Interprofessional Care Access Network (I-CAN): Scaling Health Professions Education in Population Health Statewide

Oregon Public Health Association Nursing Section Spring Conference

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The Interprofessional Care Access Network (I-CAN) is a nurse-led model for healthcare delivery and interprofessional practice and education.
Core Elements of I-CAN

Disadvantaged and underserved people and populations
Faculty practice model
Long-term commitment to community partners
Neighborhood/community academic-partnerships
Interprofessional student teams
Focus on social determinants of health
Home visitation
Population health interventions
Continuous quality improvement
Community Partnership Networks

People in the Neighborhood

Neighborhood/Community Academic-Practice Partnership (NCAPP)

Community Service Agencies

Healthcare Organizations

Health Profession Academics
Five Communities, Five Populations

**Old Town Portland (Urban)**
Homelessness, mental health, disability, low-income, veterans, seniors.

**Southeast Portland (Urban)**
Immigrants and refugees from Sub-Saharan Africa, the Middle East, Southeast Asia, and Syria.

**West Medford (Urban)**
Low-income families, homelessness, seasonal and migrant farm workers.

**Klamath Falls (Rural)**
Socially isolated, low-income, disability, comorbidity, mental health.

**Monmouth/Polk County (Rural)**
Low-income, disability, homelessness, mental health, food insecure.
Health Professions Academic Partners

- **Nursing**
  Chronic Illness, Population Health, & Leadership

- **Medicine & Physician Assistant**
  Family Medicine & Rural Health

- **Nutrition & Dietetics**
  Community-Based Practice & Internship

- **Pharmacy**
  Transitional Clerkship

- **Dentistry**
  Community Dentistry

Over 800 students
Partners Identify Vulnerable Clients

Healthcare Utilization
2+ non-acute EMS calls in 6 months
3+ missed healthcare appointments in 6 months
10+ medications

Social Determinants
Lack of primary care home
Lack of healthcare insurance
Lack of stable housing

Family Contributors
5+ unexcused school absences
2+ family members with a disabling chronic illness
Developmentally delayed parent(s)
Signs of child negligence
Client Intake Assessment

**Churn Rate: System Cycling in the Past 6 Months**
- Provider calls and provider visits
- EMS calls
- ED visits
- Hospitalizations
- Healthcare appointment adherence

**Stabilizing Factors in the Past 6 Months**
- Employment/income
- Level of social support
- Food security/nutrition
- Insurance changes
- Housing changes

**Demographics, Health Screening, Medication Review**
Faculty in Residence

Long-term commitment to community-based practice

Supervises student learning and safety

Consistent point of contact for clients

Link between university and community
Interprofessional Student Teams

Students work collaboratively with clients and community partners
• Build relationships based on trust.
• Identify and prioritize health goals.
• Develop client-centered care plan.
• Connect clients with local resources.
• Meet weekly in the home, clinic, park, etc.

Students perform intake and follow up assessments
• Care coordination
• Health literacy/Health navigation

Students review client issues to identify population-level issues
• Prioritize in collaboration with partners
• Research and develop interventions
The I-CAN Model
Client & Population Impact
Achievements & Challenges
Questions & Discussion
A 34 year old single mother
She has five children and was referred to I-CAN because she has missed multiple healthcare appointments. She has recently come to Oregon from the Congo, speaks only Swahili, and has no formal education.
• recently diagnosed hepatitis B
• underlying sickle cell anemia

Family members assigned to 2 CCO’s and multiple providers/clinics

Health insurance has lapsed
Examples of activities:

- Consolidated assigned payers and primary care providers
- Read mail through an interpreter
  - Health insurance renewals
  - Unpaid utility bills
- Reinstated lapsed healthcare insurance
- Made medical appointments for family members
- Immunized children as required by schools
- Provided follow-up teaching after an ED visit
- Provided medication safety teaching
- Turned off smoke alarm
- Referred one child for urgent dental care
- Completed housing applications
- Worked with criminal justice system to get children’s names cleared (cause of housing denial)
Population Issues Identified

Assignment of immigrants and refugees to CCOs and primary care homes

Insurance coverage lapse

Team Intervention:
Collaboration to address gaps:
Oregon Health Authority
Legal Aid
### Aggregate Health Measures

**Short-Term Outcome Measures**
Increased number of clients with:

- Primary care home
- Health insurance
- Stable housing

**Long-Term Outcome Measures**
Reduced number of occurrences of:

- ED visits
- EMS callouts
- Hospitalizations
Reducing Resource Demand

The rate of emergency and inpatient healthcare utilization decreased drastically after 12 I-CAN care coordination visits,* compared to the rate prior to joining I-CAN, for 38 clients with intake and follow up data.

*Rates adjusted and standardized for number of occurrences per 6 month period.

**Reducing Resource Demand**

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<th>ED visits</th>
<th>EMS callouts</th>
<th>Hospitalizations</th>
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<td>50 per 6 months</td>
<td>37</td>
<td>25</td>
<td>12</td>
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Estimated $224k in cost savings per 6 mo.

*Rates adjusted and standardized for number of occurrences per 6 month period.
Achievements and Developments

Carl in the Nexus: Video produced by the National Center for Interprofessional Practice and Education for national distribution
https://nexusipe.org/engaging/learning-system/carl-nexus


Funding partnerships with Coordinated Care Organizations (CCO)

Jointly funded faculty-in-residence position at a Fire Department in Rockwood (and “new” I-CAN site)

New NCAPPs in La Grande and Coos Bay (AY 2017-18)
Challenges

Need for additional evaluation:
- Client outcomes
- Cost savings
- Model for cost avoidance

Integration into curricula across Schools

Sustainable funding model
Nexus Innovators Network
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Thank You

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