Reducing Health Disparities in Underserved Neighborhoods through the Interprofessional Care Access Network (I-CAN)

www.ohsu.edu/i-can  ican@ohsu.edu
Presentation Outline

• Project Overview & Community/Academic Interventions

• Methods & Data Collection

• Time One Analysis

• Lessons Learned
Purpose of I-CAN

• 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 *Triple Aim* goals: improve outcomes, reduce cost, increase satisfaction.
Academic Partners

- OHSU School of Nursing
- OHSU School of Medicine
- OHSU Global Health Center
- OHSU/OSU College of Pharmacy
- OHSU School of Dentistry
Structure of I-CAN NCAPPs

Neighborhood Collaboratives for Academic-Practice Partnership

- People in the neighborhood
- Health care organizations
- Community service agencies
- Academic partners
Our I-CAN NCAPP Partners

Old Town Portland
  Central City Concern
  Macdonald Center
  Neighborhood House

West Medford
  La Clinica del Valle
  St. Vincent de Paul
  Family Nurturing Center

Southwest Portland
  OHSU Richmond Clinic
  Asian Health and Services
  Lutheran Community Services NW
  OHSU Russell Street Dental Clinic
Three Neighborhoods, Three Populations

Old Town Portland
Mental health needs, low-income, homeless, disabled, veterans, elders

West Medford
Low-income, homeless, families, Hispanic immigrants and seasonal workers

Southeast Portland
Immigrants and refugees from Sub-Saharan Africa, Eastern Europe, and Asia
I-CAN Neighborhood Collaboratives: Care Management Process

People who live in the neighborhood

Community Partners:
- Community Service Agency
- Community Service Agency
- Health Care Clinic

Academic Partners:
- I-CAN Team
- GHC’s iCHEE

Other Services Outside Partnership
NCAPP agencies identify most vulnerable clients

- Two or more non-acute EMS calls in the last 6 months
- More than three missed appointments in the last 6 months
- No primary care home
- No health care insurance
- More than 10 medications
- Older than 60 without stable housing
- Families with children without stable housing
- Five or more unexcused school absences for children
- Signs of child negligence
- More than one family member with a disabling chronic illness
- Developmentally delayed parent(s)
I-CAN Care Management (CM) and Follow Up

Nurse Faculty-in-Residence (FIR) coordinate interprofessional student teams
Aggregate Health Outcomes

**Short-Term Client Outcome Measures**
Increased number of clients with health insurance, primary care homes, & stable housing.

**Long-Term Client Outcome Measures**
Reduced EMS calls, ED visits, and hospitalizations, and increased satisfaction with health care services.
I-CAN Team Measurement Tools

Clients

- Intake Form (Baseline & 12th visit)
- Patient Health Questionnaire (PSQ-9)
- WHO Quality of Life

Community Partners

- Team Satisfaction Survey
- Assessment of Interprofessional Team Collaboration Scale

Grant Team

- Team Satisfaction Survey
- Team Development Measure

Student Teams

- Student Satisfaction Surveys
- Collaboration and Satisfaction with Care Decisions
Churn/Stabilization Indices

**Churn:** In the last 6 months, how often have you
- Called or visited a health care provider?
- Called 911?
- Visited the emergency room?
- Been hospitalized?

**Stabilization:**
- Health insurance
- Monthly income
- Employment
- Social support
- Food security
- Healthcare appointments
Learning from Time One

Old Town, Portland

West Medford
• 57 clients referred from 6 agencies
• 5 school terms (June 2013 – May 2014)
• Over 600 administrative & service visits
• 11 clients with follow-up assessments
• 8 clients with complete pre/post data
Number of Students Participating (n=146)

- Nursing: 66 (45%)
- Pharmacy: 62 (42%)
- Medicine: 10 (7%)
- Dentistry: 8 (5%)
Client Demographics (n=57)

Gender: Male 47.2%  Female 46.7%

Age: 20-39 year: 14.8%  40-64 year: 7.7%  65-69 year: 68.3%  70-79 year: 7.0%

Language: English 49%  Spanish 18%  Other 29%

Education: 36.7% 12 years or less  58.9% 13-16 years
At initial assessment, clients are unable to identify the name or purpose of 25-50% of their medications.

On a scale of 0-100, clients rate their overall quality of life at just 59.

Three-quarters of clients report problems with pain, mobility, and performing their daily activities.
High Utilization of Health Care

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

- 57% of clients visited the emergency department at least once
- 38% of clients were admitted to the hospital at least once
- 37% of clients used emergency medical services at least once
- 18% of clients visited the ED three or more times
**Meeting Clients Where They Are**

Nearly half of client visits take place in the home, compared to an agency or clinic.

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Client’s Home</td>
<td>44%</td>
</tr>
<tr>
<td>Agency or Clinic</td>
<td>42%</td>
</tr>
<tr>
<td>Other</td>
<td>14%</td>
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</tbody>
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The average client visit is **83 minutes**.
At time of referral, clients have poor access to care and experience high instability.

- **44%** of clients lack a primary care home
- **37%** of clients lack stable housing
- **27%** of clients lack health insurance
Client Centered Health Goals

52% of visits include interactions about seeing a provider

51% of visits include interactions about housing

35% of visits include interactions about health insurance
Examples of Client Barriers

Picked up an application for Habitat for Humanity, but... has not been able to fill it out

Client's medications (about 50 small bottles with white lids) are in a large bowl...

Still does not like his living situation, but has not had additional fights with neighbors.

It’s been 20 years since last dental visit... but could not provide us with his insurance information

Legs "feel like 100 lbs each"... not taking pills regularly and does not know which is the Lasix or Potassium

Did not know that her home health services had been discontinued due to noncompliance

...did not show up ... for our planned meeting at 2:30 pm...

Still struggles to find enough food. ...teeth are sensitive and ... prohibit him from eating some food items.
Examples of Client Goals

Client slept out last night. He is interested in getting help to get housed.

Competent in his ability to use his glucometer and self administer insulin.

Wanting his house to be cleaner.

Interested in pursuing care from Old Town clinic…care will help with consistent access to food and issues concerning funds for buying food.

A small fridge from Goodwill that he states costs around $60

Attend TPI birth certificate assistance program for use in obtaining government ID required for apartment rental.

Strong desire for more independence via an electric wheelchair, and is waiting to hear about insurance.

Help to find a couch that pulls out into a bed and a medical marijuana card.
Cost Avoidance Impact (n=11)

- 4 of 8 clients were hospitalized less frequently
- 4 of 8 clients visited the ED less frequently
- 2 of 6 clients called EMS less frequently than the previous 6 months
I-CAN Evaluation Lessons Learned so far…

• **Significant barriers** to data collection
  - Time
  - Complexity of social determinants
  - Relationships
  - Student rotations

• **Measurement** limitations
  - Reliable & valid community measures
  - Consistent data collection
  - Interventions take time
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I-CAN Project Team

Peggy Wros, School of Nursing, SON Project Director
Launa Rae Mathews, SON Project Manager
Heather Voss, SON Project Co-manager
Katherine Bradley, SON Evaluator
Tanya Ostrogorsky, Evaluation Consultant
Nic Bookman, Evaluation Coordinator
Jennifer Boyd, Provost’s Office Project Associate
Meg Devoe, School of Medicine Liaison
Juancho Ramirez, College of Pharmacy Liaison
Jill Mason, School of Dentistry Liaison
Valerie Palmer, iCHEEE Coordinator
Thank You!

I-CAN
INTERPROFESSIONAL CARE ACCESS NETWORK
www.ohsu.edu/i-can  ican@ohsu.edu