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PHARMA SUMMIT 23

PARTNERING TO IMPROVE HUMAN HEALTH

Dr Donal Bailey,
CEO

Care-Connect
Empowering Healthcare Journeys

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Care-Connect
Empowering Healthcare Journeys

Centric Health & Care-Connect

Dr Donal Bailey
CEO of Care-Connect

March 2023

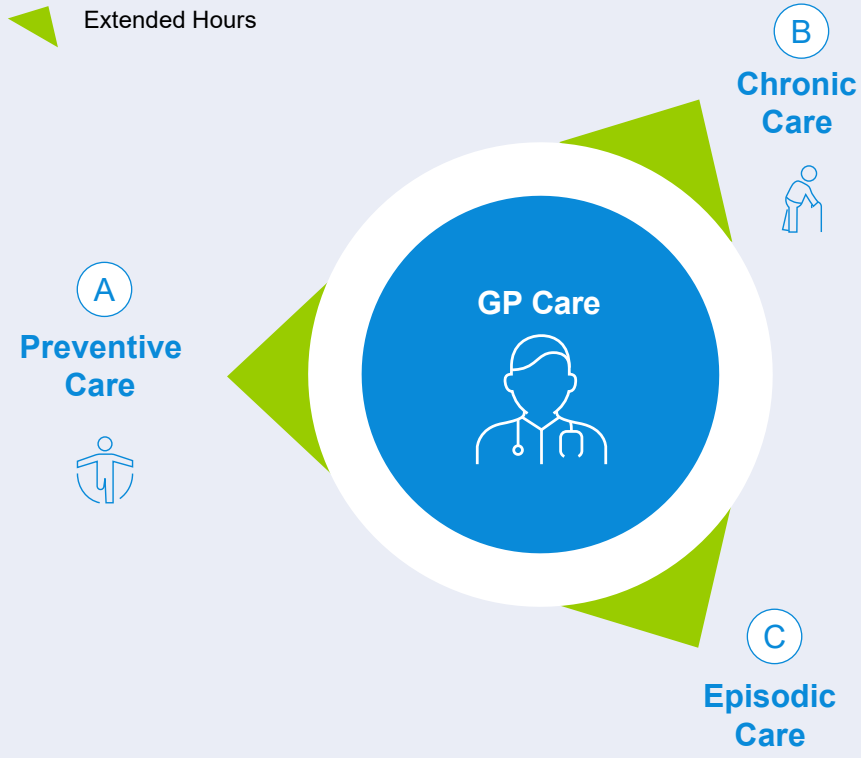
Messages for today

1. Who are Centric Health and Care-Connect?
2. How are we innovating in primary care delivery?
3. Our approach to patient care planning.
4. What does collaboration mean for us?
5. Example of our programmes and how these might evolve.
6. Plans for the future.

Our aim is to change the nature and scope of primary care

Centric Health's vision is to expand community healthcare through:

- Integrated services
- Improved access
- More means of delivery
- Learning organisation



A Preventive Care

- Scheduled Care
- Patient Education
- Health Screening
- Lifestyle mgmt.

B Chronic Disease Programs

- Heart Failure
- Diabetes
- CKD
- COPD

C Episodic Care

- Mental Health
- MSK
- Derma-tology
- Women's & Men's Health

Delivered Virtually | Via video/ telephone | In person

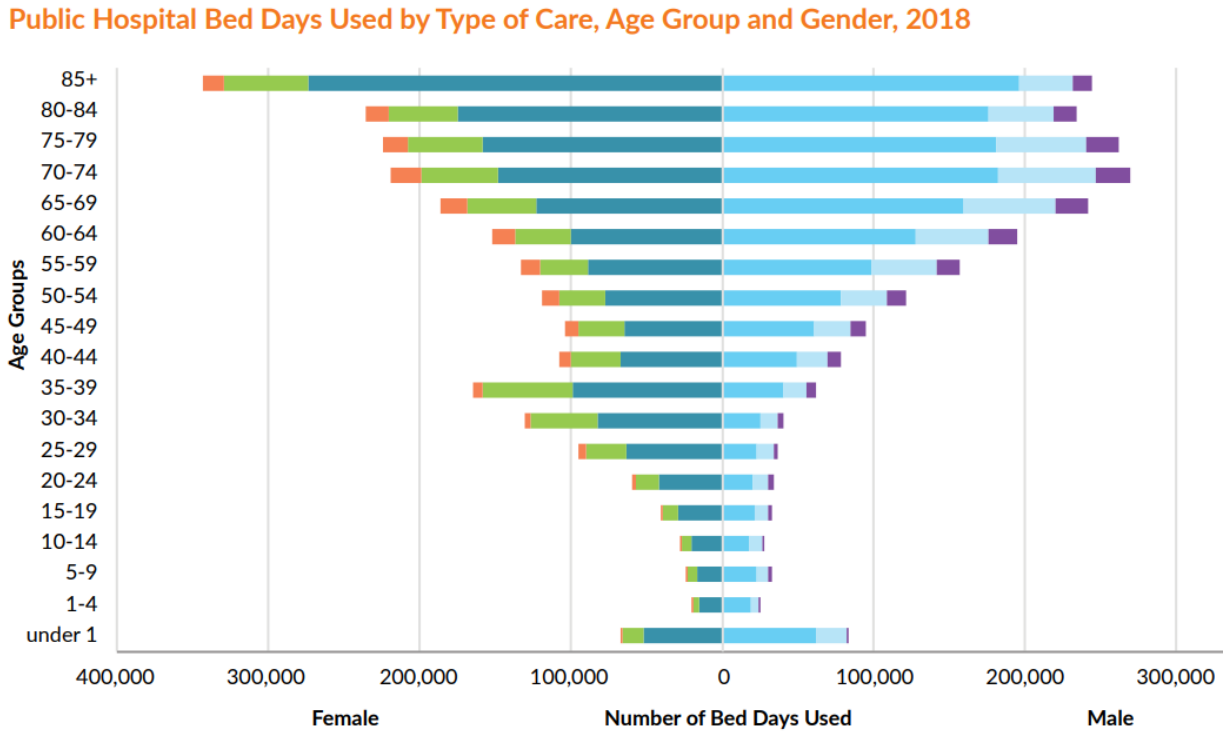
Our approach to patient and clinical service stratification

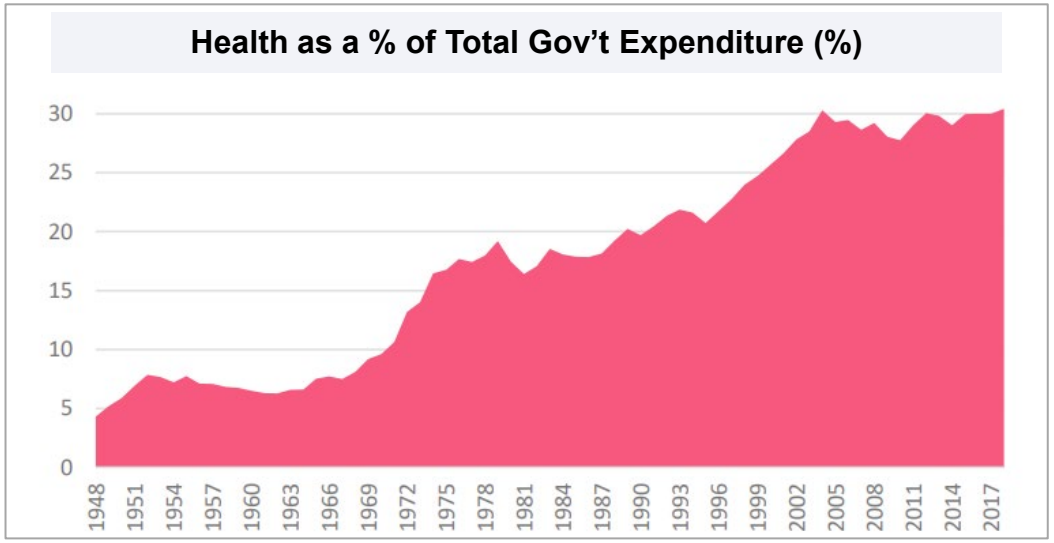
We are an increasingly data-led organization in our population health planning

Macro Challenges in European Primary Care

Numerous systemic constraints affecting healthcare delivery:

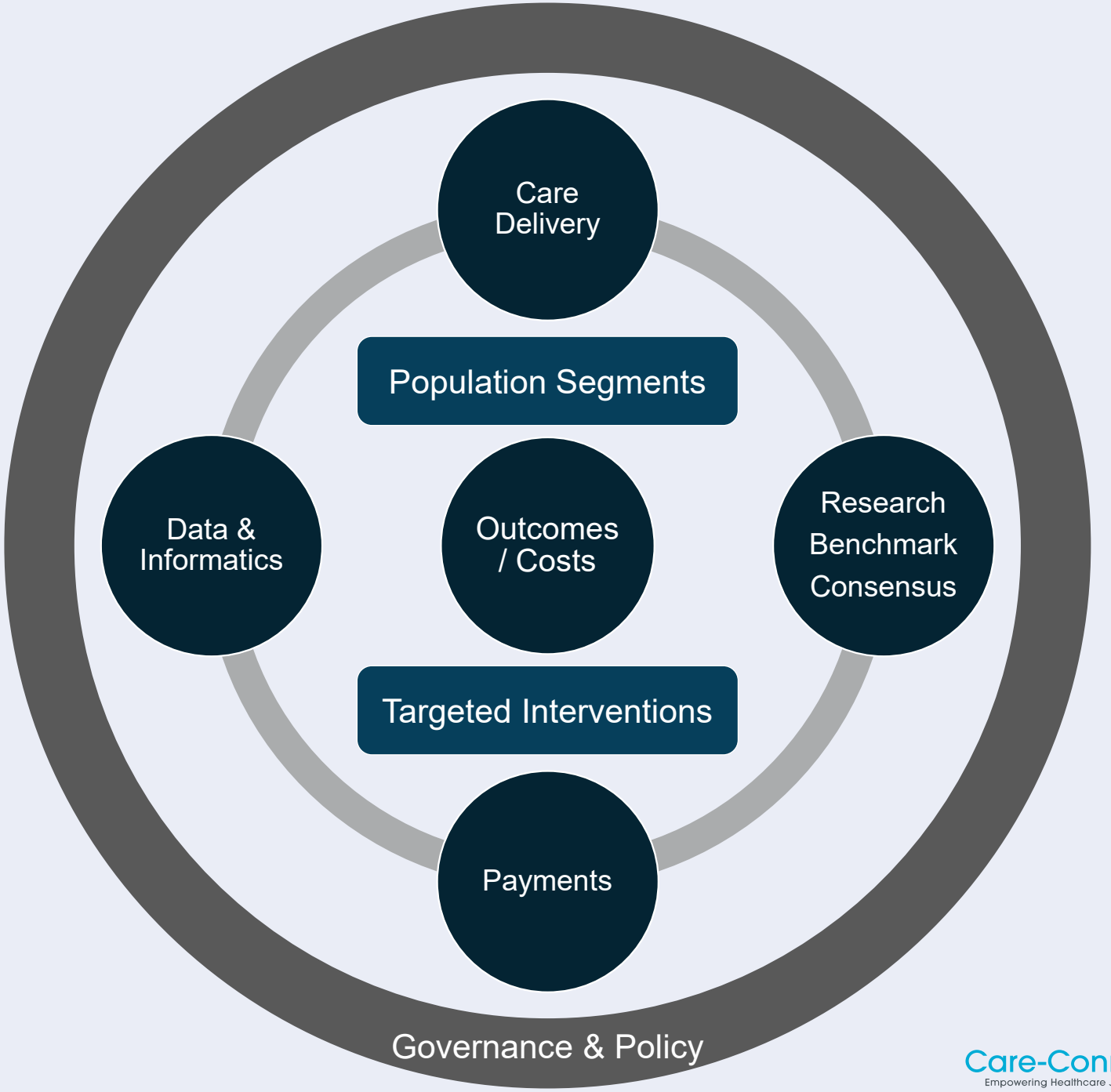
1. Cost growth out-pacing economic growth
2. Demographics & Demand
3. Skilled Workforce
4. Investment & Funding
5. Operating Model





Collaboration in complex adaptive systems

1. Common Purpose
2. Evidence
3. Aligned Incentive
4. Governance which also promotes Autonomy



Centric Health and Irish Life have partnered to deliver value-based care in Ireland

Centric Health and Irish Life's new venture called Care-Connect is tasked with

1. Targeted population health and risk stratification
2. Optimize the care of at-risk patients out of the hospital by addressing impactable health needs
3. Digitally enabled, high touch, care management and care orchestration
4. Structured care pathways to guide patients and clinicians
5. Data-led and driven by outcomes

Centric Health

Irish Life health

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"We are trusted partners in health, connecting patient care across the healthcare system to empower healthier lives."

Example: areas of focus for heart failure management

Reducing avoidable hospital admissions, readmissions and optimising long term treatment

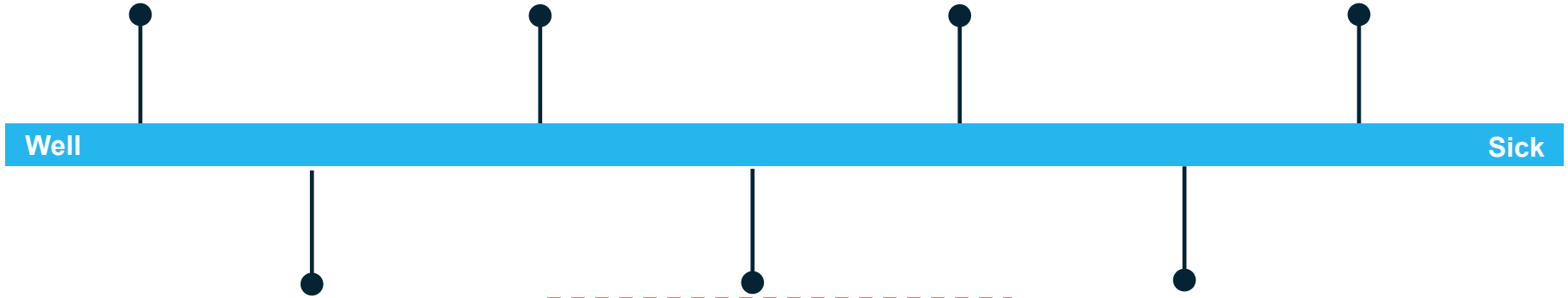
Already active

Primary Prevention:
- Psychological Wellbeing
- Smoking Cessation

ED Avoidance:
- Nurse Assessment/Triage (phone and digital)
- Urgent Care Centres

Hospital Innovation:
- Remote Cardiac Rehab

Hospital Substitution:
- Early discharge programmes
- Virtual Hospital using in-home and remote monitoring

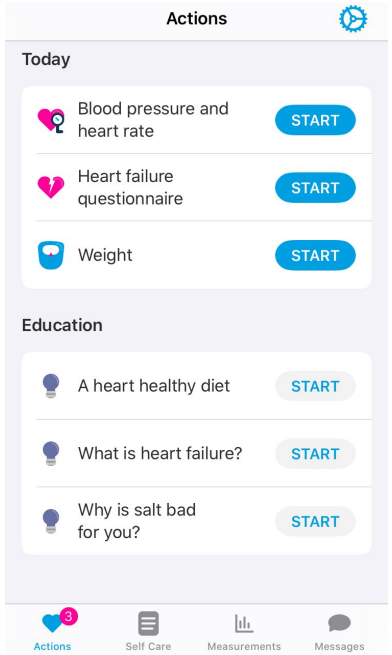


Population Health Innovation:
- Predictive, proactive & preventative models
- Follow contemporary clinical guidelines
- Reduce potentially preventable hospital admissions

Chronic Disease Management:
- Guideline directed therapy optimisation and education

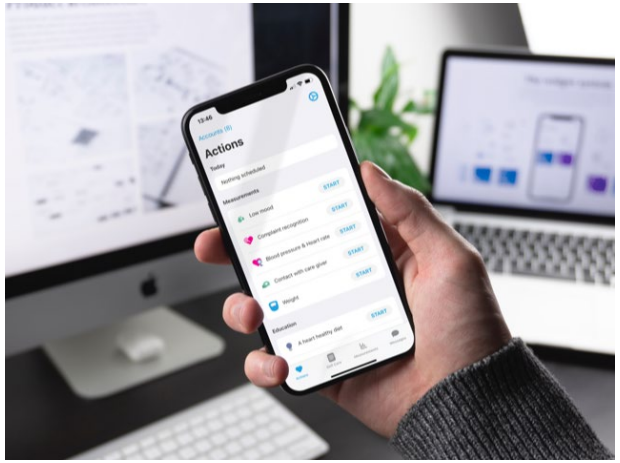
Readmission Avoidance:
- Care Transition
- Telehealth and remote monitoring

Enhancing patient access and healthcare experience



Home monitoring

Dedicated clinical team

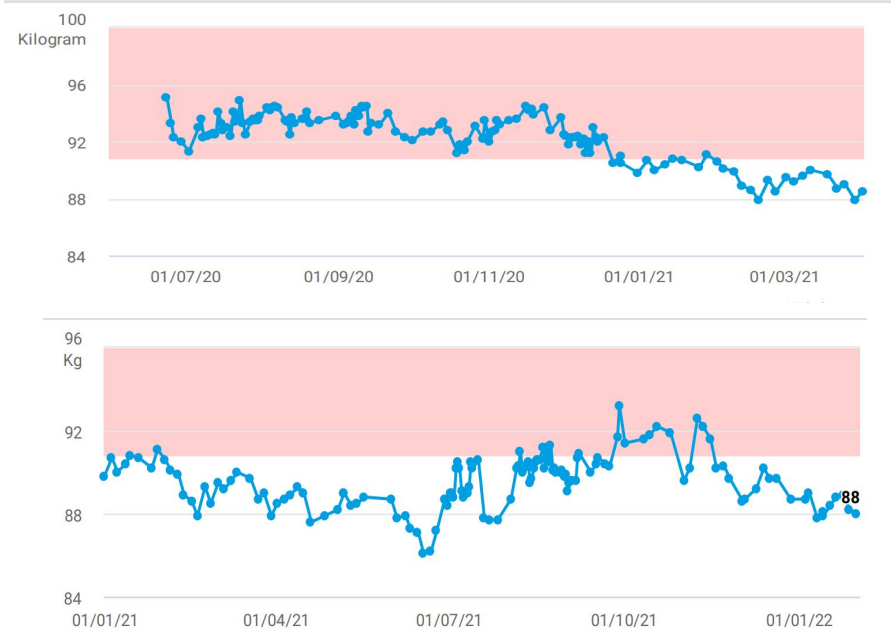


Swift intervention

The value of continuous data collection in Heart Failure care at home

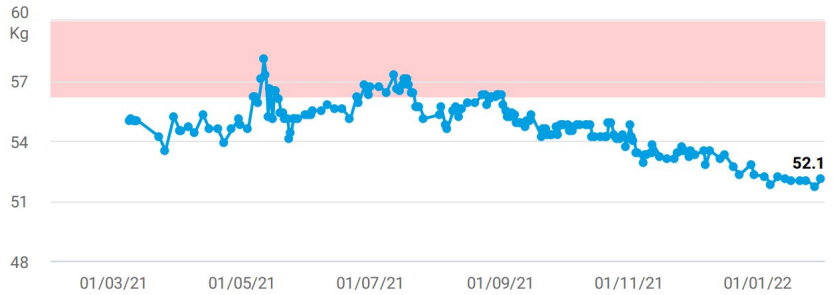
This permits early intervention and admission avoidance – demonstrated in current programme

Patient A



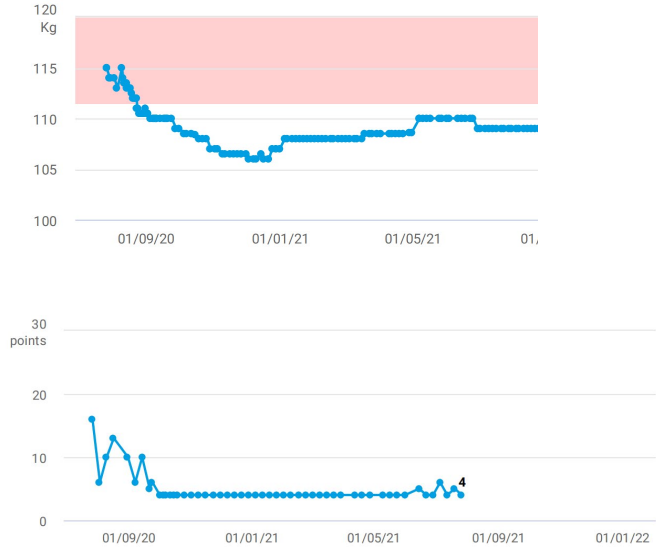
Patient initially took 5 months to reach baseline with significant improvement in control. Life event in October but regained baseline quickly with support of team.

Patient B



Patient gained improved control of body weight (fat loss), with gradual guidance as per GP advice and supported by our team.

Patient C



As patient removes excess fluid (weight) control improves, symptom control also improves.

Roadmap is predominantly in areas of chronic care

Prioritisation based on

- Disease/problem areas
- Ability to influence outcomes
- Fit with national priorities

Care Pathway Roadmap	Care Pathway Roadmap
1. Chronic Heart Failure	➢ Active, iterative refinements
2. COPD	➢ This week
3. Post-Discharge Care Transition Support	➢ Q2 2023
4. At-Risk Multiple Long Term Condition (MLTC)	➢ Q3 2023
5. Chronic Pain and OA Management	➢ Q4 2023
6. Asthma	➢ Q4 2023
7. Coronary Artery Disease and Post-AMI	➢ 2024
8. Medical Weight Management	➢ 2024
9. Type 2 Diabetes Mellitus	➢ 2024
10. Chronic Kidney Disease	➢ 2024

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