

Big Data Analytics and Applied Data Science within Geisinger's Large Integrated Health System

Brandon Fornwalt, MD, PhD

A graphic consisting of three blue curved lines with dots at their ends, sweeping from the left side of the slide towards the center.

Geisinger

CARDIAC IMAGING TECHNOLOGY
LAB

A red ECG (heart rate) line graphic positioned below the text 'CARDIAC IMAGING TECHNOLOGY'.

Disclosures

- No one works alone



Chris Haggerty PhD

A Gamecock Then vs Now



More hair

Nicer grill

Proudest Gamecock Moment

???

Correct "spur"



Circa 2001

Truly Proudest Gamecock Moments



Outline

- Intro Geisinger, people, data, infrastructure
- Clinical radiology informatics with deep learning
- Machine learning to optimize use of cardiac image data
- Deep learning with 12-lead electrocardiograms
- Machine learning to help manage heart failure
- Multi-modal deep learning in cardiology

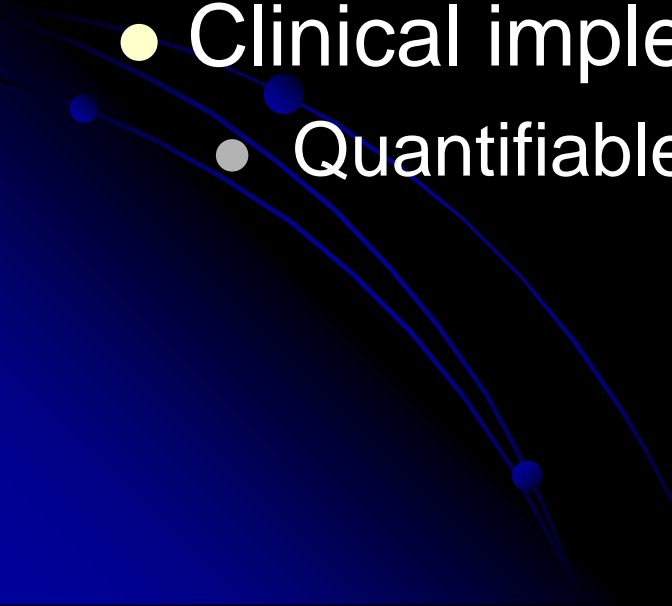
Elias Zerhouni, MD

Former Director of the National Institutes of Health and presidential science advisor



“The real winners in artificial intelligence and machine learning will be those health systems who have large databases of patients with longitudinal studies and outcomes, such as Geisinger.”

What Do We Need to Deliver on that Expectation?

- Data – including a deep understanding of the underlying concepts
 - People – diverse team
 - Infrastructure – specialized compute
 - Clinical implementation
 - Quantifiable impact on our patients
- 

Geisinger: Rich Clinical Data from Integrated Network of 13 Hospitals

1.9 Million patients

500 Million labs

800 Million vital signs

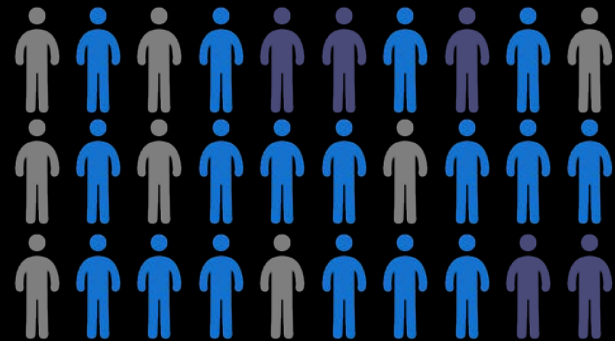
11 Million imaging studies

3.2 Billion rows

~140,000 whole exomes sequenced

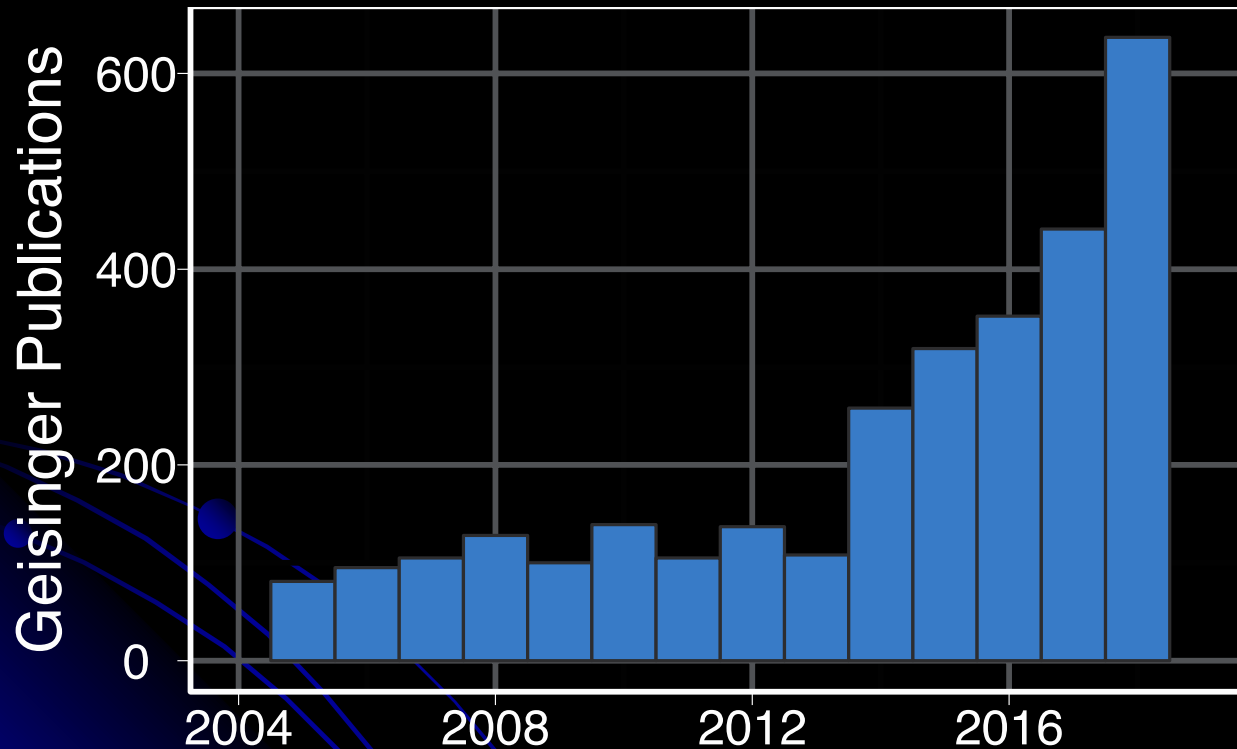
→ average 16 years follow-up

Epic (since 1996)



***Large phenotype team of data analysts / modelers
(Joe Leader, AVP of Informatics)***

People: Research Leadership With Institutional Re-Investment in 2010



David Ledbetter PhD
Chief Scientific Officer

Diverse Team: Clinicians, Comp Sci, Engineers, Ops

Ops



A Haggerty
MBA

Scientists



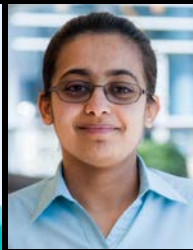
E Carruth
PhD



S Fielden
PhD



L Jing
PhD



S Raghunath, PhD



C Stillwell, PhD



A Ulloa
PhD



X Zhang
PhD

Primary Staff



B McCarty
BS



C Nevius
BS



N Stoudt
BS



D van Maanen, MS

Associated Staff



S Gazes
MS



D Hartzel
BS



J Leader
BS



N Sauers
PharmD

Primary Faculty



El-Manzaway, PhD



B Fornwalt
MD PhD



C Haggerty
PhD

Cardiology / Hospitalist Co-investigators



B Carry
MD



C Good
DO



J Pfeifer
MD, MPH



G Schneider
MD

Unique Infrastructure



A Patel MD



D Ledbetter PhD

2018: DGX-1 (8 GPUs) INSIDE clinical network (2nd hospital; 1st MGH)

2019: DGX-2 (16 GPUs)
+60TB FlashBlade Array

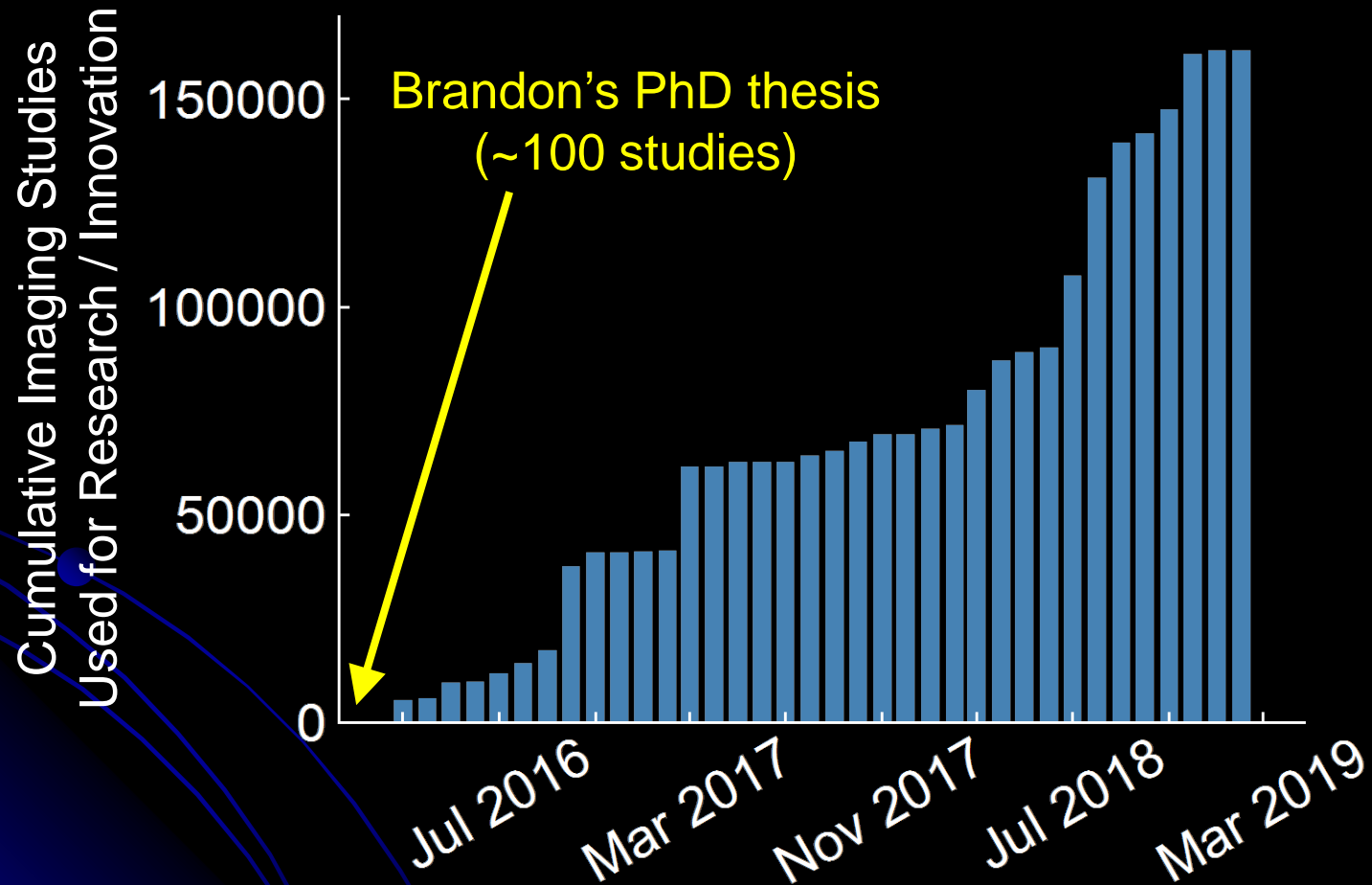
2020: 600TB Flash
+1.3PB spinning disk

From
 **PURESTORAGE**

Powered by
 **NVIDIA**



Research Image Archive (PACS) Growth



Outline

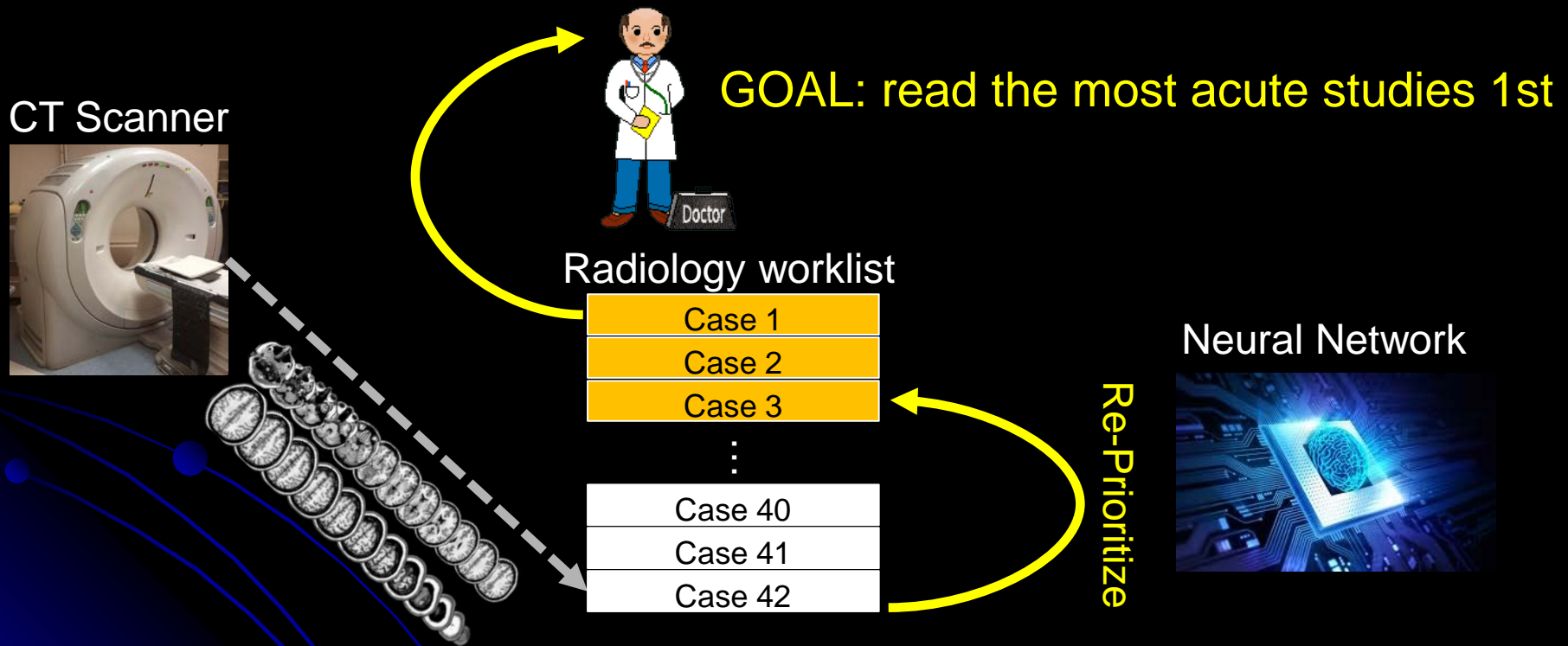
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Clinical Radiology Informatics with Deep Learning: Intracranial Hemorrhage (ICH)

- Spearheaded by Mohammad Arbabshirani, PhD
- Early and accurate diagnosis of ICH is critical to patient outcome
- Can we use machine learning to optimize radiology worklists for earlier diagnosis?
 - Quality improvement tool as initial proof of concept



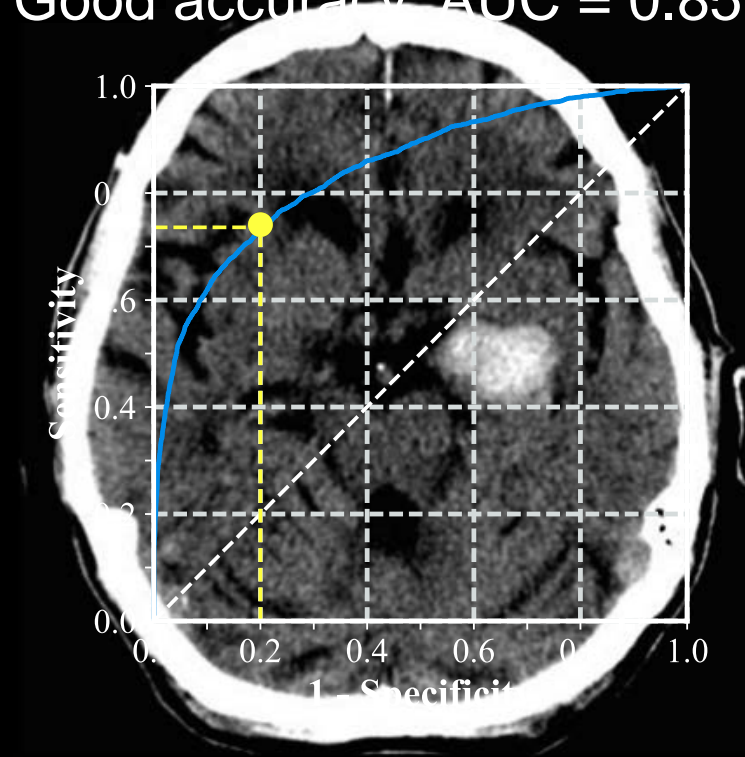
Clinical Radiology Informatics with Deep Learning: Intracranial Hemorrhage (ICH)



Clinical Radiology Informatics with Deep Learning: Intracranial Hemorrhage (ICH)

- 46,583 head CTs
 - 3D→2 million images
 - collected over 10 years
- Classified into ICH or no ICH and used to train a deep neural network

Good accuracy: AUC = 0.85



Operational >2 years

Healthcare IT News

TOPICS

Geisinger injects machine learning into clinical workflow to find health problems faster

Hospitals executive says the algorithms can help clinicians reduce time to diagnosis of intracranial hemorrhages by 96 percent.



Clinical implementation of a machine learning algorithm reduced time to diagnosis of new outpatient cases of intracranial hemorrhage by 96%

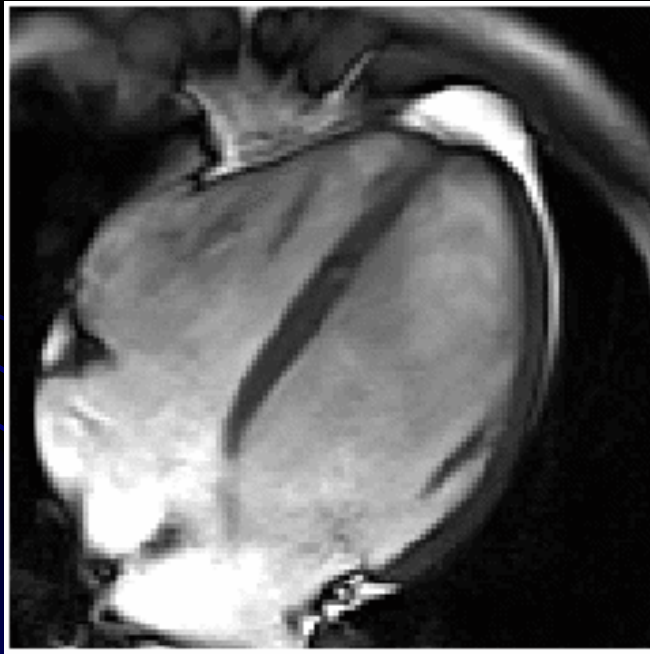
Approximately 10% of “false positives” likely have subtle hemorrhage

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Cardiac Imaging

- Imaging forms the cornerstone for diagnosis, prognosis, and management of heart disease

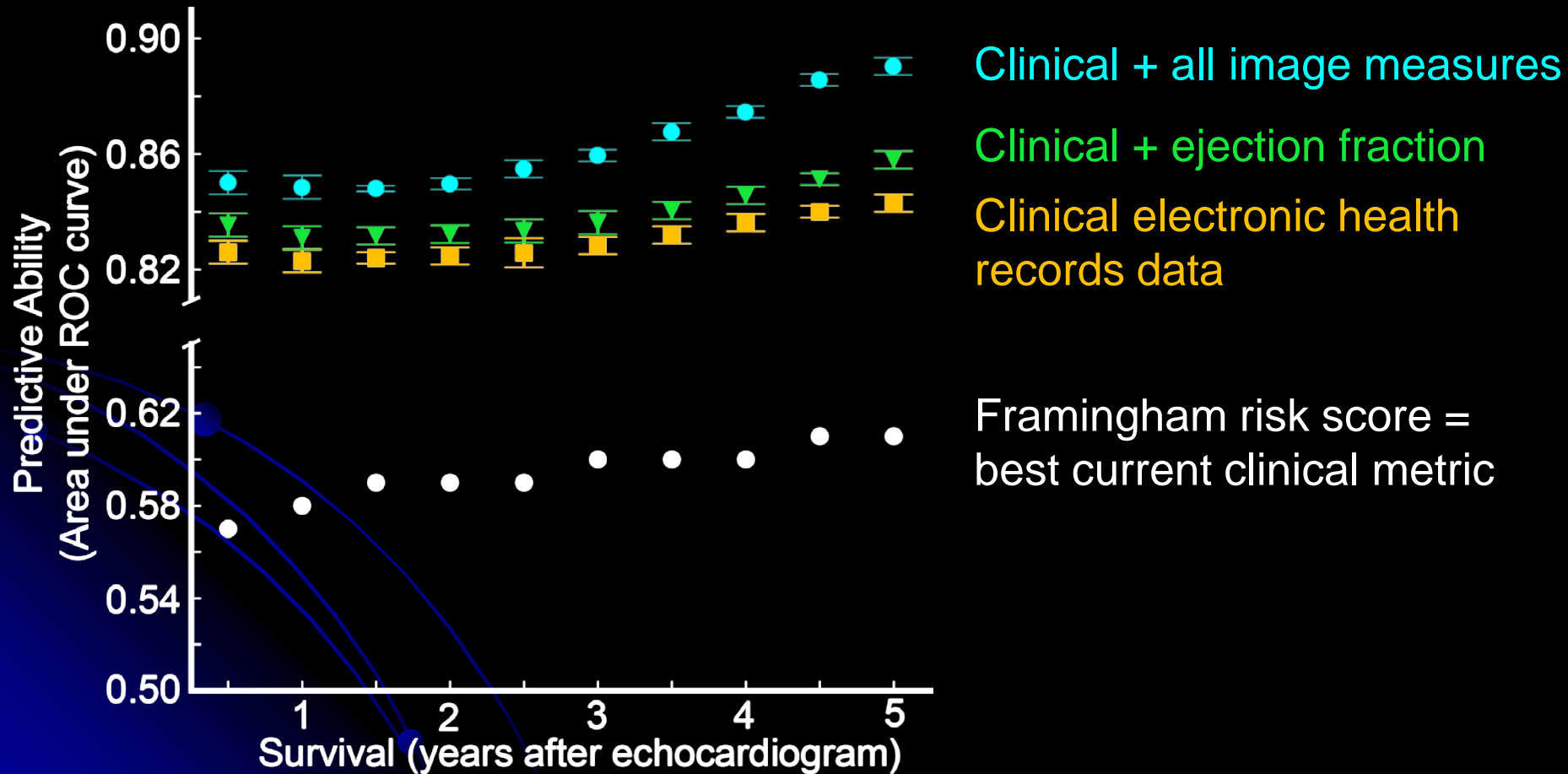


Can we improve mortality prediction after imaging using machine learning?

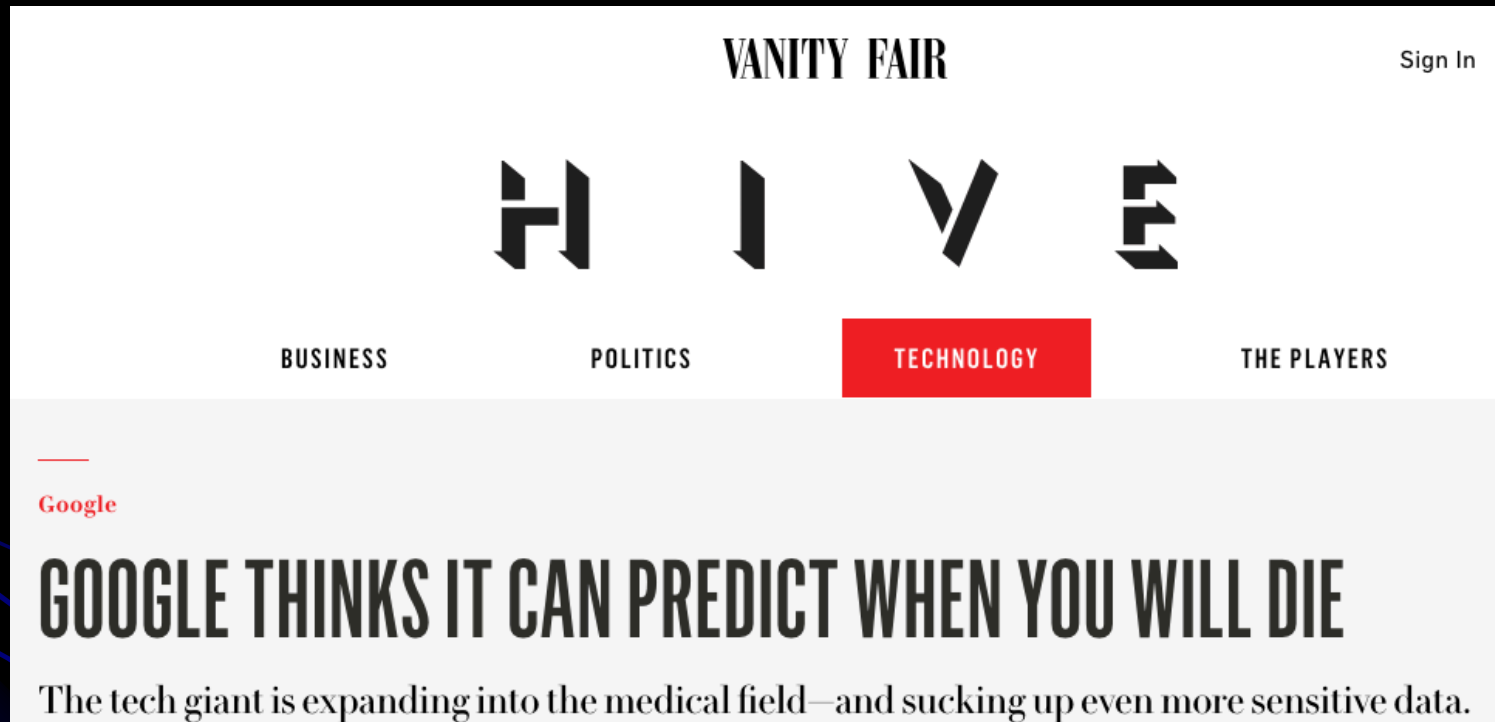
171,510 patients (331,317 echocardiograms)



M Samad
PhD



Sidenote: Comparison to Landmark Results

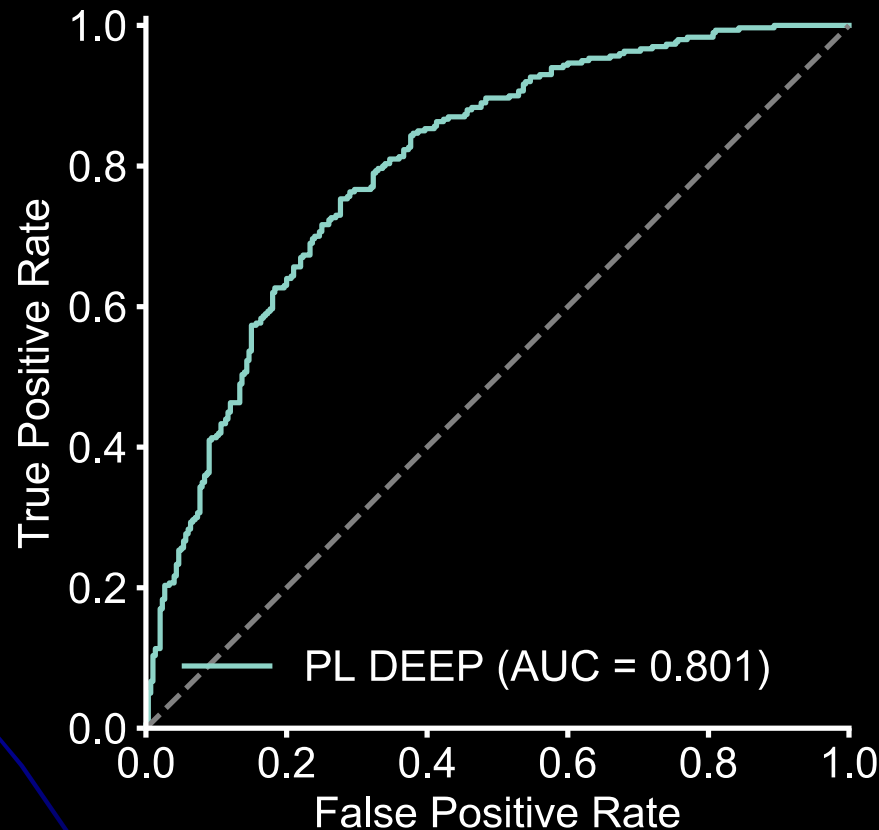
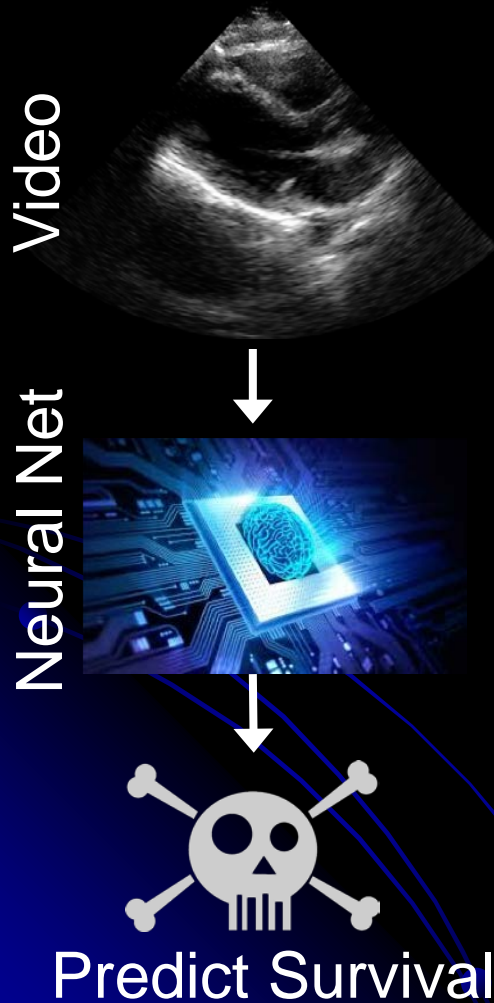


Google AUC ~ **0.93** for in-hospital mortality in **216,221 patients**
Geisinger AUC ~ **0.91** for 5-year mortality in **171,510 patients**

Next: Fully Automated Echocardiography Analysis



A Ulloa PhD

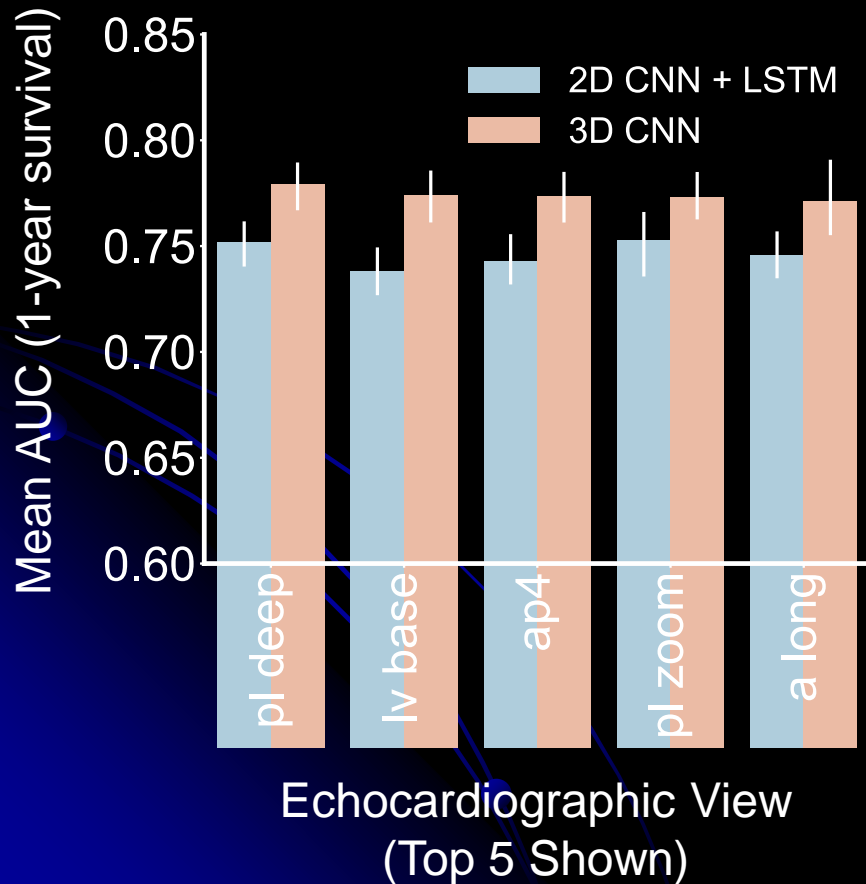


Comparison:
Clinical Score
(Framingham)
AUC = 0.62!!

Note: one of
many (>20)
videos and
clinical data
not yet added

Echocardiography Video Model Selection

723,754 videos (~45 million images)



22 views, 5 folds, 4 models,
[3, 6, 9, 12] months = 1760 Fits

1 Fit ~ 1.5 hours

→ 2,640 GPU hours ~ 3.7 months

= 2 weeks on DGX1

Can't my doctor already do that??

CARDIOLOGIST



VS

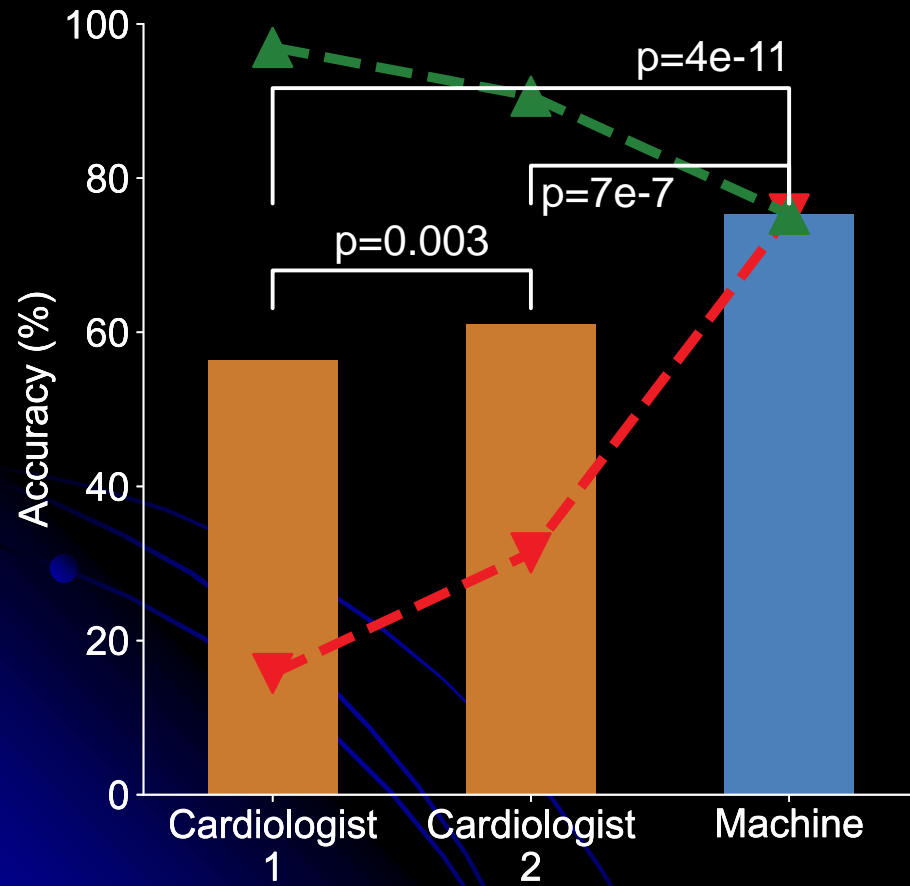
MACHINE



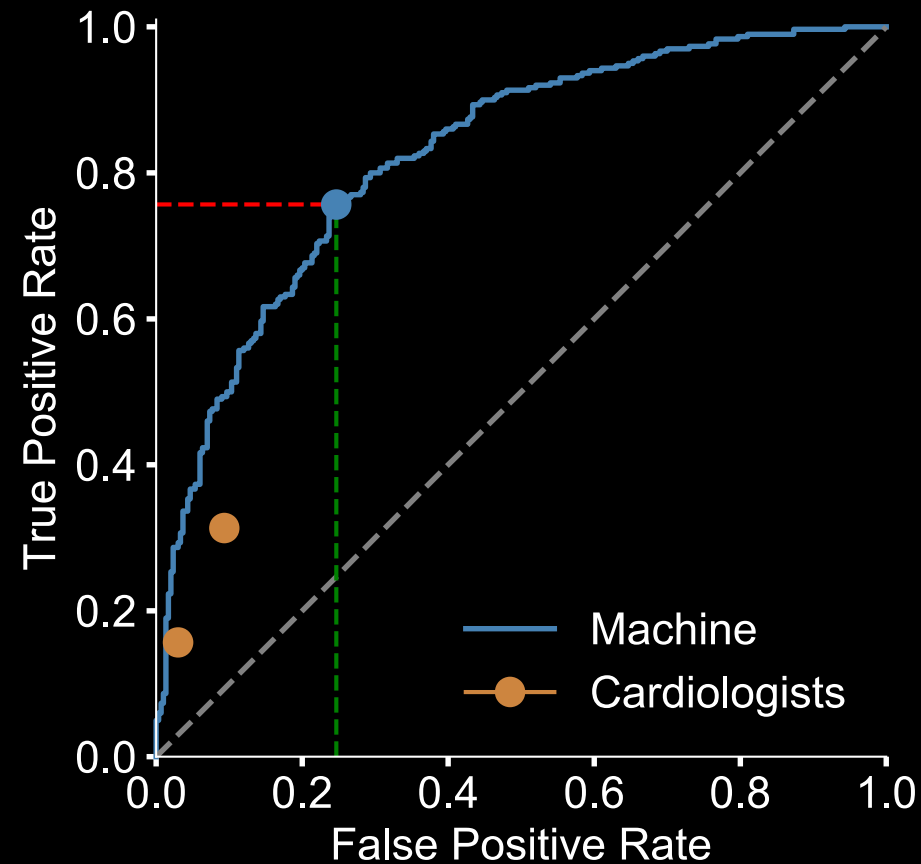
- 17 years of practice
- 10 years of indentured servitude resulting in ~\$200k of loans
- Interpreted ~35,000 echocardiograms in career
- Needs sleep

- Trained on ~30,000 echocardiograms in a week
- “Wants more data”
- Never sleeps

Machine Beats Cardiologist (n=600)



▲ Specificity (alive)
▼ Sensitivity (dead)

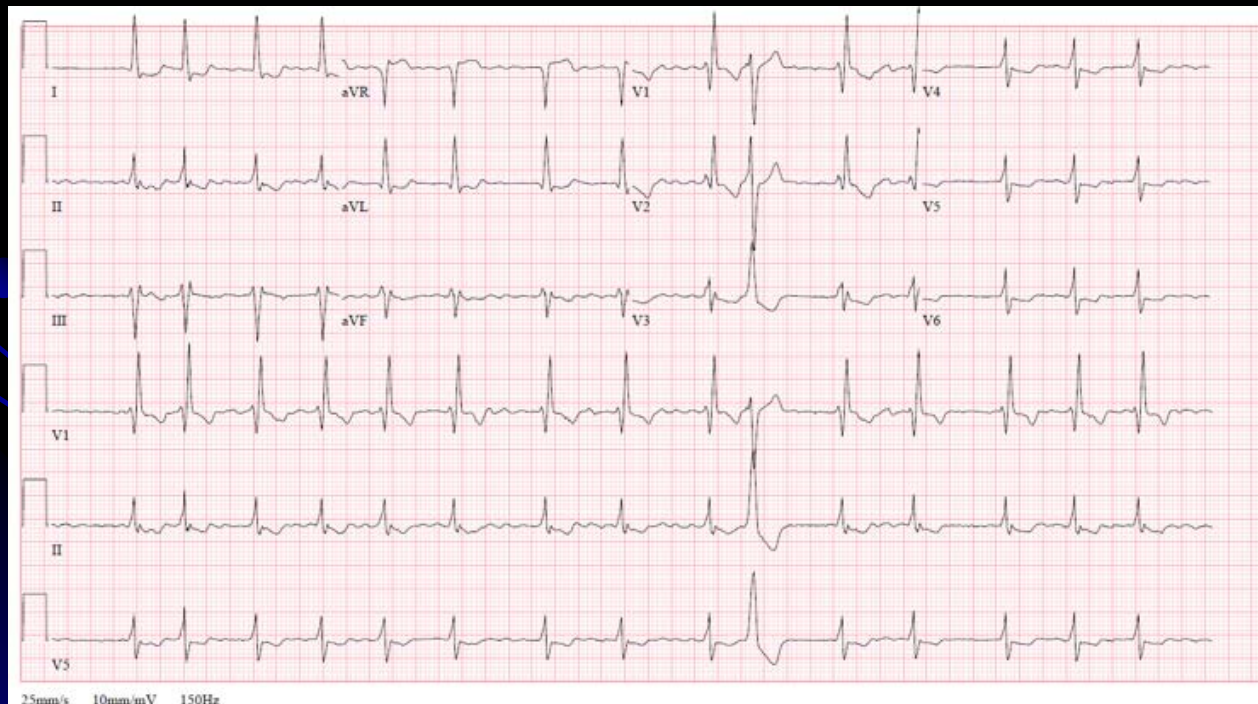


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12-Lead ECG

- Ubiquitous medical test
- ~150 million acquired annually



12-Lead ECG

- Deriving *diagnoses* with deep learning

nature
medicine

FOCUS | LETTERS
<https://doi.org/10.1038/s41591-018-0268-3>

Corrected: Publisher Correction

Cardiologist-level arrhythmia detection and classification in ambulatory electrocardiograms using a deep neural network

Awni Y. Hannun^{1,6*}, Pranav Rajpurkar^{1,6}, Masoumeh Haghpanahi^{2,6}, Geoffrey H. Tison^{3,6},
Codie Bourn², Mintu P. Turakhia^{4,5} and Andrew Y. Ng¹

Single-lead wearable
91k train
328 test
Beat cardiologists at rhythm dx

Screening for cardiac contractile dysfunction using an artificial intelligence-enabled electrocardiogram

Zachil I. Attia¹, Suraj Kapa¹, Francisco Lopez-Jimenez¹, Paul M. McKie¹, Dorothy J. Ladewig²,
Gaurav Satam², Patricia A. Pellikka¹, Maurice Enriquez-Sarano¹, Peter A. Noseworthy¹,
Thomas M. Munger¹, Samuel J. Asirvatham¹, Christopher G. Scott³, Rickey E. Carter⁴ and
Paul A. Friedman^{1*}

12-lead
36k train
53k test
Identify "asymptomatic" LV dysfn



Contents lists available at ScienceDirect

Journal of Electrocardiology

journal homepage: www.jecgonline.com



12-lead
Emergency room
100k train
1500 test
Beat old algorithm

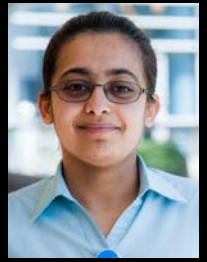
A deep neural network learning algorithm outperforms a conventional algorithm for emergency department electrocardiogram interpretation



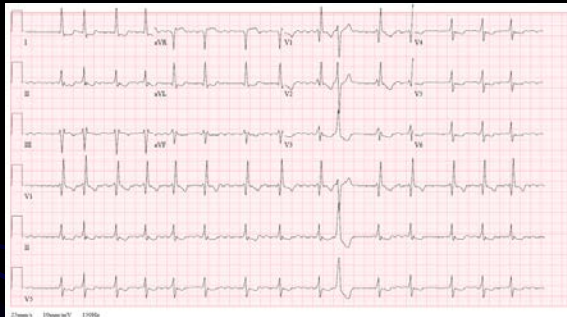
Stephen W. Smith, MD^{a,b,*}, Brooks Walsh, MD^c, Ken Grauer, MD^d, Kyuhyun Wang, MD^f, Jeremy Rapin, Ph.D.^h,
Jia Li^h, William Fennell, M.D.^e, Pierre Taboulet, M.D.^{h,g}

12-Lead ECG

- But what about predictions?



S Raghunath
PhD



Electrocardiogram



Neural Net

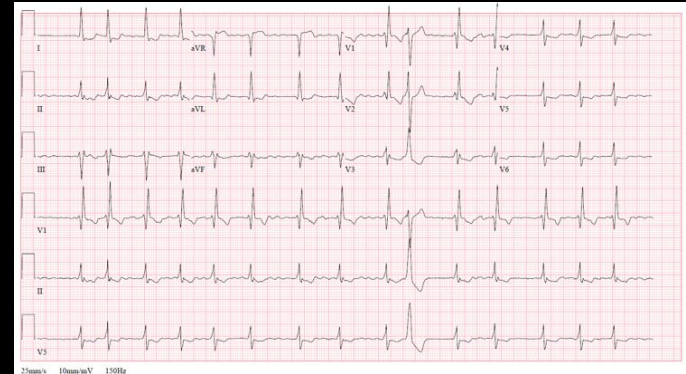


Predict

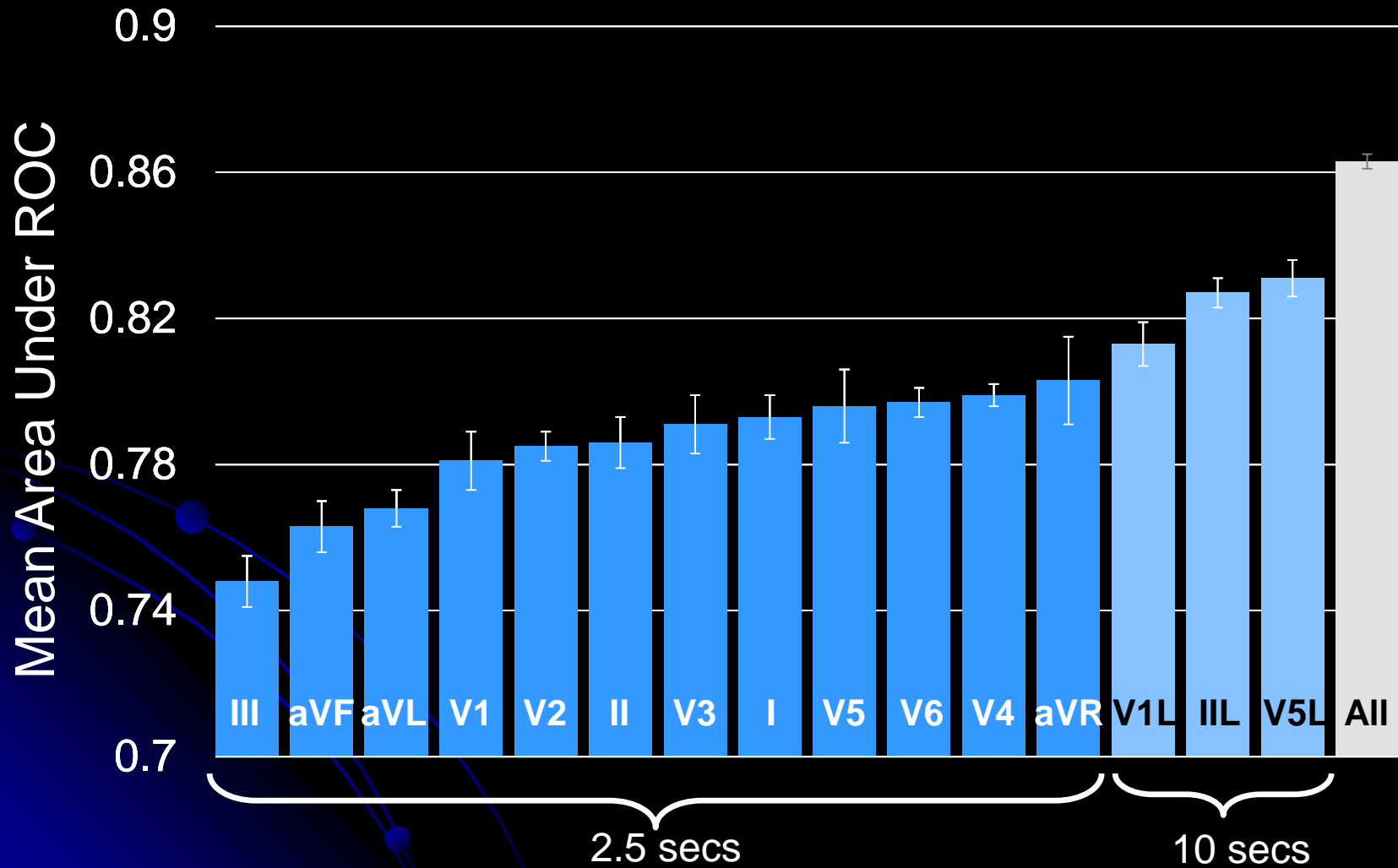
12-Lead ECG

Geisinger ECG dataset

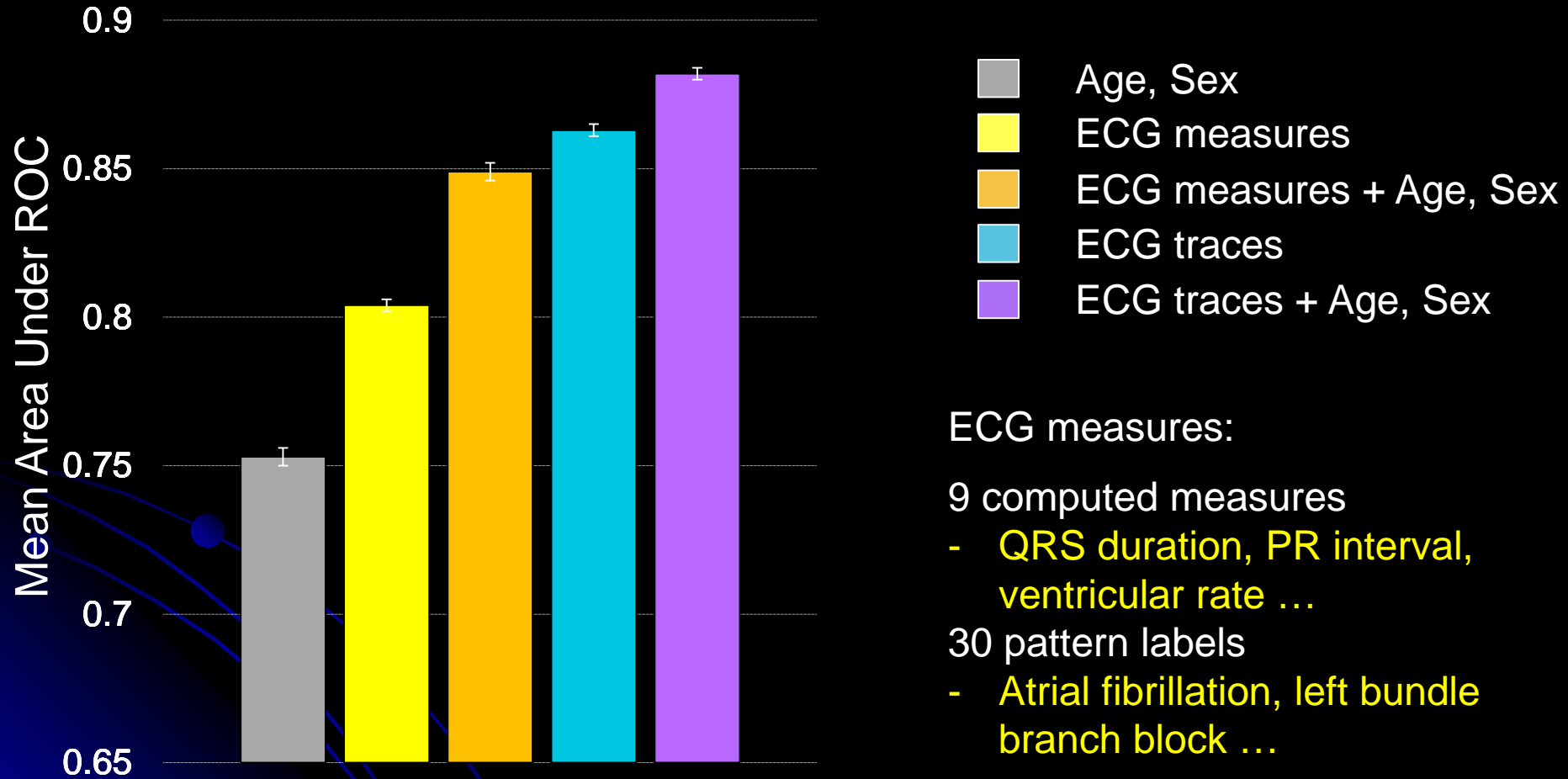
- 1.8 million 12-lead ECGs over 38 years
- ~398k patients
- 250-500Hz raw data
- Linked to outcomes (death registries, clinical events, etc)



Predicting 1-year Mortality from 1.8 Million ECGs



Predicting 1-year Mortality from 1.8 Million ECGs

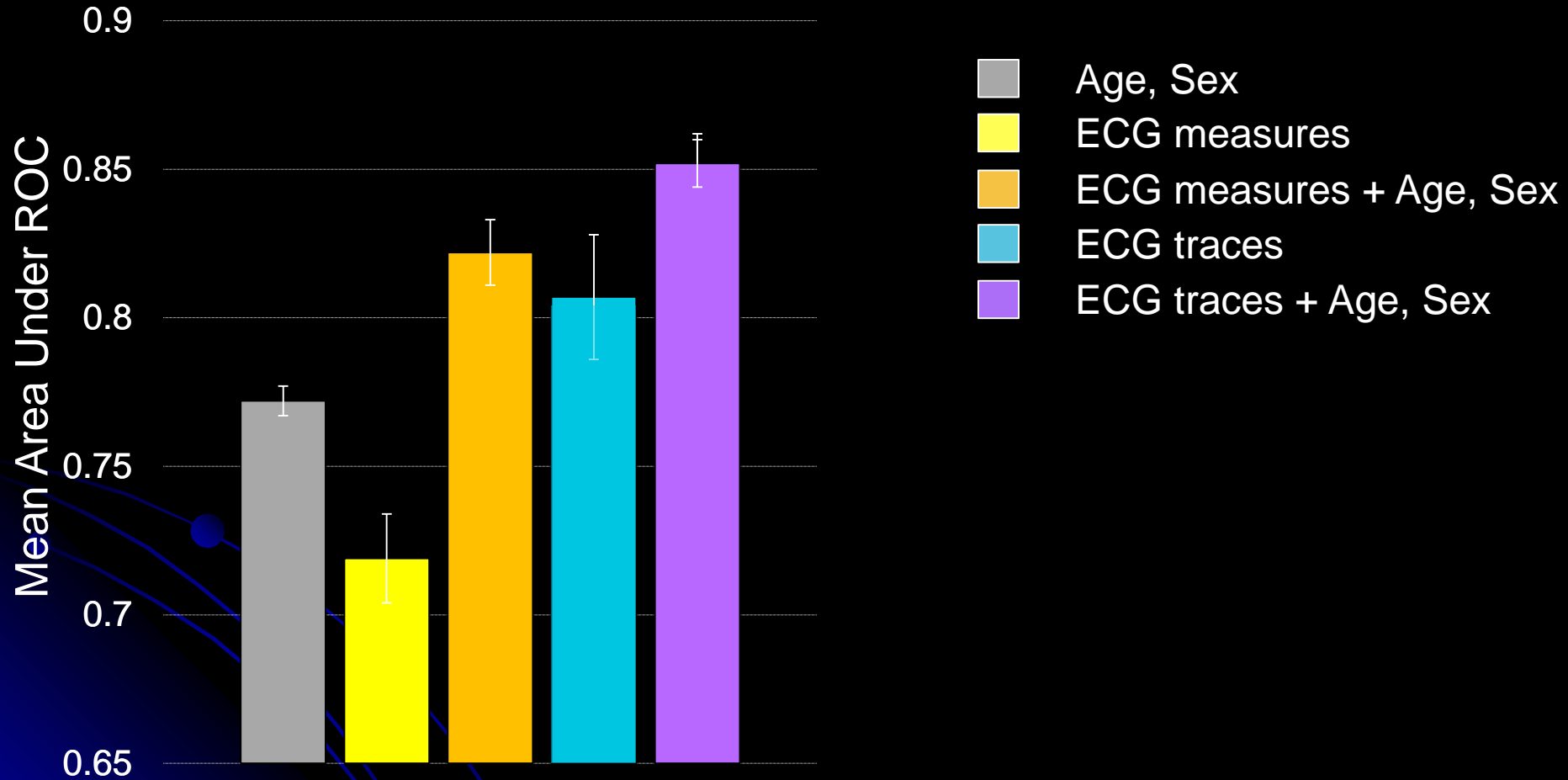


Error bars: standard deviation of 5 folds

Raghunath et al. *Nature Med.* In press.

Can a Cardiologist Do This?

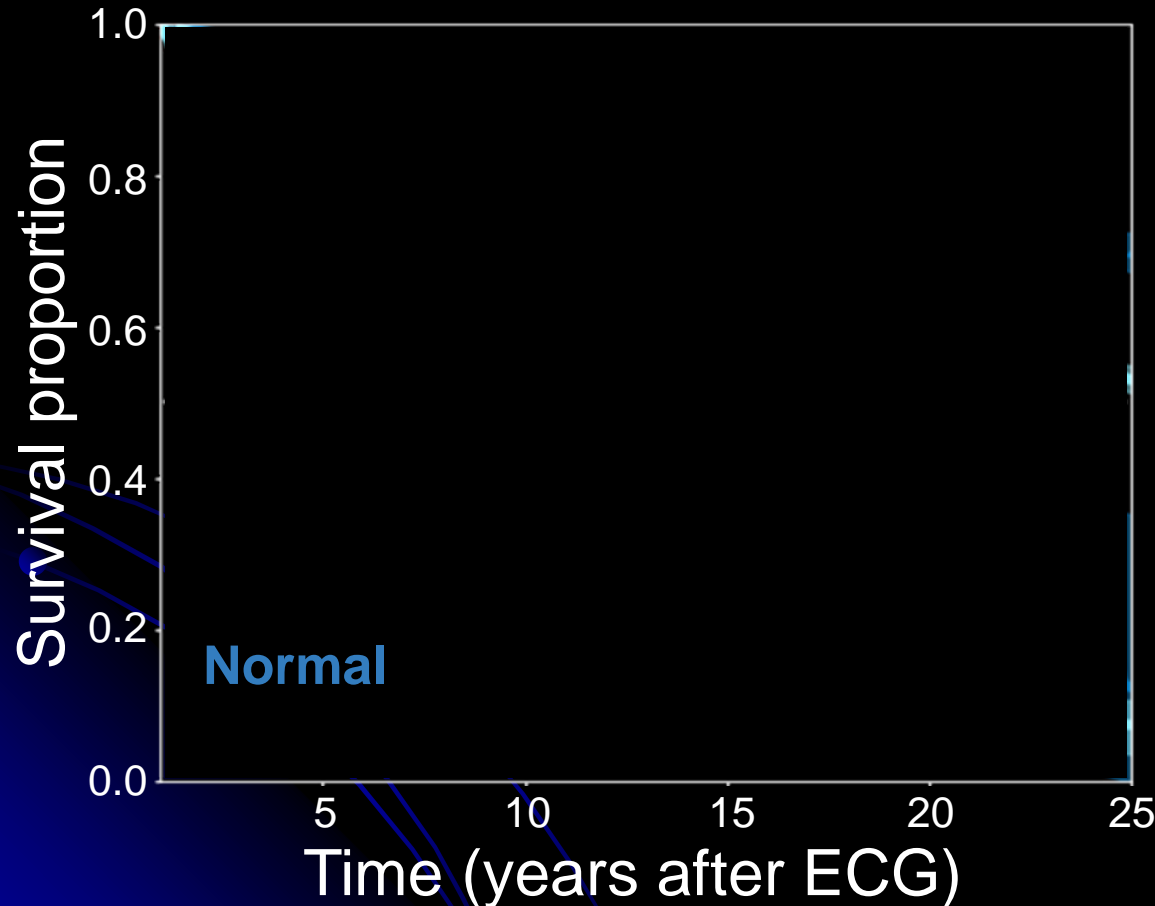
100k “*NORMAL*” ECGs



Error bars: standard deviation of 5 folds

Raghunath et al. *Nature Med.* In press.

Stratification of Predicted Groups in 1.8 Million ECGs



--- Low-risk

— High-risk

Cox Regression
 $p < 0.005$

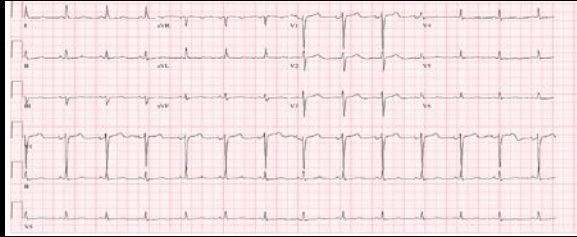
Hazard Ratios:
6.1 [5.6-6.5] (All)
7.3 [6.0-8.8] (Normal)

Note: Prediction is for 1-year mortality!

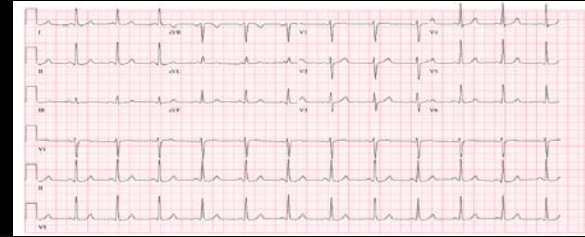
Raghunath et al. *Nature Med.* In press.

Surely My Cardiologist Can Find Features Predictive of Mortality?

40 F Vent. Rate: 87 BPM
PR interval: 110 ms Normal sinus rhythm
QRS duration: 166 ms Normal ECG
QT/QTc: 422/507 ms



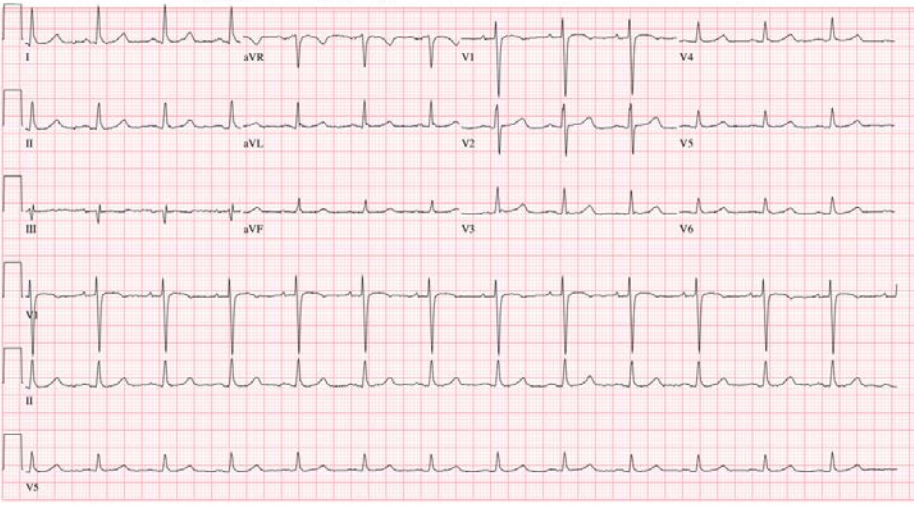
40 F Vent. Rate: 96 BPM
PR interval: 120 ms Within normal limits
QRS duration: 122 ms Normal ECG
QT/QTc: 348/442 ms



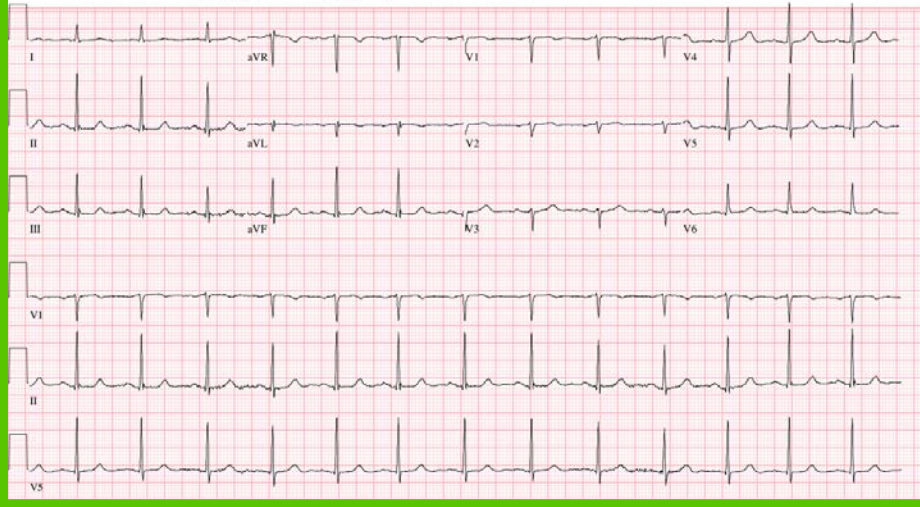
Blinded survey: Which patient will survive >1 year?
Paired sets: one true positive, one true negative.

Which One Survived?

Female (80 yr)
Vent. rate 78 BPM
PR interval 162 ms
QRS duration 88 ms
QT/QTc 410/467 ms
P-R-T axes 16 17 26
Normal sinus rhythm
Normal ECG

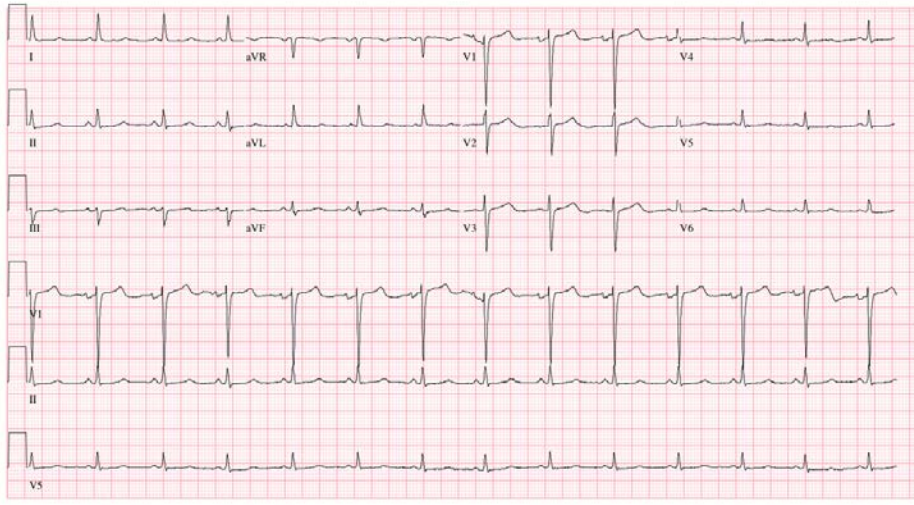


Female (80 yr)
Vent. rate 81 BPM
PR interval 162 ms
QRS duration 70 ms
QT/QTc 382/443 ms
P-R-T axes 80 71 76
Normal sinus rhythm
Normal ECG

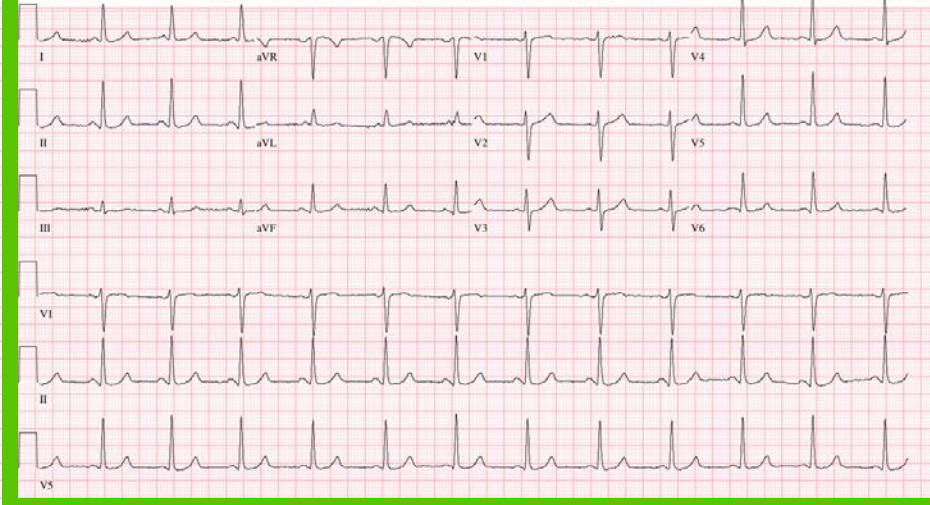


Which One Survived?

(57 yr)
Vent. rate 81 BPM
PR interval 124 ms
QRS duration 82 ms
QT/QTc 400/464 ms
P-R-T axes 48 2 50
Normal sinus rhythm
Normal ECG

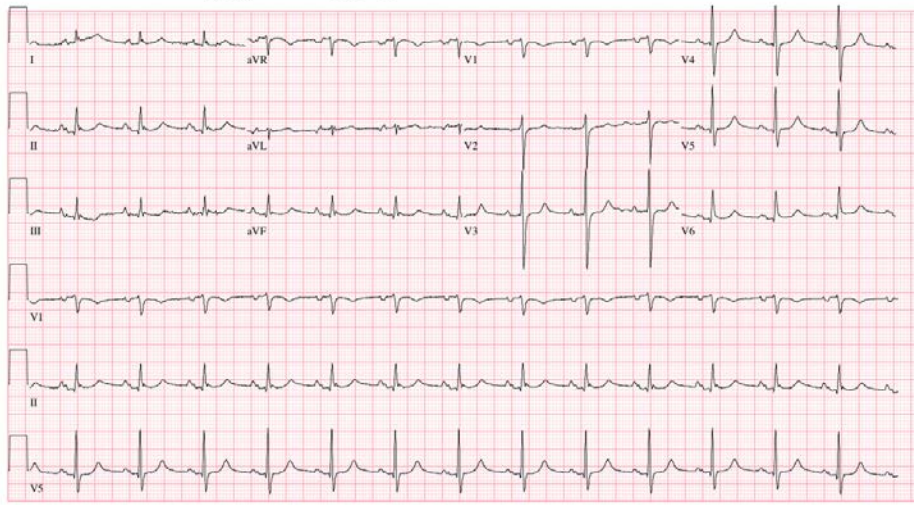


(57 yr)
Vent. rate 73 BPM
PR interval 126 ms
QRS duration 98 ms
QT/QTc 404/445 ms
P-R-T axes 60 40 49
Normal sinus rhythm
Normal ECG

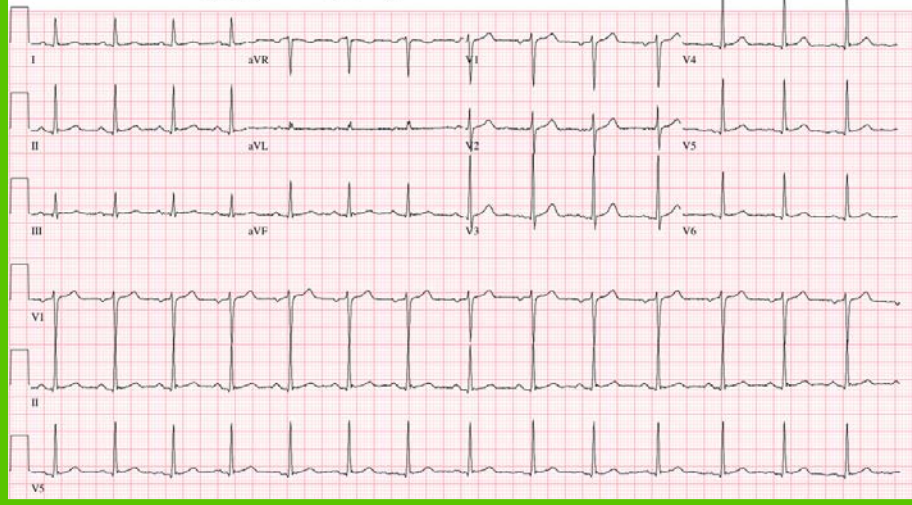


Which One Survived?

Male (80 yr)
Vent. rate 82 BPM
PR interval 164 ms
QRS duration 100 ms
QT/QTc 362/422 ms
P-R-T axes 55 64 46
Normal sinus rhythm
Normal ECG

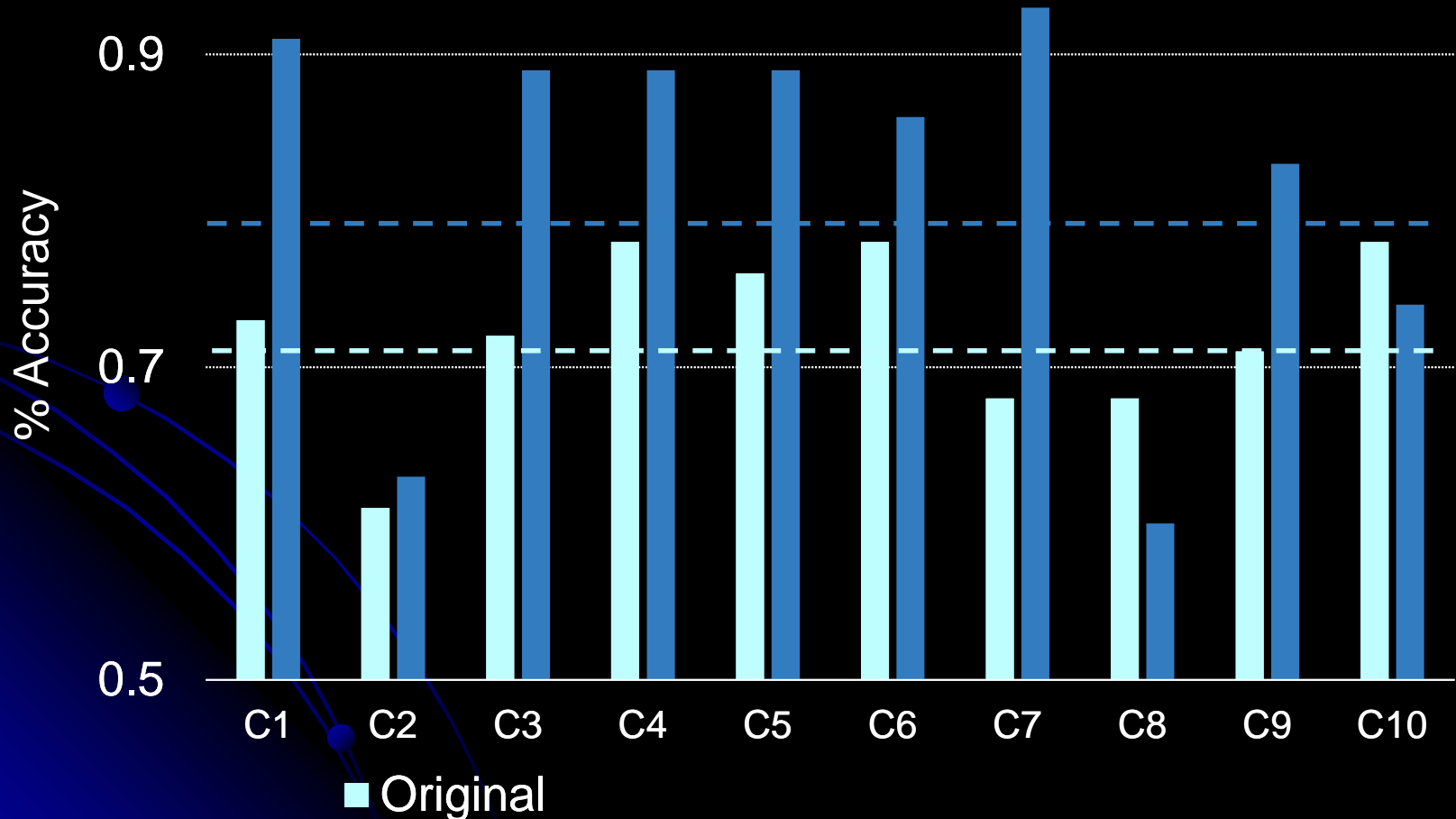


Male (80 yr)
Vent. rate 86 BPM
PR interval 162 ms
QRS duration 84 ms
QT/QTc 360/430 ms
P-R-T axes 58 55 60
Normal sinus rhythm
Normal ECG



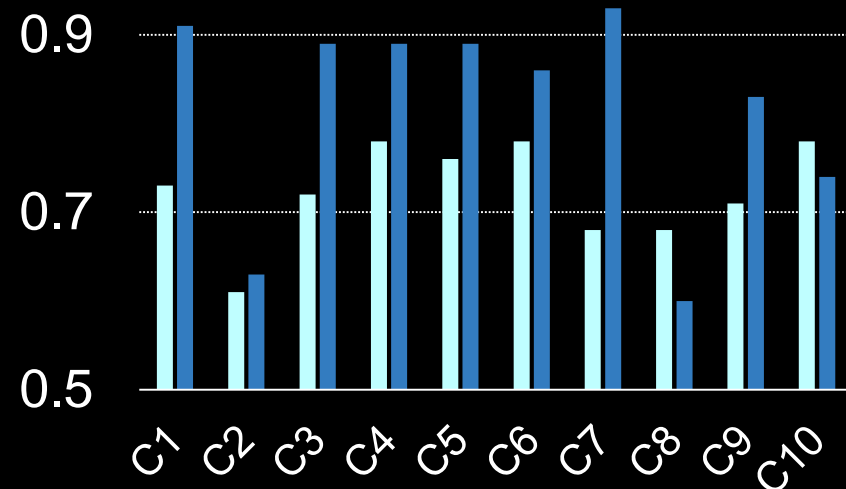
Can 10 Different Cardiologists Learn from the Model?

100 pairs presented with predictions marked



Can 10 Different Cardiologists Learn from the Model?

- Cardiologists can see some features predictive of 1-yr mortality (less than half)
- Can learn from the model
 - 8 /10 cardiologists improved
- Reported features learned:
 - Higher heart rate
 - Poor ECG baseline
 - Slight left atrial enlargement



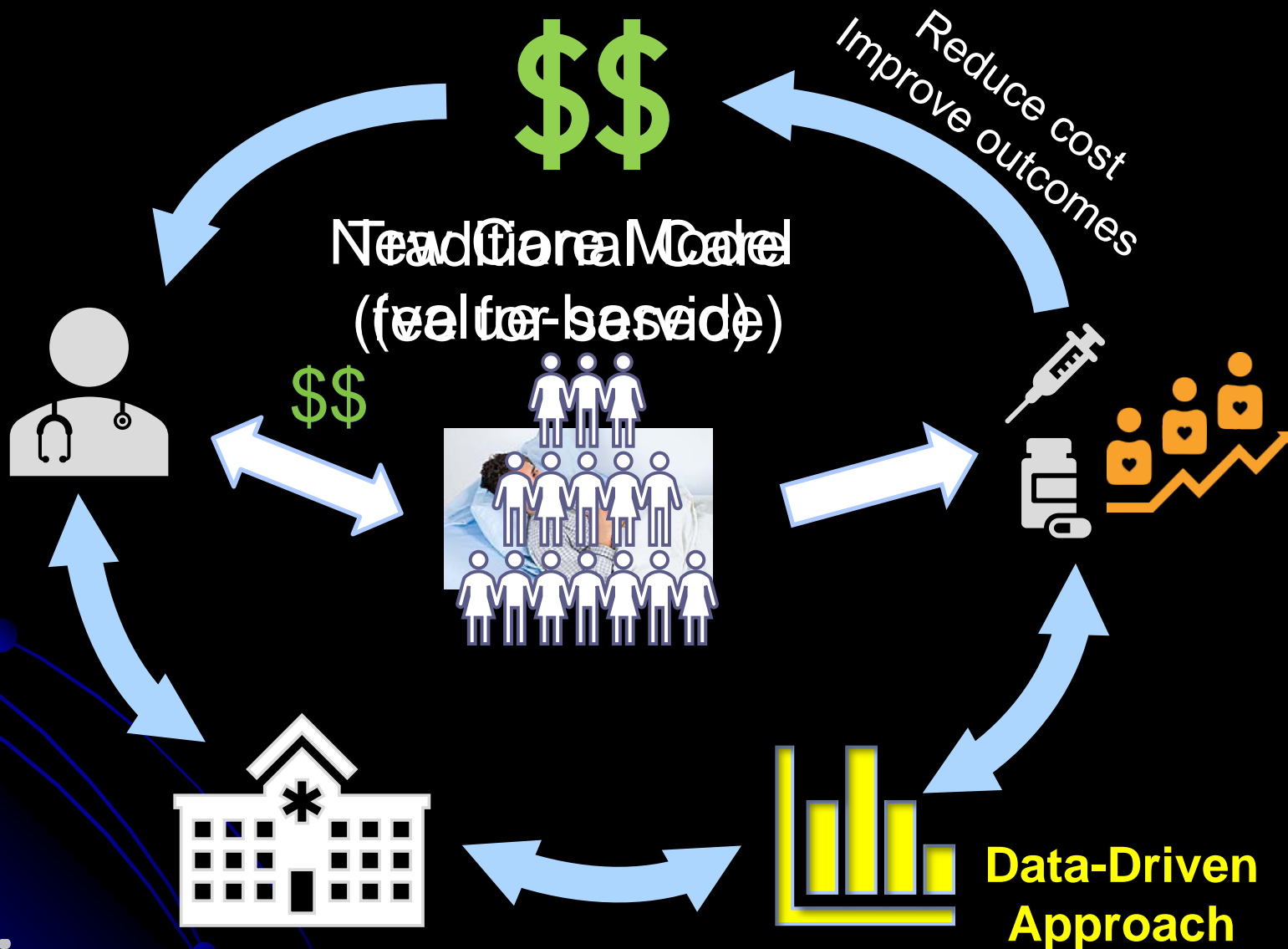
Outline

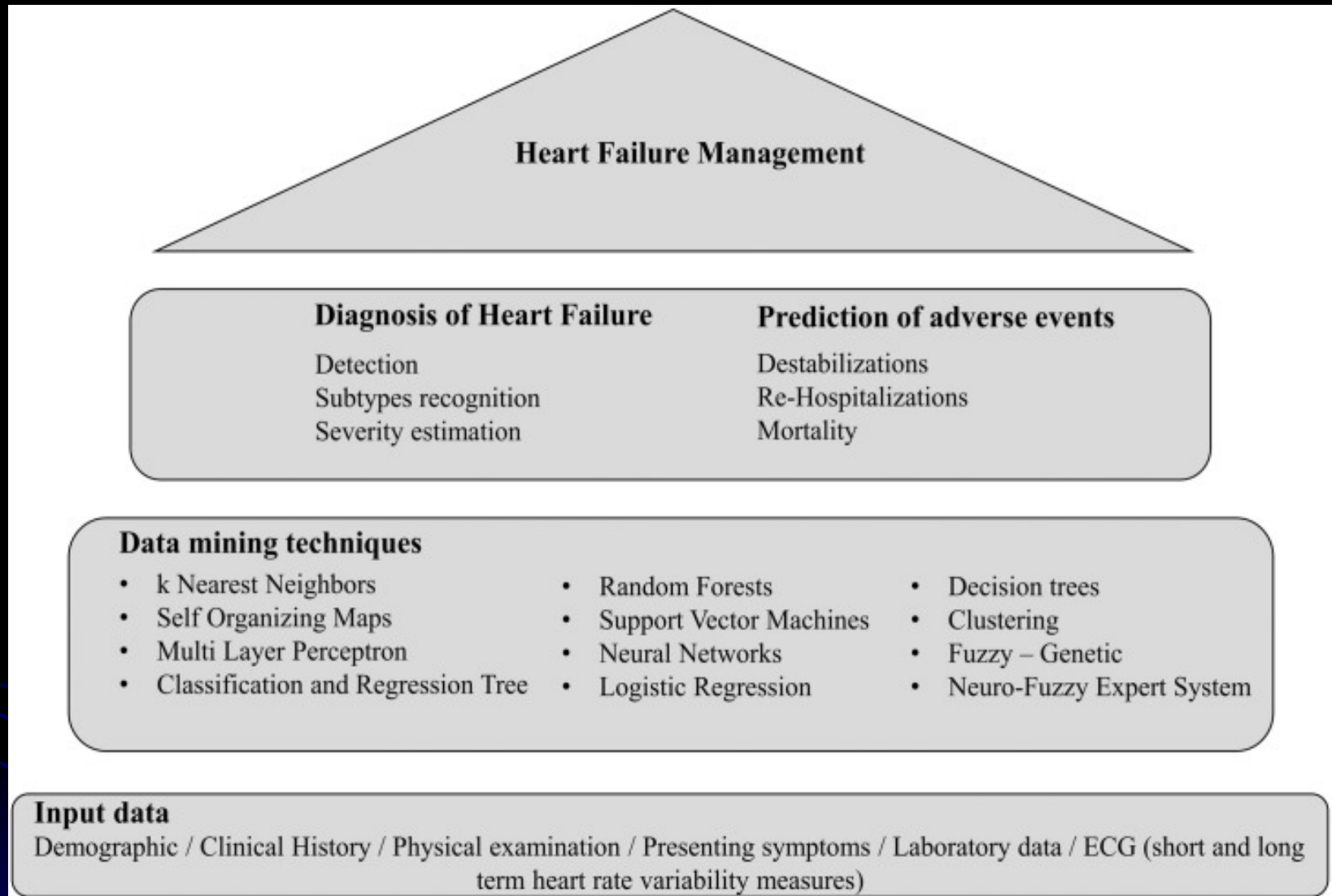
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Heart Failure Population Management



L Jing
PhD





- Previous studies using machine learning show promising results (AUC ~0.6 – 0.9)

Question: How do we drive action with machine learning models?

Answer:

1. Add actionable “care gap” variables

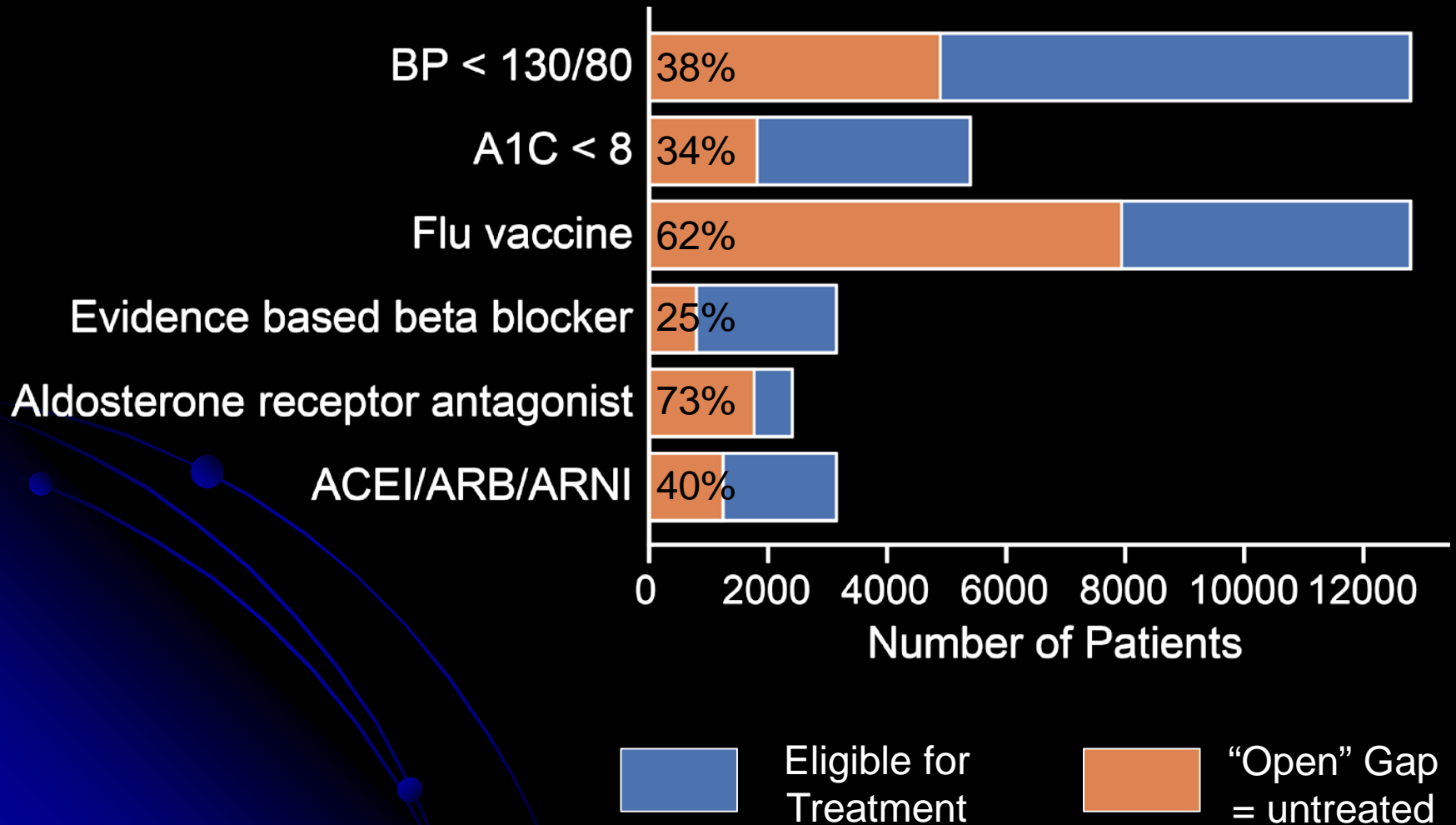
- Example: Flu shot given



2. Model effect of care gaps in retrospect

3. Predict effect of closing gaps prospectively

How Common are the “Open” Care Gaps?



268,096 episodes from ~1.5 million encounters in 26,524 HF patients from Geisinger Electronic Health Records

Demographics (5)

Vital signs (3)

Diagnostic codes (89)

Labs (15)

Medications (2)

Care gaps (6)

Echocardiographic
measurements (44)

ECG measures (9)
and patterns (32)

Machine Learning
Classifiers

- Logistic Regression (LR)
- Random Forest (RF)
- XGBoost (XGB)

Train-by-year
cross-validation

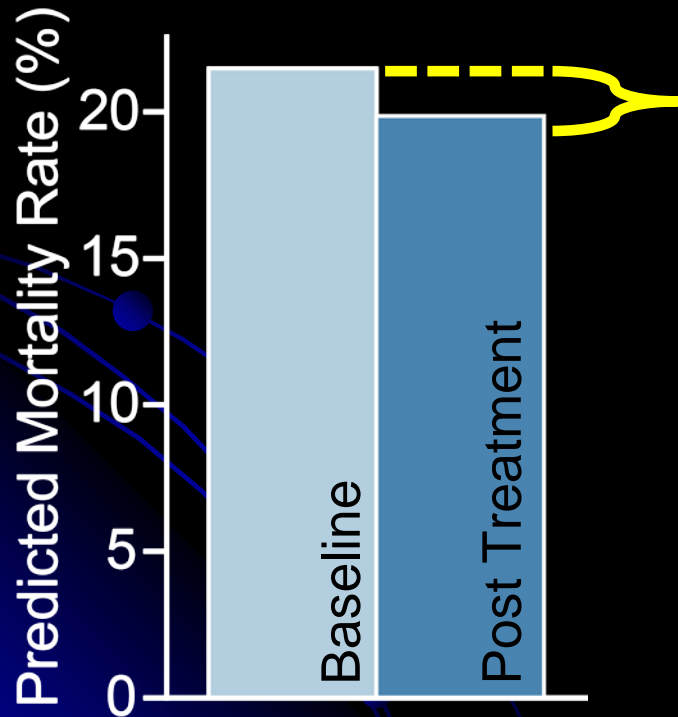


One-year
All-cause mortality

Good model performance: area under the curve (AUC) = 0.77 and 0.78 (hold-out set)

Predicting Effect of Closing Care Gaps

- “Treat” patients by closing care gaps via simulation
 - Re-calculate risk

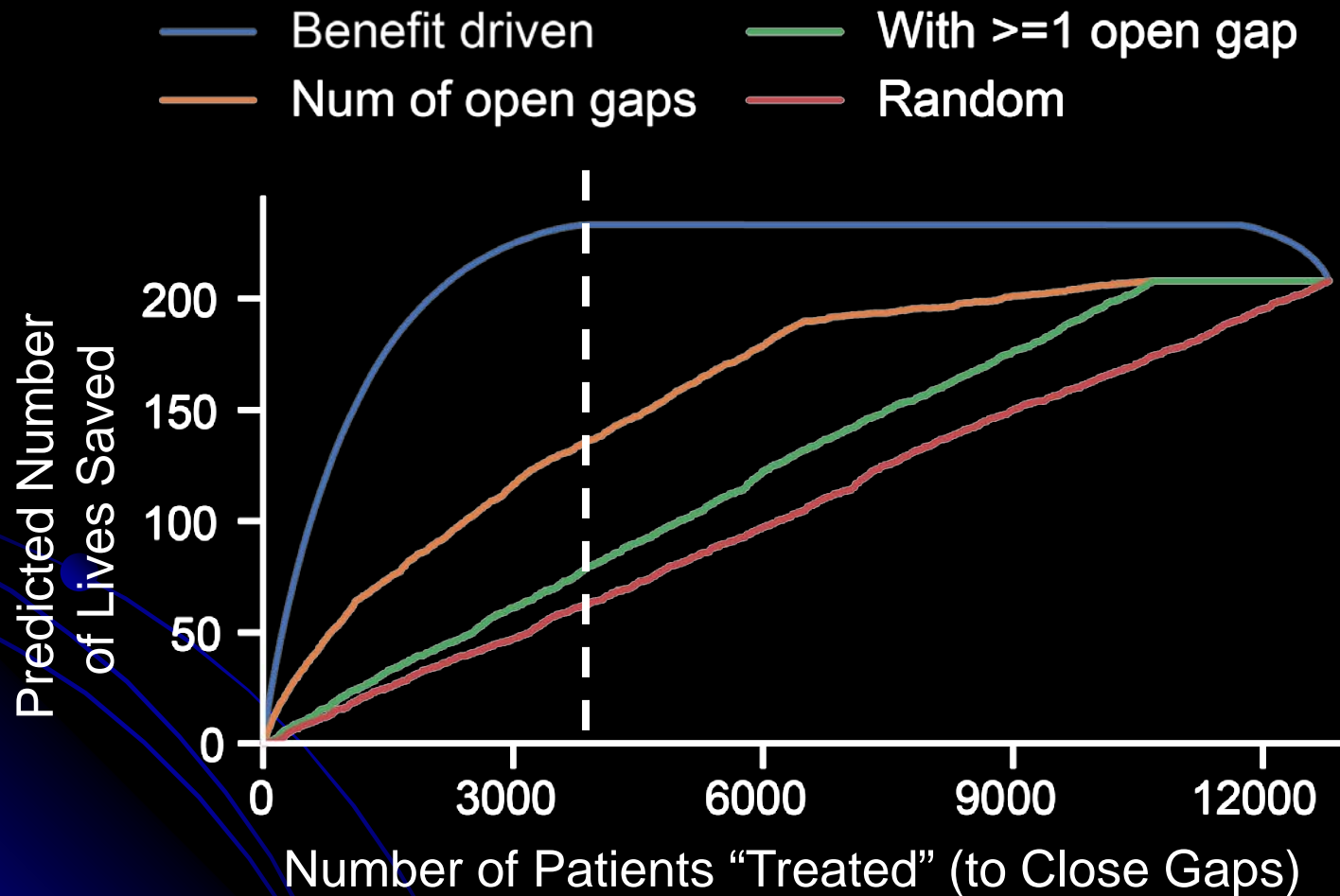


Benefit

= 1.6% mortality risk reduction

= 209 lives saved

Optimized Care Gaps Team Deployment



AIM HI Trial: Artificial Intelligence Managed Heart Failure Intervention

ClinicalTrials.gov Identifier: NCT03804606

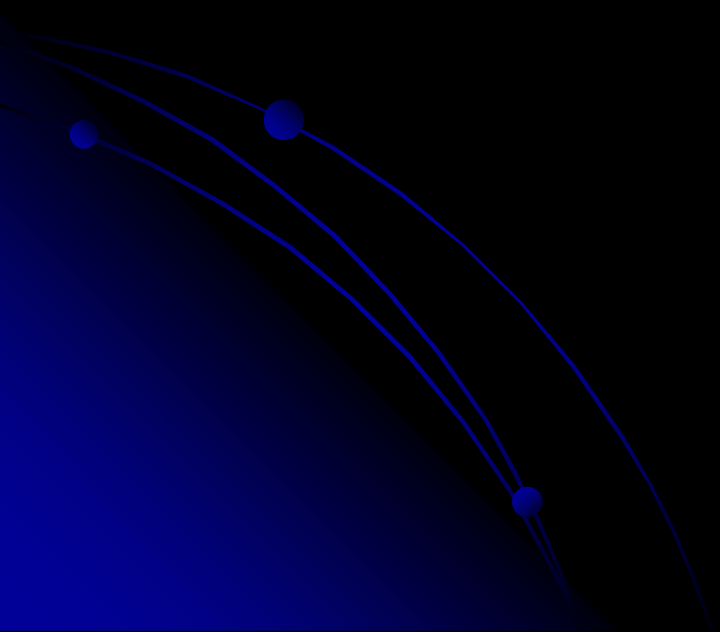


	MTM	Predicted Risk	Predicted Benefit
Group 1	No	High	High
Group 2	Yes	High	High
Group 3	Yes	High	Low

MTM = Medication Therapy Management Pharmacist

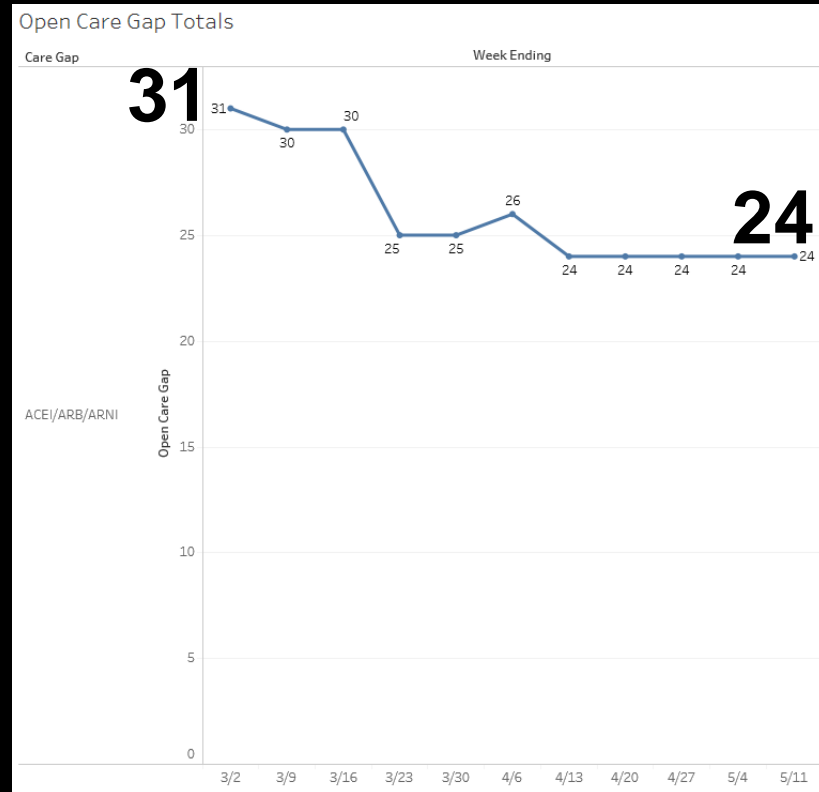
- a Effect of MTM intervention for patients predicted to be high risk and high benefit?
- b Can the model discriminate between patients with high vs low benefit?

First 100 Patients ~March 2019: It's Not Easy.



Care Gap Closure: ACE/ARB/ARNI

Open Care Gaps



March

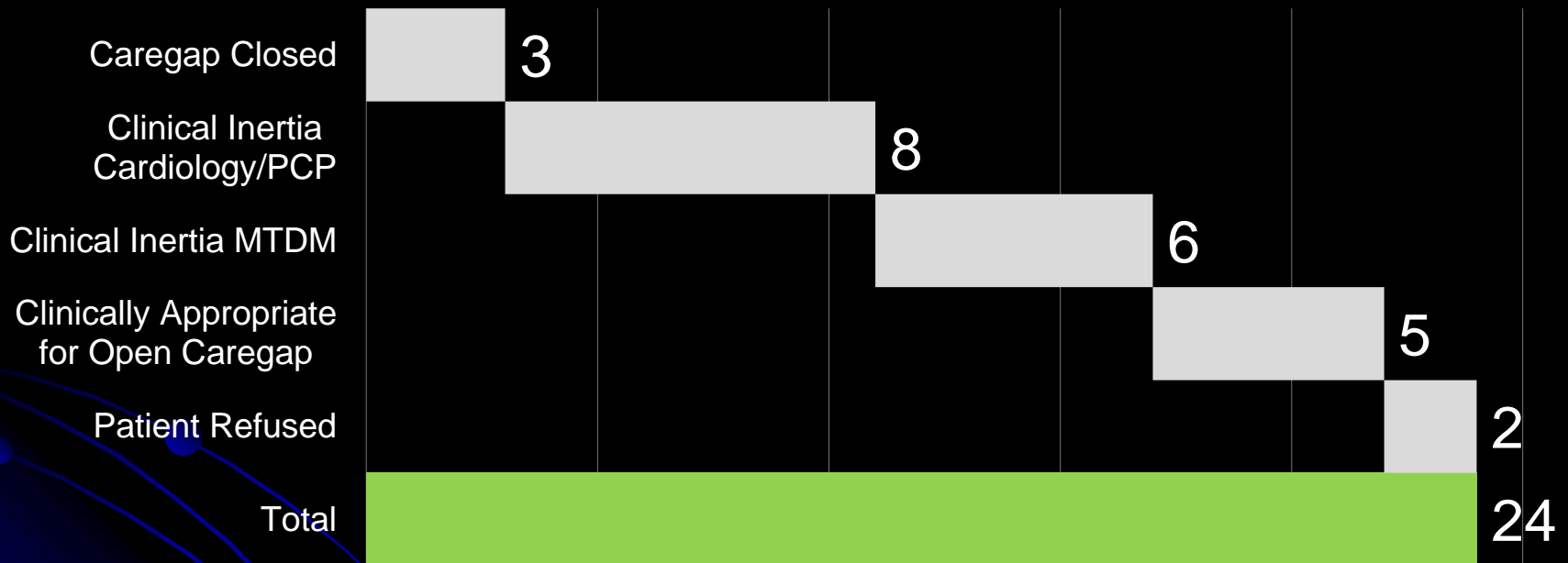
May

Eligibility - Heart Failure with LVEF < 40%

Contraindications - No due to Pregnancy, History of angioedema, Hypotension - SBP < 100 mm Hg (ave. of up to last 5 SBP within last 6 months), Serum creatinine > 2 (in any of preceding 3 readings), Potassium > 5 (in any of preceding 3 readings), Bilateral renal artery stenosis, Hemodialysis, Listed allergy, ACEI/ARB contraindicated on the problem list.

Care Gap Closure: ACE/ARB/ARNI

Why do 24 ACE/ARB/ARNI Caregaps remain open?



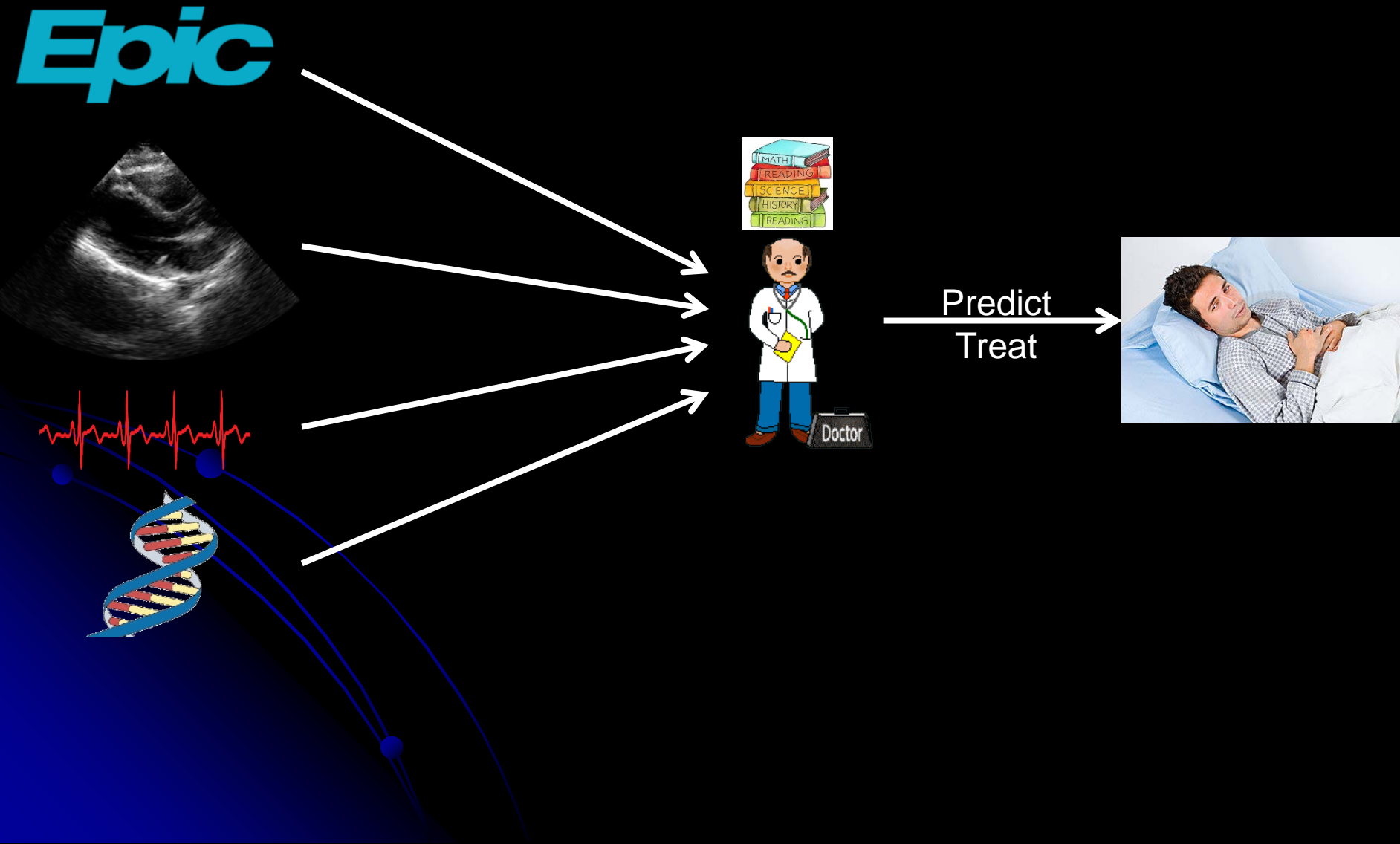
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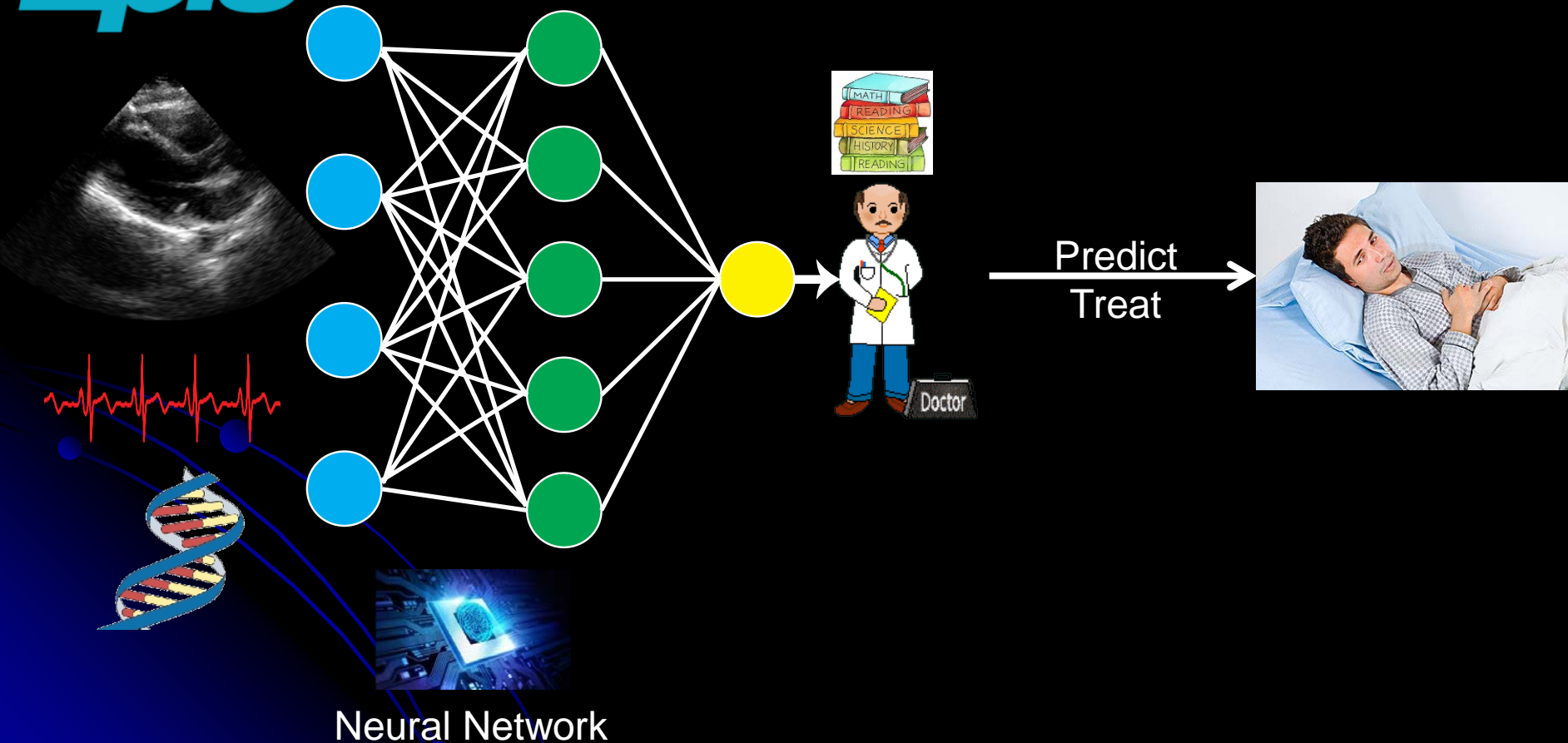
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Cardiology in the PAST



Cardiology in the FUTURE

Epic

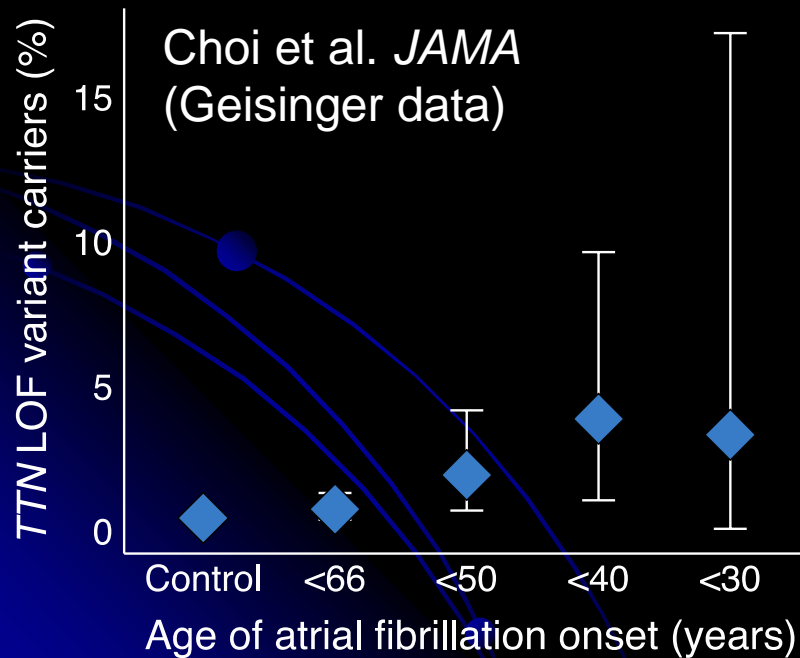


Genomic Inputs to Machine Learning Models

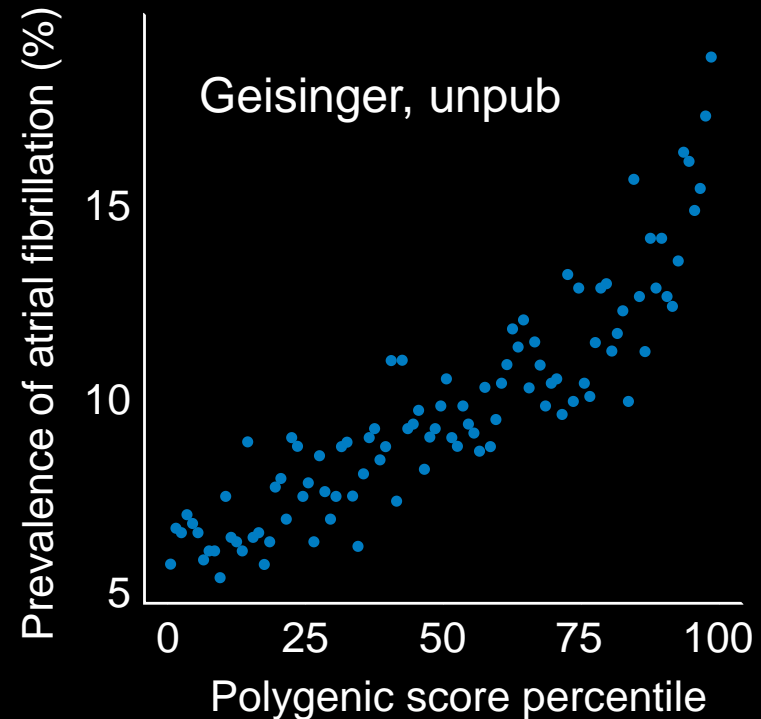


C Haggerty
PhD

Rare Variants



Common Variation



Interpretable Neural Networks for Predicting Mortality Risk using Multi-modal Electronic Health Records

Alvaro E. Ulloa Cerna^{*†}, Marios Pattichis[†], *Senior Member, IEEE*, David P. vanMaanen^{*}, Linyuan Jing^{*}, Aalpen A. Patel^{*‡}, Joshua V. Stough^{**}, Christopher M. Haggerty^{*¶}, and Brandon K. Fornwalt^{*‡¶}

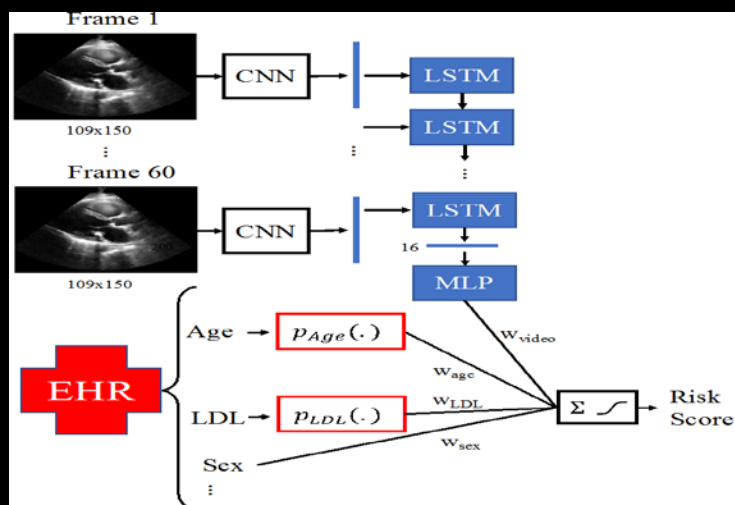
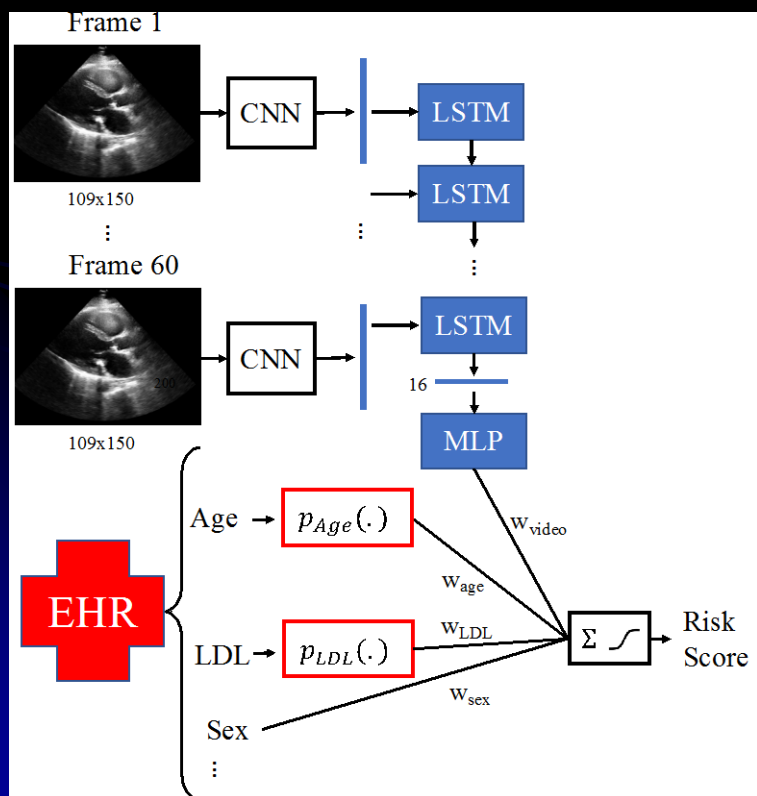
^{*}Department of Imaging Science and Innovation, Geisinger, PA 17822 USA

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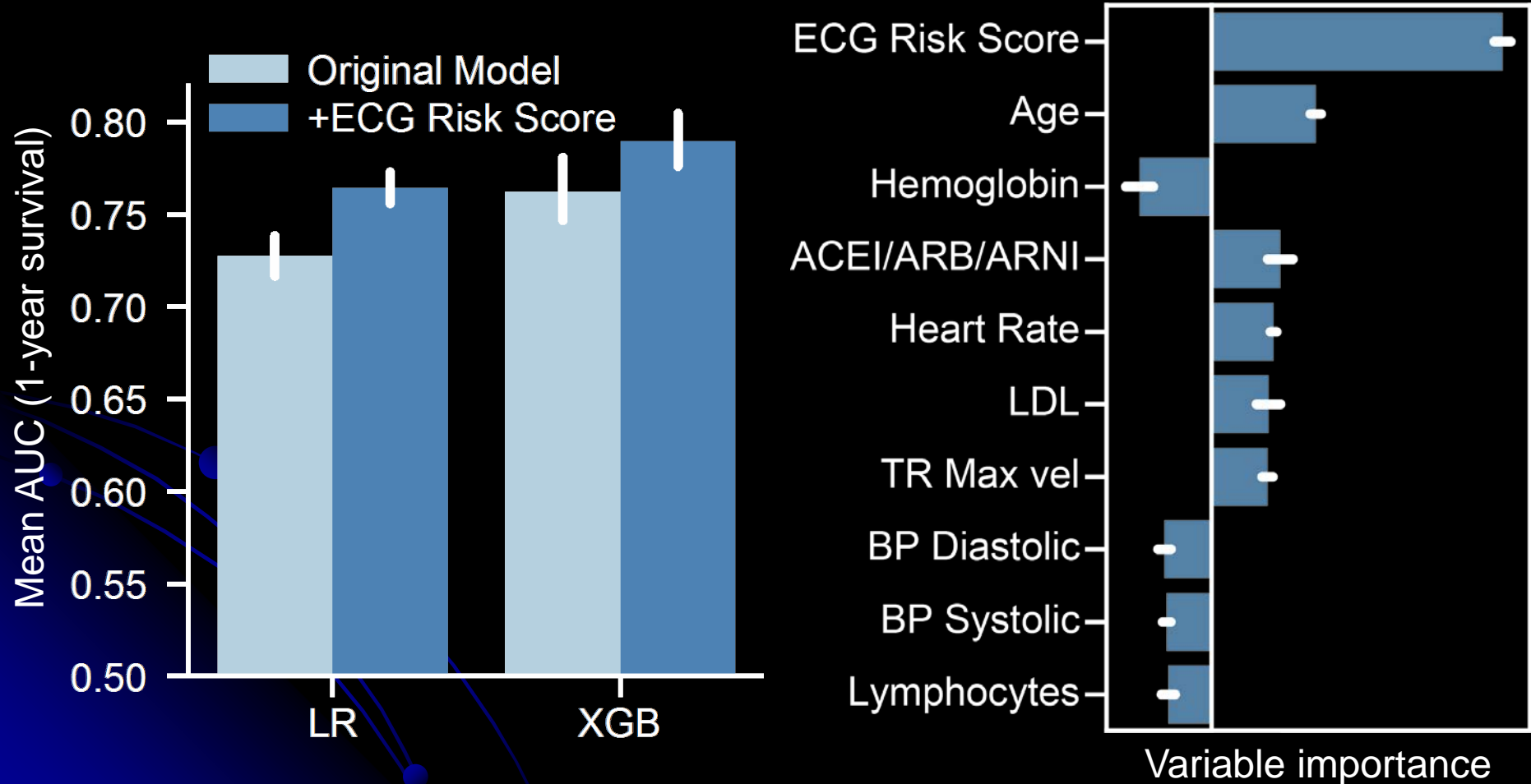


A Ulloa PhD



Heart Failure Multi-Modal Input

Example: ECG Highly Important



Trained classifier on 1.3 Million ECGs

Summary

Large clinical datasets and machine learning will change medicine

- Radiology informatics
- Optimizing predictions from large datasets
- Managing disease populations
- Actionable predictions from complex multi-modal datasets

This is Innovation



But Innovation Often Fails



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“Our team is encouraged to innovate and research topics that will actually impact the way we practice medicine. The data that is available to Geisinger researchers is incredible.”

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