Brandon Jones (00:00:00):

All right. Thank you, Olivia, for that opening and housekeeping tips there. Welcome, everyone, to today's webinar. NACHC is so pleased to welcome you to part two of our two-part webinar series on Eyes on Access: Comprehensive Vision Services being available at Health Centers is critically important to the overall health of our patients. We're so pleased to have several hundred, well over 500-plus, in fact, registrants for today's webinar, so all expressing interest in learning more about the intersection of Community Health Center, patient care, access and delivery for vision and eye health, and how to integrate or expand the service into your Health Centers. Next slide, please.

Brandon Jones (00:00:44):

I want to take a moment quickly to thank all of our health centers for all the work that you do to keep our communities, your communities, safe every day. Next slide, please.

Brandon Jones (00:00:57):

All right, NACHC wants to let you know that vision and eye health are not the only topics that we provide resource for. You can find a variety of topic areas with tailored materials for FQAC operating environments at our Health Center, our Resource Clearinghouse. Take a moment, go to healthcenterinfo.org and you can kind of peruse through some of the resources already there. Sometimes you may not need to reinvent the wheel.

Brandon Jones (00:01:25):

All right, so the Health Center Resource Clearinghouse is made possible through a collaborative effort of 21 National Training & Technical Assistance Partners, and they're all funded through the Health Resources and Services Administration, or HRSA for short. All 21 of us work together to ensure that we're providing technical assistance best suited to the needs of Community Health Centers. Today's webinar is a wonderful example of the NACHC and the Association of Clinicians for the Underserved, or ACU, coming together to provide this really important resource.

Brandon Jones (00:02:04):

We hope that you were able to join us for our first workshop, Introduction to Comprehensive Vision Services in Health Centers, which covered the intersection of vision, chronic illness, and quality of life. All registrants should have received a follow-up email with a link to the recording for that session and also other resources that were shared in that session. If not, you can easily visit www.healthcenterinfo.org to get information. You can search "Eyes on Access" and it should be the first result that pops up with those materials.

Brandon Jones (00:02:39):

All right, as we go to our overview for today, we're going to be doing a quick introduction and review of the problem. We'll take a look at the opportunity or view of the opportunity Health Center discussion. Really excited about that. We got a few Health Center leaders to provide some kind of their perspectives, and we'll do a Q&A, time permitting, summary and closing remarks, and we'll provide you some additional resources and our references near the tail end.

Brandon Jones (00:03:08):

All right, so as we set the context for today's webinar, I did want to, as we go try the next slide, I did want to provide some additional context of Health Centers as it kind of relates to today's session. I wanted to spend a couple of minutes resetting the context to remind us of the impact and power of The national Community of Health Center movement and program. Many thanks to everyone for your continued and our past Health Center service.

Brandon Jones (00:03:37):

As a reminder, we serve, Health Center serve well over 28 million patients through 1400-plus funded organizations through 13,000 or more service delivery sites. You can see from the slide that our patients span across the continuum, all of whom may suffer from vision and eye healthy issues in their lifetime. We also are primarily serving patients in public programs under our uninsured special populations and of racial and ethnic minorities, so again, thank you all for your service.

Brandon Jones (00:04:12):

As we move to our next slide, as a reminder, the Community Health Center workforce has expanded dramatically over the last decade from a little over 132,000 in 2010 to well over 255,000 in 2020. That's allowed those Health Centers to really increase the number of patients they serve by almost 50% during this timeframe. Community Health Centers also experienced a roughly 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 able to address those patients' health and well-being needs holistically.

Brandon Jones (00:04:59):

As we look at our next side, despite the demands of the pandemic as well as unprecedented rates of workforce attrition and turnover, Community Health Center personnel have still provided medical care to over 25 million patients, which includes managing those chronic illnesses and chronic conditions, hypertension and diabetes. Has continued to provide dental care to 5 million-plus patients. That includes oral exams, preventative care, restorative care such as fluoride treatments for kids. Health Centers continue to provide behavioral health services to nearly 3 million patients, which includes substance abuse services, counseling, and primary care management of those conditions, Community Health Centers who have integrated care models.

Brandon Jones (00:05:45):

Also, Health Centers continue to provide pharmacy services, prescription assistance programs, prescription management programs. Important to this session, Health Centers continue to provide vision services to about a half a million or more patients, and lastly, enabling services such as interpretation and transportation as needed.

Brandon Jones (00:06:07):

A little bit about boards, so Health Centers are possible because we're governed by the community. Health Centers are required to have a 51% patient majority board of directors and it's a complex and complicated job, of course. Any Health Center boards who are on today's call, thank you again. Any members of Health Center boards who are on today's call, thank you for your service. We know, I know, I'm a Board Chair. You volunteer your time. You volunteer your energy. You serve as a voice for your community, your neighbors, and your family, so we thank you all for the responsibilities you take in serving on Health Center board of directors.

Brandon Jones (00:06:47):

As mentioned, Health Centers are governed by volunteer board directors and those boards are required by law to include 51% patient majority, which is an essential feature of the Health Center Program. Health Center governance is very complex and the board whole governs the Health Center and must ensure compliance with all those HRSA regulations, those federal, state, and local laws, and ensure that board fulfills the roles of nonprofit boards. Most effective boards also focus on really, really good governance. Health Centers are responsible. Board members are super responsible. You have quite a bit of responsibility to cover for an organization from a volunteer perspective.

Brandon Jones (00:07:30):

All right, I'm going to move. There we go. Health Center boards also are very critical when it comes to decisions about service expansions. Now, we're going to touch into the second part of the vision webinar we're doing today, so having that support, the influence, the advocacy of the Health Center board is what makes the difference in deciding to stand up a service like eye or vision health in your Health Center and/or other service lines that the Health Center is seeking to expand or provide. Any other collaborative partnerships, you need that board kind of advocacy and support there.

Brandon Jones (00:08:07):

I hope that the board members who are on today's call will bring back anything that you've learned. Take it back to your boards and determine if the time is now to enhance. If you have vision services, enhance your existing vision services, or, if the time is now to implement a vision service line at your Health Center.

Brandon Jones (00:08:27):

All right, so I'm going to move on to our resources here. We do have some resources for our Health Center boards. It's not an easy job to have. I know personally, so please check out our resources for you as you proceed with your important strategic planning and decision-making at your own organizations. As we go, try next slide, I'm so very pleased to have The Association of Clinicians for the Underserved, or ACU, with us today to talk about some of the resources they make available as Health Centers consider how to stand up or enhance their existing eye services. I'm pleased to hand it over to my colleague, Luke Ertle, who's the Program Director at ACU. Luke?

Luke Ertle (00:09:12):

Thank you so much, Brandon. As he mentioned, I am Luke Ertle. I'm the Program Director at ACU, and just a little bit of an overview of ACU. We are a membership network, uniting clinicians, advocates, and organizations in the shared mission to improve health equity for the underserved. What we do is provide professional education, training, technical assistance, and clinical tools of programs to clinicians and organizations around the country. We got started working in the space of vision services and eyecare in 2017 through partnerships with Health Centers around the country, setting up mobile vision screening events. This evolved in 2018 to providing small grants to offset the cost of startup and expansion of vision care or care programs, excuse me. Now, with the five Health Centers you see on screen, we've worked with a total of 24 Health Centers these last few years to get programs off the ground.

Luke Ertle (00:10:02):

Just wanted to give a shout-out to our grantees for 2022 that have just been announced recently. We have El Dorado Community Health Center in California, Lowell Community Health Center in Massachusetts, Marias Healthcare Services in Shelby, Montana, and then Native Health in Phoenix, Arizona, and Peninsula Community Health Services in Soldotna, Alaska. Part of also what we do is, or what ACU does, is provide technical assistance to Health Centers who are setting up, expanding, integrating vision care services at their Health Center. We do this through our Vision Services Committee, excuse me, who they help guide some of the work that the ACU does around vision services and then, like I said, I'll help provide some technical assistance. Next slide, please.

Luke Ertle (00:10:52):

Then, we have a couple of resources available. We have the Vision Services Readiness Assessment Tool, and then best practices for integrating vision care in a primary care setting. You can find out more, find those resources on www.clinicians.org, and you can also reach out in the... or find out more information. I'm excited to also announce that we'll be opening up and accepting applications for 2023 for these. There'll be five $25,000 grants for starting up or expanding vision services. We'll be opening that up in October this year for 2023. You can get connected or find out more information through doing the evaluation at the end of this webinar. With that, I'll go ahead and wrap up and turn things over to Dr. Susan Primo.

Dr. Susan Primo (00:11:39):

Hi, thank you, Luke, so much. Good afternoon, everyone. My name is Susan Primo. I will introduce the main webinar speakers shortly, but first I want to give special thanks to NACHC and ACU for their collaboration with Prevent Blindness on this most important topic. We are thrilled to have this many attendees for the second webinar. Thank you so much for joining. Today, we have in attendance almost 60% C-suite staff, 20% operation staff, 18% clinical staff, and if we got any board members who work in IT. 45% of you are in the planning stage and you have no eyecare currently being provided. 23% are at the beginning stages of planning. 18% in the intermediate stages. 13% are well-established, thank you very much, comprehensive care services and full integration, and 9% of you are [inaudible 00:12:25] this. Thank you so much, the 9%, for being here and hoping you get inspired.

Dr. Susan Primo (00:12:30):

I'm currently the Director of Optometry Services and Professor of Ophthalmology at Emory University in Atlanta. I spend about three and a half days a week at a neighborhood Health Center, as we call it, which is basically a lookalike that falls under the auspices of Grady Memorial Hospital. I've literally spent my entire career since training at an FQHC advocating for on-site eyecare at Community Health Centers. I really continue to be excited about this two-part webinar series. I'm also Co-Chair of The Center for Vision and Population Health Advisory Committee as part of Prevent Blindness, which was developed and born after the NASEM Report, which is The National Academies of Science, Engineering, and Medicine, formerly known as The Institute of Medicine. This NASEM Report recommended the need for a national backbone organization to help move the needle in reducing vision loss. Next slide.

Dr. Susan Primo (00:13:20):

A bit more about Prevent Blindness. It was founded in 1908 and it is a national organization with [inaudible 00:13:25] affiliates. You can see from the slide that the mission is to prevent blindness and preserve sight. They do this by educating the public on every eye disease from birth to grave, empowering public health systems of care and taking a population health approach to prevention as

well as through advocacy and advancement of public policy. I personally have been involved within the volunteer structure of Prevent Blindness for several years now. Next slide.

Dr. Susan Primo (00:13:51):

Prevent Blindness has two centers, The National Center for Children's Vision and Eye Health, and on the adult side, The Center for Vision and Population Health. As a side note, Prevent Blindness hosts a Focus on Eye Health Summit every year. This year, the Summit will be held virtually on July 13th and 14th. The theme will be Eye-conic, that will be E-Y-E-conic, Approaches to Eye Health, which is fantastic by really embracing the public health intersection [inaudible 00:14:15] vision care. We welcome your attendance and you can find more information on the website, preventblindess.org. Next slide.

Dr. Susan Primo (00:14:22):

For those returning to the second webinar, then you learned from the first webinar that eye and vision problems are prevalent in the populations that Health Centers serve. For those joining for the first time, we will give a brief recap shortly. On this specific webinar, the learning objectives are increased knowledge about the levels of comprehensive vision services integration into FQHCs and Look-Alikes through peer education, enhance skills for startup of vision services in FQHCs, including school-based Health Centers and Look-Alikes, to raise awareness of the operational components, things like overhead, provider configuration to balance quality, supervision cost, vision versus medical insurance coverage, volume, et cetera." All those needed for vision services integration. I just want to give a quick reminder about the pre-reading materials that remain available for your reference. Next slide.

Dr. Susan Primo (00:15:15):

Oh, a reminder everyone. I'm excited to have Dr. Kristin White join us. She is Director of the Optometry Service at MACT Health Board in San Andreas. She's a graduate of The New England College of Optometry. She did a Community Health Optometry Residency, and she is an ACU Vision Services Committee member. Next slide.

Dr. Susan Primo (00:15:36):

Also thrilled to have Dr. Debi Sarma. She's a Public Health Optometrist and Community Outreach Specialist in Boston. She's an Optometrist at The Fenway Health Community Center, and she is also a graduate of The New England College of Optometry and has done a Community Health Optometry Residency. Next slide.

Dr. Susan Primo (00:15:54):

Finally, to round out this great group, I have Dr. Ashley Burns. She's Director of Optometry at The Coastal Family Health Center in Biloxi, Mississippi. A graduate of Indiana University School of Optometry, and she's the ACU Vision Services Committee Chair. With that, I will turn it over to Dr. Burns.

Dr. Ashley Burns (00:16:15):

Hello, everyone, and thank you again to all the participants that are here today, and we can go to the next... Okay, so I'm just going to go through a quick recap of everything that we talked about in Webinar 1. Next, please. One of the things that we discussed is just establishing that Health Centers are already very well-positioned to address some of the barriers to care and obstacles that patients face in accessing

eyecare. Next, please. We also established that Health Centers are going to be integral in helping to curb the alarming rise in vision loss that we're expected to see in the coming years. Next, please.

Dr. Ashley Burns (00:17:12):

Another thing we discussed was knowing the optometrist's role in primary care. Basically, an optometrist is a highly trained doctor that works with primary care providers as well as medical doctors in ophthalmology to provide comprehensive care for our patients. They should be included in care coordination in Health Centers. Next, please.

Dr. Ashley Burns (00:17:42):

We also discussed the different models of vision care services, and we've talked about the pros and cons of each, which included vision screenings, referrals to outside providers, mobile clinics, and ideally, on-site clinics. Next, please. One model that we did not get to discuss in the first webinar was actually teleoptometry, and we wanted to just throw it out there as an option. It's still very new as all telehealth is, so we're still trying to find where teleoptometry works best, but basically it can be in a temporary or permanent space, but it's a good option for clinics that are like very rural or may not just have the population to support a full-time clinic.

Dr. Ashley Burns (00:18:42):

You'd have an optometrist at a long distance location and the patient will be at the designated area where the equipment is and there's also a technician there to help with testing and to help operate the equipment. This isn't available in all states and the Health Center actually doesn't get paid for this. This is something that Health Centers will actually be paying a vendor for, and you can partner with other local organizations to provide it, but it is an option to help your patients access eyecare. Next, please.

Dr. Ashley Burns (00:19:26):

Then, we kind of focused on the levels of delivering vision and eyecare in-house, and so there are three levels that we broke it up into. There's the less investment space, mid-range investment space, and the full investment space. For this webinar, we wanted to just give yo a few more visual examples of each, so we'll go to the next slide, please. In the less upfront investment space option, you're going to be looking at $20,000, and that's just about for the equipment that you're going to need.

Dr. Ashley Burns (00:20:08):

If I can direct you to the top right-hand corner, this is actually Dr. Sarma's temporary clinic, and it is actually set up in a school. You can see in the background that she has her desk and the eye chart is set up there. As well, you have just a couple little trays of glasses so that kids are getting still fully eye exams and access to glasses as well. Then, at the bottom picture, this is one of Dr. White's satellite clinics, and this is a medical room that's actually shared between her and a dermatologist that they rotate between. It's a temporary space, but it still allows patients to have a full eye exam, get a glasses prescription. It's only limited by not being able to manage disease, which we still want to be able to do, but this is the basics of what you'll need. We'll go to the next slide.

Dr. Ashley Burns (00:21:18):

This is the mid-range investment space, and this is kind of something for someone who has a more permanent location space available, patient load that can be supported. In the top picture, you can see

all the equipment is permanent. This is a fully functioning optometrist office that you would see anywhere else. Below, you'll see that there is specialty equipment, lots of different testing.

Dr. Ashley Burns (00:21:52):

Dr. White's going to go into a little bit more about what the equipment is, but this allows you to manage disease, and we know a lot of our Health Center patients have multiple systemic disease and things going on. This is really an ideal setup. You're going to be looking at between 50,000 and $130,000, and the bulk of that is going to be this specialty equipment, but it allows us to give our patients the best care without referring them out to specialty that they may not be able to afford. All right, next, please.

Dr. Ashley Burns (00:22:29):

We also just wanted to show you what the full investment space looks like. This is not something that you want to be starting out. It's not really possible to start out. These type of locations are going to be... these are going to be associated with universities or large organizations. You'll see these at optometry schools and that kind of thing. THere's going to be multiple doctors, multiple subspecialties, multiple residents and students, et cetera, so this is not something that you see in an everyday Health Center, but we just want to let you know this is possible in the future, a goal to strive for. That is just a summary of everything we went to. Now, I'm going to pass it to Dr. White, and she's going to get to the nitty-gritty of what it takes operations-wise.

Olivia (00:23:37):

Dr. White, I think you're muted.

Dr. Kristin White (00:23:45):

Yeah. I'm having trouble with my computer audio. Can you hear me?

Olivia (00:23:49):

Yep. We can hear you. Actually, we can't hear you. I'm sorry. We could hear you for a second and then you went away.

Dr. Kristin White (00:24:05):

Okay. Let's try now.

Olivia (00:24:06):

Yep. Now we can.

Dr. Kristin White (00:24:09):

All right. Thank you. All right, so thanks for that recap, Dr. Burns. Next, we'll be diving into the nuts and bolts of creating an on-site mid-range optometry department. Here's a look at where we're going. We'll be discussing financials, equipment, staffing, integration, and collaboration, and a whole lot more. Next, please. We'll start with one of your biggest concerns. How are you going to pay for this new department? We'll be looking at volume needed, startup expenses, funding, revenue streams, and insurance billing. Next please.

Dr. Kristin White (00:24:52):

First, you'll really need to assess whether a full-time eye clinic is viable for your Health Center. You'll need to ask, does your Health Center see between 18 and 20,000 medical patient encounters annually? If so, then optometry will likely be viable in your Health Center, and you can expect optometry to see about 10% of that number of encounters. Another way you can expect optometry to see between 1500 and 2,000 encounters annually for optometrists. You can also keep these numbers in mind when you're thinking about future growth and projection. For example, if you have a larger Health Center and are seeing 40 to 50,000 medical patient encounters annually, then you know that once your department gets established, you should be able to support two full-time optometrists.

Dr. Kristin White (00:25:49):

Now, if your Health Center does not have this minimum number of encounters, then having a full-time eye clinic is really not going to be viable for you. However, you still be able to meet your patients' eye and vision care needs whom you're serving, so in that instance, having either a part-time or shared space or maybe a mobile clinic or a teleoptometry could be a really great option for your Health Center. Next, please.

Dr. Kristin White (00:26:18):

I know you're wondering, "What is it going to cost?" Before your eyes just jump down to those big numbers at the bottom of the table, I want you to just start at the top and realize that your basic exam room worth of equipment as well as pre-testing equipment will cost you about $50,000. You can just stop there just to get started. Of course, you'll need to pay your optometrist, which is about $160,000 with benefits. Where you get a lot of variability in the cost of what you're setting up is in advanced diagnostic equipment, which as Dr. Burns was mentioning, is equipment that allows you to manage ocular disease as well as whether and the extent of your optical. We'll be discussing both of those things in a lot more depth coming up in a few slides, so for now, we'll leave it here. Okay, next, please.

Dr. Kristin White (00:27:20):

We know you're wondering where you can get funding for your initial startup, so here are some ideas. You can use American Rescue Plan funding, You can use HRSA Service Expansion Grants. The ACU, who you heard from earlier, does have five $25,000 grants available for this startup or expansion of on-site vision services. You may contact your local Lions Club as their mission is to spread eyecare where needed throughout the world, and your Health Center is exactly one of those places. You can check The National Eye Institute or check with your congressperson if you may be eligible for any local grants. I heard from one optometrist who actually collected used equipment from eyecare providers in his area, and then traded that in for new equipment for his Health Center. You can also connect with private foundations who may share your vision. Next, please.

Dr. Kristin White (00:28:28):

Now that we've assessed whether your Health Center can support an eye clinic, initial cost, and startup funding, we want to know, how can your optometry department continue to bring in money? I want you to know that optometry is a financially profitable service. We bill Medicaid with the same encounter rate as all other Community Health Center departments. We bill Medicare and medical insurance plans for medical eye exams. You'll bring in revenue through the optical sales of glasses, possibly contact lenses, and dispensing fees from public insurances, as well as private vision plans, which include Health Center employees as patients. Next.

Dr. Kristin White (00:29:16):

The one question I get asked a lot is, "What codes do optometrists bill?" I really want to highlight two main types of encounters that optometrists will see. First, we have comprehensive eye exams. This is the meat of what we do day to day. It includes an eye health check and glasses prescription. This comprehensive eye exam I usually every one to two years as dictated by the insurance. For example, when you are looking at what Medicaid will cover for vision services in your state, when they say, as an example, that a patient can get an eye exam every two years, what they're referring to is this comprehensive eye exam. Specifically, they're referring to the 92014. 92004, and 92015 eye exam codes.

Dr. Kristin White (00:30:15):

I want you and I always tell my patients and staff, to know that if a patient needs to be seen with more frequency for a medical eye problem, they absolutely can be. Whether that's an urgent eye problem like a red eye or new flashes and floaters, or monitoring an eye disease like glaucoma, macular degeneration, or diabetic retinopathy, these patients can absolutely be seen in the eye clinic with much more frequency as indicated clinically. In that case, we would be billing either the same 99 codes that are used by other medical providers in your Health Center, or the 92 intermediate eye codes.

Dr. Kristin White (00:31:03):

One further thing I want to point out with regard to billing is that if you're a true FQHC, then a new patient for optometry will not have been seen in either medical or behavioral health in the prior three years. Keep in mind that may be different if you're a Look-Alike clinic. Next, please.

Dr. Kristin White (00:31:30):

Next, we'll move on to some more logistics related to reimbursement. For example, what insurance panels does your optometrists need to be on? Well, they should be credentialed with all the medical insurances that are already accepted elsewhere in the Health Center. When you can consider vision plans, depending on your location, whether there are other optometrists in the area, look at the reimbursement that those plans will provide, really consider the vision plan before you just go and get credentialed with every vision panel that exists. You'll certainly be getting reimbursed a lot less, and if you're in an urban area where there's a lot of private practitioners serving these patients, you may not need to. It can also complicate your optical a little it, so it's just something to keep in mind.

Dr. Kristin White (00:32:26):

One thing that I would certainly or one type of vision plan that I would encourage you to look into would be if there's a major Medicare supplemental plan in your region. Medicare traditionally will only cover an eye exam if there's a medical diagnosis, but they don't cover glasses, so a lot of Medicare supplement plans, or now the Medicare HMO plans, are offering a vision plan and it's a private vision plan that they're contracted with.

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

Because our Medicare patients also are going to be more at risk for a number of eye disease, it would certainly make sense to be on that vision plan so we can catch the eye diseases and then bill Medicare for subsequent eye monitoring of those ocular diseases. When you're setting up your fee schedule, you'll want to connect with your finance team, of course, so that your exams and procedures cost at

least what Medicare will reimburse for your area, and you should have a sliding fee scale set up for exams and glasses. Next, please.

Dr. Kristin White (00:33:43):

Next, let's talk about equipment. We already said that at the least you'll need an exam room and likely some pre-testing equipment as well. What that consists of is an exam chair, a slit lamp, which is a microscope that we exam the health of the eyes with, a phoropter, which is the piece of equipment you look through when determining your glasses prescription. Hopefully, there's an autorefractor. It's really helpful. That's kind of your standard, but where we said there's a lot of variability is in that advanced diagnostic equipment.

Dr. Kristin White (00:34:17):

What we mean by that is primarily three pieces of equipment. One is a visual field, which maps the peripheral vision and is essential for monitoring glaucoma as well as diagnosing neurological problems that express themselves through vision. The second main piece of equipment is an OCT, which is a retinal scanner. This is crucial for managing macular degeneration, glaucoma, and diabetic macular edema, and it's on this camera is used to document and monitor retinal diseases. Because space is often an issue, you can get a little bit creative with some of that equipment.

Dr. Kristin White (00:35:01):

For example, there is a company that makes an OCT and retinal camera combined in one piece of equipment. You can see that piece of equipment actually on the bottom photo all the way to the right, a combination piece of equipment. The top photo, that's a visual field, so you can see that machine takes up a lot of space in and of itself. However, there are several companies now that actually make this test in a virtual reality headset. Obviously, that's going to take up a lot less space. It has a lot of other benefits, so it's something to consider.

Dr. Kristin White (00:35:36):

Now, we understand that financially it may not be feasible to get all of this equipment on day one. If you're unable to do that, you need to do two things. One, you need to have a plan for who you're going to refer patients who need these diseases monitored to to get that testing. How are you going to get those reports back so that you can continue to monitor your own patients? Two, you'll need to create a plan for how you're going to bring in this equipment once your clinic gets a little more self-sufficient. I do want to pout out that one great way to save some money on equipment is either leasing equipment or purchasing refurbished equipment through your ophthalmic distributors. Next, please.

Dr. Kristin White (00:36:27):

Your second biggest question after, "How am I going to pay for this?", will likely be, "Where am I going to put this new department in my already full Health Center?" Here's where I ask you to get a little creative. Optometry can be housed in a secondary clinic location. You can rent or buy space nearby. You can plan to incorporate in future renovations. You can convert a conference room, or what we did at one of our satellite clinics.

Dr. Kristin White (00:36:56):

We've had renovations that have been underway for several years and are still several years away from being completed, as some of you may be able to relate to. We leased a storage unit, which you can see on that bottom photo, and then we outfitted the inside of that unit to be a standalone eye clinic. The top right photo, you can see we have all of our exam room equipment, and the top left, we were even able to fit a small optical there.

Dr. Kristin White (00:37:26):

If space is tight, having a mobile unit either contracted or purchased, could be a great way to bring in these services. Remember that you can always share space with other specialties, as you saw in a previous photo. You can collocate with other departments like dental or behavioral health. Next, please.

Dr. Kristin White (00:37:54):

We spoke last time about the importance of offering glasses on-site so that patients have easy access to getting the glasses they need. We talked about how it's really frustrating for the patients if they come in and get their exams, but only leave with the prescription. More often than not, when you see those patients back a few years later, they've never gotten the glasses. I wanted you to know that having an optical can be really simple. The bottom left photo here, that's actually one of Dr. Burns' satellite clinics where they just have a few trays of glasses on a cart and they move it between exam rooms as needed for patients to select the glasses.

Dr. Kristin White (00:38:33):

In that example, you may have 50 frames, and this could be either serving only patients with Medicaid, or maybe just an inexpensive self-pay option. The middle photo, this is our optical, and this is actually a converted storage closet that we've made into our optical. We have about 450 frames there, which is actually quite a lot, and we have a variety of price points, so low-cost frames as well as some higher brand name frames. To contrast this, on the right-hand side, this is actually one of our ACU grant recipients, the new optical that they created, and they actually have about the same number of frames as we do in the middle photo, but you can see this space where it's displayed is a lot bigger and it's set up a lot more like a commercial optical space where you may go and try on glasses.

Dr. Kristin White (00:39:35):

There's a lot to consider when you're opening an optical. First, you'll need accounts with frame vendors. These will be frames that you'll either purchase outright, or you may get them on consignment depending on the company. Then, you'll need accounts with labs. The labs are going to cut the prescription lenses and put them into the frames. You'll also need an account with courier service to bring the glasses to and from the lab, and if you're going to have an optical, you're definitely going to need some more staff who's going to be fitting the patients for glasses and dispensing the glasses to the patients. There's a lot more to consider, as a I mentioned earlier, but it's really valuable to be able to offer this for your patients. It kind of closes the loop for them.

Dr. Kristin White (00:40:24):

Do keep in mind that the insurances that you accept may have certain requirements for frames that you use and labs as well. This is why I was mentioning earlier with the vision plans, if you're on too many plans, you may end up with needing to use four or five different labs, which can get really complicated, especially if your staff doesn't have too much experience with an optical.

Dr. Kristin White (00:40:49):

One last thing I want to point out with regard to the optical is Medicaid glasses coverage. It varies by state, so some states are going to cover only glasses for children. Some states will also cover glasses for adults. The way they do this is also different depending on the state. Some states will send you a kit of frames that you'll have the patient try on, but then the lab will supply a brand new frame and a lens for the patient. Whereas, other states, you purchase the frames and send them to the labs to be made. Now, there's one last piece of variability here, which is that some plans will reimburse you for the frames, some will reimburse lenses, and some will reimburse the dispensing fee. There's a lot to look into with regard to Medicaid glasses coverage.

Dr. Kristin White (00:41:46):

Now that your clinic is funded, you have a location, equipment, and an optical, you'll need staff. If you just have an exam room, then it's fine to start off with just an optometrist in addition to your receptionist and billing specialist who can be shared amongst other departments. If you're going to have the advanced diagnostic equipment and an optical, you'll certainly need at least one other assistant or technician. Pretty common amongst Health Centers for optometrists to schedule patients about every 30 minutes, which puts between 12 and 14 patients on the schedule per day, per doctor.

Dr. Kristin White (00:42:26):

Your optometry department will use the same EHR as the rest of the Health Center, using the ophthalmic templates that should be provided. If you're going to have an optical, you will need optical inventory and frame management software, and these should be compatible with your EHR, but you may need to purchase them separately as you likely won't have that already. Okay, next, please.

Dr. Kristin White (00:42:56):

Lastly, now that your optometry department is set up, you'll need to integrate internally with the rest of the Health Center, as well as collaborate within the community to bring in patients. I would really encourage you from the beginning to set up as internal referral system with your primary care department to speak to your operations team. There's likely already a system in place for how this is done in other departments, so get plugged in with that. There's no reason to recreate the wheel. One thing you may consider is that when patients are seen by their primary care doctors for their annual diabetic exam, that they just automatically get appointed with an optometry visit or get an automatic referral to optometry.

Dr. Kristin White (00:43:38):

Remember that these referrals go both ways, so as we talked about last time, optometry will bring in novel patients to the Health Center, as we tend to be a non-threatening entry point into the healthcare system, so you'll need to know how you can best get patients into the hands of primary care as needed. Really, all departments at the Health Center should be aware of this new service and what can be provided, and anyone who's interfacing with patients should be able to at least point them in the right direction of being able to get scheduled.

Dr. Kristin White (00:44:10):

Now, we want to connect with the community, so connecting with community centers or schools or afterschool-based programs, school nurses area really great resource. They're the ones who are most

often doing vision screenings at the school, so it's really important for them to be able to tell families where they can take their children to get a full eye exam when they fail their vision screening. That's really important. You're the place that they need to be going.

Dr. Kristin White (00:44:38):

Get involved in some local health fairs. You can provide glaucoma screenings or diabetic retinopathy screenings. This is a really great way to catch patients who don't typically receive routine medical care, and it can allow... it could be an opportunity for you to share the importance of regular eye exams and allows the patients to know where they can go to have that done. If there's a homeless shelter nearby, those patients do need your care and you could connect there to let them know of your services.

Dr. Kristin White (00:45:11):

We are VA Community Care providers, which means that because the nearest VA with optometry is about two hours from where we live, veterans in our area can actually come to us for their eye exams, and then we bill the VA for that. That's a great program to get connected with if you're not located near a VA. Would absolutely encourage you to connect with a local emergency room or urgent care. These facilities are not set up to manage urgent eye problems. They need to be sending these patients to you.

Dr. Kristin White (00:45:45):

Lastly, connect with other businesses in your community, so specifically, if you took a vision plan that's relevant to a major employer in your area, that employer and its employees absolutely need to know that now they can go close to home to get their eyes checked. For us, where we work, we happen to be close to several auto body and machine shops, so we went around and met the people who worked there because they're really likely to get metal in their eyes, and when they do, now they come to us. Okay, next, please.

Dr. Kristin White (00:46:25):

One last thing I want to point out is that The American Optometric Association has created a business plan for Community Health Centers, so this is a budgeting worksheet where you can input your own payer reimbursement, salaries, and expenditures to determine the viability of opening this new department. It's a bit of a complex Excel file, and so if anyone's interested in this, rather than just sending it without any explanation, we'd be happy to put together a workshop where we could go through this together some office hours. If there's interest, if you could just pop that in the chat right now so we can kind of gauge whether there's something you'd like to hear more about. Next, please.

Dr. Kristin White (00:47:12):

In summary, Health Centers are well-positioned to provide access to growing eyecare problems in the United States. Optometry services can be sustainable and profitable for your Health Center, and I really encourage you to start somewhere, even if it's a small step in the right direction. Remember that access to eyecare and early detection lead to improved vision and overall health as well as lower healthcare costs. I'm happy to be contacted by email. I'll put my email in the chat here, and I'm going to turn things over to Dr. Sarma for our panel discussion now. Thank you.

Dr. Debi Sarma (00:47:53):

Thank you, Dr. White, for that thorough review of some of the things to think about as you build out an eye clinic. I wanted to really turn it over to our panel. We've got a great group for both providers and administrators who have gone through putting together an eye clinic and integrating primary care with routine eyecare services as well as urgent medical eye services as well. I'd be happy to introduce them to you today. Next slide.

Dr. Debi Sarma (00:48:26):

First off, we have Ramona Williams. She is an all-star RN who's at Coastal Family Health Center in Mississippi, and she's really a person who can get the vision issues right directly from the patients that she sees and how they express concern about their eyes and works with a team of people to get eyecare to the patients. Next, slide. We also have Dr. Ed Farrell, who is the VP of Integrated Health Services. He's also a Clinical Professor of Family Medicine at the University of Colorado School of Medicine. He is the VP of Integrated Health Services at Colorado Coalition for the Homeless. Next slide.

Dr. Debi Sarma (00:49:10):

We have Sean Kiley, who works alongside Dr. Farrell. He's the Director of Client Access. What's interesting about Colorado Coalition for the Homeless is that many of the providers are there on a volunteer basis. Sean works very closely with Operations and Special Projects to make sure that there's improved access to care. Next slide. Melissa Mitchell is the Chief Innovation and Strategy Officer at HealthLinc in Indiana. HealthLinc is a series of clinics, 14 with over 500 employees, and Melissa's in charge of doing the innovation, operation, and technology associated with operations. Next slide.

Dr. Debi Sarma (00:49:57):

We have Beth Wrobel as well, who's here from HealthLinc. Beth has been at HealthLinc since 2002. She's credited with taking the clinic from being a free clinic to one that's a FQHC and also integrating services like eyecare as well. Next slide. We have Clifton Bush here to kind of round it out. He is the Chief Operating Officer and manages 27 clinics under the branch of Albany Area Primary Healthcare. Eight of those clinics are in school settings.

Dr. Debi Sarma (00:50:33):

Welcome panelists. To kick it off, we're going to have each of these Health Centers and clinics share their story, funding, and how they started to integrate eyecare services. I'll start off with Ramona.

Ramona Williams (00:50:56):

Afternoon. I'm Ramona Williams with Coastal Family Health Center. We're on the Mississippi Gulf Coast. Our funding sources include the CARES Supplemental Funding, Healthcare for Homeless, Ryan White, and Community Resources. Next slide. We have a mid-range investment space. That's dedicated space in three clinics spanning the Mississippi Gulf Coast region. Within those clinics, we have full-time staffing in the Biloxi clinic and part-time staffing in the Leakesville and Gulfport locations. That is 2.8 optometrists within the three locations. We strive to have 136,000 encounters annually, and we expect optometry to have 4800 encounters. In 2021, our estimated total encounters were 96,400, and our optometry encounters, 3800. Next slide.

Ramona Williams (00:52:11):

A personal story, in 2011, my mother, who had uncontrolled diabetes and end-stage renal disease, she developed blindness as a result of that. As her disease progressed, no one suggested visual screenings, and two years before she passed, she lost her eyesight. It was very sad. It's impossible to forget this personal experience and the devastating impact, and I am thankful for the visual services offered by our Community Health Centers. Early and regular screening can make a difference for these patients. Thank you.

Dr. Debi Sarma (00:52:56):

Thank you, Ramona, and a special thank you for sharing that personal story. There might be other providers or administrators here who have also known somebody and can know what it means to lose or have changes in the vision. What can we do to protect a person's vision in their lifetime? That's really why we're here, from pediatrics to adults, so thank you so much for sharing that. I'm going to turn it over to the Colorado Coalition for the Homeless. We'd love to hear your story now.

Dr. Ed Farrell (00:53:32):

Hey, thank you so much for having us. My name's Ed Farrell, a family practice physician. Still seeing patients and doing my admin job. Sean will join us in a minute. I don't see anything on the slide. Thank you so much. We're a little bit of a unicorn at Colorado Coalition for the Homeless. I started working here in '94. We realized folks who were experiencing homelessness desperately needed eyecare, and it all started with these two nurses, Carol and Margie, who spent every Monday morning trying to desperately get an eye referral for people with pretty significant eye disease until they finally reached out to an ophthalmologist, this Dr. Tarkanian, who said, "Hey, I could come down and volunteer there and see people."

Dr. Ed Farrell (00:54:24):

Since that time, there was an avalanche snowball effect with many ophthalmologists joining us, and, of course, we instantly realized we need optometrists, too. Those come as well. We continue to have a eye clinic oversight by Nancy Sanchez and Sean Kiley, and we do get HRSA money for our clinic. We have tremendous donations that happen, including initially rag tag donations of maybe eye clinic equipment that was borderline, but with grants we've been able to improve that incredibly. Then, we get that critical FQ rate. Sean, I know you know a little bit more on how we get some of our equipment and exam rooms set up. I was hoping you'd talk about that.

Sean Kiley (00:55:21):

Yeah, so I want to echo something that Dr. White said in her presentation that you start somewhere, and we've really built our specialized equipment over time. We didn't have the funding really to get that specialized equipment from the start, so each year we're looking for grants. We're lucky that we have a fairly consistent local grant that provides us with some money as well. We've been a former recipient of grants from ACU, and that's allowed us to get more specialized equipment over time to the point where our clinic is fairly well-built-out.

Sean Kiley (00:55:59):

As far as the clinic itself, I would categorize us as a mid-tier investment. We have a dedicated space. I think it's going to get into that in a little bit, but we have two lanes in our clinic and we have some of the more specialized equipment like retinal cameras, slit lamps, things like that.

Dr. Ed Farrell (00:56:19):

Thank you, Sean. We could go to that next slide. You know, this is actually the entrance into our eye clinic. We have full optometry, the volunteer ophthalmologists, which we have unfortunately decreased during the pandemic, but the exam rooms, the equipment, and the offices are there, opticians on-site. I think other sites can definitely consider exam room flexing. No one's brought up the retinal camera. There are CHCs out there that have retinal camera images screening for folks for diabetic retinopathy.

Dr. Ed Farrell (00:56:56):

Then, the primary care providers actually are trained to read those and consult liberally with ophthalmologists as needed, or they go directly to there. I like to echo with what Dr. White said, EMR best practices. We use Next-Gen. Can't emphasize enough internal referrals and EMR. We call them warm handoffs. We can have a medical assistant who walks someone who maybe is... It's hard for them even to get from our second floor where the clinic is to the first floor. I can't emphasize enough that as soon as we send the referral across town or across the street, the likelihood of folks going there is decreased markedly.

Dr. Ed Farrell (00:57:44):

Then, our ophthalmology notes and optometry notes are scanned in the chart with excellent communication. Also, I think it's great, as Dr. White said, to think of optometry-ophthalmology as a non-threatening trauma-informed care entry point, and that we take kind of referrals back, if you will. "Hey, this person's blood pressure is super high. Can you see them?" I do encourage folks like... We started as a rag tag team in the mid-'90s, and so a lot has changed since then, including our size, but sometimes if you just dare to start small, you can build the clinical case and then the business case for this to be set up for success. The next slide is two stories.

Dr. Ed Farrell (00:58:36):

You know, one really is it's humbling and sobering, but somebody came in. He literally saw that we had eye clinic service and he said, "Well, oh my gosh, I need to talk to you." He goes, "I'm going blind." It ended up that actually all he had going on was age-associated presbyopia. A lot of our folks are so disenfranchised. They didn't have a friend or someone who could say like, "Hey, you could get a $3 pair of readers from Walgreens," so we were able to set him up that day and literally he walked out. We've had people walk out with other conditions that we've prevented blindness, but I think this story epitomizes meeting folks where we are.

Dr. Ed Farrell (00:59:24):

Then, of course, we have folks who come in with cataracts and they're also losing their vision, losing their interpersonal interactional functioning in the world, their safety. It's unbelievable that our folks from the eye clinic, spearheaded by Nancy, we had a volunteer group of folks, an eye doctor who off-site could do the cataract surgery. We took a cohort of four of them to the clinic and got four cataracts cleared on the weekend because we built those outside connections in addition to the ones happening internally. Thanks very much.

Dr. Debi Sarma (01:00:10):

You know, you bring up a few very interesting points, that not only is it the heart and the effort and the hard work of the doctors who are there, but this kind of integrated network of people internally. You

have the internal handoff that is so critical. I can't get my patient to be seen unless someone physically walks them down or they will get lost at followup. Then, you also have kind of an external relationship with people who are willing to offer up OR space for these patients who absolutely need that care.

Dr. Debi Sarma (01:00:46):

You touch on something that's really important, and something that I hear in clinic, and Dr. White and Dr. Burn can attest to this, too, people come in feeling like, "I'm going blind," and don't have resources to understand what is happening with their eyes, even if it's a normal change. These visual impacts of not having kind of a champion for the vision are significant that people need someone to help them understand and preserve their vision. Thank you so much for sharing your story. I really appreciate it. Next step, we're going to listen to Beth and Melissa at HealthLinc, and welcome, and we're excited to hear your story as well.

Beth Wrobel (01:01:35):

Thank you, and I'm going to start, and then Melissa's done all the work. I just kind of found the money and she did all the hard stuff. Let me just say, we started... I've been around since 2002, and we actually had an optometrist who had her own fundraising dinners and went to her friends to be able to start seeing our patients. We knew back then, and this was before the Affordable Care Act where people were covered, sometimes even if they could just get glasses, they could go get a job, and that was besides all the other health issues of eyecare. As we started to grow, we became a federally qualified Health Center, we had a mantra of putting the neck back in the body, and we feel this is part of putting the neck back in the body.

Beth Wrobel (01:02:36):

When we were able to get through the Affordable Health Act all the additional capital, we built a new building in Valparaiso, and we're across... For any of you that know Northern Indiana, the bottom of Lake Michigan, one of our sites is 25 minutes from Chicago. The other one, it's right where Notre Dame is and we have everything in between. When we got the money for the Affordable Care Act, they had the $5 million grant for the new building, we said, "Let's really work to put the neck back in the body," so we put behavioral health, we took optometry, and we took dental along with mental.

Beth Wrobel (01:03:16):

We were able to take some of that and put it in. I also started finding out really quick that your United Ways of the world, the foundations, whether it's a country foundation, a bank foundation, anyone who has a foundation, this is such a good story to tell. You're saving someone being able to see. What does that long-term impact have on the overall cost and that patient?

Beth Wrobel (01:03:50):

We were able to do our first site in Valparaiso in 2013. I saw someone put in, "How do you find an optometrist?" To be honest, I went to my optometrist, and a lot of them, if they're either in private practice or they work for Walgreens or Walmart or something, they're kind of only eat what they see. Usually they say kill, but I'm not going to go there, but what you see. With us, we gave them a straight salary with productivity requirements along with benefits and stuff, so we can offer... If you find the right optometrists, you could probably offer more. I will say, since then we've expanded to two other sites. Both of them we got coming out of school and were able to get them, and another one we did hire

that was trying to do it on her own and realized quickly that it was too much to manage because you have do the billing.

Beth Wrobel (01:04:52):

We've talked about it. If you don't have the infrastructure that FQHCs have, it's kind of hard. We've shown you some of the ways that we found it. Once you get started and you get the patient revenues, and I'm going to tell you, it was a little bit hard to fill up those schedules. We looked at things that were eyecare that typically are medical providers, the pink eye, the injuries or whatever. We moved those over to optometry to fill the schedule, and that helped our medical side who have all... Their schedules are super full, have some time to see the things that they really were like good at, the medical side.

Beth Wrobel (01:05:38):

We did on some of our latest one, we took some of our American Rescue Plan money and used it for funding, so again, I think if start thinking about who's out there and you get your story, whether it's about adults not losing their sight or kiddies being able to see and read, that the boards or whatever, their computers, I think it's you will find it's an easy sell. We did get one of the ACU grants. I think it was two years. With that, that's kind of the funding. I'm going to turn it over to Melissa to talk about the other things that we've done.

Melissa Mitchell (01:06:17):

Good afternoon, everybody. What we hear about a lot is, how do you fit this into your facility? As Beth mentioned, our very first one was with the help of a capital project plan, and so we determined at that time that we were going to make optometry fit. It does take a little bit of room and space, and it's important that you're able to convert the rooms properly. If you're going with what is considered a kind of standard exam room size, you want to make sure that you fulfill all the requirements for the distance measurements and the eye testing. We accomplished that through some mirrors and now that's our standard across the organization. That helps us to fit in what might be considered a smaller size room than some optometrists have used before, but we found that it's really fun and it works. The kids think the mirrors are a good time, so it's always a good way to do things.

Melissa Mitchell (01:07:11):

In some other instances, though, we did remodel some of the clinics just a little bit to fit optometry in. We've even taken advantage of using hallways. One of the things, though, when you're doing that is that you really have to take care into how you can control the lights. In most of our facilities, you do have to make sure... Well, you just walk in a room and the lights come on. We're so non-touch now and light-efficient and that type of thing, but with these cases, we did have to make sure that anywhere that optometry was, we had different light control because some of the equipment that you'll use throughout this experience, it requires dark, so we had to be really careful about that.

Melissa Mitchell (01:07:52):

We usually work with most of our optometry spaces with two rooms per the optometry provider, and in each of our facilities right now, we have a single full-time optometrist, and so the two rooms are used between that optometrist and their assistant and they just juggle those back and forth. That's really how we've done most of the setup with some of the testing equipment is in the hallway where we keep optometry because it doesn't require a ton of space. It just needs to be close to the flow of the providers.

Melissa Mitchell (01:08:30):

Then, for the next slide, what we did with our patient studies, and I just want to point out, one of the gentlemen earlier referenced that even if it's upstairs, how important it is and how hard it can be to get those patients to go between facilities, and so everywhere we wanted to do optometry, we really think it's important to collocate. Now, you had mentioned earlier that we have about 14 locations, only three of those have full-time optometrists, so we do have to work a lot with the remote retinal equipment. We trained RMAs to take those pictures on a store-and-forward-type setup that our optometrists, anytime they don't have a full schedule or a no-show, they then have the opportunity to review those and determine what the best next steps would be from some of our more remote locations.

Melissa Mitchell (01:09:25):

One of the things that we talked about when we did the collocating is how important it is for us to, one, share an EMR. Everybody in our organization, and this is important for these patient studies, we are documenting in a single EHR system, and because of that, the medical providers have the ability, even the dental providers, to go back and forth and see what's happening in these cases. In some cases, they can walk the patient right over to the optometry department and then say, "You know, here's what's happening. You'll see it here in the chart. These are their medications. Can you help me find out what's going on?"

Melissa Mitchell (01:10:02):

It really helps, and what you'll see in these two stories is the first one, I don't necessarily want to read it to you verbatim, but you'll see that they were with their primary care provider and they were able to go right to the optometrist on-site and take active and quick next steps. When you share those resources in you're all-in-one organization, what's important to this medical provider is a lot more important to their partner medical provider than sometimes you get from an outside facility. Our priorities are our priorities, where it's not always the case if you're just trying to send somebody out to get this done, but this child was able to be helped and get taken care of really quickly. Something like that, you wouldn't want them to be waiting.

Melissa Mitchell (01:10:51):

Then, as I was earlier talking about with the remote viewing, they couldn't travel in the state they were in with their eyesight. They couldn't get to another optometrist, and at least one of our locations is pretty rural, so we're talking maybe a 30, 40-minute drive to get to another location. They were able to skip the step of having to travel to see the first-line optometrist and then get right in to the specialist for what they needed to get taken care of. I don't know about anybody else, but we have high demand right now to try to get patients in. There's a lot of people who didn't get their eyecare done in a timely fashion over the last two years, and so trying to get someone scheduled who's a non-established patient into a specialist is just outrageous in timing.

Melissa Mitchell (01:11:44):

By doing it all ourselves, we were able to take care of the patient where they were, and then get them take care of in a quick and efficient way so they could be on their way to getting better and maybe not going down the path for this diabetic that one of the speakers just talked about with her own Mom. These are the stories that we think are important. There are a hundred more, but we don't have time for that today, do I'll hand it back over and thank you.

Dr. Debi Sarma (01:12:12):

Thank you, Beth and Melissa, for sharing your overview of the clinic. I think something that really stands out to me and, Beth, you kind of mentioned, that there is funding out there for these clinics to be built. There is also a need and patient base. Dr. Burns mentioned that by 2050, the amount of people with vision loss is going to increase, and Melissa, you bring up the point where, okay, if there is more of a need, especially after the two years, so what can we do to share our clinic stories with the right people to make sure we can get funding for these clinics?

Dr. Debi Sarma (01:12:53):

You also mentioned, Melissa, the slight modifications being creative. How do we measure 20-20 vision, so 20 feet distance in a shorter exam space? Using mirrors is a very creative way to do that. Yes, using something small like a hallway is a great kind of compromise for some of the equipment where you may not be talking to the patient or sharing patient information, but just that you need to take a quick image and having a light switch accessible, that just comes with experience and understanding. Thank you so much for sharing these stories. We're going to move on to Albany Area Primary Healthcare with Clifton Bush.

Clifton Bush (01:13:39):

Good afternoon, everyone. Again, I'm Clifton Bush, and I'm a Chief Operating Officer for Albany Area Primary Healthcare. I'm going to tell you about vision program and how we got it started. Back in around 2017, we received some funding from The OneSight Foundation to start our vision center inside of a school, our School-Based Health Center Program. The funding that we received was actually for construction of the site, so we took a classroom and made it into a vision clinic. Also, that funding included the salaries for one year for an optometrist, an optician, an optometric technician, and a front desk receptionist.

Clifton Bush (01:14:22):

Again, we took this classroom and made it into a clinic, which actually has two exam rooms along with a place for the frames, a waiting room area, and then there's also a workspace area for the optometric technicians and the optometrist. Also with this funding, we was able to get free frames for patients that did not have vision benefits for frames, and they had to meet the poverty guidelines and being at a certain percentage of the poverty level in order to get these frames. They could not have benefits through their vision carrier if they had one, and then they also had to meet poverty guidelines. This opportunity allowed us to open up a community clinic within one of our other sites, and then we have optometry services out of that site as well that all of the community can come to.

Clifton Bush (01:15:24):

With the school clinic, it's currently only open to the students within the school system and their dependents, and then the community clinic is open to the entire community. One more thing I'll say about the school system that we started at, which in Dougherty County School System, we serve the entire school system. There's over 10,000 students in the school system, so graciously we was able to talk with the school system and they have buses going daily for all of our School-Based Health Center sites. Kids are bused from the different schools to this vision site to be able to receive services, and so as you probably know, it's very, very, very busy. Again, that's just something we partner with the school system on. They saw the need and we was able to get that accomplished with them.

Clifton Bush (01:16:17):

We also have received some funding from The Association of Underserved Clinicians to start another school-based site, and so it was some funding actually to expand our current optometry department. We actually with this funding was able to utilize it for equipment for a vision center in another school system, which is in Dooly County, and so currently we have a vision center in Dooly County Elementary and Middle School. We do the same thing up there. The high school students are bused over from that school to the site for those vision services. Next slide.

Clifton Bush (01:16:57):

Again, I kind of tell you our space and clinic layout, we again used a classroom and turned it when we started in an elementary school and turned it into a vision center. Also, at this particular school, we do have a medical clinic, which is right across the hall. That integration of care is one thing as we are starting to open clinics, we are starting to do a lot of integration of care and have like multiple services in one site. If any students from that medical clinic need to be seen, if they're there, they can just... the medical provider can just bring them over to be seen with the parents' permission.

Clifton Bush (01:17:38):

Again, we have two exam rooms. We have a pre-test room, which I left off. We have on the front desk receptions area, a workstation for the optometrist technicians, a workspace for the optician, and then there's a frame area. Within our school clinics, we allow for optometry. We allow the students to pick out their own glasses unless the parent does not want them to. The majority of the time, the parent allows them to because we try to explain to the parents if the kid picks out their frames, then they're more prone to wear them than the parent picking something that they do not probably want to wear. Then, we have a small waiting area for the students and the patients because we do have a lot that are bused over, so we have a waiting area for them. Then, we have a nice TV that they can watch while they're waiting, et cetera. That's the layout of our clinic. Next slide.

Clifton Bush (01:18:33):

Then, I'll just tell you... Actually, I have two stories. I just got one on here. Actually, a couple of things, so the first month that we were open in the Dougherty County School System at that elementary site, we saw over 200 students. Actually, the exact number was 208 students that were seen. 160 of those 208 needed glasses, so that just goes to show you how these kids probably were having... may have had issues with their schoolwork, and it's just because they could not see. We were like.. That made us very proud that we actually opened this center just seeing those numbers.

Clifton Bush (01:19:18):

Again, we have seen over 3,000 patient encounters since the opening of this center at the school. Our optometrist that we have at this particular site works at the school in the morning, and then goes to the community clinic to work in the afternoon. Due to us doing all the transportation, the students have to get back to their school in order to make sure they get out on time, et cetera, and we try to have them back by lunchtime. If they're not back by lunch, then the superintendent allows them to eat at the elementary school so they can make sure to have lunch, but we try to have them back by lunch.

Clifton Bush (01:19:54):

We've seen over 13,000 patient encounters within the community clinic combined with the school-based clinic and also the other things that we do with optometry as well. One school system wanted optometry... knew the need for optometry so bad, they were busing their students from the county next to us, which is a little north of us in Terrell County, down to this elementary school, so their students have access. We do have a medical clinic up there, but optometry, so they were busing students down.

Clifton Bush (01:20:31):

Last year, we were able to bring in two mobile units within our organization, and with these two mobile units, one of them have vision services on them. Now, we take our mobile unit up to that county and we see the students off the mobile unit so they're not having to come down here to another school system to be seen. That mobile unit has been wonders and great for our organization as well. Again, transportation services provided to all the students within the school system to access vision services, and I just talked about the mobile unit, expanding that.

Clifton Bush (01:21:07):

Two quick stories. There was one child that we saw and when the optician went to deliver her glasses, the child started crying, and so one of the thing we was trying to figure out is, "Why are you crying?" When the optician asked the child why they were crying, the child said, "I never knew that there were lines on the blocks on these walls," because she could not see them. That's one of the stories that always sticks to me. Then, one more quick story is that in the middle school, this is a child that is bused over to the elementary school for vision services. We go actually to the school to deliver the frames so the students don't have to come back again. When the optician went to deliver the frames, the student put on the glasses and just started screaming and was so excited because they could see better.

Clifton Bush (01:22:00):

How I found out about that story is the parent facilitator for the school called me because she was just so ecstatic about how the student was so excited that they could see the difference between their vision and just thanked me for the great things that we're doing within this community with students in the school system. I'll leave you with those two stories, but that's kind of our vision program.

Dr. Debi Sarma (01:22:28):

Clifton, thank you so much for sharing this kind of expansive program that is built into the community especially for our students, which really are a vulnerable population for many of the kids. They're relying on parents or guardians to have the capacity to take them to an appointment and it's not always possible. There are so many barriers in the way, and having been in school and getting eye exams, I know that joy when you put glasses on a child's face and they, "This is what it feels like to see?" Seeing kids that are squinting so much and thinking about the amount of energy they've spent trying to squint and if they had have been able to spend that energy on school how things would be different-

Clifton Bush (01:23:21):

Right.

Dr. Debi Sarma (01:23:22):

... and with this program that you have, it sounds like you'll be catching kids a little bit earlier so that they can enjoy their education a little bit more.

Clifton Bush (01:23:30):

Yes. Thank you.

Dr. Debi Sarma (01:23:32):

Thank you. I'm going to... You know, thank you to all the panelists. I know we're running a little short on time. These are wonderful stories. We're getting a lot of questions in the Q&A. I'd love to hand it over to Brandon.

Brandon Jones (01:23:48):

Thank you, Dr. Sarma, and for everyone, all of our attendees, rest assured all of your questions, I've been tabulating those questions in a separate document for our speakers, so given the short... We're short on time, so I am not going to jump into any questions. I think we only have a couple of more minutes left, but just keep in mind that we do have those questions and I'll provide those to our speakers and we'll provide those responses back to you in a full FAQ document. We have several questions, well over 20 questions, so we wouldn't have gotten through those in today's webinar, but we'll give our speakers some time to provide some thorough responses to your questions and get those to you hopefully within another week, if that sounds okay to you all.

Brandon Jones (01:24:30):

In the meantime, our speakers, their contact info, I think they may have shared it earlier, but we'll be sure to get their contact info to all of our learners so you can reach out to them directly should you have any additional questions. All right, so I'm actually going to, given the time, hand things over to my colleague, Olivia, so she can kind of close us out. Olivia?

Olivia (01:24:53):

Okay. Thank you, Brandon, and thank you all so much for joining today. Just a few quick next steps. I mentioned this at the beginning of the webinar, but we do have an evaluation you'll get directed to once this event closes out, so we definitely encourage you to fill that out. It helps inform our future events. We really value your feedback, and then keep an eye out. I also mentioned this earlier, but the recording will be available within the next week or two. We'll make sure to email that out to you all, and Brandon mentioned an FAQ document as well, so we'll definitely make sure to include that as well. Stay tuned for that.

Olivia (01:25:29):

Then, if anyone is looking for continuing education credits for this webinar, definitely make sure you complete that evaluation. That's how you'll receive those credits, and then you should receive your certificate within a few weeks. If you have any questions regarding the credits, you can reach out to Luke Ertle, who we heard from earlier, and then his information is there on the slide. Thank you again, and Brandon, I'll hand it back to you to close us out.

Brandon Jones (01:25:57):

All right. Thank you, Olivia. You see the information there. Feel free to connect via Facebook through the FQHC and Community Optometry Groups on Facebook, and we'll go to our next slide. I think there's just some references there for you, and you all have access to this slide deck so that you can take a look

through this. Of course, if you have additional questions, you'll be able to reach back out to us and get those responses.

Brandon Jones (01:26:22):

All right. Thank you all. Lots of great discussion, lots of great resources from our speakers. Thank you to our speakers for joining us, our optometry team, as well as our Health Center leaders who were able to provide their perspectives, so thank you so much. I see some question about the slide deck. We will be sure to get that slide deck and all the resources out to all of our attendees. I believe Olivia may get that to the group. All right, thank you all. Enjoy your afternoon. Take care.