CASE STUDY

ClientTrack® by eccovia

Physicians CareConnection:

Improving Health Outcomes with Better Data Management

KEY PERSONNEL

ISI IKHAREBHA GREEN

President of Physicians CareConnection

With a master's degree in public health, Isi has been at PCC for 20 years in various capacities. Throughout her career at PCC, Isi has always focused on using data to prove the outcomes of PCC and to improve service delivery and other processes.

EXECUTIVE SUMMARY

Physicians CareConnection (PCC) has deep roots as a charitable healthcare clinic in Columbus, Ohio, serving people vulnerable to adverse health outcomes. As its mission changed over the years—and therefore its service portfolio—PCC found a need for robust case management that could coordinate care across many human service verticals, in addition to healthcare. In this case study, you will learn how PCC improved its processes and data management with best practices and with ClientTrack, Eccovia's flagship case-management platform, and you will also see how PCC has made an impact on its community by improving its processes.

INTRODUCTION

Physicians CareConnection (PCC) serves the greater Columbus, Ohio, metropolitan area, helping vulnerable and marginalized people achieve their optimal health by working holistically with families as they strive to reach their goals, build awareness, and rediscover their strengths and support networks. Originally founded in 1993, PCC is now an umbrella organization of many volunteer healthcare providers, community volunteers, and care coordinators. Because its primary focus is healthcare, PCC didn't originally track social determinants of health (SDoH), but it became clear with time that SDoH outcomes were crucial to treating the whole patient. However, electronic medical records (EMR) systems, which PCC was using at the time, don't usually have the capability to track more than clinical data, which can lead to sub-optimal (or incomplete) care.

In this case study, we interviewed the president of PCC to learn why EMR systems weren't enough, why ClientTrack was chosen as PCC's comprehensive data system, and what outcomes she's seen as a result of implementing ClientTrack.

BACKGROUND AND IMPACT

PCC's 2023 IMPACT SO FAR

Healthcare	1,164 services coordinated
Economic Stability Services	193 services coordinated
Neighborhood and Built Environment	537 services coordinated
Social and Community Support	532 services coordinated
Education	235 services coordinated

On average, Ohioans are living less healthfully and spending more on healthcare than people in most other states, according to the Health Policy Institute of Ohio (HPIO). According to HPIO, Ohio ranks forty-fourth out of all US states and DC in terms of overall health value, a metric that factors in health outcomes with costs.[1] HPIO, along with many other research and evidence-based organizations, has also found that there are close correlations between outcomes like infant mortality rates—for which Ohio was ranked fourth-highest in 2020—and factors like transportation, insurance coverage, and so on.[2,3]

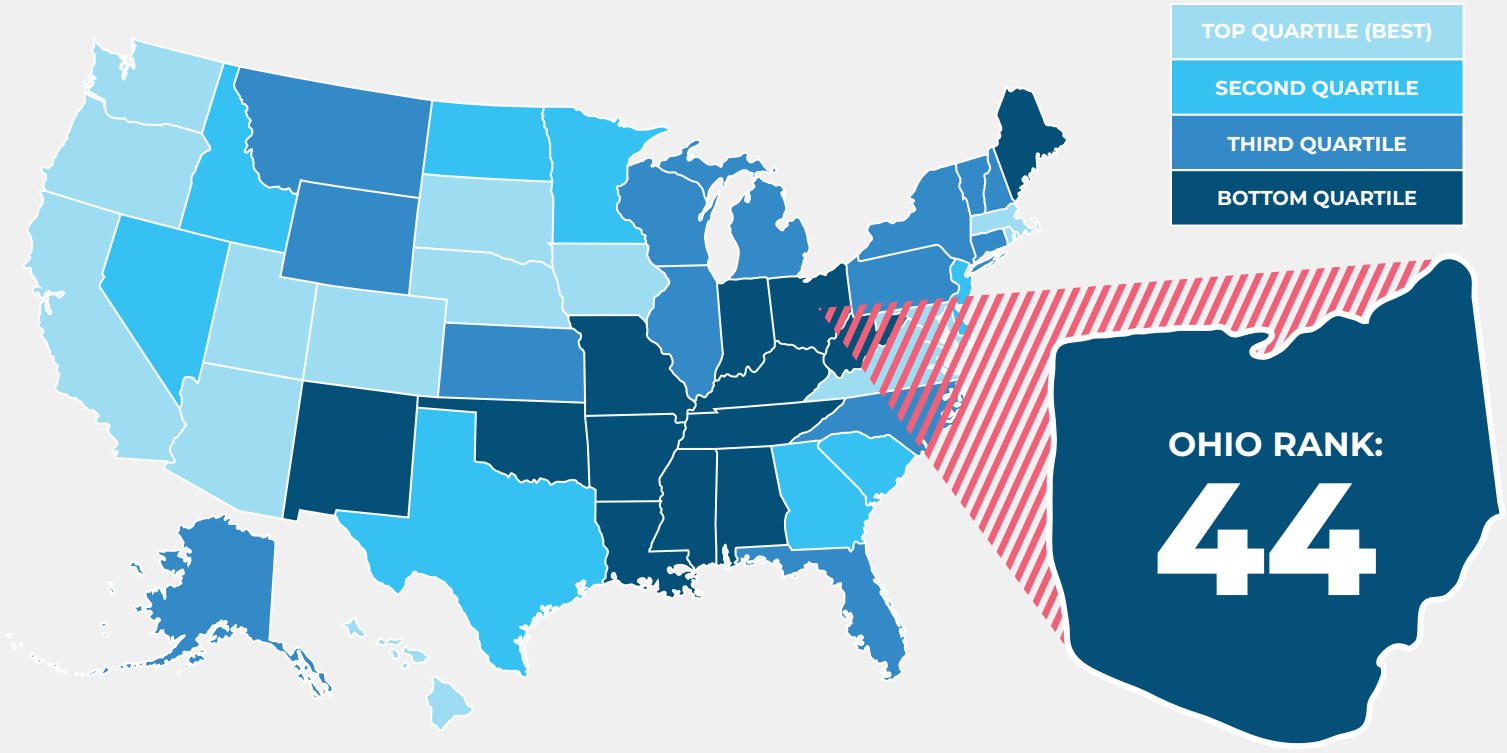
While there are countless other metrics by which Ohio's health outcomes could be measured, it's clear that Ohio's population faces significant hurdles in improving its overall public health. That's where PCC comes in.

Physicians CareConnection was originally founded as the result of a decades-long research and service effort between various nonprofits and the Columbus Health Department, which eventually formed the consortium Access HealthColumbus. When all four hospital systems in Franklin County (where Columbus is located) agreed to collaborate with Access HealthColumbus, they created an infrastructure to allow volunteer physicians to centralize scheduling and patient tracking. That infrastructure went through several iterations and eventually evolved into PCC in 2013.

1 Health Policy Institute of Ohio, Ohio Health Policy News. "HPIO releases latest Health Value Dashboard," April 28, 2023. URL: https://www.healthpolicynews.org/daily_review/2023/04/hpio-releases-latest-health-value-dashboard.html

2 Centers for Disease Control and Prevention. "Infant Mortality Rates by State," accessed August 28, 2023. URL: https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm

3 Health Policy Institute of Ohio, Ohio Health Policy News. "Study: More than 1 in 5 adults with limited transit access forgo needed health care," April 28, 2023. URL: https://www.healthpolicynews.org/daily_review/2023/04/study-more-than-1-in-5-adults-with-limited-transit-access-forgo-needed-health-care.html



SOURCE: HEALTH POLICY INSTITUTE OF OHIO 2023 *HEALTH VALUE DASHBOARD*

Challenges and Successes

Because Physicians CareConnection is a nonprofit providing medical services, it has complex reporting and data security needs, including HIPAA compliance.

Planning for Social Determinants of Health

"In the past, funders were really focused on volume of patients treated," Isi says, "but if our role is to help people optimize their health as much as we can, we don't need to focus only on quantity." She then clarified that being able to see the whole patient's needs and how they affect their health is just as important when aggregating patient outcome data.

PCC's mission is to help marginalized people realize their best health options, but there are many barriers to accessing medical care: insurance (or the lack thereof), the medical issue itself, their income level, immigration status, and so on.

For example, there are other charitable health clinics and social service organizations in the Columbus area, but when referring vulnerable people to another organization to address other needs, completing referrals or ensuring someone received that service can be difficult —primarily because community care coordination had no central system. "Referral coordination can be messy and doesn't always close the loop, which doesn't serve clients well," Isi explains.

To further illustrate, patients from outside the United States often need interpreters with cross-cultural competence. "The nutritional food advice we give has to be linguistically and culturally appropriate," says Isi. "You wouldn't tell a diabetic Nigerian immigrant to avoid 'mac and cheese' because that's not a common food in his culture. You would tell him to avoid palm oil."

"There was a time we couldn't pay attention to those factors as much, but over the years, we gleaned a lot of important information about how social determinants of health were preventing patients from taking advantage of our services."

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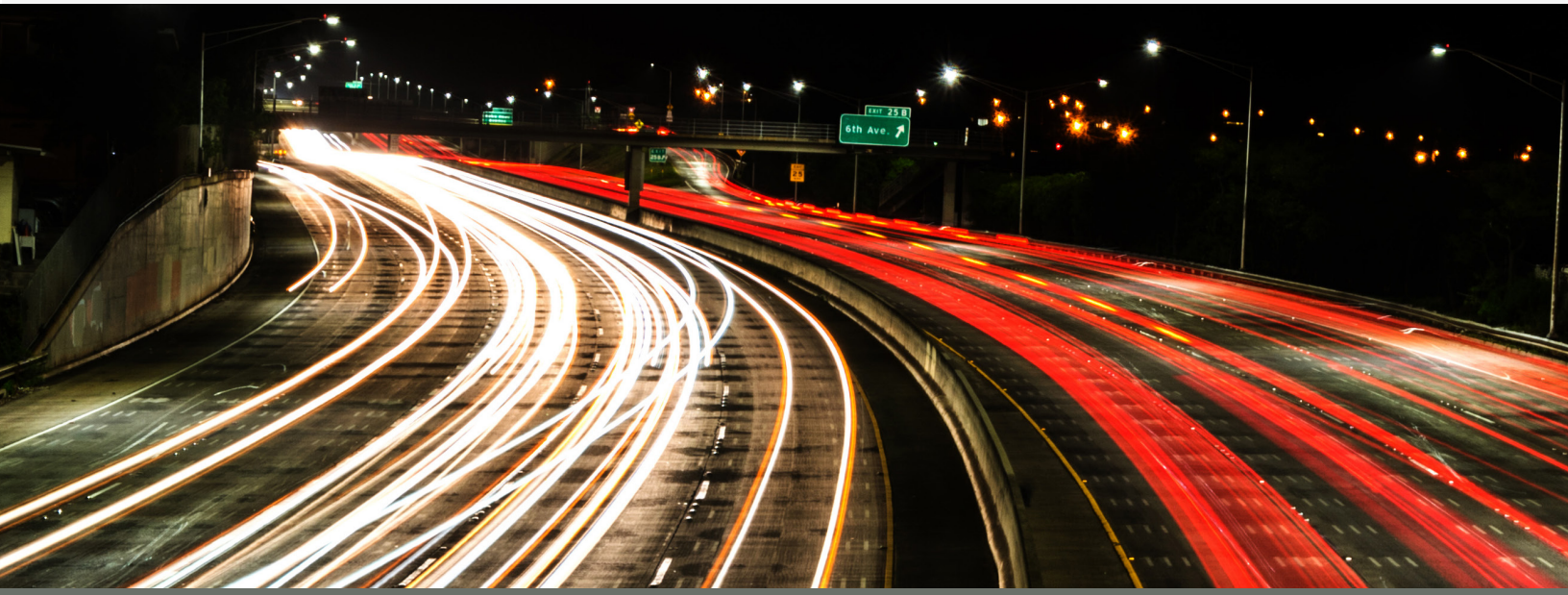


Limitations of EMR Systems

"When we were smaller, it was easier to manage the data part," Isi explains. "But for a nonprofit to do well, we have to invest in the data and its systems. Staff used to often find workarounds that circumvented the data needs, but the data needs to back up our stories; the touchy-feely anecdotes aren't enough."

For example, as PCC grew and began accounting for SDoH influences on patient outcomes, it was clear the current system wouldn't be enough. "We had turned our EMR [electronic medical records] system into an electronic storage bin, basically," because there was a lot of data the team was gathering that didn't fit neatly into the EMR system, which could only capture clinical data but not coordinate care for other services.

That need led to an ad hoc system of disparate spreadsheets stored on individual computers, which made coordinating care for PCC's supplemental services almost impossible.

PRINCIPLES ILLUSTRATED

WHEN SDoH FACTORS MAKE ACCESS TO CARE MORE DIFFICULT	Patient outcomes are less likely to improve
WHEN HEALTHCARE PROVIDERS WORK WITH VULNERABLE POPULATIONS	Medical data alone isn't enough to care for the whole person
WHEN MEDICAL CARE IS PROVIDED ONLY AFTER SDoH FACTORS BECOME ACUTELY SEVERE	Medical interventions are less effective in the long run
WHEN DATA SYSTEMS FOR HEALTHCARE PROVIDERS ONLY ACCOUNT FOR CLINICAL DATA	Care coordination is slowed, unnecessarily hampering the patient's access to care

Q What issues led you to consider other technology solutions?

A We thought we needed a new EMR system, but the size of our agency was too small for most EMR providers to even work with. We even hired a consultant to help us understand our technology needs, when we learned that most EMRs didn't even offer the care coordination functionality.

Coordinating Care with ClientTrack

"Our founding was supposed to give volunteer providers the ability to serve," Isi recalls. It was important that PCC could help people get information and services faster, which is where ClientTrack comes in.

After working with the technology consultant, it became clear to PCC that care coordination software was what they really needed, in addition to all the other functionalities provided by a comparable database. After a thorough search for care coordination technology, the PCC team saw ClientTrack demonstrated for another neighborhood organization. Then, in 2015, PCC began the process of migrating to ClientTrack.

Customization for Any Need

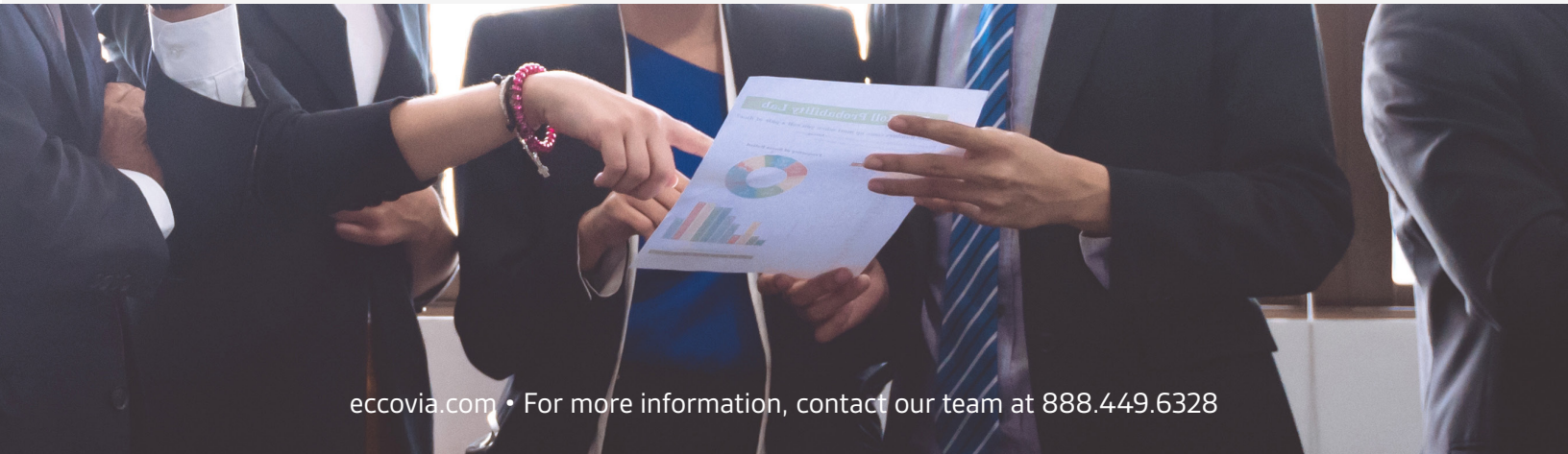
During implementation, it occurred to PCC staff that they needed a way to track IOUs for medical providers, a unique requirement that allowed doctors to see patients in their practices for free. "Eccovia customized our ClientTrack system in a way that gave us a robust way to track program activity, allow us to take all the functions needed to coordinate appointments, and do it all in one system," Isi says.

They also used Eccovia's Advanced Professional Services engagement to update data modules for intakes, mainly because there was a lot of overlap for intake questions. Isi recalled how ClientTrack creates questions and determines which intake pieces need assessment and workflow logic, which was important for PCC's processes.

PCC's ClientTrack environment soon grew to include its supplemental programs, like its transportation and interpretation services, housing and eviction prevention programs, and the like. This put all the data management for these programs into one platform, which made reporting a lot easier for Isi: "When I don't have to worry about managing data, I can spend more time with clients. I'm improving my own services."

Q Are you using ClientTrack for all your programs?

A ClientTrack is our main system for client activity; there are some systems we need to use, like an EMR, and ClientTrack has also grown its [native] integrations with other technologies and products, which really helps.



Insights and Reporting

With the power of a comparable database, Isi can now glean insights from the data ClientTrack collects. For example, she can look at the normal distribution or average of phone calls, emails, appointments, and other interactions it takes to improve patient outcomes, because the data "tells the story," as she puts it. Client history, housing status, food needs, and transportation history can also be easily seen and coordinated.

Another benefit for PCC provided by ClientTrack is that reporting is much easier. "I use the Data Explorer every day! I create reports for my staff so they can track their client loads, how many people they've enrolled in specific programs, et cetera. We can also see what other services from other organizations are being provided, getting the complete picture of each client."

Proving Improved Outcomes

In 2016, PCC received an important grant, StepOne for a Healthy Pregnancy, to improve infant mortality for pregnant mothers. With ClientTrack, PCC set up a centralized intake and referral program to link pregnant mothers to prenatal resources, Isi explains:

"One of the main goals was to get mothers into prenatal care as early as possible, preferably within their first trimester. We submitted this data to the Ohio Department of Health and Medicaid, and in 2021, they used that data to compare the delivery outcomes with other programs. The comparison found that women who received our services had, overall, positive birth outcomes." Without a comparable database to prove these outcomes, PCC wouldn't have known the effectiveness of the grant program and the ensuing services.

PRINCIPLES ILLUSTRATED

WHEN DATA COLLECTION IS CENTRALIZED	Care coordination improves service delivery
WHEN HEALTHCARE AND SOCIAL SERVICES INTERSECT AT THE CLINICAL LEVEL	Unique system customization is required
WHEN DATA CAN BE MINED FOR INSIGHTS	Strategic decisions can be made, and more time with clients can be spent
WHEN POSITIVE OUTCOMES CAN BE PROVEN WITH DATA	Organizations know where to continue allocating resources

PCC's FUTURE WITH CLIENTTRACK

"It's user friendly, and it works for our organization," Isi says of ClientTrack. At the time of this publication, PCC anticipates further partnerships in the community, so ClientTrack is going to play a big role in integrating data from other services in the area.

let's review

PCC provides medical and dental services, primarily, to marginalized individuals who lack access to affordable healthcare. To improve the outcomes of those patients, PCC also provides other supplemental services and coordinates with other providers in the area to provide transportation, eviction prevention, language interpretation, and more. The added layer of complexity requires more customization than PCC's previous systems could handle. ClientTrack has handled this complexity with care coordination functionality, a comparable database, and reporting with insights, which have all contributed to PCC's mission.

ClientTrack has provided PCC with a path to community care coordination that was previously lacking. If your organization needs a solutions expert to help you decide whether ClientTrack is right for your needs, we at Eccovia recommend scheduling a demo with an expert today.

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REAL SOLUTIONS • REAL PERSON IMPACT

Eccovia provides an industry-leading, care coordination platform for state and county Medicaid waiver programs, refugee resettlement programs, accountable care organizations (ACO), and community-based provider coalitions. Our platform helps agencies collaborate to address the physical, behavioral, and economic factors that improve the overall well-being of individuals and communities.

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