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Educational Webinar Series

WEBINAR

Preventive Care + Equitable Care = **ACCOUNTABLE CARE**

SPEAKER

John Bartolovich

Healthcare Economics and Reimbursements Manager

Topcon Screen

Learning Objectives

Overview of CMS Innovation Center ACO programs

Health Equity, SDOH affects

Point of Care Testings' impact on Health Equity/SDOH

How the Point of Care Diabetic Eye Exam increases Health Equity

How the CMS Innovation Center is

SUPPORTING PRIMARY CARE

Primary care is the foundation of a high-performing health system and essential to improving health outcomes for patients and lowering costs. For that reason, the CMS Innovation center has spent years testing models to strengthen primary care, improve care coordination, and address social determinants of health.

https://www.cms.gov/files/document/primary-care-infographic.pdf
last accessed 10/6/2023

States Advancing All-Payer Health and Development (AHEAD) Model

- Targets historical underinvestment in primary care via statewide Targets.
- Provides Enhanced Primary Care Payments to increase investment in primary care
- Uses a flexible framework of care transformation activities to align value-based-payment arrangements.

2024 - 2034

Making Care Primary (MCP)

- Improves care management, community connections, and care integration by providing resources to those new to value-based care.
- Increases access to care and creates sustainable change in underserved communities with state Medicaid agencies, social service providers, Federally Qualified Health Centers (FQHCs) and specialty care providers.

2024-2034

Primary Care First (PCF)

- Helps primary care practices better support their patients — especially patients with complex, chronic health conditions.
- Enables primary care providers to offer a broader range of health care services

For example, practices access to a clinician and support for health-related social needs.

2021-2025

ACO Realizing Equity, Access, and (ACO REACH)

- Encourages health care providers — including primary and specialty care doctors, hospitals, together to form an Accountable Care Organization, or ACO.
- Breaks down silos and delivers high-quality, coordinated care to improve health outcomes and manage costs.
- Addresses health disparities to improve health equity.

2021-2026

Definitions

High Risk represents potential future spending

High Cost represents past or current spending

High Need represents members in need of more intense coordinated care

Who are these patients?

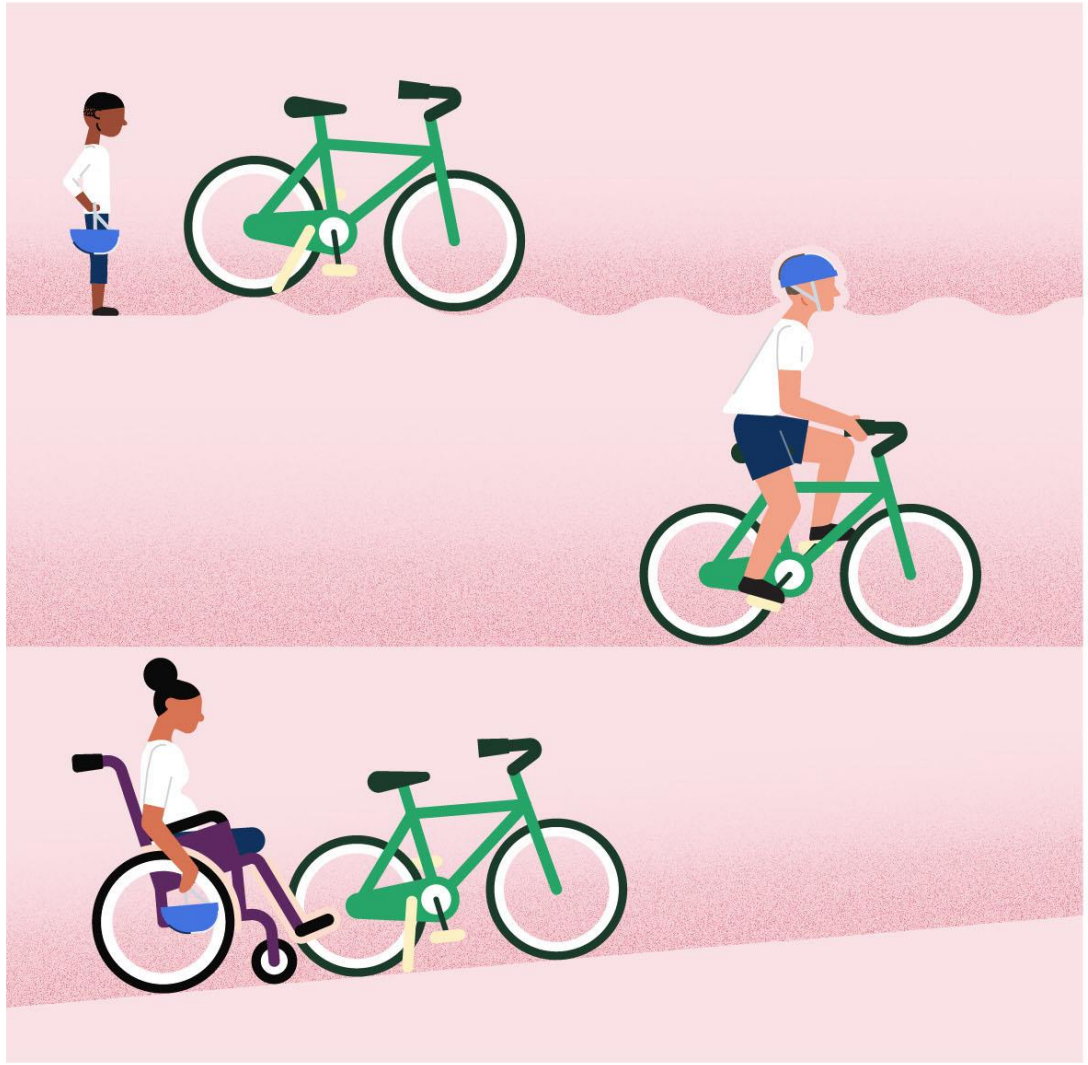
- **Multiple Chronic Conditions**
  - Diabetes
  - Heart Disease
  - Kidney Disease
  - COPD
  - Cancer
- **Complex Medical Needs**
- **Behavioral**
  - Substance abuse
  - Mental Health
- **Socioeconomic factors**

Poll question 1

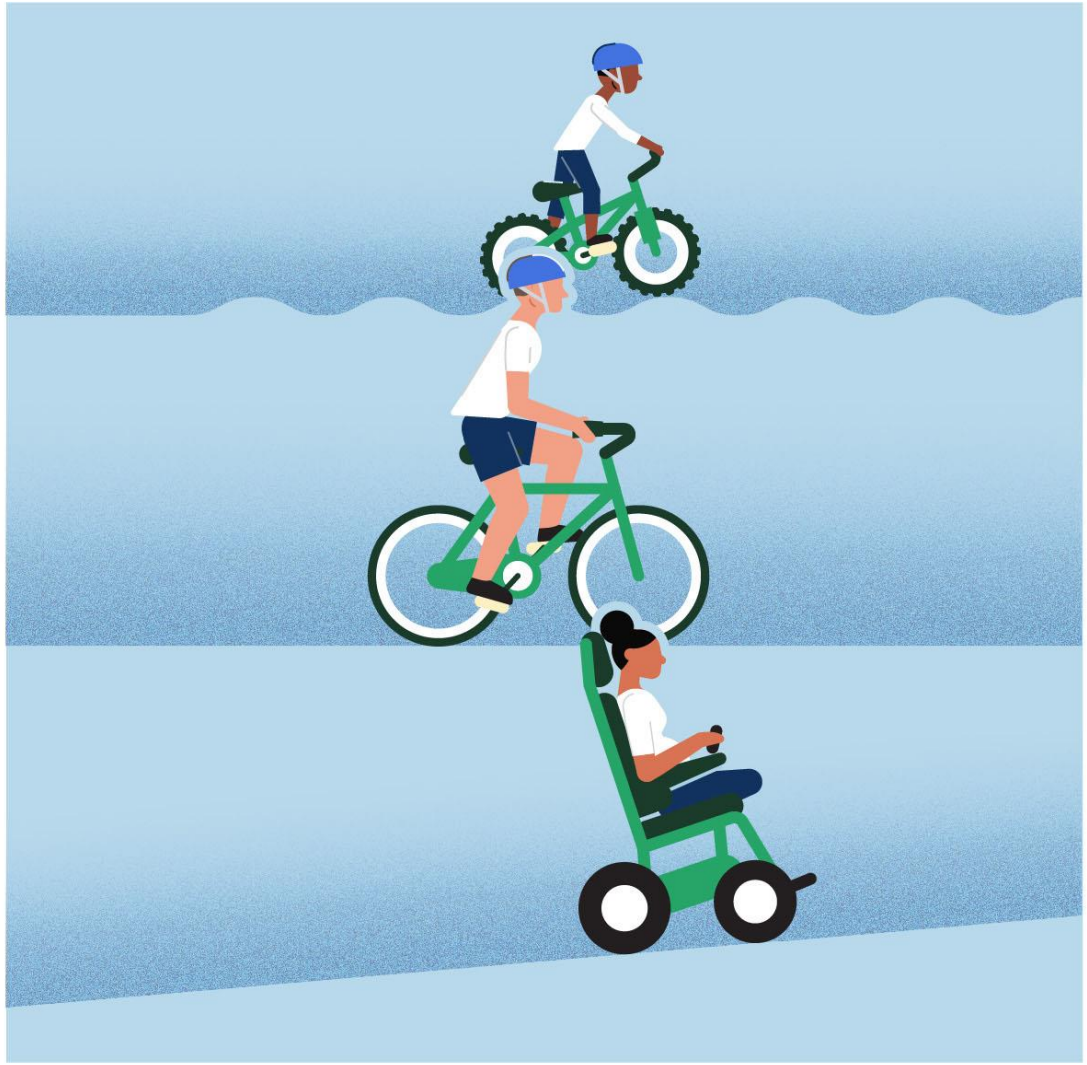
Are you using any of the programs below to target your High Need, High Cost (HNHC) individuals?

1. Traditional Care Management
2. Nurse Care Coordinators embedded in physician practices
3. Patient Centered Medical Home (PCMH)
4. Nurse Care Coordinators centrally located
5. Post Acute/Skilled Nursing Facility (SNF) program

EQUALITY:
Everyone gets the same–regardless if it's needed or right for them.



EQUITY:
Everyone gets what they need–understanding the barriers, circumstances, and conditions.



https://www.rwjf.org/en/insights/our-research/infographics/visualizing-health-equity.html Last accessed:10/06/23

What is Health Equity[1]?

- The **CDC defines Health Equity** as the state in which everyone has a fair and just opportunity to attain their highest level of health.

- **Achieving this requires focused and ongoing societal efforts** to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and healthcare; and eliminate preventable health disparities.

- **Achieving health equity requires valuing everyone equally** with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.

https://www.cdc.gov/nchhstp/healthequity/index.html#:~:text=Health%20equity%20is%20the%20state,their%20highest%20level%20of%20health.

What are the SDOH[2]?

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

1. **Economic Stability**
2. **Education Access and Quality**
3. **Health Care Access and Quality**
4. **Neighborhood and Built Environment**
5. **Social and Community Context**

2 Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [January 6, 2023], from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

What Populations are affected by SDOH?

Populations[3]

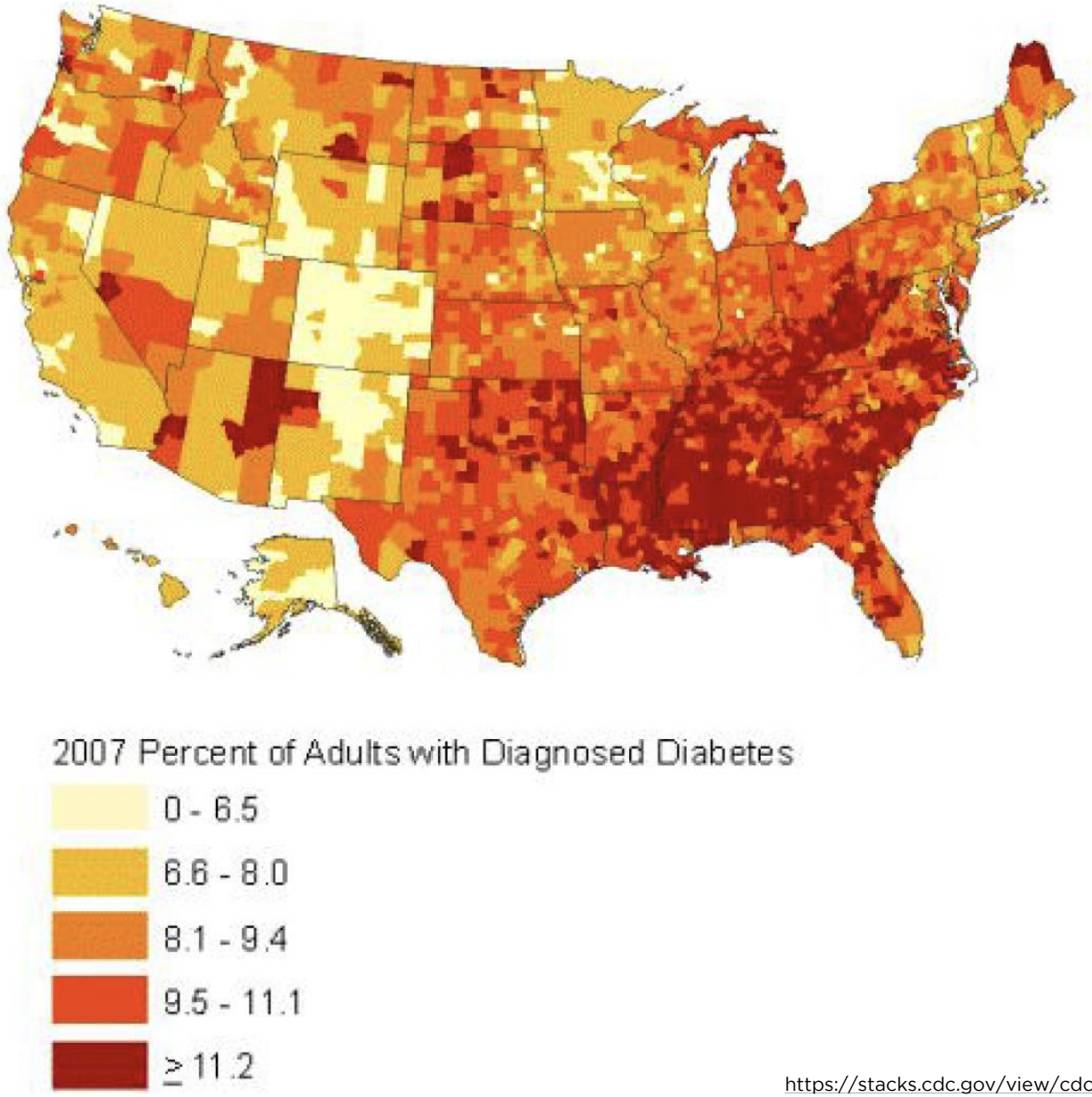
- African American
- Latino
- American Indian and Alaska Native (AI/AN)
- Asian Americans, Native Hawaiian, Pacific Islanders (AANHPI)
- LGBTQ+
- Rural Residents
- People with disabilities

Disparities[3]

- Infant and Maternal Mortality
- Heart disease
- Diabetes
- Hypertension
- Chronic Illness
- Disability
- Cancer
- Mental Illness
- Substance Use
- Overall life expectancy

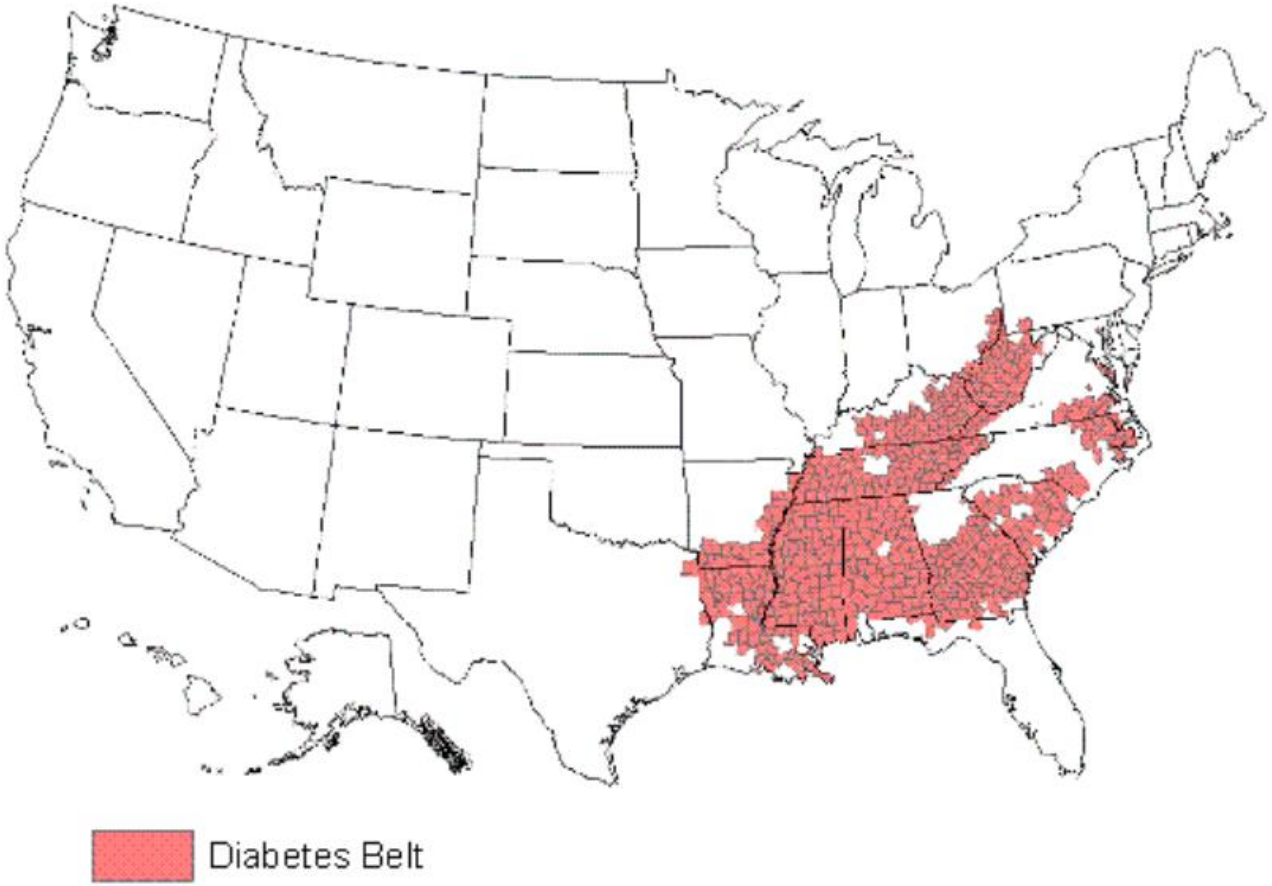
3 https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf

Diabetes Heat Map



https://stacks.cdc.gov/view/cdc/46013
Last accessed 10/11/23

The Diabetes Belt



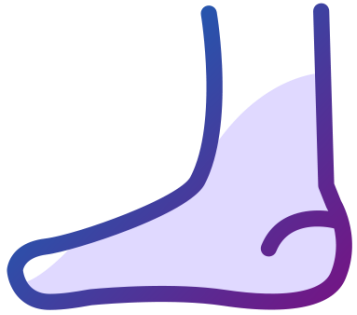
https://stacks.cdc.gov/view/cdc/46013
Last accessed 10/11/23

DIABETES IN THE U.S.

Over 30 Million patients[4]

KIDNEY DISEASE

HEART DISEASE



LOSS OF TOES, FEET, OR LEGS

VISION LOSS

[4] Centers for Disease Control and Prevention website, "National Diabetes Statistics Report", Accessed December 12, 2019, https://www.cdc.gov/diabetes/data/statistics/statistics-report.html

Point-of-Care Testing

Poll question 2

I have seen an eye care professional

a. Within the last year

b. Within the last 6 months

c. Within the last 4 weeks

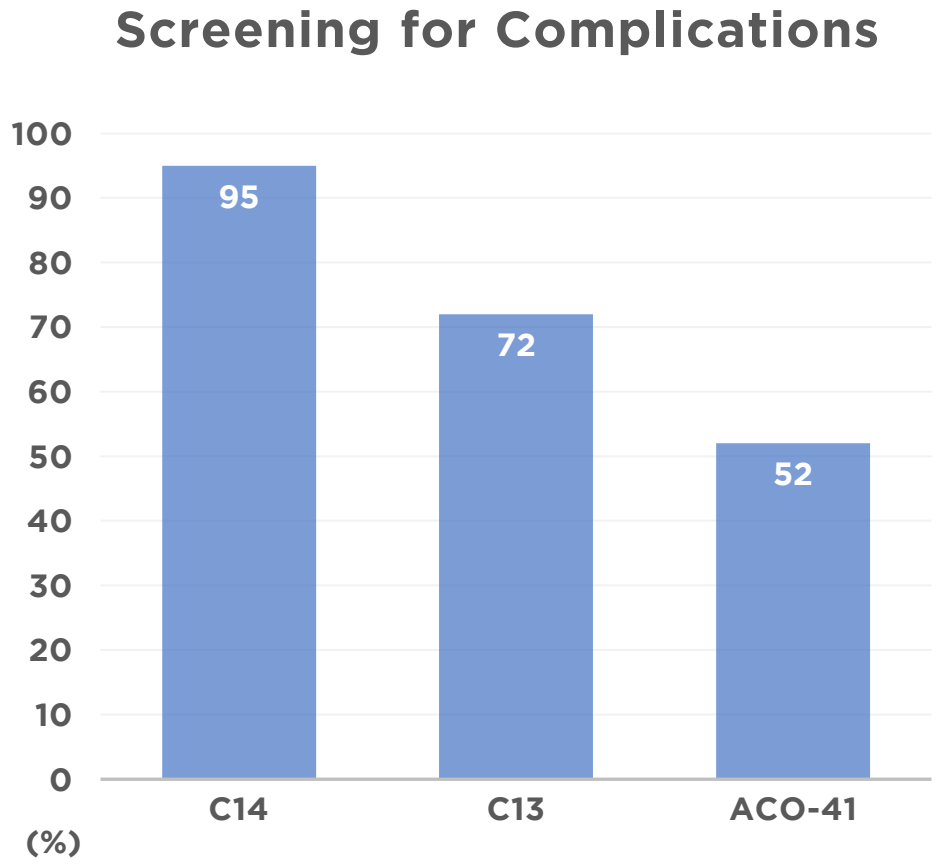
d. I can’t remember the last time

Improving Access to Care

C14: Diabetes Care – Kidney Disease Monitoring

95%

of Medicare Advantage plan members with diabetes had a kidney function test in 2018



Source: Centers for Medicare & Medicaid Services (CMS) standard analytical file "2018 Shared Savings Program ACO Interactive dataset", Accessed December 23, 2019, https://data.cms.gov/Special-Programs-Initiatives-Medicare-Shared-Savin/2018-Shared-Savings-Program-SSP-Accountable-Care-O/v47u-yq84

Normal

DR

Diabetic Retinopathy

- **Most common cause of vision loss among US adults**[8]
- More than **2 in 5 Americans** with diabetes have some stage of diabetic retinopathy[5]
- No symptoms in the early stages of the disease[5]
- **95% of vision loss can be prevented** with early detection[7]
- Up to **50% of Americans** with diabetes were not tested for Diabetic Retinopathy[6]

[5] National Eye Institute website, "Diabetic Retinopathy", Accessed December 12, 2019, https://www.nei.nih.gov/learn-about-eye-health/eye-conditions-and-diseases/diabetic-retinopathy

[6]Lee DJ, Kumar N, Feuer WJ, et al. Dilated eye examination screening guideline compliance among patients with diabetes without a diabetic retinopathy diagnosis: the role of geographic access. BMJ Open Diabetes Research and Care 2014;2:e000031.doi:10.1136/bmjdrc-2014-000031

[7]American Academy of Ophthalmology website, "Sixty Percent of Americans with Diabetes Skip Annual Sight-Saving Exams", Accessed December 12, 2019, https://www.aao.org/newsroom/news-releases/detail/sixty-percent-americans-with-diabetes-skip-exams

8 https://www.cdc.gov/visionhealth/basics/ced/index.html#:~:text=Diabetic%20retinopathy%20(DR)%20is%20a,of%20blindness%20in%20American%20adults.

Diabetes Eye Exam Care Gap

Primary Care Physician

60%

Eye Care Specialist

Specialist returns report which closes HEDIS measure

40 %

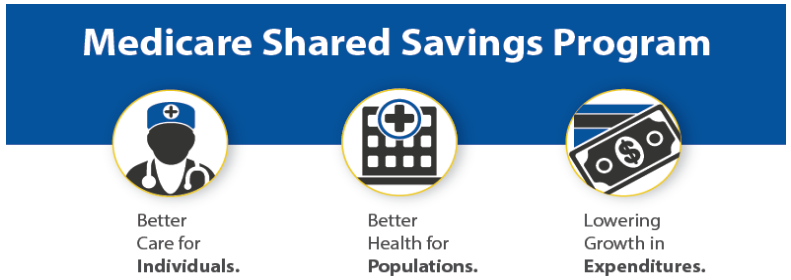
Reasons for Care Gaps

1) Patient compliance
2) Scheduling
3) Transportation
4) No symptoms
5) Financial Concerns

Impact of a Care Gap

1) Patient outcomes
2) CPT Reimbursement
3) HEDIS/ Star Measures
4) Risk Adjustment

Diabetes Eye Exam Care Gap



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
Five-Star Quality Rated

- **ACO-41:** Diabetes: Eye Exam
- 2018 Performance data average

52%

- **C13:** Diabetes Care – Eye Exam
- 2018 Report Card Average

72%

Source: Centers for Medicare & Medicaid Services (CMS) standard analytical file "2018 Shared Savings Program ACO Interactive dataset", Accessed December 23, 2019, https://data.cms.gov/Special-Programs-Initiatives-Medicare-Shared-Savin/2018-Shared-Savings-Program-SSP-Accountable-Care-O/v47u-yq84

Impact of Undiagnosed Diabetic Retinopathy

Negatively impacts patient outcomes[10]

Diabetic retinopathy at later stages reduces a patient's quality of life[10]

Later stage retinopathy increases utilization costs

Treatment costs can exceed $10,000 annually[11]

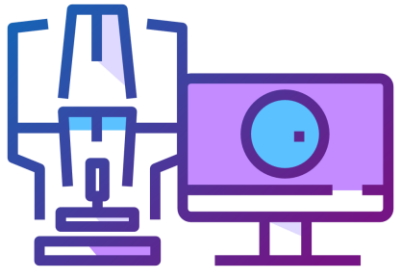
Requires urgent medical treatments upon diagnosis

- Injection Eye Drug - $300
- Fluorescein ICG Angiography - $650
- Ocular Photo Dynamic Therapy - $1,200
- Injection, verteporfin, 0.1 - $2,700

[10] Kamran, Jannat & Jafroudi, Shirin & Leili, Ehsan & Chafjiri, Sedighi & Paryad, Ezat. (2017). Quality of Life in Patients with Diabetic Retinopathy. Journal of Holistic Nursing and Midwifery. 27. 69-77. 10.18869/acadpub.hnmj.27.1.69.

[11] https://www.jmcp.org/doi/pdf/10.18553/jmcp.2020.19245

Diabetic Retinopathy Screening at Point of Care



Indian Health Service-Joslin Vision Network (IHS-JVN)[12]

- Established in 2000 to use telemedicine technology to provide high quality, cost-effective, annual diabetic eye exams
- This program has significantly contributed to a decrease in diabetes related vision loss and blindness

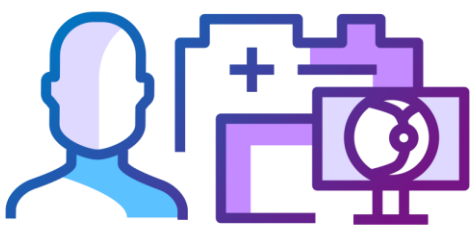
Veterans Administration[13]

- Reliably determined the level of diabetic retinopathy
- Opportunity to engage with patients
- Patients' responses to non-mydriatic teleretinal imaging are universally positive

[12] Indian Health Service. "IHS-Joslin Vision Network Teleophthalmology Program", https://www.ihs.gov/teleophthalmology/, Accessed January 2, 2020.

[13] Journal of diabetes science and technology (Online). "Teleretinal Imaging to Screen for Diabetic Retinopathy in the Veterans Health Administration", https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2769713/, Accessed January 2, 2020.

Topcon Screening Workflow



Point of Care

Diagnostic Data

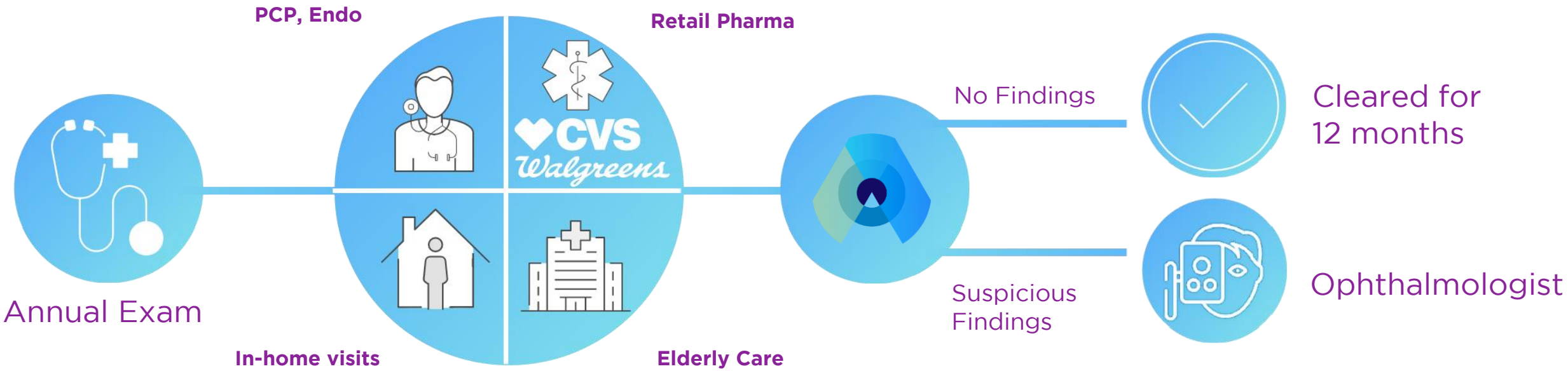
Secure, Encrypted Data Transmission via HIPAA compliant image management software

Eye Care Professional

Interpretation reports returned to practice within 48 hours

AEYE DIAGNOSTIC SCREENING

FULLY AUTONOMOUS



Solutions for Non-mydriatic Retinal Cameras

SIGNAL Handheld Camera:

- Portable
- Technique driven
- Wi-Fi enabled

TRC-NW400 Tabletop Camera:

- Robotic camera automatically captures both eyes
- Completed screen in under 2 min

POINT OF CARE

Diabetic Retinopathy Exam

At Risk Diabetic Patients

Convenient Diagnostic

Peace of Mind

Early detection and treatment

Primary Care Providers

Fast, easy to use

POC Testing

Improved control of diabetic care

Eye Care Providers

Targeted referrals

Add telehealth services

Early detection and treatment

Health Systems. ACOs and Practices

Improved Scores and quality measures

Additional POC capability

Improved Payments

Payers

Built in metric tracking

Improved cost of care

Lower rates of advanced disease

WORKING TOGETHER FOR QUALITY CARE

Case #1
UC Davis

- UC Davis launched a pilot teleophthalmology program in 2018 for DR screening using **ONLY code 92227**
- Estimated Operational Cost was **$41.02**/patient
- Estimated revenues were:
  - FFS **$19.86**/patient
  - Quality Incentive **$43.06**/patient
  - Downstream referral revenue **$39.38**/patient
- 178 clinic visits eliminated saving an additional **$42.53**/patient
- **Screening rate increased from 49% to 63%**

Ophthalmic Surgery, Lasers and Imaging Retina, 2020;51(S2):S26–S34
Published Online:January 08, 2020https://doi.org/10.3928/23258160-20200108-04
Last accessed 10/5/2023

Case #2 Valley Medical Group

- Valley Medical Group looking to standardize care for its 8000 diabetics elected to join AMGA Together 2 Goal Innovator track Eye Care Cohort. **Goal was to screen "True Gap" patients**
- Established a Wednesday Diabetes Clinic in Ophthalmology, scheduling every 15 minutes.
- Deployed 2 NW400 in Endocrinology during 4-month pilot.
  - **21.2% of patients had DR**
  - **30.5% of patients had other pathologies**
  - **60 Eyeballs saved**
- Average reimbursement from retinal photos was $77.
- Increased screening rate from 40.7% to 49.9%, screened an additional 775 patients over 12 months.
- Added 2 NW400's at conclusion of collaboration
- Currently adding NW500s to mix

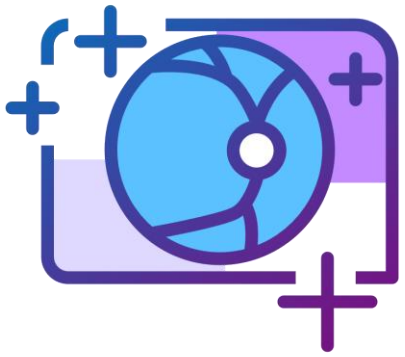
http://www.together2goal.org/assets/PDF/CS/Cohort_Valley_Med.pdf Last accessed: 10/05/2023

Crozer-Keystone Health System

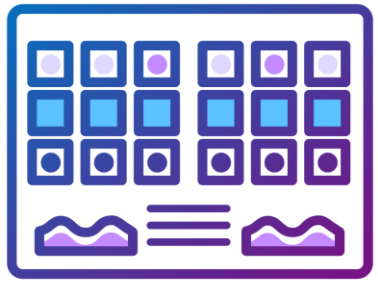
- Partnered with Vantage EyeCare and Topcon Healthcare to screen patients at point of care
- Placed Topcon **TRC-NW400 tabletop retinal cam**era in two primary care practices
  - Of the first 80 patients screened, 30 (nearly 37%) had abnormal studies
- **BENEFITS**
  - Gives patients the opportunity to get screened in their offices during primary care visits
  - Provides quality, convenience and value for the patients
- This is an effective front-line defense against diabetic retinopathy
- www.crozerkeystone.org

Crozer-Keystone. "Partnership Helps Catch Diabetic Retinopathy." Crozer-Keystone Health System Press Release, December 2019. https://www.crozerkeystone.org/health-resources/partnership-helps-catch-diabetic-retinopathy/, Accessed January 2, 2020.

Topcon Screen Solution



Fundus Camera	Diagnostic Report
• Lease option • Exam bundles • Autonomous AI or Human Reads	• Per patient exam fee • NO Software fees • NO training fees



Success Begins with our Onboarding Program:

- Workflow optimization
- Reimbursement support

Questions and Discussion

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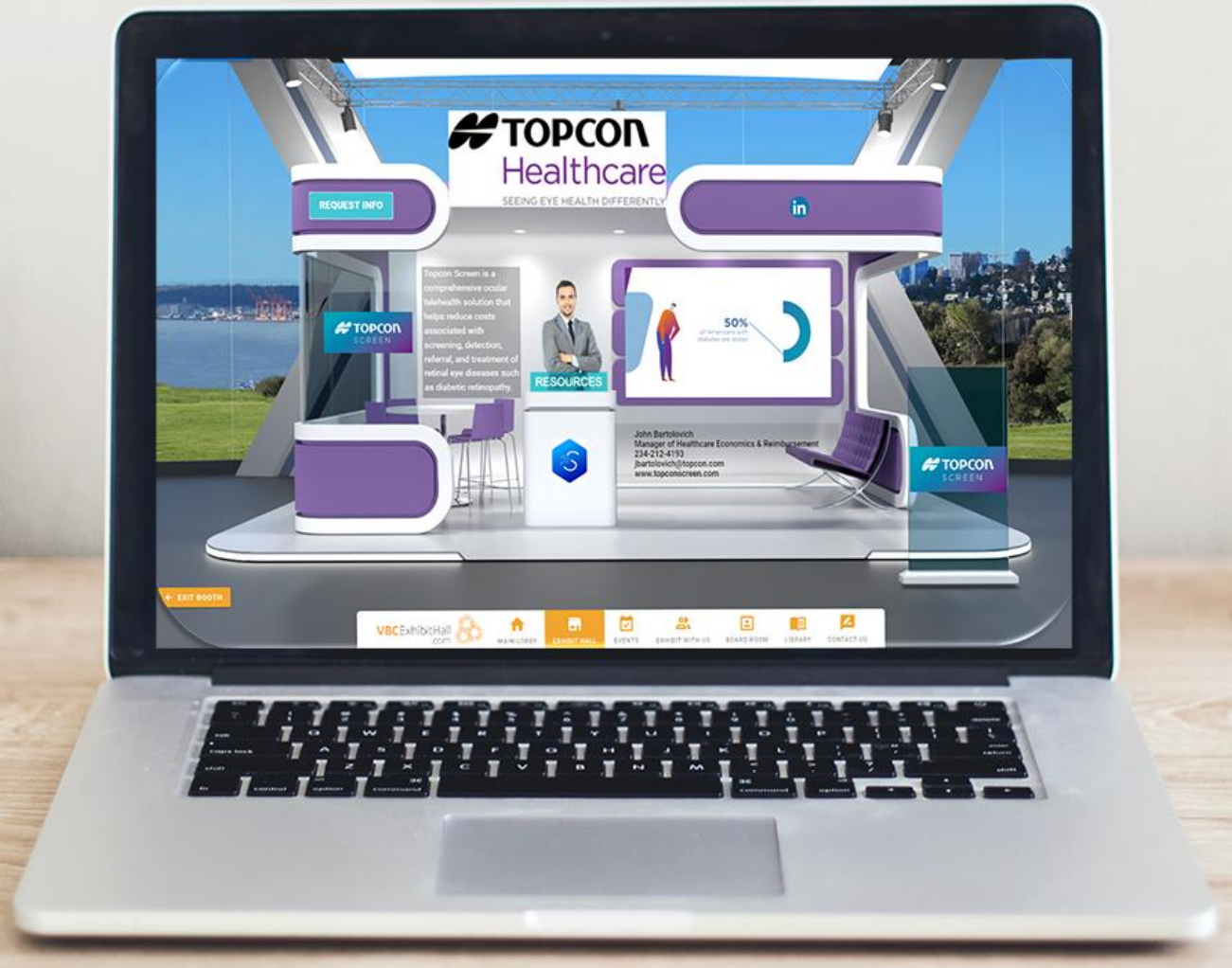
ENTER BOOTH



WEBINAR

Thank you

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