Integrated Care
A Strategic Opportunity for Eye Care

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Disclosures

Ownership Interests
- ECP Advisor Group, LLC

Consultant Fees
- The Kinetix Group
Today’s Discussion

1. Explore factors impacting providers’ strategic considerations for success in today’s/tomorrow’s environment.

2. Understand what integrated care is and why it is a critical strategy for eye care.

3. Learn potential approaches to execute eye care integration.
SWOT

STRENGTHS & WEAKNESSES
- Internal
- Practice-specific dynamics

OPPORTUNITIES & THREATS
- External
- Market conditions / events

SWOT chart
The Internal Environment

The Strengths & Weaknesses
Attributes of Successful Practices

- Collaborative relationships with all healthcare stakeholders
- A “healthy” practice environment
- Strong and sensible group governance
- Exercise of financial discipline
- Service commitment to all stakeholders
- Commitment to planning and execution
- Responsive to changing market dynamics
The External Environment

The Opportunities & Threats
Legislative & Market Forces

Healthcare reform legislation has required ECPs to:

- Increase the amount and quality of reporting
- Produce high patient satisfaction scores
- Manage costs/resources effectively
- Shift from a volume-based model to a value-based model
- Re-engage provider relationships

Consolidation among healthcare stakeholders

Shifting referral patterns

Reduce costs
- Resource allocation
- Waste reduction initiatives
- Value-based rewards

Improve experience
- Improved outcomes
- Patient experience
- Patient engagement
- Patient journey

Improve health of populations
- Patient registry/IRIS
- Diagnostic screenings
- Wellness exams
- EHR implementation
- Data analytics

EHR = electronic health records
IRIS = Intelligent Research in Sight
MACRA - Volume to Value Shift

- All Medicare FFS (Categories 1-4)
- FFS linked to quality (Categories 2-4) - MIPS
- Alternative payment models (Categories 3-4) - APMs

New Health Care Payment Models
- Category 1 – fee for service with no link of payment to quality (current system)
- Category 2 – fee-for-service with a link of payment to quality
- Category 3 – alternative payment models built on fee-for-service architecture
- Category 4 – population-based payment

Source: CMS
2019 MIPS Weighted Categories

Based on 2017 Reporting Period

- Clinic Practice Improvement Activities: 15%
- Advancing Care Information (Meaningful Use): 25%
- Quality (PQRS): 60%
- Resource Use 0% (VBPM) – NEW in 2018
Consolidation Activity

What’s Driving Consolidation?

- Combination of “strong” economy and cheap capital
- Pressure to reduce costs and increase efficiency
- Providers looking to create size needed to negotiate with payers
- Affordable Care Act is driving the pace of change
Shifting Referral Trends - Eye Care

**CURRENT DRIVERS**
- Optometry: 30-40%
- Family/Friends: 20-25%
- Existing Patient: 15-25%
- PCP: 15-20%
- Health Ins: 10-15%
- Online: 5-10%

**FUTURE DRIVERS**
- Health Ins: 40-60%
- PCP: 30-50%
- Existing Patient: 15-20%
- Optometry: 15-20%
- Family/Friends: 10-15%
- Online: 5-10%

- Network participation and PCP recommendation / care coordination will be an increasing determinant of patient access.
- Existing family / friends (i.e. previous cataract patients) will remain consistent opportunity.
- Optometry will have decreased impact on patient access.
- Use of online referral / ratings websites will still be important, but must be targeted toward network & PCP affiliations.
Patient Access Channels
Providers Must Win Share at Two Points of Sale

1. SECURE ENROLLED LIVES

- Network Assembly
  Being chosen by payers, employers, exchange operators, custom network builders, and accountable physician entities to be offered as a network option

2. WIN SHARE OF VOLUMES

- Network Selection
  Being chosen by individuals during plan enrollment

- Care Decision
  Being chosen by patients, referring physicians at the point of care

Source: Health Care Advisory Board interviews and analysis.
A Straightforward Strategic Assessment

Are You Prepared as Health Care Changes?

Is your practice growth strategy specifically designed for the new channels of a health care market, or are you relying on yesterday’s approach for today’s circumstances?
Strategic Considerations for Eye Care Providers

What are the Strategic Opportunities for your practice?
The Key Element: Focus on The Triple Aim

Strategic Initiatives

TRIPLE AIM

Reduce per capita cost of healthcare
- Resource allocation
- Waste reduction initiatives
- Value-based rewards

Improve individual experience of care
- Improved outcomes
- Patient experience
- Patient engagement
- Patient journey

Improve health of populations
- Patient registry/IRIS
- Diagnostic screenings
- Wellness exams
- EHR implementation
- Data analytics
Embrace Value Based Payment / Financial Risk

The Contracting Environment is Changing!

- Risk is / will be transitioning from payers to providers
- Providers are expected to manage populations of patients with risk and for quality
- Pace of transition is accelerating

**Provider Risk**
- Full capitation
- Population bundled payments
- Episode bundled payments
- P4P
- Fee for service

**Health Plan Risk**

Source: Health Care Advisory Board interviews and analysis.
The U.S. Payer Market is Committed to Dramatically Increasing Value-Based Care Reimbursement

GOVERNMENT PLEDGES
Health and Human Services (HHS) Announcement
- HHS announced goals for shifting Medicare business to value-based care payment models - 30% payments by the end of 2016 and 50% payments by the end of 2018
- Medicaid Agencies in numerous states expand managed care options for different populations

ALLIANCE PROMISES
Health Care Transformation Task Force (HCTTF)
- Several major providers and payors formed a nonprofit coalition called the HCTTF
- Each member of the HCTTF has committed to shifting 75% of their business to value-based care

COMMERCIAL COMMITMENTS
United Healthcare
- Made ~$36 billion in value-based care payments in 2014
- Announced plans to increase value-based payments to providers by 20% in 2015 (more than $43 billion)

Blue Cross Blue Shield
- Currently pay $1 out of every $5 of medical claims to value-based programs (~$65 billion)
- Engaged with ~350 local value-based programs nationwide
- Saved ~$500 million as a result of value-based care in 2012

Humana
- 75% percent of their 2 million Medicare Advantage members are cared for through value-based reimbursement models by 2020

Source: Valence Health summary of public statement's and press release from each named organization
What types of arrangements or models does your hospital or your owned medical groups currently have in place? In two years?

<table>
<thead>
<tr>
<th>Arrangement</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Commercial</th>
<th>DTE</th>
<th>PSHP</th>
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</thead>
<tbody>
<tr>
<td>Pioneer ACO</td>
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<td>37</td>
<td>98</td>
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<td>MSSP</td>
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<td>33</td>
<td>50</td>
<td>73</td>
<td>54</td>
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<td>Bundled Pymnts</td>
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<td>37</td>
<td>60</td>
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<tr>
<td>Medicaid contract</td>
<td>37</td>
<td>13</td>
<td>44</td>
<td>12</td>
<td>15</td>
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<tr>
<td>Bundles</td>
<td>50</td>
<td>13</td>
<td>44</td>
<td>12</td>
<td>15</td>
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<tr>
<td>Ins prod - ins admin</td>
<td>50</td>
<td>13</td>
<td>44</td>
<td>12</td>
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<tr>
<td>Ins prod - Shared risk</td>
<td>50</td>
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<td>44</td>
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<td>15</td>
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<tr>
<td>Bundled Pymnts</td>
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<tr>
<td>Direct contract</td>
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<td>44</td>
<td>12</td>
<td>15</td>
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<tr>
<td>Ins prod - Own ins license</td>
<td>50</td>
<td>13</td>
<td>44</td>
<td>12</td>
<td>15</td>
</tr>
</tbody>
</table>

The level of risk for the 1/3 today is low, but growing

Source: AHA 2015 Data Review
## Medicare Targets

Condition and Utilization (Medicare Cost Report, 2013)

<table>
<thead>
<tr>
<th>Driver</th>
<th>APC/DRG</th>
<th>HCPCS</th>
<th>Goal / Solution Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic (I, II)</td>
<td>$1.1B</td>
<td>$11B</td>
<td>Virtual care, triage platforms – app level care</td>
</tr>
<tr>
<td>Inpatient physician care</td>
<td>$7.0B</td>
<td></td>
<td>EBM, Reduce Variability, Clinical pathways, shared decision making</td>
</tr>
<tr>
<td>Joint replacement</td>
<td>$5.0B</td>
<td></td>
<td>Shared decision making, EBM</td>
</tr>
<tr>
<td>Heart Failure (cc and mcc)</td>
<td>$3.5B</td>
<td></td>
<td>Dz management technologies</td>
</tr>
<tr>
<td>Nerve Inj / Spinal Fusion</td>
<td>$2.0B</td>
<td></td>
<td>Shared decision making, EBM</td>
</tr>
<tr>
<td>Ambulance Transport</td>
<td>$2.0</td>
<td></td>
<td>Tiered transport options</td>
</tr>
<tr>
<td><strong>Cataract Surgery</strong></td>
<td></td>
<td>$1.7B</td>
<td>EBM</td>
</tr>
<tr>
<td>PCI</td>
<td>$1.2B</td>
<td></td>
<td>Shared decision making EBM</td>
</tr>
<tr>
<td>COPD</td>
<td>$1.1B</td>
<td></td>
<td>Case finding, Dz management technologies</td>
</tr>
<tr>
<td>Renal Failure</td>
<td>$1.1B</td>
<td></td>
<td>Case finding, shared decision making (peritoneal dialysis)</td>
</tr>
<tr>
<td>Echo / Cardiac Imaging</td>
<td>$1.1B</td>
<td></td>
<td>EBM</td>
</tr>
<tr>
<td><strong>Medical Eye Exam</strong></td>
<td></td>
<td>$1.0B</td>
<td>EBM</td>
</tr>
<tr>
<td>Inpatient Critical Care</td>
<td>$900M</td>
<td></td>
<td>EBM</td>
</tr>
<tr>
<td>Therapeutic Exercise (Rehab)</td>
<td>$900M</td>
<td></td>
<td>Virtual rehab platforms</td>
</tr>
<tr>
<td>Hip and Femur (=replace)</td>
<td>$900M</td>
<td></td>
<td>Shared decision making</td>
</tr>
<tr>
<td>ER (III, IV)</td>
<td>$600M</td>
<td></td>
<td>Triage platforms – app level of care</td>
</tr>
<tr>
<td>MRI</td>
<td>$423M</td>
<td></td>
<td>EBM</td>
</tr>
<tr>
<td>Sleep</td>
<td>$267M</td>
<td></td>
<td>Mobiel sleep study technologies</td>
</tr>
<tr>
<td>Medication</td>
<td></td>
<td></td>
<td>Equivalencies, generics, incentives, formulary</td>
</tr>
<tr>
<td>Behavioral Health (A)</td>
<td></td>
<td></td>
<td>Less intensive / virtual platforms</td>
</tr>
<tr>
<td>Care Gaps (A)</td>
<td></td>
<td></td>
<td>Vision plus partners</td>
</tr>
<tr>
<td>End-Of-Life</td>
<td>Big</td>
<td></td>
<td>Shared decision-making, intense education, hospice services</td>
</tr>
</tbody>
</table>

*A = Aggravating or proximate cause*
Value Based Payment Requires Clinical Integration

**VALUE-BASED PAYMENT REQUIRES COORDINATED CARE**

To serve a defined population to achieve required clinical outcomes and cost efficiencies

**COORDINATED CARE REQUIRES CLINICAL INTEGRATION**

To link (eye care) providers across all service levels (primary, subspecialty, surgical eye care with primary care medicine chronic disease management) and across a regional geographic area that can meet a payer network adequacy requirements.
What is Clinical Integration?

Clinical Integration is an active ongoing program to evaluate and modify the clinical practice patterns of the health care providers who participate in a network so as to create a high degree of interdependence and cooperation among the network's participants to control costs and ensure quality.

A network that undertakes a program of clinical integration must include one or more of the following features:

- **Methods for collecting and analyzing performance**, based on utilization, cost and/or quality on an individual and aggregate basis.
- The development and use of **performance standards** along with a system to enforce such standards.
- Use of **electronic health record system** to facilitate exchange of health information across the network of providers.
- Use of **evidenced based medicine** to establish evidence based guidelines for support of clinical decision making and treatment.
Isolated Practice or Clinical Integration?

**CONSEQUENCES**

- **Lose access** to patients due to exclusion by narrow networks and selective contracts
- **Lose revenue** from cuts in payment and limits to visit and procedure frequency

**BENEFITS:**

- **Protect and expand** referral sources from community providers and patients
- **Secure status** on payer networks because of documented improved clinical outcomes from coordinated care

Fail to act and face real threats that endanger the isolated provider.

Embrace the clinical integration model that government, payers and patients are demanding.
Understand Local Market Providers

- Once you have seen one health system or provider organization, you have (really) only seen one…

- There are incredible differences within these organizations in the following areas:
  - Resources
  - Competitive factors
  - Risk management experience
  - Market payor characteristics
  - “Attitude”

- And…
  - Optimization of CARE DELIVERY
Understand / Align with Payer & Health System Strategic Imperatives

- HEDIS Score Improvement
  - Enhanced reporting capabilities (Comprehensive Diabetes Care metric)
- Economic Benefit
  - 33% of CMS Star rating - measured from HEDIS Score measures.
  - Plans scored / paid based by CMS on Star Ratings
- Administrative Improvements
  - Enhanced workflows and technological options
- Direct Scheduling Requests
  - Improve patient engagement (diabetic exams, reminders, alerts)
- Patient Education
  - Standardized materials on (diabetic-related eye) conditions, symptoms, treatments.
- Standardized / Centralized Communications
  - Single point of contact
  - Standardized reports
“There is a significant need for a population-based reporting solution. For example, when it comes to HEDIS, we pretty much have an open check book right now.”

- Quote

Senior leadership at United Healthcare
### Medicare Advantage

“To Succeed with MA, Ascension and its physician partners need to work together to strengthen core capabilities”

<table>
<thead>
<tr>
<th>RATIONALE</th>
<th>BEST IN CLASS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stars</strong></td>
<td><strong>4+ Stars for all provider controlled measures</strong></td>
</tr>
<tr>
<td>• 4+ Stars add 5% revenue to payers and tilt economics significantly</td>
<td>• Continuous tracking of all Star measures</td>
</tr>
<tr>
<td>• Bonus results in greater provider upside</td>
<td>• Action plans to address gaps</td>
</tr>
<tr>
<td><strong>Risk Coding</strong></td>
<td><strong>Activates to improve retro- and prospective risk coding</strong></td>
</tr>
<tr>
<td>• Higher risk scores provide payers with higher revenue</td>
<td>• Up-and down-side risk sharing and capitated payments, with tools to support providers in managing risk</td>
</tr>
<tr>
<td>• This results in greater provider revenue for more complex patients</td>
<td><strong>Medical management</strong></td>
</tr>
<tr>
<td><strong>Risk-sharing with providers</strong></td>
<td><strong>Comprehensive medical management systems (eg, evidence-based protocols, high utilizer program, embedded care managers in all PCP practices)</strong></td>
</tr>
<tr>
<td>• Overall market trend toward up-and-down-side risk sharing and/or capitated arrangements</td>
<td><strong>Medical management</strong></td>
</tr>
<tr>
<td>• Required to effectively manage total cost of care and deliver superior quality and clinical outcomes</td>
<td><strong>Best in Class</strong></td>
</tr>
</tbody>
</table>

**RATIONALE BEST IN CLASS**

- To Succeed with MA, Ascension and its physician partners need to work together to strengthen core capabilities.
Strategic Opportunity

Integrate Eye Care
Integrated Eye Care

Bring eye care into population health management, effectively increasing patient screenings, diagnosis, and treatment for ocular disease.

KEY STAKEHOLDERS

- Patients
- Primary Care Physicians
- Health Systems / ACOs
- Payors
- Ophthalmologists
- Optometrists
Eye Care Providers (ECPs) Play Critical Role

• ECP routine services in a comprehensive eye examination helps patients:
  ▫ Continue in wellness
  ▫ Identify risk factors associated with chronic disease
  ▫ Manage diagnosed medical conditions.

• People often visit their ECP more frequently than their PCP\(^1\), so ECPs have the opportunity to be gatekeepers to health.

• UnitedHealthcare found that ECPs were effective in identifying patients with diabetes, high cholesterol, hypertension, juvenile rheumatoid arthritis and multiple sclerosis.

• In a May 2013 study, UHC reported that eye exams were effective in re-engaging patients in needed healthcare.
  ▫ The study followed 2,300 UHC members and identified those with chronic conditions who had not sought care within the past 18 months.
  ▫ 33% of these patients made an appointment with a specialty physician or primary-care doctor within 60 days of an optometrist visit and another 24% were engaged after 60 days.

\(^{1}\) Vision Care: Focusing on the Workplace Benefit, Fall 2008
Eye Care Practitioners can play a critical role in care coordination of chronic conditions.

Identification of high-impact diseases
Diabetes as the Starting Point for Horizontal Integration of Eye Care and Specialty Referrals

1. Diabetes
2. Glaucoma
3. Cataract / Other Eye Related Disease

Prioritized at risk patient population with ACOs, Health Systems, PCPs, etc.

Strength of relationship with PCP groups, ACOs, & health systems
Diabetes is a costly condition that affects millions across the US:

- Approximately 86 million people in the United States have prediabetes, and more than 47 million Americans have metabolic syndrome [7,8]
- In 2012, there were 1.7 million new cases of diagnosed diabetes among people aged 20 years or older [9]
- In 2012, 29.1 million Americans, or 9.3% of the population, had diabetes [9]
- 8.1 million people or 27.8% of people with diabetes are undiagnosed [10]
Eye Care Disease Prevalence Among Diabetes Patients

Vision loss due to diabetes is associated with major depression.\textsuperscript{17}

Hearing loss is higher among individuals with diabetic retinopathy.\textsuperscript{24}

Worsening diabetic retinopathy is associated with elevated diastolic blood pressure.\textsuperscript{19}

Diabetic retinopathy is associated with early kidney disease - Albuminuria.\textsuperscript{22}

New research is showing an association between Alzheimer’s disease and Amyloid β Signature in the lens and retina.\textsuperscript{25}

Diabetic retinopathy is associated with periodontal disease.\textsuperscript{18}

Retinal plaque signals obstructive vascular disease of the heart or carotid artery.\textsuperscript{23}

65% of individuals with diabetic vision impairment could achieve normal vision with an eye exam and new glasses, reducing falls leading to fractures.\textsuperscript{20}

Signs of diabetes detected in the eye are associated with peripheral neuropathies of the foot and foot ulcers.\textsuperscript{22}

Reduced corneal sensitivity, dry eye, and ocular muscle palsies are early indicators of diabetes and associated neuropathies.\textsuperscript{21,22}
### Financial Implications for Diabetes and Eye Disorders

<table>
<thead>
<tr>
<th>Condition</th>
<th>Cost (B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td>$112.3B</td>
</tr>
<tr>
<td>Cancers</td>
<td>$86.6B</td>
</tr>
<tr>
<td>Emotional Disorder</td>
<td>$77.2B</td>
</tr>
<tr>
<td>Pulmonary Conditions</td>
<td>$72.6B</td>
</tr>
<tr>
<td>Eye Disorders</td>
<td>$66.8B</td>
</tr>
<tr>
<td>Hypertension</td>
<td>$55.8B</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$48.8B</td>
</tr>
<tr>
<td>Stroke</td>
<td>$22.2B</td>
</tr>
</tbody>
</table>

Of the $66.8 billion in costs associated with eye disorders, approximately $31 billion can be associated with vision problems among diabetes patients.

**Cost Source:** Cost of Vision Problems: The Economic Burden of Vision Loss and Eye Disorders in the U.S., 2013, Prevent Blindness America. Cost based on 2011 U.S. population (all ages) and in 2013 dollars. “Physical disorders” include conjunctivitis, disorders of the eyelids and lacrimal system, disorders to the globe, injuries and burns to the eye, and strabismus.

**Prevalence Source:** Vision Problems in the U.S., 2012, Prevent Blindness America and National Eye Institute. Prevalence based on 2010 U.S. Census data, in which 142.6 M Americans were ≥ age 40.
Critical Risks in Diabetes Management: ER Visits

EMERGENCY ROOM / DEPARTMENT VISITS

Of 560 visits to an accident and emergency department, 38% could have been managed by an OD outside a hospital setting. [3]

<table>
<thead>
<tr>
<th>Treat and Release: 57.9%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approximately 57.9% of all diabetes related ER visits were treat and release. [4]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diabetes ER Related Visits: 12.1M</th>
</tr>
</thead>
<tbody>
<tr>
<td>In 2010, there were approximately 12.1 million diabetes-related ER visits for adults aged 18 years or older (515 per 10,000 U.S. population), or 9.4% of all ER visits. [5]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Average ER Visit: $750</th>
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</thead>
<tbody>
<tr>
<td>The average Emergency Room (ER) visit costs about $750. [6]</td>
</tr>
</tbody>
</table>
Diabetes Patients Have a Higher Risk of Prominent Eye Conditions and Blindness

Diabetic patients are

- 40% more likely to have glaucoma \[^{12}\]
- 60% more likely to develop cataracts, and at an earlier age \[^{12}\]

186K

Diabetes-related ED visits for eye complications in 2010 \[^{14}\]

Diabetic retinopathy accounts for approximately 12% of all new cases of blindness each year \[^{13}\]

The estimated prevalence of diabetic retinopathy and vision-threatening diabetic retinopathy was \[^{16}\]

28.5% and 4.4%
## Example - Quality Performance Improvement

### 2015 Quality Performance Results Table

<table>
<thead>
<tr>
<th>Measure number</th>
<th>Measure Name</th>
<th>2015 reporting period</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>ACO Performance Rate</td>
<td>Mean performance rate (SSP-ACOs)</td>
<td></td>
</tr>
<tr>
<td>ACO-1</td>
<td>CAHPS: Getting Timely Care, Appointments, and Information</td>
<td>83.86</td>
<td>80.61</td>
<td></td>
</tr>
<tr>
<td>ACO-2</td>
<td>CAHPS: How Well Your Providers Communicate</td>
<td>93.78</td>
<td>92.65</td>
<td></td>
</tr>
<tr>
<td>ACO-3</td>
<td>CAHPS: Patients’ Rating of Provider</td>
<td>92.83</td>
<td>91.94</td>
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<tr>
<td>ACO-4</td>
<td>CAHPS: Access to Specialists</td>
<td>86.10</td>
<td>83.61</td>
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<tr>
<td>ACO-5</td>
<td>CAHPS: Health Promotion and Education</td>
<td>64.83</td>
<td>59.06</td>
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<tr>
<td>ACO-6</td>
<td>CAHPS: Shared Decision Making</td>
<td>79.64</td>
<td>75.17</td>
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<tr>
<td>ACO-7</td>
<td>CAHPS: Health Status/Functional Status</td>
<td>73.48</td>
<td>72.30</td>
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</tr>
<tr>
<td>ACO-34</td>
<td>CAHPS: Stewardship of Patient Resources*</td>
<td>23.66</td>
<td>26.87</td>
<td></td>
</tr>
<tr>
<td>ACO-36</td>
<td>All-Cause Unplanned Admissions for Patients with Diabetes*</td>
<td><strong>49.05</strong></td>
<td>54.60</td>
<td></td>
</tr>
<tr>
<td>ACO-38</td>
<td>All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions</td>
<td>54.37</td>
<td>62.92</td>
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</tr>
<tr>
<td>ACO-39</td>
<td>Documentation of Current Medications in the Medical Record*</td>
<td><strong>32.02%</strong></td>
<td>84.07%</td>
<td></td>
</tr>
<tr>
<td>ACO-16</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up</td>
<td><strong>59.94%</strong></td>
<td>71.15%</td>
<td></td>
</tr>
<tr>
<td>ACO-21</td>
<td>Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented</td>
<td><strong>31.74%</strong></td>
<td>70.04%</td>
<td></td>
</tr>
<tr>
<td>ACO-27</td>
<td>Diabetes Mellitus: Hemoglobin A1c Poor Control</td>
<td><strong>18.50%</strong></td>
<td>20.38%</td>
<td></td>
</tr>
<tr>
<td>ACO-41</td>
<td>Diabetes: Eye Exam*</td>
<td><strong>31.35%</strong></td>
<td>41.05%</td>
<td></td>
</tr>
</tbody>
</table>

CAHPS = Consumer Assessment of Healthcare Providers and Systems, PQI = Prevention Quality Indicator, LVSD - left ventricular systolic dysfunction, ACE = angiotensin-converting enzyme, ARB = angiotensin receptor blocker, CAD = coronary artery disease.

* = Measure required beginning Reporting Year 2015
N/A = Reporting on the depression remission measure is not required for 2015, as indicated by N/A

ECP ADVISOR GROUP
Integrated Eye Care Model

Concept and Function
Eye Care Network

1. Single point of contact for all primary & specialty eye care needs
2. Care coordination, referral management
3. Clinical protocols, outcome development, analysis/reporting
4. Quality benchmarks, care management goals
5. Patient education, chronic disease identification/monitoring
6. MSO services, provider credentialing
Eye Care Network - Critical Needs

- Physician leadership
- Legal entity approach
- Clear financial model
- Performance improvement
- IT
- Contracting flexibility
- Participation criteria
ECN – Business Model

Full Service Provider Platform

EYE CARE NETWORK

Eye Care Integrated Business Entity
- Corporate structure (LLC, JV, MSO, IPA)
- Services:
  - MSO
  - Contracting
  - Credentialing
  - Referral Management
  - Fee Management
  - Care Coordination
- Non exclusive
- Not a medical entity

Healthcare System/PCPs

OPH OD
OPH OD
OPH OD
OPH OD
Potential Financial Models

1. **Healthcare System/PCPs**
   - Payment for ECP services

2. **Eye Care Network**
   - Patient Management System
   - Licensing fee for IT
   - ECPs (MD / OD)

3. **Eye Care Network**
   - Collection Agency / MSO
   - Fees for MSO / IT services
   - Payment for ECP services
   - ECPs (MD / OD)

4. **Equity Shares (Limited Partnership)**
   - Payment for ECP services
   - Fees for MSO / IT services
   - ECPs (MD / OD)
People with diabetes do have a higher risk of prominent eye conditions and blindness than people without diabetes. Prevalent diseases include:

- Diabetes
- Coordinator

**HEALTH CARE SYSTEM**

- Patient referral
- Diabetes Coordinator
- Patient alerts

**EYE CARE INTEGRATION ENTITY**

- Patient scheduling
- Eye Care Coordinator
- Patient summary report

**EYE CARE NETWORK**

- OPHs/ODs

An integrated / coordinated referral network all while maintaining patient choice.
Referral Workflow: SoC to ECP

Coordinator sends letter to the patient

Did the patient answer one of the first 3 phone calls?

Coordinator schedules appointment with PCP/Diabetic Specialist

Coordinator observes the list of patients and commences their outreach process through a telephone call

Coordinator identifies patient population that has not received an eye screening within the past year

Is an annual diabetic eye screening required?

Coordinator commences diabetes outreach process

Has the patient seen by their PCP/Diabetes Specialist within the last 3-6 months?

PCP/Diabetes Specialist completes appointment with patient

PCP/Diabetes Specialist shares patient education materials with patient

PCP/Diabetes Specialist addresses importance of diabetes health maintenance

PCP/Diabetes Specialist provides patient the notes

Referral form completed for Eyecare Center

Requests that healthcare system coordinator updates the patient record

Coordinator documents this as such and communicates with the healthcare coordinator

Coordinator identifies why the exam was incorrectly identified as necessary

Has the patient received their annual eye exam?

Eyecare Coordinator verifies that they need this eyecare exam

Eyecare Coordinator receives referral document to eyecare network

Coordinator sends letter to the patient

Resource Key:
1. Telephone outreach script
2. Outbound letter
3. PCP/Diabetes Specialist Script
4. Patient Education Resources
5. Patient Facing videos
6. Referral Template
Patient Summary Workflow: ECP to SoC

Resource Key
1. ECP Provider Script
2. Patient Education Resources
3. Patient facing videos
4. Patient Summary Report Template

*Common Conditions Causing Emergent Referrals
1. High Blood Glucose (AIC)
2. Hypertension
3. High Cholesterol Level
4. Kidney Disease
5. Severe Eye Complications
6. Severe Skin Complications

No immediate actions needed
Does the patient require further actions?

Coordinator refers as needed
Coordinator refers to nephrologist
Coordinator refers to podiatrist
Coordinator refers to dentist

Healthcare System coordinator receives patient level information
Program Resources
Supporting the Diabetes Patient and Integrated Care Team
(Illustrative)
Leverage Technology…

• Referral Management
• Information Exchange
• Data Analytics & Reporting
Referral Management

PCP makes a referral...

Eye Care Provider gets an APPOINTMENT

EHR-agnostic Platform

Patient has confirmed APPOINTMENT
Care Coordination
Tracking Program Success

Key Performance Indicators

Identify key performance metrics and collect / analyze key metrics to demonstrate program success.

• Partnership Measurement
  – Number of patient referrals
    • By referring provider
    • By plan type
  – Number of completed patient visits
    • Number of emergent issues
  – Patient self management

• ECP Network Measurement
  – Incremental revenue gains
    • By eye care provider
    • By disease / service line
## Integration Alignment – MIPS

### Potential Quality (PQRS) Measurements
IRIS Registry and EHR data - 14 Measures
60% of Total Score

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes: HgA1c Poor Control</strong></td>
<td>Closing the Referral Loop: Receipt of Specialist Report</td>
</tr>
<tr>
<td>Documentation of Current Medications</td>
<td>Pneumonia Vaccination Status</td>
</tr>
<tr>
<td><strong>Diabetes: Eye Exam</strong></td>
<td>Cataract: Complications within 30 days</td>
</tr>
<tr>
<td>Cataracts: 20/40 or better VA within 90 days</td>
<td>Preventive Care and Screening of Tobacco Use</td>
</tr>
<tr>
<td><strong>Diabetic Retinopathy: Communication with PCP</strong></td>
<td>POAG: Optic Nerve Evaluation</td>
</tr>
<tr>
<td>Preventive Care and Screening: Influenza Immunization</td>
<td>Use of High-risk Medications in the Elderly</td>
</tr>
<tr>
<td><strong>Diabetic Retinopathy: Severity and +/- Edema</strong></td>
<td>Falls: Screening for Fall Risk</td>
</tr>
</tbody>
</table>
## Integration Alignment – MIPS

### Potential Advancing Care Information (ACI - MU) Measurements
25% of Total Score

<table>
<thead>
<tr>
<th>Base score (pass or fail)</th>
<th>Performance – optional points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Security risk analysis</td>
<td>Provide electronic access via patient portal</td>
</tr>
<tr>
<td>E-prescribing (1 prescription written)</td>
<td><strong>Patient specific education (handouts)</strong></td>
</tr>
<tr>
<td>Patient portal (1 patient views)</td>
<td><strong>Secure messaging</strong></td>
</tr>
<tr>
<td><strong>Health information exchange (1 electronic transfer of care summary)</strong></td>
<td>Send/Receive Secure Patient Message</td>
</tr>
<tr>
<td></td>
<td><strong>Health Information Exchange (NG Share)</strong></td>
</tr>
<tr>
<td></td>
<td>Medication reconciliation</td>
</tr>
<tr>
<td></td>
<td>Immunization registry reporting</td>
</tr>
</tbody>
</table>
Integration Alignment – MIPS

<table>
<thead>
<tr>
<th>Potential Practice Improvement Activities/Measurements</th>
</tr>
</thead>
<tbody>
<tr>
<td>15% of Total Score</td>
</tr>
</tbody>
</table>

**Improvement Activity:**

- Participation in IRIS registry and use of registry for quality improvements
- 24/7 access to physicians for advice about urgent and emergent care
- Provision of same or next-day care for urgent care needs
Integration Alignment – MIPS

Resource Use (Cost): coming in 2018

HCC codes (hierarchical condition category):

- Payment based on risk
- More complex patients are more costly to the practice
- **Will be required to code comorbidities relevant to each visit**
  - Ophthalmic codes
  - Systemic codes
$12.5 million in eye care related fees, managed through the integration of 50 providers

Assumptions:
- 400 MD Health System MDs treat approximately 50,000 diabetics
- Assume a 50% diabetes patient referral rate
- 1000 referred patients generate approximately $500k Vision Management Revenue (includes optical, clinical & surgical utilization)
Integrated Eye Care
Reduce Costs - Achieve the Triple Aim

500 Patient Example

- **$11K** in savings with vision exams
- **$316K** annual savings (low vision)
- **$1.4M** annual savings (blindness)
- **$375K** cost of ER visits

Utilize integrated resources to **improve patient care** and reduce overall costs.

Assumptions:
- 500 vision exam of all adults, saves $11,000
- Reduce annual excess medical care expenditures for low vision by $316,500
- Reduce annual excess medical care expenditures for blindness by $1,401,500
- Prevent 500 Emergency Room (ER) visits, which costs about $375,000

ECP Advisor Group
# Integrated Eye Care Value Proposition

<table>
<thead>
<tr>
<th>HEALTH SYSTEM / PCP / ACO</th>
<th>OPHTHALMOLOGISTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Single solution provider</td>
<td>• Patient / payer access</td>
</tr>
<tr>
<td>• Reduced costs</td>
<td>• Improved quality of care (MIPS)</td>
</tr>
<tr>
<td>• Improved quality (MIPS)</td>
<td>• Branding opportunity</td>
</tr>
<tr>
<td>• Increased revenue (HEDIS &amp; Star ratings)</td>
<td>• Increased revenue</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OPTOMETRISTS</th>
<th>PATIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medical management adoption</td>
<td>• Provider choice / access</td>
</tr>
<tr>
<td>• Access to payer panels</td>
<td>• Enhanced patient:</td>
</tr>
<tr>
<td>• Provider collegiality</td>
<td>– Care</td>
</tr>
<tr>
<td>• Sustainable model</td>
<td>– Experience/Engagement</td>
</tr>
<tr>
<td></td>
<td>– Education</td>
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</tbody>
</table>

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Health Care is Shifting

What will you do?
Questions

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Philip@ecpadvisorgroup.com
727-433-9899
References

5. Washington, 2013, Emergency Department Visits for Adults with Diabetes, Highlight 1 [Link](https://www.hcup-us.ahrq.gov/reports/statbriefs/sb167.jsp)