OCULUS health

The Four Steps to Making Primary Care Great Again

Ready Yourself for Value Based Care with a Fee For Service Solution

2019

Background

The push toward value-based reimbursement is strengthening each day, especially given the mandate by Health and Human Services (HHS) that has set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018.

How can healthcare providers and administrators prepare their teams for a transition to value-based reimbursement and minimize risk in the process?

Over the past five years CMS has introduced a group of billing codes that maximize fee for service revenue by implementing a methodical program to optimize patient care and outcomes.

Why isn't every healthcare organization doing this already?

There are 3 primary reasons:

- CMS introduced these programs individually and without direct reference to each other.
- While these programs are well known, they are nearly impossible to implement internally irrespective of the size or shape of the healthcare organization.
- The programs are only effective when coupled with consistent patient engagement.

Fortunately, Oculus Health has cracked the formula to make Value Based Care principals work for you as Fee For Service billing codes. The Four steps to Population Health Management are:

1. Preventive Care
2. Chronic Disease Management
3. Managing Care Transitions
4. Behavioral Health and Telehealth

This paper will be entirely focused on helping providers and administrators work to implement or align with these Value Based Care principals by sharing some of Oculus' secret success tactics.

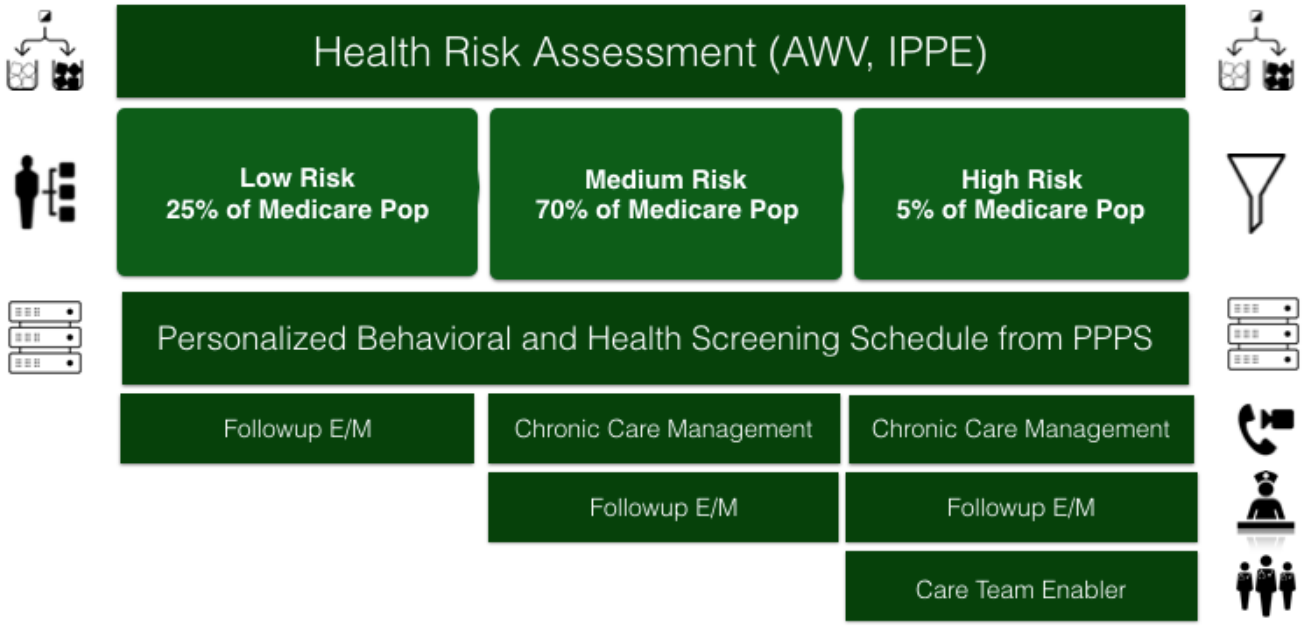
In the (unfortunately likely) event that an internal implementation attempt is not possible, this paper will provide providers and administrators a step-by-step formula to make this work for you.

The end result is creating a lifecycle management program that ensures that every provider is presented cases in the most prioritized order with the appropriate context.

Step One: Preventive Care

The linchpin of any successful health management and prevention program is to establish a baseline of the patient's health. Practicing generalized medicine based on the individual health characteristics of each patient requires a baseline understanding of health and function risks as the means to apply a risk stratification filter.

On a broad basis, patients can be grouped into Low, Medium, and High Risk categories, each paired with a appropriate care management strategy.



Preventive care services are built into the patient care plan as templates, and therefore encouraged and scheduled by the patient's care manager with the patient's permission. For instance we automate reminders for flu vaccinations as well as cancer screenings based on the age of the patient.

The Preventive care services and followup screenings, such as Depression Screening, Smoking Cessation and dozens more, are to identify patient pre-condition risk factors, and then get the patient started down the appropriate path toward prevention and treatment.

When conducted thoroughly across the entire Medicare Patient Population, this shifts your practice into proactive mode, ready for Value Based Care.

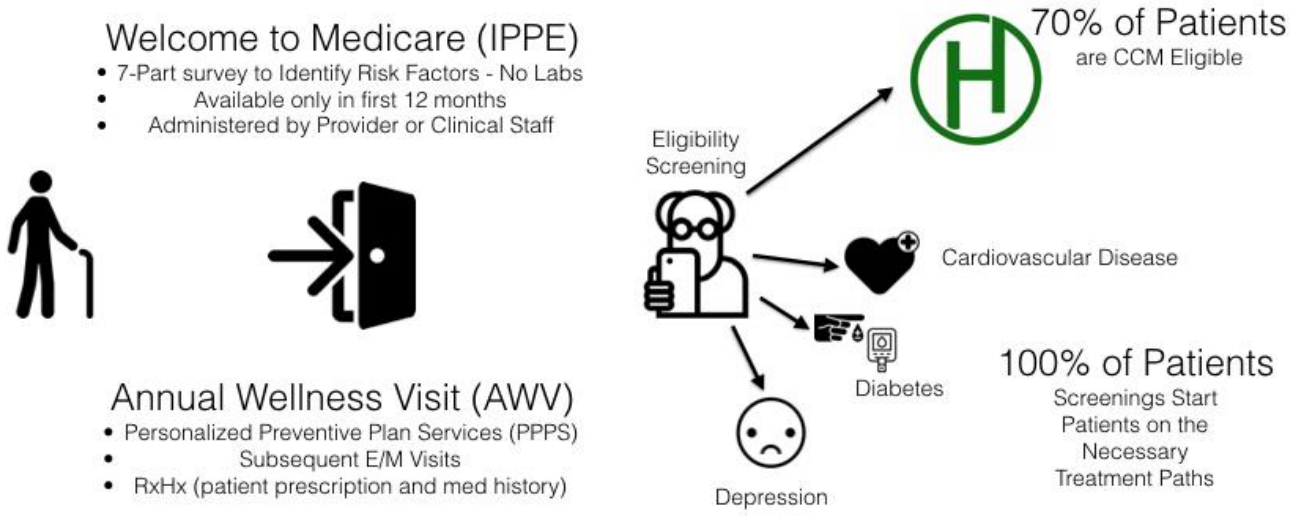
Despite the obvious slew of benefits, practices and health systems have been slow to adopt any sort of preventive care programs to a successful degree. In 2015 less than 15% of the total Medicare population had received a health risk assessment in the form of an IPPE or AWV. The exams are too time consuming, require additional staffing, and there are no existing success templates to model.

Oculus has a simple solution for this.

As part of the Oculus CareSuite Solution, Oculus will take the responsibility of staffing the necessary medical personnel to conduct the Preventive Care Exams on behalf of the practice. The staff will be placed inside the clinic, practice, and/or hospital, and their primary purpose will be to conduct the exam component, generate the Personalized Preventive Plan using Oculus' proprietary software. Lastly, the staff members will schedule a follow up visit for the patient to come in and see his/her provider to discuss the PPP and set goals going forward.

This also acts as the perfect feeder into Chronic Care Management. Patients with 2+ chronic conditions will be identified, and offered CCM enrollment as they are completing the AWV or IPPE questionnaire.

The Oculus CareSuite workflow follows the image below. The only responsibility of the provider, support, and office staff is to see the patient at their next scheduled appointment and discuss the PPP. Oculus handles everything else.



Step Two: Chronic Disease Management

The most popular and poorly executed form of chronic disease management is CMS' January 2015 CPT 99490, Chronic Care Management. This program is designed to provide non face-to-face care for patients with 2+ chronic conditions. Non face to face care can fall into any number of activities ranging from phone calls to care coordination.

Practices and Physician Groups have struggled with the staffing component, particularly the 24/7 nurse on call requirement, and every healthcare organization has struggled with the technology component. The technological infrastructure required to share the care plan electronically and in real-time with both the patient as well as all of the members of the patient's care team is far beyond the capabilities of nearly every existing software solution available.

Last but not least, the extensive documentation requirements alone are a non-starter for a vast majority of healthcare organizations. The end does not justify the means.

Oculus has a simple formula to remedy this problem.

As patients qualify for Chronic Care Management, as indicated by the results of their Annual Wellness Visit, the first steps are a thorough review of the patient's personalized prevention plan and goal setting with their care manager.

Everything starts with the initial phone call between the care coordinator and newly enrolled patient. As with practices, there is no one size fits all, so we start every relationship by determining how this program can be most valuable to the person on the other end of the phone.

Is the person high-tech? Low-tech? No-tech?

If high-tech or even low-tech does the individual use a Bluetooth, WiFi, or GSM chip enabled glucometer, BP monitor, scale, or any other of hundreds of medical devices that Oculus has built an integration path with?

Does the patient use a wearable such as a FitBit, Apple Watch, or any other of hundreds of wearable devices that Oculus has built an integration path with?

Does the patient use any health apps such as Apple Health Kit, Google Health Kit, MyFitnessPal to log meals, MapMyRun to track walks or jogs, or any other of hundreds of apps that Oculus has built an integration path with?

Would the patient benefit from logging medication and care plan adherence on their smartphone using the Oculus Health app? Are they interested in the rewards program that gives them prizes such as gift cards, flower bouquets, FitBits, etc. for them actively and regularly logging their medication and care plan adherence?

What do all of the above questions have in common? They provide the data necessary to paint an accurate picture of how each patient is doing at any given point in time. The more accurate and real-time our patient picture is, the better we are able to get them actively involved in managing their own health. The more involved we can become in helping them actively manage their own health, the greater the likelihood of improved health for the patient.

The Care Manager that calls the patient that first time is that patient's point of contact from that point forward. We believe in and have seen the power of the 1:1 patient to care manager relationship.

During that initial call, the Care Coordinator and patient will make a plan for how to move forward. For some patients that could mean syncing a glucometer and Fitbit, and logging their medications daily – therefore they only need a call every other week. For other no-tech patients that could mean two calls each week at set times.

Whatever is most valuable to the patient is what we do. There is no one size fits all.

Step Three: Managing Transitional Care

One of the most commonly used words to day is “readmissions.” Providers are incentivized to facilitate the appropriate followup care for each individual patient post-discharge, whether the patient goes home or to a skilled nursing facility. The best litmus test of how well a healthcare organization manages its patients’ health is in fact the readmission rate.

Discharge planners have their hands tied on pointing patients toward one care option or another, and therefore can’t walk the patient through the process up until the transition is complete. And with no mention of quality of specific care facilities, the patient is flying blind and often ends up choosing a facility or provider based on geographical convenience.

This presents a few problems in particular:

- Patients will fill all prescriptions and be able to afford them
- Patients will follow the discharge order timeline
- Patients will have no problem getting an appointment with appropriate providers
- Patients will take the time to find the best PAC facility

All too often, these touch points when the patient is solely responsible for their own care management are not followed through on as intended. Without proactive post-discharge outreach, there is no means to reduce or prevent readmissions.

Oculus has one simple solution.

As a patient is discharged from the hospital, the patient is under the immediate direction (not care) of an Oculus employed care manager.

Right off the bat the care manager touches base with the patient by any means possible, phone, email, fax, etc., to review the discharge summary with the patient and come up with a plan of action. The first step being scheduling a follow-up appointment with the appropriate provider.

The provider will take ownership and provide instructions and treatments to the patient, but once the patient leaves the office they are now responsible for following through.

Not the case.

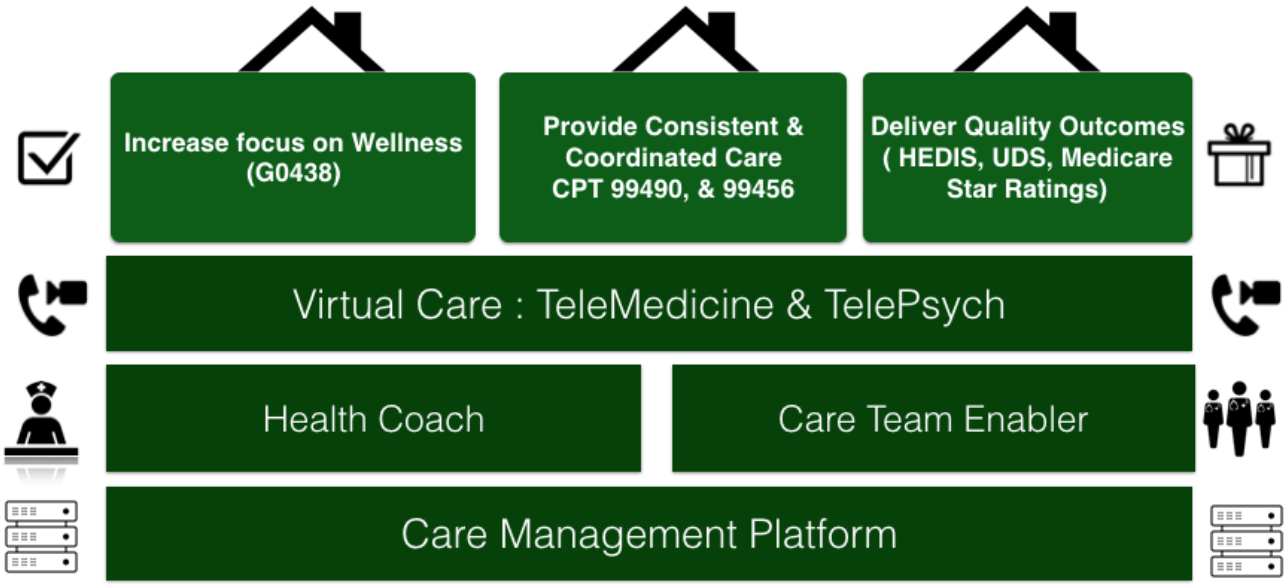
The Oculus care manager ensures that all instructions are followed, appointments are scheduled, patients are reminded of appointments and transportation arranged if necessary.

It is not that the patient is incapable of following instructions and treatment plans, that couldn’t be further from the truth. But helping the patient navigate the healthcare system appropriately and effectively has shown tremendous results in reducing readmission rates as well as improving patient satisfaction.

Step Four: Behavioral Health and Telehealth

Physicians and other practice employees will use the Telehealth component in addition to Oculus-employed care managers. As more and more Telehealth billing codes are introduced, providers will utilize this more and more. We may integrate with an existing telemedicine provider.

The Telehealth capability, when combined with Preventive Care Services such as depression screenings, becomes very powerful. For example, depressed patients not currently under the care of a psychiatrist can be paired with a tele-psych consult via Oculus' Telehealth portal.



Everything Hinges on Patient Engagement

The fact of the matter is that none of the above matters, or is even possible, unless you are successfully able to engage the patient. This has been the achilles heel of healthcare for quite some time.

By starting the process off with a health risk assessment, such as the AWV, you have a report from which you can guide the relationship with the patient going forward. Identifying the starting point is an absolute necessity to establish relevance and value of engaging with you, the provider.

Patients are used to the way things are currently done. Go into the provider's office. Talk for 15 minutes. Leave and don't come back until you need another 15 minute slot.

Motivating patients to become actively involved in managing their own health requires providing enough value to the patient to justify the means on their part.

It begins with the patient and care manager relationship. First, the care manager that reaches out to the patient the day after enrolling will be that patient's point of contact from that point forward. This 1:1 relationship has proven itself very effective in retaining patients. On the other side of the equation many of our competitors try to minimize human contact (care manager outreach), and utilize technology only tactics to reach the 20+ minute threshold. We see that as a mistake with this particular demographic.

During that initial call, the Care Coordinator and patient will make a plan for how to move forward. For some patients that could mean syncing a glucometer and Fitbit, and logging their medications daily – therefore they may only need a call once every other week. For other no-tech patients that could mean two quick check in calls each week at set times. Whatever makes the program the most valuable to the patient is what we do. We recognize that patients do not have to participate, so therefore there is no one size fits all offering we employ.

Oculus has a patent-pending experiential patient rewards program that awards points to patients for reporting activities such as medication adherence and diet within their Oculus profile app. An overarching objective is to get patients actively involved in managing their own health, and the point rewards program gives patients prizes from flower bouquets, gift cards and FitBits to reinforce this behavior.

Currently, **more than 55%** of our enrolled patients actively record 1+ data points using their **Oculus app 2+ times each week**. This includes no-tech patients.

Results To Date

With respect to clinical quality, Oculus Health can say that it has a clinically proven solution. Internal and independent data analysis has identified and confirmed the positive impact on actively engaged patients' vitals. Included with this is a study conducted on 500 Type II Diabetic patients that as of January had been on our platform for 9 months*.

The study concluded the average across the 500 patients being evaluated:

- HbA1c blood sugar levels reduced by 36%;
- Triglyceride levels reduced by 37%;
- Inpatient hospital admissions reduced by 29%; (compared to average hospital admissions with specific characteristics)
- Emergency room visits reduced by 25%.; (compared to average ER visits for a diabetes profile patient)

Additional measures include:

- Member satisfaction up by 4x compared to patients not enrolled in CCM

- Maintain < .001% of unplanned admissions
- Timeliness of care transition notification of the receiving care setting from the sending setting
- 96% Medication Adherence
- Improved activity, nutrition and lifestyle improvements

This is what is possible when Chronic Care Management is done well. We plan to deploy a stronger scientific way to baseline and quantify the outcomes from both disease management and cost savings perspective(s) in Q3 2016.

Patient and Provider Testimonials

A small sampling of our Patient testimonials include:

- "It's nice to have a phone call just to check on me"
- "It's great that I can ask questions about specific lab results and what exactly they are checking for."
- "I don't feel rushed when you call to discuss my health"

Provider/Office Staff stated:

- "Refill request are so much easier to fill coming from you. It defiantly speeds the process since you include the exact medication, dose, sig and pharmacy name."
- “I’m not entirely sure what it is that you do, but my Medicare patients seem to love me lately!”
- “We have had so many patients come in asking for their care coordinator by name. They looked so excited like they were about to reunite with their best friend!”

The doctors/office staff also has been very grateful that we are informing them when patients are having issues that need to be addressed promptly. They have stated that our phone call or emails have made it possible for them to address these situations much more quickly, especially since they don't have to listen to numerous voicemails and messages. CCM helps to bring these pressing issues to their attention ahead of the less urgent ones.

End Result: Making Primary Care Great Again

Healing healthcare requires leveraging the gifts of our population’s first line of defense and offense; the Primary Care Provider. Every effort should and must be made to free our PCPs of all administrative burden, and empower them with the right context at the right time to provide the right priority care.

That means extending the reach of the provider beyond the four walls of the clinic.

That means remotely monitoring patients and bringing those needing their Provider's care in at the right time with all supporting reason and data.

I strongly urge you to allow Oculus to do all of this for you. It is as simple as signing on the dotted line, and we can take it from there.

At the end of the day CareSuite™ brings us another step closer to achieving our mission; making it great to be in Primary Care again.