PointClickCare®

Supporting Health Equity through ED Optimization

Health inequities currently cost $320 billion in annual healthcare spending —impacting affordability, quality, and access to care for marginalized populations.[i]

Emergency department (ED) utilization directly affects these costs, with the U.S. Department of Health and Human Services reporting that ED utilization increases nearly 60% for individuals in communities with the lowest quartile of income.[ii]

Unfortunately, even with the best intentions, the fast-paced and transitory environment of emergency departments leave providers ill-equipped to support the unique challenges faced by these populations.

Without the right interventions, these disparities in care restrict access for vulnerable populations and triple the overall cost of healthcare for the average American household.

PointClickCare is North America's largest Care Collaboration Network, enabling access to real-time insights at any stage of a patient's healthcare journey. Our network spans the care continuum, fostering proactive, holistic decision-making, and improved outcomes for all.

We help care teams address health equity by closing gaps and improving care through ED Optimization, a solution that provides actionable, real-time information and enables collaboration to facilitate high-quality patient care for the most vulnerable populations.

Health equity breakdown: United States

High rates of poverty and a uniquely diverse Medicaid population create additional challenges that highlight the importance of improving health equity nationwide:[iii]

- 29% of the population qualifies as low income
- 60% of non-elderly Medicaid enrollees are people of color
- Acute care accounts for roughly $145.6 billion in state Medicaid spending annually

Improving care in settings such as the ED is critical to reducing health disparities due to race, gender, socioeconomic status, and other non-medical factors impacting health.

Empower ED providers to make more informed decisions--quickly

Emergency departments process over 130 million[iv] visits annually leaving acute care physicians with less than twenty minutes, on average, for each patient encounter.[v] With little time to collect full patient histories, and even less to make decisions, these brief and often isolated encounters can quickly put the patient at risk for suboptimal treatment and poor health outcomes.

We deliver individualized insights at the point of care—ensuring each clinician has the information they need to make informed care decisions without disruption to clinical workflows.

Insights and guidelines for care can be delivered within the hospital's native system in several ways, including ED track boards or through EHR integration. For Cerner and Epic EHRs, notifications, including insights, can be automatically filed directly into the patient's chart, and insights can be reviewed, authored, and edited within the EHR. This incorporates the information from the platform directly into existing workflows, saving time, and reducing duplicative documentation.

Flag underlying behavioral health conditions

Social determinants of health influence rates of mental illness, substance use, and other behavioral health conditions. Unfortunately, these conditions often go undiagnosed or overlooked in acute settings when patients present reporting only physical symptoms. Without addressing both medical and behavioral diagnoses, patients are at higher risk for complications, readmissions, and overprescribing of pain medications that can exacerbate—rather than alleviate—current conditions.

Through the care collaboration platform, providers and other care team members can share patient-specific information such as how a patient presents when they are decompensated, which interventions are effective for that patient, and who to contact in the time of crisis.

ED Providers can see the broader care team, including the patient's behavioral health providers, to allow them to collaborate on the patient's care. With access to each patient's care history, providers can identify any patterns or trends in ED utilization, the patient's presenting complaint, and diagnosis at each encounter. Case Managers can also group patient populations of interest to manage follow-up care.

Identify social determinants of health

Health disparities directly impact cost and quality of care—with studies showing that 80% of individuals experiencing homelessness utilize the ED for an illness that could have been treated with preventive care,[vi].[vii] Unfortunately, isolated ED encounters make it difficult to identify these disparities and social determinants.

Our platform uses predictive modeling, risk stratification, and data aggregation to identify patterns that suggest underlying social determinants and alert care teams for further follow-up.

Further, our platform now offers optional integrations with FindHelp and UniteUs, market leaders that pair traditional care team members with social service providers. With this integration, care managers, social workers, and others within the clinical ecosystem are provided with actionable information about the non-medical needs of patients, so social services can take action providing food, transportation, short-term shelter, community or long-term housing, clothing, and groceries. Only when these foundational needs are being met can a patient truly focus on improving their health, and only when care teams have access to this information can they ensure a holistic approach to care planning, ensuring a more equitable approach to healthcare.

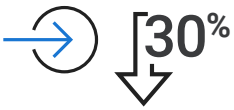
Case study: Addressing health equity at the point of care

University of Virginia Health (UVA Health) aims to provide quality care to some of the state's most complex, and costly, patient populations. Many of these patients also experience social determinants—including homelessness, food insecurity, and lack of transportation—that make contacting and caring for these populations difficult and create disparities in care received.

Leadership at UVA Health implemented a pilot with the PointClickCare platform to alert specialized, multidisciplinary teams whenever patients with complex needs presented at the emergency department. This enabled appropriate care team members to intervene at the point of care and address both medical and socioeconomic needs more effectively.

12 month pre-/post Analysis

inpatient and/or observational admissions



30-day Readmission Rates

Total Costs of Care

> We're always trying to break down barriers to care and care silos—especially when treating our most vulnerable patients. This program supports a highly informed and highly coordinated approach that improves care and reduces costs for patients with complex conditions.

Dr. Amber Inofuentes
Medical Director
UVA Health

[i] DeLoitte study. US Healthcare Can't Afford Health Equities. June 2022.

[ii] Department of Health and Human Services. Report to Congress March 2021: Trends in the Utilization of Emergency Department Services.

[iii] Kaiser Family Foundation. Medicaid in United States Fact Sheet. October 2022.

[iv] Centers for Disease Control and Prevention. Fast Stats: Emergency Department Visits. December 2022.

[v] Wrede J, Wrede H, Behringer W. Emergency Department Mean Physician Time per Patient and Workload Predictors ED-MPTPP. J Clin Med. November 2020.

[vi] GreenDoors. The Cost of Homelessness Facts.

[vii] Oregon Criminal Justice Commission. Improving People's Access to Community-Based Treatment Supports, and Services (IMPACTS) Grant. January 2021.