oberoi
consulting

Intelligent Population Health Reporting
through Oberoi Disease Management

Heart Failure

Asthma

Atrial Fibrillation

Diabetes

Cancer

Osteoporosis

CKD

Stroke

CHD

COPD

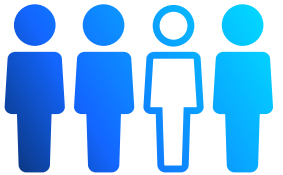
Millions

of people in the UK

are living with chronic diseases, resulting in poor quality of life, emergency hospitalisation & at risk of early death

Many of these people may **not be optimised on treatment** and even **missing from GP practice registers**

Missing medications



Incomplete registers

Coding omissions

We know your patients are **more than just numbers**

Identify the patients hidden in the numbers

Making your data count

Trusted for more than

20 YEARS

across healthcare and the NHS

Oberoi Disease Management is aligned to NHS governance policies

HSCN HEALTH & SOCIAL CARE NETWORK COMPLIANT

NHS Digital

CYBER ESSENTIALS CERTIFIED

Intelligent Population Health Reporting through Oberoi Disease Management

Interactive dashboards & reporting coupled with quarterly feedback with goal setting at **Practice, PCN** and **ICB level** to empower healthcare providers to improve patient outcomes

Searches & Alerts*

Integrated within EMIS, SystmOne & Vision

Dashboards

Interactive dashboards & dynamic reporting over 12 months

Clinical Guidelines

Easy to implement latest clinical guidelines and evidence based practice

Data Analytics

Gain valuable insights into patient care

No patient identifiable data is extracted from the GP clinical system

* Available across the UK

Spotlight on HF

The Heart Failure module harnesses the latest clinical evidence for diagnosis & treatment of HF, aligned to the 2021 ESC and 2018 NICE (NG106) guidelines.

Enabling you to categorise & optimise medication for patients with:

HFrEF **HFmrEF** **HFpEF**

Impacting the lives of patients with HF to live well for longer

Video on ODM HF

Example practice report

Example PCN report

Each patient added to the HF QOF register equates to £67.59

Spotlight on AF

The Atrial Fibrillation module is aligned to the 2021 NICE (NG196) guidelines for the diagnosis & management of AF.

Enabling you to identify, intervene & impact the lives of patients with AF to prevent strokes.

DETECT **425,000** people estimated to be undiagnosed & untreated

PROTECT **Stroke prevention** through anticoagulation of high-risk patients

PERFECT Perfecting Anticoagulation of **Direct Oral Anticoagulants (DOACs)** & **Vitamin K Antagonists (VKAs)**

Example practice report

Each patient added to the AF QOF register equates to £30.72

Spotlight on CKD

The Chronic Kidney Disease module is aligned to the latest evidence for the treatment of CKD (NICE guidelines NG203 (2021) & NG28 (2015).

Utilising KDIGO* classification to support the recall & review of patients.

Supporting the clinical management of:

- Lipids
- Proteinuria
- Blood pressure
- Anaemia

Example practice report

Each patient added to the CKD QOF register equates to £3.43

*Kidney Disease Improving Global Outcomes

Spotlight on Diabetes

The Diabetes Disease module is aligned to the latest NICE guidance (NG28) for the treatment of Diabetes.

Prioritising patients with Type 2 Diabetes by comorbidities:

- T2DM & CKD
- T2DM & HF/CVD
- T2DM & QRISK >=10
- T2DM & Low risk of CVD

Further stratified by HBA1c & BP targets and evidence based medications

Each patient added to the Diabetes QOF register equates to £21.32

Spotlight on Lipids

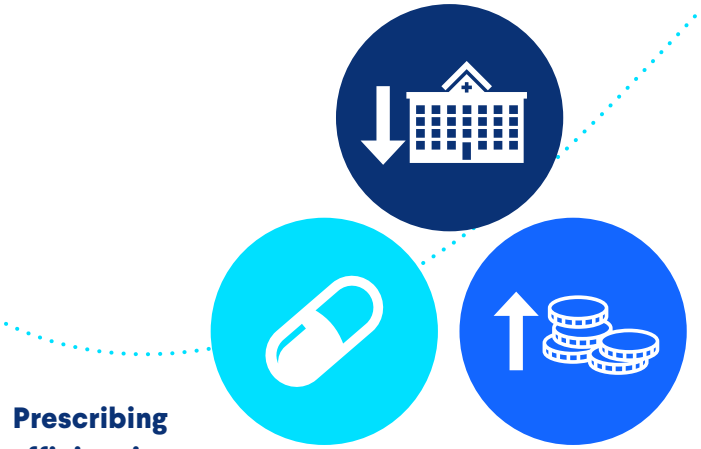
The Lipid module is aligned to the AAC pathway - National Guidance for Lipid Management for Primary and Secondary Prevention of CVD.

Supporting delivery of the AAC pathway to prevent CVD:

- **Primary Prevention**
- **Secondary Prevention**
- **Severe Hyperlipidaemia/FH**
- **Triglycerides**

Impacting QOF indicators CHOL 001, CHOL 002, DM022, DM023

What are the benefits?



Lead HCP Journey

Clinical system resources deployed

Baseline report created, dashboards populated

Training Webinar baseline report debriefed, alerts agreed & activated, goals set for next quarter

Quarterly re-audit report (3m) created, dashboards populated

Training Webinar re-audit report reviewed with achievements to date, goals set for next quarter

Quarterly re-audit reports (6m/9m/12m) created, dashboards populated

Service starts → 12 months

Testimonials

"As a large PCN with 34,000 patients, who merged into one practice over the pandemic, we had an urgent need to do a deep dive into the heart failure data to identify and categorise patients.

With over 500 clinical records to review after Oberoi's initial audit, it was clear further support was needed to expedite timely identification and review of heart failure patients thus enabling appropriate treatments for their defined heart failure diagnosis. As a result, our prevalence is now well above national average and patients are benefitting from the 4 pillars of heart failure treatment."

Furthermore, we have a clear coding strategy to future-proof our registers."

- Liz Darlington
Advanced Nurse Practitioner with a Specialist Interest in HF

"What we achieved, in just 6 months working with Oberoi, is remarkable. 24% of patients with HFrEF in our practice are now on all 4 pillars of treatment versus just 5.7% at baseline, while the PCN now has 16%, versus 4.7% at baseline. As a PCN, the platform allows us to continually track improvement across all our practices. Patients who are still not yet on all 4 pillars of heart failure treatment can be optimised using the searches & prompts integrated within our own clinical systems – providing ongoing legacy."

– Jaya Authunuri
Practice Director & Clinical Pharmacist Drs Reddy & Nunn

"Oberoi's Digital Audit Platform for heart failure has helped us to improve our HF coding, increased prevalence of HF patients and the input of the specialist heart failure nurses working to local guidelines helped increase uptake of evidence-based treatment for the patients of my practice and across Eston Primary Care Network. The feedback I received from practices was that they were, in addition able to achieve QOF and HF targets and related funding.

The Oberoi nurse allocated through our PCN was very efficient, contacted the practices to have access to our data so that she could carry out her work. The responses I received from patients after their recommended treatment had been implemented has improved their conditions. I highly recommend this service to other practices and PCN."

- Dr Ifti Lone MBE, GP partner at Normanby Medical Centre and
Clinical Director of Eston Primary Care Network in North Yorkshire

"Through the intervention of Oberoi, this organisation, along with their many skilled clinicians, are putting patients' health and wellbeing first and foremost, by identifying patients who are at risk, ensuring they are targeted, reviewed and monitored, enabling them to receive the best care and treatment from their health provider.

I myself was one of those patients, that had fallen through the net I was contacted by one of their skilled clinicians Amanda Crundall. Who then liaised with my GP, working together they arranged for me to have further investigations to manage my condition more effectively can't thank them enough for their intervention."

- Mrs Carol Owen
Patient Testimonial

Clinical Resource

Oberoi Disease Management can include clinical resource to **support your disease response**

Our industry leading clinicians deliver **targeted clinical expertise** to validate registers and intervene to optimise treatment

Oberoi Clinical Resource - £600.00 per day

Potential funding opportunities available

Cost

Any single module is **12p+VAT per patient** (based on practice population)

If you purchase 2 modules, you will receive a 3rd module free of charge

For each additional modules purchased, the further cost is **2p+VAT per patient**

Example 10,000 patient population

1 Module
Annual Cost £1,200 +VAT
Monthly Cost £100+VAT

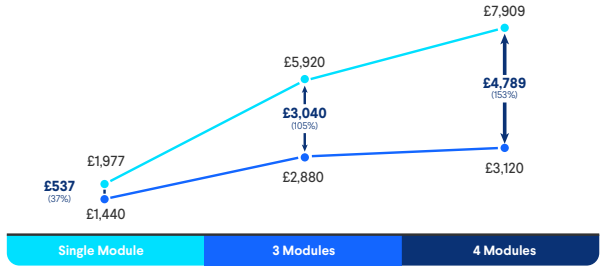
3 Modules
Annual Cost £2,400 +VAT
Monthly Cost £200+VAT

Additional Module
Annual Cost £100+VAT
Monthly Cost £16.67+VAT

Invoiced monthly, 12 month contract

Calculate your Return on Investment

Potential Return on Investment



Discover how **Oberoi Disease Management** can power your response to chronic and long-term conditions, **together we can change lives**

W: https://www.oberoi-dm.co.uk
E: sales@oberoi-consulting.com
T: 01332 224 251

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