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www.nwmomentumhealthaco.com

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

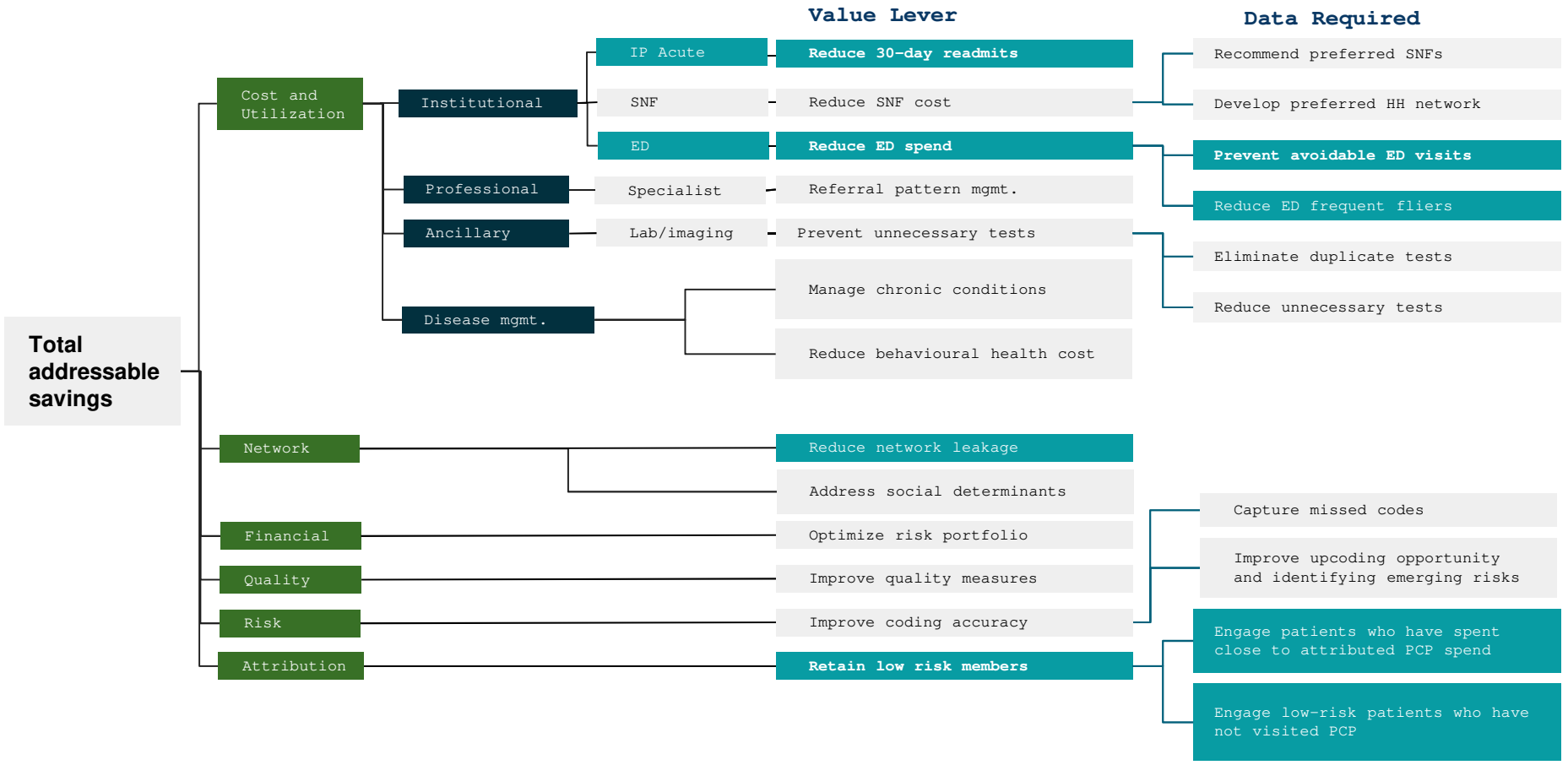
Innovaccer Platform Functionality

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



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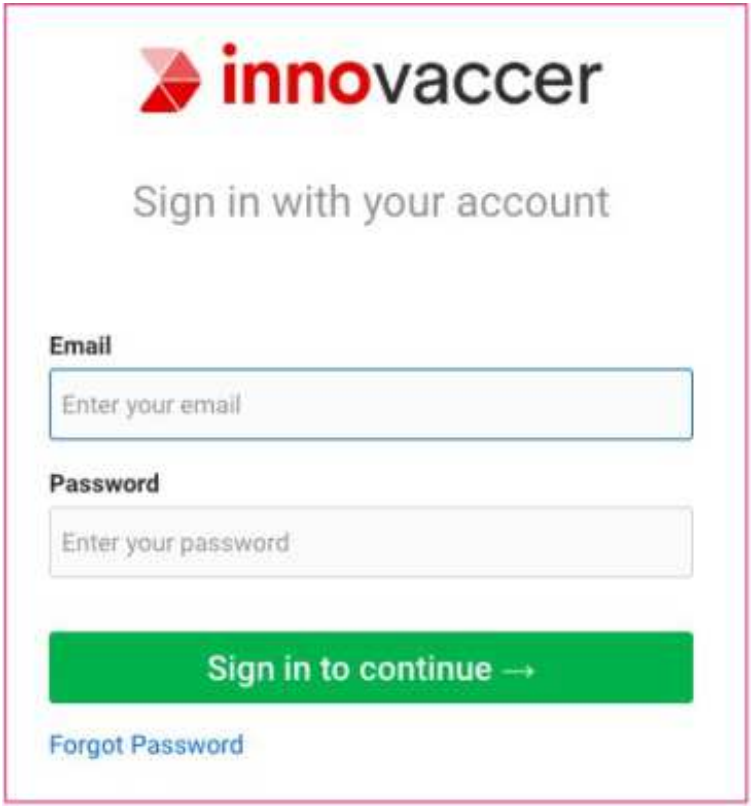
Getting Started

Usernames & 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

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

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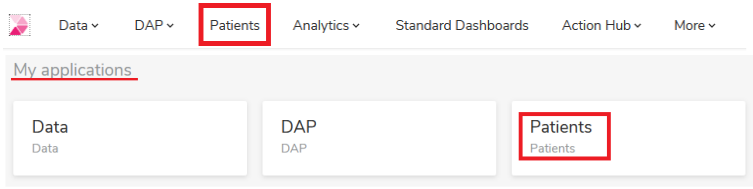
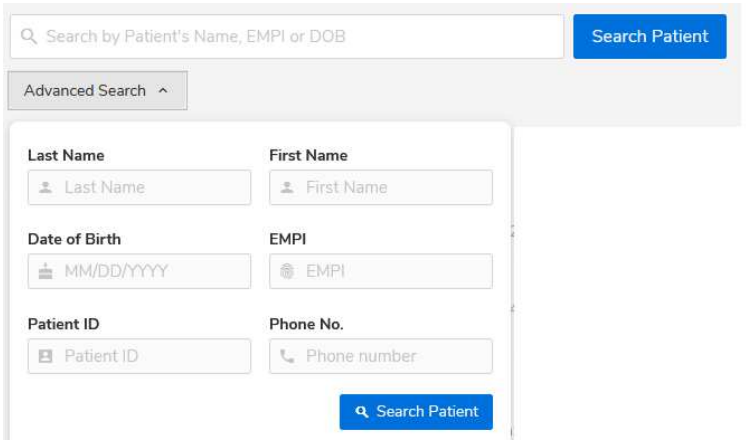
Individual Patient Data

How to View Patient Information

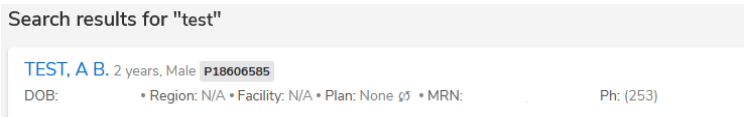
Search for a patient by selecting "**Patients**" from the banner across the top or "**My applications**"



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



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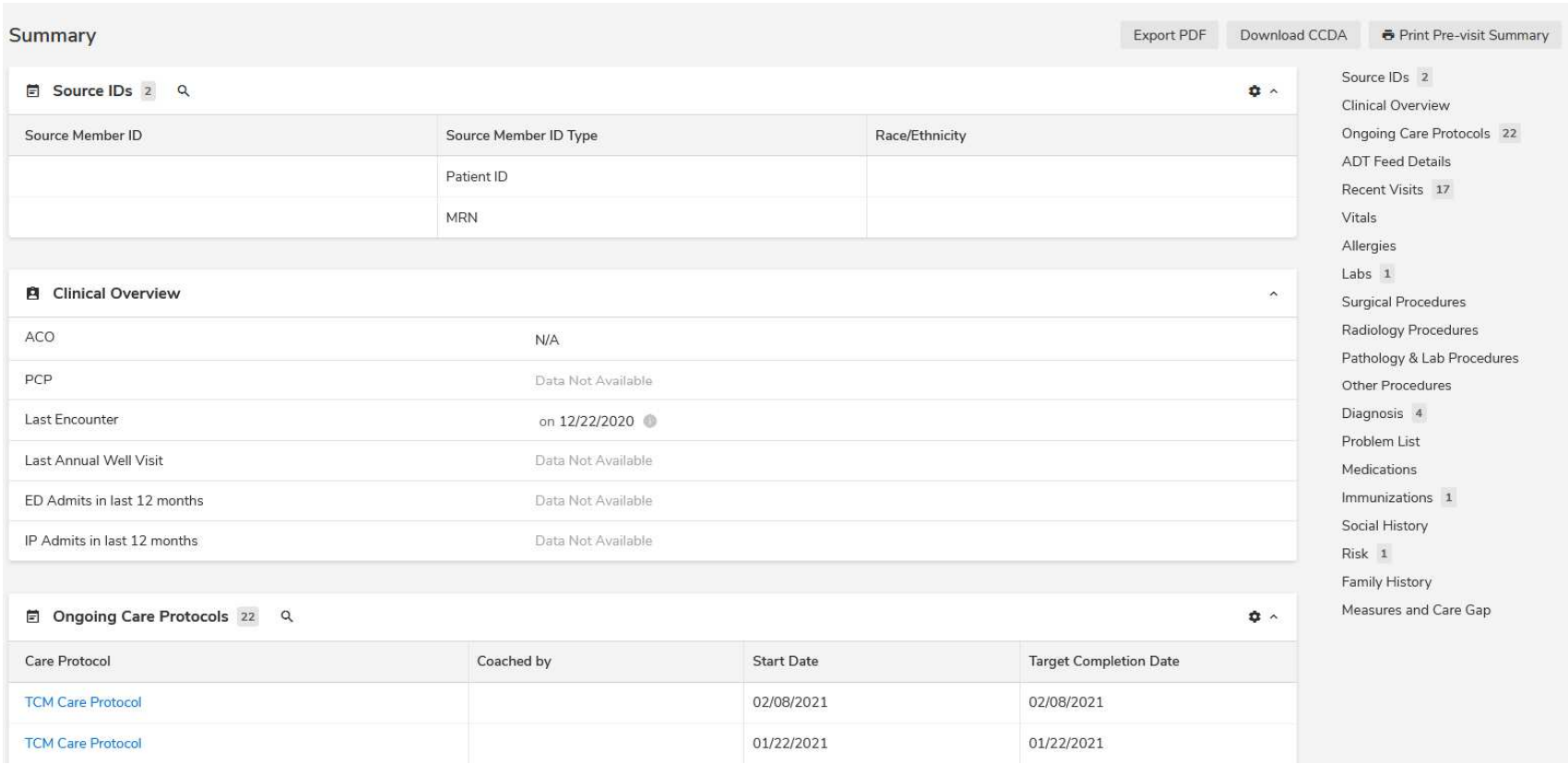
Patient 360 View

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.



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

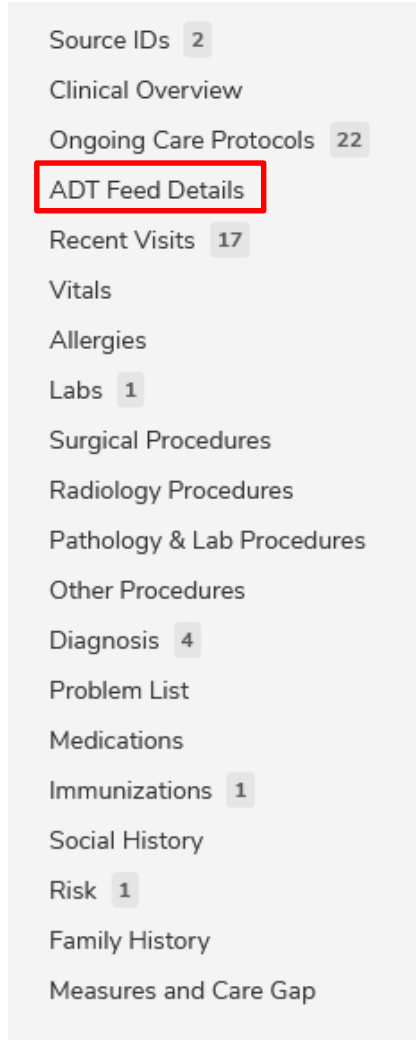
ADT Feed Details 7

Chief Complaint | Actual Diagnosis	Encounter Type	Discharge Dispositi...	Admit Date Time	Discharge Date Time	Encounter Class
R LE 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.

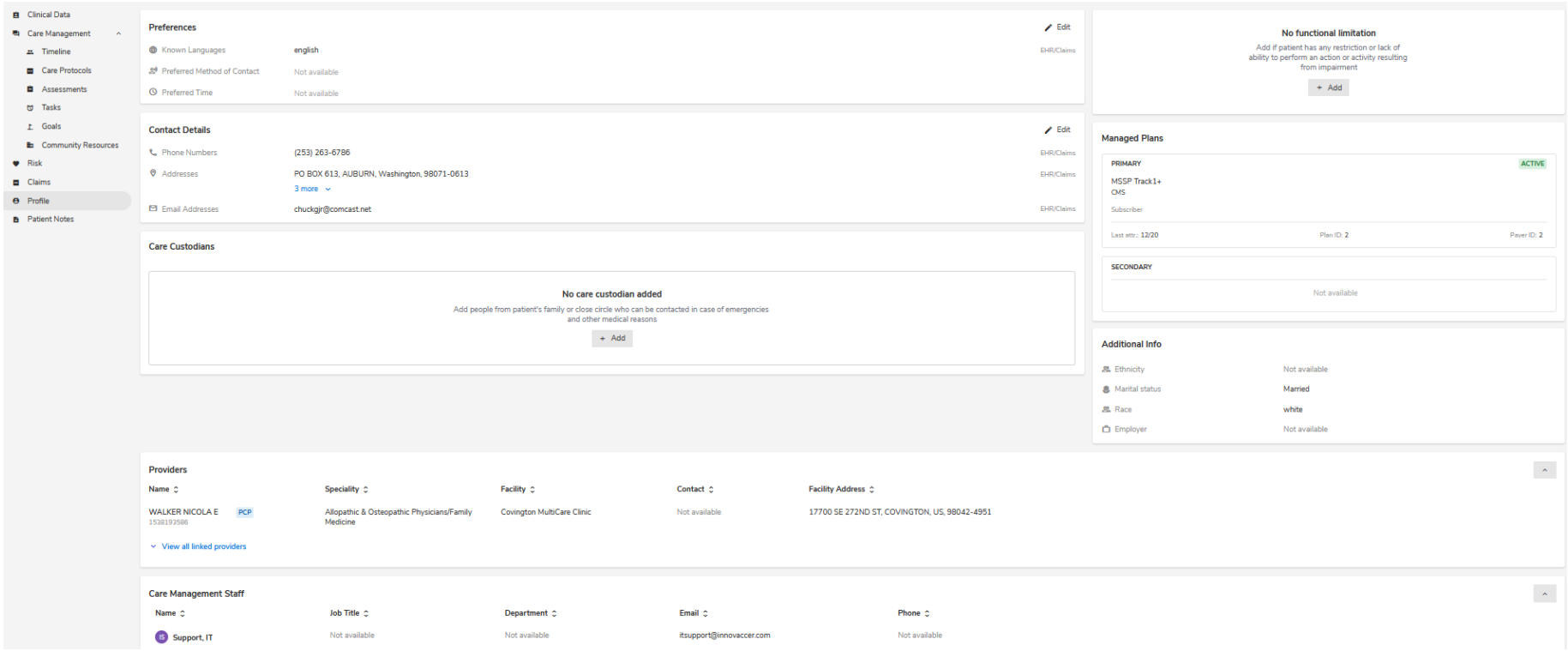


Source IDs 2
Clinical Overview
Ongoing Care Protocols 22
ADT Feed Details
Recent Visits 17
Vitals
Allergies
Labs 1
Surgical Procedures
Radiology Procedures
Pathology & Lab Procedures
Other Procedures
Diagnosis 4
Problem List
Medications
Immunizations 1
Social History
Risk 1
Family History
Measures and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

Patient Information

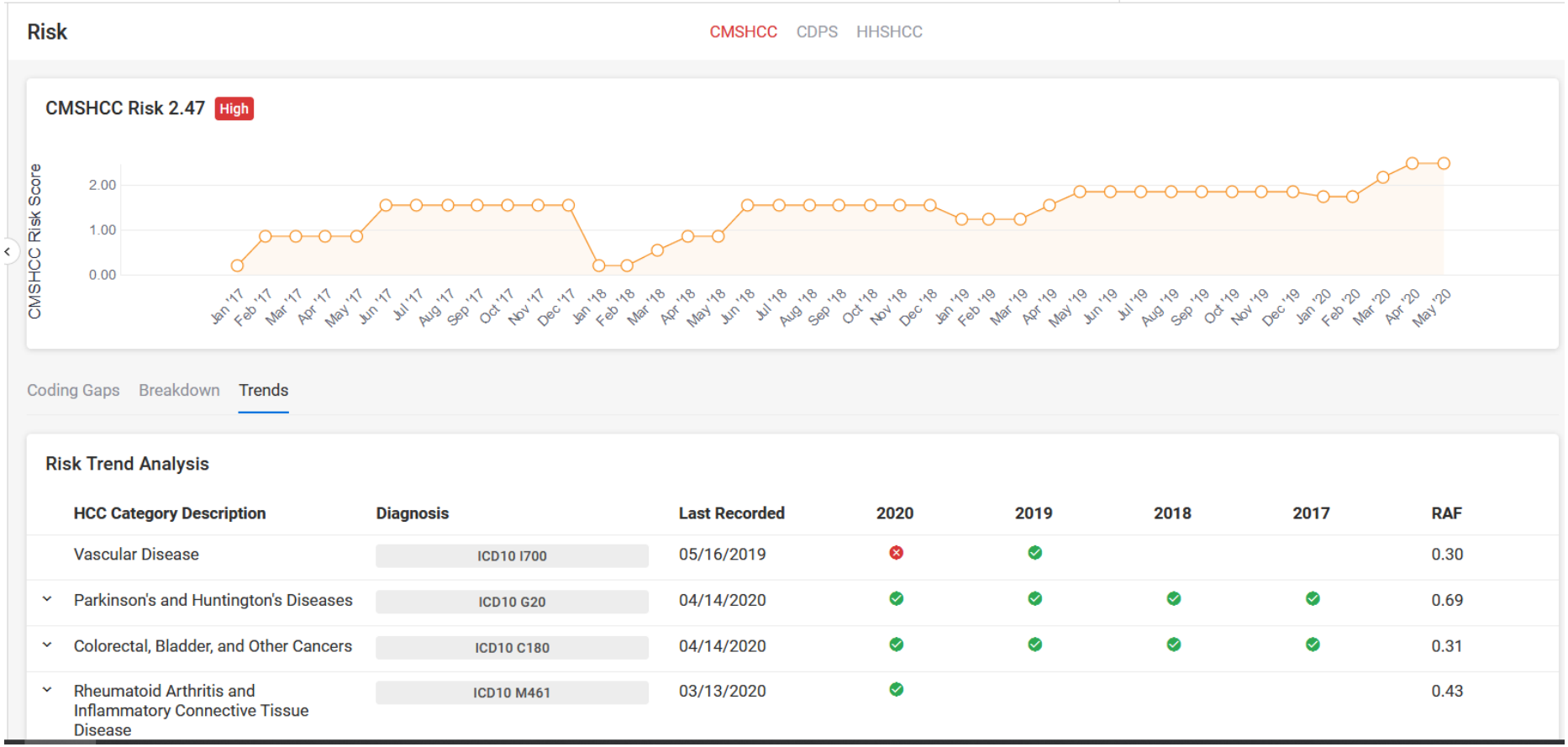
From the left navigation menu, selecting “Profile” allows users the ability to view patient level details such as:

- Contact details
- Assigned providers
- Managed plans



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.



HCC Category Description	Diagnosis	Last Recorded	2020	2019	2018	2017	RAF
Vascular Disease	ICD10 I700	05/16/2019	✗	✓			0.30
Parkinson's and Huntington's Diseases	ICD10 G20	04/14/2020	✓	✓	✓	✓	0.69
Colorectal, Bladder, and Other Cancers	ICD10 C180	04/14/2020	✓	✓	✓	✓	0.31
Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	ICD10 M461	03/13/2020	✓				0.43

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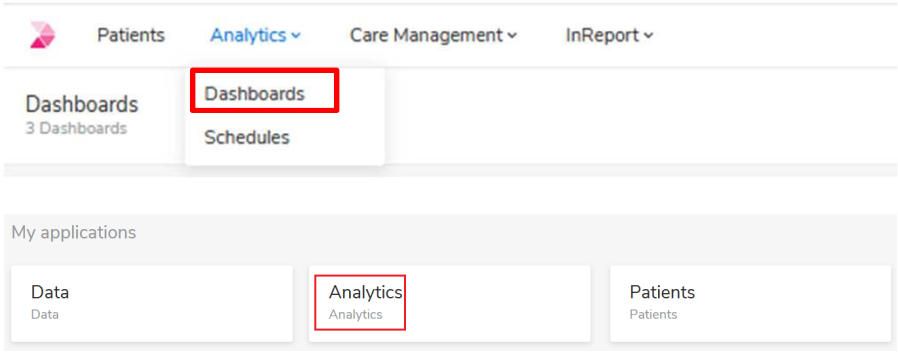
Analytics

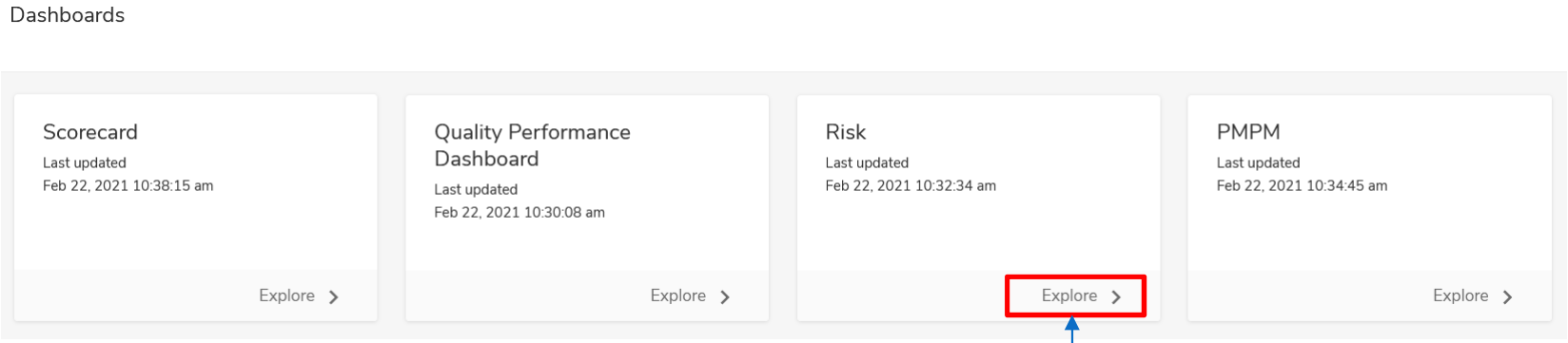
How to Get to Dashboards

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

OR

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





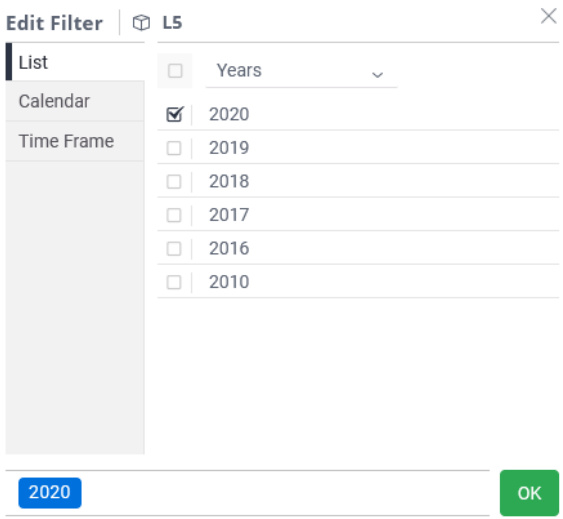
To open the dashboard and view the analytics, click “**Explore**”

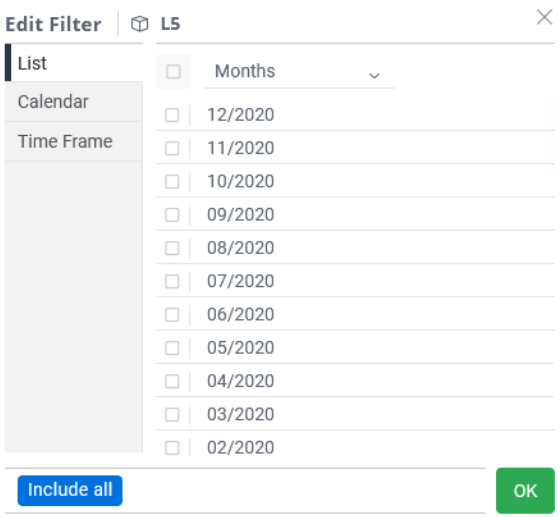
*Access to certain dashboards is dependent on users’ permissions

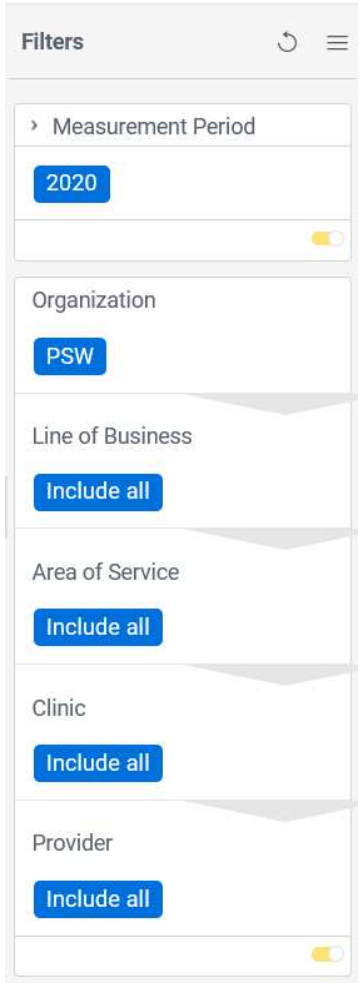
How to Filter and its Importance

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

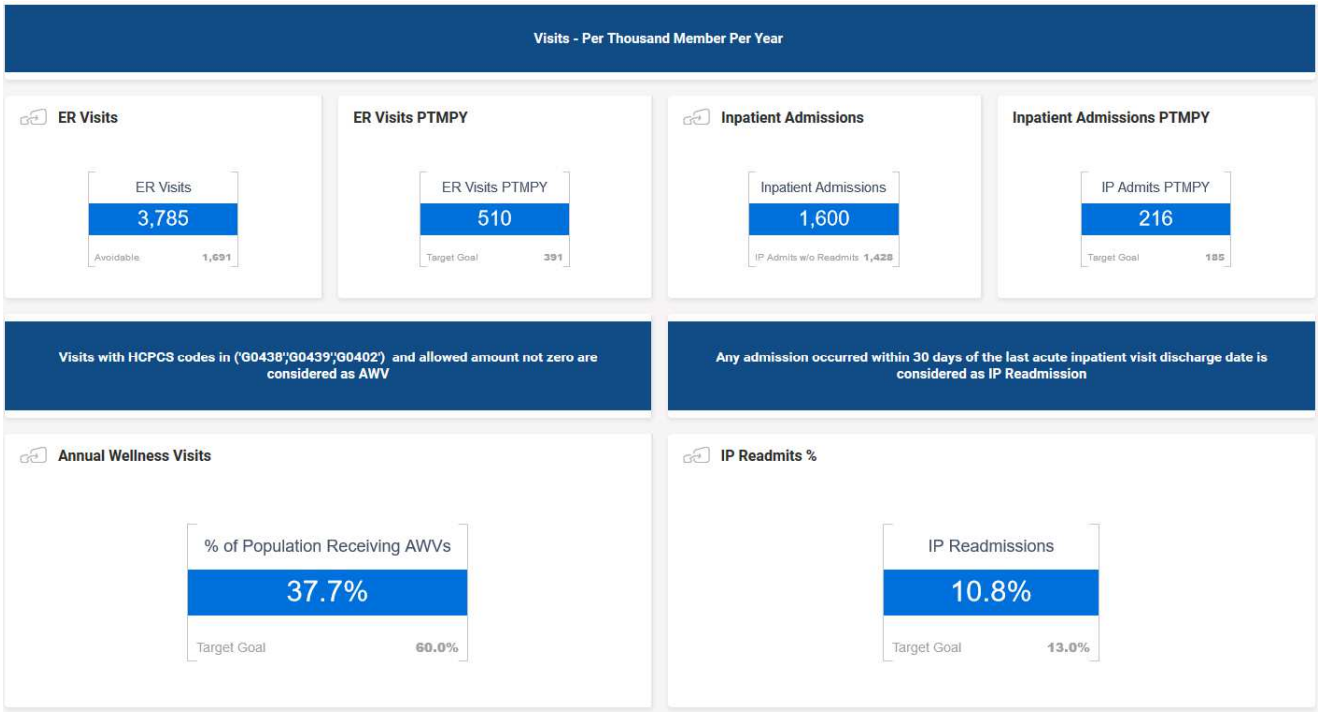






Scorecard Dashboard

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



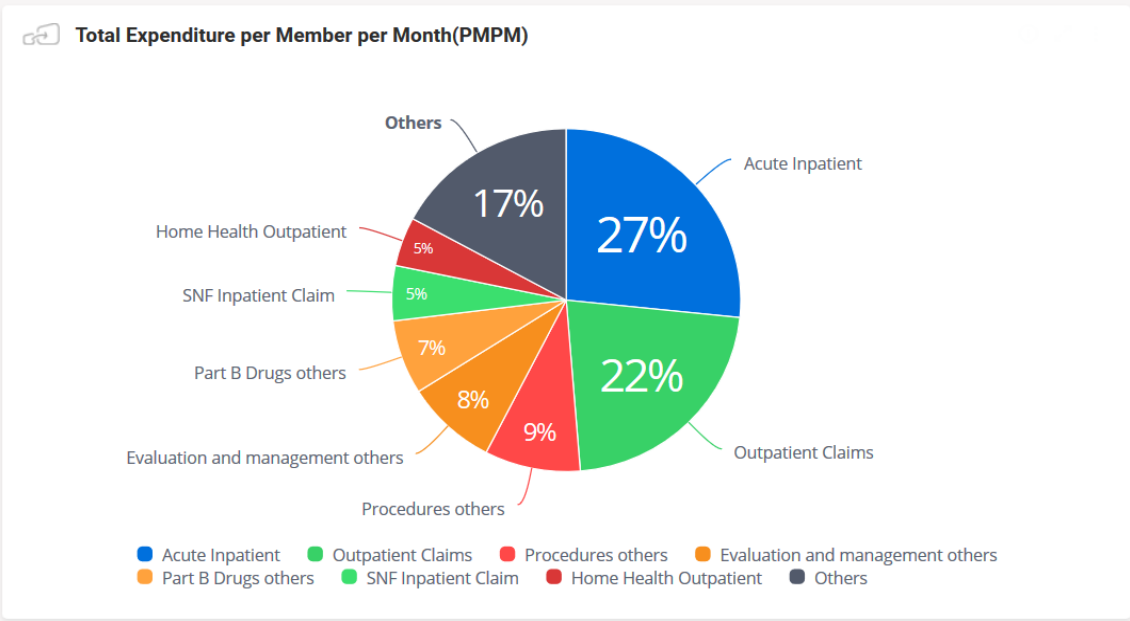
Metrics drill down

- 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 AWV Date
- PCP Alignment – AWV
- AWV 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) .

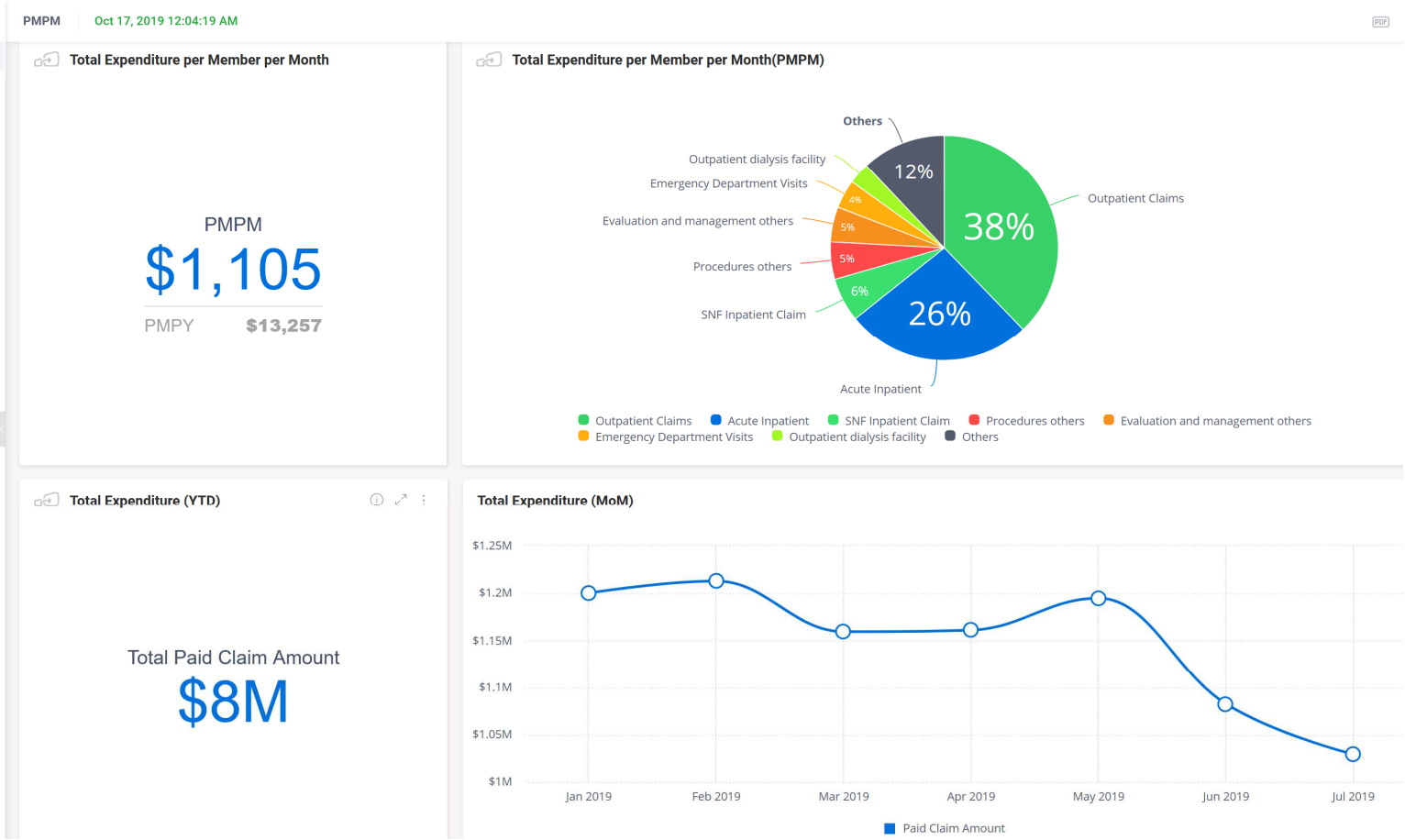


Spend type drill down

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

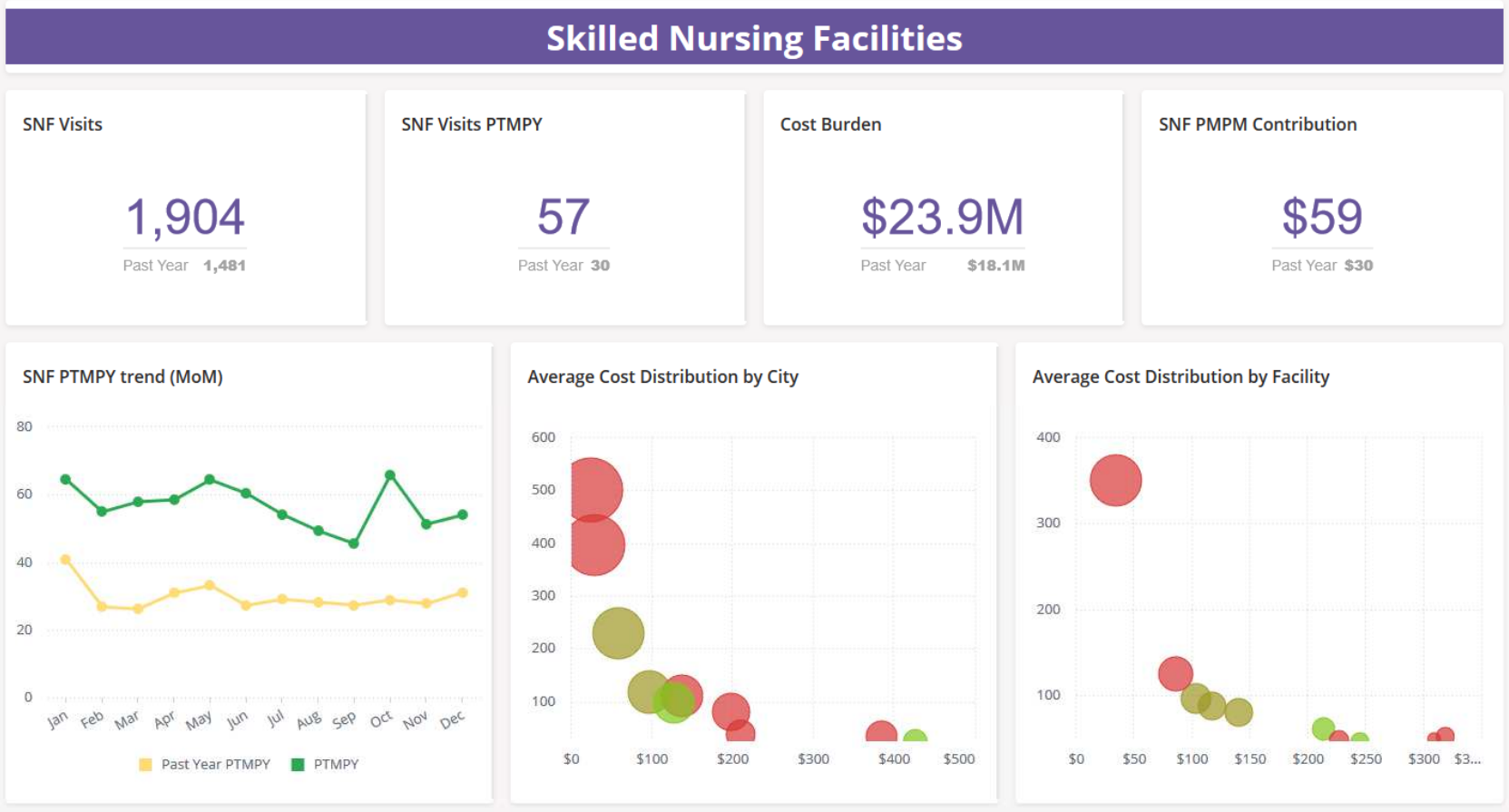
All data can be pulled into csv format for further evaluation.

Dashboard PMPM



SNF Dashboard Detail

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



*Additional detail coming soon (AVG LOS)
SNF with DBA naming convention

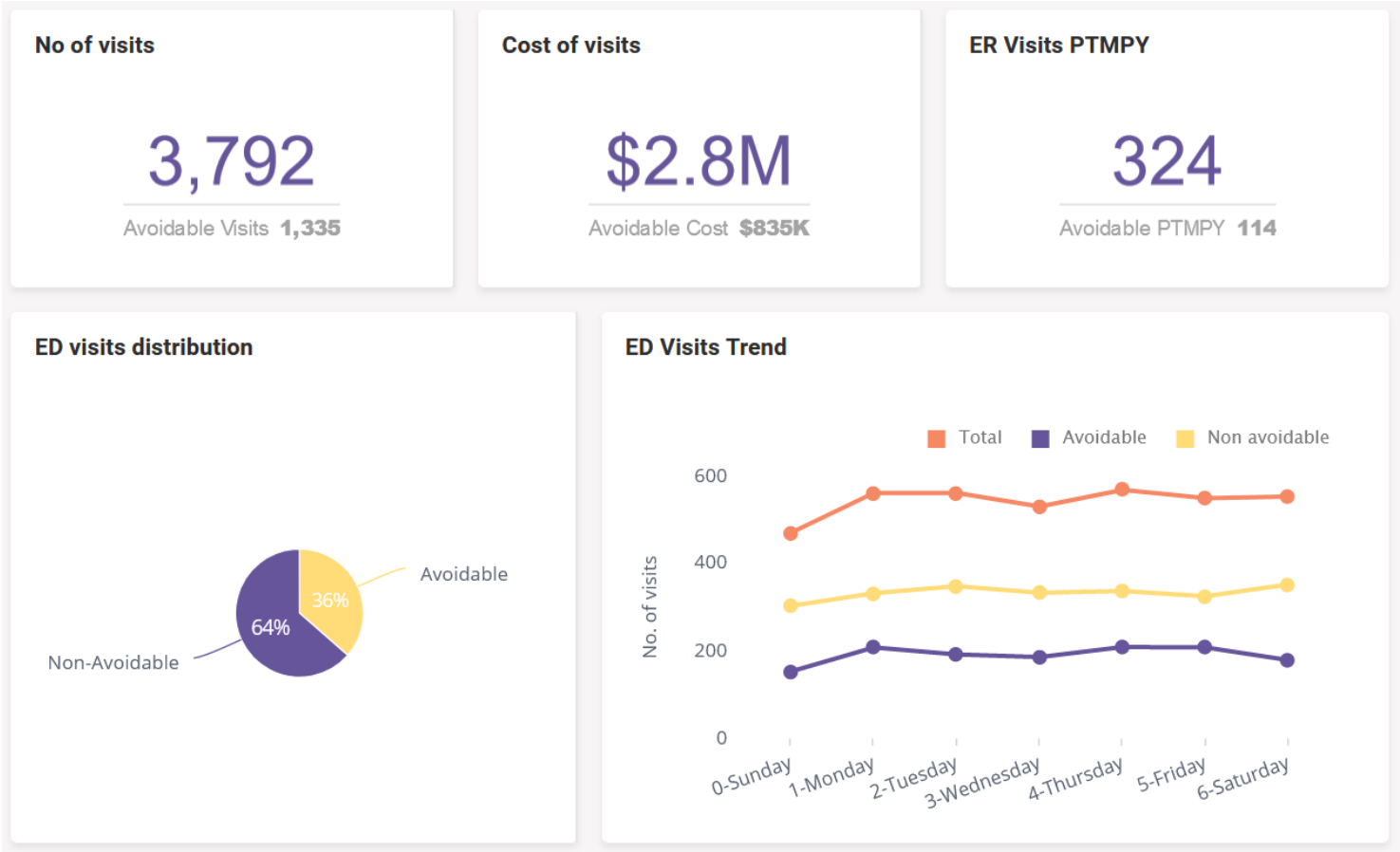
SNF Dashboard Drill Down

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

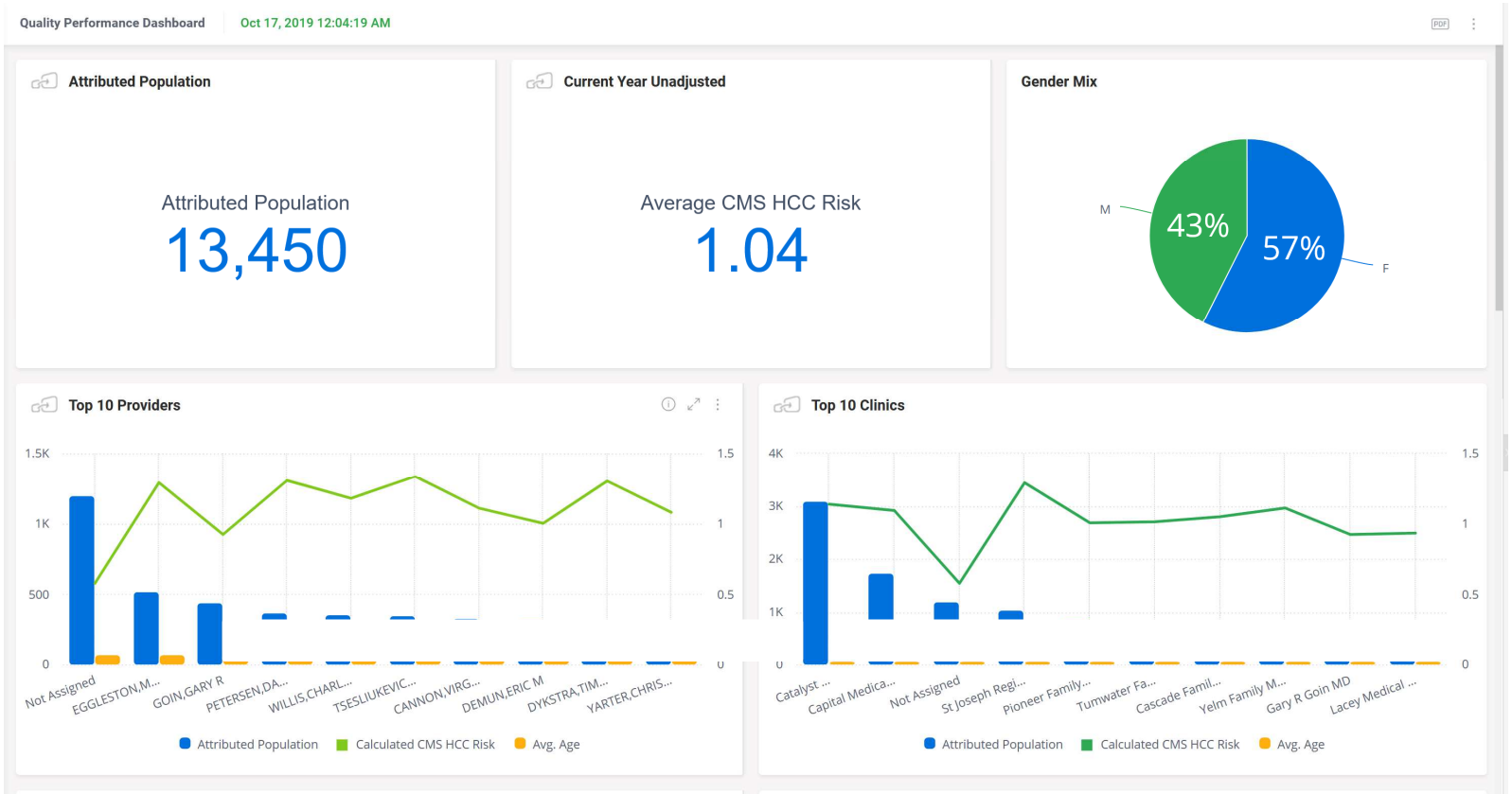
Emergency Department Dashboard

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)

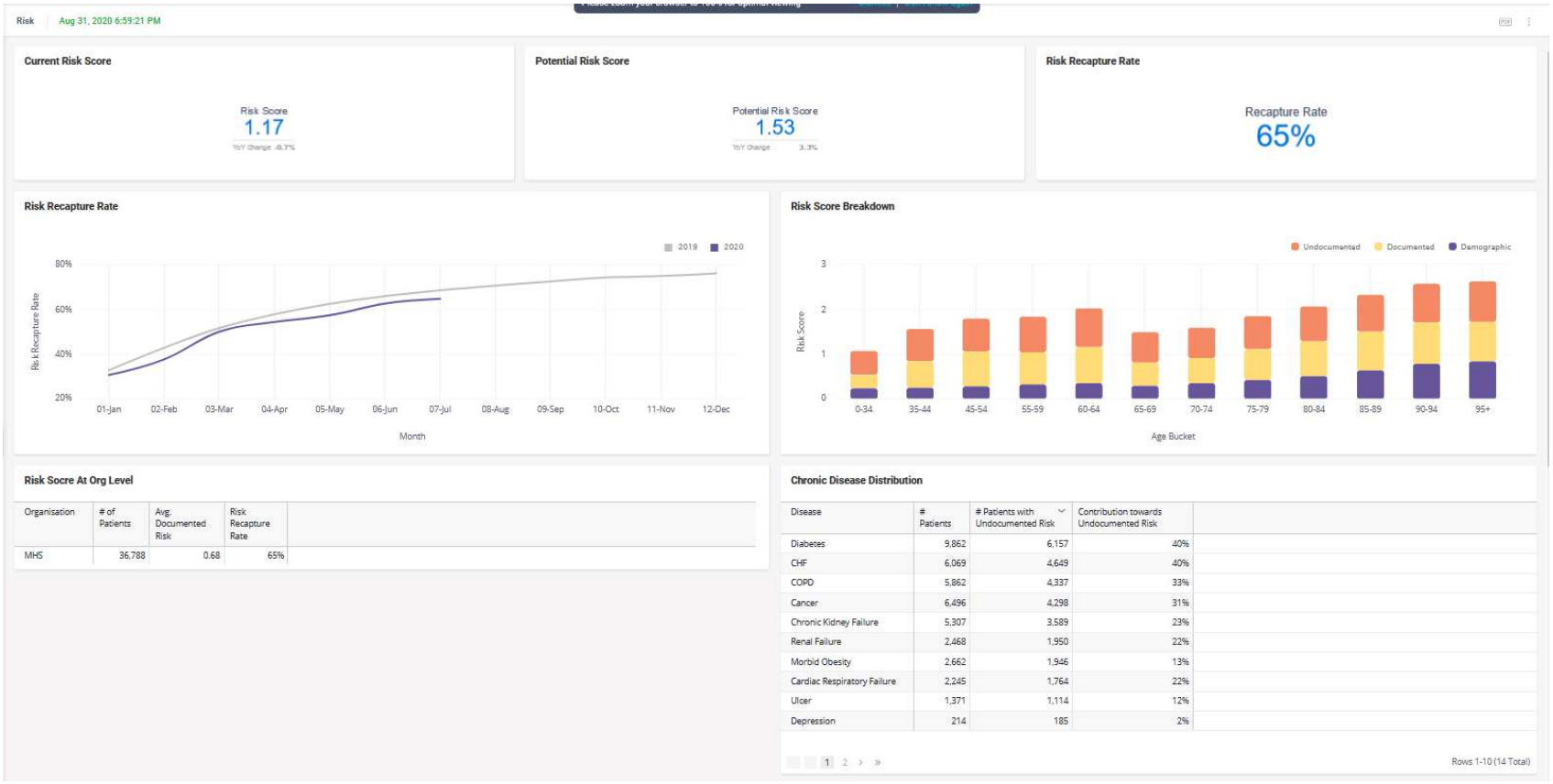
ACO Measures: Care and Preventive

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

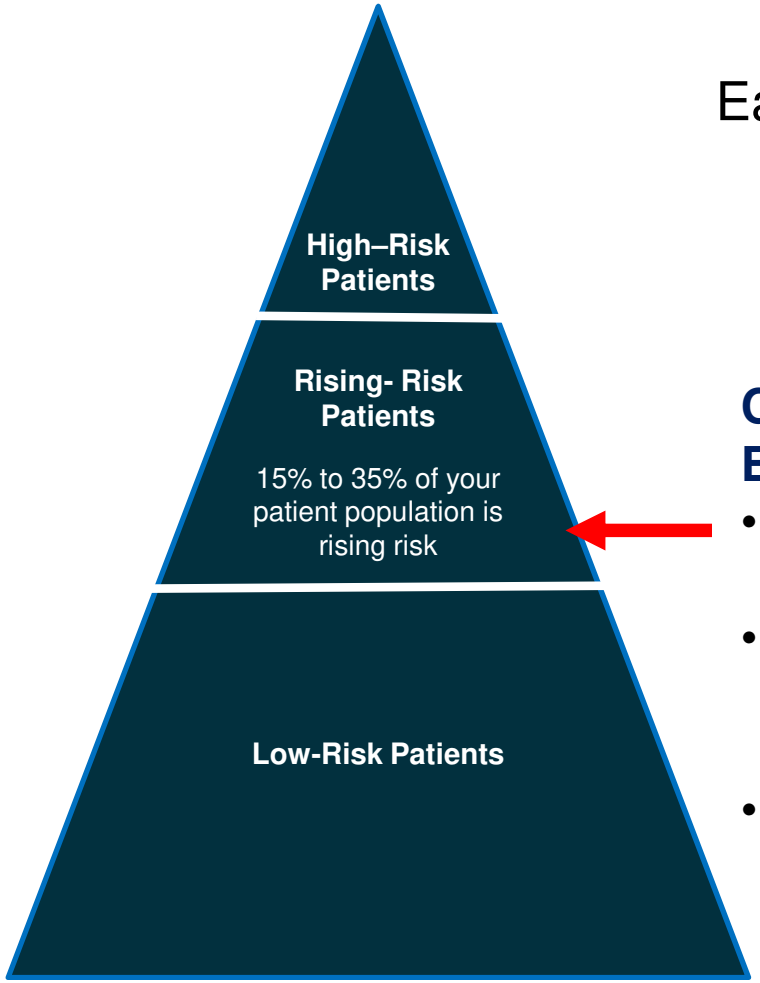
Dashboard – Risk

Purpose: to monitor recapture rate and understand risk score trends and assist at the provider and individual patient level is 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

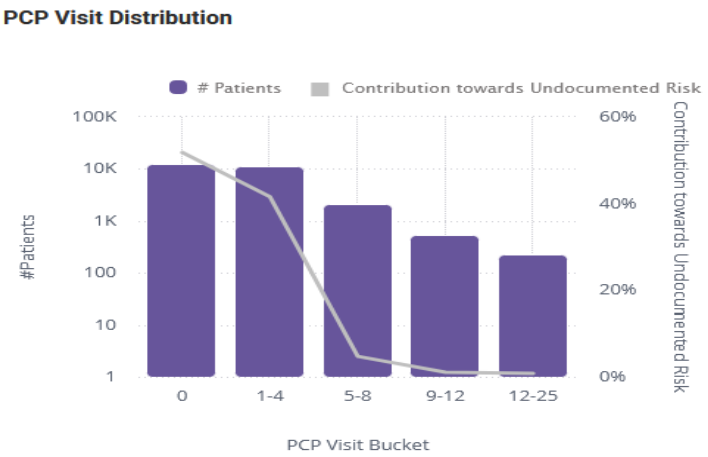
Innovaccer Risk Dashboard

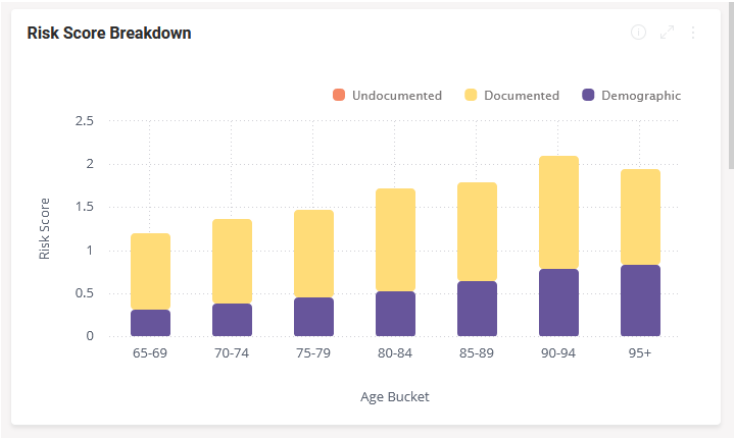
NGACO Population

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





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

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 AWV, and has nine or more open care gaps.
- Narrows patient list from **1699 to six patients** needing outreach.

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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