EFFICIENCY AT EVERY STAGE

Structured workflow enhance outcomes and reduce chair time.

Optimizing Team Communication for IOL Success

BY JOAQUIN O. DE ROJAS, MD, AND PRIYA M. MATHEWS, MD, MPH

When we adopted the Light Adjustable Lens/Light Adjustable Lens Plus (LAL/LAL+, RxSight) technology at our high-volume practice more than 2 years ago, we faced a familiar challenge: balancing the promise of exceptional visual outcomes with the operational demands of a busy clinic. It took nearly a year of refining our workflow to increase efficiency without compromising patient care. With the right guidance and effective communication, however, the journey to a seamless, high-quality patient experience can be much shorter.

STRUCTURING WORKFLOW

A defining feature of the LAL process is the patient's involvement in refining their vision postoperatively based on their refraction and visual needs. Although this offers flexibility, it also necessitates a structured workflow, careful planning, and clear communication to set appropriate expectations.

We developed an LAL workflow that integrates with our vertically structured care model and leverages the strengths of all stakeholders, including five surgeons, five patient care counselors (one per surgeon), three optometrists dedicated to performing light adjustments, and 22 internal and external optometrists providing postoperative care. Aligning communication among these professionals and delivering a unified message to patients has been essential.

Many patients arrive with high expectations and a desire for white-glove service. To address

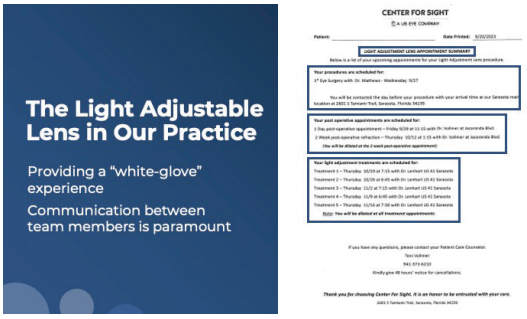

Figure 1. An example of a customized appointment summary handout detailing a patient's surgical and follow-up appointments.

this, a patient care counselor meets with them immediately after their consultation. The counselor performs two key tasks: (1) educating patients about their postoperative time commitment and (2) acting as a consistent point of contact throughout their journey. Patients also receive a customized appointment summary detailing their surgical and follow-up visits (Figure 1). Our proactive approach has significantly reduced patients' confusion and ensures they remain engaged and prepared during their surgical and postoperative care.

STREAMLINING POSTOPERATIVE CARE

Our practice spans a large geographic area in Florida, so efficient comanagement with optometrists is vital. The referring optometrist takes an active role in early postoperative care, including the visits 1 day and 2 weeks after surgery. At the latter follow-up appointment, the ocular surface is assessed, and any dry eye symptoms are managed. The optometrist also looks for signs of posterior capsular opacification, which, if present, is treated by the surgeon.

Adjustments typically begin around 3 weeks postoperatively, with subsequent treatments spaced about a week apart. The final two treatments involve locking in the lens power. Initially, our surgeons performed all light adjustments, but this quickly became unsustainable as procedural volume grew. We streamlined the process by training a few technicians to assist with light adjustments and refractions and then designating one optometrist to perform most adjustments. Since then, we have certified more technicians to perform precise refractions and trained two additional optometrists to perform light adjustments. About 95% of our patients are comfortable with our having optometrists handle the adjustments, and those who prefer a surgeon are accommodated.

Light adjustments are now performed during dedicated morning or afternoon session blocks, each accommodating up to 18 patients without disrupting the optometrist's regular clinic schedule. Technicians conduct evaluations, including history taking, binocular vision testing, and refractions. The optometrist then reviews the treatment plan, addresses patients' concerns, and performs the light adjustment.

This structured approach has increased precision and efficiency while maintaining continuity of care.

PRIORITIZING PATIENT SATISFACTION

From the outset, our practice's goal has been to deliver premium vision correction options that prioritize patient satisfaction and individualize care. Multifocal and toric IOLs are integral to our practice. Even with precise measurements and advanced surgical technology, however, some patients experience residual refractive errors or are not suitable candidates for certain premium lenses. Offering the LAL helps us address those limitations.

The LAL allows patients to trial their vision and fine-tune it postoperatively to fit their lifestyle. In our experience, the lens is also better than a monofocal IOL at preserving contrast sensitivity, and the LAL may reduce visual disturbances such as halos and glare that are more common with multifocal IOLs.[1] Offering the LAL/LAL+ has thus broadened our pool of candidates for a premium lens. It has also reduced our volume of enhancement procedures, thereby streamlining postoperative care and increasing patient satisfaction.

TIPS FOR A SEAMLESS WORKFLOW

Integrating the LAL/LAL+ into our practice required careful planning, especially given the intricacies of its adjustment and lock-in process. Our success hinged on three key elements: collaboration among providers, robust training, and patient-centered care.

Collaboration Among Providers

We recommend that surgeons learn and refine each step of the LAL process. Once proficient, they can begin delegating responsibilities to other staff members and define clear roles for all stakeholders to ensure a streamlined approach. Written guidelines and protocols are essential. Our team's responsibilities are outlined in Figure 2. What works for one practice may not work for another, so a period of trial and refinement is to be expected.

A structured communications strategy is necessary to circulate information effectively among surgeons and team members. In our practice, this strategy includes the following:

- Comanaging optometrists communicate with surgeons if posterior capsular opacification is detected before an adjustment;
- Optometrists performing light adjustments inform surgeons if a YAG laser treatment is needed on the adjustment day; and
- Optometrists performing light adjustments update comanaging optometrists and surgeons if the patient exhibits worsening dry eye symptoms, may be at risk of developing cystoid macular edema, or is dissatisfied.

All team members should understand that pausing adjustments to regroup and consult with surgeons or other care providers is always an option. Coordinated efforts optimize efficiency while supporting patient outcomes and satisfaction.

Robust Training

Technicians play an integral role in the LAL workflow. In our practice, they receive rigorous training on inputting data into the Light Delivery Device (RxSight). Additionally, we implemented a quality control system and require technicians to complete five supervised refractions before independently managing patients. This process improves accuracy while fostering confidence and accountability among staff. It has also

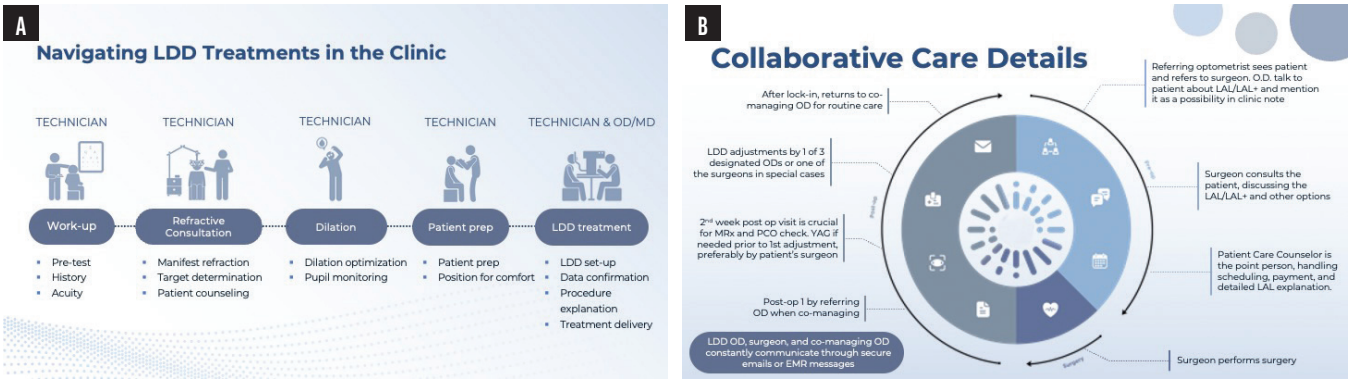

Figure 2. Navigating light adjustment procedures involves establishing responsibilities for team members (A) and protocols for patient care (B).

allowed optometrists and surgeons to focus on higher-level tasks and contributed to overall efficiency.

Training optometrists to consult with patients and determine refractive targets using established guidelines is another way we have enhanced patient care. Many of our optometrists have found this process rewarding because it has deepened their involvement in patient outcomes.

Patient-Centered Care

We set up multiple touchpoints for patients' LAL journey. Outlining each step of the process promotes transparency and helps them plan their treatments without becoming overwhelmed (Figure 1).

Appointing a dedicated patient care counselor as a primary contact for scheduling, financial questions, and treatment-related concerns has further streamlined the process. We have found this structured support system fosters patient confidence and engagement.

CONCLUSION

Strong communication, a well-trained team, and patient-centered care can help establish an effective workflow for LAL/LAL+ integration. Multifocal lenses are a valuable option, but some patients prefer a lower risk of dysphotopsias and the ability to fine-tune their vision postoperatively. Additionally, the LAL and LAL+ offer an alternative for patients with a history of refractive surgery.

The postoperative process for the LAL/LAL+ is more complex than for traditional cataract surgery. Streamlining workflow and fostering teamwork can help deliver customized outcomes that align with patients' expectations. As we continue refining our processes, we remain committed to collaborating with referring optometrists and optimizing patient outcomes.

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Don't Overlook the Ocular Surface

BY MARGUERITE B. MCDONALD, MD, FACS

We cataract surgeons devote considerable attention to biometry, IOL power calculations, and surgical mechanics, but too often, we overlook a powerful refractive component: the ocular surface. Ocular surface disease (OSD) can lead to inaccurate preoperative biometry measurements, flawed surgical plans, and suboptimal IOL selection. Untreated OSD has also been linked to an increased risk of postoperative endophthalmitis.[1]

The postoperative recovery of patients with untreated blepharitis or meibomian gland dysfunction (MGD) is generally slower than that of their peers with a healthy ocular surface. When a patient has elected to receive a premium IOL, they are bound to be dissatisfied if their outcome is compromised by OSD.

EFFICIENT PREOPERATIVE WORKFLOW

In my practice, every patient contemplating cataract surgery or a refractive procedure undergoes a structured preoperative workup before I enter the room. As part of this process, it's important to ask whether the patient experiences fluctuating vision—a hallmark symptom of OSD that may otherwise go unreported.

Psychometric Testing

The Standardized Patient Evaluation of Eye Dryness Questionnaire allows me to identify a patient's primary complaints quickly.

Tear Osmolarity Testing

Tear osmolarity has been central to my preoperative evaluation of patients for years. It has a better positive predictive value than the Schirmer

QUICK OCULAR SURFACE CHECKS THAT HELP KEEP WORKFLOW EFFICIENT

- Ask about fluctuating vision (a hallmark of ocular surface disease)
- Preoperative psychometric test
- Tear osmolarity testing (perform before the surgeon enters the room)
- Corneal topography (look for dropout patterns)
- Lid examination with meibomian gland expression
- Cylindrical dandruff inspection upon downward gaze (*Demodex* screening)

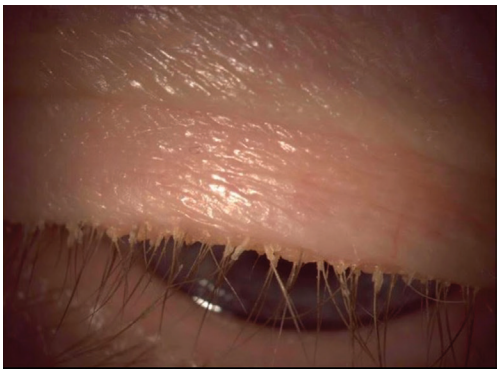

Figure 3 courtesy of Alice T. Epitropoulos, MD, FACS

Figure 3. Cylindrical dandruff along the upper lash line, a hallmark sign of *Demodex* blepharitis.

test (87% vs 31%), is quick and easy to perform, and has a low-cost entry point.[2,3] Importantly, tear osmolarity testing is conducted by staff before I see the patient, facilitating an efficient, data-driven clinical discussion.

Corneal Topography

Every surgical candidate undergoes topography. My team is trained to flag maps that show dropout patterns—whether in the concentric rings or as patchy color zones—that signal dry eye disease (DED). I have found entering the room with this information makes clinical decision-making far more efficient.

Lid Examination and Meibomian Gland Expression

At the slit lamp, I ask patients to look down while I briefly examine their eyelids for cylindrical dandruff (a hallmark of *Demodex* infestation; Figure 3). I assess meibomian gland function by applying gentle pressure on the middle to lower lid with my thumb. The expression of clear fluid is reassuring, whereas absent or purulent discharge signals MGD requiring preoperative management. Complete blockage—no fluid expression—also signals that treatment is required before surgery.

A STAGED APPROACH TO DED

Grading

Patients with *Demodex* blepharitis begin treatment with twice-daily hot compresses and lid scrubs using over-the-counter eyelid wipes as a long-term maintenance strategy. I also prescribe lotilaner ophthalmic solution 0.25% (Xdemvy, Tarsus Pharmaceuticals), dosed twice daily in both eyes for 6 weeks. During this period, all preoperative testing—including biometry, repeat topography, and a dilated fundus examination—is delayed until medical therapy is complete.

In-office procedures such as BlephEx (BlephEx) and LipiFlow (Johnson & Johnson Vision) can be highly effective in reducing mite burden and inflammation. When financially feasible for the patient, these treatments are integrated into the management plan. Preoperative assessments resume 7 weeks after the initiation of therapy.

If OSD—manifesting as symptoms, elevated tear osmolarity, topographic dropout, or clinical signs of MGD—is noted at the initial visit, the preoperative workup is deferred, and the patient is informed that the health of their ocular surface must be optimized. In my experience, patients appreciate the cautious approach. I am not aware of anyone who has elected not to proceed with surgery due to this temporary delay.

Nutritional support is recommended at every stage of DED and MGD management. I prescribe a high-quality omega-3 supplement for all patients, regardless of disease severity. My preferred product is DE3 (PRN), which is available in softgels, a liquid formulation, and a vegan option. The reesterified triglyceride form of DE3 enhances bioavailability, resulting in nearly complete absorption—unlike most other omega-3 products that pass through the gastrointestinal tract with minimal uptake and are excreted in the stool.[4]

Treatment

Stage 1 DED. Initial therapy includes a topical immunomodulator such as cyclosporine 0.09% (Cequa, Sun Pharma) or lifitegrast ophthalmic solution 5% (Xiidra, Bausch + Lomb). Preservative-free artificial tears, administered four times daily and as needed, are also recommended.

Stage 2 DED. In addition to the stage 1 regimen, patients are asked to administer a bland ophthalmic ointment at night and perfluorohexyloctane ophthalmic solution (Miebo, Bausch + Lomb) four times daily. Perfluorohexyloctane treatment frequently eliminates the need for artificial tears. If this drug is not covered by insurance, the dosing frequency for the artificial tears is increased to every 2 hours while awake. To control DED symptoms faster, the immunomodulator is often combined with a steroid such as loteprednol 0.5% (Lotemax, Bausch + Lomb) dosed four times daily for 1 week, tapered to twice daily for a second week.

Stage 3 DED. In addition to stages 1 and 2 therapy, patients undergo occlusion of all four puncta with LacriFill Canalicular Gel (Nordic Pharma).

Dual immunomodulator therapy is also initiated and typically combines lifitegrast and cyclosporine 0.09%, which have complementary mechanisms of action.

Stage 4 DED. Stages 1 through 3 treatment is supplemented with amniotic membrane therapy. My preferred approach involves the placement of a 12-mm Biovance 3L membrane (Versea) under a bandage contact lens and maintained for 7 to 10 days. Serum tears, dosed four times daily, are also initiated.

A STAGED APPROACH TO MGD

Stage 1 MGD

First-line treatment includes twice-daily hot compresses and lid scrubs with over-the-counter wipes. All patients receive brief hands-on instruction to promote proper technique. My preferred wipe is the OcuSoft Plus (OcuSoft), which offers antimicrobial properties, but several effective alternatives are available.

Stage 2 MGD

In addition to stage 1 treatment, patients administer erythromycin ophthalmic ointment at night and perfluorohexyloctane four times daily.

Stage 3 MGD

In addition to stages 1 and 2 therapy, patients begin a 4-week course of oral doxycycline: 100 mg twice daily for 1 week followed by 50 mg once daily for 3 weeks. In-office treatment with a combination of BlephEx and LipiFlow is highly recommended.

Stage 4 MGD

In addition to treatment for stages 1 through 3 MGD, a 4-week taper of loteprednol is prescribed: four times daily for 1 week, three times daily for 1 week, twice daily for 1 week, and then once daily for 1 week. Eligible (ie, nondiabetic and systemically healthy) patients may also begin a 6-day oral prednisone taper, with each daily dose taken in a single administration. The regimen is as follows:

- Prednisone 80 mg daily for 2 days;
- 40 mg for 1 day;
- 20 mg for 1 day;
- 10 mg for 1 day; and
- 5 mg for 1 day.

This taper is accompanied by treatment with ranitidine (Zantac, Sanofi) for gastric protection.

Combined BlephEx and LipiFlow treatments are helpful at any stage of MGD but are virtually essential for stage 4 MGD. These procedures are typically performed at least 1 month before the final preoperative workup, particularly biometry, to ensure ocular surface stability. ■

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