Clinical education and community outreach in underserved neighborhoods: The Interprofessional Care Access Network (I-CAN)
I-CAN Overview and Evaluation

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I-CAN Overview and School of Nursing Perspective

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School of Medicine Perspective

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College of Pharmacy Perspective

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School of Dentistry Perspective

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Community Partner Perspective

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Implications for Population Health
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Presentation Outline

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I-CAN is an Academic-Practice Partnership model that:

- Serves disadvantaged and underserved clients, families, and populations.
- Includes long-term commitment to a specific neighborhood and community partners.
- Introduces a faculty practice model in the community.
- Integrates interprofessional student teams into authentic collaborative community practice/learning experiences with health care professionals.
- Addresses social determinants of health through health navigation and health literacy.
I-CAN Goals

I-CAN seeks to:

• 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.
I-CAN brings together students and faculty from the:

- School of Nursing
  - 3rd and 4th Year Students

- School of Medicine
  - 2nd and 3rd Year Students

- School of Dentistry
  - 4th Year Students

- Global Health Center
  - Multiple academic programs

- OHSU/OSU College of Pharmacy
  - 3rd and 4th Year Students
Community Partners

Old Town Portland
- Central City Concern
- Macdonald Center
- Neighborhood House

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

Southeast Portland
- OHSU Richmond Clinic
- Russell Street Dental
- Asian Health & Service Center
- Lutheran Community Services NW
Formation of NCAPPs

I-CAN forms Neighborhood Collaboratives for Academic-Practice Partnerships (NCAPPs).

- People in the neighborhood
- Health care organizations
- Community service agencies
- Academic partners
Old Town Portland (Urban)
Homelessness, mental health, disability, low-income, veterans, seniors.

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

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

Neighborhood Collaborative for Academic-Practice Partnership

- People in the neighborhood
- Health care organization
- Community service agency
- Community service agency
- OHSU Global Health Center
- I-CAN student teams
- Other local resources

Neighborhood Collaborative for Academic-Practice Partnership
Identification of Clients

Community partners identify their most vulnerable clients.

- Two or more non-acute EMS calls in the past 6 months.
- More than three missed appointments in the past 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).
Faculty in Residence

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.
- Complete intake and follow-up assessments.
- Partner with client and community 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 (12-16 clients per neighborhood).
- Identify population-level health issues and potential student projects.
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Panel Presentation

School of Nursing Perspective

Launa Rae Mathews, RN, MS, COHN-S
Assistant Professor
OHSU School of Nursing
I-CAN Project Manager
Exemplar Case:
- Client-centered.
- Learning from context.
- Impact of social determinants of health on health outcomes.
- Impact of churn on health outcomes.
School of Nursing Perspective

Challenges with consistency and continuity:
• Client churn and general chaos.
• Clients focus on present, not future.

Challenges creating partnerships between primary care and community service agencies:
• Community agencies address social determinants of health.

Pre-primary care work challenges:
• Not recognized or reimbursed.
• How can primary care have a greater role in “pre-primary care” outreach?
Preparing students to be the future healthcare workforce:

- Interprofessional collaborative practice.
- Teamwork, safety, patient-centered care.
- Valuing the importance of context.
- Care coordination in the “spaces” between healthcare visits.
School of Medicine Perspective

Meg Devoe, MD
Assistant Professor & General Internist
OHSU School of Medicine & Central City Concern
I-CAN Liaison to the School of Medicine
Student engagement in Old Town Portland:
- Pre-clinical students (second year) participating in weekly preceptorship experience at a FQHC.
- 4 hours/week for a full academic year.

West Medford:
- Third year students participating in Rural Medicine Clerkship.
- 5 week intensive clinical experience.

Southeast Portland:
- Third year students participating in Family Medicine Clerkship.
- 5 week intensive clinical experience.
Factors affecting medical student engagement in I-CAN:
- I-CAN client census.
- I-CAN client availability on clinical days.
- Changes in student schedule.
- Student role and conflicting commitments.
- “Teamness”
Second year student perspectives from Old Town Portland:

- “I appreciate being a part of this project and want to connect better with group members this term!”
- “I didn't hear from any of my team members this term so did not participate in any home visits.”
- “I communicated with [the faculty in residence] on occasion but our schedules didn’t align.”
Third year student perspectives from Southeast Portland:

- “Loved working with the nursing students every week. They did a great job of filling me in when they had done extra visits on other days I could not attend. I learned more about their role in caring for the patient.”
- “I really enjoyed the experience and found it to be quite rewarding.”
- “I often felt confused about what our larger goals were with patients and what was expected of each member of the team.”
Challenges:
• Aligning interprofessional schedules.
• Pairing I-CAN across multiple years/levels of medical students.
• Identifying student roles in care continuum.
• Need for interprofessional supervision (faculty role modeling).
• Harmonizing I-CAN experience with coursework objectives.
• Refining educational objectives regarding social determinants of health.
• Lack of partnerships between neighborhood agencies.
Future efforts for achieving synergy between:

- SOM course/clerkship objectives.
- Interprofessional experience.
- Interprofessional team building.
- Service learning.
- Client experience.
- Population health.

“A tall order?”
Panel Presentation

College of Pharmacy Perspective

Juancho Ramirez, PharmD
Assistant Dean, Experiential Programs
OHSU/OSU College of Pharmacy
I-CAN Liaison to the College of Pharmacy
OHSU/OSU Pharm.D Program:
• 3 years didactic with some clinical experiences.
• 1 year clinical experiences (hospital, ambulatory care, and community).

All third year students (P3s) participate in I-CAN.
• Interprofessional education.
• Patient advocacy.
• Cultural sensitivity.
• Communication.
Health is a complete state of physical, mental, and social well-being, and not merely the absence of disease or infirmity.

- World Health Organization
“The meeting with the third client was unlike anything I have ever encountered. The client's room smelled strongly of urine, rotten food, and feces. I have never experienced a smell like this in my life. There was a blanket on the floor that appeared to be smeared with feces, and moldy trash was scattered throughout the apartment along with many empty beer and liquor bottles. The client appeared to be mentally capable; however, it appeared as if he had just decided to give up.”
Student perspective on interprofessional education:
“We had a psych health nurse come to inform us about how to deal with patients who are suicidal or victims of domestic abuse. It was very informative and something we don’t learn in pharmacy school.”
Student perspective on communication: “The students specifically expressed interest in finding out more about the PharmD. program, what pharmacists can contribute to the team, and how interactions between pharmacy and nursing in a hospital or clinical setting can be better negotiated.”
Challenges:
• Direct vs. indirect supervision of unlicensed students.
•Aligning student schedules with variable timing; competing with work, lab, and course time.
• Student apprehension to engage with clients.
School of Dentistry Perspective

Jill Mason, MPH, RDH, EPP
Associate Professor, Director of Community Rotations
OHSU School of Dentistry
I-CAN Liaison to the School of Dentistry
School of Dentistry Perspective

Student Experience:
• Generally positive, but confused.
• New paradigm is a challenge, but a good one.
• Challenging comfort zones.
• Role models.
Challenges:
- Scheduling.
- Licensing/supervision.
- Student orientation.
- Role models with limited experience in IP practice.
- Addressing client oral health needs in a system that is not easily accessible.
- Oral health needs that are not available in the system even if access is available.
Exemplar Case:

- Client with only lower dentures.
- No payer/provider willing to pay for uppers.
- Dental student identified funding through Aging and Disability services.
- Dental and nursing students worked collaboratively to connect client with resource.
Community Partner Perspective

Pierre Morin, MD, PhD, LPC
Clinical Director
Lutheran Community Services NW
I-CAN Liaison to Lutheran Community Services NW
Community Partner Perspective

The role of Lutheran Community Services in I-CAN is to:

- Provide access to refugee communities/clients.
- Include I-CAN partners in refugee dialogues.
- Make individual referrals for I-CAN student teams.
- Discuss the experience and learning with I-CAN students.
- Give feedback about I-CAN processes.
Benefits of the partnership:

• Refugees have access to input and services from an interprofessional team of students.
• Improved care coordination.
• Students and refugees learn from each other.
• Clinicians receive valuable feedback and information from the interprofessional teams.
• The agency receives input about unmet needs and challenges.
Community Partner Perspective

Challenges:
- Some increase in administrative burden.
- I-CAN services are not “captured” or included in the regular clinical process.
- Refugees can be confused about roles and scope of services.
- Communication and care coordination between clinicians and I-CAN student team members.
- I-CAN student team members change each academic term.
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Since April 1, 2013, I-CAN has worked with 322 students.

**Student Participation**

- **Nursing**: 131 (41%)
- **Pharmacy**: 126 (39%)
- **Dentistry**: 46 (14%)
- **Medicine**: 19 (6%)

While numbers are low, 2\textsuperscript{nd} year medical students have year-long rotations.
Since April 1, 2013, I-CAN has worked with 110 clients.

- **59 active clients**
  - 7 on hold (jail, hospital)
  - 9 never consented
  - 10 left the area or agency
  - 5 transitioned or met goals
  - 13 unable to contact
  - 4 deceased
  - 3 withdrew by request

- **51 non-active**
First-year data from April 1, 2013 through May 15, 2014, representing 4 terms in Old Town and 2 terms in West Medford.

**Client Demographics (n=57)**

Gender:
- Female
- Male

Language:
- English
- Other

Education:
- 12 years or less
- 13-16 years

Age:
- 20-39
- 40-64
- 65-79
- 80-79
Evaluation Measures

Clients:
- Healthcare utilization
- SDH
- Medication health literacy
- Depression; quality of life
- Satisfaction with the healthcare experience

Students:
- Satisfaction with IP teamwork
- Satisfaction with IP team decision making

Community Partners:
- Satisfaction with IP teamwork
- Satisfaction with IP team collaboration

Academic Partners:
- Satisfaction with IP teamwork
- Satisfaction with IP team development and functioning
High Utilization of Healthcare

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

- **57%** of clients visited the emergency department at least once
- **18%** of clients visited the emergency department three or more times
- **38%** of clients were admitted to the hospital at least once
- **37%** of clients used emergency medical services at least once
Primary Care, Housing, & Insurance

At the point when clients are referred to I-CAN:

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
Health Literacy and Healthcare Need

At the time of 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 59.

Three-quarters of clients report problems with pain, mobility, and performing their daily activities.
I-CAN takes students out of the four walls of the clinic/agency.

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

<table>
<thead>
<tr>
<th></th>
<th>44%</th>
<th>42%</th>
<th>14%</th>
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</thead>
<tbody>
<tr>
<td>Client’s Home</td>
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<tr>
<td>Agency or Clinic</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

The average client visit is 80 minutes.
Students discuss goals with clients at every visit:

52% of visits include interactions about seeing a provider

51% of visits include interactions about housing

35% of visits include interactions about health insurance
Aggregate Health Outcomes

Short-Term Client Outcome Measures
• Increase in number of clients with health insurance, primary care providers, and stable housing.

Long-Term Client Outcome Measures
• Reduction in number of non-acute EMS calls, visits to the emergency department, and hospitalizations.
• Increase in satisfaction with the healthcare experience.
Achieving Client Goals

First-year data from April 1, 2013 through May 15, 2014, representing 4 terms in Old Town and 2 terms in West Medford.

- **↑ 63%** Increase in clients with access to regular primary care (N=30)
- **↑ 39%** Increase in clients living in stable housing (N=19)
- **↑ 53%** Increase in clients with access to healthcare insurance (N=30)
Incidences of inappropriate healthcare utilization decreased after twelve I-CAN visits, compared to the six month period prior to I-CAN participation.

Preliminary Outcomes (n=8)

- Seeing a Provider: 30 (8)
- Visits to the ED: 22 (2)
- Use of EMS: 13 (2)
- Hospital Admissions: 5 (1)

91% reduction in ED visits after participation in I-CAN.
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Burning Questions
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Consider and discuss the following questions:

1. How is the I-CAN model relevant to you and your work?

2. How do you integrate social determinants of health into patient care?

3. What are the barriers that you face in developing interprofessional collaborative practice?
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Implications of I-CAN Work

Implications for Primary Care and Practice

Dan Sengenberger, DO
Family Physician
La Clinica’s West Medford Health Center
I-CAN Physician Liaison
La Clinica Strategic Plan
“Better empower people to dramatically improve their health and well-being by transforming our model of care.”

Jackson County
• Population of 204,000.
• 8.0% unemployment (compared to 6.6% statewide).
• 17% on SNAP.
• 7000 homeless.
La Clinica Overview

Federally-Qualified Health Center (FQHC) and Patient-Centered Medical Home (PCMH).

16 health centers in Medford and Central Point:
• 5 community health centers, 1 dental clinic, 9 school-based health centers, and 1 mobile clinic.

In medical clinics in the last 6 months (35,000 patient visits):
• 66% OHP, 17% self-pay.
• For dental, 55% self-pay.
La Clinica – Exemplar Client

Client DD needed improved health literacy.
• 66 year old female.
• Peritoneal dialysis, with complications, needing multiple medications.

Referred to the I-CAN interprofessional student teams:
• Students were extraordinary.
• Assisted with cleaning living environment, moving client to new housing, and educating client.
• Client started hemodialysis and was able to stop multiple medications and become more active.
Client SC needed social services and medical support.

- 63 year old male.
- Diabetes Mellitus II, Interstitial Lung Disease (ILD), pacemaker, dementia; on oxygen and insulin.
- Daily EMS calls for chest pain.
- Discharged by home health due to noncompliance.

Referred to the I-CAN interprofessional student teams:

- Facilitated client move into assisted living.
- Client reports being happier.
- Client no longer calls EMS.
Client LM needed medication assistance.
- 53 year old female.
- Poor cognitive function from TBI.
- Polypharmacy.
- Brought different pill bottles to every visit.

Referred to the I-CAN interprofessional student teams:
- Students performed pill counts and medication reconciliation.
- Excess medication was discarded.
- Discovered possible caregiver abuse.
Client SB needed medication assistance.

- 57 year old male.
- Homeless.
- Congestive Heart Failure (CHF), Atrial Fibrillation, Chronic Obstructive Pulmonary Disease (COPD), alcohol dependence.

Referred to the I-CAN interprofessional student teams:
- Student interactions improved client self-esteem and medical compliance.
Client RH needed medication assistance.

- 47 year old male.
- Intellectual delay, depression, Congestive Heart Failure (CHF).
- Polypharmacy.
- BMI 54.
- Overwhelmed by family and work stressors.

Referred to the I-CAN interprofessional student teams:
- Student established a strong connection with the client and were able to get the client to seek mental health treatment.
Implications of I-CAN Work

Implications for Population Health

Molly Osborne, MD, PhD
Associate Dean for Students
OHSU Office of the Provost
I-CAN Liaison to the OHSU Interprofessional Initiative
Risk behaviors for common diseases not randomly distributed.

The ACE Pyramid

- Early death
- Disease, disability, & social problems
- Adoption of health-risk behaviors
- Social, emotional, & cognitive impairment
- Adverse childhood experiences

I-CAN is here
Social and environmental conditions that often underlie sickness include:

- Substandard housing conditions; poor diet.
- Inadequate education.
- Lack of fresh air; environmental exposures.

“Upstreamists” are health care professionals who recognize that health begins where we live, work, and play…

… And who mobilize resources to create systems in their clinics and hospitals that start to connect people to the resources they need outside the four walls of the clinic.
The health outcomes of a group of individuals, including distribution of such outcomes within the group.

Population health outcomes include:

- Health care.
- Public health.
- Genetics.
- Behavior.
- Social factors.
- Environmental factors.
Three Eras of Healthcare

**Halfon et al Health Affairs 2014; 33: 11**

### Three Era Of Health And Health Care—Three Operating Systems

<table>
<thead>
<tr>
<th>First era—1.0: medical care and public health services (1850s to 1960s)</th>
<th>Second era—2.0: health care system (1950s to present day)</th>
<th>Third era—3.0: health system (2000 going forward)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition of health</strong></td>
<td>Absence of acute disease</td>
<td>Reduction of chronic disease</td>
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<tr>
<td><strong>Goal of health system</strong></td>
<td>Improve life expectancy</td>
<td>Reduce disability</td>
</tr>
<tr>
<td><strong>Model of health and disease causation</strong></td>
<td>Biomedical</td>
<td>Biopsychosocial</td>
</tr>
<tr>
<td><strong>Primary focus of services</strong></td>
<td>Diagnose and treat acute conditions</td>
<td>Prevent and manage chronic disease</td>
</tr>
<tr>
<td><strong>Organizational operational model</strong></td>
<td>Clinics and offices linked to hospitals</td>
<td>Accountable care organizations and medical homes</td>
</tr>
<tr>
<td><strong>Dominant payment mechanisms</strong></td>
<td>Indemnity insurance; fee-for-service</td>
<td>Prepaid health benefits, capitation</td>
</tr>
<tr>
<td><strong>Role of health and health care provider/organization</strong></td>
<td>To protect from harm, cure the sick, and heal the ill</td>
<td>To prevent and control risk, manage chronic disease, and improve quality of care</td>
</tr>
<tr>
<td><strong>Role of individual and community</strong></td>
<td>Inexperienced patient</td>
<td>Activated partner in care</td>
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<tr>
<td></td>
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<td>Creating capacities to achieve goals, satisfy needs, fortify reserves</td>
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<td>Optimize health</td>
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<td>Life-course health development</td>
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<td>Promote and optimize health of individuals and populations</td>
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<td>Community-accountable health development systems</td>
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<td>Health trusts and management of balanced portfolio of financing vehicles</td>
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<td>To optimize health and well-being</td>
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<td>Co-designers of health</td>
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</table>
Towards Sustainable Improvements

**FIGURE 1**: U.S. Healthcare Delivery System Evolution: Health Delivery System Transformation Critical Path

- **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

*Hester et al. CDC health policy series
I-CAN is here*
As the infrastructure, delivery, and financing of community and population health evolve, so will the role of the public health enterprise and public health departments.
The design elements and leadership required for significant reengineering into a 3.0 health system are still emerging.

Halfon et al Health Affairs 2014; 33: 11
Challenges: Strategies

CDC/Kaiser Permanente: The ACE study
• Assessed associations between childhood maltreatment and later-life health and well-being (1995-1997).

RWJ: Commission to build a healthier America (2008)
• The guiding coalition adopted 6 core strategies to achieve the goal of 100 million people living healthier lives by 2020.
Challenges: Strategies

**RWJ: Commission to build a healthier America (2008)**

- Looking outside the health care system at how we live, work, learn and play for ways to improve health for everyone.
- Invest in the foundations of lifelong physician and mental well-being in our youngest children.
- Create communities that foster health-promoting behaviors.
- Broaden health care to promote health outside the medical system.
The world changes when we change.

- Rick Brush
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The National Center has designated I-CAN as a Nexus Innovation Incubator Project, as well as two others at OHSU.

23 projects underway
11 states participating

Testing new models for integrating health professions education and health care delivery systems through applied research.
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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Asian Health & Service Center
Lutheran Community Services NW
Russell Street Dental

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Janice Jones
Alma Elder, RN
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And countless others at OHSU and our partner agencies who help to make I-CAN possible.
Thank You!

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