Integrated Care
A Strategic Opportunity for Eye Care

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Disclosures
Ownership Interests
• ECP Advisor Group, LLC

Consultant Fees
• Alcon Laboratories, Inc.
• The Kinetix Group

Today’s Discussion

1. Explore factors impacting providers’ strategic considerations for success in today’s/tomorrow’s environment.
2. Understand what integrated care is and why it is a critical strategy for eye care.
3. Learn potential approaches to execute eye care integration.

SWOT

STRENGTHS & WEAKNESSES
• Internal
• Practice-specific dynamics

OPPORTUNITIES & THREATS
• External
• Market conditions / events
The Internal Environment

The Strengths & Weaknesses

Attributes of Successful Practices

Collaborative relationships with all healthcare stakeholders
A "healthy" practice environment
Strong and sensible group governance
Responsive to changing market dynamics
Exercise of financial discipline
Commitment to planning and execution
Service commitment to all stakeholders

Legislative & Market Forces

Healthcare reform legislation has required ECPs to:
- Increase the amount and quality of reporting
- Produce high patient satisfaction scores
- Manage costs/resources effectively
- Shift from a volume-based model to a value-based model
- Re-engage provider relationships

Consolidation among healthcare stakeholders
Shifting referral patterns

Reduce costs
Resource allocation
Waste reduction initiatives
Value-based rewards

Improve experience
Improved outcomes
Patient experience
Patient engagement
Patient journey

Improve health of populations
Patient registry/IRIS
Diagnostic screenings
Wellness exams
EHR implementation
Data analytics

EHR = electronic health records
IRIS = Intelligent Research in Sight

**MACRA - Volume to Value Shift**

- All Medicare FFS (Categories 1-4)
- FFS linked to quality (Categories 2-4)
- Alternative payment models (Categories 3-4)

**2016**
- 85%
- 30%

**2018**
- 90%
- 50%

New Health Care Payment Models
- Category 1 – fee-for-service with no link of payment to quality (current system)
- Category 2 – fee-for-service with a link of payment to quality
- Category 3 – alternative payment models built on fee-for-service architecture
- Category 4 – population-based payment

**Total Public and Private ACOs: 2011-2015**


- Since Jan. 2014
  - 4.5 million people have been added to ACOs
- Jan. 2015 total ACO lives = 23.5 million
- Of those, 7.8 million are part of Medicare ACOs

**Consolidation Activity**

- **What’s Driving Consolidation?**
  - Combination of “strong” economy and cheap capital
  - Pressure to reduce costs and increase efficiency
  - Providers looking to create size needed to negotiate with payers
  - Affordable Care Act is driving the pace of change

**Source:** CMS
### Payer Mergers & Market Share

<table>
<thead>
<tr>
<th>Payer</th>
<th>Commercial Members</th>
<th>Medicare/Medicaid</th>
<th>Total Members</th>
<th>% Total</th>
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<tbody>
<tr>
<td>United HealthGroup</td>
<td>29,530,000</td>
<td>12,540,000</td>
<td>42,070,000</td>
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<td>Anthem</td>
<td>31,397,000</td>
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<td>Cigna</td>
<td>14,215,000</td>
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<td>Combined Anthem/Cigna</td>
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<td>7,860,000</td>
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<td>Aetna</td>
<td>19,503,000</td>
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<tr>
<td>Humana</td>
<td>6,057,000</td>
<td>8,131,000</td>
<td>14,188,000</td>
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<tr>
<td>Combined Aetna/Humana</td>
<td>25,560,000</td>
<td>12,134,000</td>
<td>37,694,000</td>
<td>28.3%</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100,702,000</strong></td>
<td><strong>32,534,000</strong></td>
<td><strong>133,236,000</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Source: Q-3 2015 earnings reports for each company noted above

### Consolidation Activity

**What's Driving Consolidation?**
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- Providers looking to create size needed to negotiate with payers
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### Hospital / Health Care System Consolidation

Create **value-based care**, optimize delivery networks, **enhance** efficiency, and **improve** market position

**Future activity expected to focus on hospital acquisition of physician practices**

**Most significant:**
- Emory Healthcare and WellStar Health System merger Produce high patient satisfaction scores
- Barnabas Health & Robert Woods Johnson Health System merger = NJ largest healthcare system

**49 transactions** in first half of 2015 - compared to –

**43 transactions** in 2014
Provider Consolidation

1. Increased activity in most markets
2. Larger practices looking to become more “relevant”
3. Smaller practices interested in strategic alignment
4. Focus on enhancing one’s “product” as a provider partner
5. More collaborative discussion between payers and providers

Shifting Referral Trends - Eye Care

**CURRENT DRIVERS**
- Optometry 30-40%
- Family/Friends 20-25%
- Existing Patient 15-25%
- PCP 15-20%
- Health Ins 10-15%
- Online 5-10%

**FUTURE DRIVERS**
- Health Ins 40-60%
- PCP 30-50%
- Existing Patient 15-20%
- Optometry 15-20%
- Family/Friends 10-15%
- Online 5-10%

- Network participation and PCP recommendation / care coordination will be an increasing determinant of patient access
- Existing family/friends (i.e. previous cataract patients) will remain consistent opportunity
- Optometry will have decreased impact on patient access
- Use of online referral/ratings websites will still be important, but must be targeted toward network & PCP affiliations

Patient Access Channels

Providers Must Win Share at Two Points of Sale

1. SECURE ENROLLED LIVES
   - Network Assembly
     - Being chosen by payers, employers, exchange operators, custom network builders, and accountable physician entities to be offered as a network option
   - Network Selection
     - Being chosen by individuals during plan enrollment

2. WIN SHARE OF VOLUMES
   - Care Decision
     - Being chosen by patients, referring physicians at the point of care

A Straightforward Strategic Assessment

Are You Prepared as Health Care Changes?

Is your practice growth strategy specifically designed for the new channels of a health care market, or are you relying on yesterday’s approach for today’s circumstances?

Source: Health Care Advisory Board interviews and analysis.
Strategic Considerations for Eye Care Providers

What are the Strategic Opportunities for your practice?

The Key Element: Focus on The Triple Aim

**Strategic Initiatives**

- Reduce per capita cost of healthcare
- Improve individual experience of care
- Improve health of populations

**TRIPLE AIM**

- Improve outcomes
- Patient registry/IRIS
- Diagnostic screenings
- Wellness exams
- EHR implementation
- Data analytics

**Improve outcomes**

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**Improve health of populations**

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**Improve individual experience of care**

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**Strategic Opportunities**

- **Focus on The Triple Aim**
  - Improve individual experience of care
  - Improved outcomes
  - Patient experience
  - Patient engagement
  - Patient journey

- **Improve health of populations**
  - Patient registry/IRIS
  - Diagnostic screenings
  - Wellness exams
  - EHR implementation
  - Data analytics

- **Reduce per capita cost of healthcare**
  - Resource allocation
  - Waste reduction initiatives
  - Value-based rewards

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**Embrace Value Based Payment / Financial Risk**

The Contracting Environment is Changing!

- **Risk is / will be transitioning from payers to providers**
- **Providers are expected to manage populations of patients with risk and for quality**
- **Pace of transition is accelerating**

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**GOVERNMENT PLEDGES**

Health and Human Services (HHS) Announcement

- HHS announced goals for shifting Medicare business to value-based care payment models - 30% payments by the end of 2016 and 50% payments by the end of 2018
- Medicaid Agencies in numerous states expand managed care options for different populations

**ALLIANCE PROMISES**

Health Care Transformation Task Force (HCTTF)

- Several major providers and payors formed a nonprofit coalition called the HCTTF
- Each member of the HCTTF has committed to shifting 75% of their business to value-based care
- Made ~$36 billion in value-based care payments in 2014
- Announced plans to increase value-based payments to providers by 20% in 2015 (more than $43 billion)

**COMMERCIAL COMMITMENTS**

- **United Healthcare**
  - Made ~$36 billion in value-based care payments in 2014
  - Announced plans to increase value-based payments to providers by 20% in 2015 (more than $43 billion)

- **Blue Cross Blue Shield**
  - Currently pay $1 out of every $5 of medical claims to value-based programs (~$65 billion)
  - Engaged with ~350 local value-based programs nationwide
  - Saved ~$500 million as a result of value-based care in 2012

- **Humana**
  - 75% percent of their 2 million Medicare Advantage members are cared for through value-based reimbursement models by 2020

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Source: Health Care Advisory Board interviews and analysis.

Source: Valence Health summary of public statements and press release from each named organization.
Value-Based Care Learning Curve
Only One-Third of Providers Are Currently Taking Risk
Source: AHA 2015 Data Review

The level of risk for the 1/3 today is low, but growing

Value Based Payment Requires Clinical Integration

**VALUE-BASED PAYMENT REQUIRES**
**COORDINATED CARE**

To serve a defined population to achieve required clinical outcomes and cost efficiencies

**COORDINATED CARE REQUIRES**
**CLINICAL INTEGRATION**

To link (eye care) providers across all service levels (primary, subspecialty, surgical eye care with primary care medicine chronic disease management) and across a regional geographic area that can meet a payer network adequacy requirements.

Medicare Targets
Condition and Utilization (Medicare Cost Report, 2013)

<table>
<thead>
<tr>
<th>Driver</th>
<th>APC/DRG</th>
<th>HCPCS</th>
<th>Goal / Solution Examples</th>
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</thead>
<tbody>
<tr>
<td>Inpatient physician care</td>
<td>$1.1B</td>
<td>$11B</td>
<td>Virtual care, image platforms – app level care</td>
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<tr>
<td>Joint replacement</td>
<td>$3.0B</td>
<td>$28</td>
<td>EBM, Reduce Variability, Clinical pathways, shared decision making</td>
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<tr>
<td>Heart Failure (cc and ncc)</td>
<td>$3.0B</td>
<td>$37</td>
<td>EBM, Dz management technologies</td>
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<tr>
<td>Nerve&lt;td&gt; Spinal Fusion</td>
<td>$2.0B</td>
<td>$44</td>
<td>EBM, Shared decision making</td>
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<tr>
<td>Ambulance Transport</td>
<td>$2.0B</td>
<td></td>
<td>Shared transport options</td>
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<tr>
<td>Cardiac Surgery</td>
<td>$1.1B</td>
<td>$69</td>
<td>EBM, Shared decision making</td>
</tr>
<tr>
<td>COPD</td>
<td>$1.1B</td>
<td>$54</td>
<td>EBM, Case finding, Dz management technologies</td>
</tr>
<tr>
<td>Renal Failure</td>
<td>$1.1B</td>
<td>$62</td>
<td>EBM, Case finding, shared decision making (pneumonia, dialysis)</td>
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<tr>
<td>Echo / Cardiac Imaging</td>
<td>$1.1B</td>
<td>$56</td>
<td>EBM, Case finding</td>
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<tr>
<td>Medical Eye Exam</td>
<td>$1.1B</td>
<td>$64</td>
<td>EBM, Case finding</td>
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<tr>
<td>Inpatient Critical Care</td>
<td>$2.0B</td>
<td>$56</td>
<td>EBM, Shared decision making</td>
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<td>Therapeutic Exercise (Rehab)</td>
<td>$2.0B</td>
<td>$98</td>
<td>EBM, Virtual rehab platforms</td>
</tr>
<tr>
<td>Hip and Femur (replacement)</td>
<td>$3.0B</td>
<td>$13</td>
<td>EBM, Shared decision making</td>
</tr>
<tr>
<td>ER (III, IV)</td>
<td>$6.0B</td>
<td>$54</td>
<td>EBM, Triage platform – app level of care</td>
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<tr>
<td>MRI</td>
<td>$4.2B</td>
<td></td>
<td>EBM, Case finding</td>
</tr>
<tr>
<td>Sleep</td>
<td>$26.7M</td>
<td></td>
<td>EBM, Mobile sleep technologies</td>
</tr>
<tr>
<td>Medication</td>
<td>$26.7M</td>
<td></td>
<td>EBM, Equivalences, generics, incentives, formulary</td>
</tr>
<tr>
<td>Behavioral Health (A)</td>
<td>$5.0B</td>
<td></td>
<td>Less intensive / virtual platforms</td>
</tr>
<tr>
<td>Care Gaps (A)</td>
<td>$5.0B</td>
<td></td>
<td>Visioin plus partners</td>
</tr>
<tr>
<td>End-Of-Life</td>
<td>$5.0B</td>
<td></td>
<td>Shared decision making, intense education, hospice services</td>
</tr>
</tbody>
</table>

A = Aggravating or proximate cause

**Isolated Practice or Clinical Integration?**

**Isolated Practice**

Fail to act and face real threats that endanger the isolated provider

**CONSEQUENCES**

- **Lose access** to patients due to exclusion by narrow networks and selective contracts
- **Lose revenue** from cuts in payment and limits to visit and procedure frequency

**Clinical Integration**

Embrace the clinical integration model that government, payers and patients are demanding

**BENEFITS:**

- **Protect and expand** referral sources from community providers and patients
- **Secure status** on payer networks because of documented improved clinical outcomes from coordinated care

Isolated Practice Clinical Integration
Understand Local Market Providers

• Once you have seen one health system or provider organization, you have (really) only seen one...

• There are incredible differences within these organizations in the following areas:
  - Resources
  - Competitive factors
  - Risk management experience
  - Market payer characteristics
  - “Attitude”

• And...
  - Optimization of CARE DELIVERY

Understand / Align with Payer & Health System Strategic Imperatives

• HEDIS Score Improvement
  ◦ Enhanced reporting capabilities (Comprehensive Diabetes Care metric)

• Economic Benefit
  ◦ 33% of CMS Star rating - measured from HEDIS Score measures.
  ◦ Plans scored / paid based by CMS on Star Ratings

• Administrative Improvements
  ◦ Enhanced workflows and technological options

• Direct Scheduling Requests
  ◦ Improve patient engagement (diabetic exams, reminders, alerts)

• Patient Education
  ◦ Standardized materials on (diabetic-related eye) conditions, symptoms, treatments.

• Standardized / Centralized Communications
  ◦ Single point of contact
  ◦ Standardized reports

HEDIS Scores / Star Ratings

“There is a significant need for a population-based reporting solution. For example, when it comes to HEDIS, we pretty much have an open check book right now.”

- Quote
Senior leadership at United Healthcare

Medicare Advantage

“To Succeed with MA, Ascension and its physician partners need to work together to strengthen core capabilities”
Strategic Opportunity

Integrate Eye Care

Bring eye care into population health management, effectively increasing patient screenings, diagnosis, and treatment for ocular disease.

KEY STAKEHOLDERS
- Patients
- Primary Care Physicians
- Health Systems / ACOs
- Payors
- Ophthalmologists
- Optometrists

What is Clinical Integration?
Clinical Integration is an active ongoing program to evaluate and modify the clinical practice patterns of the health care providers who participate in a network so as to create a high degree of interdependence and cooperation among the network's participants to control costs and ensure quality.

A network that undertakes a program of clinical integration must include one or more of the following features:
- Methods for collecting and analyzing performance, based on utilization, cost and/or quality on an individual and aggregate basis
- The development and use of performance standards along with a system to enforce such standards
- Use of electronic health record system to facilitate exchange of health information across the network of providers
- Use of evidenced based medicine to establish evidence based guidelines for support of clinical decision making and treatment.

Diabetes as the Starting Point for Horizontal Integration of Eye Care and Specialty Referrals

Prioritized at risk patient population with ACOs, Health Systems, PCPs, etc.

1. Diabetes
2. Glaucoma
3. Cataract / Other Eye Related Disease

Strength of relationship with PCP groups, ACOs, & health systems
Diabetes is Highly Prevalent in Today’s Society

Diabetes is a costly condition that affects millions across the US:
- Approximately 86 million people in the United States have prediabetes, and more than 47 million Americans have metabolic syndrome (7,8)
- In 2012, there were 1.7 million new cases of diagnosed diabetes among people aged 20 years or older (9)
- In 2012, 29.1 million Americans, or 9.3% of the population, had diabetes (9)
- 8.1 million people or 27.8% of people with diabetes are undiagnosed (10)

**Diabetes Prevalence**

86 MILLION total patients with prediabetes

29.1 MILLION total diabetes patients

8.1 MILLION undiagnosed diabetes patients

Eye Care Disease Prevalence Among Diabetes Patients

- New research is showing an association between Alzheimer’s disease and Amyloid β Signature in the lens and retina. (11)
- Diabetic retinopathy is associated with periodontal disease. (12)
- Retinal plaque signals obstructive vascular disease of the heart or carotid artery. (13)
- 65% of individuals with diabetic vision impairment could achieve normal vision with an eye exam and new glasses, reducing falls leading to fractures. (20)
- Signs of diabetes detected in the eye are associated with peripheral neuropathies of the foot and foot ulcers. (20)

Financial Implications for Diabetes and Eye Disorders

<table>
<thead>
<tr>
<th>Condition</th>
<th>Cost (B)</th>
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<tbody>
<tr>
<td>Heart Disease</td>
<td>$112.3B</td>
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<tr>
<td>Cancers</td>
<td>$86.6B</td>
</tr>
<tr>
<td>Emotional Disorder</td>
<td>$77.2B</td>
</tr>
<tr>
<td>Pulmonary Conditions</td>
<td>$72.6B</td>
</tr>
<tr>
<td>Eye Disorders</td>
<td>$66.8B</td>
</tr>
<tr>
<td>Hypertension</td>
<td>$55.8B</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$48.8B</td>
</tr>
<tr>
<td>Stroke</td>
<td>$22.2B</td>
</tr>
</tbody>
</table>

Of the $66.8 billion in costs associated with eye disorders, approximately $31 billion can be associated with vision problems among diabetes patients.

Critical Risks in Diabetes Management: ER Visits

Of 560 visits to an accident and emergency department, 38% could have been managed by an OD outside a hospital setting. (3)

**EMERGENCY ROOM / DEPARTMENT VISITS**

- Treat and Release: 57.9%
  Approximately 57.9% of all diabetes related ER visits were treat and release. (4)
- Diabetes ER Related Visits: 12.1M
  In 2010, there were approximately 12.1 million diabetes-related ER visits for adults aged 18 years or older (515 per 10,000 U.S. population), or 9.4% of all ER visits. (5)
- Average ER Visit: $750
  The average Emergency Room (ER) visit costs about $750. (6)

Diabetes Patients Have a Higher Risk of Prominent Eye Conditions and Blindness

Diabetic patients are 40% more likely to have glaucoma and 60% more likely to develop cataracts, and at an earlier age.

Prevalent diseases include:

- Diabetic patients are 60% more likely to develop cataracts, and at an earlier age.
- Diabetic retinopathy accounts for approximately 12% of all new cases of blindness each year.

186K Diabetes-related ED visits for eye complications in 2010.

The estimated prevalence of diabetic retinopathy and vision-threatening diabetic retinopathy was 28.5% and 4.4%.

Integrated Eye Care Model

Concept and Function

Eye Care Network

1. Single point of contact for all primary & specialty eye care needs
2. Care coordination, referral management
3. Clinical protocols, outcome development, analysis/reporting
4. Quality benchmarks, care management goals
5. Patient education, Chronic disease identification/monitoring
6. MSO services, Provider credentialing

ECN - Critical Needs

- Physician leadership
- Legal entity approach
- Clear financial model
- Performance improvement
- IT
- Contracting flexibility
- Participation criteria
ECN – Business Model

Full Service Provider Platform

**EYE CARE NETWORK**

**Eye Care Integrated Business Entity**
- Corporate structure (LLC, JV, MSO, IPA)
- Services: MSO, Contracting, Credentialing
- Non exclusive
- Not a medical entity

**Potential Financial Models**

- **Healthcare System/PCPs**
  - Payment for ECP services
  - ECPs (MD / OD)

- **Eye Care Network**
  - Patient Management System
  - Licensing fee for IT
  - ECPs (MD / OD)

- **Collection Agency / MSO**
  - Fees for MSO / IT services
  - Payment for ECP services
  - ECPs (MD / OD)

- **Equity Shares (Limited Partnership)**
  - Fees for MSO / IT services
  - Payment for ECP services
  - ECPs (MD / OD)

**Integrated Eye Care Management Workflow (Illustrative)**

- **Healthcare System**
  - Patient referral
  - Diabetes Coordinator
  - Patient alerts

- **Eye Care Integration Entity**
  - Patient scheduling
  - Eye Care Coordinator

- **EYE CARE NETWORK**
  - OPHs/ODs

- **Patient Journey**
  - An integrated / coordinated referral network all while maintaining patient choice
  - Patient referrals
  - Patient scheduling
  - Patient alerts
  - Patient summary report

People with diabetes do have a higher risk of prominent eye conditions and blindness than people without diabetes. Prevalent diseases include:

- Diabetes
- Coordinator

**Integrated Eye Care Management Workflow (Illustrative)**

- **Healthcare System**
  - Patient referral
  - Diabetes Coordinator
  - Patient alerts

- **Eye Care Integration Entity**
  - Patient scheduling
  - Eye Care Coordinator

- **EYE CARE NETWORK**
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  - An integrated / coordinated referral network all while maintaining patient choice
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  - Patient summary report
Leverage Technology…

- Information Exchange
- Referral Management
- Data Analytics & Reporting
Tracking Program Success

Key Performance Indicators

Identify key performance metrics and collect / analyze key metrics to demonstrate program success.

- Partnership Measurement
  - Number of patient referrals
    - By referring provider
    - By plan type
  - Number of completed patient visits
    - Number of emergent issues
  - Patient self management
- ECP Network Measurement
  - Incremental revenue gains
    - By eye care provider
    - By disease / service line

Program Resources

Supporting the Diabetes Patient and Integrated Care Team

(Illustrative)

- Patient Summary Report
- Care Coordination Flashcard
- Consultation Request Form
- Team-Based Care Task Grid
- Referral Checklist
- Care Plan
- Self Management Checklist
- Food and Activity Tracker
- Pre-Visit Plan
- Consultation Request Form
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- Referral Checklist
- Care Plan
- Self Management Checklist
- Food and Activity Tracker
- Pre-Visit Plan
**Eye Care Proforma**

**Integrated Diabetes Referral Program**

400 MD – Professional Fee Example

- **50K** Diabetics
- **25K** Referred diabetics
- **12.5M** Eye care management revenue

$12.5 million in eye care related fees, managed through the integration of 50 providers

Assumptions:
- 400 MD Health System MDs treat approximately 50,000 diabetics
- Assume a 50% diabetes patient referral rate
- 1000 referred patients generate approximately $500k Vision Management Revenue (includes optical, clinical & surgical utilization)

**Integrated Eye Care**

**Reduce Costs - Achieve the Triple Aim**

500 Patient Example

- **$11K** in savings with vision exams
- **$316K** annual savings (low vision)
- **$1.4M** annual savings (blindness)
- **$375K** cost of ER visits

Utilize integrated resources to improve patient care and reduce overall costs.

Assumptions:
- 500 vision exam of all adults, saves $11,000
- Reduce annual excess medical care expenditures for low vision by $316,500
- Reduce annual excess medical care expenditures for blindness by $1,401,500
- Prevent 500 Emergency Room (ER) visits, which costs about $375,000

**Integrated Eye Care Value Proposition**

- **HEALTH SYSTEM / PCP / ACO**
  - Single solution provider
  - Reduced costs
  - Improved quality
  - Increased revenue (HEDIS & Star ratings)

- **OPHTHALMOLOGISTS**
  - Patient / payer access
  - Improved quality of care
  - Branding opportunity
  - Increased revenue

- **OPTOMETRISTS**
  - Medical management adoption
  - Access to payer panels
  - Provider collegiality
  - Sustainable model

- **PATIENT**
  - Provider choice / access
  - Enhanced patient:
    - Experience
    - Education
    - Engagement

**Final Thoughts**

1. **Know thyself**
2. Maintain a disciplined approach to planning and operational excellence
3. Stay focused on and engaged with local market activity
4. Align to strengthen access channels
5. Be proactive – embrace the opportunities
Health Care is Shifting

What will you do?

References


Questions

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