



**NWMOMENTUM**  
HEALTH PARTNERS



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# Innovaccer Training 101

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# Innovaccer: Population Health Platform



# Population Health Management



# Innovaccer Purpose & Capabilities

## Purpose:

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

## Capabilities:

- Clinical Data Connectivity
- Care Management facilitation
- Dashboarding
- Quality Metric facilitation
- Risk Management facilitation



# Innovaccer Uses and Benefits

- ▶ Innovaccer solutions is working to generate further improvements in our KPI's
- ▶ Real-time monitoring of current year RAF score
- ▶ Stratified patients - recapture of HCC's year over year
- ▶ Analytic reporting now being generated monthly through the InGraph solution which equates to a reduction in resource utilization
- ▶ Care Management workload is built based upon ADT feeds which is automated and through stratification of specific patient cohorts
- ▶ Care protocols have been built and provide robust solutions
- ▶ Social Vulnerability Index available and in the future referral processes can be made available through use of this tool
- ▶ Dashboard reports are available and used for provider engagement



# Innovaccer Platform Functionality

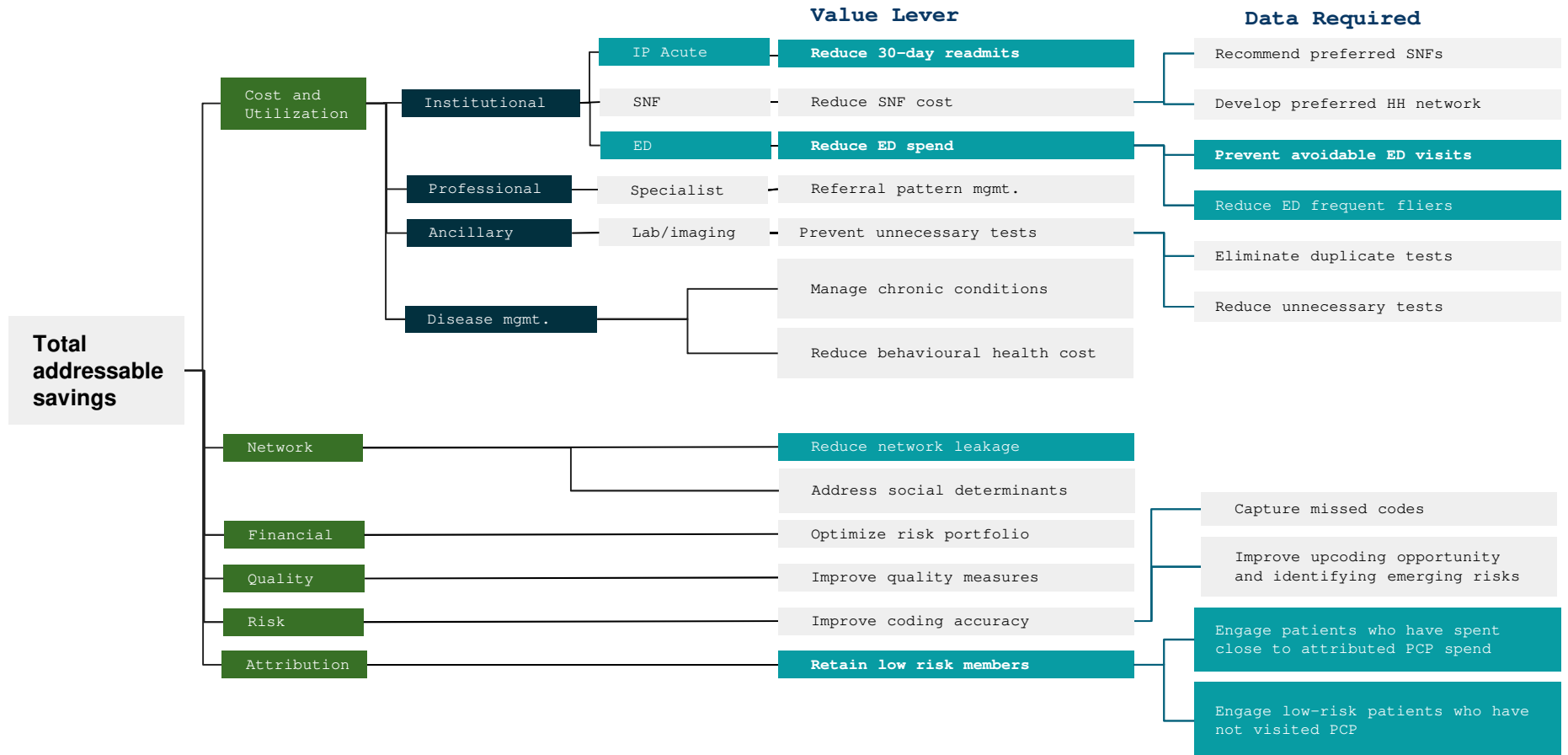
Available Solutions		
Data Aggregation	High and Rising Risk	SDoH Referral Process*
Quality Data Review	Care Management Productivity	InConnect – Campaign Management*
Utilization Metrics	Patient Level Data Drilldown	Cohort Identification
Connects to EHR's, HIE's, FHIR API's, HL7 as well as other variations	Risk Adjustment	Point of Care Solution
Attribution Logic	Network Leakage	Discharge Driven Care Management - PreManage

\*Available but not yet in use



# Innovaccer Levers

13 Key levers driving overall population health opportunity





# Getting Started



# Username & Access

Each partner or group (ie: Summit Pacific, Vancouver Clinic, etc.) will need to designate a single point of contact for user access approvals and terminations.

## User Names

- Users are required to have individual logins
- Password recovery tool available
- Innovaccer Support will assist with username/login issues
  - 5 failed attempts or 45 days without utilizing will cause your account to be locked and require email support

## Access

- Detailed logs for audit purposes
- Break the Glass feature



The screenshot shows the Innovaccer login interface. At the top is the Innovaccer logo, which consists of a red geometric shape followed by the text 'innovaccer'. Below the logo is the text 'Sign in with your account'. There are two input fields: one for 'Email' with the placeholder text 'Enter your email', and one for 'Password' with the placeholder text 'Enter your password'. Below these fields is a green button with the text 'Sign in to continue →'. At the bottom left of the form is a blue link that says 'Forgot Password'.

\*A Form for requesting access will be available closer to end of March as data should be ready in early April



# Individual Patient Data



# How to View Patient Information

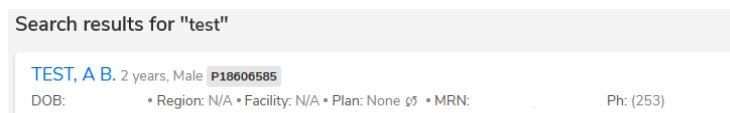
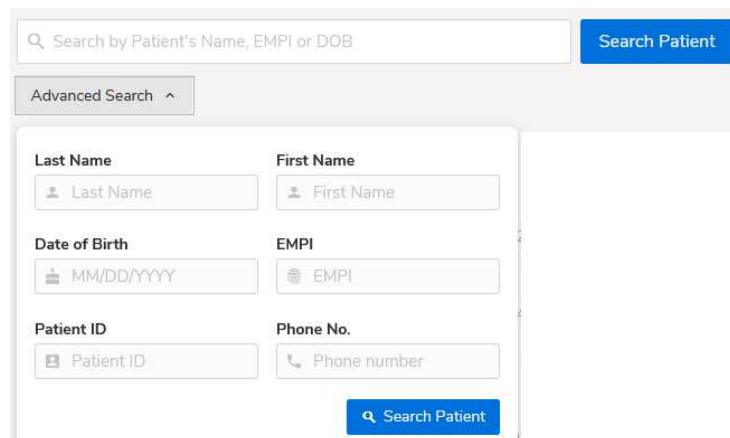
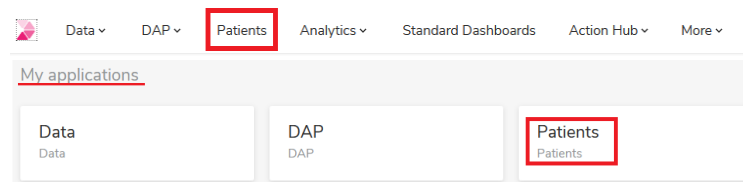
Search for a patient by selecting **“Patients”** from the banner across the top or **“My applications”**



Select **“Search Patient”** or the **“Advanced Search”** option to search for patients by name, date of birth, etc.



Click on the patient's name to view Patient 360



# Patient 360 View

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

Summary
Export PDF
Download CCDA
Print Pre-visit Summary

Source IDs 2 🔍
⚙️ ^

Source Member ID	Source Member ID Type	Race/Ethnicity
	Patient ID	
	MRN	

Clinical Overview ^

ACO	N/A
PCP	Data Not Available
Last Encounter	on 12/22/2020 <span>📌</span>
Last Annual Well Visit	Data Not Available
ED Admits in last 12 months	Data Not Available
IP Admits in last 12 months	Data Not Available

Ongoing Care Protocols 22 🔍
⚙️ ^

Care Protocol	Coached by	Start Date	Target Completion Date
<a href="#">TCM Care Protocol</a>		02/08/2021	02/08/2021
<a href="#">TCM Care Protocol</a>		01/22/2021	01/22/2021

- Source IDs 2
- Clinical Overview
- Ongoing Care Protocols 22
- ADT Feed Details
- Recent Visits 17
- Vitals
- Allergies
- Labs 1
- Surgical Procedures
- Radiology Procedures
- Pathology & Lab Procedures
- Other Procedures
- Diagnosis 4
- Problem List
- Medications
- Immunizations 1
- Social History
- Risk 1
- Family History
- Measures and Care Gap



# Contents in Patient 360

## Example

- Selecting “**ADT Feed Details**” provides patient details found on an ADT feed such as Actual Diagnosis, Discharge Disposition, Admit/Discharge Date Time



- Source IDs 2
- Clinical Overview
- Ongoing Care Protocols 22
- ADT Feed Details**
- Recent Visits 17
- Vitals
- Allergies
- Labs 1
- Surgical Procedures
- Radiology Procedures
- Pathology & Lab Procedures
- Other Procedures
- Diagnosis 4
- Problem List
- Medications
- Immunizations 1
- Social History
- Risk 1
- Family History
- Measures and Care Gap

ADT Feed Details 7

Chief Complaint   Actual Diagnosis	Encounter Type	Discharge Dispositi...	Admit Date Time	Discharge Date Time	Encounter Class
R L E WOUND/CELLULITIS/IVDU/O...	Inpatient	Left against medica...	2021-02-08 20:08:...	2021-02-10 16:00:...	Surgery

- Selecting “**Recent Visits**” provides details that come from Clinical data

Recent Visits 17

Start Date	End Date	Facility Name	Encounter Type	Encounter Type	Provider	Provider Specialty
01/19/2020	01/19/2020	MULTICARE HEAL..			SCHADE AMY GE...	Physician Assistant
01/17/2020	01/17/2020	MULTICARE HEAL..				Physician Assistant



# Patient Information

From the left navigation menu, selecting “Profile” allows users the ability to view patient level details such as:

- Contact details
- Assigned providers
- Managed plans

**Left Navigation Menu:**

- Clinical Data
- Care Management
  - Timeline
  - Care Protocols
  - Assessments
  - Tasks
  - Goals
  - Community Resources
- Risk
- Claims
- Profile**
- Patient Notes

**Preferences**

- Known Languages: english
- Preferred Method of Contact: Not available
- Preferred Time: Not available

**Contact Details**

- Phone Numbers: (253) 263-6786
- Addresses: PO BOX 613, AUBURN, Washington, 98071-0613 (3 more)
- Email Addresses: chuckgjr@comcast.net

**Care Custodians**

No care custodian added. Add people from patient's family or close circle who can be contacted in case of emergencies and other medical reasons.

**Managed Plans**

**PRIMARY** (ACTIVE)

MSSP Track1+  
CMS  
Subscriber  
Last str: 12/20 Plan ID: 2 Payer ID: 2

**SECONDARY**

Not available

**Additional Info**

- Ethnicity: Not available
- Marital status: Married
- Race: white
- Employer: Not available

**Providers**

Name	Speciality	Facility	Contact	Facility Address
WALKER NICOLA E 1538193586	Allopathic & Osteopathic Physicians/Family Medicine	Covington MultiCare Clinic	Not available	17700 SE 272ND ST, COVINGTON, US, 98042-4951

[View all linked providers](#)

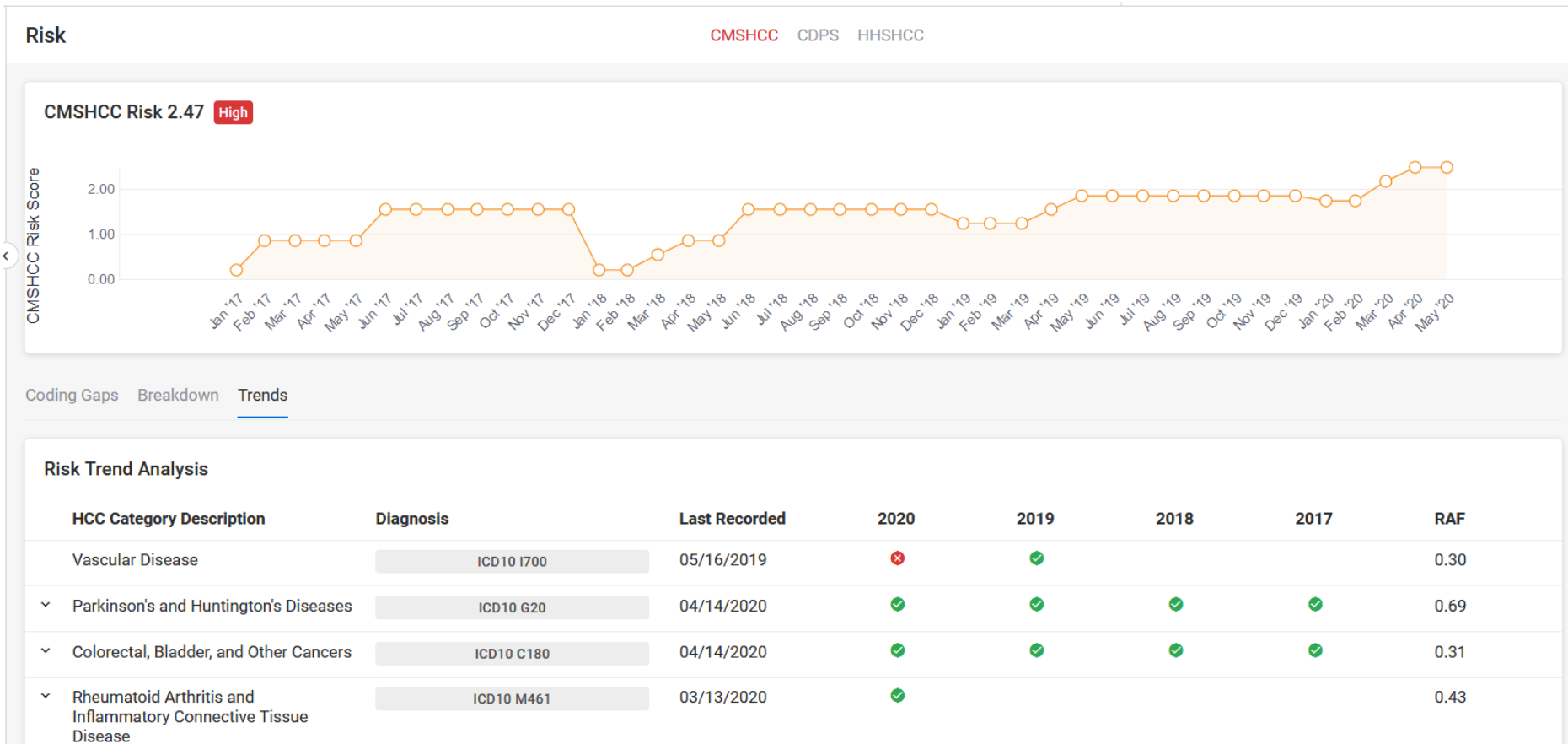
**Care Management Staff**

Name	Job Title	Department	Email	Phone
Support, IT	Not available	Not available	itsupport@innovaccer.com	Not available



# 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.





# Analytics

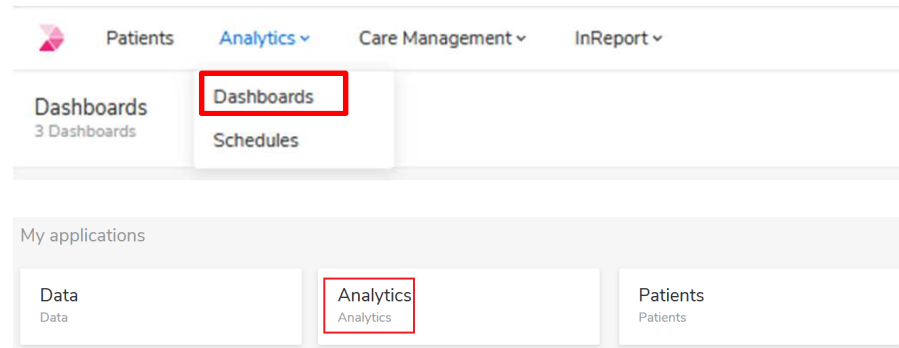


# How to Get to Dashboards

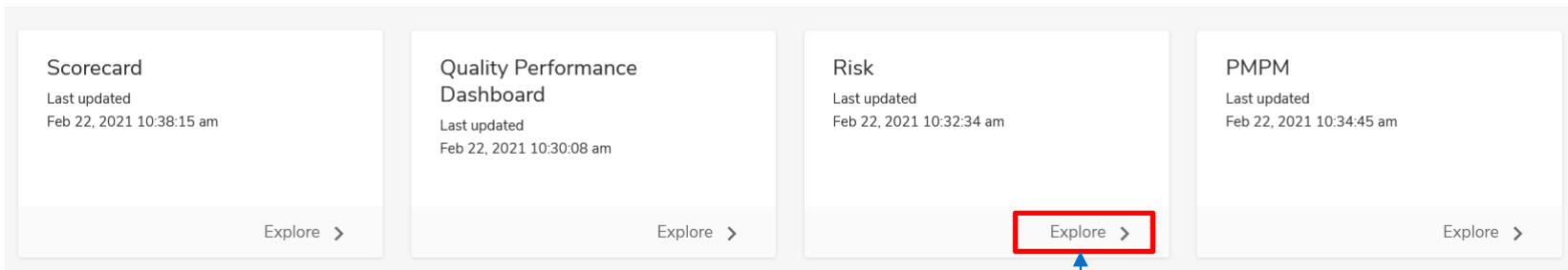
Hover on “**Analytics**” from the banner across the top and click on “**Dashboards**”

OR

Choose “**Analytics**” from “**My applications**” in the home screen



Dashboards



To open the dashboard and view the analytics, click “**Explore**”

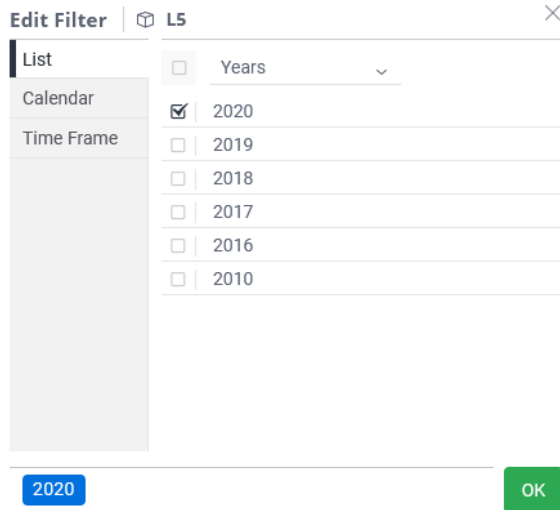
\*Access to certain dashboards is dependent on users' permissions



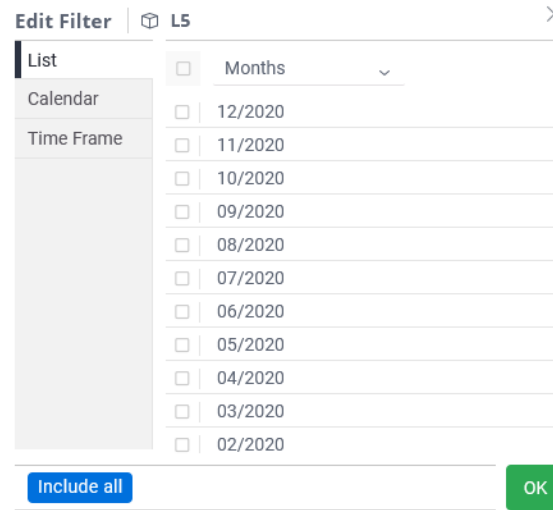
# How to Filter and its Importance

Various data filters are available in the right-side menu to filter what data is being displayed

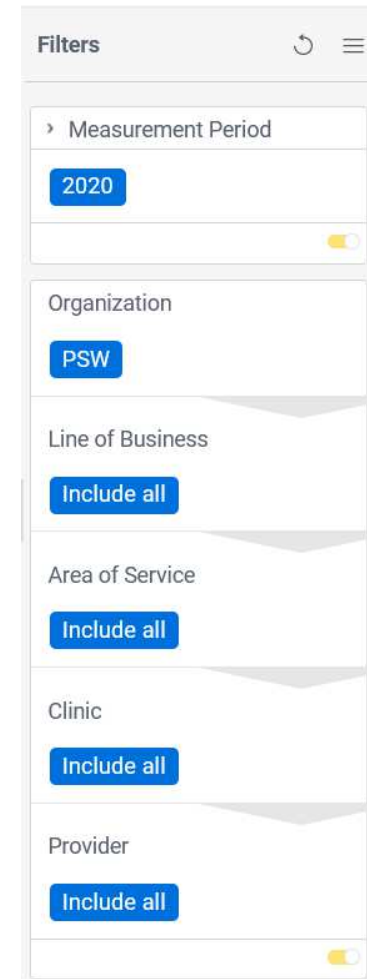
\*There is a 45-day claims lag and we project an additional 45 day incurred but not received (IBNR) lag



Dialog box titled "Edit Filter" with a close button (X) and a filter icon. It shows a "List" tab selected. Under "Calendar", the "Time Frame" is set to "Years". A list of years is shown: 2020 (checked), 2019, 2018, 2017, 2016, and 2010. At the bottom, there is a blue button labeled "2020" and a green button labeled "OK".



Dialog box titled "Edit Filter" with a close button (X) and a filter icon. It shows a "List" tab selected. Under "Calendar", the "Time Frame" is set to "Months". A list of months for 2020 is shown: 12/2020, 11/2020, 10/2020, 09/2020, 08/2020, 07/2020, 06/2020, 05/2020, 04/2020, 03/2020, and 02/2020. At the bottom, there is a blue button labeled "Include all" and a green button labeled "OK".



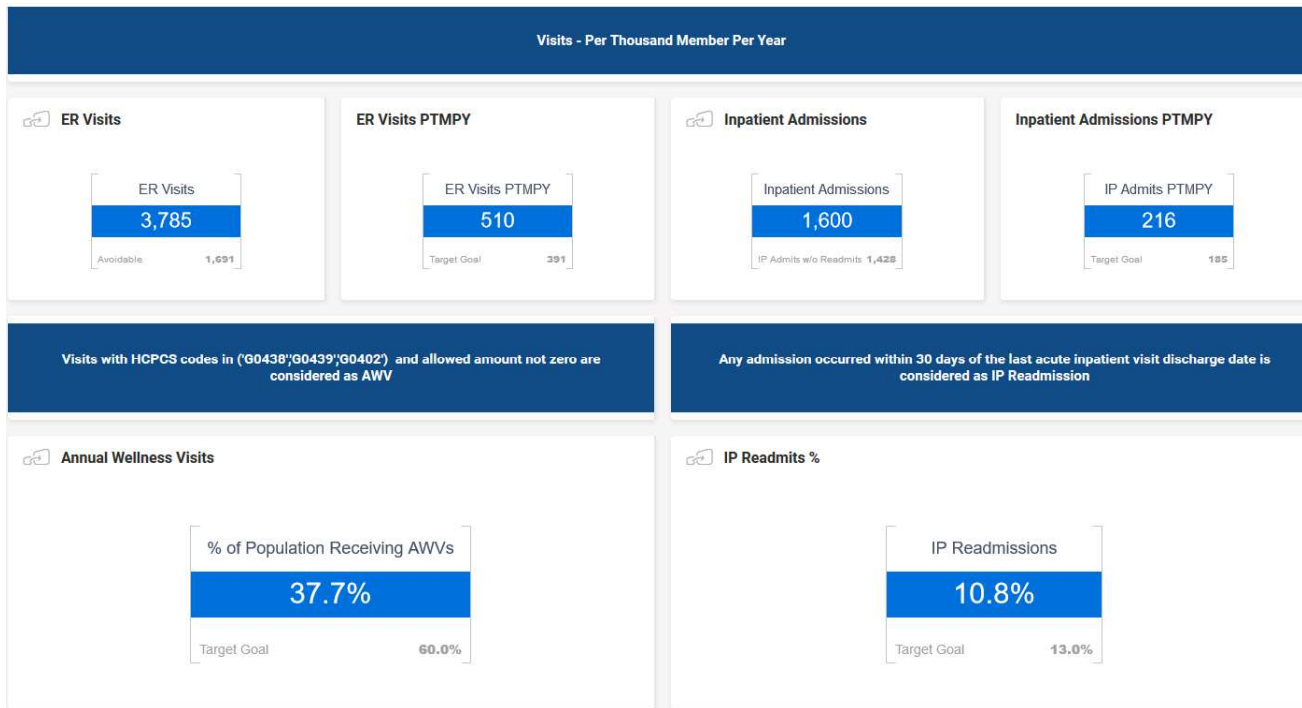
A vertical "Filters" menu with a refresh icon and a menu icon at the top. It contains several filter categories, each with a blue button and a toggle switch at the bottom right:

- Measurement Period: 2020
- Organization: PSW
- Line of Business: Include all
- Area of Service: Include all
- Clinic: Include all
- Provider: Include all



# Scorecard Dashboard

**Purpose:** to monitor clinic and provider utilization performance based on attributed population



## Metrics drill down

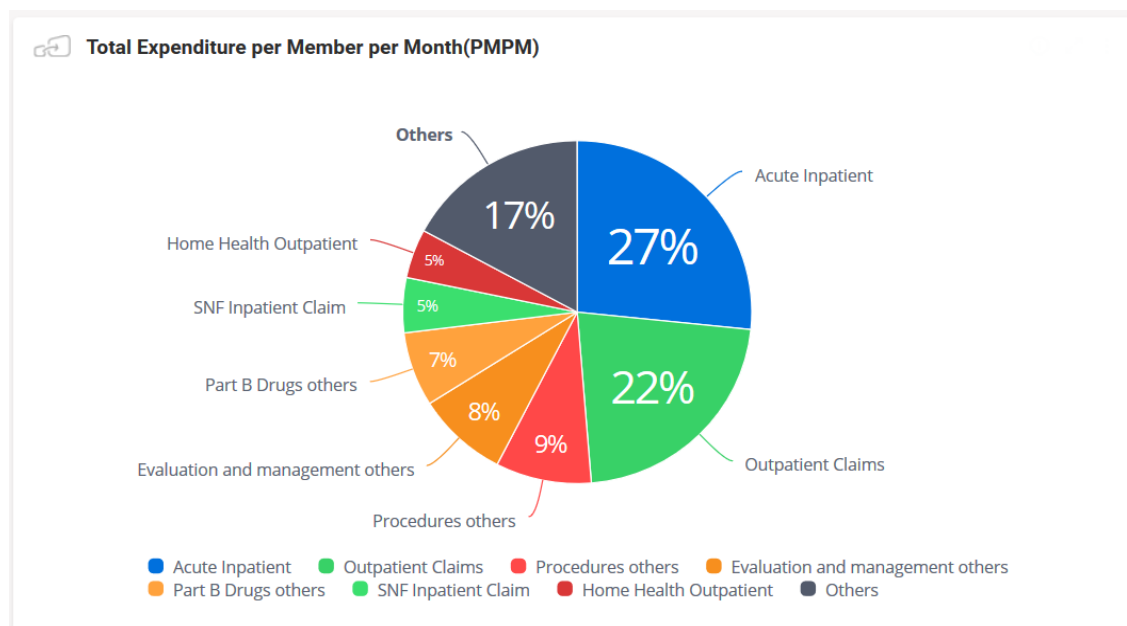
- Procedure code (level of care) – ER Visits
- Bill Type (identify CAH)
- Utilization counts by patient
- NPI Facility Identifier
- DRG
- Readmit Identifier (patient level)
- Visit Date
- Last AWW Date
- PCP Alignment – AWW
- AWW Code Billed (Initial, Welcome, Subsequent)



# Per Member Per Month Dashboard

## Categorized Spend

**Purpose:** evaluate spending trends and monitoring financial performance at clinic and/or provider level for attributed populations, 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

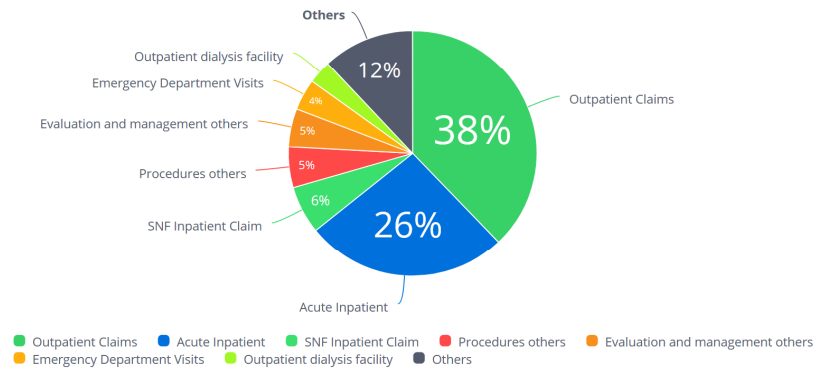
PMPM | Oct 17, 2019 12:04:19 AM

PDF

Total Expenditure per Member per Month

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

Total Expenditure per Member per Month(PMPM)



Total Expenditure (YTD)

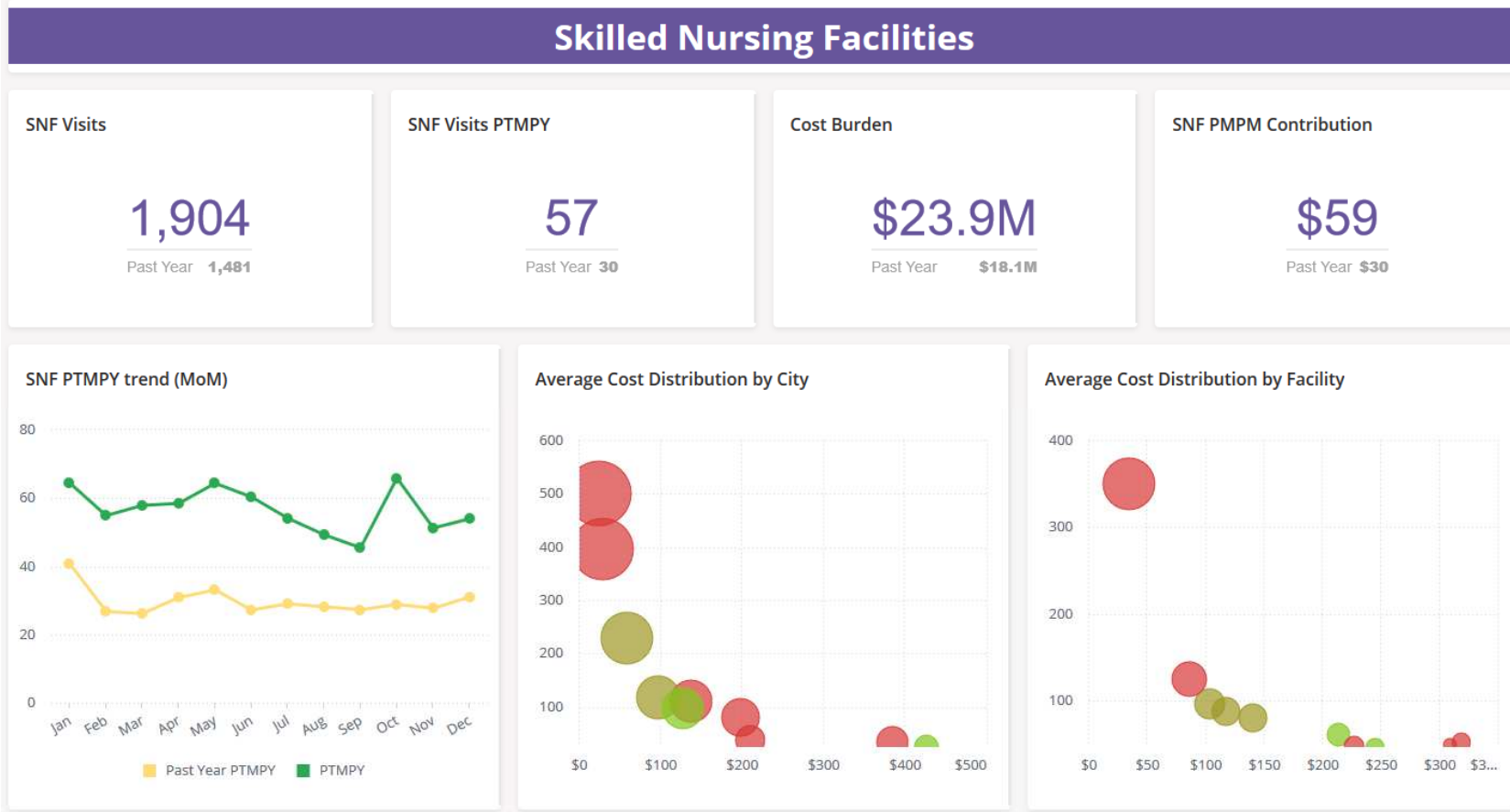
Total Paid Claim Amount  
**\$8M**

Total Expenditure (MoM)



# SNF Dashboard Detail

**Purpose:** to compare SNF level detail, contracted performance, length of stay, per days **costs & readmissions** based on attributed population



# SNF Dashboard Drill Down

Data downloadable into Excel for sorting and filtering

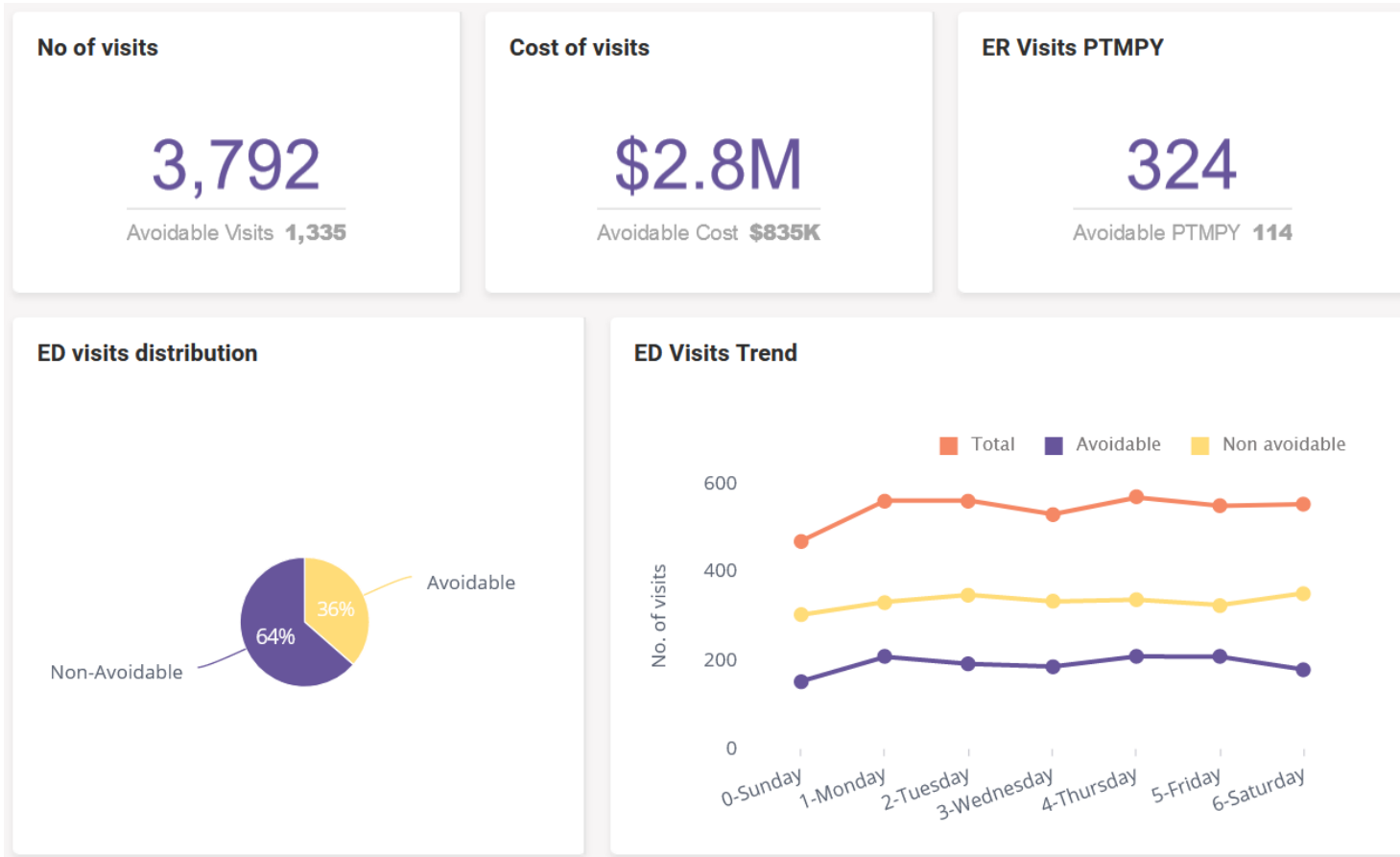
City	No of visits	Cost Burden	Length Of Stay	Risk adjusted cost per visit	Cost per day	Number of Readmission to IP Based on 30 Days	% Readmission to IP Based on 30 Days	# No of ED visits during SNF
OLYMPIA	37	\$460K	22	\$2,882	\$560	8	22%	7
FRUITLAND	58	\$632K	21	\$2,760	\$515	6	10%	5
CENTRALIA	24	\$291K	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





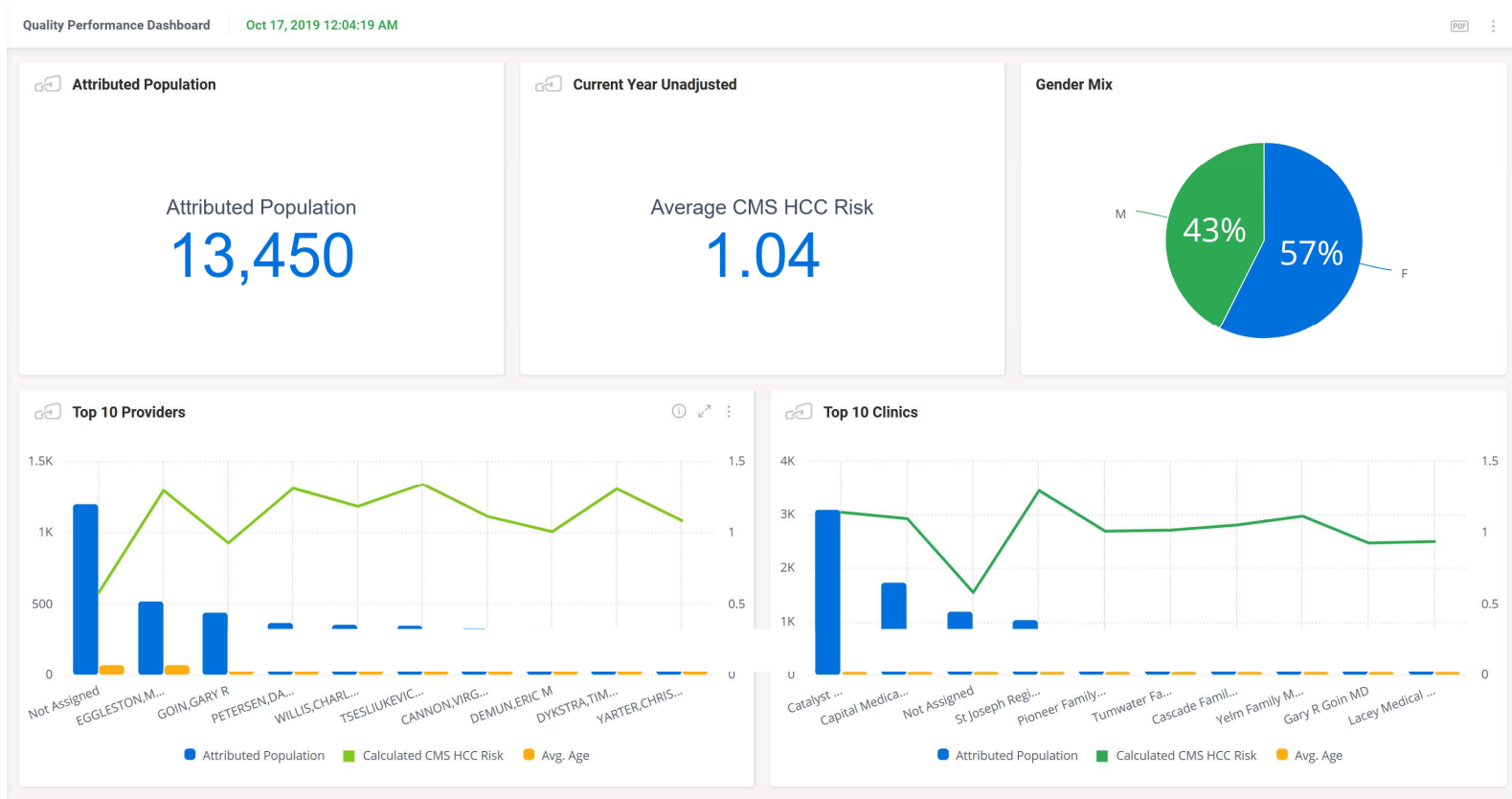
# Emergency Department Dashboard

**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

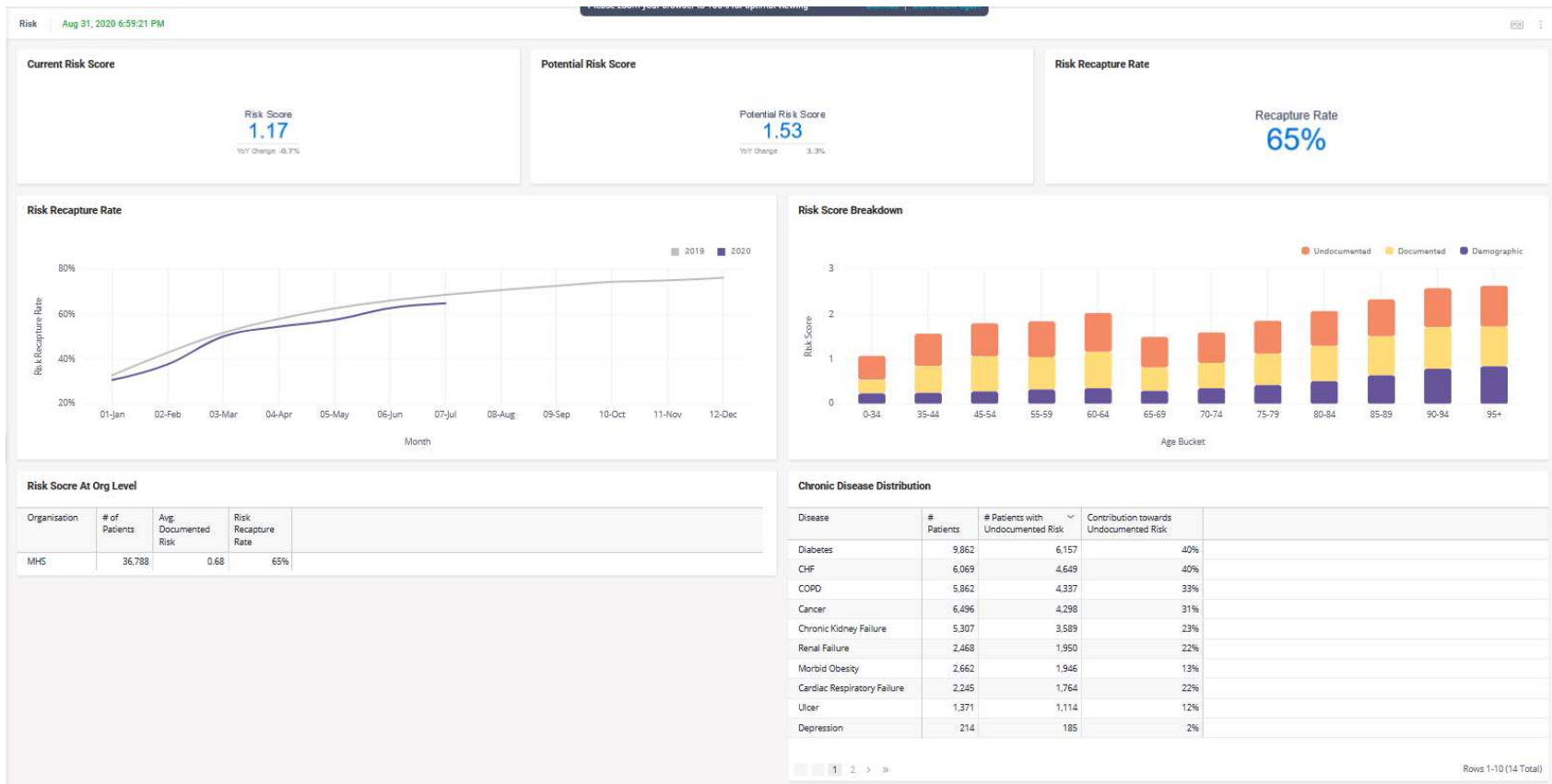
Measure Code	Measure Name	30th percentile	90th percentile	Performance %	Qualified	Care Gap	Eligible populati...
ACO-15	Pneumonia Vaccination Status for Older Adults	30.0%	90.0%	76.65%	8,325	2,808	10,861
ACO-14	Preventive Care and Screening: Influenza Immunization	30.0%	90.0%	67.83%	8,116	3,849	11,965
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

\*2021 metrics are subject to change



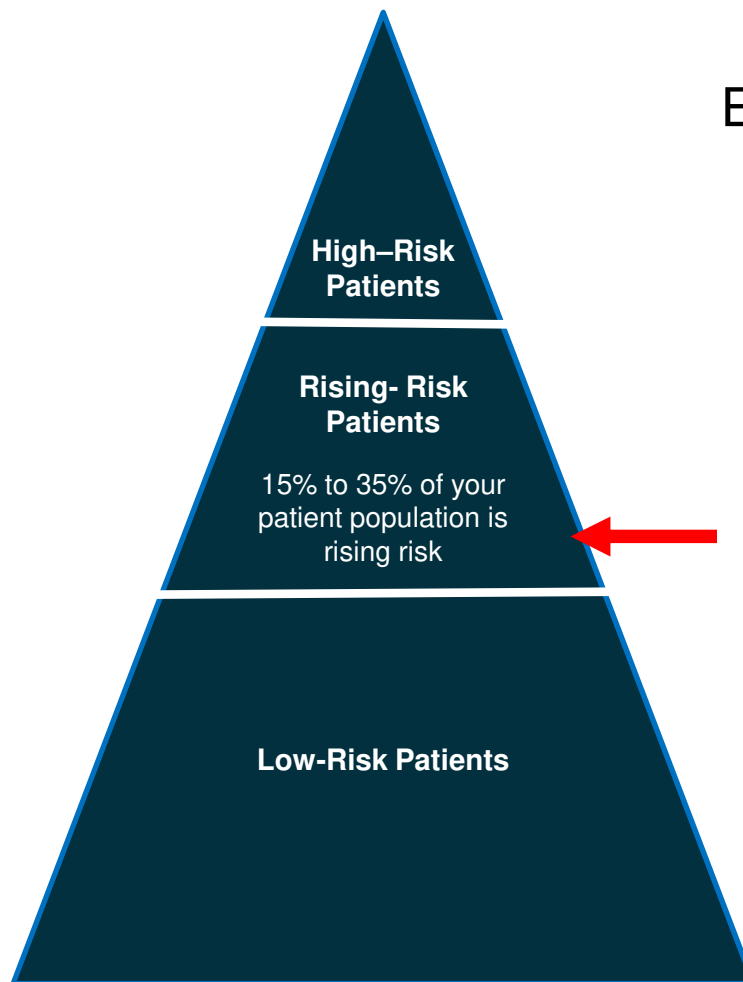
# Dashboard – Risk

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



# Risk Populations

## Patient Risk Escalation



Each year about 18% of rising risk patient escalate to high-risk patients.

### Common Triggers of Rising Risk Escalation

- Unpredicted exacerbation where patient is unable to recover
- Patient unaware of condition or ignores it and therefore is not managing
- Natural deterioration based upon based upon managed condition



# High Risk

## Rising Risk Identified Patients

### Innovaccer Risk Dashboard NGACO Population

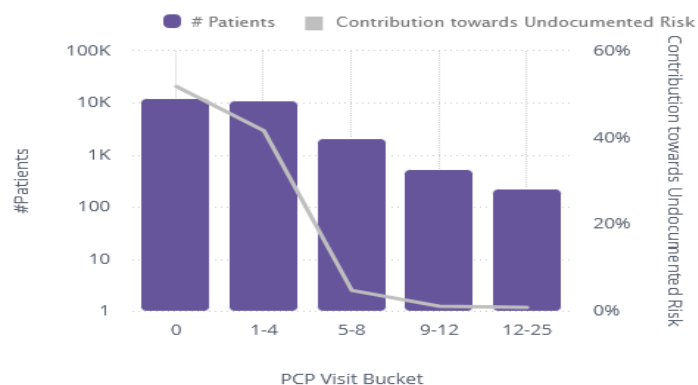
Disease	# Patients	Prevalence
Diabetes	4205	26.7%
CHF	2329	14.8%
Cancer	2452	15.6%
COPD	2248	14.3%
Chronic Kidney Failure	1699	10.8%
Morbid Obesity	1245	7.9%
Ulcer	611	3.9%
Cardiac Respiratory Failure	553	3.5%
End Stage Renal Disease	54	0.3%
HIV/AIDS	3	0.0%



# Rising Risk Variables

## Innovaccer Risk Dashboard: A Case Study Example

PCP Visit Distribution



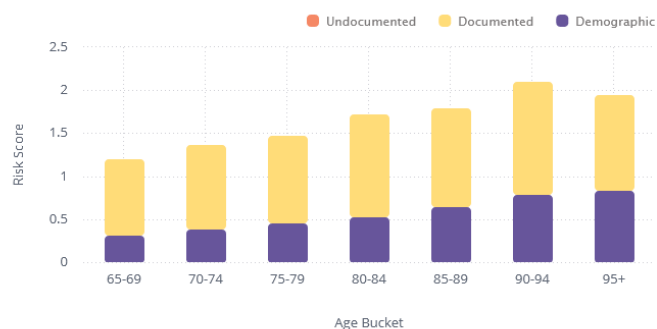
**Managing disease states:** understand and filter on several factors:

- PCP Visit distribution
- Age grouping

**Additional filtering options:**

- Annual Physical or Wellness Visit Completion
- Open care gaps
- Undocumented diagnosed chronic conditions year over year

Risk Score Breakdown



**CASE STUDY EXAMPLE:**

**Data** → **Actionable Information**

- Filter on the Chronic Kidney Failure population of 1699
- Look at the age group between 65 and 69 where a patient did not have a PCP visit in 2020, needs an AWW, and has nine or more open care gaps.
- Narrows patient list from **1699 to six patients** needing outreach.



The background is a solid green color. A large, semi-transparent green arrow graphic is positioned on the left side, pointing towards the right. The arrow is composed of several overlapping, curved segments that create a sense of motion or a path.

# Optional Modules: InNote



# 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

