EPIC on the Move: Empowering OHSU's Mobile Health Coalition Via Integrated Operations

Oregon Health & Science University (OHSU) demonstrates a strong commitment to health equity through its Health Equity Organization, striving to ensure equitable healthcare access for all Oregon residents, irrespective of demographic factors. A key initiative in this endeavor is the Mobile Health Coalition (MHC), a collaborative network of mobile health programs designed to deliver vital healthcare services directly to underserved communities across the state. These programs provide crucial services such as vision care, cancer screenings, chronic disease monitoring, and basic health screenings at no cost to patients, effectively removing barriers to care.

The *EPIC on the Move* project was undertaken to address the growing need for enhanced operational efficiency and seamless data integration across these diverse mobile health programs. Recognizing that the current decentralized operational models and disparate data collection methods hinder the coalition's collective potential, this report presents recommendations for a unified approach to leveraging OHSU's Electronic Health Record (EHR) system, EPIC, and centralizing key logistical functions.

Mobile Health Clinics Nationally

The background analysis highlights the significant role of Mobile Health Clinics in the broader healthcare ecosystem. National data indicates that mobile clinics provide a median of **3,491 visits annually**, with a significant reach into underserved populations: **59% of their clients are racial/ethnic minorities**, and **55% are women** (Malone et al., 2020). Furthermore, **85% of clients served by reporting mobile clinics are either uninsured or publicly insured** (Malone et al., 2020). Economically, the mean cost per patient visit in mobile clinics has been estimated to be lower than standard costs for Medicare beneficiaries receiving identical services at traditional institutions (Attipoe-Dorcoo et al., 2020). Notably, studies have also demonstrated the capacity of MHCs to reduce unnecessary Emergency Department (ED) visits, with one program for children with asthma achieving an estimated annual cost reduction of **$2.5 million** in ED visits (Morphew et al., 2013), and aggregate data from 16 national MHCs showing average cost savings of **$561,220 per MHC** through ED visit avoidance (Mobile Health Map, 2016). Despite the demonstrated value of mobile clinics, the OHSU MHC faces challenges related to inconsistent billing practices and fragmented tracking of services due to varied data recording methods. In-depth interviews with key stakeholders across the OHSU Mobile Health Coalition reveal a strong consensus on the need for centralized support and improved data integration.

Coordinated Infrastructure

While each program operates with unique workflows and service models—for instance, one clinic relies on a paper-based system for its **40+ rotating volunteers** to maintain a "no charting, no ICD-10" approach for donor-funded, free vision care, versus the use of EpicCare Link for basic cancer screening documentation—the desire for a more coordinated infrastructure is evident. The thematic analysis of interviews identified four key areas: **Operational processes**, highlighting the need for streamlined workflows and resource sharing; **Technological barriers**, focusing on the challenges of EHR integration and data continuity; **Staff experience**, emphasizing the importance of minimizing documentation burden, especially for volunteers; and **Patient and community impact**, underscoring the strong community trust built through accessible and culturally relevant care.

Recommendations for MHC

Based on these findings, this report puts forth the following key recommendations:

Electronic Health Records Adoption: Mandate a phased standardization of data recording across all OHSU MHCs into EPIC's EMR to ensure continuity of care and facilitate Health Information Exchange (HIE) with the broader healthcare system. This will allow for comprehensive tracking of patient encounters, test results, and interventions, ultimately improving the quality and safety of care provided across multiple touchpoints. Specific recommendations include adopting a cloned EPIC department for standardization, keeping volunteer EPIC training optional while exploring minimal training for basic registration and documentation, and implementing EPIC safeguards against unwanted billing. Additionally, optimizing existing EPIC billing workflows to accurately quantify the value of their services.

Establish a Dedicated Mini ITG Implementation Team for Mobile Health Integration: Form a specialized interdisciplinary team within OHSU's Information Technology Group (ITG) dedicated to configuring, implementing, and supporting EPIC workflows tailored to the unique needs of each mobile health program. This team will provide end-to-end support and ensure effective training for all users.

Centralize Logistical Functions: Create a centralized back-end support system or digital platform to manage logistical tasks such as scheduling, fleet maintenance, supply chain coordination, and event registration for all mobile programs. This shared service model will enhance efficiency, reduce administrative burdens on clinical teams, and create economies of scale.

Conclusion

In conclusion, the OHSU Mobile Health Coalition stands at a pivotal point where strategic integration can significantly improve its impact on community health equity. By embracing the recommendations outlined in this report, particularly the thoughtful adoption of EPIC as a

unified EHR platform and the centralization of logistical operations, OHSU can empower the community of mobile health programs to operate more efficiently, share critical patient data, and ultimately deliver even more effective and equitable healthcare services to communities across Oregon. The successful implementation of these strategies will not only streamline internal processes but will further OHSU's commitment to innovation and leadership in accessible healthcare delivery.

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References

Attipoe-Dorcoo, S., Delgado, R., Gupta, A., Bennet, J., Oriol, N. E., & Jain, S. H. (2020). Mobile health clinic model in the COVID-19 pandemic: Lessons learned and opportunities for policy changes and innovation. International Journal of Equity in Health, 19(1), Article 73. https://doi.org/10.1186/s12939-020-01175-7

Malone, N. C., Williams, M. M., Smith Fawzi, M. C., Bennet, J., Hill, C., Katz, J. N., & Oriol, N. E. (2020). Mobile health clinics in the United States. International Journal of Equity in Health, 19(1), Article 40. https://doi.org/10.1186/s12939-020-1135-7

Mobile Health Map. (2016). Clinic database. Retrieved April 23, 2025, from http://www.mobilehealthmap.org/index.php

Morphew, T., Scott, L., Li, M., Galant, S. P., Doctor, L., Marzo, A., Blaisdell, C. J., Jones, C. A., Huang, W., & Jones, F. (2013). Mobile health care operations and return on investment in predominantly underserved children with asthma: The breathmobile program. Population Health Management, 16(4), 261-269. https://doi.org/10.1089/pop.2012.0060