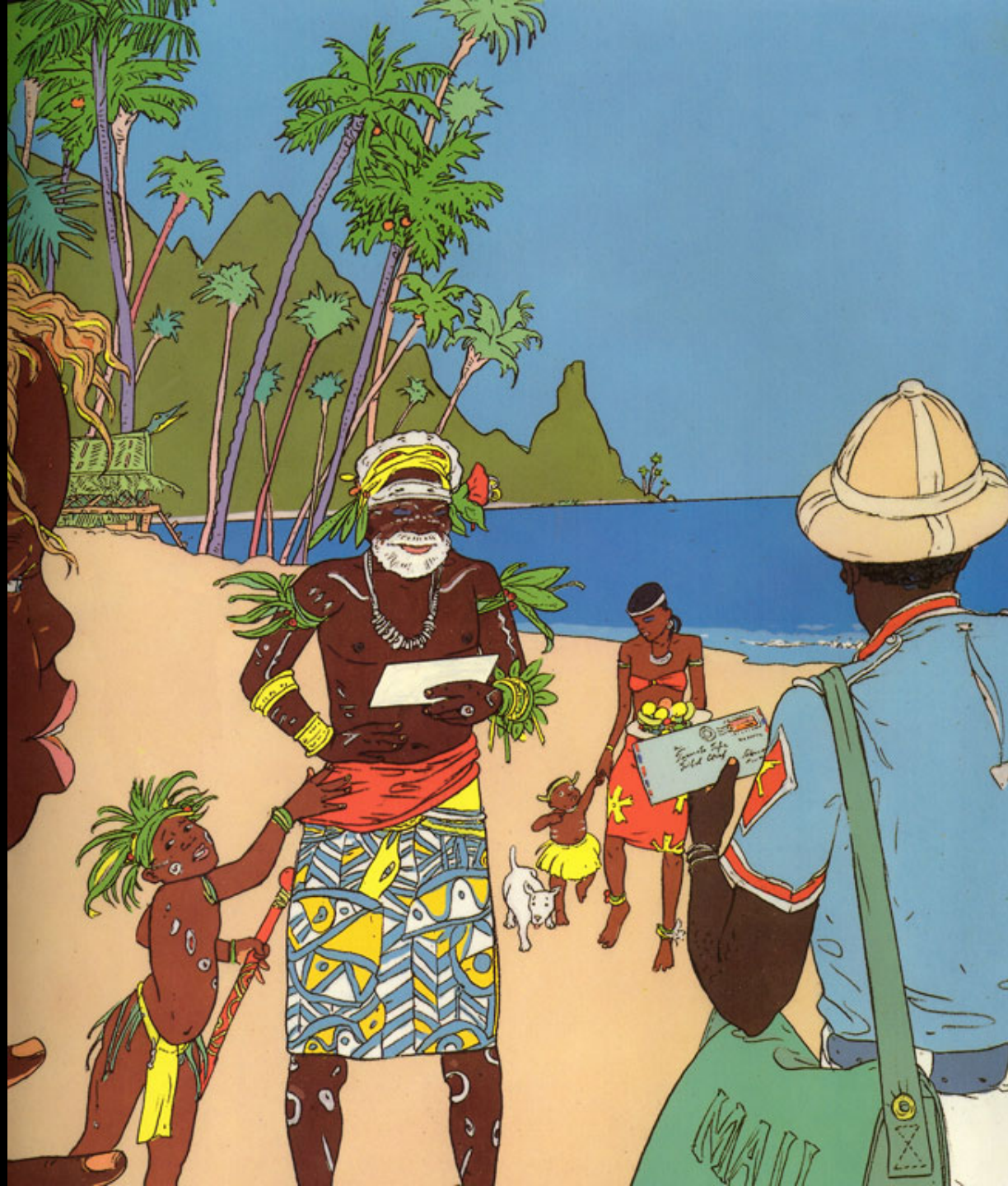


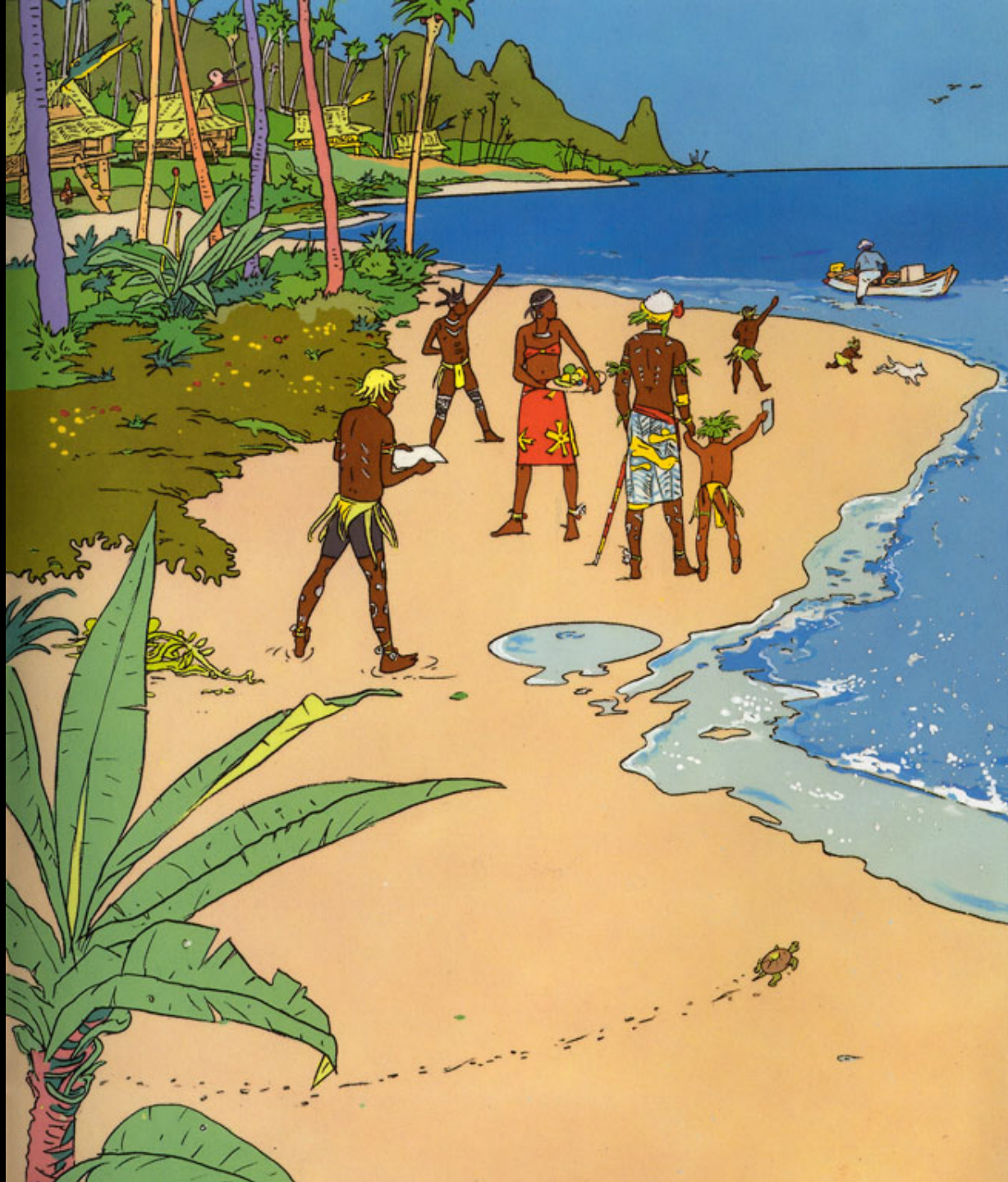


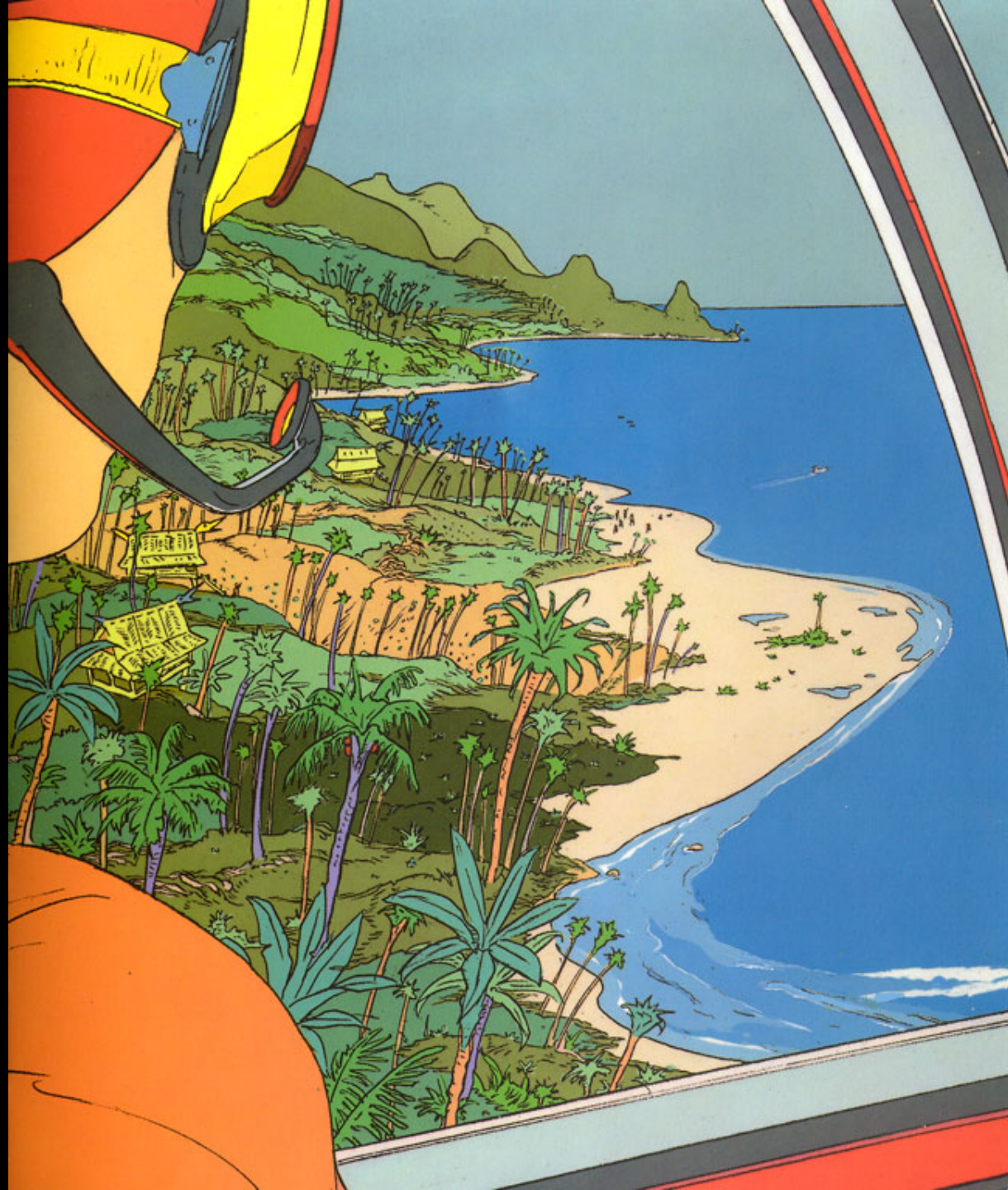






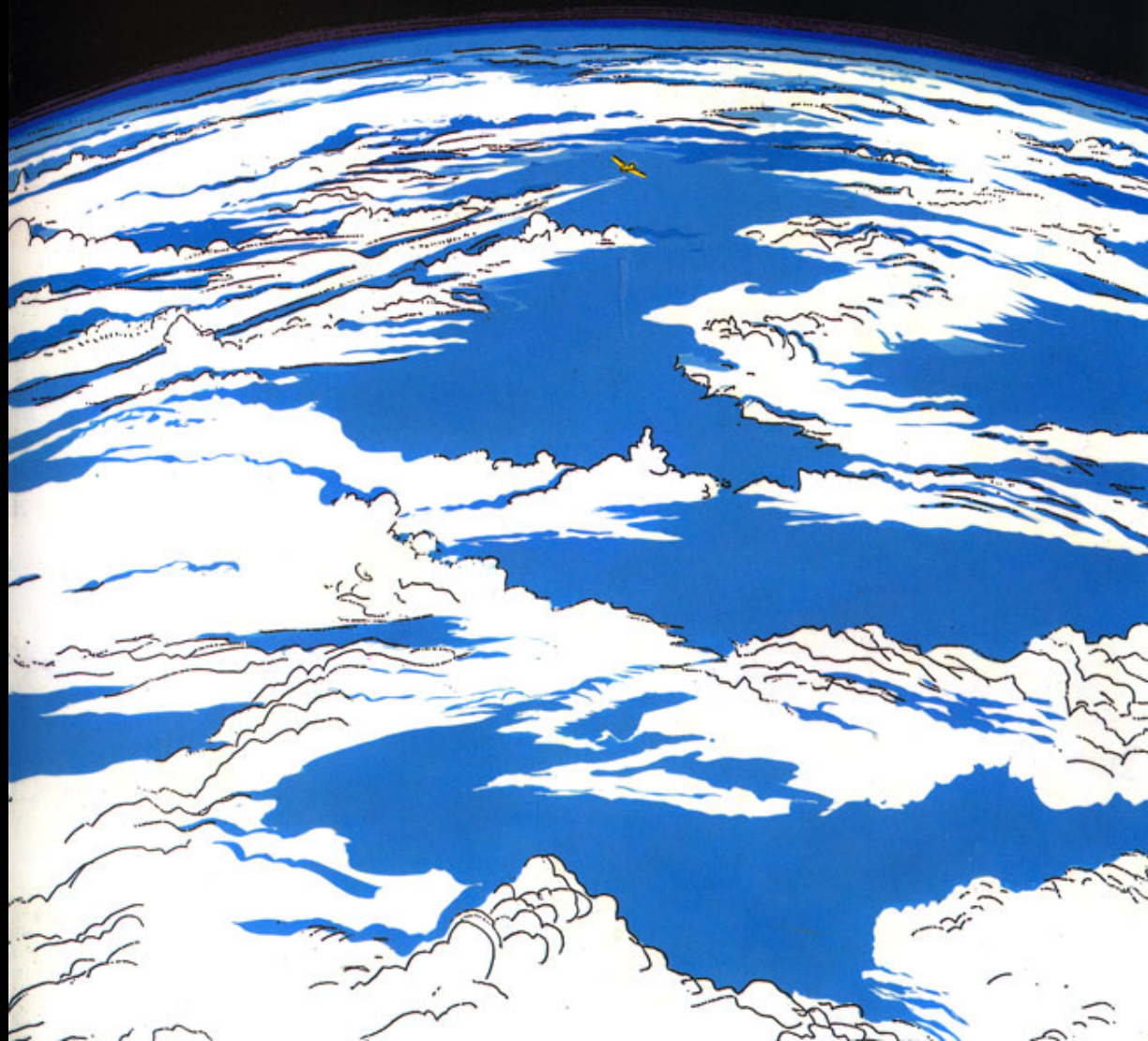












Using Zoom



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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Round 2 Discussions



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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Full Group Discussion



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.

Primary Care, Housing, & Insurance

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

High Utilization of Healthcare

In the six-month period prior to working with I-CAN:



48%

of clients visited the
emergency department
at least once



33%

of clients were admitted
to the **hospital** at least
once



24%

of clients who visited the
ED visited **three or more**
times in six months

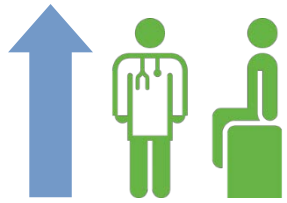


33%

of clients called
emergency medical
services at least once

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% ↑

Increase in clients
with access to
primary care
(N = 30)



39% ↑

Increase in
clients living in
stable housing
(N = 19)

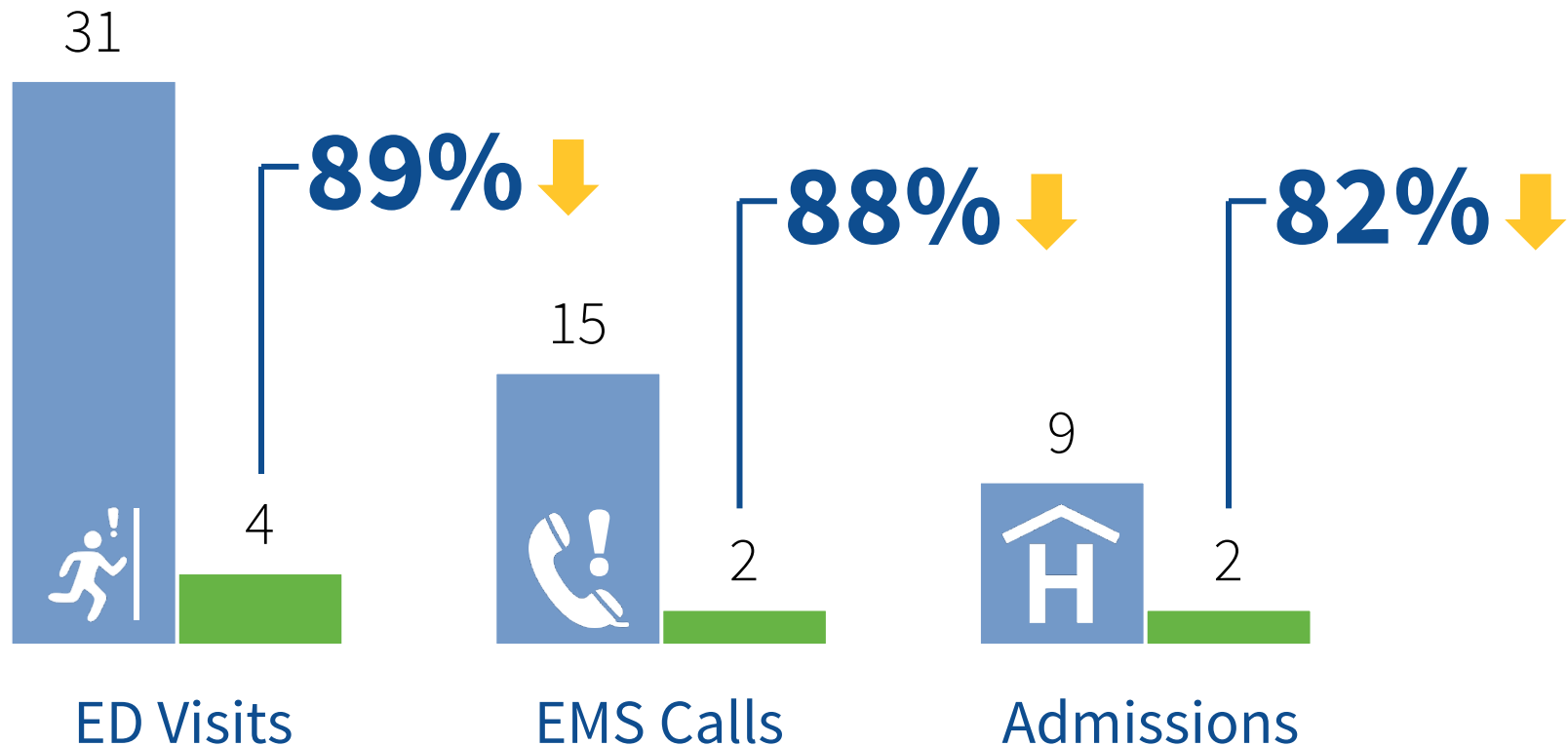


53% ↑

Increase in clients
with access to
health insurance
(N = 30)

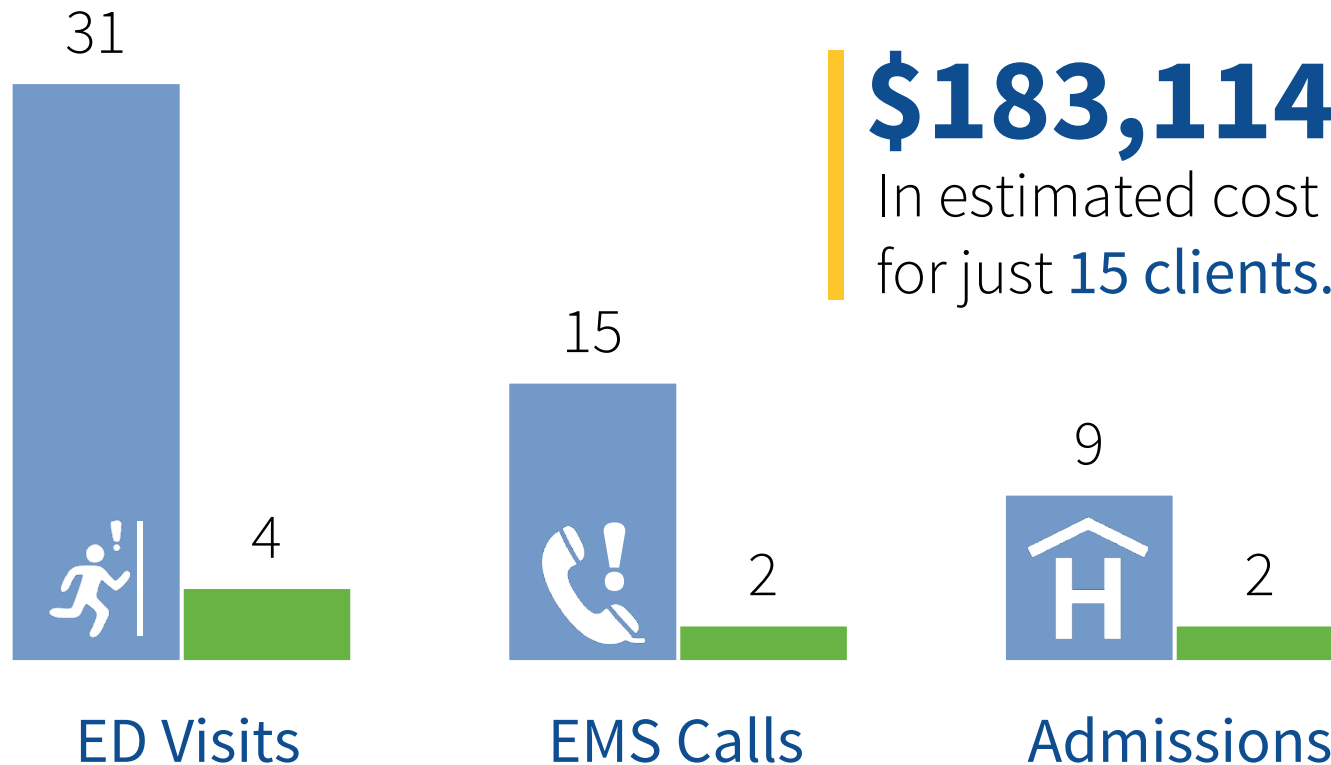
Reducing System Utilization (N = 15)

Healthcare utilization decreased significantly **after twelve I-CAN visits** when compared to the **six month period prior to I-CAN**.

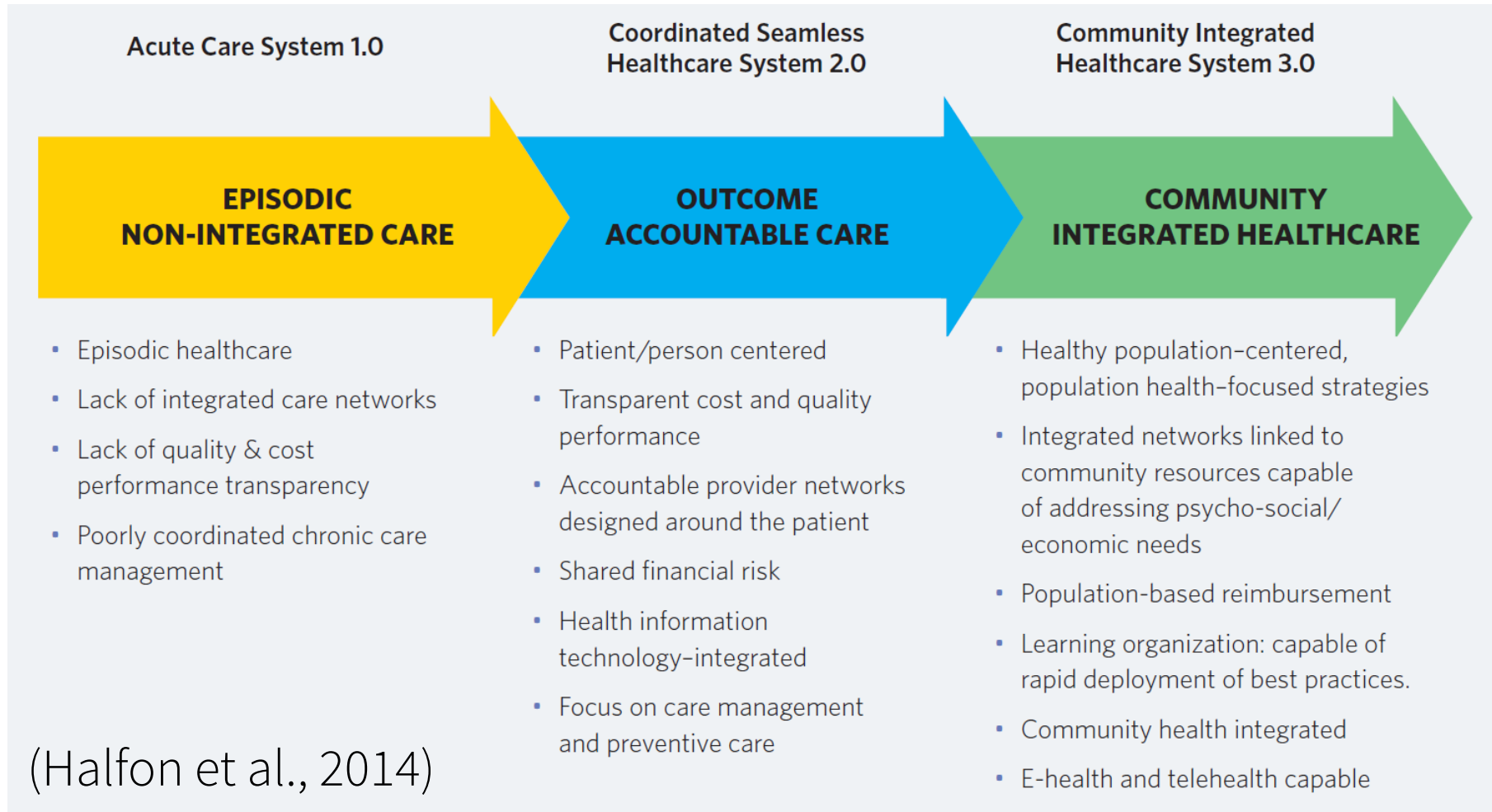


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Health Delivery System Transformation



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
Project Coordinator	Nic Bookman, MPH
Lead Project Evaluator	Katherine Bradley, PhD, RN
Evaluation Consultant	Tanya Ostrogorsky, EdD
Liaison to Provost's Office	Jennifer Boyd, PhD, MBA
Liaison to School of Medicine	Molly Osborne, MD, PhD
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

Community Partner Liaisons

Central City Concern	Chuck Sve, LAc
Macdonald Center	Kristrun Grondal
Neighborhood House	Janice Jones
La Clinica	Alma Elder, RN
Family Nurturing Center	Beth Jaffee-Stafford
St. Vincent de Paul	Berry Birmingham
Family Medicine at Richmond	Erin Kirk
Asian Health & Service Center	Christine Lau
Lutheran Community Services NW	Jacinda Paschoal
Russell Street Dental	Alisha Brazzle

HRSA Funded

Disclaimer

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UD7HP25057 and title “Interprofessional Care Access Network” for \$1,485,394. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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Thank You



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