Overview and Problem:

Practice:

The traditional model of care and the necessary surrounding infrastructure to support that model are rapidly becoming obsolete in the face of economic overhaul, transitioning from volume to value.

There is no success template in terms of making the transition internally, and providers are trained to practice one way and one way only from day 1 of medical school.

The opportunities that exist for private practitioners are:

- Sell to hospital / health system
- Concierge Medicine
- Try and weather the storm

Selling to hospital / health system requires a loss of autonomy and often joy in practicing medicine. Hospital and health systems are ramping up patient throughput across the nation in an effort to maximize reimbursement.

Concierge medicine requires convincing 300-600 of your existing patients to remain under your care, and ultimately having to say goodbye and reassign 65-85% of your total practice. The revenue model can be comfortable, but lacks certainty and rigid timeline. Not to mention the underlying distaste providers have towards asking patients for money in exchange for services.

Weathering the storm and remaining independent is faced with downward reimbursement pressure, diminishing reimbursement for traditional care practices, and a tremendous increase in administrative overhead, including but far from limited to quality reporting requirements, are mounting in terms of volume necessary and complexity.

Oculus:

Oculus has effectively married a technology company, staffing agency, and personal call center into one business model. The result of this hybrid model is the pursuit of the ultimate compliment to providing care; transitioning the old model to the new. It is not the patient care that needs overhauled, rather the delivery medium.

Oculus is uniquely positioned to lead that charge, defining the care of tomorrow.

Here's Where We Are:	**What It Should Be:**
Apply to 25% of patients	Apply to 85% of patients
80% Care Management Services	20% Care Management Services
10% Preventive and 10% Custom Services	80% Preventive and Reporting Services

The primary challenges that exist for Oculus' PLM Solution can be summed up in one sentence - We need to be 20% Care Management and 80% Preventive and Reporting Solutions to 80% of their patient panel instead of 20% of their patient panel. The three challenge categories are:

- Preventive Utilization
- Care Management framework
- Depth of Clinical Integration

The effectiveness of a transition from reactive to proactive care can be summed up in the amount of preventive care administered during the transition.

Yet utilization of preventive services remains low or nonexistent at most practices. The Annual Wellness Visit is beautifully and UI friendly designed on the Oculus platform, yet it is wildly difficult to get a support staff member let alone a provider in the platform.

The opportunity is a deeper level of clinical integration

Top patient and practice complaints, valid or not, are that the patient never consented to services, the call was “not 20 minutes,” or did not “focus on health.” Because there is little expected from practices up front, and we don’t equip them to defend us on our behalf, this flows over to the practice sentiment towards Oculus Health.

The fault is not Oculus’ Care Managers - but rather that Oculus’ Care Managers are carrying the program and patient participation in near entirety.

Patients are receiving a new type of care, in a new setting that they’re not used to, and without seeing their HCP face-to-face. Without everyone (provider, patient, and care manager) rowing in the same direction from the beginning, each patient enrollment is at risk and puts the relationship with the practice at risk.

Solution Elements:

The ultimate solution for all parties involved from a ROI, fulfillment and satisfaction perspective must contain the following elements (in no particular order):

<u>1. Be valuable for their entire patient panel. Not just Medicare patients.</u>

Catering to the bulk of the provider’s population is invaluable. With many of the programs limited to Medicare and MA patients, we are working towards shifting a practice to a new model of care, utilizing a platform outside of their EHR, etc. for…30% of their patient panel.

Success requires expanding beyond CMS population into commercial payers.

The silver lining is that the ACA required private payers to adopt a multitude of the preventive services offered by CMS at no out-of-pocket expense. With 7 years in practice, irrespective of whether the ACA is appealed, the value these codes have generated for payers will keep them around.

So while we won’t be able to bill G0438 / G0439 in the case of private payers, the resulting recommendations (IBT for CVD, Obesity, Tobacco - immunizations, etc.) ARE THE SAME BILLABLE CODES.

This is huge as it

Going forward - every patient, irrespective of payer, will be handed a tablet to do their “next / initial appointment assessment.” They will vary slightly according to the patient’s carrier, however, the involvement of the staff in the office will be identical.

Adding something small to 10 out of 10 patients is worlds simpler than adding to 3 out of 10 patients.

2. Getting claims paid, and get paid.

A/R. EOBs. Woof.

Built into the backend of our platform going forward will be Real Time Eligibility (RTE) Verification. When a a Medicare Advantage patient walks in the door, we’ll know that they’re eligible for an AWV, and with the results of the AWV we’ll know everything they’re eligible for going forward.

Except for in this particular case, Eligible = Covered = Gets Paid.

Switch Preventive and Reporting services to monthly subscription fee (which must be perfect on the data component - more on this in number 3), so we’re on a regular payment schedule which practices are used to seeing coming out of their account each month.

Not to mention, when you’re checking eligibility, you’re not in a position where they’re super worried about denials. Also look at the amount of additional revenue we’re generating for them.

We have options for getting this in place - 1) partner with RCM companies that have a RTE component, and/or 2) plug in a RTE Verification vendor API into our backend that has a long reach (RTE with 95%+ of payers).

3. Data Transfer, now and ongoing

HL-7

It’s that simple. We need to be at the level to do the rest of our solution justice. Anything less is leaving too much to chance, and our solution is better than that.

4. All Parties rowing in same direction

In some sense, our Care Managers are hanging out to dry in certain scenarios, just waiting for a patient to say “I didn’t agree to service,” and the chain of events that follows is outlined above.

By starting with preventive, a strong focus on patient education, and provider setting up CPI and RPM - now when the Care Manager calls the patient, there aren’t any surprises.

Education and preparation - those are the keys to carry the patient momentum from appointment to first contact. Patients will be given a folder containing information about the

program. Financial disclosures will be up front and center. Truthfully - these services are a bargain *if they're understood* - so lay everything out there, and if you aren't getting great participation rates we need to revisit the collateral and messaging.

Data is impact. Data is engagement.

Within the patient resource packet will be a first call preparation guide as well as a first call checklist. The preparation guide will outline what the provider indicated s/he wanted the patient and CM to measure and monitor (CPI/RPM), and also walk the patient through various ways to report data.

There will be a checklist - do you have a computer, tablet, and/or smart phone? Do you have a glucometer, BP monitor, fitbit, etc. etc.?

For Care Management and RPM patients, active app participation is not an option, unless they have no reliable internet source, smart phone, etc.

Before getting off that first call, get the patient set up on the app. Show them around, and how to track various parts, sync their bluetooth, wifi or GPS enabled devices to automatically sync collected data, and lastly INTRODUCE THEM TO THE REWARDS PROGRAM! Show them how to get points, and motivate them stick with the reporting - particularly daily medication adherence.

5. Deep level of clinical integration - Oculus' Care Managers being equal to internal support staff

When a provider tasks a care manager within the EHR - just like s/he would internal staff - we know we're on track. When a provider communicates with a CM and patient within the Oculus platform - we know we've made it.

The whole point of the program is for our CMs to do what it is that the provider wants and tells them to do to support patients outside of the office.

Keeping patients on top of data reporting, health goals, and serving as a resource is our job - tying everything back into the practice - creating a deep level of communication and integration is our mission.

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Practice / Provider Business Case for Adopting Oculus Connected Clinic

First, let's look at dollars and cents.

Under this program, an average Solo PCP will net $268,041 after subscription and per use fees for services including AWV, ACP, CPI, CCM, TCM, RPM and CFA.

Additional $73,691 net revenue in first tier preventive screenings and services. That becomes $290,154 when you expand to a patient panel of 1,500.

Additional $119,648 in second tier preventive services net revenue. That becomes $397,943 when you expand to a patient panel of 1,500.

*Bottom line: The average PCP is looking at **$956,138** in net revenue.*

Where do you find the time?

The first question is how can we possibly find the time to generate even a fraction of this additional revenue? We are overworked as it is!

The reason you're overworked is because you're already doing so much of this the hard way, and not to mention Oculus brings additional staff to the equation.

Step 1: Handing patients tablets

The only way any of this is going to happen is if we effectively get out ahead of patient's health as opposed to the traditional methodology of treating what presents when the patient comes into the office.

The workflow necessary to make this transition requires the following steps:

1. Hand patient tablet and folder at reception, open to his/her "Patient Assessment Portion"
2. Instruct the patient to review the material in the folder once Assessment is complete
3. Roomer opens "Roomer Assessment Portion" when getting patient from waiting room
    1. Records Vitals
    2. Get up and Go portion of Fall Risk Assessment
    3. Cognitive Screening
4. Provider opens "Provider Assessment Portion" when appropriate in the exam room
    1. Indicate preventive assessments, screenings, IBT, etc.
    2. Address indicated components of ACP patient selected to discuss
    3. Walking through CPI module if Care Management services are selected
    4. Walking through RPM portion if selected
5. At checkout print the "Patient Initial Report" and give to patient for their folder

Step 2: Determine RPM data group session time slots (CVD, Obesity, MNT, etc)