



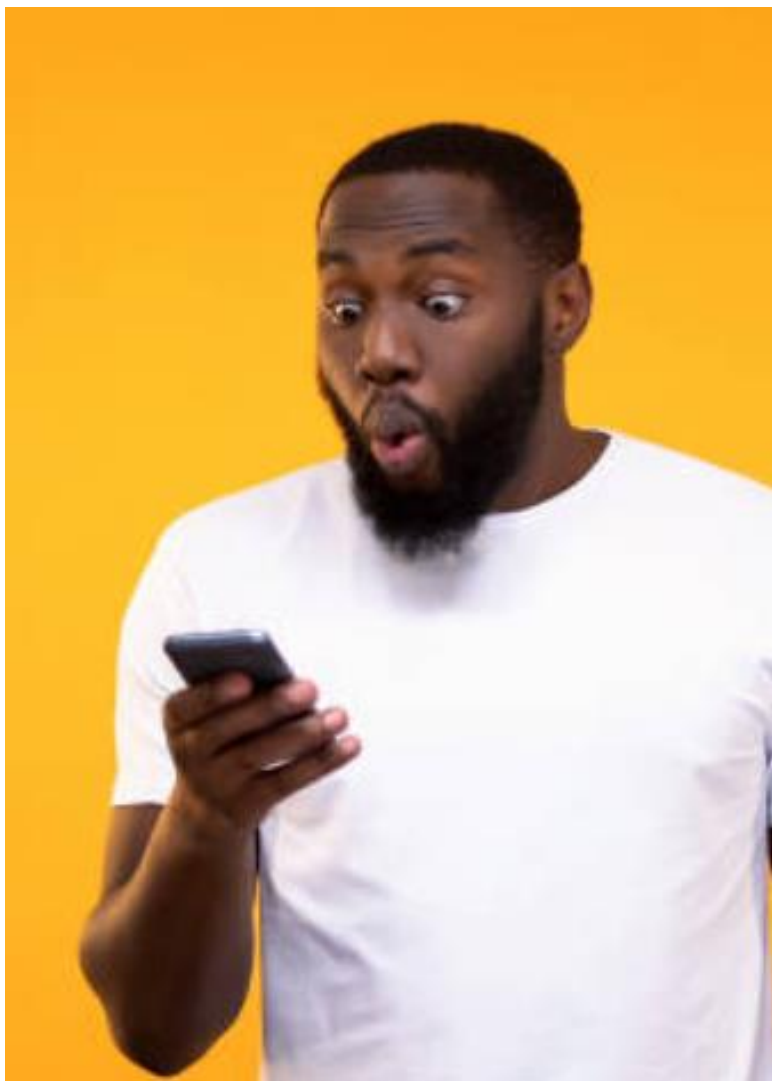
Enhancing the Way We Collaborate, Care and Conquer Disparities in the Healthcare Ecosystem

**The Wins of Change – Breakthrough to
Excellence**

OHIT Digital Health Summit

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**What if your
cell phone
could only
connect you to
family?
family and
friends?
people on the
same network?**



Healthcare
Providers



Patients



Public Health
Agencies



Health
Information
Networks



Payers



Pharmacies

Health Information Exchanges (HIEs)



The seamless and secure exchange of electronic health information across healthcare settings.



Goal: to enable timely access to health data, improve care coordination, and reduce duplication of services.

Trusted Exchange Framework and Common Agreement (TEFCA)



The United States nationwide network of networks for health information sharing created by the U.S. Department of Health & Human Services Assistant Secretary for Technology Policy (ASTP) to remove barriers for sharing health records electronically among healthcare providers, patients, public health agencies and payers.

The Way We Collaborate, Care and Conquer

How can data
exchange impact
the way we
collaborate?



Quick Access to Patient Data:

Immediate access to comprehensive patient histories, lab results, medications and imaging.



Improved Workflow Efficiency:

Reduces time-consuming data entry and paper-based records.

Payer Prior Authorizations: Faster turnaround times for insurance authorizations



Supports Team-Based Care: Easier to coordinate with specialists, primary care, and allied health professionals.

Emergency Department and Community Clinics HIE

Problem: Uncoordinated care and oversuse of the Emergency Department for low income and Medicaid patients in Orange County, CA

Solution: Collaboration to connect EDs (22) and community clinics (14)

- Make medical record available at POC (labs, scripts, ED visits, diagnoses, claims based outpt hx, hospitalizations
- Community clinics accept referrals from EDs

Outcomes: 5% less ED utilization; less duplicate prescriptions (\$600/pp/yr); less testing (\$130/pp/yr)

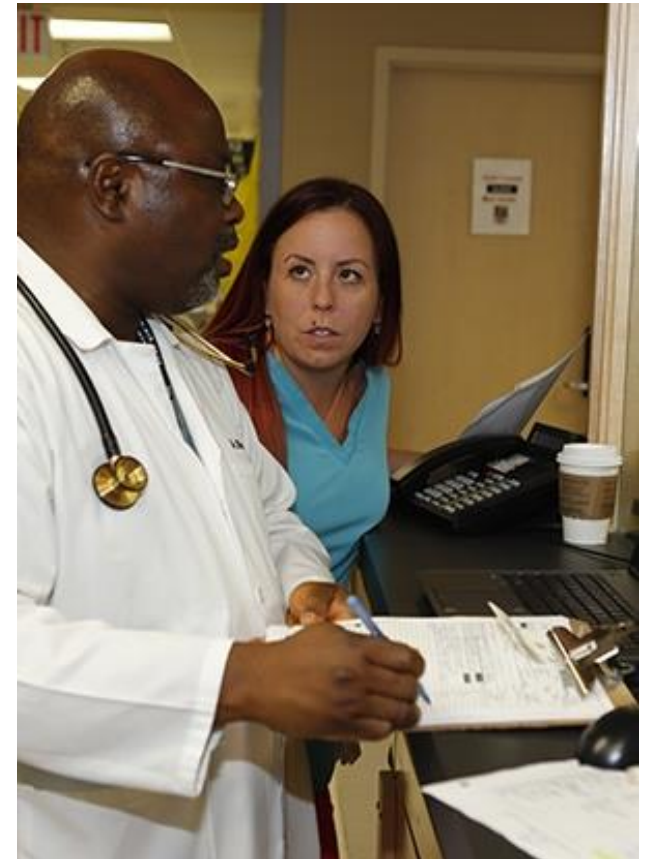
Prescription Drug Monitoring

Problem: Opioid and other prescription drug abuse and diversion

Solution: Collaborate via the Prescription Drug Monitoring Program

- Reported by controlled substance dispensers, including pharmacies and healthcare practitioners
- Data is securely stored
- Available at point of care in emergency departments to inform prescribing decisions
- Data sharing with 31 states and the military health system

Outcomes: 6-12% year over year decrease in prescribing of controlled substances



The Way We Collaborate, **Care**, and Conquer

How can it
impact the
way we care?



More time for patient care:
reduces administrative
burden and streamlines
tasks, enabling more time for
patient care.



Enhanced Decision-Making:
Access to up-to-date patient
data supports informed
clinical decisions.



Improved Patient Safety:
minimizes diagnostic errors,
reduces medication errors,
and enhances emergency
care.

The Way We Collaborate, **Care**, and Conquer

How can it
impact the way
our patients
experience care?



Reduces Duplication of Tests:
Prevents unnecessary testing by
providing access to prior test
results.



Removes burden on the patient: Since providers have
the data they need instantly –
less filling out forms, removes
the need for recall



More coordinated care: Fewer
studies and lab draws, fewer
doctor visits



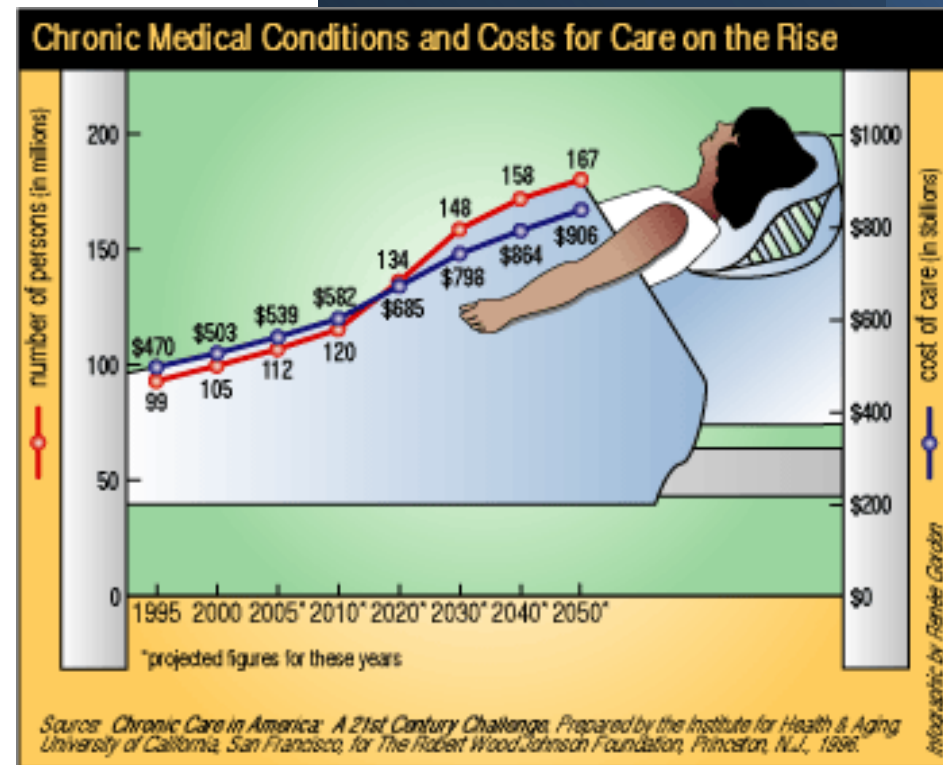
Maryland Back to School Example:

Immunization records for back to school

- Immunization records are sent to the state government for public health reporting.
- Just in time for back to school parents can access their child's immunization records through the Maryland Department of Health's (MD) MyIR.net web portal or the MyIR Mobile app
- This can help reduce over- and under-vaccination

Rising Costs: 21st century challenge

- Healthcare costs are 17% of GDP, rising faster than the growth of the economy
- 10% of all individuals are responsible for 65% of the costs
- Almost 40% of ED use & 10% -17% of inpatient hospitalization costs are estimated to be preventable**
- Physicians can drive transformation



Accountability – the new healthcare paradigm

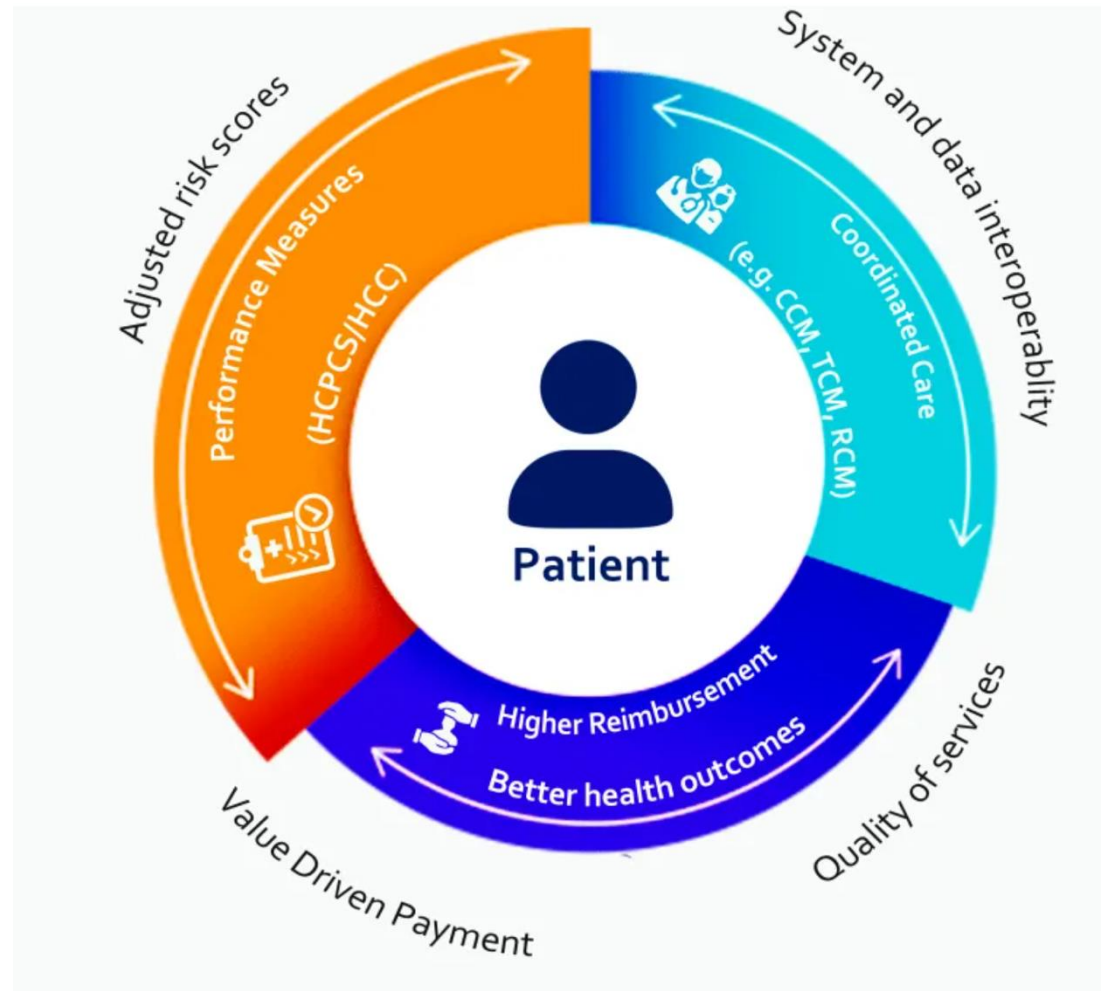
Accountability for health outcomes leads providers to have to think holistically about factors that affect a patient's success with treatment

What is Population Health?

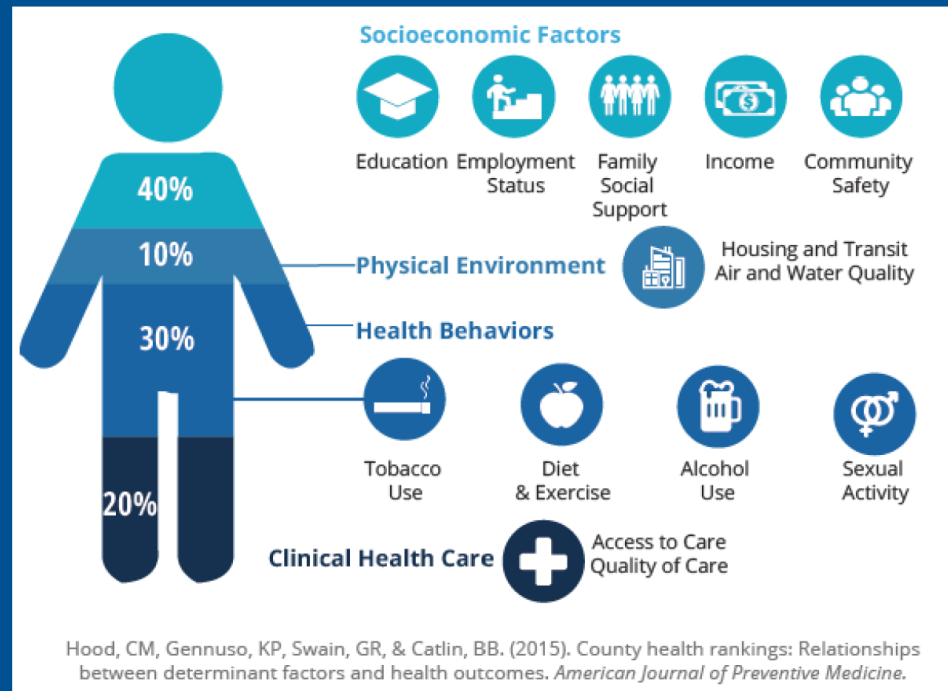
- **Population health** is the framework to identify and assess the collective health outcomes of a group of individuals
- **Population Health Management**
 - **Collect Data** - Get a comprehensive clinical picture of your population using analytic tools that aggregate patient data from multiple inputs
 - **Identify Care Gaps** - Proactively assesses the care needs of individuals in your patient population
 - **Close Care Gaps** - Deploy programs and resources to improve both clinical & financial outcomes.
 - **Use Metrics** - Use measures of success to improve program and system performance
 - **Track Outcomes** - Gather and report on outcomes data for accountability

Value Based Care (VBC)

Value-based healthcare is a healthcare model that focuses on improving patient outcomes and the quality of care while also keeping costs down. In this model, healthcare providers are paid based on the results they deliver for patients, such as the quality, equity, and cost of care.



Factors
outside
clinical care
have the
greatest
impact on
health



Together, social drivers of health and bias in healthcare account for most health disparities and inequities

Key Health Disparities in the U.S. Virgin Islands



1. Chronic Disease

2. HIV

3. Preterm births

The Way We Collaborate, Care and **Conquer**

How can data exchange impact health outcomes and **conquer** health disparities?

Value Based Care –

- pay for outcomes
- solving for health equity



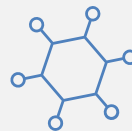
Improves transitions of care: Allows providers to view the accurate real time patient data, improving care transitions and reducing readmission rates



Population Health Management: identify at risk populations to support interventions



Chronic Disease Management: Continuous access to records supports better management of chronic illnesses.



Social care connectivity: Connecting healthcare and community-based organizations for ease of referrals

Example

Using HIEs to predict ED revisits

- HIE data found to be the best predictor of return visits to the Emergency Department
- Demographics, social drivers, chronic disease burden



Staffing Burnout
*63% of surveyed
U.S. physicians
experienced
burnout in 2021⁵*



Overcrowding
*More than half of
US hospitals report
overcrowding in the
ED⁴*



Length of Stay
*Delays treatment,
impacts outcomes
and patient
satisfaction⁶*



**Left without being
seen (LWBS)**
*Median rate of
patients doubled from
1.1% to 2.1% from
2017 to 2021⁷*



ED revisits
*Account for 21-22%
of all Emergency
Department visits⁸*

Moving Forward: Improving How We Care, Collaborate and Conquer



Promote health and wellness for individuals, populations, and communities



Enhance the delivery and experience of care for patients, caregivers, health care providers,ⁱⁱⁱ public health professionals, and others in the health care continuum



Accelerate research and innovation through the collaborative efforts of researchers, technology developers, and other health IT users



Connect the health system with health data for all health IT users



Conclusion

