



Best Practices

in Integrated Care

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Best Practices

in Integrated Care

This ongoing series, now in its second year, is featured in each issue of AOC and its sister publication *CRST*. The articles will clarify how eye care providers can best work together to provide patient-centered care of the highest quality possible.

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CURRENT TRENDS IN SHARED CARE

The growing complexity of surgical planning and rising patient expectations necessitate increased MD-OD communication.

BY DAVID W. FRIESS, OD, FAAO

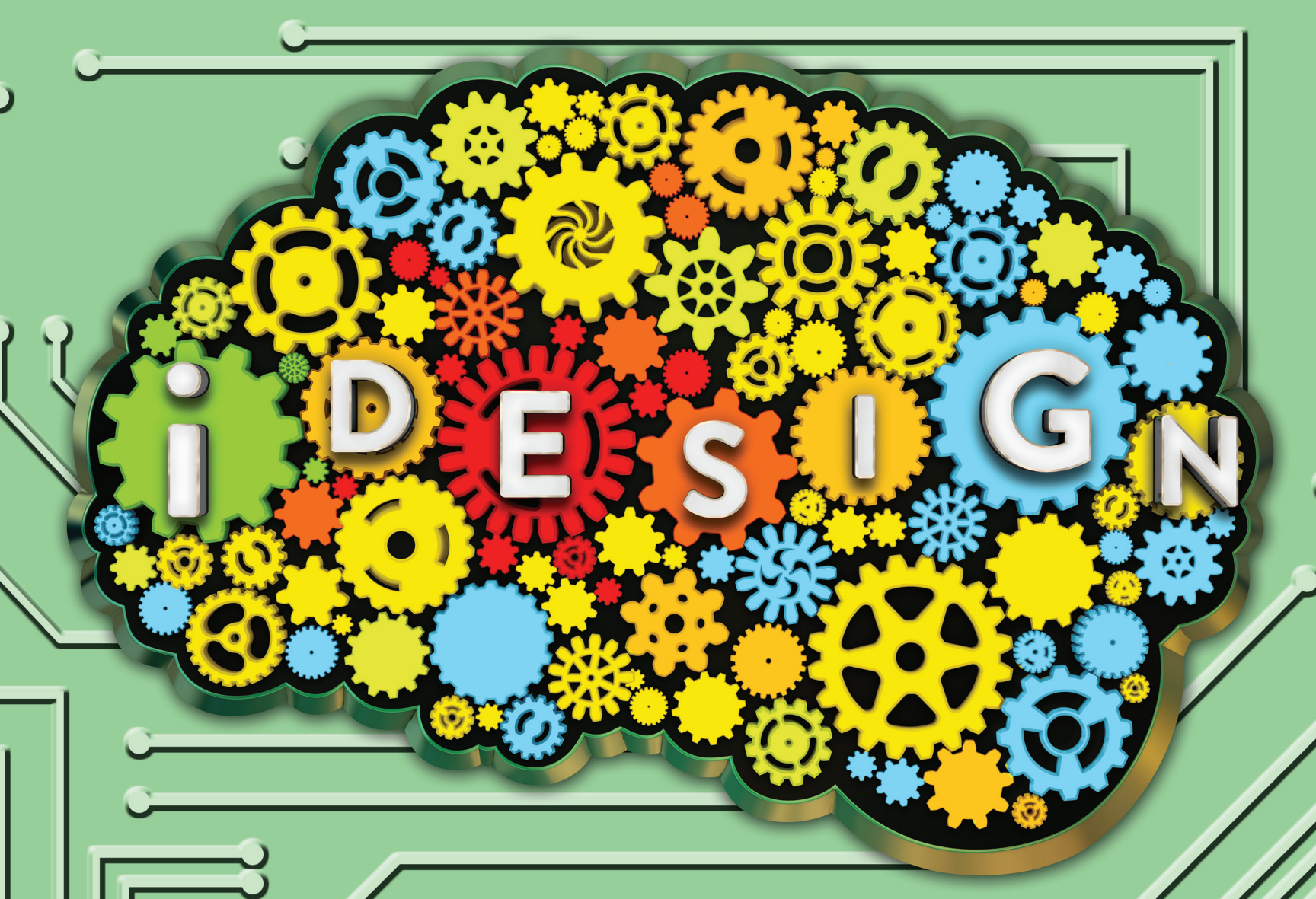


The patient comanagement model used successfully by many practices in the refractive market provides an interesting comparison to today's growing area of premium cataract surgery management.

As new and more advanced diagnostic and surgical planning technologies are used in the clinical setting for cataract surgery as well as during the postoperative analysis process, the comparison to customized refractive surgery is clear. Just as early refractive

surgery methods became more precise and complex with the addition of diagnostic imaging for customized treatment planning, cataract surgery is incorporating more diagnostics and intraoperative technology to measure and guide procedures.

To go along with these more advanced surgical planning and treatment methods, the constant challenge of setting proper patient expectations and delivering high-quality patient outcomes is assisted by improved communication between surgeons and integrated care optometrists.



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WARNINGS AND PRECAUTIONS: LASIK is not recommended in patients who: have a history of Herpes simplex or Herpes zoster keratitis, have severe allergies or tendency rub their eyes often, are taking the medication Isotretinoin (Accutane®), are taking antimetabolites for any medical conditions. The safety and effectiveness of this laser for LASIK correction have NOT been established in patients: with progressive refractive errors; previous corneal or intraocular surgery; or trauma in the ablation zone, who are taking the medication Sumatriptan (Imitrex®), or Amiodarone hydrochloride (Cordarone®), with corneal neovascularization within 1.0 mm of the ablation zone, over the long term (more than 1 year after surgery), for patients who engage in activities that could endanger or damage the LASIK flap, for patients who have a family history of degenerative corneal disease, history of inflammation of the eye, for patients who have a history of crossed eyes (strabismus) or who have undergone strabismus surgery, prior LASIK or Refractive Surgery, with history of any eye diseases or abnormalities such as corneal scars or active disease, and whose BSCVA is worse than 20/20. To reduce the risk of corneal ectasia, the posterior 250 microns (μm) of corneal stroma should not be violated. The treatment of highly myopic eyes necessitates the removal of significant amounts of corneal tissue. The **iDESIGN** System calculates the estimated residual bed depth using the pachymetry and intended flap thickness entered by the user. Actual flap thicknesses may vary. If the estimated residual stromal bed is ≤ 320 microns, an in-the-bed pachymetric measurement should be performed.

ADVERSE EVENTS: Possible adverse events include loss of best spectacle corrected visual acuity (BSCVA), serious Transient Light Sensitivity Syndrome, serious primary open angle glaucoma, miscreated flap, melting of the flap, severe glare, and severe dry eyes. Complications can include corneal edema, epithelial ingrowth, diffuse lamellar keratitis, foreign body sensation, and pain.

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Our comanagement processes with ODs have evolved tremendously over the past few years with the complexities of refractive cataract surgery. We now hold multiple educational events throughout the year as well as individual shadowing opportunities to keep optometrists trained and up to speed on the current best practice patterns.

Optometrists can be a tremendous help to surgeons in the preoperative and postoperative care of the refractive cataract patient. An open line of communication with specific protocols of information exchange is needed to keep everyone on the same page. In addition, it's well worth the effort and time to educate the ODs in your community about the care of these patients. If done properly, the patients receive excellent continuity of care with an increase in subspecialization and efficiency for the doctors and the patient.”

Robert J. Weinstock, MD

Use of more advanced diagnostics before, during, and after surgery allows for total data flow to develop more refined surgeon-specific nomograms. The use of corneal topography and high-resolution imaging for cyclotorsion registration of incision placement or toric IOL positioning, for example, is analogous to customized corneal ablation. Advanced optical biometry and intraoperative wavefront analysis are being used to further refine cataract procedures.

A key part of MD-OD communication is to ensure that postoperative imaging and data are routinely collected for use in outcomes analysis. Recognizing that future surgical planning can be enhanced by analyzing surgeon-specific and procedure-specific outcomes is important to move the results trend within a busy surgical practice.

It seems that during every conference discussion regarding surgeons and optometrists directly involved in surgical care, the goal is always to find ways to improve outcomes. The past focus on refractive surgery shared care is now shifting to include customized laser cataract surgery, presbyopic corneal surgery, and microinvasive glaucoma surgery implants during cataract procedures.

The fact that surgical planning has become much more complex while patients' expectations have risen clearly presents a need for increased MD-OD communication. Today, integrated patient care also means more comanagement of outcomes data than ever before. ■

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TECHNOLOGY HAS TRANSFORMED INTEGRATED CARE

Having trusted partners in the community who offer services in an integrated, collaborative fashion has been a benefit to my practice.

BY WILLIAM B. TRATTLER, MD



There are many factors that have led to the expansion of the integrated care model in eye care. Shared care promises to be even more prevalent with the continued development of advanced imaging technologies that help in the diagnosis and management of various ocular conditions. Enhanced technology has been a crucial factor in our ability to manage the

increasing numbers of patients requiring eye care services while delivering ever-improving quality of care.

Technological advances have, in general, facilitated the ability of optometrists to move to the medical model of patient management. Modalities such as ocular coherence tomography and widefield imaging allow a detailed view of the posterior segment, while an expanding array of diagnostic and prognostic tools aid in the assessment of the anterior segment, thus affording the means to perform a truly comprehensive eye examination. What this all means is that technology has leveled the playing field, ensuring that more patients have access to critical high-level services.

Another implication of advanced technology and expansion of the medical model is that both have led to greater subspecialization among optometrists. Ample markets exist for optometrists who want to specialize in dry eye care, glaucoma, or corneal conditions. Beyond the opportunity to provide more tailored services, technology allows the means to fulfill on the promise of this enhanced care. The field of optometry has diversified itself, and those in practice have a wider range of choices.

From my vantage point, having trusted partners in the community who offer services in an integrated, collaborative fashion

has been a benefit to my practice, especially for patients who have to travel long distances for my surgical services. Many of the optometrists in my referral network do a stellar job of diagnosing ocular surface issues and treating them before the patients are referred to my care. This helped me to be more efficient, and it also reduces the likelihood that I will have to delay surgeries. And, when patients who travel long distances can visit an optometrist for postoperative follow-up, it extends my ability to continue caring for the patients.

Although technology may broaden the ability for optometry and ophthalmology to work together, the real key to integrated care's success now and in the future is putting the needs of the patient first. There must always be a collaborative, team-based approach to care, with the providers involved at the individual patient level ultimately dictating the care being delivered. The evolving health care landscape has created a need for more efficient care delivery, and expanding technology has provided a means to make the integrated care model possible. It is up to us as providers to make sure all parts of the equation continue to benefit patients. ■

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INTEGRATED CARE: LESS AN OPTION AND MORE A NECESSITY

The efficiency of the integrated model allows more patients to have access to care.

BY ANDREW S. MORGENSTERN, OD, FAAO



As I look to the future of eye care, I see a world in which private practice optometry and private practice ophthalmology are going to struggle without one another. I see the potential for a failing model of eye care delivery if providers fail to practice at the fullest extent of their education. The changing demographics of the population and the health care environment necessitate a new way of doing

things. In my opinion, that equals a need for even more integrated care.

The efficiency of the shared care model in terms of allowing more patients into the system is one benefit. When optometrists practice in the medical model, it means there are more providers to meet the needs of patients. The swelling population of older individuals coupled with the expansion of insurance coverage under reform measures—against the backdrop of potential shortages of ophthalmologists—means that we are facing the prospect of there being many more patients than the system can handle. The concept of integrated care answers the human resources crisis facing eye care.

Another aspect of the efficiency of care sometimes gets overlooked but may be as important. When optometrists are allowed to practice to the fullest extent of their education, they free surgeons of their clinic duties, in turn providing those surgeons with the opportunity to utilize their specialized skills where it is needed most: in the OR. There many implications if surgeons pull double duty in the clinic and OR. For example, both the clinic and the OR will be less efficient, fewer patients will have access to surgical care, and surgeons will have less earning potential and optometrists will have less of a financial ceiling (being restricted to refractions and eye wear sales). On the other hand, when surgeons are given latitude to use the skills they have practiced and honed in their training because optometrists are assuming clinical responsibilities, there is a better chance for everyone involved to benefit.

The VA health system in which I work provides some insight into these dynamics. The recent involvement of our nation's military in overseas operations has resulted in more individuals requiring care. This is analogous to the swelling population demands presented by

the baby boomer segment coupled with increased access to care by way of health care reform. In the VA system, there are a finite number of providers; so, too, eye care has limited or dwindling human resources. The VA failed to react in time to accommodate the needs of returning soldiers, and the implications of not being able to provide the care that they need have been well documented. Although we function in eye care with a very different set of demands and patient needs compared to the VA, we can still learn from this cautionary tale: The system must change so that we can provide the care patients need, and, frankly, that they deserve.

There is another element to integrated care that I think will help the model succeed in the future. To realize the efficiencies and full potential of shared care, more than just ophthalmologists and optometrists must work together. Truly integrated care must encompass the entire surgical team, inclusive of the front desk, the technicians, and everyone who comes in contact with the patient, in addition to all the back office support staff that helps the team operate. The surgeon is the captain of the ship, but the surgeon cannot be the one in the engine room, and he or she cannot be the one operating the radio room. All of the pieces need to be in place for the entire team to be successful. That essence of teamwork, with everyone acting in the same interest of best serving the patient, is what will truly allow integrated care to deliver on its promise. ■

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NEW TYPES OF PATIENTS WILL INCREASE THE NEED FOR INTEGRATED CARE

Expanding options for cataract patients and presbyopes improve the likelihood of clinicians helping patients achieve the vision they want.

BY SONDRA BLACK, OD



Much has changed in the surgical management of patients in eye care in the past decade. There are more patients than ever before, and we eye care specialists are treating a significant amount of age-related diseases in younger patients. In part, the demand for services is being driven by the growing baby boomer segment, a demographic that is highly active, motivated, and willing to spend money to preserve quality of life.

It is a chicken-egg debate as to whether the expanded market came first or whether our ability to treat patients at a younger age drove demand. Nevertheless, in the cataract world, we no longer wait for the lens to become dark and brunescient before referring to a surgeon. Today, as soon as there are minor lens changes, patients become frustrated because their glasses no longer seem to be working. When they are not seeing clearly, patients start complaining to their eye care provider. The provider then refers the patient to a surgical center knowing that options exist to help reduce patients' dependence on eye wear and keep them happy. In the past, optometrists likely waved good-bye forever to patients as they moved on to surgery. Today, however, optometrists are becoming increasingly important in the pre- and postoperative care of their patients.

There are two kinds of patients who are presenting in greater numbers for optometric services, and a quick glance across the demographic horizon suggests there is no slow down imminent in the demand for our services. As optometry looks to its future, providers would be wise to pay particular attention to the needs of these patients.

CATARACT PATIENTS

As noted, cataract patients are younger than in previous years. It is not entirely clear what is driving this trend. It may be that



patients are more demanding than ever, or it could be the case that we are better at taking care of their needs. Our ability to recognize lens changes earlier may also be a factor. What I do know is that I am seeing more patients at a younger age than ever before in my practice, and I hear a similar sentiment from my colleagues. We have seen similar trends in other areas of health care, too. In the orthopedic marketplace, for example, there are now a plethora of total knee and hip arthroplasty devices to accommodate the desire of baby boomers to stay fit and active. Many of them are not retiring at 60 or 65 years of age (or even 70 or later), and there are any number of metrics demonstrating that older individuals want to travel, exercise, and stay active.

Fortunately, there is technology at our disposal to recognize subtle lens changes that may not be apparent on slit-lamp

examination and provide an answer for patients beginning to notice loss in acuity due to lenticular changes. For example, the AcuTarget HD (AcuFocus) measures optical scatter to let us know what is going on in the lens. The i-Trace (Alphaeon) can be used to help indicate lens dysfunction in an apparently healthy lens.

As well, there are the plethora of IOL technologies that have filtered into the marketplace to suit virtually every patient's visual needs and expectations. I practice in Canada where we have gotten access to the Symphony extended range of vision lens (Abbott Medical Optics). These lenses have been a real game-changer as they provide patients with an expanded range of vision naturally from distance through to near. This technology, should it become available in the United States, could have a significant impact on the premium lens market.

Within the cataract surgery category, there are increasing numbers of patients who previously underwent refractive surgery. Both the expectations for a refractive outcome and the ability to achieve that refractive outcome after cataract surgery are complicated by the previous refractive surgery. The Symphony lenses may be of great benefit to these patients, as the extended range of vision helps avoid optical aberrations. As well, the availability of intraoperative aberrometry and sophisticated biometry during the preoperative evaluation positively affect the ability to select and place the appropriately powered lens.

PRESBYOPIA

It seems that in many ways, the world is moving closer to our eyes. The advent of handheld technology, from computers to smartphones to tablets, has changed patients' visual demands to an increasing reliance on intermediate and near. It is too bad that our eyes naturally regress over time in their ability to accommodate to near visual tasks.

Presbyopia has been and will continue to be a maddening condition for many patients. That said, however, the days of our sending patients to the pharmacy to pick up a pair of readers because of a lack of alternatives are happily over. Many patients do not want reading glasses for a variety of reasons: cosmesis (they indicate to the world that they are over 45) and convenience (having multiple pairs of glasses all over the house), being the two most common. Fortunately, we now have options for presbyopia, such as the Kamra Corneal Inlay (AcuFocus). Refinements in hyperopic LASIK have also led to greater success with this option. The point is that expanding options create opportunities to positively affect patients' happiness.

MAKING IT WORK

The future of eye care is full of good news. Expanding treatment options, novel patient types, and swelling demographics suggest an ongoing demand for eye care services. Yet, despite the framework

for success this scenario provides, patients' education and managing their expectations will be critically important to achieving the best outcomes. Thanks to the Internet, patients are doing their own research and are approaching their optometrists and ophthalmologists already asking questions. That, in turn, should alert providers that it will pay to stay abreast of the evolving landscape and to become better informed about the treatment options patients ask about.

When I talk to members of my practice's referral network, I like to convey the important role they play in introducing the technologies and options that will be discussed in our clinic. I want the patient to make the final decision, but I prefer that the patient comes in knowing his or her options for near and distance correction. By the same token, however, I do not want referral sources to overpromise what the technology can deliver. Striking that balance means knowing the technology and being educated so that providers can have informed, fact-based conversations with patients that help to manage their expectations.

There is another practical aspect to improving the ability to achieve a successful outcome—and this applies to more patient types than discussed herein. I cannot emphasize enough the importance of managing the ocular surface in any and all patients being referred for surgical services. Dry eye disease compromises the ability to perform accurate biometry, it slows down the healing process, and it can lead to refractive surprises in the postoperative period. More to the point, if we have patients in our clinic with significant ocular surface issues, we more than likely must delay the surgery. It can be difficult to make a patient happy when you start out telling him or her this when they are prepared to move forward immediately.

CONCLUSION

More patients than ever before are in need of cataract surgery, and the numbers tell us the individuals are being treated at a younger age than ever before in history. Expanding technology has increased the ability to help these patients achieve the vision they want, and the same can be said for our presbyopic patients. However, just because the opportunity exists does not mean that success is automatic. Patients must be educated properly and their expectations managed. Patients must be put in the best situation for them to succeed, and that means optimizing the ocular surface before referral for surgical services. ■

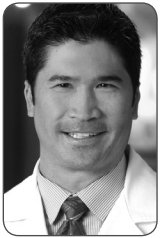
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FUTURE OF INTEGRATED CARE HAS NOT YET BEEN DEFINED

Optometry has made tremendous strides in collaborative care.

BY WALTER O. WHITLEY, OD, MBA, FAAO



The future of integrated care depends on how much optometry as a profession can educate specialists in other fields about the potential for collaboration. For better or worse, the era of big data in medicine is here. As providers, we need to adapt or risk getting left behind. In some ways, eye care is somewhat isolated and insulated from general medicine. Yet, the very real cost containment affecting the entire system has the potential to filter into our corner of health care.

In other words, we cannot ignore the omnipresent buzzwords commonly associated with modern health care: *accountability, efficiency, cost containment*. Nor can we afford (literally and figuratively) to look away from the increasing rise of chronic conditions and the requirement for more eye care services against a backdrop of looming manpower shortages.

An ancient proverb says, “May you always live in interesting times.” It is intended to be cynical, and we are indeed in pejoratively interesting times in health care. The complexities of modern health care create tremendous opportunity, however, so the news is not all bad. We should be optimistic about the potential future of integrated care.

Optometry has made tremendous strides in the collaborative care of cataract and refractive surgery patients. The medical model has led to our enhanced ability to take the lead in the care of glaucoma patients. Today, retina is ripe for our services. Our profession has the ability to diagnose patients earlier and refer them sooner to appropriate care for conditions that may rob them of their visual potential. In a condition like diabetes, optometry really should be involved in the educational efforts that help patients manage their own disease. This means asking about hemoglobin A1C levels, but also counseling about diet, smoking cessation, and healthy lifestyle choices. I would argue that these discussions could take place with any patient, and they need not be confined to patients with chronic systemic conditions.

The diabetes example is an interesting case study in how optometry may become increasingly involved with general practitioners. Patients with diabetes need regular monitoring to ward off the development of ocular manifestations in both the lens and in the back of the eye. Optometry’s extension into this area is limited only by the

effort we put forth by educating our peers about the role we can play. As well, building successful collaborative teams is going to require greater emphasis on communication and a mindset that always puts patients’ care first.

Technology plays a role in the expansion of collaborative care from improved imaging to the availability of point-of-care testing. For example, the Sjögren test for Sjögren syndrome (Baush + Lomb) has put optometrists in touch with rheumatologists. A point-of-care test for A1C has the potential to improve our ability to work as part of the team in that diabetes care. In the future, autofluorescence may be a means to monitor for lens changes secondary to diabetes, and there are a number of examples of technology in the pipeline that facilitate shared care opportunities.

There may also be collaborative opportunities beyond the obvious. I recently met with members of an urgent care team who were surprised to learn that optometrists could be a referral source. It had been ingrained in them that patients who passed through the emergency department and who required follow up eye care ought to be sent to an ophthalmology. In an era when medical ophthalmology was much more prevalent, this may have been the case. Today, however, very few patients, aside from those with immediate ocular trauma, need to be evaluated for surgery. Therefore, it becomes a matter of educating care givers about optometrists’ role.

The question is, “What do we want to achieve as a profession?” In truth, optometry has changed remarkably during the past decade with the expansion of the medical model. Many of our peers are interested in increasing subspecialization and in broadening their horizons in the care they provide. We have taken the first steps in making that potential possible. Now it is upon each of us to decide where we want to go in the future and to take wise steps that lead us to where we want to be. ■

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