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## Designing Efficient Clinic Workflows for TED Therapy Access

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### Episode 5

#### Dr. Subramanian:

Hi, I'm Dr. Prem Subramanian, and I'm here today with my friend and thyroid eye disease expert, Dr. Kim Cockerham. We're going to talk about treatment logistics because they can be challenging in thyroid eye disease for both patients and clinicians.

So, Kim, what strategies should we be using to improve care coordination and patient monitoring when they have thyroid eye disease?

#### Dr. Cockerham:

This is such an important, important starting point is what is the baseline workup?

And Prem and I are both neuro-ophthalmologists, so of course we always do visual field testing and look at optic nerve function, but it's so important that these patients, if they're seeing an oculoplastics doctor that doesn't have these tests, to refer them. So the patient needs a complete eye exam, including dilated exam, visual field, OCT.

Then they also need thyroid function testing. This can be done either by the endocrinologist or the eye care specialist. They need a thyroid exam, especially if the thyroid is enlarged or it's firm or there's nodules, because it could be something more—it could be even a thyroid cancer.

And then they need orbital imaging. If there's going to be a therapeutic intervention, there's a lot of mess. You can have thyroid eye disease and lymphoma. You could have not really thyroid eye disease, but rather something else, like a CC fistula or some other entity. So it's super important that you get the correct orbital imaging and that somebody who understands the scan looks at it because there can be misreads. So super important.

And then to improve thyroid care overall, you want to get early referral to specialty care if possible. Certainly, some patients can't get to an endocrinologist because of their insurance, and you want to control the risk factors and make sure the primary care—if you're dealing directly with the primary care rather than an endocrinologist—they understand that active disease can be worse in smokers, that having the thyroid imbalance off is not a good thing, that having really high antibodies can be predictive of more severe disease. And then an emerging risk factor is high cholesterol, so pairing with whoever you have—so the eye specialist plus the primary care, or better yet, an endocrinologist.

Then, if you decide you're going to move forward with, for instance, teprotumumab or corticosteroids, or whichever one you want to use, you want to make sure you do informed consent. You want to have a prescribing doctor to provide informed consent about what are the

risks, what are the benefits, and also how to mitigate the side effects.

Specifically, tepro, we recommend audiology as a baseline and give the patient informed consent. If they have audiology that demonstrates hearing loss, then perhaps this isn't the medication for them, or it's at maybe at a different dose.

And then, especially during their treatment with teprotumumab, you want aural hygiene, which means basically avoiding loud sounds. It's not the time to go listen to a rock and roll band.

And then you want to communicate. You want to make sure that the patient has good communication with their whole team. So it might just be a primary care and an eye specialist, or it might be an endocrinologist, a primary care, and a couple eye specialists, but just having everybody know what's going on.

And then strategies to streamline. In an ideal world, you build a coordinated care team. Many universities now have wonderful referral pathways. They have team approaches, but a lot of people in private practice, especially in more rural communities, don't have this. So you have to build the team you can build for the best you can for the patient.

You want to screen early and often. So you want to check the patient's CAS, look at the validated quality of life tools, and make sure you're not letting the patient fall off the cliff instead of getting care when they need it.

You want to plan the infusion logistics as we described, trying to incorporate maybe you can have home care with home care nurses. Maybe they have to go to the infusion center the first couple times.

You want to standardize handoffs. When there's a team, everybody needs to know who's caring for the patient and who's mitigating the side effects, who's making sure bad things aren't happening.

And you want to assign a patient navigator. Ideally, there's some provider that's a lead, and that provider with their navigator is going to coordinate that post-monitoring. For instance, teprotumumab is not a drug to start the patient and say, "I'll see you in 24 weeks." You really need to watch the patients, look at the audiology, look at the glucose, make sure that you're providing mitigating recommendations, because sometimes they can have severe muscle spasms that, if they just took some magnesium, they'd be just fine. But the key is definitely close communication after every single infusion with the navigator and/or the provider, depending on the symptomatology.

**Dr. Subramanian:**

Kim, I want to thank you for sharing this great information about how to establish a team to take care of our patients with thyroid eye disease. Some of our listeners may not feel confident leading that team, and you've set out a pathway for them to identify a team leader and to be part of this process to deliver excellent care to our patients who really need it to recover from this devastating disease to them.

And so I want to thank our listeners, and stay tuned to more episodes about the treatment of thyroid eye disease.

**Announcer:**

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