



NWMOMENTUM
HEALTH PARTNERS



www.nwmomentumhealthaco.com



Innovaccer Overview

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Purpose

Innovaccer Purpose

- **Automate** the population health management of NGACO patient lives to allow staff to **efficiently** manage these patients with regard to **care, risk, utilization, and finance** to achieve **high quality outcomes** while **minimizing expenditures**.





InCare and Analytics

Care Management - Worklist

Purpose: Provide an automated worklist for management of daily activities. Provides insights into the types of activities scheduled and allows for risk stratification of outreach based on HCC Risk Score.

Strategy Patients Worklist Dashboards

Forbes, Amy [Back to My Worklist](#) = To-do's < Activity Received > Activity Sent

🔔 **Viewing other team member's worklist** Any changes you make will affect Amy's worklist

10 Activity Due 0 Completed All Activity

<input type="checkbox"/>	P	Patient	Activity	Scheduled		CMSHCC Risk	PCP	Insurance	Source
<input type="checkbox"/>	🚩	LAST NAME, FIRST NAME GENDER, DOB	ED Discharge ✓ Follow-up Call ED Visit	Today	...	1.7	PCP NAME	✓ NGACO	Scheduled Activity
<input type="checkbox"/>	🚩	LAST NAME, FIRST NAME GENDER, DOB	ED Discharge ✓ Follow-up Call ED Visit	Today	...	1.77	PCP NAME	✓ NGACO	Scheduled Activity
<input type="checkbox"/>	🚩	LAST NAME, FIRST NAME GENDER, DOB	ED Discharge ✓ Follow-up Call ED Visit	Today	...	1.84	PCP NAME	✓ NGACO	Scheduled Activity
<input type="checkbox"/>		LAST NAME, FIRST NAME GENDER, DOB	ED Discharge ✓ Follow-up Call ED Visit	Today	...	5.16	PCP NAME	✓ NGACO	Scheduled Activity
<input type="checkbox"/>	🚩	LAST NAME, FIRST NAME GENDER, DOB	ED Discharge ✓ Follow-up Call ED Visit	Today	...	0.46	PCP NAME	✓ NGACO	Scheduled Activity
<input type="checkbox"/>	🚩	LAST NAME, FIRST NAME GENDER, DOB	ED Discharge ✓ Follow-up Call ED Visit	Today	...	1.29	PCP NAME	✓ NGACO	Scheduled Activity
<input type="checkbox"/>	🚩	LAST NAME, FIRST NAME GENDER, DOB	TCM Care Protocol ✓ Pre-Contact	Today	...	1.6	PCP NAME	✓ NGACO	Scheduled Activity
<input type="checkbox"/>	🚩	LAST NAME, FIRST NAME GENDER, DOB	TCM Care Protocol ✓ Pre-Contact	Today	...	0.35	PCP NAME	✓ NGACO	Scheduled Activity
<input type="checkbox"/>	🚩	LAST NAME, FIRST NAME GENDER, DOB	TCM Care Protocol ✓ Pre-Contact	Today	...	0.45	PCP NAME	✓ NGACO	Scheduled Activity
<input type="checkbox"/>		LAST NAME, FIRST NAME GENDER, DOB	TCM Care Protocol ✓ Pre-Contact	Today	...	2.74	PCP NAME	✓ NGACO	Scheduled Activity



Patient 360 View

Purpose: view of aggregated patient level data (clinical and claims, ADT feeds) used by care management to have holistic view of patients prior to outreach.

PATIENT NAME and INFORMATION

Export PDF
Download CCDA
Print Pre-visit Summary

Clinical Data

- Source IDs 3
- Clinical Overview
- Ongoing Care Protocols
- ADT Feed Details
- Recent Visits 516
- Vitals 56
- Allergies 2
- Labs 89
- Surgical Procedures 97
- Radiology Procedures 74
- Pathology & Lab Procedures 340
- Other Procedures 545
- Diagnosis 1326
- Problem List 44
- Medications 638
- Immunizations 9
- Social History 134
- Risk 24
- Family History

Source IDs

Source Member ID	Source Member ID Type	Race/Ethnicity
490203049A	HICNO N/A	White N/A
6FC0WX1UT04	MBI N/A	White
52901	Patient ID N/A	White

Clinical Overview

PCP	Kuo, Calvin (1477569143) Tumwater Family Practice Clinic, PSW	NAME AND PRACTICE
ACO	NGACO	
Last Visit Date	10/06/2019 (17 days ago)	
Last Annual well visit	N/A	

Ongoing Care Protocols

(No data)

ADT Feed Details

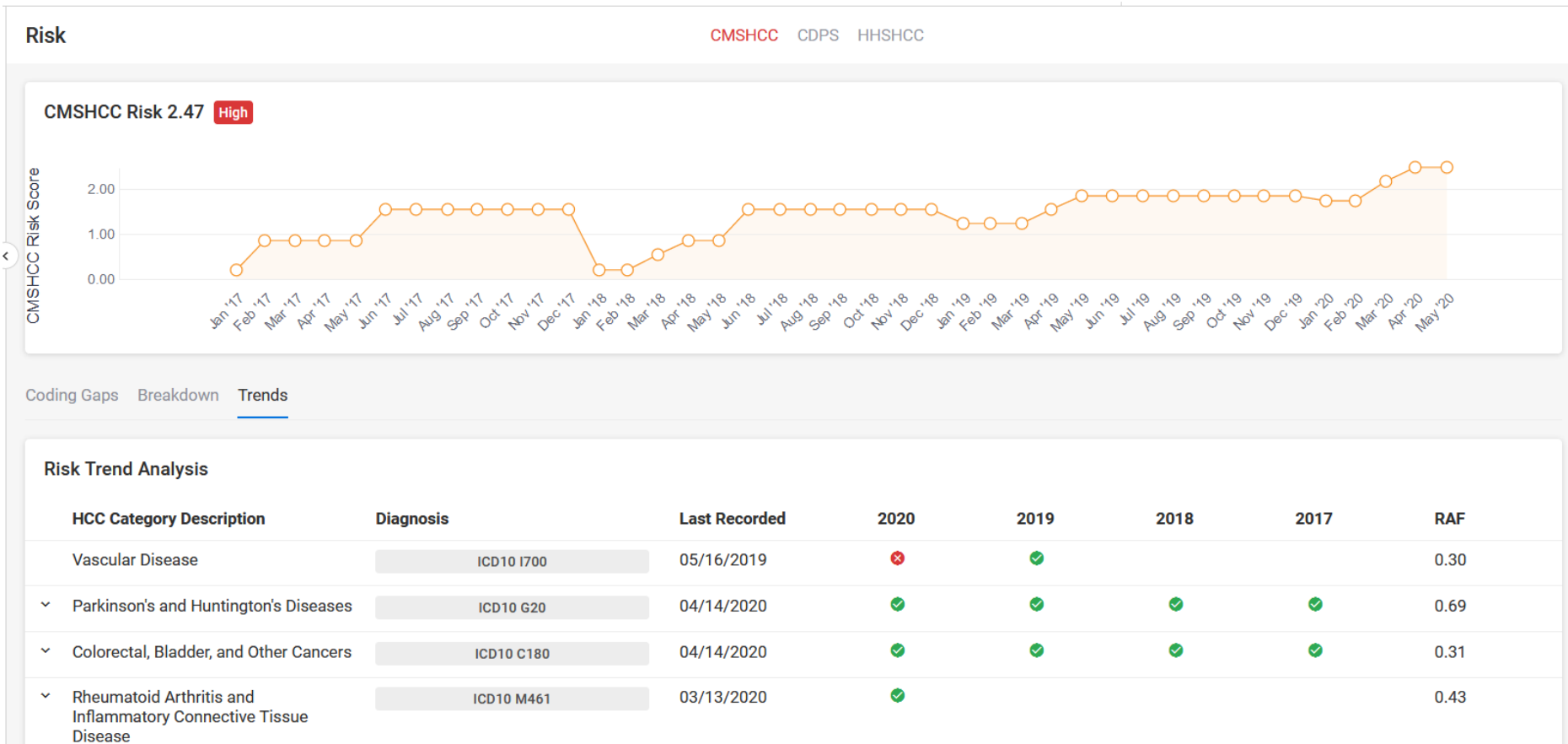
(No data)

Recent Visits



Patient Level Risk Detail

Purpose: Provides insight into the patient's risk score and the chronic conditions associated. Identifies and assists care managers in addressing gaps prior to outreach.



Care Management Timeline

Purpose: view of all outreach activities that have occurred in order of most recent first for a patient. Shows active and completed care protocols and names of care team members who have worked on patient case.

JAN's Care Timeline All Activities

- ✔ **ED Discharge Care Protocol Assigned**
Innovaccer, Healthcare assigned care protocol • 10/18/2019
- ✔ **Completed Care Protocol TCM Care Protocol**
Forbes, Amy completed care protocol • 09/23/2019
SUCCESSFUL
- ✔ **Completed Call Summary 1st Call in TCM Care Protocol**
Forbes, Amy completed task • 09/23/2019
 - ✔ Contact the Patient 1st Call
 - ✔ Contact the Patient 2nd Call
 - ✔ Contact the Patient 3rd CallSUCCESSFUL
- ✔ **Note added in TCM Care Protocol**
Forbes, Amy added note • 09/23/2019

TCM/RN OBS 9/15/19-9/19/19 PSPH - Wedge compression fracture of second lumbar vertebra, initial encounter for closed fracture: Spoke with member who stated new medication of fentanyl has been picked up, no scheduled f/u at this time, but has been in contact with Member stated she had gone to PSPH ED on 9/7/19 for back pain, had been taking Tramadol and Tylenol at home, which was not adequately managing the pain. Member stated no etiology was determined at that time and was sent home with Rx for Norco. Member stated her sx did not improve and so she returned to the ED, was found to have L2 compression fx, was admitted to OBS for 2 days. Member stated she is going to defer "all day x-rays" that are ordered by in preparation for TAVR. Member stated she is not a candidate for kyphoplasty due to being on anticoagulants. Member stated she is having some loose stools as a result of using stool softeners and laxatives, which were taken to relieve ASE of opioid pain medications/constipation

TCM gave education on red flags of numbness/tingling, weakness. No needs or barriers to care identified at this time. TCM to mail CM flyer and UC list, address verified. TCM goals met, this episode to be closed. AForbes, RN
- ✔ **Task Completed in TCM Care Protocol**
Forbes, Amy completed task • 09/23/2019
 - ✔ Contact the Patient 1st Call

DETAILS RECORDED

First Call: Successful, First Call Details: Engaged, First Call Date: 09/23/2019, With whom are you speaking?: Patient, Encounter type?: Phone call, Date Case Management Flyer sent: 09/23/2019, Phone Number: (360) 754-5226
- ✔ **Encounters updated in Contact the Patient 1st Call of Call Summary 1st Call for TCM Care Protocol**
Forbes, Amy updated this encounter • 09/23/2019
 - ✔ Contact the Patient 1st Call

DETAILS RECORDED

Phone Number
- ✔ **Completed Pre-Contact in TCM Care Protocol**
Forbes, Amy completed task • 09/23/2019
 - ✔ Point of Care ReviewSUCCESSFUL

Care Protocols (1) Goals (0) Tasks (0)

ACTIVE CARE PROTOCOL 1

ED Discharge

● **Ongoing** Coached by Forbes, Amy

Assigned on 10/18/2019 • Due on 10/18/2019

FINISHED CARE PROTOCOLS 2

TCM Care Protocol

● **Successful** Completed by Forbes, Amy

Assigned on 09/19/2019 • Completed on 09/23/2019

ED Discharge

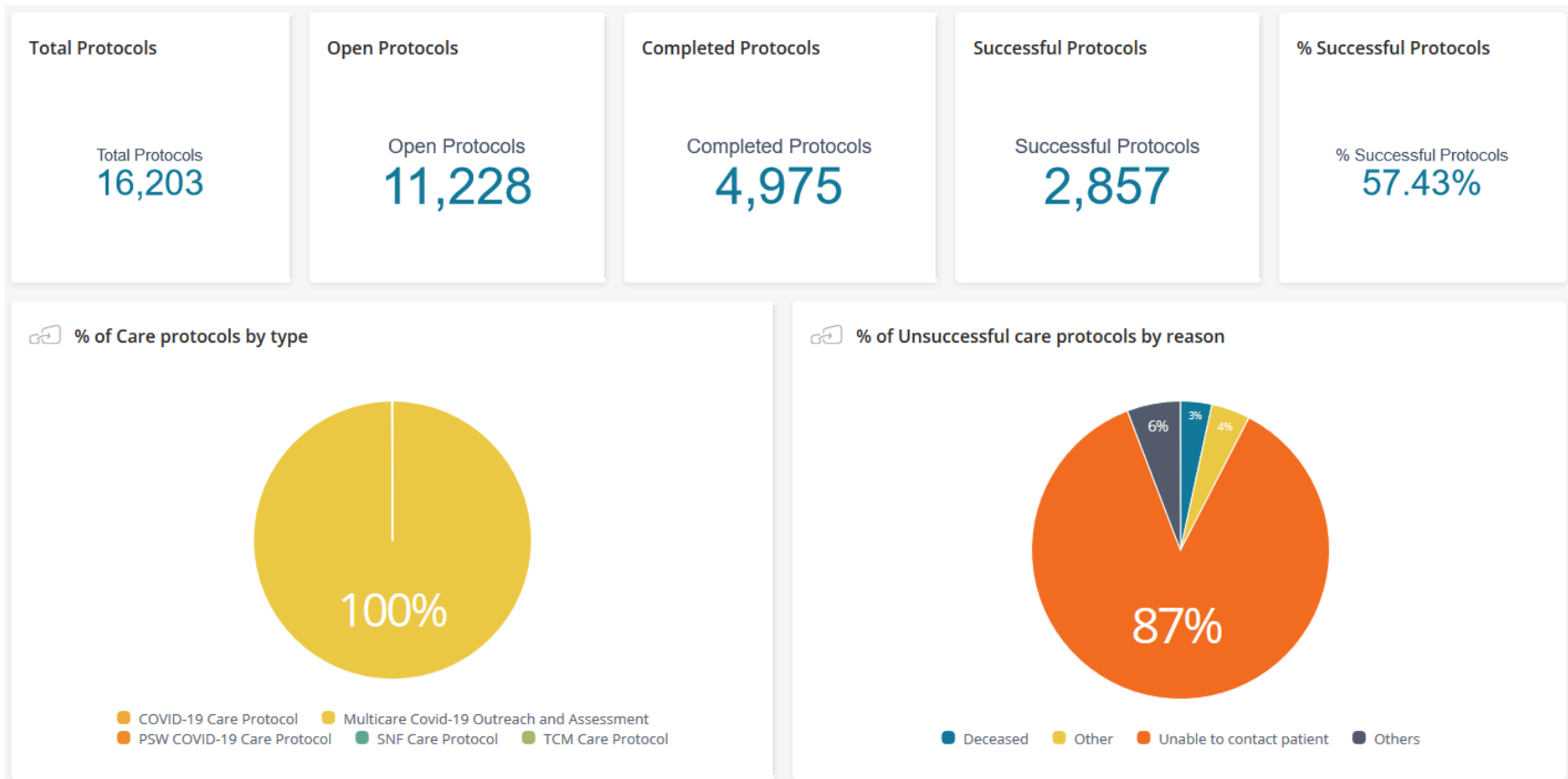
● **Successful** Completed by Forbes, Amy

Assigned on 09/09/2019 • Completed on 09/10/2019



Care Management Productivity Dashboard

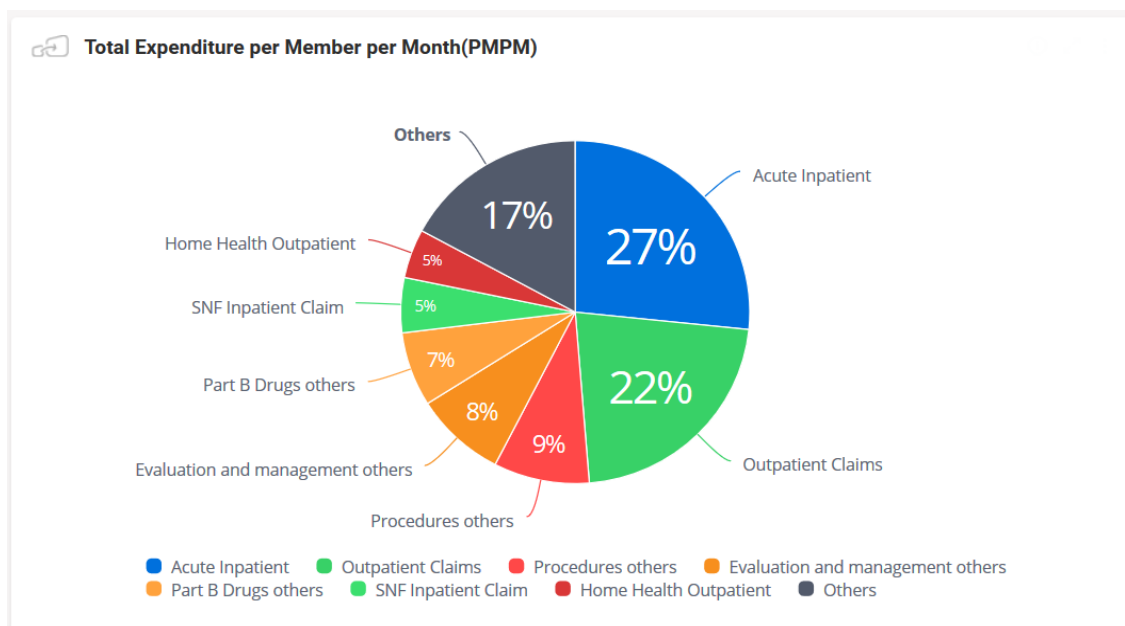
Purpose: to monitor care management activities and protocols overall and specific to individual care managers performance



Per Member Per Month Dashboard

Categorized Spend

Purpose: evaluate spending trends and monitoring financial performance at regional, clinic / provider level, and within lines of business, drill down functions available at patient level (i.e: acute care facilities and DRG views) .



Spend type drill down

- Top 10 Diagnoses (each category)
- Patient level detail:
 - Cost
 - Facility based on NPI and Name
 - DRG
 - Bill type
 - Primary procedure

All data can be pulled into csv format for further evaluation.



Dashboard PMPM

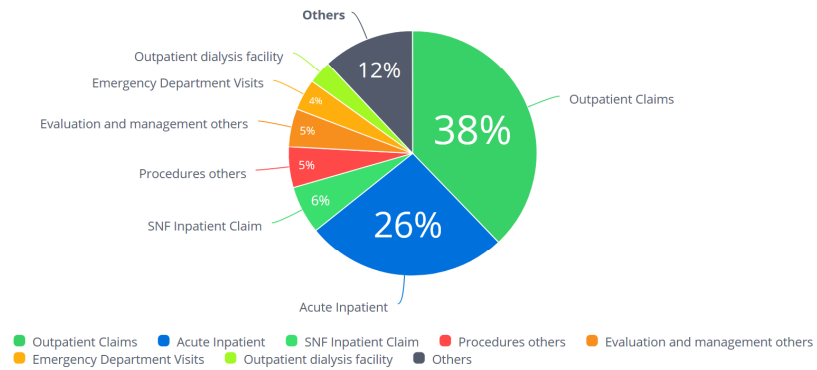
PMPM | Oct 17, 2019 12:04:19 AM

PDF

Total Expenditure per Member per Month

PMPM
\$1,105
 PMPY **\$13,257**

Total Expenditure per Member per Month(PMPM)



Total Expenditure (YTD)

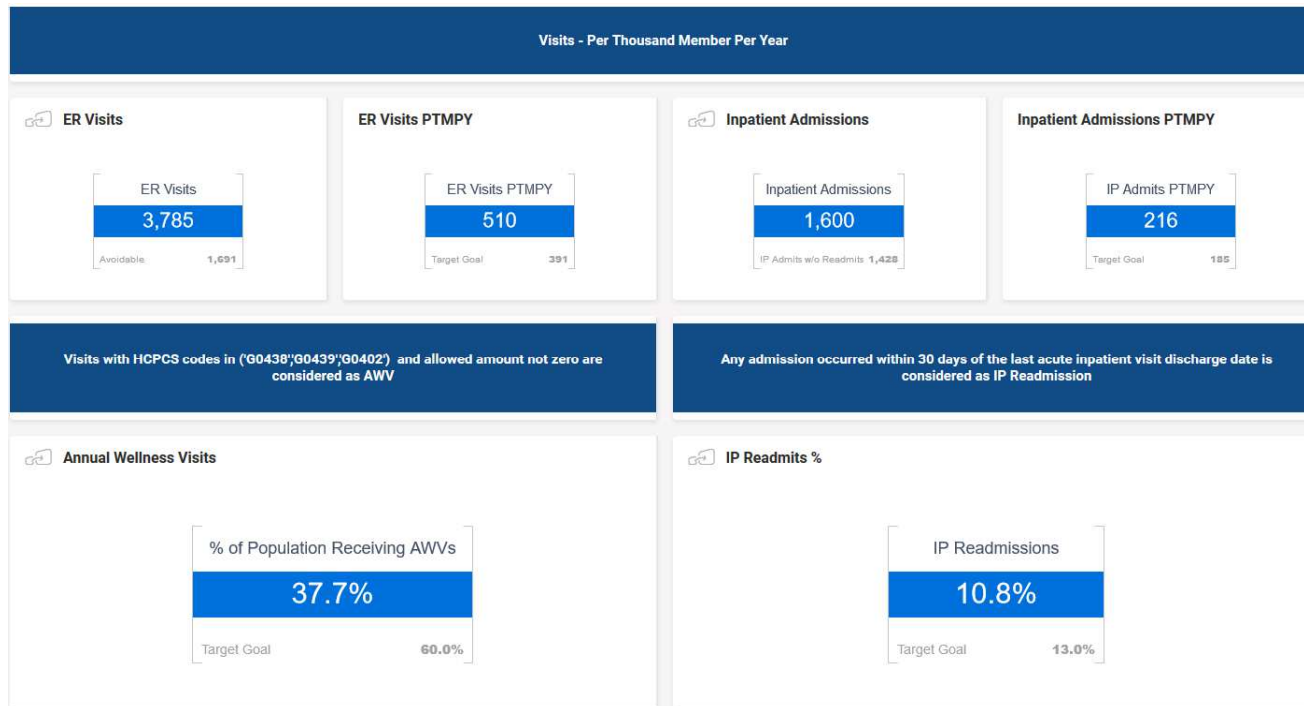
Total Paid Claim Amount
\$8M

Total Expenditure (MoM)



Scorecard Dashboard

Purpose: to monitor organizational, clinic and provider utilization performance and use for fund flow of shared savings distribution



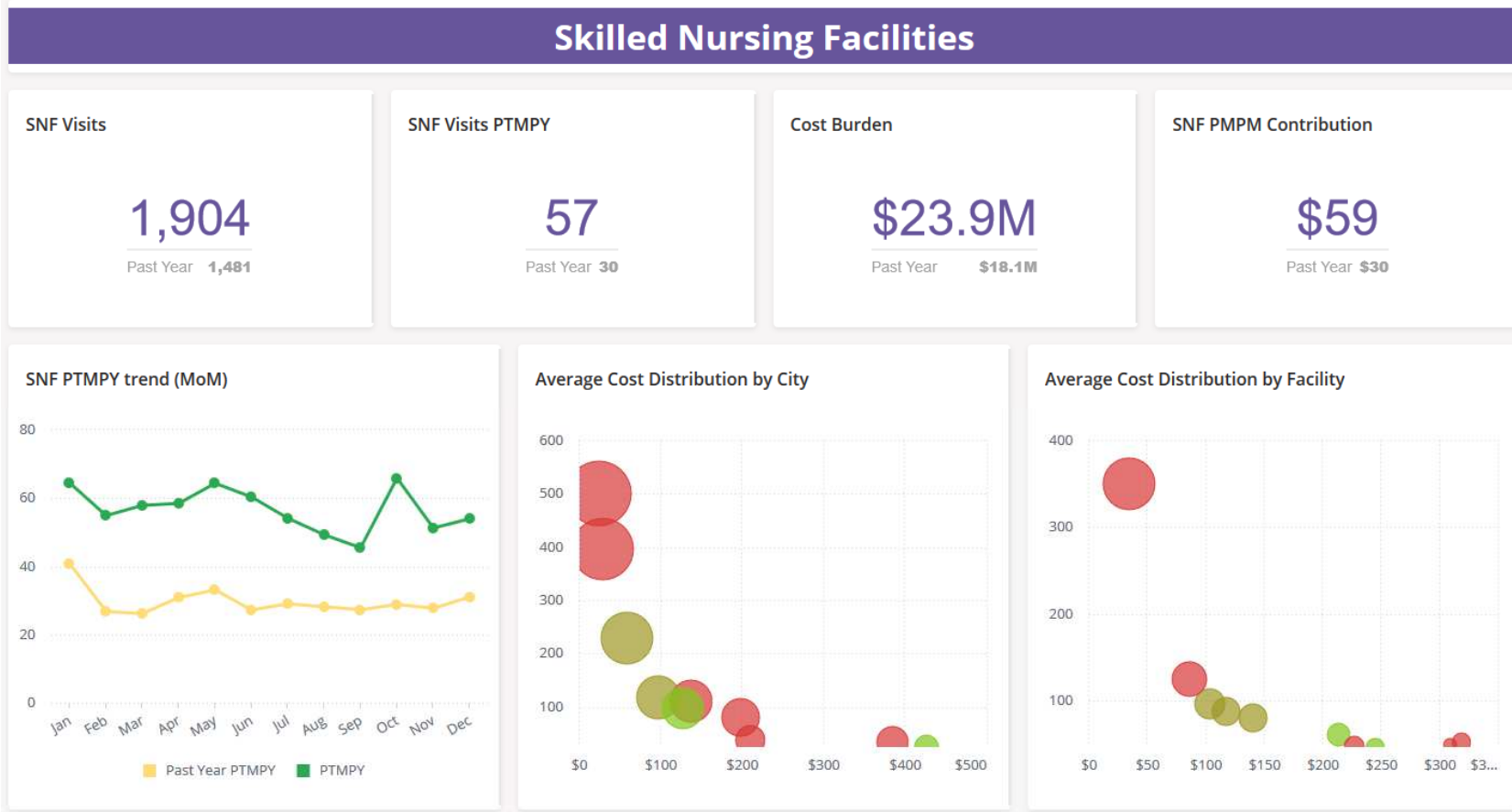
Metrics drill down

- Procedure code (level of care) – ER Visits
- Bill Type (identify CAH)
- Utilization counts by patient
- NPI Facility Identifier
- DRG
- Readmit Identifier (patient level)
- Visit Date
- Last AWW Date
- PCP Alignment – AWW
- AWW Code Billed (Initial, Welcome, Subsequent)



SNF Dashboard Detail

Purpose: to compare SNF level detail, contracted performance, length of stay, per days costs & readmissions



SNF Dashboard Drill Down

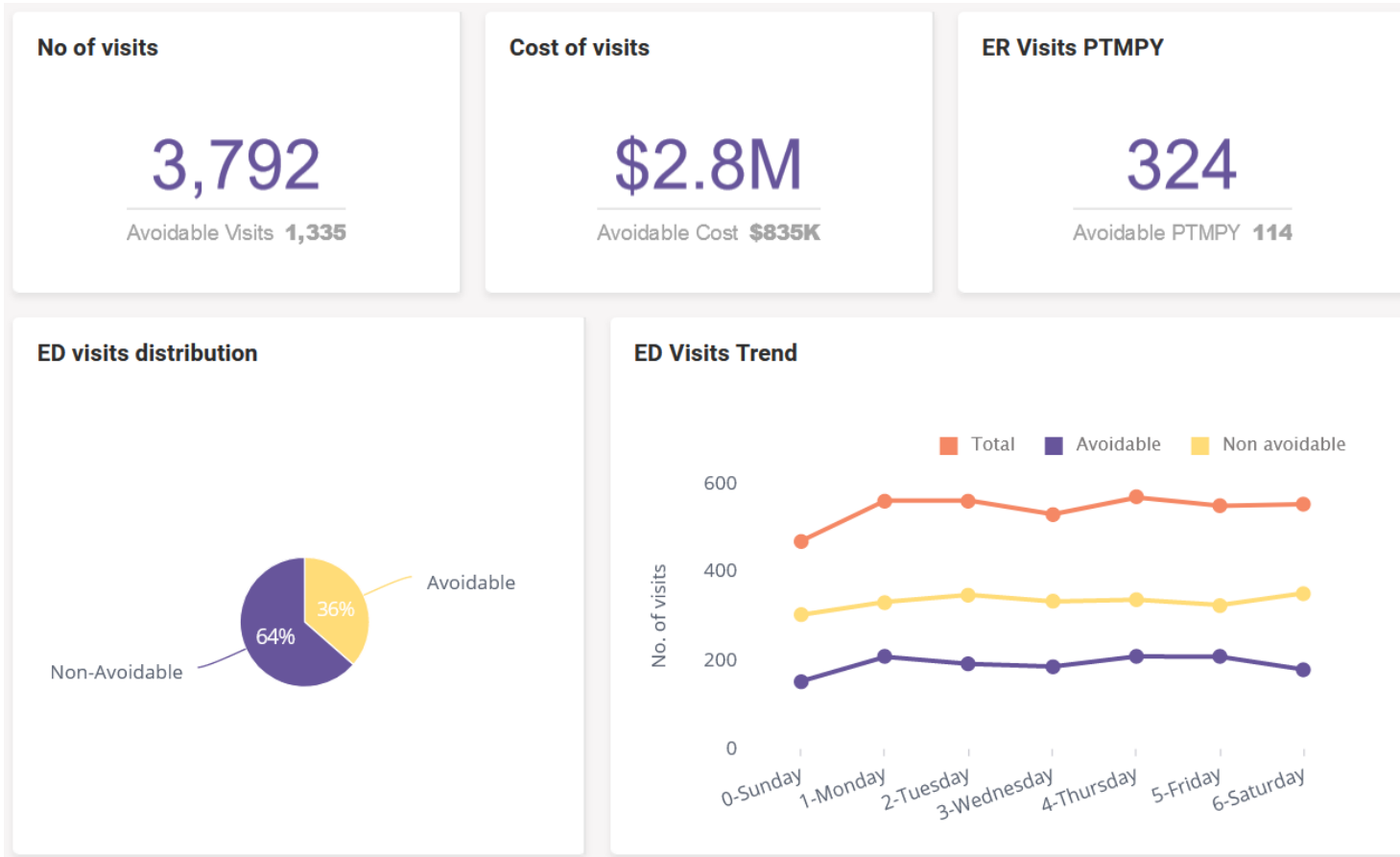
Data downloadable into Excel for sorting and filtering

City	No of visits	Cost Burden	Length Of Stay	Risk adjusted cost per visit	Cost per day	Number of Readmission to IP Based on 30 Days	% Readmission to IP Based on 30 Days	# No of ED visits during SNF
OLYMPIA	37	\$460K	22	\$2,882	\$560	8	22%	7
FRUITLAND	58	\$632K	21	\$2,760	\$515	6	10%	5
CENTRALIA	24	\$291K	23	\$2,839	\$523	5	21%	3
LEWISTON	21	\$205K	22	\$2,821	\$453	4	19%	3
LEWISTON	23	\$236K	23	\$3,077	\$451	3	13%	6
LACEY	32	\$410K	23	\$3,525	\$552	3	9%	4
OLYMPIA	13	\$298K	38	\$4,750	\$606	3	23%	1
TACOMA	2	\$24K	23	\$2,810	\$532	2	100%	0
CLARKSTON	15	\$154K	26	\$2,066	\$399	2	13%	7
LEWISTON	14	\$203K	35	\$4,206	\$417	2	14%	2



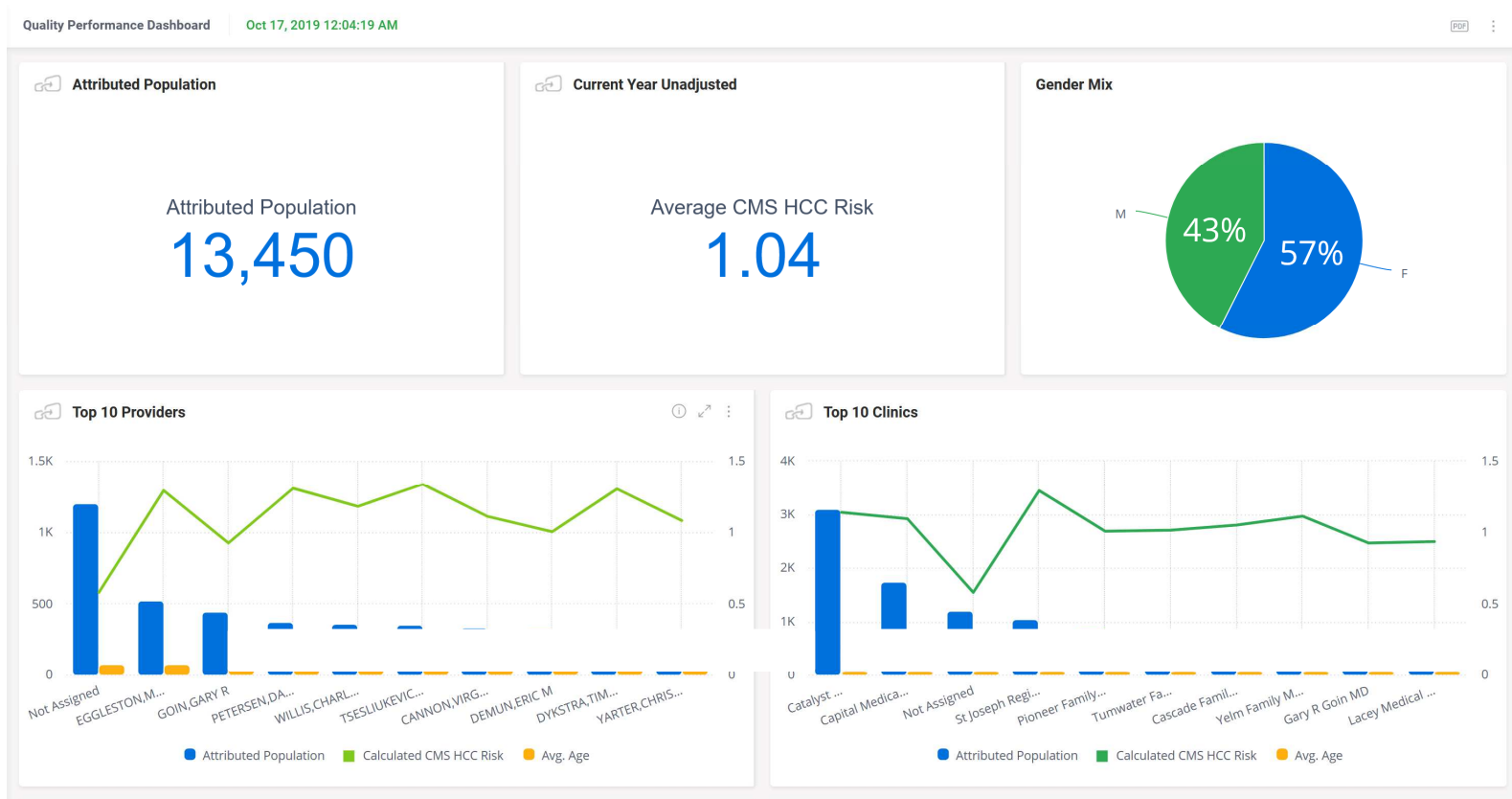
Emergency Department Dashboard

Purpose: drill down data for potentially avoidable utilization based on NYU algorithm identify high-fliers.



Dashboard - Quality Performance

Purpose: to monitor quality performance, create targets / measures based on contract requirements, prioritize patient level outreach to create campaigns for gap closure. Drill down at provider level with patient level detail.



Dashboard - Quality Performance

(Slide 2)

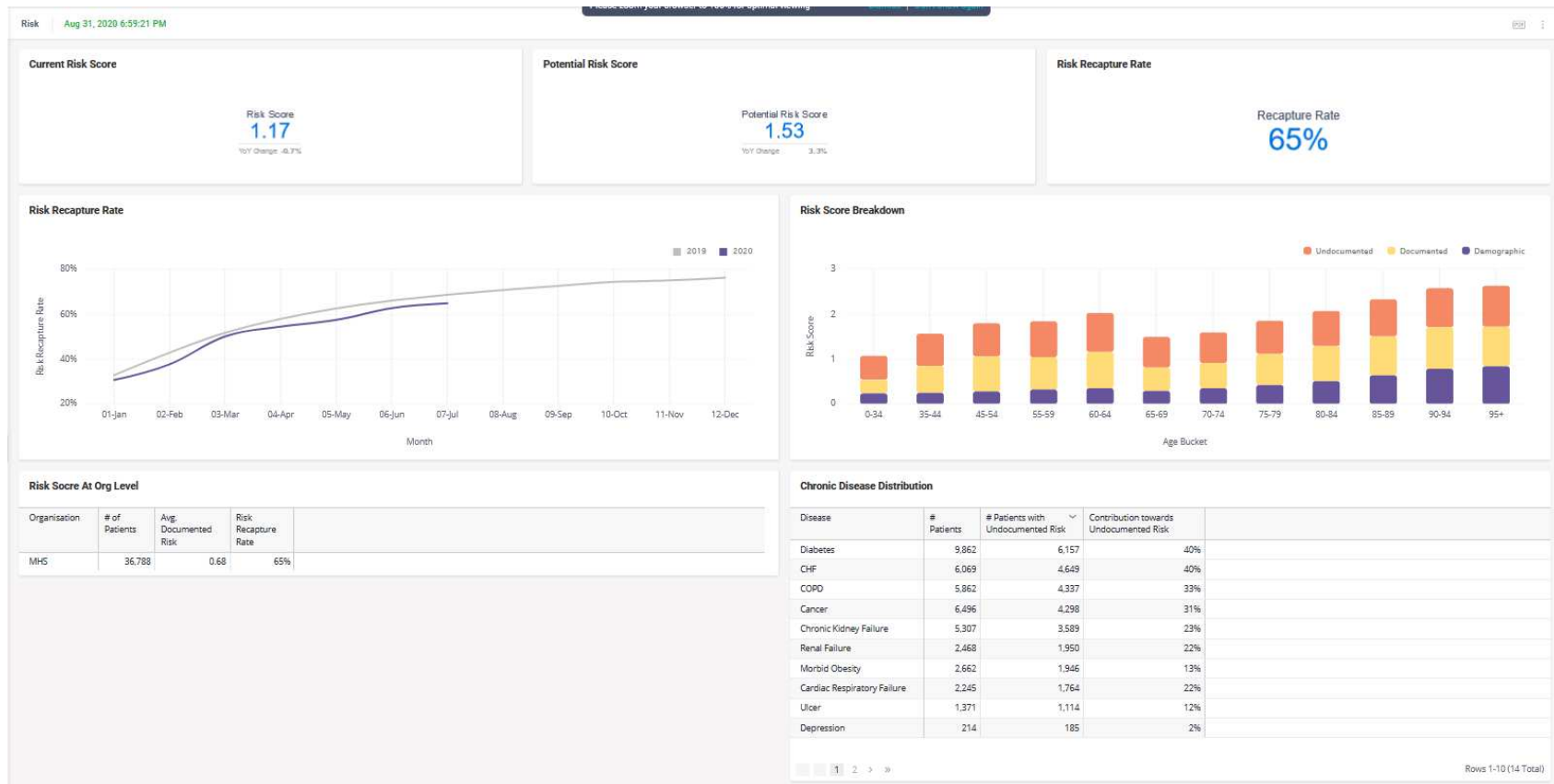
ACO Measures: Care and Preventive

Measure Code	Measure Name	30th percentile	90th percentile	Performance %	Qualified	Care Gap	Eligible populati...
ACO-15	Pneumonia Vaccination Status for Older Adults	30.0%	90.0%	76.65%	8,325	2,808	10,861
ACO-14	Preventive Care and Screening: Influenza Immunization	30.0%	90.0%	67.83%	8,116	3,849	11,965
ACO-42	Statin Therapy for the Prevention and Treatment of Ca...	NA	NA	48.79%	3,535	5,123	7,245
ACO-19	Colorectal Cancer Screening	30.0%	90.0%	51.64%	3,424	3,757	6,630
ACO-16	Preventive Care and Screening: Body Mass Index Scree...	30.0%	90.0%	24.08%	2,941	10,590	12,213
ACO-20	Breast Cancer Screening	30.0%	90.0%	70.17%	2,355	1,318	3,356
ACO-17	Preventive Care and Screening: (Population 3) Tobacco...	55.22%	92.31%	15.18%	1,714	10,242	11,290
ACO-30	Ischemic Vascular Disease: Use of Aspirin of Another A...	30.0%	90.0%	19.73%	520	2,352	2,636
ACO-18	Preventive Care and Screening: Screening for Clinical D...	30.0%	90.0%	0.60%	71	11,786	11,813
ACO-41	Diabetes: Eye Exam	29.9%	60.37%	3.23%	61	1,872	1,889
ACO-13	Falls: Screening for Future Fall Risk	43.42%	90.73%	0.46%	51	11,073	11,086



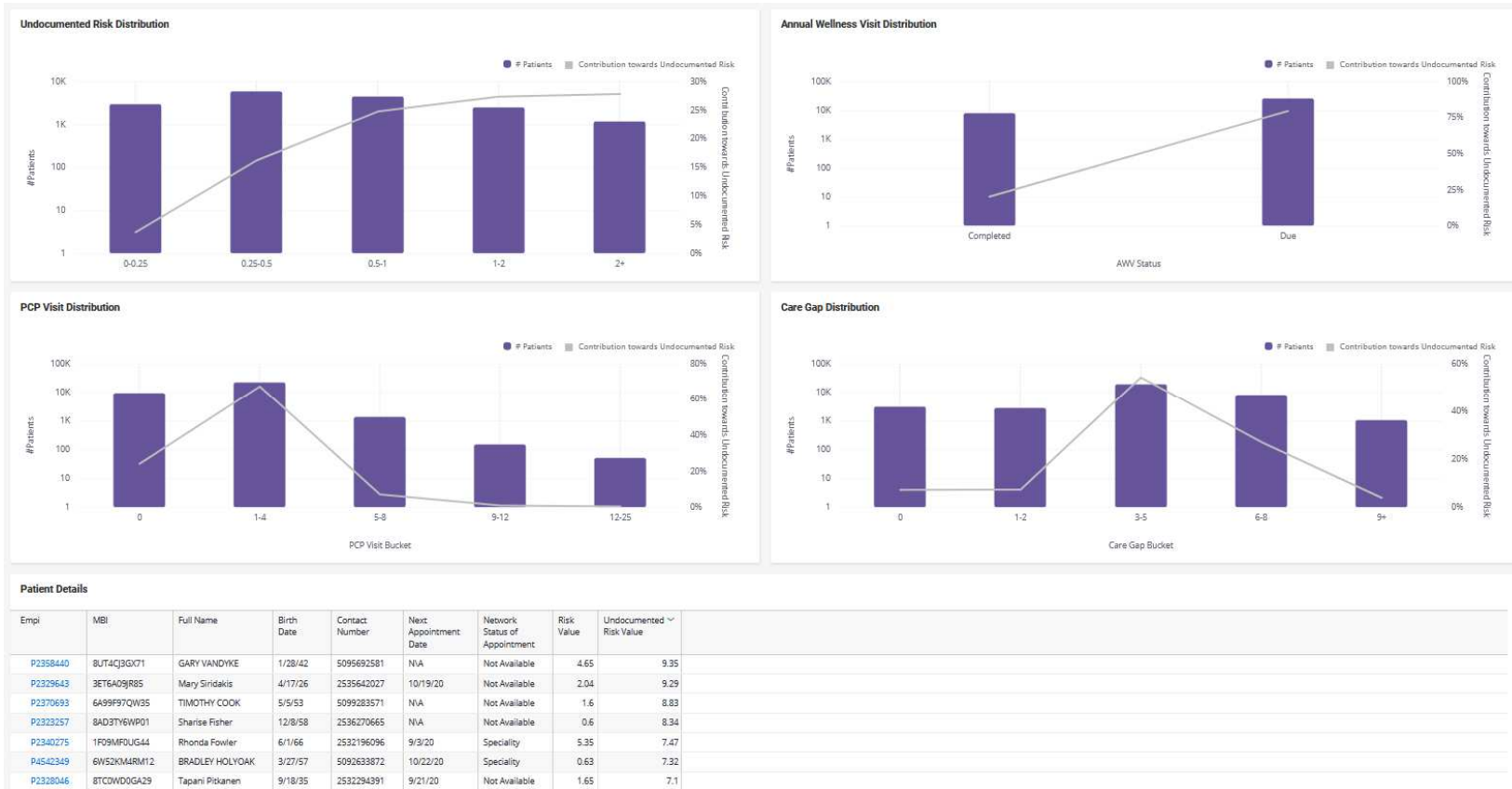
Dashboard – Risk

Purpose: to monitor recapture rate and understand risk score trends and assist at the provider and individual patient level in workflow process development.



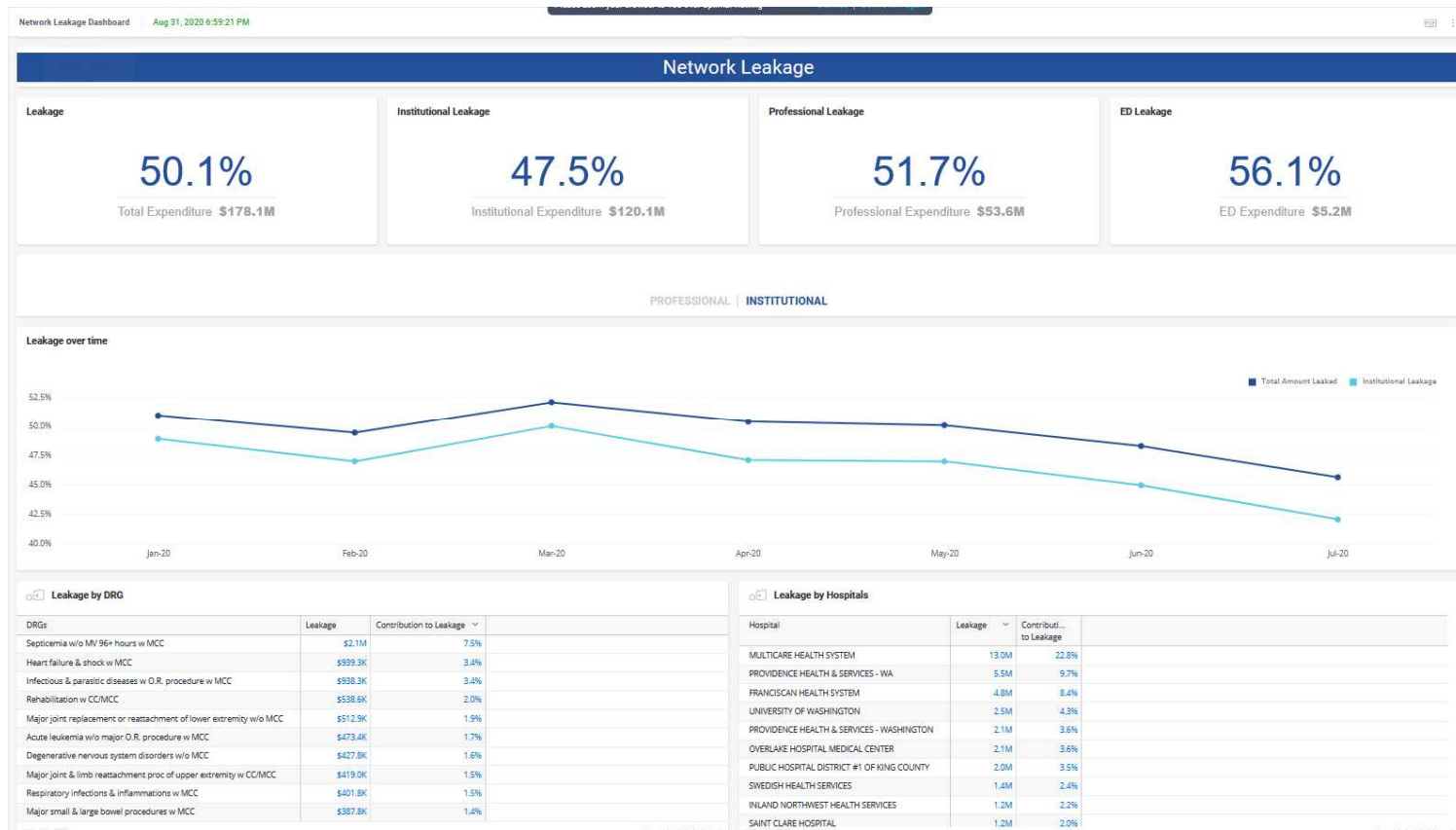
Dashboard – Risk

(Slide 2)



Dashboard – Network Leakage

Purpose: to provide insight into current network utilization, understand leakage by DRG and facility as well as specialty and provider allowing for potential future contracting





**Coming Soon: SDoH, InNote and
InConnect**

SDoH

- Innovaccer platform built using the Aunt Bertha for referral resourcing
- Social Vulnerability Index based upon the following:

Socio-Economic

- # civilians below poverty
- # civilians (age 16+) unemployed
- Per Capita Income
- # civilians with no high school diploma (age 25+)
- # Schools

Housing Composition/Disability

- # civilians aged 65 and older
- # civilians aged 17 and younger
- # civilians non-institutionalized population with disability
- # of single parent households with children under 18

Minority Status/Language

- #of White population
- # of Black or African American population total count of Asian population
- # of American Indian and Alaska Native population
- # of Other/Multiple race population
- #of Hispanic or Latino population
- # of civilians (age 5+) who speak English "less than well"

Housing and Transportation

- # of housing in structures with 10 or more units
- # of occupied housing units with more people than rooms
- # of households with no vehicle available Total count of housing units receiving SNAP benefits
- # of persons in institutionalized group quarters
- # Bus stations

Lifestyle

- # Restaurants
- # Shopping Malls
- # Churches
- # Tobacco Retailers

Access to Healthcare

- # Dentists
- # Doctors
- # Hospitals
- # Pharmacies

Food Security

- Population count beyond 1/2 mile for urban areas or 10 miles for rural areas from supermarket
- Low income population count beyond 1/2 mile for urban areas or 10 miles for rural areas from supermarket
- Kids population count >1/2 mile from supermarket
- Seniors population count >1/2 mile from supermarket
- White population count >1/2 mile from supermarket
- Black or African American population count > 1/2 mile from supermarket
- Asian population count >1/2 mile from supermarket
- American Indian or Alaska Native population count >1/2 mile from supermarket
- Other/Multiple race population count >1/2 mile from supermarket Hispanic or Latino ethnicity population count >1/2 mile from supermarket
- Housing units without vehicle count >1/2 mile from supermarket
- Housing units receiving SNAP benefits count >1/2 mile from supermarket

Sources: Centers for Disease Control and Prevention/ Agency for Toxic Substances and Disease Registry/ Geospatial Research, Analysis, and Services Program. Social Vulnerability Index 2014; US Department of Agriculture, Food Research Atlas Data 2015; Google Maps; Health Data NY and CMS Prescription Data



InNote

- EHR Ribbon or Pop-up for Point of Care solution
 - 1 click to close
- Care Gaps
 - Presents care/measure gaps for care planning and improved quality outcomes
 - Presents potentially dropped diagnosis codes identified for clinical documentation improvement
 - Shares patient education opportunities through analysis of ED utilization
- Patient search function available



InConnect

- Analytics driven patient engagement solution
- Assists in scaling outreach workflow
 - Initiatives like cancer screenings, annual wellness visits, etc
- Provides care team additional capabilities for outreach
 - Care Management introduction letters
 - Urgent care collateral materials for avoidable ED visits

