Gina Capra (00:00:00):

Thanks, Olivia. Welcome everyone to today's webinar. NACHC is so pleased to welcome you to part one of our two part webinar series on eyes on access. The importance of comprehensive vision services and health centers cannot be overstated, and we're so pleased to have several hundred registrants for today's webinar, all expressing interest in learning more about the intersection of community health center, patient care, access and delivery for vision and eye health. Next slide please.

Gina Capra (00:00:37):

And Olivia, I just wanted to let you know, for some reason on my screen, I'm not able to see that this slides are advancing. So, I'm going to ask if ... Oh, there we are. Okay. Thank you so much. Appreciate that. Sorry for that glitch. The National Association of Community Health Centers want to let you know that vision and eye health are not the only topics that we're pleased to provide training opportunities on. You can find more at our Health Center Resource Clearinghouse, www.healthcenterinfo.org. We have a variety of topic areas with tailored materials suitable for the FQHC operating environment. Next slide please.

Gina Capra (00:01:22):

The Health Center Resource Clearinghouse is made possible through a collaborative effort of 21 national training and technical assistance partners funded by the health resources and services administrations, all 21 of us work together to ensure that we're providing training and technical assistance suitable to the needs of health centers. Today's webinar is a great example of the National Association of Community Health Centers and the Association of Clinicians for the Underserved coming together to provide this important session. Next slide please.

Gina Capra (00:01:56):

As mentioned earlier, this is part one of a two part webinar. We hope you'll join us for the second webinar on June 9th. Sounds like a long way from now, but it'll be here before you know it. So mark that on your calendar please. So today we're going to go through several major components of the session as outlined here on the agenda slide. But before we get there, I'd like to set a little bit of context, next slide, please, next slide, please, to remind us all about the impact and power of the national health center program.

Gina Capra (00:02:32):

For those of you who are joining us from health centers across the country, thank you so much for your service. You serve over 28 million patients through 1400 funded organizations in 13,000 service delivery sites. You can see from the slide that our patients are from across the lifespan, all of whom can be affected by vision and eye health issues in their lifetime. We also are primarily serving patients who are under or uninsured on public programs and of racial and ethnic minorities. The service you give in your communities is profound. We thank you. Next slide, please.

Gina Capra (00:03:17):

Health centers are possible be because they're governed by the community. Health centers are required to have a 51% patient majority board of directors. It's a complex and complicated job. For any members of health center boards who are on today's call, thank you for your service. You volunteer your time, your energy, you serve as a voice for your community, your neighbors and your family. We thank you for all the responsibilities you take serving on the board of directors. Next slide, please.

Gina Capra (00:03:48):

Health center boards are very critical when it comes to decisions about service expansion at the health center. Having the 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, or seeking collaborative partnerships to increase access to eye and vision services in your community. So we hope that health center board members who are on today's call will bring back what you learn to your boards to determine if the time is now to enhance or implement vision services at your health center. Next slide, please.

Gina Capra (00:04:31):

We do have some resources for our health center boards. It's not an easy job that you have. Please check out our resources for you as you proceed with your important strategic planning and decision making. Next slide, please. And we're so very pleased to have the Association for Clinicians for the Underserved with us today, to talk about some of the resources they make available as health centers consider how to stand up or enhance their eye services. I'm pleased to hand that over to my colleague, Luke Ertle, program director at ACU. Luke, over to you.

Luke Ertle (00:05:08):

Thank you for that introduction, Gina. As Gina mentioned, my name is Luke Ertle, and I am the program director at ACU, and ACU is a transdisciplinary, excuse me, membership network uniting clinicians, advocates, and organizations, and the shared mission to improve health equity for the underserved. We provide professional education, training, technical assistance and clinical tools and programs to thousands of clinicians and organizations every year.

Luke Ertle (00:05:33):

We got involved in the space of vision care starting in 2017 with a support of the Centene Foundation for Quality Healthcare to fund a number of mobile vision units across the country to provide comprehensive vision services to individuals at health centers. Since then, we've moved into the space of helping health centers start up or expand their vision programs with grants and technical assistance. And as you can see on the screen in front of you, so far we've funded 19 health centers. We also have on our website, which is www.clinicians.org.

Luke Ertle (00:06:06):

As you can see on the screen that we've got some different summaries of what grantees have done, patient success stories, things of that nature that if you want for your own information or if you are getting started, that can be some information to help. We also provide technical assistance to health centers through our vision services committee, who two of which are on our call today. Next slide. Also, just want to make a quick note of some of the different resources that we have available. So we have a vision services ready and assessment tool on our website as well as the best practices for integrating vision care in a primary eyecare setting. With that, I'll now turn things over to Dr. Susan Primo.

Susan Primo (00:06:51):

Thank you Luke. Good afternoon, everyone. My name is Susan Primo, and I will introduce the main webinar speaker 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. Thank you so much for joining. Today we have an attendance, 44% C-suite staff, 18% operation staff, 13% clinical staff, 23% other and a few governing board members, and folks who work in IT.

Susan Primo (00:07:21):

46% are in the planning stage, so no eyecare currently being provided, 20% in the beginning stages of planning, 14% in the intermediate stages, 14% well established comprehensive care services, meaningful integration, and 6% not on the agenda. So thank you so much to the six percenters for being here. I'm currently director of Optometry Services. I'm professor of ophthalmology at Emory University here in Atlanta. I spent three and a half days at a neighborhood health center as it's called, which was basically like a lookalike that falls under the auspices of Grady Memorial Hospital, and I've literally spent my entire career since training at an FQHC advocating for onsite services, eye services at community health center. So I'm very excited for this webinar.

Susan Primo (00:08:04):

I'm also co-chair of the Center for Vision and Population Health Advisory Committee as part of Prevent Blindness. Next slide, please. A bit about Prevent Blindness. It was founded in 1908 as a national organization with six affiliates. 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 many years now.

Susan Primo (00:08:37):

Prevent Blindness has two centers, as you can see on the slide, the National Center for Children's Vision and Eye Health, and on the adult side, the Center for Vision and Population Health. Prevent Blindness hosts the focus on eye summit every year. This year, the summit will be held virtually on July 13th and 14th, and the theme will be Eye-conic. That would be E-Y-E-conic approaches to eye health, which is fantastic by

really embracing the public health intersect of eye and vision care. We would welcome your attendance, and you can find more information on the website at preventblindness.org. Next slide, please.

Susan Primo (00:09:13):

As you learn from this webinar, eye and vision problems are prevalently population health center serve. And specifically in the webinar, the learning objectives are, to increase awareness of health center vision and eye health needs through the patient perspective, increase knowledge of disparities and barriers to assessing high quality vision services, increase the knowledge of the intersection of vision and chronic disease, child development milestones, cognitive impairment, and quality of life, and identify strategies for integrating vision service into community health clinics.

Susan Primo (00:09:44):

To set the stage for the wonderful speakers that you will hear from shortly, I will present a couple slides to show some important data and leave you with a visual before the formal presentation begins. Thank you. Next slide. Next slide, please. So most recent data from HRSA shows among all health centers, 36% do offer optometry services through the three delivery models, 9% through ophthalmology services. Next slide.

Susan Primo (00:10:13):

The three delivery service delivery models you see there in the various columns, regarding optometry services, again, 36% total health centers offer these services, and column one shows 17% through direct services only, column two, 7% through contract agreement only, where the health center pays, and column three, 4% through referral arrangement agreement only. And the health center does not pay. So among our health centers, 9% to offer ophthalmology services. And you can see the breakdown there. Today we'll be focusing really on column one model as we are primarily discussing what we believe is the most effective way. Next slide, please.

Susan Primo (00:10:52):

Lastly, urban health centers comprise nearly twice as many eye services as rural centers. And so we believe there's a real opportunity there for sure. Next slide. I'm going to briefly show some yearly trends from 2016 just to show the progress being made. As you can see in that first line, there has been steady increase in FTEs for doctors of optometry, and we are really proud of that, as you know that in 2020 there was the pandemic, and so as a result, there were obviously less visits, encounters, FTEs. Given our close physical contact with the patients just like dental, that was greatly reduced and we couldn't readily convert to telehealth. And so, we did do some telehealth, but really very little. So the growth is slowed, but we expect to see better numbers for 2021 and 2022. Next slide.

Susan Primo (00:11:45):

So I will leave you with this visual from 2020 showing so few eyecare patients as compared to dental and medical patients at health centers. It really is astounding to

see this, but we do know that there are less than 3% eye visits compared to 22% dental visits and almost 9% mental health. So, more current data, and we want to illustrate that we have a long way to go to improve eye and vision care among community health center patients. Next slide. So with that background, I will now introduce everyone. First we have Dr. Ashley Burns. She is director of optometry at Coastal Family Health Center Biloxi, Mississippi. She went to the Indiana University, School of Optometry, and she is currently ACU vision services committee chair.

Susan Primo (00:12:27):

Next slide. Next we have Dr. Kristin White, who is director of optometry service at MACT Health Board in San Andreas, California. She went to the New England College of Optometry and she completed a community health optometry residency in 2014. She is also a member of the ACU vision services committee. Next slide. And lastly, we have Dr. Debi Sarma, who is a public health optometrist and community outreach specialist from Boston, and she optometrist at the Fenway Health Community Health Center. She also attended the New England College of Optometry and also did a community health center optometry residency. So I will turn it over to Dr. Sarma.

Debi Sarma (00:13:11):

Thank you, Dr. Primo. Hello everyone, thank you for joining us today. We've got a great list of items to go through today. We're going to talk a little bit about the patient statistics and go over some patient cases. We'll share some national statistics with you as well. And then we'll talk about the components of eyecare integration, and then we'll go over the last bit summary and closing remarks. Next slide. So let's talk a little bit about the patient experience. In my career, being very lucky to spend time with people as they go through learning about their eyes and also as they experience changes in their vision and vision loss through their ages and stages of their life. Next slide.

Debi Sarma (00:14:03):

So let's take a moment, and really take a look at this photo. For those of you who might not have a visual or a dialing in, it's an image of a family, some grandparents, some grandkids, and an uncle, looks like enjoying a really beautiful summer day outside. There's bright green foliage, there's tricycle, there's a child running after a ball. And I think what's really important is that, when we talk about vision health, we're really dialing in on quality of life for the communities that we serve.

Debi Sarma (00:14:42):

So much of how we enjoy the life that we have now is through our vision. If you close your eyes and think about a really memorable moment in your life, the way that the expressions were, what you were seeing, imagine that same memorable moment for you without your vision. And yet so many people among us and many patients in your health center are experiencing vision loss that's going untreated or unmitigated because they don't have a place to go. And when you look at this photo, what this really looks like on a granular level is, different concerns that come up.

Debi Sarma (00:15:25):

When I see patients in a day to day at a health center, it can sound a little bit like this. I might have a parent come in and say, "My child is six months old and they don't give me eye contact. I feel like she can't see me or she's not seeing her grandparents. I'm not sure what's going on." It can also sound like, an eight year old child coming in and saying, "I can't see the board, how come my friend next to me can see all the math problems and I can't? People say that I'm not that smart." Sometimes it can be someone saying, "I can't seem to track the ball when I'm playing soccer, or have the coordination to ride that tricycle or bike."

Debi Sarma (00:16:10):

It could be that uncle in the background who's saying, "I didn't realize that I had color vision loss and that so many opportunities for my career would be limited because I just didn't know. I wasn't informed." And we expect that over time as well into the golden years, you can have other changes in the vision. For example, conditions like macular degeneration, glaucoma, are basically causing vision loss very slowly over time without causing any pain. So patients don't tend to notice them until the late stage.

Debi Sarma (00:16:47):

It's not surprising to me sometimes when I'll have someone come in like this grandfather here in the image and say, "I'm looking through every part of my glasses, doc, and I just can't seem to see my grandson's face like I used to." And find an eye condition. The hardest part is when you look inside the eye and you see that the vision loss was completely preventable and could have been intercepted a lot earlier by routine clinical care. And that brings us to the next few cases. I'll have you go to the next slide.

Debi Sarma (00:17:23):

So there is a video, we'll send the link to you at a different point, but it is two patients in this first testimonial. They come from different health centers, and these are health centers that were ready and prepared to serve these patients and understood the need of vision care in their communities. The first message is by a gentleman named James. James has been previously incarcerated, was also a veteran and lived with homelessness status. He was seen at the Colorado Coalition for the Homeless as one of the patients, and he was found to have tremendously high eye pressure.

Debi Sarma (00:18:05):

An eye pressure is a risk factor for a condition called glaucoma that can cause irreversible damage to the visual field and cause vision loss. That's really important to catch these high eye pressures early in order to use eyedrops to lower the pressure and allow for good or better vision outcomes. So, it took him a while to realize that, "Hey, the vision isn't where it should be." And by the time he had left prison and was seen at this health center, they found really tremendously high eye

pressure and were able treat and stabilize the vision so that it slowed down the progression of glaucoma.

Debi Sarma (00:18:49):

The other case in a more rural scenario, it is a woman named Meredith, who said that her health center was very instrumental in helping her son find care. Her son was experiencing double vision while in school. This was causing him to not be able to read and see the things that he needed to in class like his classmates. Luckily the health center had vision services and she was having issues with insurance. And the health center also provided a sliding scale for allowing to cover their eye exam and their glasses as well.

Debi Sarma (00:19:27):

And so, over time with treatment and with glasses, they diagnosed an exotropia, where their eye turns out and they were able to give the child glasses. And with this treatment, the child was able to resume studying as normal and continue growing through the developmental milestones as they should through school. And we'll send out the link to you afterwards, after the presentation so that you can enjoy on your own time. Next slide. Now we're going to have Dr. Ashley Burns go through some of the statistics of vision loss.

Ashley Burns (00:20:07):

Thank you, Dr. Sarma, thank you for showing us what vision loss looks like on an individual scale. So, now I'm going to talk more on a large scale and I'll show you how vision loss is expected to affect our communities in the coming years. All right, next slide. So vision loss is a public health crisis and poses a huge economic burden. Between 2019 and 2050, it's expected that there will be an increase of 115% of people with vision impairment. Overall, the cost is expected to increase by 157% reaching $373 billion by 2050. Next, please.

Ashley Burns (00:20:59):

So vision disability is actually one of the top 10 disabilities affecting adults, 18 years and older, and it's one of the most prevalent disabling conditions among children. Amazingly, almost all vision loss is preventable. Patients of all demographics are at risk for vision loss, but our most vulnerable populations will include elderly, people of color, women and children. Next. So vision disorders are the fourth most common vision or fourth most common disability in children in the US. And one in four children has a vision problem that may affect their ability to learn, meet milestones and play sports. Next, please.

Ashley Burns (00:21:53):

So, looking at this graph, this is an analysis of children's vision disorders from 2015 projected to 2060. And as you can see, there is upward trend in children of African American, multiracial and Hispanic descent, and with our Hispanic children being the most impacted. So looking at this, we want to ask ourselves, what are we doing to combat these numbers? And what can our health center do to play a part in creating

a better future for these children, which they deserve? Next. All right, moving on to vision loss in the adult population. It's true that one in 11 adults over 65 is visually impaired, doubling their risk for falling, which is the leading cause of injury in that population.

Ashley Burns (00:22:53):

So, being unable to see your surroundings accurately has a serious consequence for your overall health and quality of life. Next, please. Okay. This is an interesting graph of the study done, which patients would self report visual impairment. In this study, you'll see that poor health is associated with chronic conditions among older people with visual impairment. So older adults with visual impairment were three times more likely to report having poor health as compared to those without vision impairment, but also with chronic condition. And those with severe visual impairment were more than 10 times as likely to report poor health.

Ashley Burns (00:23:44):

So this really reiterates the impact vision has on a patient's perception of their own health and quality of life. And the takeaway from here is basically just to show that vision loss is comorbidity with several different conditions and it affects how patients see their overall health. All right. Next, please. All right. So, looking at the burden of vision loss by race on this chart, in terms of absolute numbers, non-Hispanic whites represent the largest proportion of people affected by visual impairment. That's the top line there. And currently, African Americans have the second highest proportion of visual impairment.

Ashley Burns (00:24:37):

But if you can see in 2040, that's actually going to switch places with the Hispanic population. And this is believed to be in part of a high rate of diabetes in that demographic, which is associated with diabetic eye disease, the number one cause of preventable blindness. So, next please. All right. So even though based on the last graph, we know that the numbers show that non Hispanic Whites are expected to experience large numbers of visual impairment, we know that the rate of vision loss is much higher and disproportionately affects people of color. So looking at this graph, you can see that non-Hispanic Whites actually have the lowest prevalence of vision loss, and our Hispanic population is the most at risk.

Ashley Burns (00:25:31):

And while the best data we have today is based on race, we know having backgrounds in community health, that there are other social determinants of health, such as income, neighborhood, access to care, education. All these things play a part in these statistics. Next, please. But unfortunately, nearly a quarter of all counties in America have no eyecare whatsoever. And without routine eyecare, patients are at risk for blinding eye disease with no opportunity for intervention. And it can be even harder to find a provider that takes Medicare or Medicaid. So this is why existing health centers are already well positioned to address these disparities and barriers, and it's crucial to changing the course of these projections.

Ashley Burns (00:26:29):

Next, please. Okay. So now that you know more about the need for eyecare, let's discuss the types of professionals that we'll be providing these services. Next, please. Okay. First, what we'll do is take a quick poll. We're going to ask you about what your thoughts of an optometrist role is in eyecare. Remember that your poll will be at the lower right hand corner of your screen. Okay. So, are all optometrists licensed to, one, prescribe glasses and contacts only. Two, diagnose and manage many eye disorders and diseases. Three, perform cataract surgery, or four, all of the above.

Ashley Burns (00:27:19):

So, we are going to give you guys about one minute, one and half minutes-ish to answer. Okay. So, can we get the results? All right. Looks like the majority of participants chose B, which is actually the correct answer. So, this is actually, was kind of a trick question. Those are some really good guesses, but yes, the correct answer is B, and I'm going to go into why that is on the next slide. All right. So this table gives a basic breakdown of the roles different eyecare providers play, and ophthalmologist is a medical doctor and is primarily going to be involved in invasive surgery, such as cataract surgery or retinal detachment.

Ashley Burns (00:28:56):

And there simply aren't enough ophthalmologists to provide primary eyecare. That's the role that optometrists will play. And an optometrist holds a doctorate in optometry, of course, and we provide primary eyecare. And in addition to prescribing glasses and contacts, we can also manage diseases. And in some states, we're even licensed to perform laser surgeries, small injections and incisions as well. And then your optician is going to be an expert on making and fitting glasses, and they'll be the ones managing inventory and sales. So typically you're going to see an optometrist in a health center working along other primary care providers. So, next I'm going to turn it to Dr. White for our next section.

Kristin White (00:29:57):

Thanks so much Dr. Burns for breaking down all of that really complex information for us. Next we're going to be sharing a few patient cases from a day in the life of a typical optometrist at a community health center. Next slide, please. So our first patient is a 58 year old female coming in for her first ever eye exam saying that her vision is blurry while she's reading. So right off the bat, that's a pretty typical complaint of someone in their fifties. So I'm not too wound up yet. One thing that stands out to me is that, her best corrected vision is only 20/25. So that's actually one line up from our smallest letters, which are the 20/20 letters.

Kristin White (00:30:37):

So in the absence of disease, this patient should be able to read the smallest line of letters. So I'm storing that in the back of my mind, as I'm checking this patient. Her medical history, she actually hasn't had any sort of medical care in years. So we dilate her eyes to check the health of them. Next slide, please. And these are photos inside this patient's eye. So this is in the back of the eye, the retina, and the eye is a

really exciting or interesting part of the body because it's the only place where we can look right in and see what the blood vessels are doing.

Kristin White (00:31:17):

The part that's even more interesting is that, what's happening with the blood vessels inside our eye is also happening in the blood vessels elsewhere in the body, like the kidneys or your feet and causing other symptoms. So we see here the blood vessels, and the blood should only be within those vessels. But actually, if you can notice the little red spots throughout your picture, those are actually hemorrhages. So those are areas where blood has leaked out of the blood vessels and it's caused by elevated blood sugar that's been going on for years unchecked, but this patient didn't know she had that going on because she hadn't had any medical care. Next slide, please.

Kristin White (00:32:01):

So for management for this patient, we're going to get her set up with a primary care doctor at the health center, so that diabetic labs can be ordered. We can begin treatment and lifestyle management for diabetes, we'll prescribe her glasses for her reading complaints and follow up with her in three to six months in the eye clinic. But what I love about this case is that it highlights two really important topics. The first is that, optometrists serve as a non-threatening entry point into the healthcare system. So on a daily basis, I see patients who haven't had any sort of medical care for a number of years, sometimes even decades, but they come to me because they believe they need glasses.

Kristin White (00:32:45):

And while that may be part of what's going on, as in this case, we can see that it's often not the whole picture. The other thing that this case highlights is it's an example of one of over 300,000 cases of diabetes that are diagnosed annually by optometrists through an eye exam. I'm going to pass over to Ashley for the next patient case.

Ashley Burns (00:33:12):

Thanks Dr. White. Okay. So our next patient is a 59 year old who presents for the first time complaining of blurriness when looking at the words on the bottom of his TV. So we were actually able to correct his vision to 20/20 in both eyes, but his pressure was really high in the right eye. That's the intraocular pressure there. He also mentions thoughts of self harm during the exam. So looking through his chart, he's already been seen at the health center. I can see that he has a diagnosis of bipolar disorder and also has high blood pressure control with medicine, and his eye exam reveals, next slide, please, glaucoma.

Ashley Burns (00:34:06):

So, when you are looking at the picture on the left, this is again, the optic nerve, and this is what connects your eye to your brain. And this is where glaucoma happens. And it's actually a measurable with a visual field, which is on the right side of your

screen. And the black areas on the visual field actually represent vision that is lost forever. So as Dr. Sarma mentioned, in glaucoma, the loss is irreversible and there's no cure for glaucoma. So, if the patient had waited any longer, it's possible that he could have gone completely blind in the right eye. So we'll go. Next, please. All right.

Ashley Burns (00:34:57):

So for this patient, we are going to, of course, prescribe glasses, which is what he came in for, but we're also going to address the glaucoma and start treatment with eyedrops to lower the pressure. And then we'll monitor him with that visual field and other special tests every three to six months. And another important part of this case is immediately attending to this patient's behavioral mental health. And this highlights for me one of the best parts of working in a community health center, which you don't really find outside community health is that, you're taking care of people's minds and bodies all in one place. All right, thank you. I'm going to pass it to Dr. Sarma.

Debi Sarma (00:35:47):

Thanks Dr. Burns. So the third case, we're going into school now, we're talking about a child who's failed a school screening. This is really common that children have their school screenings and they'll bring in paperwork to the eye clinic at the health center and say, "My child has failed the screening. Let's talk about what's going on." So this child is an eight year old, they come in with their parent. They say they're struggling to get focused in school.

Debi Sarma (00:36:15):

And the child has an interesting complaint. They say, "It's blurry when I look up at the board after reading for a long time." So it's not that the vision is always blurry at distance. In fact, when I checked his vision, looking far away, he actually sees 20/20, that's the lowest line on the chart. And if you weren't paying too much attention, you might have actually passed him on the screening, but it's that he actually had blurry vision up close when trying to read. His medical history was positive for ADHD, and he has an education plan for school. And the comprehensive eye exam reveals, next slide, that he had an issue focusing up close with his eyes, which would require him to have specialty glasses just for reading. I'm going to have you go to the next slide.

Debi Sarma (00:37:13):

So the treatment for this was that he had glasses just for extensive homework to help him relax his eyes up close. We wanted to see him back in about three months to follow up. And if his vision didn't get any better, there's vision therapy, kind of like physical therapy for the body where you can do a series of exercises for the eyes to help the eyes learn to focus when going from distance to near and vice versa. Next slide.

Kristin White (00:37:42):

So these cases really highlight that eyecare is so much more than 20/20 vision. Many blinding eye diseases are silent, meaning that in the early stages they don't cause

any pain and they don't cause any loss of vision. So, eye health education and regular eye exams are critical to maintaining good long term eye and overall health. So next, Dr. Sarma is going to be discussing four models for providing vision services for your patients.

Debi Sarma (00:38:18):

Thanks Dr. White. So yes, we're going to go into the models for vision service. It can be intimidating to think about starting a whole new eye clinic from scratch, but there are several options that are out there for ... Next slide. Thank you. So, these are the four models of vision service that we put together, and we look at them as, you could do screenings, vision screenings to check the vision of your patients, consider referrals to an outside clinic. So a clinic that you know outside of your health center, that does eyecare, you could consider mobile eye clinic services.

Debi Sarma (00:39:07):

You could also consider in-house eye services as well. And Dr. White is going to go through that in-house eye services in more detail. Next slide. So let's talk about what screenings are. Screenings are a limited portion of the exam that you do to look for patients who may have a certain eye condition or disease. We typically think about them in two different ways. One is through vision screenings that we see in kids mostly, and the other is for retinal screenings that we use for diabetics.

Debi Sarma (00:39:44):

Let's talk about the vision screenings in children. This is when a child is usually seen by somebody who's not necessarily an eyecare provider, maybe a school nurse or administrator to help check the vision. Usually at distance and looking at an eye chart, will check the vision in one eye covered, and then the other eye, it's a limited exam, and you're really not looking at the health of the eye, you're not looking at the structures of the tissue, but vision screenings are really important in finding the children, especially in a school setting that may have eye issues that limit their ability to learn in class.

Debi Sarma (00:40:23):

Retinal screenings are used very commonly in adults with diabetes. For example, if your eye clinic does not have an eyecare provider or eye clinic on site, you can consider using an integrated system with a fundus or retinal camera, where it takes an image of the inside of the eye. The images are sent to an eyecare provider at another facility for interpretation, and the results are sent back to you. So the results might look like no diabetic retinopathy, have them back in a year. It might look like mild diabetic retinopathy, please have them refer to us for a dilation. It might even look like urgent retinal disease associated with diabetes or macular edema associated with diabetes, please refer to a local retina specialist within the next two weeks.

Debi Sarma (00:41:16):

The nice part about screenings is that it requires minimal staff and minimal training. Almost anyone can help with these types of services. What you need to have is a very good referral location for the screen fails. And also keeping in mind that, even if you pass a screening, it doesn't mean you don't need an exam, every person needs an eye exam, at least one to two times a year, just to make sure that their eyes are healthy and the tissues are normal, and the other parts of the exam are covered. And the other thing I want you to keep in mind is that with the screening, you don't get glasses prescriptions. So those needs might not be fulfilled by this modality. Next slide.

Debi Sarma (00:42:01):

You might be in a setting where you have a pretty full setup for other services in the clinic, you might not have room for an eye clinic there. Some hospitals or health centers may be referring out to an eye clinic provider that's in the community. These types of services do require some level of coordination, either by the health center or the patient is given a name and a number, and they need to coordinate themselves. What we know about outside referrals is that, 50% of outside referrals are not completed, meaning that the patient is told that they have to go. But for a multitude of reasons, whether it's transportation, education, finances, they may not go to get those services.

Debi Sarma (00:42:48):

It can also be extremely difficult to find Medicaid providers who are able to do the eye examinations. And this is especially true as we go across the country to rural parts, especially for pediatric patients. I remember a few months ago, I was trying to coordinate care for a sibling set in Virginia, and their next wait time for an eye exam for the three kids was eight to nine months away because the wait list was so long for an eye exam. And by that time, a huge portion of the school year would have already been finished.

Debi Sarma (00:43:26):

If the exams are going out of the health center for care, if the patients are going elsewhere, the health center is not really receiving the funds for that exam. And it will take coordination to retrieve the notes, meaning that, your patients may come back to you, but you might not know what happened, unless there's a robust way of sharing information back and forth with that eye clinic. The other thing that is important too, and one of the reasons I love working in a health center is that, when I do an eye exam, it's nice to have the full picture, meaning that if I see a retinal hemorrhage, knowing the history, helps me deduce whether it's from their high A1C or their blood sugar, is it from their blood pressure? Is it from anemia? Could it be a risk of a cancer of the blood?

Debi Sarma (00:44:19):

So these are all things that we look for when we're trying to figure out what is the cause of findings inside of the eye. So having that complete picture is very helpful. Next slide. Another modality that you could consider is a mobile eye clinic. Mobile

eye clinics could be purchased. You could build them out using a recreational vehicle, or you could consider contracting with a mobile eye clinic service for temporary care or seasonal care for your patients. This can be really helpful if you have multiple satellite clinics and patients with difficulty with transportation.

Debi Sarma (00:44:56):

So maybe the mobile clinic is parked at the main center some days, sometimes, maybe a couple of times a month, it might go to the satellite location. It could also have the opportunity to see patients at their home. So, maybe for patients who are home bound or have difficulty with transportation, you could get the care directly to them. You could also consider community locations, whether it's a local fair, at the grocery store, somewhere to really embed yourself with the community so that they could have better access to services.

Debi Sarma (00:45:29):

On board, you could easily fit an eye exam lane. You can see this picture in the back as a full doctor's examining. You could do screenings as well. There are some challenges with mobile eye clinics that need to be considered, for example, geographic coordination. When is the mobile clinic going to be and which location, and scheduling it based on a route is a kind of interesting challenge. You may need to schedule patients based on a route and route logistics. Doctor scheduling is something to think about, that a doctor might have to go to different locations every single day.

Debi Sarma (00:46:05):

Parking logistics, where can you park, are you authorized to park there? And weather should be considered too. For example, if you live in a really hot location, you'll have to make sure that there's a good location to keep the mobile clinic in a cool location, or make sure that there's adequate time to cool down the mobile clinic on a really hot day with the air conditioning. Next slide. And lastly, we will touch on in-house eye services. So this is the most comprehensive and effective option for patients who are just looking to get care within the health center.

Debi Sarma (00:46:45):

The eye doctor could be an employee or somebody that you contract. They could be part-time or full-time. It's really convenient for patients to have the same patient services, front desk person for a primary medical care schedule for eye clinic as well. And there's less confusion and back and forth between providers. What you're looking for with the in-house eye services is really comprehensive medical care, as well as emergency eyecare services. So patients coming in with acute red eye, could it be a viral or bacterial conjunctivitis? Could it be trauma? Could it be inflammation of the tissues inside of the eye?

Debi Sarma (00:47:26):

All of that we can figure out because we have the tools in the eye clinic to help with them. It's really important that you know that the eye clinic encounters are billable

at the same rate as in office exam, and the clinic investment and space may vary. And Dr. White is going to go into that in a little bit more detail. Next slide.

Ashley Burns (00:47:54):

All right. So, Dr. Sarma has highlighted that in-house optometry can best serve the patients, but it also best serves the health center itself. When striving to be a PCMH, eye doctors should certainly be included among primary care providers. And having these services helps the clinic provide better management of at risk patients with complex health and social needs. And in return, it helps your clinic reach goals and quality and other metrics. So, now that we know we've convinced you to start an onsite eye clinic, let's hear from Dr. White about what that would actually look like.

Kristin White (00:48:46):

Thanks so much. So, here we'll be discussing from low to full financial investment and space allocation for providing onsite vision services. I was in your shoes five years ago when I was working with the community health center where I now practice in deciding how we were going to establish and create this optometry department, deciding what level of services we would be providing and what that would look like across our multiple locations that our clinic serves. Next slide, please. I'd like you all to know that with minimal space and financial investment, you can start providing optometry services on a basic level.

Kristin White (00:49:32):

So when we're thinking about this, I want you to think onsite or community based, part-time, shared space and portable equipment. So if it's onsite, this will likely be a shared medical exam room with another specialist. So, for example, I go to one of our satellite clinics and alternate days with a dermatologist. Now, this means that every time I'm setting up for my exams, I spend the first 30 to 45 minutes of my day unpacking equipment, setting up and creating an eye clinic, and then at the end of the day, breaking it down, taking another 30 minutes or so to pack everything away and store it so that the space is set for a different provider on a different day.

Kristin White (00:50:21):

So just to be clear about the logistics of what needs to go in when you're offering this type of service, if your clinic already has a school-based clinic, for example, having optometry a day or two a week at that location could be a great way to get in the community and start providing exams for the students. So, most importantly is that, you need to be clear on what it is you want to achieve when deciding what level of care you're actually going to provide. If you want to be providing routine eye exams to adults and children, you want to be providing diabetic eye exams and glasses prescriptions, maybe providing glasses for Medicaid patients.

Kristin White (00:51:09):

Then this basic model could definitely work for you for something to start with. It's also a great option for a satellite clinic or a smaller or a less busy location that wouldn't support a full-time optometrist. But you need to be clear about what you

can achieve and what you can't. So you're not able to manage ocular diseases like glaucoma or manage macular degeneration in this setting, because you don't have the specialized equipment to do so. And again, for logistic and planning purposes, you would be seeing less than a thousand patients per year using this part-time shared space model. Next slide, please.

Kristin White (00:51:54):

So when we think of a mid-range investment, we're thinking of an in-house dedicated space for a full-time optometrist with support staff. This is going to be what most of you end up doing. And this is what we decided for my clinic as well. You're going to have more equipment that's going to be pretesting and specialty testing equipment, which will allow you to manage ocular disease, provide glasses, not just the prescriptions, but even provide them in-house and take really good care of your patients, because of the extra equipment and support staff, you'll have enhanced deficiency, and you should expect to see between 1500 and 2000 patients annually per optometrist.

Kristin White (00:52:41):

So even within this mid-range investment model, there's a spectrum of the type of services that you can provide. And this would be based on the type of equipment that you offer. So, to start off with, you may only have a visual field machine. So if we think back to case number two, the patient who had glaucoma, we saw that dark area on his visual field, which was a mapping out of his vision that showed us where the vision had been lost from glaucoma.

Kristin White (00:53:11):

So that test was a visual field, and you may start with only that machine, but then in six months or a year or two, once your patient volume builds, and once your clinic has become a little more self-sufficient, you may then decide to add an OCT, which is a retinal scanner, or even a fundus camera that took those images of the patient's eyes with diabetes in our first case. A note on glasses because it's a big question that comes up, I really would recommend if you're going with this model of care that you do offer onsite glasses, meaning that you have a selection of frames that patients choose, and whether it's covered by insurance or self pay, that the glasses can be ordered through your clinic.

Kristin White (00:54:02):

For the same reason that it's so hard for patients to find their way to another eye doctor outside of the health center, it's really hard if they just leave with a piece of paper with their prescription, they feel like the visit is wasted, even if you diagnosed a brain tumor or found some really significant eye disease in their mind, they needed glasses and you were unable to provide that for them. So from the patient perspective, it's really crucial if you can provide glasses onsite. Next, please.

Kristin White (00:54:38):

So here, when we're talking about a full investment clinic, we're really talking about a really small percentage of the clinics as a whole, because as I said, the majority of you are going to be doing that mid-range clinic that we just talked about. You can't actually start with this level of investment for a number of reasons, what we're talking about here is a really large scale, and it's going to take a lot of time to build that patient volume before you can support it.

Kristin White (00:55:09):

So what I'm referring to is a location that has multiple optometrists, possibly multiple locations, likely optometry students and residents that will help subsidize the workforce. And you'll be seeing over 2000 patients per year per optometrist in this setting because the student work subsidy. You'll have a large support staff of opticians, technicians, billing specialists, receptionist dedicated to your clinic. You'll likely have a moderate to large selection of glasses here. And you'll definitely be able to manage advance disease. You may even have multiple optometry subspecialties like pediatrics or low vision or specialty contact lenses.

Kristin White (00:56:00):

This could be a setting where you might even bring in ophthalmologists like a retina or glaucoma specialist who can provide consultation and pre-op care, because if you think it's hard to get in for a routine eye exam, think about how hard it is trying to get in for a specialist. So this is a really extensive clinic model, and these are most often affiliated with optometry schools. So I worked through several of these throughout my training in Boston. What I want to point out to you about this model, even if you're not going to be expanding to this degree is that you can take pieces of it and fit it in with your mid-range model once your clinic grows.

Kristin White (00:56:42):

So, say like me, you're in a really rural location where it's hard to get patients to specialists. Even though we're only a two optometrist practice, it could be a really great opportunity for us to bring in an ophthalmologist who maybe comes in once a month and does cataract pre-op visits, so that the patient don't have to travel four hours round trip to get seen for that initial visit prior to their surgery. So, I just want you to think big and realize that there's a lot of wiggle room within each of these models of how you can be providing care. Next slide, please.

Kristin White (00:57:22):

So you can see that even if space or finances are a limiting factor now, you can start doing something to meet your patient's eyecare needs. So whether that's screenings for pediatric patients or retinal photos for patients with diabetes, whether that's creating a great relationship with your local optometrist and being able to refer patient there, and they'll happily see them, that can be a great system to get started to providing that need for your patients.

Kristin White (00:57:53):

Maybe you're going to hire a mobile clinic who comes with some regularity to the clinic, and you schedule your most high risk patients, or maybe you're ready, like a lot of you are, based on our initial survey, maybe you're ready to have onsite vision services, whether that's a low, mid or full range of services. In our second webinar, the one that Gina mentioned that'll be in June, we'll be providing a lot more logistics on how you can integrate optometry with the other departments. We touched on a few points of that earlier today.

Kristin White (00:58:28):

But just to leave you with a few numbers, you should expect your optometry department to see about 10% of the medical patient visits annually and your health center should be seeing 18 to 20,000 medical encounters annually to make an eye clinic at a mid-range sustainable. I think most important, what I want to leave you with today is that, you should meet with your team and really discuss what your goals are. What types of exams do you want to be able to provide based on your patient demographics, what type of space do you have now, or could you get creative and find for the future, and how many patients do you hope to see on an annual basis?

Kristin White (00:59:15):

These main points will help you create your plan and decide what model is going to be best for you. I hope you've realized throughout this talk today, that eyecare services are vital and that your work in the community health centers is the perfect opportunity to be providing these services for our patients. Next slide.

Debi Sarma (00:59:39):

So we'll be sending you another testimonial of a board member from a health center, Family Health Services of Darke County in Greenville, Ohio. This health center is one of the few places where there is an eye clinic that takes Medicaid for Ohio patients. The patient that you'll see, Kathy is a patient there, she's also on the board, she was being seen there for routine eyecare and was diagnosed with cataracts.

Debi Sarma (01:00:13):

And shortly after, was also diagnosed with normal tension glaucoma, where the nerve of the eye becomes unhealthy and might have difficulty seeing, losing peripheral parts of the vision, but the eye pressure is normal. So she describes it, the eye clinic as being very vigilant in monitoring her every few months, utilizing technologies like optical coherence tomography, and visual field that we've described during the presentation as part of her routine eyecare to make sure that she doesn't have any effects of the glaucoma going forward long term effects.

Debi Sarma (01:00:59):

And I think what you'll also see is that she describes herself as a nurse and talks about how I'm important it is to have vision care in children. She describes children failing vision screenings, and the ones that do end up getting care and surviving through school and the ones that don't get care, fail the vision screening and don't

end up having that resource, how they may fall behind. And so if you'd love to hear from Kathy, please feel free to check out that link that will be sent to you after the talk today. Next slide.

Ashley Burns (01:01:42):

Okay. So, in summary, we've heard now how vision loss is a major public health problem, and we'll continue to grow without corrective actions. We've learned the role of an optometrist in a primary healthcare team. We can see that in-house optometry services will serve to increase access to care and also to help maximize reimbursement. And that eyecare is a value-based service that provides a positive impact for the whole community.

Ashley Burns (01:02:16):

It gives a child a chance to thrive in school and extracurricular activities, a mother a chance to return to work and provide for her family, and a grandfather a chance to play with his grandchildren in their home without fear of injury. So, on a large scale or a small scale, we are on the cusp of a great opportunity to address the complete needs of our patients. Thank you all very much for your attendance and attention today, I'm going to hand it over to Dr. Primo for the question and answer portion of the webinar.

Susan Primo (01:02:53):

Thank you colleagues for an outstanding presentation. I hope you in the audience enjoyed that. It was really phenomenal, and really laid the groundwork for what we think is very important. So I want to take this opportunity for a few moments to see if any of the audience has any questions. Okay. It was so good, it was so clear and concise that people have no questions. So thank you so much. Next slide, please.

Susan Primo (01:03:34):

So I wanted to remind you about some resources that were in your preregistration packet. You can see the list of them there. I won't read them off, but we presented a lot of information there so that you will find really information about what we talked about in these resources. And so please take note when you get a copy of the slides and try to visit some of these websites, they're all a little bit different, and I think you'll find them very informative. Next slide, please.

Susan Primo (01:04:04):

And here are some references as well. So, as a reminder, the next webinar will be on June 9th, where we'll talk about funding, costs and planning for integration, and feel free to register when you can. We'll review the planning factors, including provider configuration, cost, volume and supervision. So basically we'll get really into the nuts and bolts of how to get started. You've heard a little bit about how from each level, low investment to full investment, but we'll really get again to the nuts and bolts of actually how to do it. Thank you so much. We'll now turn it over to Olivia.

Olivia (01:04:48):

Great. Thank you so much, Dr. Primo. I just want to go over a couple of quick next steps for everyone. So, as we mentioned at the start of the webinar, we do have an evaluation that you'll be directed to. So, I really encourage you to fill this out. We thank you for your responses, and if you're looking for credits for this webinar, you can receive those also by filling out the evaluation. So definitely make sure to do that, and you will receive a certificate within two to three weeks after filling that out. If you have questions, you can always reach out to us.

Olivia (01:05:26):

And then, as I mentioned before, definitely keep an eye out, we are going to be emailing out those two patient testimonial videos right after this webinar along with the slides. So keep an eye out for an email with those, and then we will also be sharing the recording once it is available within the next week or so on the Health Center Resource Clearinghouse. Want to extend a really heartfelt thank you to our faculty, as well as to you for joining for this webinar. We definitely appreciate it. And then Gina, I'll turn it over to you in case you have a few words to close us out.

Gina Capra (01:06:07):

Thanks so much, Olivia, and thanks for everyone hanging in there for this excellent presentation. I did want to acknowledge, we are keeping track of the questions you've submitted today, and those that we were not able to respond to today, we will use that to inform some of our content for the webinar in June.

Gina Capra (01:06:27):

I can see that many of your questions are operational in nature regarding acquisition of local vision practices, other barriers to access and operationalizing vision services. And of course, some questions around funding these important service lines and provider positions. So, we'll certainly take that under advisement in our content development for the June webinar. Looking forward to seeing everyone in June. Thanks so much. Have a great day.