MEDINFO23

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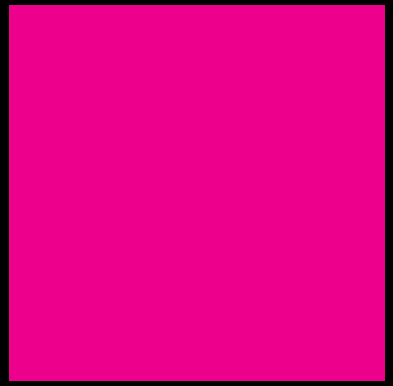
Population Health and the future of patient data



@michaeldraheim_

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Chief Clinical Information Officer

Oracle Health JPAC

AIDH IMIA

Quintuple Aim

- Improved collaboration and communication
- Seamless transitions of care
- Engaging patients and family in their care

- Eliminated chart fragmentation
- Inclusion of clinical decision support, evidence and best practices
- Connected medical device data to eliminate transcription

- Identifies vulnerable populations
- Data provides ability to level up health inequities

- Reduced readmissions
- Reduced duplicate/ inappropriate tests

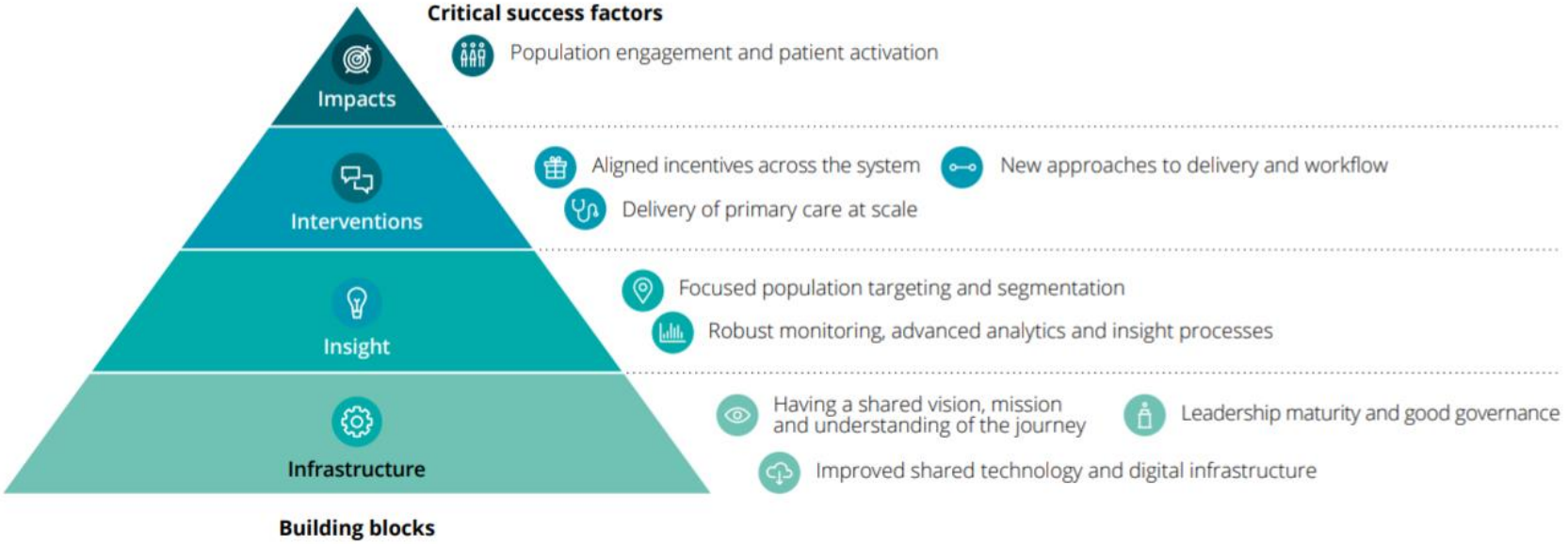
- Coordination of care across the continuum
- Data sharing across venues

Impacting Health and Wellbeing

80%

of what impacts a person's health are non-clinical factors[1]

The four key building blocks – Infrastructure, Insights, Impact and Intervention – and nine critical success factors enabling population health management



The transition to integrated care: why population health management is critical to the future sustainability of health and social care - Thoughts from the Centre | Deloitte UK

Overview of HealtheIntent

- HealtheIntent is a comprehensive population health management platform
- **Data aggregation:** HealtheIntent consolidates health data from diverse sources, creating a comprehensive and unified patient record.
- **Advanced analytics:** The platform utilizes powerful analytics to derive actionable insights, identify trends, and support evidence-based decision-making.
- **Care coordination:** HealtheIntent enables seamless collaboration among care teams, enhancing care coordination and patient outcomes.
- **Patient engagement:** HealtheIntent empowers patients through access to their health data, educational resources, and personalized care plans.

Big data, Integrated Care Systems platform

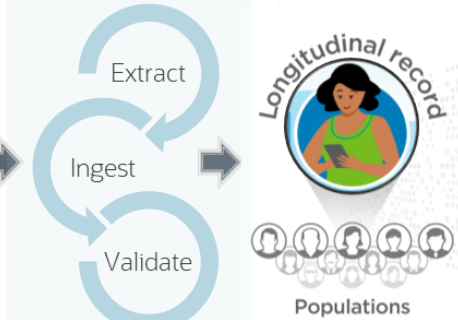
Infrastructure

Aggregate and Normalise

2,720+
Data sources

Intelligence

Create and Apply Intelligence

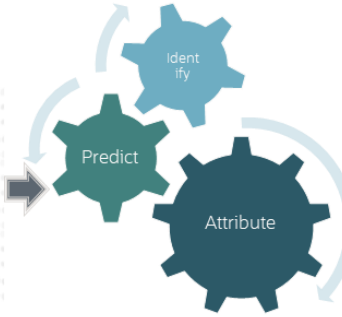


Master Person Management (MPM) person matching occurs within this phase

342m+
people in platform

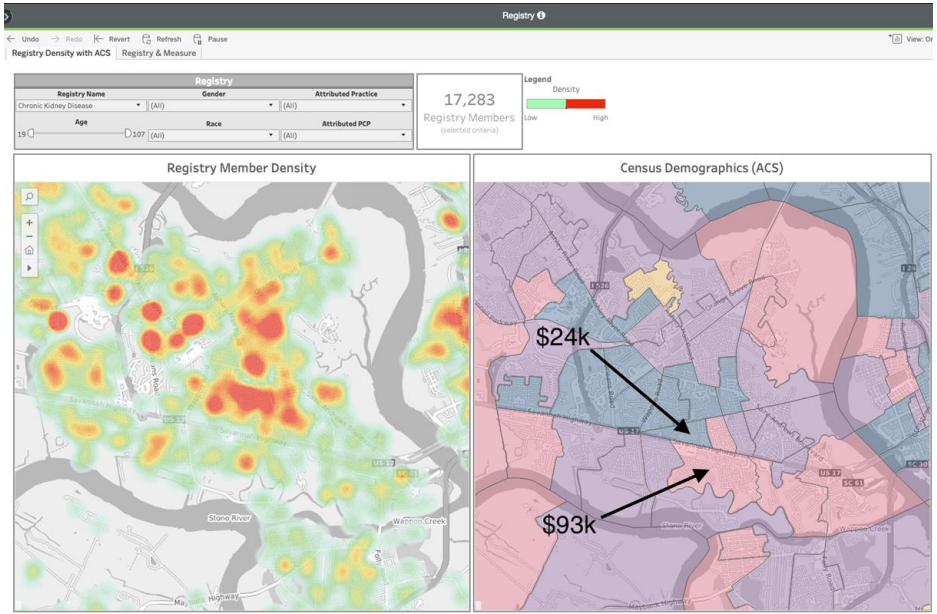
Intervention

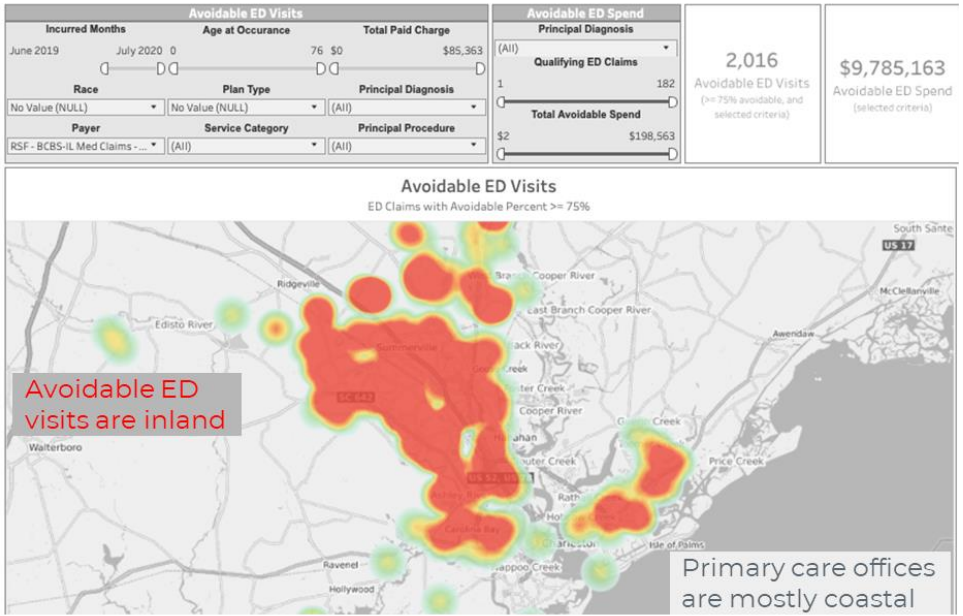
Act and Measure



- Person
- Health Coach
- Care Manager
- Home Health Assistant
- Clinician
- Data Scientist
- Executive

Data Insights



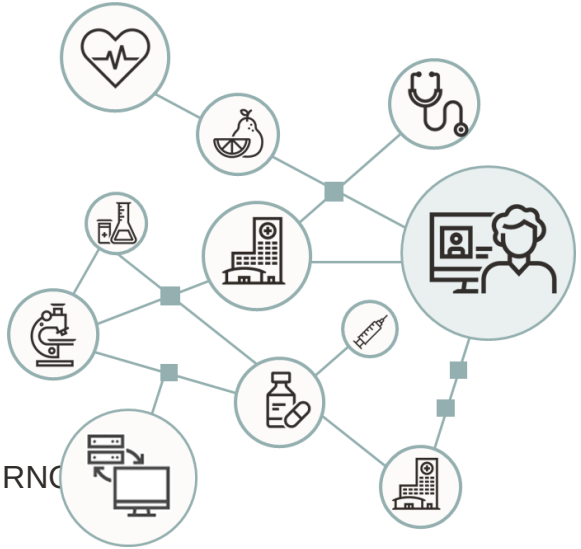


NHS case studies

- **Improved care coordination:** HealtheIntent facilitates real-time information sharing among clinicians, reducing delays and enhancing care coordination across departments.
- **Chronic disease management:** With HealtheIntent, NHS Trust A reduced hospital admissions by 20% for patients with chronic conditions, resulting in better outcomes.
- **Population health statistics:** Through HealtheIntent's analytics, a NHS Trust achieved a 15% improvement in overall population health outcomes, including reduced incidence of preventable diseases.

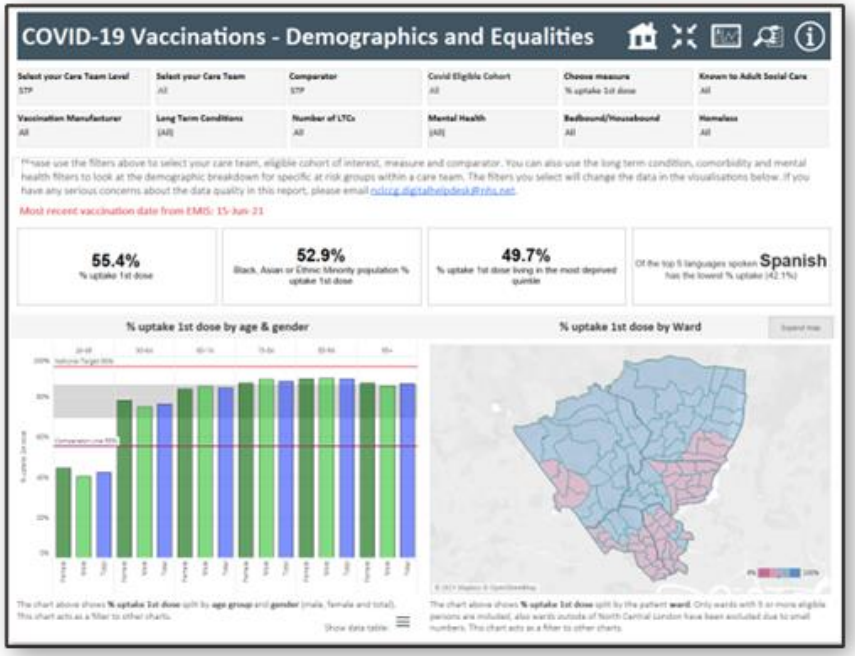
North London Partners - Insight-driven allocation of scarce resources

- **System**
  - Five London boroughs:
    Barnet, Camden, Enfield, Haringey, Islington
  - North Central London CCG
  - 12 NHS Trusts
  - Six GP federations
- **Population**
  - 1.65 million
- **Data Sources**
  - GP data from all practices
  - Hospital/acute data: Daily extracts from UCLH, Whittington, NMUH, RFH, RNC
  - Other NHS: C&IFT, BEHMT, CNWL, CLCH
  - Local Authority data: Adult social care (daily) from five councils, housing, council tax (monthly) data from four councils



North London Partners – COVID Response

- Identifying local areas and communities with lower vaccine uptake, supporting tailored strategies to increase access to vaccination and address any vaccine hesitancy.
- Targeted communication and engagement interventions to increase uptake by ethnicity, deprivation, religion and first language



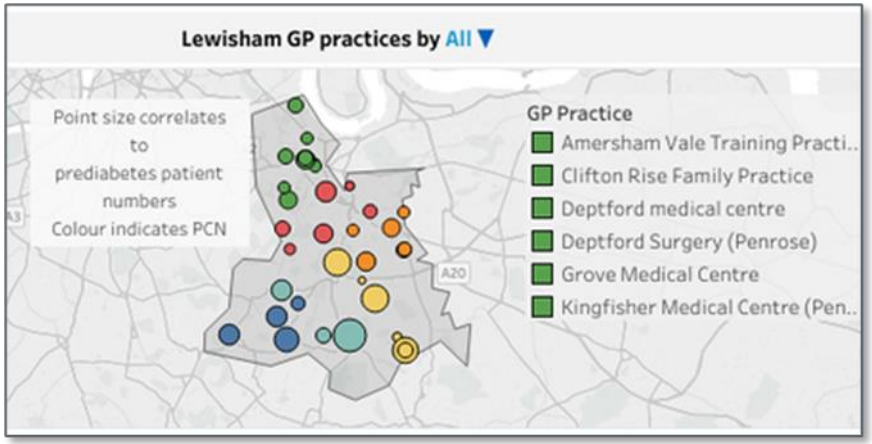
North London Partners – Waiting List Recovery

- “Are people receiving equal access to care for equal need once they are on the waiting list?”.
- Using demographic and social determinant factors such as age, gender, location, ethnicity, deprivation and first language spoken.
- Are those from deprived areas waiting longer for their treatment?

Lewisham Health and Care Partners: Proactive population health

Identifying disease and actioning meaningful intervention

- System
  - NHS Lewisham Commissioning Group
  - Lewisham Council (social care)
  - One Health Lewisham Ltd GP Federation (38 GP practices)
  - South London and Maudsley NHS Foundation Trust (specialist mental health services)
  - Lewisham and Greenwich NHS Trust (acute and community)
- Population
  - Over 300,000 residents
- Technology
  - *HealtheIntent*®
  - *HealtheEDW*℠
  - *HealtheAnalytics*℠
  - *HealtheRegistries*℠



Four actionable diabetics cohorts identified

- Gestational diabetes
- Prediabetics
- Three treatment target (3TT – HbA1c, cholesterol, BP)
- Undiagnosed/uncoded

Lewisham Health - Outcomes

- 15,000 residents recorded as diabetic, up to 8,000 more estimated to be undiagnosed T2
  or prediabetic
- System proactively identifies those in the four cohorts for intervention and appropriate care pathway management
  - **82** patients identified as undiagnosed and untreated
  - **4,237** prediabetic follow-up, 13 diagnosed with diabetes
  - **66%** women three months postpartum not screened and **99%** not screened annually (increased risk of T2)
- Those identified flagged to GP practices via One Health Lewisham for validation and follow-up
  - CCG invested in upskill and support of primary care clinicians to deliver higher quality services
  - GD diagnosis now recorded on discharge so GP aware and can initiate follow up

Lewisham's story… in their own words

Identifying diabetes – population health management in Lewisham

- Infrastructure:
  - "We chose Cerner to be our strategic partner across Lewisham Health and Care Partners, using the HealtheIntent platform to gather and then use our data to improve our decision making and think about how we intervene earlier in people's journeys."
    - Martin Wilkinson, managing director, Lewisham CCG
- Intelligence:
  - "People who might have had blood tests done elsewhere that are actually in the diabetic range were unseen to me until I had the means to connect up data from a variety of sources."
    - Dr Charles Gostling, GP diabetes lead, Lewisham CCG
- Interventions:
  - "We are now segregating patients into groups, based on their levels of diabetes control and the kind of interventions required and have we can have that impact."
    - Dr Ravi Sharma, GP, Hilly Fields Medical Centre
- Incentives:
  - "The future really is about population health. We talk about place-based care and for far too long we've operated as a group of disjointed organisations."
    - Dr Charles Gostling, GP diabetes lead, Lewisham CCG