



Best Practices

in Integrated Care

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Best Practices

in Integrated Care

This ongoing series, now in its third 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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PATIENT-CENTERED CARE:

IMPROVING THE ODDS FOR A SUCCESSFUL OUTCOME

Perioperative management of cataract patients may differ among practices; the importance of serving the patient's best interest does not.

BY CECELIA KOETTING, OD, FAAO



Cataract surgery has become one of the most frequently performed surgeries in the United States, and it is easily the most common surgery in eye care. Yet, it has also become a highly technical procedure with many nuances to consider. Ensuring patients have the best possible chance of achieving their refractive target and being happy with their vision requires diligence and precision—and this is especially true

for patients paying out of pocket for a premium implant.

While every clinic's particular process for the perioperative management of cataract patients will differ, there are nevertheless several important principles that are likely applicable for the wide swath of patients. In the following pages, I highlight five areas of focus for management of the surgical cataract patient that I believe to be important for both providing a successful outcome and making sure patients have a positive experience.



OPTIMIZE THE OCULAR SURFACE ...

At our clinic, we place a high priority on evaluating and optimizing the ocular surface prior to surgery. This has several benefits, including giving the patient the best chance to achieve the desired refractive

outcome and ensuring the accuracy of measurements. In addition, because corneal nerves are truncated during the procedure, cataract surgery will induce a certain amount of dryness in the early postoperative period. Unresolved ocular surface disease will exacerbate any existing issue, whereas treating it beforehand will help facilitate healing, improve comfort for the patient, and decrease the longevity of irritation postoperatively.

Our protocol for ocular surface evaluation begins with a SPEED questionnaire, with the answers alerting us to potential visual symptoms that will help direct the examination and subsequent testing. Our goal is to identify any issues and resolve them without having to delay the actual procedure. However, for patients getting a premium or toric lens, the threshold to delay surgery is much lower. These kinds of implants—and the patients paying out of pocket for them—have a much lower tolerance for any refractive error. Ideally, we would prefer to observe stability of the ocular surface over the course of at least two consecutive appointments before proceeding. This thinking changes for patients with corneal dystrophy or more severe corneal problems such as Sjögren syndrome, as these issues, in my experience, greatly compromise the likelihood of a successful outcome with a premium IOL.



... BUT DO NOT FORGET THE REST OF THE EYE

In addition to ocular surface issues, we are also diligent about ruling out macular or retinal pathology that might dissuade our surgeons from implanting a premium

IOL. Macular issues, such as macular degeneration, drusen, scarring, or holes, may indicate a need for specialist referral, and they are also relative contraindications for a premium IOL.



PROPERLY EDUCATE PATIENTS TO HELP MANAGE EXPECTATIONS THROUGHOUT THE PROCESS

Ensuring patients are matched with the lens that will allow them the vision they want postoperatively begins with rigorous testing and evaluation during the initial surgical examination, but that cannot be the sum total of our efforts. Patients typically have three separate encounters in which they learn about the various options available to them: a counselor who knows the surgeon's particular preferences; the interaction with the surgeon and optometric staff; and, finally, the surgery



scheduler who will reiterate the information and make sure the patient understands all the information.

Those multiple touch points are entirely intentional, as they somewhat follow a mantra in public speaking: tell them what you are going to tell them; tell them; then tell them what you told them. There is a great deal of information that must be conveyed to patients during the preoperative period. However, for many patients, the prospect of surgery induces anxiety and fear that may make it hard to retain that information. Clinical protocols and processes aside, this is one aspect of working with patients when empathy and understanding are the best asset.

One reason why education is so important is that it helps to establish proper expectations for the final outcome. The adage to underpromise and overdeliver really rings true: If you set patients up with unreasonable expectations about what the surgery or the technology used can do, you are really setting that patient up for failure—especially with regard to premium lenses. There is no question that modern lens options are designed to give patients a better chance of achieving the vision they want postoperatively. However, while advances in technology have improved predictability, nothing is without room for error.

To anyone involved in the regular care of cataract patients, the subject of managing expectations preoperatively is not new. Yet, the message is worth repeating, especially in the context of providing a good experience. To that end, I find it curious that our field does not place the same emphasis on managing expectations during the postoperative period, especially when the vision is not where it should be. The healing process can be variable, and when patients do not see the results immediately or as quickly as they expected, they may start to doubt their decisions. Therefore,

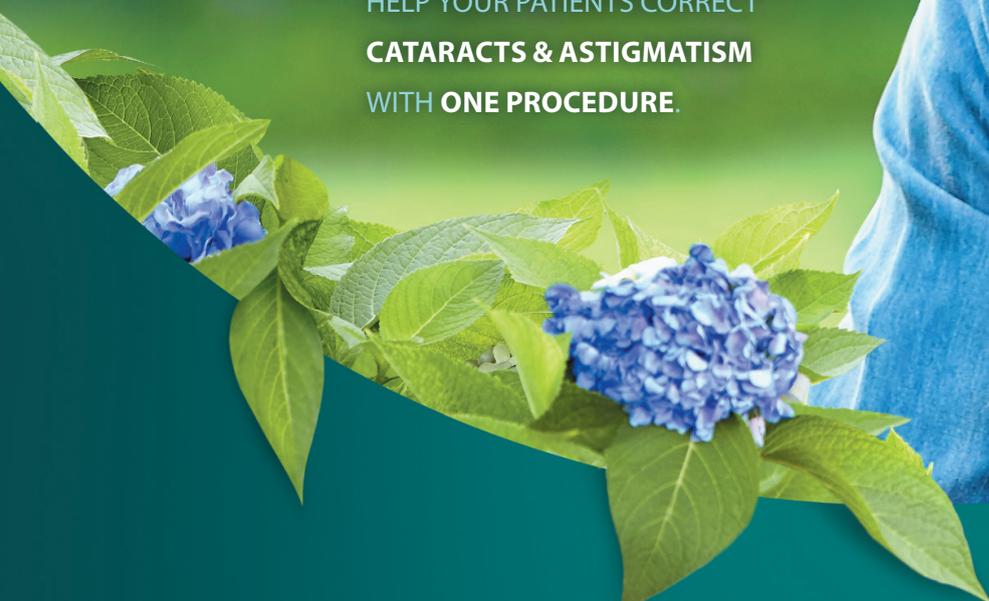


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2 1

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PATIENT-FACING MATERIALS ARE ADDITIVE IN PATIENTS' EDUCATION

By **Lawrence Woodard, MD**



Modern cataract surgery has become an amazingly complex and nuanced process. On one hand, the various technologies we use in the preoperative workup and in the OR lend themselves to greater predictability in the final vision outcome, better efficiency, and an enhanced facility to ensure patients are satisfied with their experience. Yet, the downside of this sophistication is that patients need to be equipped with more information than ever before in a limited amount of time.

Keeping in mind that the enhanced pressure to educate patients about cataract surgery is, indeed, a very good problem to have, there is nevertheless often a disconnect between what we can reasonably convey during the patient encounter and what needs to be communicated to properly set expectations and guide decision making. One way we may be able to bridge this divide is to devise multiple layers of education that are organized and deliberate, and which convey consistent messaging at every step. From the referring optometrist, to the inhouse staff (front office personnel and technicians), and including patient educators and/or surgeons, everyone needs to be on the same page to maintain efficiency and accuracy of information.

In our practice, we make regular use of patient-facing materials that are provided prior to the appointment so that patients come into the practice prepared with questions and ready to make decisions. We feel this approach has myriad benefits. First and foremost, we believe that a well-informed patient is our best consumer, especially with respect to advanced technology lenses that require out-of-pocket expenditures.

As well, distributing materials before the appointment gives patients time to think about their options, to research the technology, and to formulate questions and concerns. From the patient's perspective, the stress of thinking about cataract surgery may interfere with the ability to retain the information being provided; that information may resonate much better when it can be digested at one's own leisure. Additionally, carefully crafted content that is reviewed prior to the appointment, and before we talk about cost, tends to avoid the perception that we are trying to sell them something.

As a surgically oriented ophthalmic practice, patients enter our clinic via referral from community optometrists and other eye care providers. Thus, we do not necessarily have the burden of having to educate about a cataract diagnosis, which gives us an opportunity to work with our referral sources to start directed education early in

the process. The materials we use are multiple, including brochures that outline the mission of our practice and our specialties. We find that the more a patient knows about the office and about the doctor who they are seeing, the more comfortable and more attached to that doctor they feel before they enter the office.

We also have materials that describe the technologies that we use to help patients through cataract surgery. These do not contain infinitesimal detail about every little machine we have, but, rather, outline that we have a femtosecond laser and that we have the supporting instruments to help that laser best deliver the outcome that the patient desires. As well, our materials describe the different lens implant options in a very general fashion.

Once the referral source calls our office to schedule an appointment for the patient, we get the patient's email address so we can send an introduction to our practice as well as patient information forms that we want them to fill out before they enter the office (an important time-saving mechanism). We also send links to portions of our website that educate about cataracts and about different lens implants, thereby providing another touch point for the options we offer.

With so many moving parts in our education process, there is a risk of confusing the patient. One way we try to avoid that is to have our referral sources provide general information and not recommendations. We feel it is important for them to gear education toward piquing patients' interest and getting them thinking about their postoperative goals. The optometrists we work with in the community are excellent at developing relationships with patients—so, who better to have a fruitful discussion about the kind of vision the patient wants to achieve?

This sort of education model actually relates back to many of the principles we already follow in the integrated care model, wherein specialists are trusted to perform their role and in which we all share in the delivery of patient-focused care. When the system works, it is like a well-oiled machine, and my role in the cataract surgery process becomes that much simpler. Instead of spending time reiterating education points, I can use my expertise to guide patients to a proper lens selection and then use the technology at my disposal to help them achieve the vision they want.

Lawrence Woodard, MD

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-

sometimes it may be necessary to do a little hand holding and counseling to reinforce their understanding and confidence. This is particularly true when the patient is between surgeries, with one eye completed and the other yet to have surgery. At this point in the process, especially with premium lenses, the end goal can become hard for the patient to visualize, so to speak.



BE SENSITIVE TO COST CONCERNS BUT NOT AT THE EXPENSE OF THE FINAL OUTCOME

The topical therapies used prior to and after cataract surgery are fairly standard—most patients get an antibiotic

to reduce the risk of infection, a nonsteroidal antiinflammatory drug, and a steroid, which act synergistically to reduce inflammation, including cystoid macular edema. Which agents are used and for how long remains a subject of debate. What is less questionable, at least in the eyes of our surgeons, is whether branded or generic formulations are most desirable.

Many patients in our clinic express concern about the cost of their medications. This is reasonable and understandable. Yet, depending on insurance and rebates offered, generics are not necessarily cheaper, and they may not always be the best option for the patient. Because branded medications are put through rigorous clinical trials, their safety and efficacy are known variables. With generic products, we are dealing with an unknown quantity that is not subject to the same kind of testing. In cataract surgery, where we are making every effort to improve the accuracy and predictability of outcomes, it does not seem to make sense to use products, when possible, that carry uncertain risks. My colleagues and I have observed a greater incidence of corneal irritation and dryness among patients who use generic products during the perioperative cataract period, especially among those with pre-existing dry eye.

Some newer alternatives exist to the traditional triad of operative ocular medications, such as compounded drops and dropless surgery. Benefits of compounded drops often include a lower cost and increased compliance due to fewer drops needed. Dropless surgery, while not used currently by our surgeons, has increased in popularity in recent years. Medication is injected into the eye at the time of the surgery allowing the patient to be free from the need of postoperative drops. In both cases, there is a lower risk for corneal irritation and dryness, either by reduction of number of drops or elimination of drops completely.

Cost concerns are very legitimate, and we need to be sensitive to them—we never want patients to have to choose between paying the rent and getting their eye drops. At the same time, branded medications provide patients the best chance of achieving the goal they started out with, and that is to regain visual ability that has been compromised by changes in the crystalline lens.



LEARN THE SURGEONS' PREFERENCES

There are six surgeons in our practice who perform cataract surgery and I work with all of them. Each surgeon does things a little differently. For example,

one surgeon uses subconjunctival steroid injection at the time of surgery in cases where there is a pre-existing risk of increased postoperative inflammation, such as patients with a history of rheumatoid arthritis.

Keeping everyone's personal preferences straight can get confusing, especially in a high-volume practice. However, understanding those nuances can be critically important to maintaining an efficient operation. In our case, we are fortunate that the surgeons have collaborated on designing a protocol for the perioperative management of cataract patients that standardizes the treatment of most patients that come through the clinic. Thus, the variations from the norm are minimized.

That said, understanding the preferences of the various surgeons in one's practice, as well as appreciating how they like to operate, will assure that everyone is on the same page. This, in turn, helps to minimize confusion and maintains a high level of efficiency. It may seem like a minor consideration in the grand scheme, but when all members of the eye care team have a clear understanding of the perioperative protocol, it serves to keep the patient's best interest as the focus of attention.

CONCLUSION

Entire textbooks can and have been written about the evidence-based care of cataract patients. There are many nuances and testing requirements to consider, and each is as important as the next. Fundamentally, however, the role of the optometrist in the integrated, or comanaged, setting is to assure that the patient is properly prepared for surgery and that he or she is afforded the greatest chance of obtaining the desired visual outcome. Achieving that goal depends significantly on how well the perioperative care plan is executed. An equally important aspect is the ability to listen to and respond quickly and empathetically to the needs of the patient. There can never be an absolute guarantee; yet, when the best interest of the patient is the central focus, the potential for a successful outcome is greatly enhanced.

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THE CHANGING MINDSET OF THE CATARACT PATIENT

The expectation for high-quality vision following surgery is the new normal.

BY JEFFREY MACHAT, MD, AND SONDRAL BLACK, OD



Over the past few years, we have noticed a dramatic change in the mindset of patients coming in for cataract surgery. What they are asking for is not only high-quality distance vision, but they also want to be glasses free at near and intermediate. Fundamentally, what this

signals is a change from cataract surgery being a medically necessary surgical procedure to it becoming a refractive procedure.

In part, this change has been prompted by the successful introduction of advanced tools and techniques used during the perioperative period to assess the lens, better biometry, the introduction of new IOL options that extend the range of vision, improved multifocal designs, and, the ability to refine the outcome with excimer lasers, just to name a few. The sum total of innovation in cataract surgery has made it a procedure that is highly predictable and repeatable, in turn leading to improved accuracy of the refractive outcome. A natural downside is that patients have much higher expectations postoperatively. However, we see this trend as a net positive, as it eliminates much of the confusion and can serve as an entry point to discussing surgical options with patients.

20/20 QUALITY VISION IS THE NEW NORM

One thing we have noticed is that our cataract patients tend to come into the clinic at a younger age. Instead of waiting until they are 70 or 80 years old and nearly blind from a progressed cataract, we are seeing patients in their 50s or 60s with mild lens changes but who are complaining about their night vision or just overall quality of vision. For many of these patients, a cataract diagnosis may be premature. In fact, the uncorrected visual acuity may be misleading as it is an issue of quality of vision not quantity of vision.

For this reason, we have found it valuable to obtain an Objective Scatter Index (OSI; HD Analyzer, Visiometrics) in these patients, as it measures the effects of optical scatter on the entire vision system, thereby accounting for all manner of higher-order aberrations. This test will essentially measure the patient's quality of vision as it

measures the effect of lens scatter due to normal aging changes. In a multicenter study of nearly 1,800 eyes, the OSI demonstrated significant correlation with cataract grade and the VF 14 Visual Function questionnaire and was shown to be an effective tool for early cataract diagnosis.¹

For our purposes, if we diagnose a patient with dysfunctional lens syndrome, which can be understood loosely as a precataractous lens,² we know that a corneal-correcting procedure will be insufficient to address the full visual problem and quality of vision issues experienced by the patient. Therefore, we are going to discuss a refractive lens exchange with such a patient as opposed to a corneal procedure. In these kinds of cases, understanding that quality vision is the desired outcome and having the ability to objectively measure it guides our clinical decision making.

EXTENDED RANGE OF VISION

Knowing that these patients are coming in not only to improve quality of vision that has been compromised by lens changes but also to eliminate the need for glasses postoperatively alters the way in which these patients should be treated. This is a prime reason why all patients coming into our clinic for a presumptive cataract evaluation are administered a modified questionnaire that seeks to understand what kind of vision the patient is hoping to have after surgery (distance only vs distance and near), and, perhaps more important, what he or she hopes to do with that vision. The questions are carefully worded to gauge what kind of activities the patient regularly participates in, determine the interest level in spectacle-free vision, and get a sense of the patient's psychological profile, all to help us recommend the correct lens and procedure for that patient.

A quick example helps illustrate this point. Let us say the results from the questionnaire from Patient A indicate that he or she is not overly concerned about occasional glasses use, and then later in the consultation, he or she relays that they spend a lot of time at the computer. These are elements of a patient profile that may succeed with bilateral implantation of IOLs with an extended depth of focus (we use the Symphony from Johnson & Johnson Vision in our clinic), permitting the ability to perform intermediate tasks (ie, computer

use) without sacrificing distance vision; there is a reasonable certainty that near vision will be improved, but in case it is not adequate for close work, this patient has already demonstrated a willingness to wear +1.00 D spectacles for near tasks.

An important concept to realize with the IOLs offering extended depth of focus or standard multifocal lenses is that each patient has an optimal distance for near tasks. We use a simple reading card with a string attached to it. The string has raised beads corresponding to working distances of 50, 42, or 33 cm. One trick we have learned is to hand the card to the patient upside down; when they get it in their hands, they will instinctively position it at the ideal distance they prefer to read at.

The reason we mention this caveat is that determining the individual's reading distance preference is helpful for making lens recommendations. For instance, patients who prefer a 33 cm reading distance who also use the computer a lot will do well with a Symphony in the dominant eye and a +4.00 D add multifocal with a working distance of 33 cm in the non-dominant eye.

MANAGING EXPECTATIONS

If there is a downside to the greater emphasis placed on quality of vision, it is that patients tend to be more demanding about the accuracy of the outcome, and so managing expectations becomes more crucial. The IOLs available on the market are leaps and bounds beyond what was available just a decade ago; I would encourage any eye care provider with a previous bad experience with advanced technology lenses to seriously investigate the current array of lens offerings.

The innovation inherent in the Symphony is particularly noteworthy in this regard. The concept behind this lens is to elongate the effective focal point, which results in more light reaching the retina from various viewing distances. In modulation transfer function studies in which the performance of the Symphony was compared with aspheric and spheric IOLs, the Symphony was shown to improve simulated retinal image quality without sacrificing depth of field or tolerance to decentration, thereby implying a greater ability to improve visual performance relative to the comparators.³ This design consideration has a couple of implications. First and foremost, it means that vision is available at near, intermediate, and distance visions. However, because light is elongated and not split, the potential to induce halo, glare, and other dysphotopsias is greatly reduced. Overall, the lens provides the best conditions to restore quality vision across viewing distances, and because it is more forgiving, it is suitable for patient types that may not have been candidates for multifocal lenses in the past, such as post-LASIK eyes, mild age-related macular degeneration, or even mild amblyopia.

The thing eye care providers should be wary of, however, is to avoid creating unreasonable expectations. Careful and meticulous surgery is still required to get a good outcome, and even in the best scenario, unexpected circumstances can affect the final refraction.

No matter how good the technology is, we simply cannot give patients back the vision they had when they were 20. While we work with patients through a process of understanding what they want to accomplish with their vision, there are never absolute guarantees. In all settings, we prefer to underpromise and overdeliver.

CONCLUSION

This article addresses a trend we have observed with regard to the mindset of the modern cataract patient. Overall, we have sensed that more patients are desirous of not simply achieving improved vision after cataract surgery with an IOL implantation, but rather, that they expect and sometimes demand high-quality vision that will allow them to be free of glasses at all distances. That mindset has caused us to shift how we approach the evaluation and consultation, including implementing protocols and diagnostics such as the HD Analyzer, which give us objective information about the individual's quality of vision. It has also led us to begin the process by asking patients what they want—an approach that is only possible because we have excellent technology at our disposal that will usually allow us to give patients the vision they seek.

At the same time, we also readily acknowledge that this approach is not appropriate for every patient. Some patients may be medically contraindicated to get a premium IOL. Others may have unreasonable expectations about what the technology can deliver. Yet, this is also the beauty of modern cataract surgery. The array of excellent lens options at our disposal allows us to lead a conversation not just about refractive cataract surgery, but a truly customized approach that will provide the patient the best chance of returning to the activities he or she participated in before surgery and enjoying them without glasses.

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FORMALIZED TRAINING IN INTEGRATED CARE

All fourth year students at the Rosenberg School of Optometry have a mandatory rotation in a busy ophthalmic refractive surgery center.

BY GREGORY D. PARKHURST, MD, AND KYLE A. SANDBERG, OD



Collaboration between ophthalmologists and optometrists in the care of patients is becoming increasingly normalized. Many eye care clinics now employ professionals from each discipline, and even those clinics that are exclusively ophthalmology are

likely to see patients referred from optometrists practicing in the community.

According to data compiled by the American Optometric Association, optometrists perform over 88 million of the 104 million refractive eye examinations each year, thus accounting for 85% of all comprehensive eye examinations.¹ While a great number of those patients will stay within the primary eye care setting, it is also likely that the care of many of those patients will intersect with other disciplines, including formal comanagement of refractive surgery, interoffice integrated services, referrals to other specialists, and beyond.

On top of this, the aging Baby Boomer generation is likely to bring even more patients into the eye care setting in the near future for surgical treatment of cataracts, glaucoma, macular degeneration, and other age-related eye conditions. There are also several other factors—excitement over new refractive surgical procedures, safe and effective surgical solutions for treating presbyopia, increased habitual use of digital devices that may set the stage for dry eye, growing appreciation of the implications of dry eye on quality of life, etc.—that could drive exponential growth in the need for eye care services. The bottom line is that, as our patient rosters swell, a more efficient model of care must emerge to ensure that high-quality care can be consistently delivered to patients along the continuum of eye care.

What these factors ultimately lead us to conclude is that most, if not all, subspecialty-trained ophthalmologists will,

during the course of their career, encounter situations where the care of a patient in some way involves the work of an optometrist, even tangentially. Given this reality, we believe it is time for a more formalized approach to training with respect to the principles and practices of integrated care to prepare practitioners within our respective disciplines for the realities of modern eye care.

COLLABORATIVE PARTNERS IN EDUCATION

Starting in 2014, the Rosenberg School of Optometry at the University of the Incarnate Word and the Parkhurst NuVision clinic began a collaborative educational partnership. Under the program, all fourth year optometry students are required to participate in a nearly 1-month rotation at Parkhurst NuVision,



Figure 1. The educational component of the rotation includes review of active cases as well as interaction with staff of Parkhurst NuVision, as depicted here, where Dr. Parkhurst is introducing optometry students to critical components of ocular anatomy.

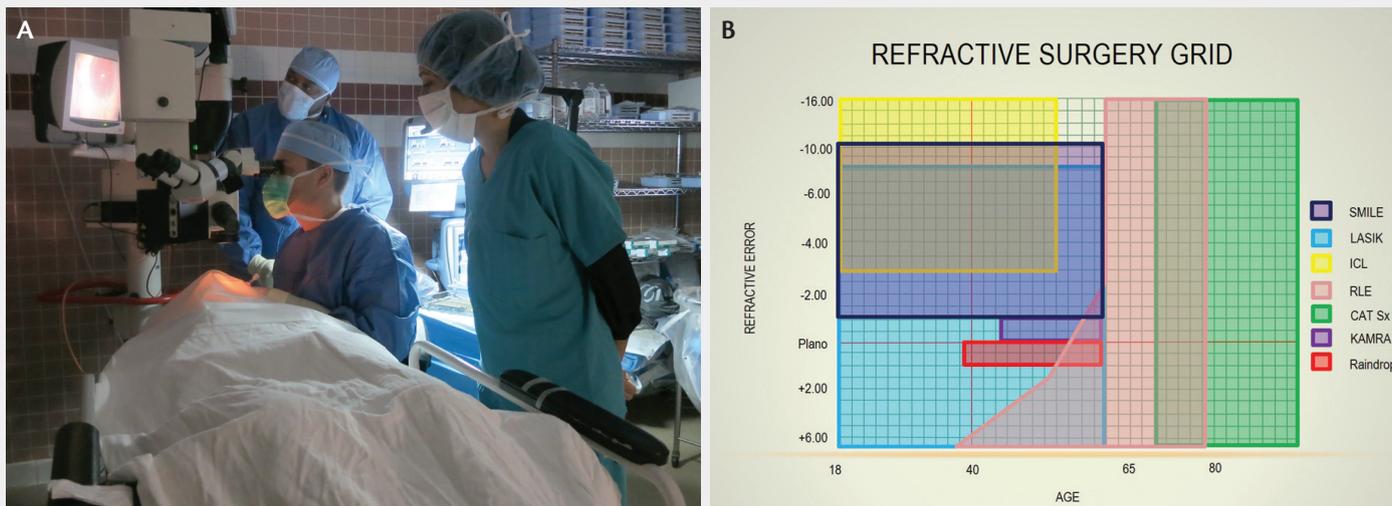


Figure 2. Students from the Rosenberg School of Optometry watch as Dr. Parkhurst performs laser cataract surgery (A). The Refractive Surgery Grid helps students determine what surgical procedure is best suited for each patient (B).

where they are fully immersed in refractive surgery clinical operations, from performing patient encounters to observing surgical procedures. Depending on annual class size, more than 60 students each year are afforded access to this enriching educational experience (Figure 1).

Through exposure to the hundreds of patients who would typically cycle through Parkhurst NuVision during a 3 to 4 week timeframe, students are exposed to the variations in corneal appearance before and after various surgeries; they gain an understanding of how to perform various measurements; and they get to see firsthand how various clinical scenarios are managed, among other things. Students are trained to think like independent practitioners throughout the rotation. They interact with patients, conduct slit-lamp examinations, and formulate treatment plans for each encounter. The students also perform the necessary testing during the preoperative assessment of cataract and refractive surgery patients, working up patients for follow-up appointments, and literally holding their hands in the operating room. This approach allows the student to gain valuable insight from one-on-one patient interaction while preserving the patient's high expectation for service.

Thus, the potential to impart valuable clinical lessons is abundant. For example, when students are tasked with building a management plan based on their findings during a patient encounter, they receive immediate feedback on their clinical judgment when their plan is reviewed and used as a teaching point by a senior optometrist at Rosenberg. As well, students get exposed to a gamut of refractive surgical procedures, including corneal inlays, crosslinking, refractive cataract surgery, refractive lens exchange, phakic IOLs, SMILE, PRK, and LASIK,

and so they start to gain an understanding of the procedures, how demand for those procedures will benefit their patients and their practices, and how they can be applied (Figure 2).

But the teaching moments go beyond the obvious. By actively participating in clinical scenarios, students are introduced to the sort of autonomy that will be necessary to thrive in clinical practice. We also like to think that they are learning the awesome responsibility involved in caring for patients' vision. The obligation to be available to the patient, perhaps past regular clinical hours, can be conveyed over and over in the classroom or during didactic lectures. That first time students get a call about a postoperative pressure spike at midnight, however, is when those lessons finally crystallize.

PRACTICAL APPLICATIONS OF THEORETICAL KNOWLEDGE

If the program described above sounds like an integrated model of education, that is because that is precisely what it is. In many ways, the rotation of fourth year optometric students through a busy refractive surgery clinic is intended to mirror experiences in the real world. The booming demand for eye care services (both surgical and nonsurgical), as well as the looming potential for a shortage of providers, suggests a need to improve how patients are managed. Integrated care is a plausible way to do just that, but growing that model will require education that prioritizes understanding patients' needs.

This last point is conveyed nicely by Timothy A. Wingert, OD, dean and a professor of Optometry, Rosenberg School of Optometry, "We highly value the relationship we have with Parkhurst NuVision and the educational opportunities it offers

“We highly value the relationship we have with Parkhurst NuVision and the educational opportunities it offers for students in our program. The rotation immerses our students into a situation where there is a seamless integration of the professions with each concentrating on taking care of the patient. The rotation removes some of the mystery as to when surgical approaches can best serve the patient and how to counsel the patient during the process.”

— Timothy A. Wingert, OD, dean and a professor of Optometry, Rosenberg School of Optometry

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One of the other valuable exposures students get in our program is that they hear firsthand and listen to the perspectives of patients prepping for surgery, including not only their excitement, but also any anxieties and fears they may have. They also get to talk to patients after surgery and hear about their success stories. In our minds, those types of experiences lend themselves to creating better doctors, because if students get to understand what a patient is going to go through for surgery—what their anxiety level is, and how they anticipate going into surgery—it affords a view from the other side of the slit lamp, so to speak.

Although we are aware of several opportunities for optometry students to participate in externships at ophthalmology clinics, we believe our program is one of the first formalized approaches to training. Beyond the interest of teaching best practices for the perioperative care of refractive surgical patients, it is our contention that our program also delivers practical lessons in building relationships that complement and add to the theoretical knowledge students gain in school. Our particular model is successful because of the proximity of our respective offices, and it is already serving as a model for other optometry schools.

There are many ways we can measure outcomes of our program, and we are actively gathering data that will hopefully guide us on ways to refine the experience for students to make it even more beneficial. We have received feedback from several students who have passed through the program, many of whom have expressed gratitude for the experience. Some never knew they wanted to work with surgical patients until the rotation, while others have learned an equally valuable lesson when they realized that managing perioperative patients would not be their professional ambition.

There is another metric of our program that, although anecdotal, is something that makes us particularly proud. Many of the optometrists who practice in and around San Antonio

direct referrals to the Parkhurst NuVision clinic not only because of the elegant surgical outcomes they have come to expect, but also specifically because they know how patients will be treated in our collaborative care model. In studying those referral patterns, we have learned that many community optometrists know their patients are going to get excellent care, and with informed consent of the patient, they are assured of being returned back for postoperative comanagement. Many have also told us that they refer to us, in part, to support the continued education of their profession.

This last point, we believe, is extremely important. Ophthalmologists and optometrists each take an oath to always maintain the best interest of patients, promising to advise all patients fully and honestly of all which may serve to restore, maintain, or enhance their vision and general health. Yet, while unspoken, there is also an implied duty for those in eye care to be stewards of their profession, including attending to the training of the next generation. The integrated model of eye care is a relevant practice model in which all sides benefit, especially the patient. We believe the adoption of formalized training programs that advance evidence-based practices within that model will serve to produce practitioners more versed in its nuances, ultimately laying the groundwork for even better delivery of eye care in the future. ■

1. American Optometric Association. State of the optometric association: 2013. Available at: https://www.aoa.org/Documents/news/state_of_optometry.pdf. Accessed May 4, 2017.

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