Brandon L. Jones (00:00:01):

Thank you Olivia. And again, welcome everyone. This is I think, our third national audience webinar on Vision Services in Health Centers, so thank you all and thank you all for all the work that you do every day for your communities and responding to all their needs, especially in these tough times. So thank you again for all the work that you're doing every day for your communities. So really quickly before we jump in, NACHC wants to let you know that outside of today's webinar, vision and eye care are not the only topics. You can find a variety of topic areas with tailored materials specifically for FQHCs operating environments at our Health Center Resource Clearinghouse. You can find that at healthcenterinfo.org.

(00:00:51):

So the Health Center Resource Clearinghouse is made possible through a collaborative effort of 21 national training and technical assistance partners funded by HRSA, Health Resources Services Administration. And all 21 of us work very, very closely together to ensure that we're providing technical assistance best suited to the needs of you, our health centers. Today's webinar is a wonderful example of continuing that partnership between NACHC and the Association of Clinicians for the Underserved, or ACU, coming together to provide this really, really important resource.

(00:01:30):

So we hope that you were able to join us for our first two web workshops, particularly the first one on Introduction to Comprehensive Vision Services and Health Centers, which covered the intersection of vision, chronic illness, and quality of life. All registrants should have received a follow-up email to both of those workshops with a link to the recording and other resources. And if not, you can easily visit the healthcenterinfo.org page and search Eyes on Access to locate both of the recordings and any materials for both of those webinars.

(00:02:05):

So today's overview, we're going to do obviously some introductions, look at the review of the problem, a review of the opportunity. There'll be some health center provider staff panel discussions, there'll be some Q&A probably interspersed between some of the segments, and the majority of that will be near the end, so please feel free to submit your questions during the session, we'll try to get those answered throughout the session. Then we'll close the summary and closing remarks and just additional resources and references for you post the session.

(00:02:38):

All right, so setting the context. Before we get started into the content, if you can go to the next slide for me, Olivia, before we get started into the content of today's session, I just want to spend a couple minutes resetting the context to remind you, remind us of the impact and the power of the National Health Center program. Many thanks to everyone for your continued and/or past health center service, you serve 28 million-plus patients through 1,400 funded organizations, and that's through 13,000 service delivery sites. You can see from the slide that our patients span across, they span across the continuum, all of whom suffer from vision eye health issues in their lifetime. We're also primarily serving patients in public programs, under and uninsured patients, special populations, and racial and ethnic minorities. Again, thank you for your service to our communities.

(00:03:46):

So the community health center workforce has also expanded dramatically over the past decade from 132,000 staff in 2010 to around about 255,000, a little over that staff in 2020, which has allowed them to increase the number of patients they serve by almost 50% during this time. Community health centers also experience around a 282% increase in vision services provided during this time. These

service expansions have enabled community health centers to be full medical homes for their patients and also to address those patients' health and wellbeing needs holistically.

(00:04:33):

So despite the demands of the pandemic as well as the unprecedented rates of workforce attrition, community health centers personnel have still provided medical care to 25 million patients, that includes managing chronic conditions such as hypertension, diabetes, and depression, prenatal and postpartum services, as well as providing adults and children with prevention and wellness care. Dental care to 5 million patients, which includes oral exams, restorative care, and prevention services. For example, fluoride treatment to our children, behavioral health service to nearly 3 million patients, which includes substance abuse services, counseling, primary care management, and conditions such as anxiety and depression. Pharmacy services, which includes prescription management and medication management, and then of course vision services to half a million patients.

(00:05:28):

And lastly, enabling services which includes interpretation, case management, transportation, eligibility assistance, and many, many other services. Social determinants of health, for example, enabling services touched well over 2 million patients, so lots of great work that health centers are doing every day.

(00:05:51):

Health centers are possible because they're governed by the community. Health centers are required to have a 51% patient majority board of directors. It's a complex and very, very complicated job. So for any members of health center boards who are on today's call, thank you for your service, I'm one of them. You volunteer your time, your energy, you serve as a voice for your community, your neighbors, and your family. We thank you for all the responsibilities you take serving on the board of directors at our health centers. Health centers are also governed by volunteers, so we're also volunteer board members. Health center boards are required by law to include, again, I mentioned that 51% patient majority as an essential feature of our health center program.

(00:06:40):

So there's federal, state, and local laws that we have to comply with. HRSA, as I mentioned earlier, really allows us to and provides us guidance through that compliance manual to ensure that we meet all of those responsibilities. Boards must also fulfill the roles of all non-profit boards and most of these effective boards focus on good governance. All right. Okay.

(00:07:12):

So again, these health center boards are very critical when it comes to decisions about service, expansion of the health center, having support the influence, certainly the advocacy of the health center board is what makes the difference in deciding to stand up a service like eye and vision health in your health centers or seeking collaborative partnerships to increase access to eye and vision services in your communities. So we hope that health center board members who are on today's call will bring back or take back what you learn to your boards to determine if the time is now to enhance or to implement vision services at your health centers. So a health center board play, again, the health center board plays a critical role in identifying these opportunities, so ensuring that you have the appropriate information to get back there allows you, and certainly the senior leadership team at your health centers, to make those decisions around addition and expansion of services.

(00:08:05):

Okay, resources for our boards. So we have several resources available via NACHC. It's not an easy job of course, that you have, so please check out our resources for you as you proceed with your important strategic planning and decision making at your health centers.

(00:08:29):

All right, so we're so pleased now, if you go to my next slide, we're so pleased to have the Association of Clinicians for the Underserved with us today to talk a little about their resources that made available to our health centers and consider how to stand up or enhance their services, so I'm pleased to hand things over to my colleague, Luke Ertle. Luke.

Luke Ertle (00:08:50):

Thank you so much, Brandon. As Brandon said, my name is Luke Ertle. I'm the program director at Association of Clinicians for the Underserved, excuse me. And ACU is a transdisciplinary membership network, uniting clinicians, advocates, and organizations to lead advocacy, clinical, operational, and equity excellence to develop and support clinicians and the healthcare workforce caring for America's underserved communities. We support thousands of clinicians and organizations each year with technical assistance, programs, advocacy, and more. And to talk a little bit about the work that we do around vision services and eye care, we started our work in this realm in 2017 with a grant from The Centene Foundation for Quality Healthcare to fund mobile vision units. And ACU collaborated with health centers around the country to fund some events where members of the community could receive comprehensive exams.

(00:09:42):

Since then, our programming has expanded where we are providing $25,000 grants, five of those per year. And we actually have an application process open right now that will run until December 31st, 2022, as you can see on the screen. And there will be five grants available for $25,000 help start up or expand vision services at health centers or lookalikes. Along with the development of our grant program in 2022, ACU started this vision services committee, which is mainly comprised of optometrists from around the country who help guide ACUs programming and provide technical assistance and mentorship to health centers looking to start up or expand their optometry department. If anyone is interested in joining the committee, we're also currently accepting applications or just interested for mentoring health centers and helping them along.

(00:10:34):

We're also excited to announce that we are now assisting with the recruitment of optometrists and support staff at health centers. We actually, I saw a question come through a little bit ago about this as well, about difficulty recruiting optometrists. So for FQHCs and lookalikes, we are offering free postings of any openings that you have for optometrists and technicians on our website for free. So recruitment of course, like I said, is an issue that has been coming more and more to our attention, so this is a first step in looking into helping address that issue. Next slide, please.

(00:11:10):

Getting into learning objectives for today's webinar. So after attending today's webinar, you'll have a greater understanding of opening an optometry department within your health center, in addition to what goes into the creation of an optical and the hiring and staffing needs. You'll also gain a better understanding of how you can integrate vision services in the broader services provided by your health center. And lastly, you will learn from peers around the country about how to overcome the challenges in the process of integrating vision services into health centers.

(00:11:38):

With that, I'll go ahead and turn things over to my colleague, Julie Grutzmacher, who is the director of National Collaboration and Engagement at Prevent Blindness. Julie?

Julie Grutzmacher (00:11:48):

Thank you, Luke. Hello everyone, my name is Julie Grutzmacher and I'm the director of Patient Advocacy and Population Health Initiatives at Prevent Blindness, it was an old job title that Luke quoted. Prevent Blindness is very proud to partner with NACHC and ACU in the development of this webinar and this very important topic. We were founded in 1908 as a national advocacy organization with six affiliates. Our mission is to prevent blindness and preserve sight, and our vision is envisioning a world where preventable blindness is no longer a public health issue. The three pillars of our strategic plan are education, advocacy, and empowerment. Empowerment both of individuals and of systems of care.

(00:12:29):

Next slide, please. We work hard to reduce all barriers to eye care and needless vision loss, and we do so through our two main centers at Prevent Blindness, the National Center for Children's Vision and Eye Health, and the Center for Vision and Population Health on the adult side of things. We also host a focus on Eye Health Summit every year in July. This past summer, the theme was Eye-conic, Approaches to Eye Health. Please check us out at preventblindness.org. And now I am pleased to turn it over to Dr. Kristin White.

Dr. Kristin White (00:13:05):

Thanks, Julie. Hi everybody, I'm Kristin White, I am the director of optometry at the MACT Health Board, which is a community health center with Indian Health Service affiliations in a rural part of Northern California. I helped open the eye clinic here in 2017, so I very acutely understand what you are all going through in the creation of your eye clinics. I feel really passionately about helping health centers incorporate eye care and would love for more health centers to expand that service, so I'm really excited to be able to talk with you all today. I'm also a member of the ACU Vision Services Committee and I did a residency in community health in Boston.

(00:13:50):

Next slide, please. So what I'd like to talk with you all today, since you've decided that you want to incorporate optometry, I'd like to talk with you today about what questions you need to be asking yourself as a health center to be able to create this department. So our previous two webinars, we focused a lot more on the nitty-gritty of how to dive into some of these different categories, but now we're going to be taking a step back and asking questions that'll help you figure out where you need to go within each aspect. So from what degree of vision services you're able to provide, space options, what you need to do to create your optical, staffing considerations, and other advanced testing equipment.

(00:14:40):

Next slide, please. So to start with, you want to incorporate optometry, which is great, but how much of a service can you really provide based on the size of your health center? So if your health center sees between 18,000 and 20,000 medical encounters annually, then we would say generally that you'd be able to support one full-time optometrist. Now, if your health center is larger than that, then you can expect more optometrist kind of based on this ratio of one optometrist to about 20,000 medical encounters annually. And the reason for that is that we would expect an optometrist to see roughly 10%

of the number of medical encounters, so if you're seeing 20,000 medical encounters that your optometrists would see roughly 2,000 encounters annually.

(00:15:32):

Now, that's not a super hard and fast number. So if your health center sees maybe 15,000 to 16,000 patients annually, you still may be able to support one full-time optometrist because your optometry department will bring in new patients to the health center, especially depending on your location. So for us, we're really rural, there's no other Medicaid eye care providers in our county. And so plenty of patients are brand new to our health center just coming in for optometry services initially, and then of course we realize that they also haven't had any other sort of medical care in quite a while, we connect them to our primary care team that way as well.

(00:16:16):

But if your health center is a lot smaller than this, maybe only 10,000 medical encounters, then you're probably not going to be able to support a full-time service. That doesn't mean that you can't provide optometry services for your patients, you just want to do something that's realistic that's not going to put you into spending a bunch of money that you're not going to be able to support the department. So if you have a smaller clinic, then you would want to consider part-time services, so maybe contracting with a local optometrist in the community who can come to the health center with a certain frequency, you might consider having a mobile unit come out or possibly telehealth services depending on the numbers that you need.

(00:16:55):

Next slide please. We talked about this more in one of our previous webinars, but just wanted to have a brief review of some upfront costs. So a basic exam room and pre-testing equipment will cost about $50,000. We have an average or rough optometrist salary with benefits about $160,000 for a full-time. That of course completely varies depending on what part of country you're in, but that does fall right in the middle of a range of what I've been hearing across the country. So you'll see where there's a lot of variability are on the advanced diagnostic imaging, so on some specialty equipment, which isn't really specialty equipment, it's actually necessary if you're going to be managing ocular disease, but depending on the size of the clinic you're going to be starting, some of that may not be required at the onset. And the optical dispensary, that means where you're going to be selling your glasses and you can see here that there's quite a range of how big or small you can make that depending on what options you have available to you. We'll jump into that a little bit more.

(00:18:09):

Next slide please. So when we're thinking about space, that's our first issue we need to tackle, "Where am I going to put this department?" So as a minimum, if you are maybe going to have part-time services or you just want to get started now and you only have one exam room in your medical clinic that you can start having an optometrist see patients in, then that's great, start there. If you just have an exam room, keep in mind your optical is going to be quite limited, you're not going to have anywhere to really keep glasses, and your ability to manage ocular diseases is also going to be significantly limited. If you want to provide basic eye exams, glasses, prescriptions, you can certainly do that in one room, but I would really encourage you to plan in future renovations or leasing external space to allow that department to expand.

(00:19:11):

Later on today when you start to see from our panelists the health centers that they're a part of, you're going to really see some expansive and beautiful clinics where they are providing comprehensive care to

their patients at a very high level. And it may not be realistic for everyone to start out there, but I think it's really helpful to see those opportunities as an option of where you could grow to. So if you have some more space, or maybe you're doing some renovations right now, or just planning for where you could put this department to really have it become integrated into the health center, then you're going to need at least one to two exam rooms for one doctor, one pretesting room, and a room for the optical, which may be a part of the waiting room or at least visible from the waiting room.

(00:20:01):

Next slide, please. When we're thinking about an optical, again, all of these things can be really variable, we can go super minimal or we can go really expansive. And so these are the questions I'm trying to get you to ask yourself depending on your own health center situation. So when thinking about the optical, you may only be able to provide glasses for your Medicaid patients to start with. And so if that's the case, then you need to know who is covered for glasses under Medicaid in your state. In some cases, it's just children. In some cases it's adults and children. And in some cases, it's children and adults with specific medical conditions. So there's certainly a lot to know, and once you get into the managed Medicaid plans, it gets even more complicated. So that's one area to figure out upfront.

(00:20:54):

And then, what type of space is available? So do you have a wall that you could use maybe in the waiting room where you could display glasses? If so, you may want to have them be locked so that someone or a staff member needs to be assisting the patients so they can try them on, so people passing through aren't just trying glasses on. Do you have a whole room that could be devoted to this? And maybe that has a locked door. So again, a staff member is assisting the patient. Or if you're just working out of one exam room, you may just have some trays or a cart where you have some glasses stored and you might have 50 or 60 pairs of glasses that patients can choose from, whereas some of the more expansive opticals that you'll see later on today from our panelists, they're really providing glasses for all patients. So they're providing glasses for Medicaid patients, patients with Medicare HMO vision plans, commercial vision plans, as well as self-pay.

(00:21:58):

And I do want to point out that self-pay, we really want to make sure that our patients can afford the glasses that we're offering, especially if they don't have coverage elsewhere. So even if you diagnose a brain tumor on their eye exam, but if your patient can't get the glasses they need, in their mind it was a somewhat wasted visit and they're also less inclined to come back when they know they can't get the glasses that they need, so having a really inexpensive package option is definitely recommended. I would also really encourage you to get involved with some programs that offer free glasses for your patients who just can't afford even your less expensive option. Some programs that do that is Essilor's Changing Life Through Lenses, there's Eyes of Hope and New Eyes for the Needy as well. There's lots of programs that you can get involved with.

(00:22:58):

What we do at our health center to determine who is eligible for the free glasses is we have them fill out a sliding fee scale. And if they qualify for the maximum discount, then we equate that to them being eligible for a free pair of glasses, so we'll order through one of those programs. If you're going to have a more full scope optical, you do need a dedicated space, you would be having over 400 frames likely with a variety of sizes, styles, and certainly prices.

(00:23:31):

Okay, next slide please. So thinking about staffing. Again, when we're starting really minimal, if it's just one exam room without pretesting, advanced diagnostic imaging or an optical, then you can certainly just have an optometrist and the receptionist can be shared amongst other departments. But if you're going to be having a really integrated clinic, which I of course is what I encourage all of you to do eventually, if you're going to have one optometrist, then at a bare minimum you would need one receptionist and one technician. And certainly both of those staff members would need to be cross-trained to help in the optical.

(00:24:15):

That's really a bare minimum though. And as soon as one person's out sick, you are really scrambling. But once the clinic is growing and getting closer to full capacity, you're absolutely going to need at the least a third staff member. And you'll see later on today from our panelists where these clinics have, two of the three have multiple optometrists and therefore multiple receptionists, technicians, and optical staff as well. So all of those numbers are going to increase, but I wanted to provide you with some bare bones starting points.

(00:24:49):

Okay, next slide please. So when should you hire your optometrist? Well, I think as soon as possible because as we're hearing all around, it's really hard to recruit right now especially. But the other reason is that the optometrist who's going to be working there should be the one to determine what equipment is necessary, helping your team create the equipment list, setting the schedule, hiring staff, and establishing the clinic protocols. Also, keep in mind that insurance credentialing can take three months or more in some cases, so that's another reason to start really early with that process.

(00:25:35):

Sometimes I've heard of certain clinics where they may be consulting with a particular optometrist on what equipment is necessary, but that doctor isn't the one who's actually going to be working there. And so then by the time they actually hire their optometrist, now they have this equipment, but it may or may not be relevant depending on the initial doctor's training if it wasn't actually as modern of equipment as should have been recommended. So you may save yourself a little bit of hassle in having the doctor who's going to be working with you be the one who's really helping you determine what equipment is necessary.

(00:26:17):

On the topic of recruitment, I want to point out an opportunity. I had a conversation recently with the president of the New England College of Optometry, which is my alma mater. And as you likely all know, everyone finishing any sort of medical school has a lot of debt for the most part, and paying off that debt is a really big priority for new grads. And there seems to be this perception among new grads that the only way they can pay off those loans is if they go and work in a commercial place like a LensCrafters, or Warby Parker, or something like that. But in fact, many community health centers do offer very competitive salaries. In addition, optometrists would qualify for the public service loan forgiveness program, but I've also heard of several health centers in and of themselves creating their own loan repayment programs for optometrists and for other healthcare providers who don't qualify for the National Health Service for Loan Repayment Program.

(00:27:23):

So what I'd like to do is help kind of bridge this gap between health centers who are offering a loan repayment and partnering with NECO to start and then possibly other optometry schools so that you as the health center, could sign on your optometrist when they're a third or fourth year or new resident. So

they would sign a contract with you that upon graduation or upon completion of their residency, they'll be working with you, that way you have one to three years to then start planning your optometry department. And when they sign on, they would, in addition to their other benefits and a competitive salary, they would be getting say, $20,000 a year extra to pay on their loans. And that's an exchange for a certain time limit of working with you, or a time minimum, so maybe a three year term commitment in exchange for $20,000 a year on their loans.

(00:28:28):

So I'd really like to put this list together and help connect the health centers with new grads and optometry residents. So if any health centers are interested in learning more about that program or becoming a part of that program and getting someone to sign on in advance, please put your information in the chat right now, get some contact information so that I can reach out to you afterwards because I'm really excited about trying to bridge this gap. I think students really need to know that community health is a really viable option, not only for professional satisfaction, but also in being able to pay off their student loans.

(00:29:09):

Next slide, please. Some health centers will ask about an OCT because, so an OCT is the retinal scanner, it's a crucial piece of equipment if we're going to be managing diabetes, glaucoma, macular degeneration, but it's an expensive piece of equipment. So in and of itself, it costs about $50,000. If your health center is seeing a large number of adult patients, we know they're going to have diabetes and hypertension and high risk for glaucoma. So if you can afford it on day one, it is absolutely going to be necessary to take care of your patients. If you can afford it on day one, then you need to have it in your budget for how and when you're going to be able to afford it. Maybe once the department breaks even or brings in a certain amount of money, then you would be able to bring it in. You may also consider asking managed Medicaid plans or applying for grants to help cover the costs for this particular piece of equipment.

(00:30:10):

Now, that's going to be the majority of you that if you're going to be providing full scope care, you do need this piece of equipment to be able to do so. But if your health center is going to be primarily seeing pediatric patients, so maybe it's school based or that's just the demographic of that particular location, then you don't really need an OCT and you may consider it in the future if your health center, if that location is going to be expanding to a broader adult population.

(00:30:38):

Okay, next please. And I also wanted to highlight the AOA business model. We had a separate workshop about this, you'll be emailed a link to the recording to that workshop if you weren't able to participate, you don't need to give your contact information, everyone who's registered for this will receive that link afterwards, but this is a workable spreadsheet that the American Optometric Association created a number of years ago where you can input your own health center's actual numbers, so you can put what your actual reimbursement rates are for the various plans that you accept, whether there would be any cost to building out or leasing space to create the department. And then this spreadsheet will give you information as to how much money you should be bringing in at each year, at what point you should be breaking even.

(00:31:37):

And so I would definitely encourage if you haven't had a chance to listen to that workshop recording and we can also send out the file as well so that anyone who's interested want to work with your finance

team to work your way through that. Okay, next please. All right, I think we're ready for some questions. Dr. Sarma, are you going to join?

Dr. Debi Sarma (00:32:05):

Hi there, my name is Dr. Sarma. I work very closely with Dr. Kristin White. I'll be facilitating some of the Q&A. We've got some exciting questions coming in. One of the questions that has come up a couple times is if you wouldn't mind repeating some of those resources that you had for free glasses or affordable or subsidized glasses for the patients?

Dr. Kristin White (00:32:29):

Yeah, definitely. And I'll pop some of those in the Q&A too so everyone can get some links. But one is Essilor's Changing Life Through Lenses program, they offer frame and lenses that they'll send you. Another is New Eyes for the Needy, I think another is called Eyes of Hope, but I will provide some information in the chat.

Dr. Debi Sarma (00:32:53):

Fantastic. And another question here is, what is the annualized growth rate for the patient base in optometry year by year?

Dr. Kristin White (00:33:04):

Yeah, so the AOA business model does a really nice job of breaking that down. So in your first year, you would expect the eye clinic to maybe be operating at about 70% capacity. So even though if you're working on that 20,000 medical encounters and then expecting 2,000 optometry encounters for a full-time, full-capacity clinic, you may expect about 70% of that in the first year and then ideally 80% in the next year, 90% in the next year. So you're kind of working your way up in that regard.

Dr. Debi Sarma (00:33:43):

Fantastic. We'll take one more and then we'll answer the other questions through the Q&A chat. If you're looking at optometry, I'm getting a question here about discussing ophthalmology as well. "Is there a need for this in an FQHC?" Is the question.

Dr. Kristin White (00:34:02):

So I would definitely say that as far as your primary eye care goes, those providers are going to be optometrists. So those are going to be the ones managing the majority of your ocular disease and seeing these patients on a regular basis. Certain states may have limitations to what can be done by an optometrist in terms of prescribing certain medications. And so I know a lot of those states do bring in some ophthalmologists to consult maybe on a monthly basis or so. And other instances, even regardless of prescribing, they may bring ophthalmologists in on a consulting basis, usually once a week or once a month to provide services for patients who are unable to travel, but I would say ophthalmology's going to be more consulting, whether that's done in-house, especially in a really busy clinic to help facilitate patients who do have trouble getting elsewhere, versus the optometrist providing the day-to-day primary care.

Dr. Debi Sarma (00:35:09):

Wonderful, thank you. I think we're going to head over to the next slide. Well, that's me. I'm a public health optometrist based in the Boston area, I'm at Fenway Health and Manet Community Health Center, and I also graduated from the New England College of Optometry and completed a residency in Community Health Optometry.

(00:35:34):

Next slide. I'll be moderating the panel discussion. Up first, we'd love for you to hear from Julie Le. Dr. Le is the chief of specialty services and eye care at Lowell Community Health Center in Lowell, Massachusetts. And she'll be sharing her story here.

Dr. Julie Le (00:35:52):

Thank you, Dr. Sarma. So welcome and good afternoon. I just wanted to share a little bit of me. I'm originally from Michigan, so I had an opportunity to study at Southern California College of Optometry. And after practice I moved to New Hampshire to work in private practice and I opened up my own private optometry practice, which helped me get the experience I needed in terms of helping Lowell Community Health Center and their needs that they had for expanding services. So just a little bit about what Lowell is like. Lowell, Massachusetts is a gateway city and we have a multicultural diverse population of patients. We have served the Greater Lowell Community at Lowell Community Health Center for over 50 years and nationally recognized for our culturally competent care. Our patients are varied and I learn a lot about their culture each day I'm at work and our focus is on patients, we're culturally rooted and community centered.

(00:37:00):

Next slide, please. As I mentioned before, we are located in Downtown Lowell, excuse me. Our medical home is in a renovated, beautiful historic mill building. Over the last 10 years, it's been restored. We have about 165,000 square feet and it's a medical home for the greater Lowell community. And we have multiple service lines there, I'm just going to list a few. There are a lot, but we do do primary care, pediatrics, OB-GYN, behavioral health, and we also have our Metta department, which really concentrates more on the Eastern and western healing practices in our community and also has a refugee clinic because many of our patients are immigrants and new to the country, so we definitely want to help support them in their medical care and their needs.

(00:37:54):

Last year we saw about over 31,000 unique patients and provided about over 250,000 patient visits. In that timeframe, we saw about 5% in the eye care center and 66% of our patients fall at or below 100% of the federal poverty level, and 71% of those patients are covered by Medicaid. We have 45% of our patients that speak a language other than English, we are very fortunate that we have included in our services community health workers as well as medical interpreters. Our top three languages spoken at the health center are Spanish, Portuguese, and Khmer, which is the language of Cambodia. We also include specialty services with dental and eye care. In addition, we have two school-based health centers located in Lowell, Massachusetts. We have one at Stoklosa Middle School and the other is located at Lowell High School.

(00:38:57):

Next slide please. So as Kristen was mentioning earlier, it's extremely important to have consultative help when you're opening up an eye care center. We opened the Niki Tsongas' Eye Care Center at Lowell in March 2018, and we did so through a HRSA grant that allowed us to expand not only primary care services but also to expand and include eye care and dental services as well. So we were very fortunate to receive this grant and they hired me about six months before opening. So because I had my private

practice, I understood what we needed to do to get that up and running in terms of what type of staffing we needed, equipment, workflows, billing, all the information that would be helpful to starting up this service line at Lowell Community Health Center.

(00:39:53):

We are very fortunate, we have about 7,000 square feet and in our renovated mill building. We have at the first floors, so what's nice about it is we have these glass windows that patients can actually walk by to see our beautiful full service optical shop. We have stylish frames that fit every budget. And as Kristen was mentioning, we have packaged pricing for all of our patients that can afford little or a lot depending on their budget. We've been very fortunate, we have an in-house lab, so glasses can be made on site for our patients that really need glasses right away, so it's been a tremendous help for them. We have, which I find super fortunate, two full-time opticians. One is our optical manager and he has over 20 years of retail experience and the other is also a full-time optician, has over 20 years of experience as well.

(00:40:48):

And with that experience, we work with the State of Massachusetts because in Massachusetts opticianry is a trade. And so we developed a workforce program with the State of Massachusetts and have an optician apprenticeship program. So we currently have two optician apprentices that we're trying to train and get ready to become opticians and licensed in the State of Massachusetts. We have a wonderful group of development group and they helped and saw ahead of time that we might need help for our patients that may not be able to afford certain things, so they set up glasses for family fund with their fundraising. And what that does is it helps cover things that may not be covered by their insurances. For example, if they have a high copay and they're not able to afford that, they may not come in for the medical services that they need.

(00:41:38):

In addition, we've had a patient that needed transitions because they had ocular albinism, so we were able to do that for that patient. High myopes, we can order high index lenses for them. So really a great opportunity to bridge that gap for those patients. We have two care coordinators, they've been a fantastic resource for us. We've been very fortunate in having integrated care model at our health center. And so that's been helpful for us to not only grow our eye care center, we get a referral from primary care, our patient walk-in center, which is our urgent care department, we get pediatric referrals. And so that has to be managed by somebody, so our care coordinators help with our internal referrals. They also help to coordinate care for our referrals that go to specialty like ophthalmology. And so the patients can have better care coordination as a result of having our care coordinators.

(00:42:34):

We also have three ophthalmic assistance currently and we've been fortunate that our health center has a program called Bridging the Gap and that helps with medical interpretation training. And so two of our assistants actually have gone through medical interpretation training, one Spanish and one Khmer. So our patients are better served in the language that they feel most comfortable with. They can understand what you're saying to them, it's much easier for them to follow your treatment plan and understand their condition in the language that they're best served in and in person as well.

(00:43:08):

So a little bit about our Eye Care Center. We have seven eye lanes, I feel like we're growing out of our space already, but have seven eye lanes, two of them are traditional in that they are set up for our pediatric patients and our wheelchair-bound patients. Traditional meaning we have our chair stand,

everything looks as it would. And our five other lanes, we have our fully automated eye lanes that we use and it's from the Topcon CV-5000. So what's been beneficial for us is we can be much more efficient in our care using this type of system. In addition to that, we'll be integrating with Epic and we're running Epic in 12, 2022. And so our devices will be able to be inputted into Epic, so that would be a great time saver, less transcription errors from our assistance and providers, so really looking forward to being much more efficient.

(00:44:00):

As Kristen mentioned earlier, we have two separate rooms that contain specialized equipment. We have Topcon Maestro, it's been probably the most utilized equipment in our health center, the Maestro has not only the OCT, it takes retinal images as well as anterior segment photos and images as well as PEC imagery. So that's a great option for our patients when we're managing disease. We also have a corneal analyzer and an Octopus Visual Field and pretesting equipment as well. Through a grant, we are able to purchase two portable retina cameras, which we'll be utilizing for our diabetic retinal screenings in primary care. And in addition to that, taking it to our school-based health center.

(00:44:46):

We have three full-time optometrists currently working and a fourth one starting in January. I work part-time in the clinic and we also have fourth-year optometry students that rotate through from my alma mater, Southern California College of Optometry, Illinois College of Optometry, and New England College of Optometry. And NECO has been fantastic, a great resource for us from the beginning and throughout our opening. And so it's been a fantastic opportunity that I encourage those on this call to reach out to nearby optometry schools to help you with this as well.

(00:45:24):

We've been super fortunate that to have our consultative ophthalmologists come once a month to see our patients and he is the chief of ophthalmology at Boston Medical Center. He's a pediatric specialist by training, but he also does general ophthalmology consults for our patients with the social determinants of health, being transportation is a big issue. They have to travel over an hour to get to Boston Medical Center, but because their insurance is such that they're underinsured, that's the only area or local area facility that would accept their insurance. And so as a result, we've been able to coordinate care much more effectively having him come on site, especially for those in need and care, and they also have language services too.

(00:46:08):

Next slide, please. So this is a great thing, one of my doctors, Dr. Hillary Hamer did, was conduct a retrospective study after our first year of opening the Eye Care Center. And so what was interesting is we found that one in five patients had never had an eye exam, so we had to spend much more time to explain what we're doing to them and understanding what their conditions are as they were worried and nervous. 10% of our patients also were diabetics, never had an eye exam either. We found that 33% of our Lowell Community Health Center pediatric patients were not quite the number we saw in the Eye Care Center. We only saw about 21% of pediatric patients and we found that the top five diagnosis included amblyopia, so we really wanted to strategically plan our focus on those particular groups, diabetics as well as our pediatric patients.

(00:47:00):

Next slide, please. So what we did is we were looking for funding and trying to figure out a way to improve the access to that pediatric population. And we're fortunate that we have a school-based health center already established in Lowell High School, and so we decided that we would just start

there first and we were able to do that as Luke had mentioned earlier, through a $25,000 grant that we received from the Association of Clinicians for the Underserved. And with that money we were able to buy equipment and utilize a flexible space in our school-based health center that was being used primarily just for other students and other disciplines in the school-based health center, but we decided that that would be the best use of space there and that they could still use that space for other things when we weren't there.

(00:47:52):

We found that it wasn't quite enough to get the equipment that we needed to really give the comprehensive eye exams that we were looking for, but also the efficiency of seeing more patients if we could at the high school, so we did include more to the budget, about $10,000 with extra equipment, and we were also bringing optical services. So in addition to the comprehensive eye exam and optical services once a month for a morning session, we were also looking to provide the care that the patients needed in terms of broken classes and delivery of glasses, things that were challenging for many parents and relatives to try to get to our main location in time and during our hours. And these students, our wait time is about three months because we are so busy trying to get as many patients in.

(00:48:47):

So if you can imagine having a high school student have to wait for three months to get their glasses updated, it's just not a good thing. So we've been really fortunate that our nurse practitioner at the school-based health center has really marketed us and we actually have a wait list and we have only opened in October 2022. So it's definitely a need that we are seeing.

(00:49:11):

We're also at our Eye Care Center and our main location as well as the school-based health center, we see patients that are of the community, they don't have to be Lowell Community Health Center patients to come and seek services there, which I find a huge benefit for the community. And in addition to that, we share an EMR with the school-based health center. So being able to book appointments is very easy and we can certainly send messages when students have broken glasses, we can deliver glasses to them and it's just a huge benefit and improving access to care for those in need.

(00:49:47):

So I really hope that you've gotten a chance to get a little sense of what Kristen had said earlier and what it could look like, so I appreciate your time for letting me share that information. And Debi, I don't know if we have time for questions.

Dr. Debi Sarma (00:50:04):

I think we're actually going to hold all of the questions until the very end. Thank you, that was wonderful. And for all the people who are joining today, all of the questions are going to be compiled into an FAQ document, Frequently Asked Questions, and you will get a copy after the presentation so you'll get your questions answered as well.

(00:50:29):

What's interesting about Lowell Community Health Center was that so many of the top five conditions were chronic conditions, one of the five being amblyopia, that we see in children that can cause vision loss, so thank you for highlighting that. Up next we have Greg Stone, who's the CEO at Peach Tree Health. He'll be sharing the story of Peach Tree Health and integrating the vision services there.

Greg Stone (00:50:55):

Thanks, Debi. So I'm the token administrator today, so you're going to hear a lot from clinicians, which is great. These are good stories and I'm going to try my best not to overlap. I've been trying my best to keep up with your questions in chat too, there's some good ones. So a little bit about our center, we are an FQHC that's located kind of in the north central part of California. We serve the greater Sacramento area, about four counties. We've about 40,000 active patients, about 70% Medicaid. We have five eye care clinics, we have eight clinics altogether. Two of our eye centers are standalone, which is kind of unique, two of which actually are in counties we don't have primary care in, we just provide eye care because we've been recognized that being expert at doing that in other areas, we will see probably about 20,000 eye care visits this year and probably just spent somewhere in the 7,000 to 8,000 pairs of glasses during that same time.

(00:51:58):

And also, you've heard this a few times today, and I know it's a little bit of acronym soup, we do have full scope care in all of our sites. We find that having an OCT and visual field and all of the diagnostic equipment becomes really vital. Not only because you're going to need it to deal with the pathology you see, but also there are a very few places to refer outside your health center for these services if they're needed, so ultimately there is a cost to upgrade, but once you do that you'll be able to retain a lot more of your patients' needs.

(00:52:28):

Next slide, please. So I want to talk about integrating, there's been a lot of questions about that in the chat and I can tell you that eye care is one of those programs that patients don't naturally gravitate towards if they feel like they have decent vision, they're not seeking eye care. It's something that you need to push them into. We're trying to save their vision, we're trying to deal with comorbidities of their other diseases, so you need to add this service to your panel of care for your diabetic, to your hypertensive, your high cholesterol patients. These patients who have comorbidities with eye care, you need to make it part of their care and your providers ideally need to promote that, and that really does drive the volume. Naturally, everybody will equate eye care with glasses. If they think they can see or they have Cheaters they got at the drug store, then they won't come in unless the doctor tells them it's vital.

(00:53:27):

The other is that I think you'll be surprised at how many people even in your health center don't understand what eye care is. It's complicated, it has a very big group of new pieces of equipment that are unusual in your health center, many of your staff probably never had an eye exam. I would say that one of the best things we did early on was get everybody in the clinic to get a free eye exam, so we brought all of our staff in, all of our providers sit down and did go through the pretesting, look at all the equipment, discuss what it does, just touch and feel and do it so that they can see like, "Oh, it was just that simple and it didn't hurt." People have an issue with potentially having their eyes touched or anything like that. This sort of gets over that hump because you want everybody to promote this in your health center and to get everybody the experience of it does tip that over a bit.

(00:54:19):

The other thing that really can help is if you can make your optical dispensary visual to your patients. So this is an example of one of our clinics we've built as you walk in the door, kind of a big glass, Apple Store sort of thing, people walk by and say, "Oh, can I get my glasses here?" Otherwise, if it's behind a door, they won't know to ask for it and we may not recommend it. This is really been a good thing for people to start browsing while they're waiting and start up a conversation, it typically turns into a visit. And finally that old mantra of until you start measuring it, it doesn't happen is true with eye care two. So

don't make it a weird specialty that's on the side of your program, you have quality metrics you're monitoring, add this to it, make this part of something you're always measuring, make it something you're always promoting to your team, make sure everybody knows if their patients are being completely served. That really does help drive the volume.

(00:55:20):

Next slide. So a lot of chat was going on with how to find ODs. So that's true with every clinician right now, but finding your first optometrist is difficult, so clearly the first thing I think that we get a lot of traction with is optometry schools. And I know some of you've tried that and struggled, I would recommend that you think about states perhaps pretty far from you because it is a job that people will actually travel for or you don't know if people want to come back to the state they grew up in. So widely advertising in OD schools across the country is pretty inexpensive and you never know when you're going to get a hit.

(00:56:00):

The other is that a lot of these folks when they're coming out of school, they can't afford to open their own practice, so they end up working for a big box somewhere, a LensCrafters, Walmart, or Stanton. And that's your main competitor. Now, recently they've increased some of their salaries so you might feel a little salary pressure locally, but I would tell you that if this is your first optometrist, they're probably working somewhere else right now and they're not looking for a job. So somehow you're going to have to get their attention and let them know that there is a greener field outside of fitting glasses on people at LensCrafters. So poaching people from these actually is a win-win, they want something more robust, they want to make more money, they want to run their own practice but they can't afford it. You might be able to offer that.

(00:56:45):

And the other is a loan repayment. Other people have talked about this, we have adopted a process by which we have created our own loan repayment program. And not to go into too much detail about it, but basically creating it as a multi-year forgivable loan. So it's not just, "Here's some money," it is something that pays out over time and is forgiven over time so that it's a little sticky now for that provider to leave you because if you're paying the same as the other providers in your area, then maybe just the fact that you're going to take care of the loan repayment is going to tip them over to go to you.

(00:57:22):

So we have done a few other things I think is maybe a little unusual and maybe tough for your first practice, but we've purchased a few private ODs that retired. So especially after COVID, there are some ODs that struggle to come back to life and might want to retire and they do see some Medicaid. And we've purchased those practices, taken on their patients, and opened that into an FQHC. It's been very productive. Their staff is already there, they have a volume, they have equipment, they have stuff on the walls, it's ready to go.

(00:57:54):

You might also think about instead of a one full-time FTE provider is maybe getting a few experienced providers to help tag team that. If you can get a day or two a week out of some people, then that might really work, even for some of these folks that are maybe feeling underworked at LensCrafters to be able to take a day or two with you might really help you. And the other is like I've seen a lot of optician questions in there. Opticians in most cases, that's a certificated license position, states deal with that, I think, a little differently at times, but you might be able to get that as a branch of an existing group in your town already. Somebody that wants to expand, sell glasses in your clinic, they might be able to

expand over and help support that at little to no cost for you. We've had some good experience with that in local communities where small opticians want the extra volume.

(00:58:50):

And then lastly, the other side of the recruitment chain is paying people to go recruit for you. And sometimes when we have difficult recruitments, and OD can be that way, I offer a pretty significant referral bonus to my staff and even local ODs if that results in a signed contract. So oftentimes word of mouth is, "Isn't so-and-so's daughter an OD somewhere? Isn't So-and-so wanting to work extra hours?" And those sort of word of mouth things, if they know they're going to get a few bucks, gets you some traction. So don't be afraid to do a one-time signing bonus to get that first OD.

(00:59:29):

And the last thing I'd say about this is I think it's difficult for a new grad OD to come out into a new practice. They might feel a little bit unsupported, so that's a little bit of a barrier, I would have your medical directorship involved in that recruitment and conversation early on so they know that there is a medical backdrop between them and their new practice. They're going to have questions, they're going to have concerns, but this is a medical service and if they know they have a doctor behind them, that oftentimes gives them a lot more comfort.

(01:00:03):

Next slide. So on the business side, you've heard this already today too. Every state covers eye care differently, so you need to spend your time really figuring that out because sometimes it's not really evident. You need to go out and figure out what every part of your eye exam is covered and what isn't, and for the age groups and for the frequencies. So how often can you have an eye exam? How often can you get new frames and lenses? These sort of things are important when you're working through your proforma and understanding your business plan. But what I would tell you is your bread and butter is going to be medical office visits.

(01:00:42):

So I saw some coding questions in there. I mean, I think coding is something you should probably talk to your individual health plans with because they're each going to want to see something different as far as coding, but as far as the CPT goes, a lot of these visits are medical office visits, they just have an optical component to it. People forget that the eye is an organ and it's part of the body, and so we bill mostly medical visits for these. Not to say we're not going to refract them or do other optical-related services in there that may or may not be covered, but ultimately you're dealing with saving the vision of people with chronic disease and that's a medical solution, so it's not as unusual as you may think it is.

(01:01:26):

And then I think really I can't overestimate the impact that bringing eye care is to your clinic because people will come through your doors for the first time, perhaps for all medical care, looking for eye care for some reason, and now they find a new medical home and it has been a door for us in a lot of places, so I would say adding that is going to be something that you can bank on happening, but difficult to predict.

(01:01:52):

And then lastly, for you administrators, adding this to your PPS rate is important. So optometry is a triggering event in most cases to go out and get a new PPS rate, so don't skip that, might have the time when you start your year and how you do that tracking, but all those expenses that you put into this system could be recouped in a higher PPS rate. Don't skip over that.

(01:02:21):

Next slide. Just a few tips. Things that I've learned that I find are useful for those starting out. And one is that really you're going to see a lot of people with corrective vision needs and that's great, that's a real life-changing event, but your bread and butter are people with chronic diseases, so you have these in your health center already, probably half your patients have any one of these things that are going to have an issue with eye care, so make sure they're getting their visits and they typically will see more than one visit a year because if you have a really significant chronic disease, really high A1C, really high pressure, you are losing eyesight, and so you need to be checked every couple three months. So that is an annuity that becomes a way to kind of build the practice instead of just putting glasses on people.

(01:03:13):

We've heard this a little bit today too, it takes a surprising number of patients to actually keep a busy clinic. One because you only see them periodically, but the biggest issue is that most people just don't feel they need it. And it's like dental, you run a dental program and you think like, "Everybody has teeth, look at all these patients I have, we're going to print money." It doesn't work that way, they only come in when it's really bad. And that's kind of true of eye care, unless you make it part of your whole person care plan it's not going to grow.

(01:03:55):

And also I think a vast majority of our patients, well over 50%, have never been into an eye doctor and most people have never had anybody in their family do this. So walking into an eye clinic with this complicated equipment and all these people doing these weird things to your eye is intimidating and it's a barrier to care for some people, and culturally it can even be a barrier to some group. So we invite patients to come in and meet the doctors, we invite the families in to watch their kids get an eye exam, we try and demystify the whole thing to overcome that barrier.

(01:04:33):

And then lastly, as you get busy, it takes a surprising amount of floor space to do this. And as an administrator, knowing that you have a cost per square foot and you have a value for those rooms, it could be a hard decision sometimes, but eye care ends up being worth it. If you skimp on the space needed to put your equipment and deliver glasses, it's going to feel constrained, patients aren't going to flow right, you're not going to be able to support and sustain your program. So whenever you have a chance to remodel or a new vacancy somewhere, think about moving eye care in that position. The equipment is difficult to transition, it pretty much lives in the room. So once you're there, it's kind of dedicated to it. So it's something to grow into, but when you can, dedicate the space you need to make it flow. I think that's it. Thank you.

Dr. Debi Sarma (01:05:31):

Thank you so much, Greg, for your insights. I think what's really helpful about what you're saying is that eye care is part of chronic disease management. And allowing, it's really wonderful how you've let the eye care team and systems be so integrated into primary care, even just physically creating a space where people can approach the glasses section in a non-threatening way, makes it more open to the community. So thank you so much for sharing your insights on integration of vision care into the community.

(01:06:13):

Up next we have Dr. April Walgenbach. She is the director of optometry at Peninsula Community Health Services of Alaska. What's interesting about Dr. Walgenbach is that she is a new grad, 2021, and she

became the director in a rural clinic and saw it through. And for those of you who are working in areas where it's hard to find a new grad or new OD, I hope you'll have your ears open to see her story and how she was able to help build out the clinic. Thank you, April.

Dr. April Walgenbach (01:06:49):

Thank you, Debi. Hi, everyone. As she said, I'm Dr. April Walgenbach and I work at Peninsula Community Health Services of Alaska. We're located in Soldotna, Alaska, which is a small rural community in southern Alaska. We serve a greater population of the Kenai Peninsula. And I'm just looking at the chat and seeing a lot of questions about how to recruit optometrists and questioning new grads. And as Debi had said, I am a new grad, graduated from Pacific University College of Optometry last year. I was from the small town of Soldotna, Alaska originally and came back to provide services here to the community that I'm from. And I was looking at different job opportunities. And the CEO of PCHS actually contacted me, he had heard that I was back in the community and looking for a job opportunity and he reached out to me and he had seen a need for eye care at his clinic and wanted to kind of partner.

(01:07:57):

So what he did was reach out to me and contracted with me to help come up with a business plan, so I was brought on early on from the very beginning to come up with that business plan. I worked closely with our CFO and our COO to build that business plan and present it to the board to come up with all of the numbers and get the approval from the board to move forward with the eye care clinic. I think that was really important to bring me early on so they knew that they had an optometrist before they even went on to purchasing any of the equipment and converting the space. They knew that I was committed and it was a bonus that I was from the community as well.

(01:08:43):

Some of those suggestions about contacting your optometry schools I think is great as well as going to all of the schools, even if they aren't local, because a lot of those classmates of mine were from all over the country, so that is very smart to do that. Once it was approved by the board, they did bring me on and hired me full time and that was nice so that I was brought on early and can do the credentialing. It does take quite a while to be credentialed by all of the insurance companies, and during that time of just finalizing, working with different vendors, bringing on glasses, purchasing equipment, getting quotes on equipment, all of those logistics I was doing behind the scenes, being a new grad, it is challenging and it is something that I was nerve-wracking, but I did have a lot of close friends and colleagues that I could turn to.

(01:09:42):

One being Kristin, who you guys heard from today, she was a huge help to me and I reached out to her and she provided a lot of guidance, so don't be scared to reach out to other FQHCs and get help from them.

(01:09:56):

We can go to the next slide. And I just wanted to show our clinic layout. So we just opened in May of 2022, we have already expanded, we did start with one exam room, but just saw early on the need for another exam room to have a better flow and to see more patients, so just try to be aware that you will probably be expanding, so opening up your clinic in a space that you have that possibility of expanding or moving things around, shuffling. We have two exam rooms now, a pre-testing room, we do have an OCT. As discussed earlier, we have a full optical dispensary. And with that being said, we were really lucky to bring on an optician who had years of experience, which was huge, especially being a new grad,

to have someone with that experience to help me on that side of things was just amazing. We do have one technician and we have the optical space and an office.

(01:11:02):

We can go to the next slide. So some of the equipment in the pre-testing room as discussed earlier, we did find the need to get an OCT, we do see a ton of diabetics here, so having that OCT I just don't think I could do the job I'm doing without that. Also, having a visual field analyzer and the exam room, making sure it's ADA accessible, having the exam chair that slides back so you can bring in a wheelchair is very important. And some of the things that you need to think about with your space, which was huge for us, is that you will need sinks in the exam room and potentially the pretesting room. If you're going to do contacts, you will want another sink in there as well, so plumbing was one thing that we didn't initially think about, but we had to kind of make some changes to make the plumbing work.

(01:12:00):

We can go to the next slide. Some of our biggest challenges, just being a new clinic, getting the word out to the community, letting them know that we are here and we now provide eye care. That has been a huge challenge that we are working through and I will actually share in the next slide some of the things we did for that. Another big challenge is billing, a lot of the FQHCs I know have their own billing department, but optometry is kind of its own world. So making sure you get your billers some training or bringing on someone who has billed optometry in the past, just to know the differences between billing medical optometry and routine vision. And then integrating with the current health center, I think it's important to do things, you could have luncheons with your primary care providers to discuss the importance of eye care and the new services that you're going to offer so you can get those internal referrals. And just as Greg was saying, they provided free exams, things like that would be a great idea to get your staff comfortable with your optometry.

(01:13:14):

Experienced staff members, so finding an optician that has experience is huge. It is possible to train and hire a technician that doesn't have much experience, or I heard someone in the chat saying, "Can a medical assistant be trained?" And that is very possible, it's great if they have experience with pre-testing, but they can also be trained as well. And then another big challenge is the space.

(01:13:41):

Next slide. And then some of the marketing, we realized that we weren't on Google early on, so Google is huge, so just make sure that you pop up in a Google search, not just your health center, but as eye care or optometry services is huge. We did a radio ad, being a small community, we've had so many patients tell us that they heard about us from the radio, so that was actually a really big success. Getting on Facebook, social media. One of the biggest things was internal marketing, so making your clients who are already your patients in the rest of the health center aware that you do have eye care services. A lot of our patients still to this day don't know that we're here and we've found that setting up booths by the front desk with placard cards to show we now provide eye care services has been huge, so just marketing within your own health center and sending out things like flyers in the mail to those patients. And that's about it.

Dr. Debi Sarma (01:14:52):

Thank you, Dr. Walgenbach. It's really interesting to hear you talk about your journey as a new grad. And one thing that might stand out to others on this webinar as well is that you had support, that it wasn't just you alone, but certainly having a health center that was willing to support you as you build out a business plan that you don't necessarily learn at optometry school, but you had kind of champions

behind you, the CEO, CFO, and other mentors like Dr. White who was able to connect with you and help you along the way has been really important in supporting a new grad. So certainly it can be done with a new grad, fresh out of school and directorship, but that support system is helpful as well.

(01:15:39):

And another thing that you mentioned that I thought was interesting is that you couldn't possibly do the care that you do without an OCT. And for many clinics that are operating in locations without other eye care or support services, if you're the only eye clinic within a two or three hour radius of anyone else, you do need that OCT, especially in more rural locations to manage the inevitable chronic disease that's out there, so thank you so much for sharing your story.

Dr. April Walgenbach (01:16:14):

Yeah, of course. Thank you.

Dr. Debi Sarma (01:16:18):

So now we're going to go into the Q&A portion of the webinar. Dr. White?

Dr. Kristin White (01:16:31):

Hello there.

Dr. Debi Sarma (01:16:32):

All right. Hi, welcome back. That was fun, wasn't it?

Dr. Kristin White (01:16:36):

Everyone did great. Yeah, I love learning what other health centers are up to.

Dr. Debi Sarma (01:16:40):

So let's answer a couple of questions that we have coming through the chat. I know some people were asking a little bit more about the square footage, what is kind of the base square footage that you're looking at for an eye clinic? Would you mind reviewing that?

Dr. Kristin White (01:16:58):

I actually wanted to bring Greg in on that one, I didn't answer that one intentionally. I thought you might have a better idea of numbers on that.

Greg Stone (01:17:05):

Yeah. I mean, it's one of those super variable things. So if you think about your normal health center going into a space you already have, so you're thinking exam rooms and you begin, you're going to have one exam room dedicated to the OD, you'll probably have another exam room that's dedicated to maybe a pre-testing and maybe OCT kind of testing. And these are instruments that are fairly small, they involve someone sitting on either side of it, but you can often fit them sometimes in spaces you may not think about, doesn't necessarily have to be an exam room. We've taken over maybe a supply room, or a call center room, or some other thing that was non-clinical to put some of these services in, but really it's, if you think about a three exam room model to start out, you can probably get away with that.

(01:17:56):

Now, the optical part is going to depend on how much you want to get into glasses, how quickly. And that may not be adjacent to your clinic either. Don't think about, you need to have it immediately next to the eye care clinic. That's ideal because patients don't have to get lost going back and forth and you can communicate with the doctor, but it could be on the other side of the clinic if you need to, but try and do it. As you grow, hopefully your volume will keep up to a place where if you are having to take over another exam room here, another exam room there, you're actually seeing enough patients to warrant that. That's been our experience, so it kind of keeps pace with a two-provider practice. The volume typically is more than that once you get to multiple exam rooms and lots of testing equipment.

(01:18:43):

Technicians do a lot of the heavy lift in some of these visits, so you'd be surprised with the volume you can put through a fairly confined space. So there are some resources out there too, I think, and we can look for some links that have better descriptions about how some of these layouts are and some of the equipment that are difficult to talk about, but you could already do it in the space you have, you just need to rethink it.

Dr. Debi Sarma (01:19:10):

Wonderful, thank you. Another question that was coming in is just about sustainability, was one of the questions that we saw prior to starting the webinar today is that how sustainable is eye care in the long term and what are the things you can do to keep it more sustainable?

Greg Stone (01:19:35):

I think that has everything to do with how well you're reimbursed. I mean, that's really the baseline. So every state's going to be different and your reimbursement's going to be different depending on your payer mix. Many people on this call, and I've talked to several health centers that have very high uninsured and sliding fee patients, that's a tough business, especially if you're not well reimbursed in your PPS, but what I would say to this is generally if you are being reimbursed in Medicaid for your general eye visits, this is a little higher volume than you might be doing now in traditional medicine, so don't be afraid to be thinking the future of, "I'm going to be seeing more than 20 patients a day with one doctor."

(01:20:21):

You're going to need to have that sort of volume to help cost shift some of this, but if you can keep up with your PPS rate increases, I know that takes some time and effort, but if you can float it for that first year when you're doing your rate setting, that could be a gold mine for you because that can catch you up with a lot of unreimbursed costs in your health centers, but if you can make it work on PPS with a normal nurse practitioner or any other service line, you're easily going to cover it with eye care, so I wouldn't be too concerned about that. The upfront costs are significant, but so are exam rooms and things too, it all costs, but it'll pay for itself and it all depends on how well you get reimbursed and what your payer mix is.

Dr. Kristin White (01:21:09):

And I think to add to that too, is just really making sure that from the beginning, optometry is a service that is integrated and that the primary care providers are really encouraging their patients or referring their patients or getting their patients scheduled to come in to see optometry. And then just to reiterate, one other thing that Greg had said during his portion of the talk was that a lot of these patients do need to be seen multiple times a year to manage their chronic ocular diseases like glaucoma,

and macular degeneration, and diabetic retinopathy. So it's not that you're just seeing some of these patients once every two years for their Medicaid covered eye exam, oftentimes they're being seen multiple times a year.

Greg Stone (01:21:51):

Just like they are for their diabetes, right?

Dr. Kristin White (01:21:54):

Yeah.

Greg Stone (01:21:54):

You're not just seeing them once a year. If you're struggling with their A1C and their diabetic control, their heart disease, you're seeing them three or four times a year. And that's good care, and it's the same with eye care.

Dr. Debi Sarma (01:22:08):

Thank you. Dr. Le, I saw you kind of hop on there. Is there something you wanted to add?

Dr. Julie Le (01:22:12):

I was just going to say the same thing about diabetics, you're the first to see the retinopathy and the patients are going to see you maybe because their glasses are broken before they see their primary care physician, so it's a very entry point into the health system, especially for those that fall out of the care, so I would 100% agree with Greg and also with the medical visits, it's helpful to have the best rate possible in that to help you sustain an eye clinic.

Dr. Debi Sarma (01:22:47):

Wonderful. So we are just wrapping up the Q&A section. You will get a copy of the Q&A questions, I'll send to you for your reference and that will be sent at a later date. If you have any other additional questions, feel free to add them now and we'll get to them as well.

Dr. Kristin White (01:23:09):

And I will be providing the links to those free glasses sites in that general FAQ document that you'll receive after.

Dr. Debi Sarma (01:23:19):

Thank you. Thank you, Dr. White. Thank you everyone for joining today. Oh, and we have one last poll, Dr. White.

Dr. Kristin White (01:23:32):

That's right, we do. Okay. So we would like to know what topics you would like to hear more about for future webinars. So we're thinking about next year planning ahead, do you want to learn more about optical creation? There were lots of questions coming in about billing, internal promotion, and integration of optometry with other community health center services, diabetic retinal screenings, vision screenings, and eye care for children in health centers or school-based clinics or other. And if it's other,

please add your suggestions to the Q&A, so we'll give you about a minute to please select your choice here.

(01:24:14):

And this is really going to help guide what topics we do cover next year. As was mentioned earlier, we've done three webinars in pretty much the second half of this year with the collaboration between NACHC, Prevent Blindness, and the ACU, so we're really looking forward to expanding that more for next year. Okay. So yeah, it looks like there's a big need for learning more about how we bill, which makes a lot of sense, it is complicated if you're not used to it. It looks like vision screening and eye care for children is our second highest. So thank you everyone.

Dr. Debi Sarma (01:25:08):

Wonderful. We'll hand it over to the NACHC team to finish up.

Olivia Peterson (01:25:14):

Great. Thank you, Dr. Sarma and Dr. White. So hello again everyone. So just a couple next steps, reminders for everyone. So as we've said before, we will be sharing the slides as well as some additional resources and handouts with you all. And then the recording, once it is available, it should be within the next week, we'll be emailing out the link to that. As we mentioned before, there are CME credits available for this webinar, so if that's something as you are interested in, please make sure to fill out the evaluation. You'll be automatically directed to the evaluation once the webinar ends, we're always very happy to hear your feedback, so feel free to share your feedback.

(01:25:57):

And then if you would like to receive credits, there will be a few questions for that as well. If you have questions about any of the credits or the steps required, you can feel free to reach out to Luke Ertle, who you heard from earlier. His information is listed on the screen and then you can expect to receive your certificates within two to three weeks. So I am going to hand things over to my colleague, Brandon Jones, who will wrap things up for us. Thank you.

Brandon L. Jones (01:26:28):

All right, thank you Olivia. And thank you again to all of our amazing presenters who all happen to be, minus one, Greg an administrator, everyone else is some really amazing optical, and I'm going to say it wrong, ophthalmologists, but vision care service providers at our health centers. I just think it's really amazing that we have so many in one space. So thank you again for some really, really great resources. And as a quick reminder, look for the slide deck, look for the recording link as well as some additional resources that were shared during the webinar. We'll get those out to you post webinar, in particular, the FAQ document, we have well over 40-plus questions.

(01:27:09):

Many of them have been answered, so you can access those here, but we'll have all of those questions tabulated into one FAQ document with some additional links as well from some of the providers. So you'll get that about a week from today, give us time to get all those questions answered into the document and reformat it and we'll get that to you in about a week. So look for that as well in a mass email to our attendees.

(01:27:34):

All right, thank you all for spending an hour and a half with us this afternoon, I hope you enjoyed the resources we provided and we look forward to seeing you again. Thank you.