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A National Eye Institute Initiative—Practice Strategies to Optimize Continuity of Care for Eye Health During COVID-19

Announcer:
Welcome to CME on ReachMD. This activity, entitled "A National Eye Institute Initiative—Practice Strategies to Optimize Continuity of Care for Eye Health During COVID-19" is provided by Prova Education and is supported by an independent educational grant from Regeneron Pharmaceuticals, Inc. The National Eye Health Education Program of the NEI is acknowledged for its important contributions to this initiative.

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Dr. Shechtman:
This is CME on ReachMD. I'm Dr. Diana Shechtman, and today I'm joined, to answer these questions related to ensuring the continuation of the care of the patient with diabetic retinopathy and wet AMD during COVID-19, by Dr. Charles Wykoff.

Dr. Wykoff:
Diana Shechtman, it's great to be here with you. This is an important discussion. We have all learned a tremendous amount in these last six months, with COVID-19 bearing down upon us, and we continue to learn a lot. I look forward to this discussion.

Dr. Shechtman:
Let's get started, Dr. Wykoff. Discuss the importance of adherence to therapy and continuation of the care of the patient with both diabetic retinopathy and wet macular degeneration.

Dr. Wykoff:
This is a critical topic, and the answer to this is not what any of us would like to be able to say, right? We'd like to be able to say, you know, COVID-19 is upon us, let's just take a holiday and not worry about retina care for a few months until things blow over. But unfortunately, we have many, many years' worth of data showing that consistent care for exudative retinal diseases leads to the very best outcome. And of course, our exudative diseases include, as you point out, diabetic retinopathy, diabetic macular edema, neovascular AMD and retinal venous occlusive disease, among many others. And in these disease states, the pharmacotherapies that we have are quite good. They're excellent, I would say, at inhibiting the exudative process and improving visual function long term. Their biggest challenge, of course, is that they're not a cure, that these treatments are required repeatedly, over many, many years, in most cases. For example, we have many prospective data sets showing that when you treat patients as needed, most of the patients need ongoing, repeated therapies to maximize their anatomic and visual outcomes long term, with all of our currently approved pharmacotherapy options. And the one data point I would point out, showing consistency of care is really optimal, was a very recent paper that was published just this year, 2020, in *JAMA Ophthalmology*, which was a post hoc analysis of the CAT data set. Remember, CAT was a prospective trial with four arms, looking at management of wet AMD. And the summary from this paper was that each missed visit was associated with an average visual acuity letter score decline of just under one letter, about 0.7 letters, which doesn't sound like much for one missed visit, and it's not. But the problem is, when you have cumulative numbers of missed visits over time, you allow the disease to go unchecked, leading to more permanent anatomic changes, leading to long-term suboptimal visual acuity

outcomes. And so, the take-home message here is that really consistent long-term care is going to achieve the best outcomes for exudative retinal disease patients.

Dr. Shechtman:
That's absolutely excellent. So, let me ask you another question here. With that in mind, tell us more – a little bit about ensuring that the patient actually is coming for their therapy. You know, they're coming in a time that they're scared, they're unsure. How does your office and yourself ensure that – the safety of the patient?

Dr. Wykoff:
Yeah, Dr. Shechtman, it's a great point. I'm glad you're bringing this up, and I'd love to hear what your team does, as well. But really, from day one, we have emphasized safety, as you point out, right? Safety is paramount here, because retinal diseases are very important to optimize, but if we can't do it in a safe way, then it would be better for our patients to stay home in this time of COVID-19. And so, from day one, we've chose to stay open, and we never shut down. We believe that retina patients need care today and tomorrow, regardless of what's going on around us, as long as we can do it in a safe way. But we have put in place many, many precautions, as I'm sure you have as well. Sort of the first one I would mention is masking, right? All patients, all staff, all physicians in the office, 100% of the time, have a mask on. We really have no exceptions to that because this virus unfortunately is transmitted really through nasal and oral sort of discharge. And so you want to try to keep people masked at all times. The second point I bring up is contact precautions. So we all wear gloves, really 100% of the time, and change the gloves between each patient, make sure that we are constantly washing our hands when we are not wearing gloves. The third one I would mention is really exposure of patients over time. We are trying to minimize the number of patients that come into clinic. So for example, patients that don't need to be seen, for example, if they have had a stable ERM for a long time and they're not noticing any symptom changes on a phone call, then we often will have them delay their visit. But most of our patients do need to continue to come in, and so when they do, we're trying to allow increased office hours. Patients come in earlier or later, trying to space them out in both time and space. And then the last point I would mention is family members. We're really minimizing the family members and caregivers that come into the clinic, which is a double-edged sword in this situation. And it's good because you're trying to decrease the number of people in clinic because you want to avoid anyone with COVID coming into the office. But the double-edged sword, the negative side of that, is that, really, it takes a village to deliver high-quality retinal care, right? The caregiver and family need to be engaged in the care process. And so how do you maintain that engagement? Well, we are trying very hard to communicate with the family and caregivers, often by phone, during the visit, with the caregivers out in the car, so we can talk about the plan and what we're doing for the patient moving forward.

Dr. Shechtman:
Those are great plans, and very similar to some of the ones we're having in our office, except for the caregiver one, which I'm going to steal because I think it's a great idea. We do utilize telehealth. I notice that you didn't mention – I'm sure that you do. Obviously, within the era – within the parameters of retinal disease, that's hard. But I'm looking at things for ocular surface diseases like evaluating a sty or red eye. By caring for those cases, you're preventing those patients from coming into the office as well. We do educate our patients via websites, messages left in a voicemail, even as we are confirming the patient. Again, we are sharing them time and time again about the safety parameters that we are taking here. Initially, when patients were quite scared to come in, we send mass texts and emails to reassure them, not only that we were open, much like you, during the whole entire time, but we encouraged them to come for their appointments, and again, explaining the safety parameters that we are taking. And I think this kind of gave the patients a little bit more security when they came in.

So, after discussing the challenges, and some of the best practices you have in your office, can you give us a little bit of information regarding the American Academy of Ophthalmology guidelines and how they play a part in your office practice?

Dr. Wykoff:
Yeah, great question. And, you know, communication here is a key part of how we all stay safe and how we continue to move forward through this pandemic. And the AAO, along with other leading organizations, have been instrumental in providing guidelines on how to achieve best practices. Many of these are related to the CDC guidelines. There are also local hospital guidelines. I would encourage all of our listeners to make sure they're familiar with at least their local hospital guidelines and then their practice management guidelines more broadly. And the two that I would point out, I guess, from the AAO, would be, first of all, to make sure that patients that have any potential symptoms of COVID-19 really don't come into the office unless absolutely necessary. And if patients with COVID or that are suspected of having COVID do absolutely need to come into the office, there needs to be a very special circumstance around that and very specific considerations, right? Overall, the goal here is to not bring patients into the clinic, not have staff come into the clinic who might have or do have COVID-19 in an active state, because you really want to avoid transmitting this to our high-risk patients. And the second point, of course, becomes a little more difficult to enforce, but worth asking of all patients. If you've been exposed to someone who has had COVID in the last two weeks, probably better for those patients really not to come into clinic, again,

just to minimize the risk of transmission of the virus to our other patients.

Dr. Shechtman:
For those just tuning in, you're listening to CME on ReachMD. I'm Dr. Diana Shechtman, and I'm joined by Dr. Charles Wykoff. We are discussing the importance of continuing of care with patients with diabetic retinopathy and wet macular degeneration during the COVID-19 pandemic.

Dr. Wykoff:
Dr. Shechtman, tell me about the referral patterns there, where you're practicing. Are you seeing the number of patients increase, decrease? How are you keeping your colleagues that refer to you guys patients sort of informed about your current status and the management of patients?

Dr. Shechtman:
That's a great question. I think if you ask different doctors, they probably have similar answers. One of the key things we're seeing there is we're seeing a number of increase of anterior surface disease. Predicting it's probably associated with the mask wearing, but we're seeing a number of red eyes, dry eyes, chalazions, lid swellings, much more than we have seen in our retina practice. Lack of access to primary care offices – there is many offices around this area that are still closed. There are some limitations, in even ophthalmology practice. And I have a feeling probably the sedentary lifestyles that some of these patients are dealing with nowadays has also caused an increase in the progression of diseases. Patients who were seen with mild to moderate disease just a few months ago are beginning to have more severe diabetic retinopathy. So we're seeing a little bit of an increase of the progression of the disease. Because general ophthalmology and optometric practices were not open for quite some time, we are also – and they're still limited – we are also seeing a lot more of the primary care diseases, or just symptoms such as flashes and floaters or just nuisance kind of things that would have been seen at other offices. Even though there was an initial downward trend, we are seeing kind of a stability again, and I think it's a reassurance of the many aspects of practice safety within our guidelines here.

Dr. Wykoff:
All great comments, and we're seeing the same trends. If anything, we're seeing an increase in the acuity of retinal diseases in our clinics for two main reasons that is driving that. First of all, we're seeing the patients that don't have, sort of, active diseases, are sort of self-selecting to stay away from the clinic in many cases, which is completely understandable. And then we're also seeing referrals from many other clinics that don't feel as comfortable seeing such a high volume of clinic patients. I'm sure you guys are the same way. You know, it's important for our broader community to realize that these patients, especially with retinal diseases and acute anterior segment problems, really do need to continue to have access to care. And we need to continue to keep the lines of communication among practitioners open so that people that can see patients safely are seeing the patients that need to get care.

So with that in mind, Dr. Shechtman, can you discuss the American Optometric Association's COVID-19 guidance for optometrists and other practitioners and key takeaways for all of us?

Dr. Shechtman:
Well, they kind of mirror some of the same as the American Academy of Ophthalmology and the CDC and are some of the perspectives that we even follow in our office here. Prior to entering the office, we check temperatures, we ask the correct questions in regards to any exposures to COVID patients or just to COVID in general and, of course, of symptoms, which are growing on an everyday basis. We are providing in our office and all our staff with masks, and we even have extra ones for our patients when they are in need. Everybody here – the front desk wears protective shields, but we only have protective shields in the back office for slit lamps and as well as our check-in areas. Rooms are always cleaned in between patients, and the patient can actually see this, which gives them a little bit of a sense of security. One of the key things that we're facing now, especially with the growing number, is our staff and the doctors may have been exposed. And there's questions with symptoms, so much like you said, we do quarantine them. They do get tested. We're actually beginning to do in-office testing too. That gives us reliable tests within one or two days, so that kind of helps us to kind of reassure the patients are safe, our staff is safe, and they can return to the office safely. We have separations, particularly in the choking areas, which are the dilation rooms, the waiting rooms, and the check-out areas, and schedules are a bit more limited. But we have expanded our schedule to different areas as well, so those are probably the same key points that you have within your office as well.

Dr. Wykoff:
I think those are great observations and we do very similar things to keep our patients and our staff safe. Absolutely agree.

Dr. Shechtman:
So what would you say is your final take-home message from all this that you really want to give our listeners?

Dr. Wykoff:
You know, I definitely echo all the details we talked about. I guess the overarching principle, I'd say, is just to allow yourself, and maybe encourage your staff, to recognize that this is an anxiety-provoking and a fearful time for our patients, right? Many of these are older patients with a lot of comorbidities. They are high-risk populations, and they're scared. And they have a right to be scared, and certainly we are scared for our, you know, elderly family members that we might have. And so, we need to reassure them and let them know that we understand that there is anxiety there and that, first and foremost, their overall safety is the most important thing on all of our minds. And that's why we're doing all of these safety precautions, from the phone calls, to the masks, to the handwashing. All the things we're doing are focused exclusively on providing them the safest environment possible so that we can then deliver the optometric care that they need and deserve.

Dr. Shechtman:
I think that is excellent. Emphasizing safety parameters is critical. I also think in a time of crisis, communication and education is critical to help disseminate not only accurate but reliable information. There is a lot of information out there, and I think it's important for, especially our listeners here, to note that you're getting the information from credible resources. We are in this together, and together we'll get through it.

Unfortunately, that is all the time we have right now, so I wanted to thank the audience for your participation. It's been an honor and a pleasure to be doing this particular talk with Dr. Charles Wykoff, joining me today and sharing some of his valuable insight. I will be speaking to you all in the future. Thank you so much.

Dr. Wykoff:
Dr. Shechtman, thank you very much. Great discussion.

Announcer:
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