Provider, Patient, and Community Engagement

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Innovaccer's Community Footprint

7M+

Lives

60+

EHRs

$412M

Healthcare Cost Saved

3,000+

Interfaces

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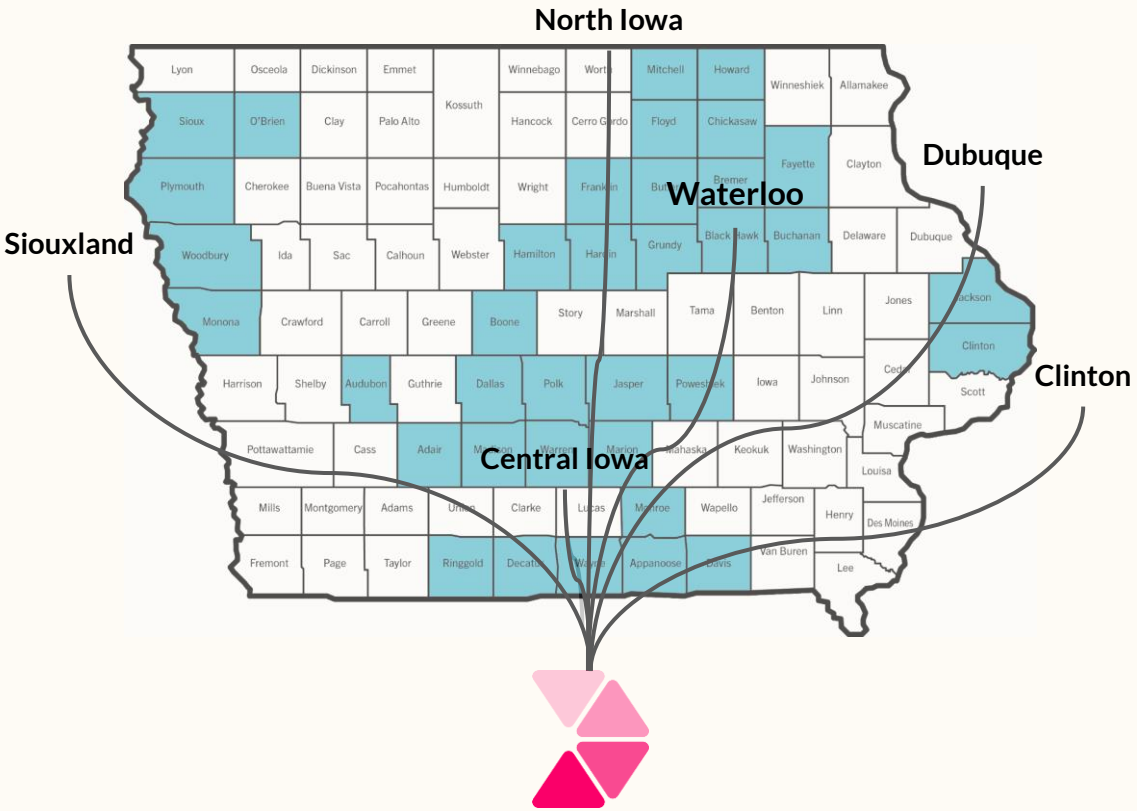
Market Example: Iowa

Co-developed and deployed a unified healthcare data platform to integrate disparate data sources:

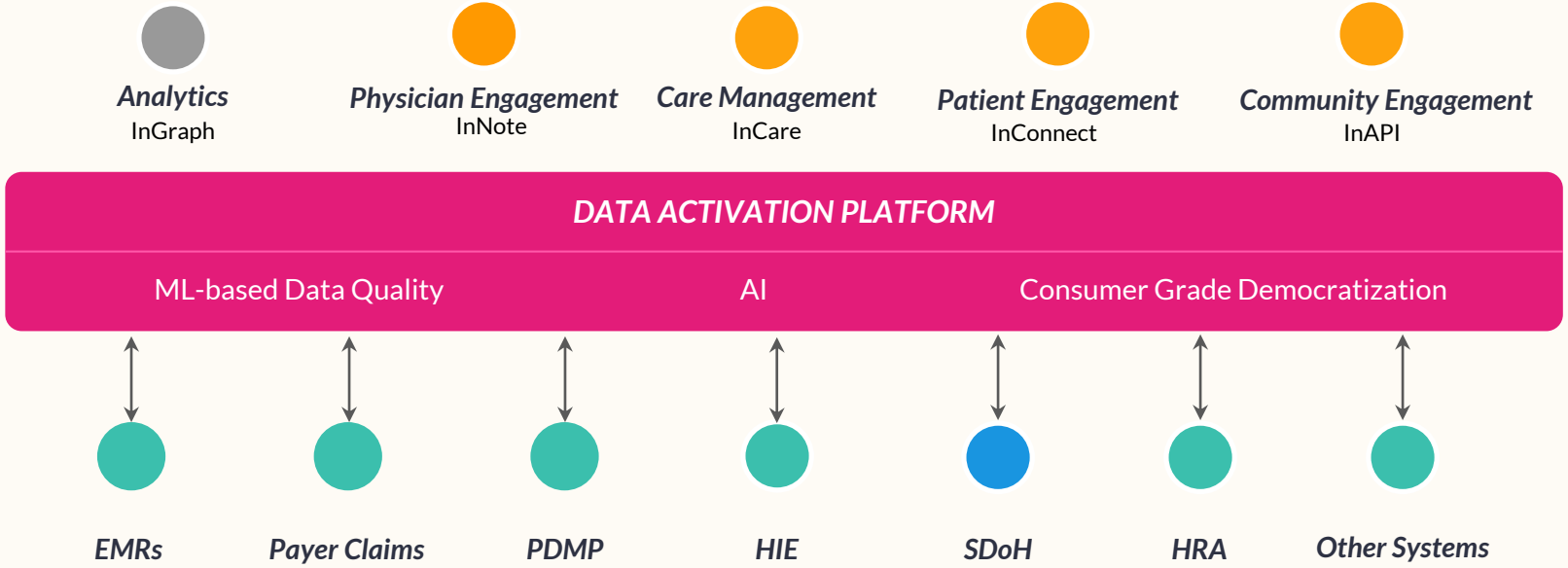
- EHRs and Billing
- Immunization and ADT feeds
- Scheduling data
- Payer claims
- The State of Iowa HIE

Integrated workflows for physicians, patients and care teams to coordinate care processes across the network.



The Data Activation Platform

Building an Information Superhighway



*SDoH - Social Determinants of Health
HRA - Health Risk Assessment
PDMP - Prescription Drug Monitoring Program

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Social Determinants of Health

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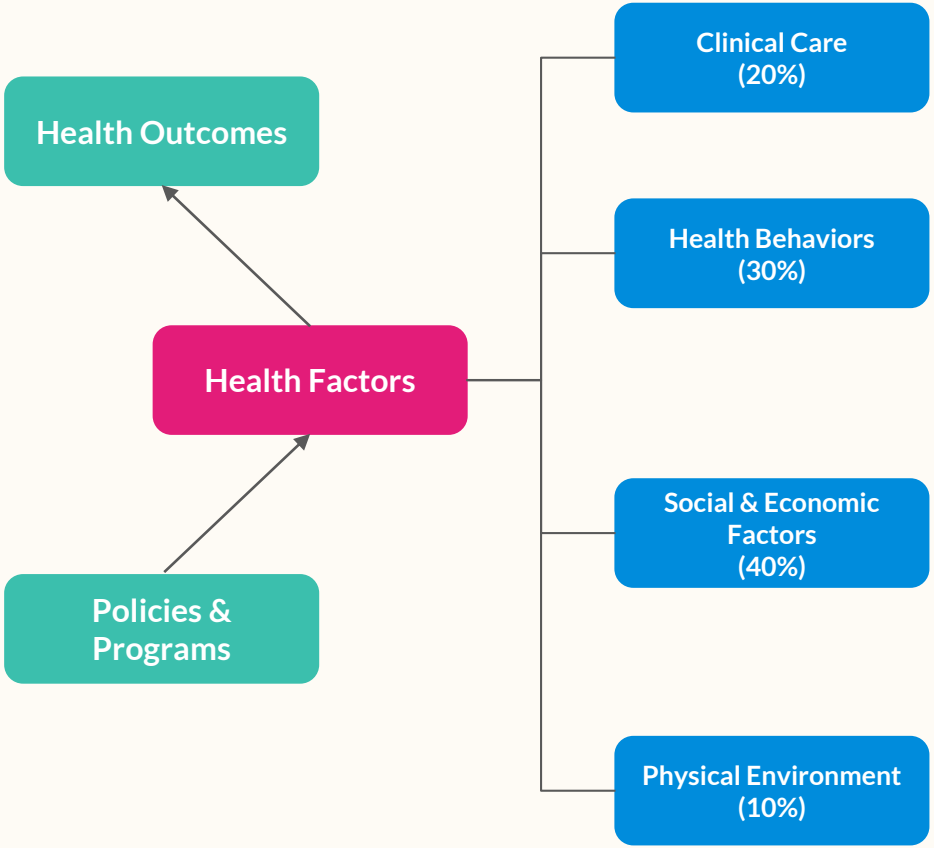
Non-Clinical Determinants of Health determine 80% of Outcomes



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Social Factors Across Data Sources

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

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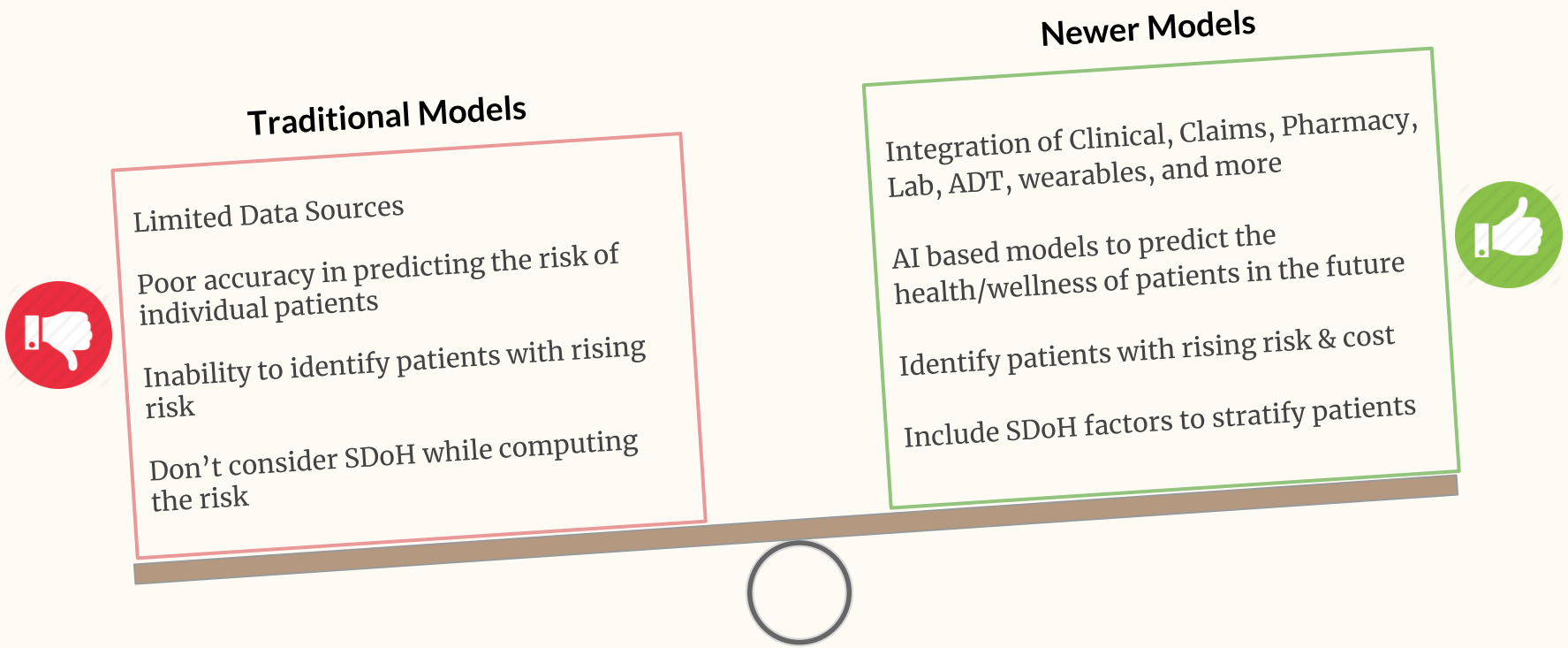
Traditional vs. Evolving Risk Models



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Provider Engagement

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An *Activated* Physician

THEY SEE BEYOND THE EMR TO GET A 360° PATIENT VIEW

THEY KNOW THEIR POPULATION INSIDE OUT

THEY KNOW THEIR PATIENTS COMMUNITY AND CAN CONNECT THEIR PATIENTS WITH APPROPRIATE RESOURCES

THEY ENGAGE THEIR PATIENTS IN THE MOMENT OF NEED WITH A PATIENT ENGAGEMENT APP

THEY WORK WITH CARE MANAGERS AS A TEAM

THEY KNOW AND IMPROVE THEIR QUALITY AND COST

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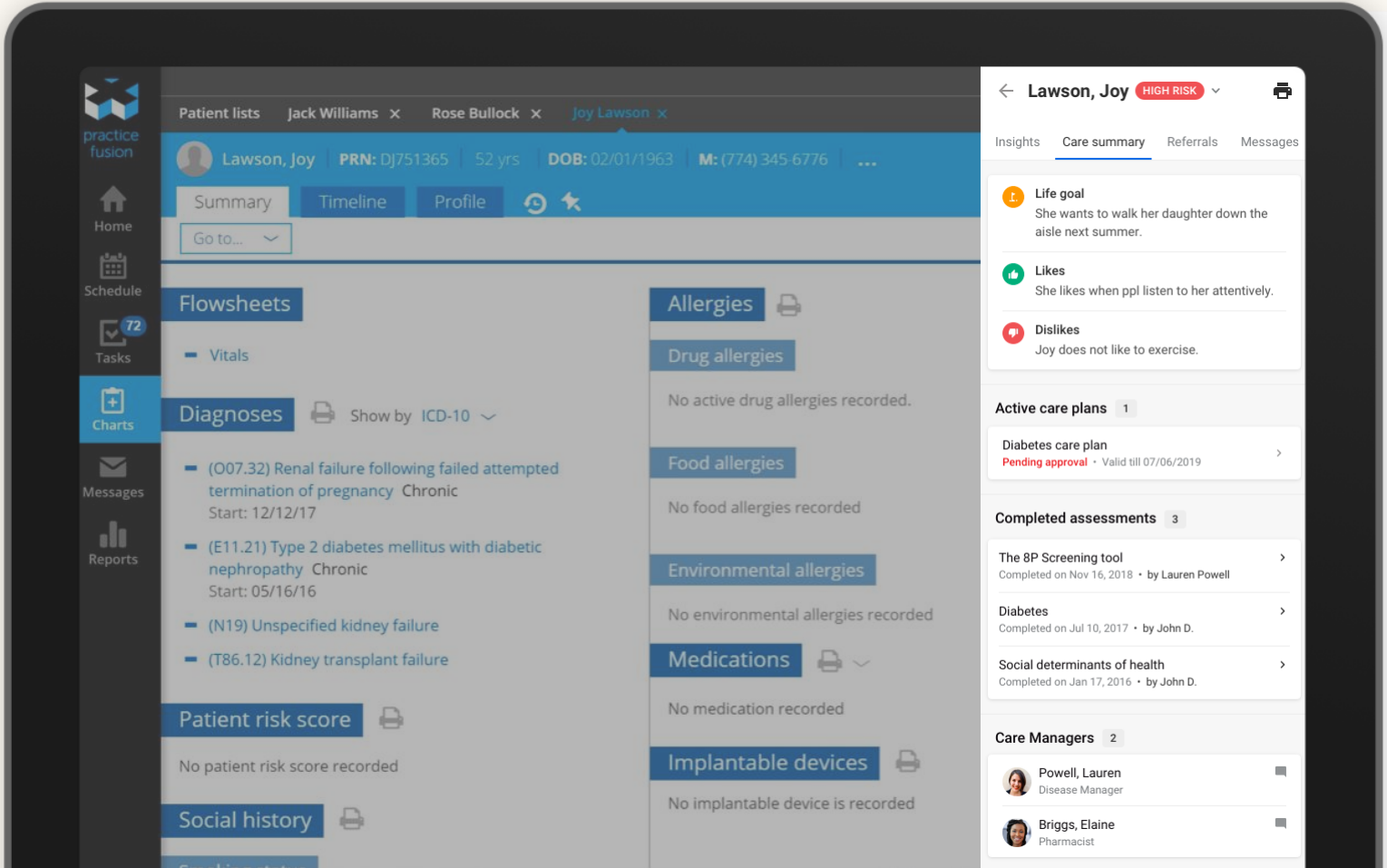
InNote


practice fusion
Home
Schedule
72
Tasks
Charts
Messages
Reports
Patient lists
Jack Williams
Rose Bullock
Joy Lawson
Lawson, Joy
PRN: DJ751365
52 yrs
DOB: 02/01/1963
M: (774) 345-6776
Summary
Timeline
Profile
Go to...
Flowsheets
Vitals
Diagnoses
Show by ICD-10
(O07.32) Renal failure following failed attempted termination of pregnancy Chronic
Start: 12/12/17
(E11.21) Type 2 diabetes mellitus with diabetic nephropathy Chronic
Start: 05/16/16
(N19) Unspecified kidney failure
(T86.12) Kidney transplant failure
Patient risk score
No patient risk score recorded
Social history
Allergies
Drug allergies
No active drug allergies recorded.
Food allergies
No food allergies recorded
Environmental allergies
No environmental allergies recorded
Medications
No medication recorded
Implantable devices
No implantable device is recorded
Lawson, Joy
HIGH RISK
Insights
Care summary
Referrals
Messages
Life goal
She wants to walk her daughter down the aisle next summer.
Likes
She likes when ppl listen to her attentively.
Dislikes
Joy does not like to exercise.
Active care plans 1
Diabetes care plan
Pending approval • Valid till 07/06/2019
Completed assessments 3
The 8P Screening tool
Completed on Nov 16, 2018 • by Lauren Powell
Diabetes
Completed on Jul 10, 2017 • by John D.
Social determinants of health
Completed on Jan 17, 2016 • by John D.
Care Managers 2
Powell, Lauren
Disease Manager
Briggs, Elaine
Pharmacist

Patient Engagement

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An *Activated* Patient

THEY ARE CONNECTED TO THEIR CARE TEAM IN THEIR HOMES AND COMMUNITIES

THEY KNOW THEIR CARE TEAM INSIDE OUT AND ARE REGULARLY ENGAGED

THEY ENGAGE WITH THEIR CARE TEAM IN THE MOMENT OF NEED WITH THE INCONNECT APP

THEIR HEALTH SYSTEM IS ACTIVELY ENGAGED WITH THEIR COMMUNITY

THEIR CARE MANAGERS CONNECT THEM WITH APPROPRIATE RESOURCES

THEY ARE EMPOWERED TO OWN AND IMPROVE THEIR CARE QUALITY

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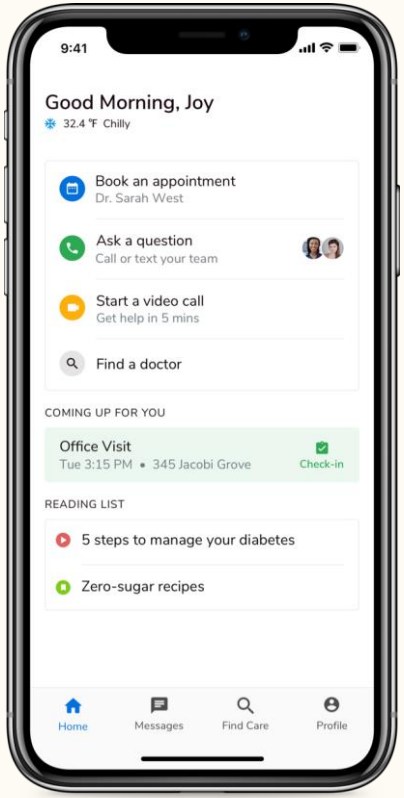
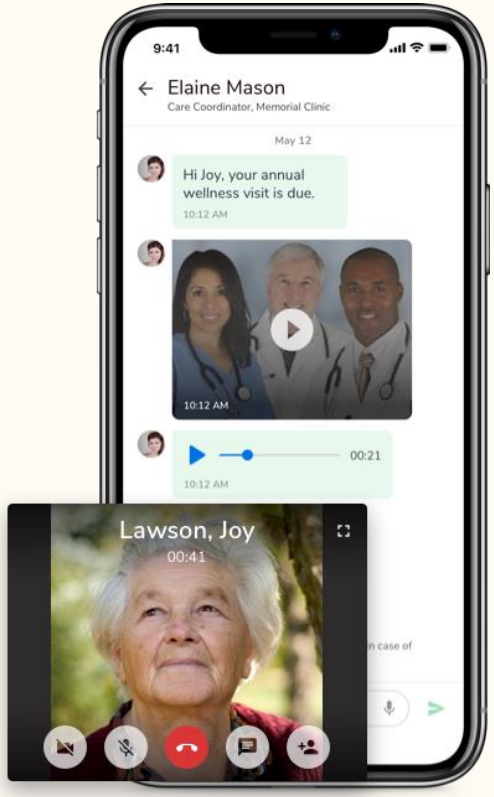
InConnect





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Community Engagement

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Health-Related Core Needs in Clinical Settings

Impact of Core Determinants on Health and Healthcare Utilization is well established

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Takeaway Questions

- What resources does your community include? What does it not include?
- How are resources (e.g., food, housing, local businesses, transportation, health care services) distributed within your community?
- Are they clinically aligned? Can they be?
- How can we create a connected ecosystem involving both the community and the health system?