

Profitable Partnerships via Co-Management

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Disclosures
All Conflicts Have Been Mitigated

<p><i>Allergan</i> Advisor Alcon Advisor and Speaker Aerolux Advisor Astellera Advisor Aurelia Advisor Azura Advisor Bio-Tissue Advisor and Speaker Biosite Advisor B&L Advisor and Speaker Dampc Advisory and Speaker Johnson and Johnson Advisor Speaker Kala Advisor and Speaker Lumera Advisor and Speaker Neovartis Novartis Advisor and Speaker Ducloft Advisor</p>	<p><i>Ocuvite</i> Advisor Oyster Point Advisor and Speaker Orion Advisor Optivium Resource Partner Quidel Advisor RA Advisor and Speaker Science Based Health Advisor and Speaker Sightlife Sight Science Advisor and Speaker Sun Advisor and Speaker Teva Advisor Thera Advisor Truista Advisor Venzol Advisor Viva Advisor/Quidel Advisor</p>
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Financial Disclosure: Jerry Robben, O.D.
These Disclosures have been mitigated

<p><u>Speaker/Consulting</u></p> <p>Allergan/Abbvie Bausch & Lomb Bio-Tissue E-SWIV EyeVance I-MED Pharma Johnson & Johnson Vision Kala Pharmaceuticals Novartis Oyster Point Santeni Sun Pharma Tangible Science Tarnis Viatris X-Cel Specialty Contact Lenses PECCA</p>	<p><u>Research Investigator</u></p> <p>Alcon Allegion Alvita Pharmaceuticals Bausch & Lomb Chari Pharmaceuticals Formosa Pharmaceuticals Hologic Scientific Johnson & Johnson Vision Kala Pharmaceuticals Kowa Research Institute Oyster Point Nicon Ophthalmics Novartis Novartis Biopharmaceutics Rescorp Insight, LLC Santeni Sun Pharma Global FEZ Surfont Ophthalmics Surgent, Inc. TearSolutions, Inc Viva Therapeutics</p>
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Office of Inspector General (OIG)

- Issued specific guidelines on co-management
- Co-management is legal
- Case by Case Basis – Can't be considered routine
- Transfer of care occurs with medical stability and is in writing
- Patient must agree to being co-managed (informed consent)
- Patient agrees to return to the operating surgical facility if complications
- Fees must be disclosed to the patient

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Office of Inspector General (OIG)

- Must disclose the education of each provider along with the governing body for each profession ie State Board of Optometry and State Medical Board
- Payment is according to work performed
 - Percentage of the post-operative 90 days commencing with the written transfer of care

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Discussion

- Benefits and potential pitfalls to look for and avoid regarding crossing your Tx and dotting your i's
- The patient that doesn't want to return to their referring optometrist
 - How to handle that delicate situation
 - Steps that referring optometrists can take to avoid that confrontation
 - Communications with the referring optometrists
- The patient that just wants a refraction after surgery by the surgeon's office
- Benefits to the surgeon, benefits to the referring optometrist and benefits to the surgical patients
- Hot topic
 - Fees for advanced technology IOLs
 - Which fee is involved in that decision?
 - Fee's for work provided
- What happens when a patient is returned to the surgeon for complications?
 - Transfer of care?
 - Fees?

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Optometric Co-Management

- High quality eye care
- Benefits to patient care
 - Patient comfort
 - Patient convenience
 - Efficiency
 - Cost effective
- Utilize skills and expertise of each practitioner

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What's Being Co-Managed in Your Center?

- Cataract
 - Refractive cataract surgery
 - LASIK and PRK
 - Capsulotomy's
 - SLT
 - Fornix Restoration for Conjunctival Chalasis
 - Pterygium Surgery
 - Plastics
- Panel Discussion
 - What is being co-managed in your individual practices?
 - What are procedures are on the horizon for co-management?
 - What training needs to place prior to co-management?

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Today's Optometrists

"To be on the cutting edge of optometry, you need to be on the cutting edge of science and technology."

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Why Is This Important For Optometry?

- 4 out of 5 patients diagnosed with a cataract are done so by an optometrist
- Optometrists are the "gatekeepers" to cataract referrals and ATIOLs
- Referring O.D.'s must discuss all IOL options and educate patients about cataract and treatment options

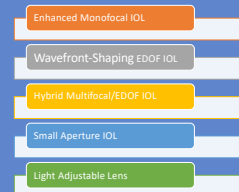
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Patient Education

- Elements of effective education
- Explain the condition
 - Cataract
 - Astigmatism
 - Presbyopia

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Today's Presbyopia-Correcting IOL Options



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It is important to choose the correct IOL for the individual patient.

Considerations:

- Visual needs
- Lifestyle
- Daily activities
- Concerns about dysphotopsia
- Comorbidities

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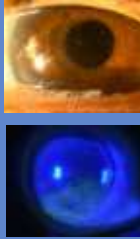
Expect (Avoid) the Unexpected!

- Pre-op for Lifestyle IOLs
 - Topography, ocular surface testing
 - Macular OCT
 - Reliable biometry, reproducible astigmatism measurements
- Under promise and over deliver for ATIOLs
 - Emphasize need for +1.00 readers for near tasks ***
 - Discuss starbursts around lights at night

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Preparation for Ocular Surgery


- Optimize the Ocular Surface
- Normalize the Lids
- Prepare the Cornea
- Eliminate Intra-ocular Inflammation
- Control Glaucoma
- Satisfy the Macula
- Evaluate the Retinal Periphery
- **Patient Education**



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Dry Eye Disease

- Chair time: blurred vision from cataracts versus DED
- Cataract sx can worsen DED for months after surgery
- Quality of vision may require chronic DED therapies



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Prevalence of ocular surface dysfunction in patients presenting for cataract surgery evaluation

Price E, Gupta RB, Hoss J, Shalagin JJ, Kirk W, Tardif JL

Results: There were 120 patients (69% women), mean age 69.5 years ± 8.4 (SD). Abnormal corneal topography was found in 60 patients (50.7%), and abnormal MWF-Q in 70 patients (58.3%). Clinical findings showed that 47 patients (39.2%) had positive corneal staining on presentation, 19 patients (15.8%) had epithelial basement membrane dystrophy, and 2 patients (1.6%) had Salzmann nodules. Questionnaire data showed 54 (45.0%) of 120 patients reported symptoms suggestive of ocular surface dysfunction. In the asymptomatic group of 46 patients, 30 (65%) had at least 1 abnormal tear test (osmolarity or MWF-Q) and 22 (48%) had both tests abnormal. Overall, 98 (82%) of 120 patients had at least 1 abnormal tear test result suggestive of ocular surface dysfunction and 49 patients (40%) had 2 abnormal results.

J. Cataract and Refractive Surgery 2018

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Post Op Pearl: Proactive Treatment of Ocular Surface Disease

PHACO Study: Prospective Health Assessment of Cataract Patients Ocular Surface

- Purpose: to determine the prevalence of dry eye in patients undergoing cataract surgery
- 136 patients, 272 eyes having cataract SX
- Avg. age 70
- Test used Shimmer's, TBUT, corneal staining, and subjective questionnaire
- Results:
 - 171 eyes (62.9%) had a tear break-up time of less than 5 seconds
 - 209 eyes (76.8%) showed positive corneal staining
 - 136 eyes (50%) showed central corneal staining
 - Shimmer's Scores: 132 eyes (48.5%) had a score of 10 or less, and 58 eyes (21.3%) scored less than 5

Trotter W, Goldberg D, Reilly C. Incidence of concomitant cataract and dry eye: prospective health assessment of cataract patients. Presented at World Cornea Congress, April 8, 2010; Boston, MA.

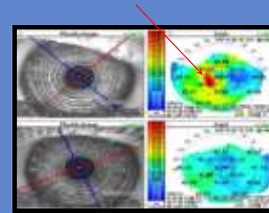
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Discussion

- What are your expectations, testing or treatment prior to referral?
- How do you manage patients that have not been identified with OSD but discovered within the surgical practice
- Slippery slope of a discussion with the patient. How is it handled?
- Tests being run in the surgical practice to detect dry eye disease by various practices.
- Treatments being provided in the surgical practice to OSD patients?
- Advise for referring doctors in screening, testing, and treating the cataract or refractive surgery patient
-

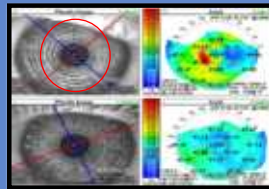
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“Hot spots” and “Flat spots” are abnormal



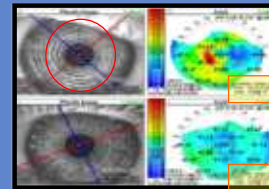
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Irregularly shaped or smudgy placido disk is abnormal!

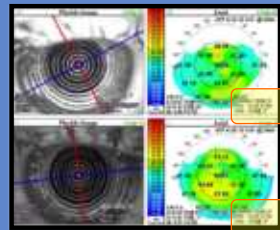


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Take a closer look if average K values are different



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Other Corneal Issues

Can Limit Visual Outcome:

- Fuch's
- Corneal Scar (RK, AK)
- Salzmann's nodular degeneration
- Lagophthalmos
- Exposure Keratitis
- ABMD

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Pearl: Pick the Right IOL

- You know your patients better than the M.D!
- Develop a refractive treatment plan and goal
- Options: 1. Distance only
 - Toric, traditional, LRI's, Arcuate incisions
- 2. Distance and Intermediate
- 3. Distance, Intermediate and Near
- Send written letter of surgical goal/plan to surgeon prior to pre op consult

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REVISION/UPDATE

An algorithm for the preoperative diagnosis and treatment of ocular surface disorders

Christopher E. Starr, MD, Pradyu E. Gupta, MD, Hanyar Farid, MD, Kenneth A. Rademan, MD, Clara C. Chen, MD, FRCSC, Elizabeth Sze, MD, Ian A.P. Gomes, MD, PhD, Brandon J. Ayers, MD, John P. Rosta, MD, Edward J. McDevitt, MD, Terry Kim, MD, Francis S. Mak, MD
 The ACRS Clinical Committee

An algorithm for the preoperative diagnosis and treatment of ocular surface disorders
 Starr, Christopher E, et al.
 Journal of Cataract & Refractive Surgery, Volume 45, Issue 5, 669 - 684 2019

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5 Pearls ("P's") for Success

- Plano Outcome
- Proactive Tx of Ocular Surface Disease
- Pre Op Counseling – Setting Realistic Expectations
- Properly Screen Candidates
- Pick the Right IOL

Other:

- Pick the Right Surgeon
- Posterior Capsular Opacification
- Poor IOL Centration

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Postoperative Complications

- 1 day – High or low IOP
- 3-7 days – Endophthalmitis
- 2-3 weeks – Steroid Responder
- 3-4 weeks – Iritis/Uveitis
- 3-6 weeks – CME
- 1-3 months – Posterior capsule opacification

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20/Unhappy

Causes of unhappiness

Woodward WA, Rendleman JB, Stilling PD. Dissatisfaction after multifocal intraocular lens implantation. *Journal of cataract and refractive surgery*. 2012;38(9):962-967. doi:10.1016/j.jcrs.2012.01.001

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Neuroadaptation of Multifocal IOLs

- Patients' expectations of time frame needed to adapt needs to be managed
 - These patients require more counseling post-op
 - Neuroadaptation can take as long as 6-12 months
 - About 10% never neuroadapt (will need IOL exchange)
 - No way of testing before surgery which patients will be able to adapt vs not
- Multifocal IOLs will induce more aberrations than monofocal IOLs

Take away: no YLC to be performed until rule out that IOL exchange is necessary

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Donnenfeld's Five C's for Unhappy Patients

- Cornea
- Cylinder
- Centration
- Capsule
- CME
- (6) You can't fix crazy

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Refractive Enhancement: Laser Vision Correction (LVC)

- Timing is everything!
- Wait at least 2-3 months after cataract surgery for wounds and LRIs to settle
- Nd:YAG posterior capsulotomy **BEFORE** LVC
 - No YAG in multifocal IOL that was never happy



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Managing the Unexpected Outcome: Have an Algorithm to Identify the Issue

- Develop communication with your staff regarding dissatisfied patients
 - Encourage clinic techs to communicate patient satisfaction to you
 - Have work-up done before you see the patient
 - [MRK BCVA/Topo/OCT/Ocular surface testing](#)
 - Have a plan to fix the problem before you enter the room!

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Co-management Pearl

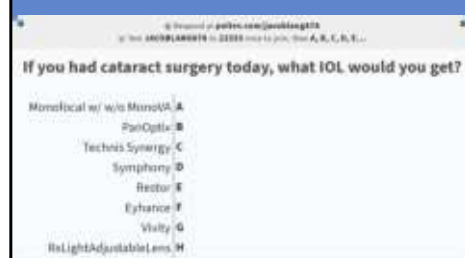
- Opportunity to provide cutting edge technology
- Importance of your recommendation
- Patient education is critical!

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Co-management Pearl

- Identify potential causes of surgical complications
- Educate your patients your role within medical eye care
- *We are all judged by the visual outcomes our patients. Comfort and quality of vision is the key!*

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Refractive Opportunities

- Case 1;
- 38yo
- +6.00-1.50x180 OU
- w/ +1.00 add
- Desires spectacle independence

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Biometry

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Refractive Opportunities

- Options?

Parameter	Current	Target
CCV	3.00	3.00
AD	3.00	3.00
ACD	3.65	3.65
LT	3.25	3.25
WTW	13.50	13.50

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Refractive Opportunities

- What would you recommend?

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What surgical intervention would you recommend?

- LASIK
- SMILE
- RLE, Toric IOL, MonoVA
- RLE Multifocal IOL
- WAIT

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Refractive Opportunities

- case 2;
- 54 yo -11.00 +2.25 add

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Refractive Opportunities

- Options?

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What surgical intervention would you recommend?

LASIK
 SMILE
 RLE, Toric IOL, MonoVA
 RLE Multifocal IOL
 WAIT

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Refractive Opportunities

- Studies on cataract surgery outcomes show that; 50-70% within 0.5 D
- 79-94% 1.0 D of the intended target
- A study of patients undergoing placement of toric IOLs found that 88% had less than 1.0 D of astigmatism postoperatively.

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Patient Satisfaction

All-implanted analysis set at 6 months post-op

Response	Trifocal n (%)	Monofocal n (%)
Patients never wearing glasses?	8%	80%

8% Monofocal **80%** Trifocal

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Refractive Opportunities

Hindsight is 20/20?
 Adjustable

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Adjustment Beam → **Photopolymerization** → **Diffusion and Power Change** → **Lock-In Beam** → **Final Focus**

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Prediction to Prescription


Standard cataract procedure



17-21 days

Lockin Modified Shape Polymerization Light exposure

Residual refractive error is determined using standard phoropter



RxLAL and RxSight LDD TREATMENT RANGE

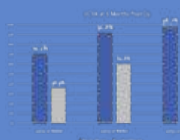
SPHERICAL -2.000 to +2.000

CYLINDRICAL -0.250 to +

AXIS 0-180

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- LAL eyes achieved UCVA of **20/20 or better** at 6 months postoperatively at approximately **2x** the rate of patients receiving a monofocal lens
- 91.8%** of LAL eyes achieved result within **0.50 D** of target MRSE (similar to LASIK results)
- Superior Quality of Vision** at all measures compared to control lens:



LAL FDA Clinical Trial

U.S. FDA Clinical Study
Prospective Randomized Study
NCT01107449 (LAL vs. Monofocal)
Control Treatment: Monofocal
U.S. Sites:
Wentz and Associates, LLC
Comprehensive Ophthalmology and Eye
Care Center

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- Refractive Opportunities**

Multifocal IOLs

Strategies;

Bi-Tri focal extending depth of focus **accommodating**

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- Refractive Opportunities**

Multifocal IOLs

Strategies;


Bi-Tri focal extending depth of focus **accommodating Crystals?**

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- Refractive Opportunities**

Bi-Tri and Multi-Focal

restor
panoptix
Technis Multifocal and TMFI
Technis Synergy




50% distance, 25% intermediate (24"), 25% near (16")

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- Refractive Opportunities**

Extended depth

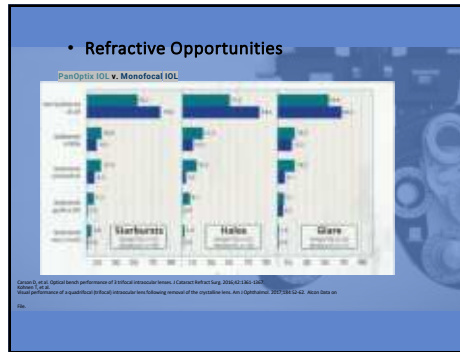
symphony/EyeHance
vivity



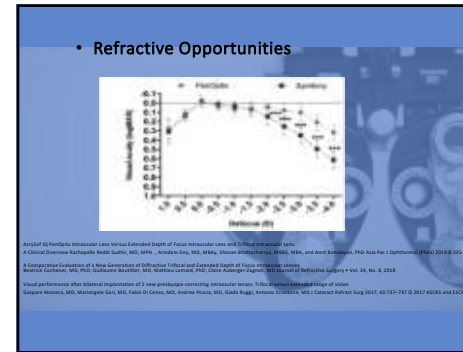
Extended Depth of Focus (EDOF)
-not splitting into distinct focal points, but extension

Continuous vision with high image contrast

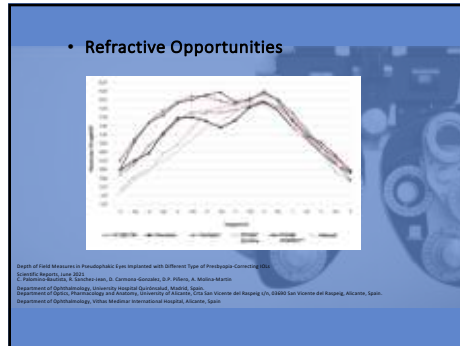
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Drops on top?

Emerging medical presbyopia options and their possible interactions with these patient populations

(Vuity Approval)

Method of action and its implications on MF IOLs

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JRL Case Discussion;

62 yo M
 Started latanoprost 2009
 Tmax 28OU, Pachy 485, 487
 stable poag since (IOP aprox 15, Target upper teens)

Habitual Rx approximately +2.00 with +2.50 add
 Developed a -2.00 myopic shift secondary to NS and va
 dropped to 20/40

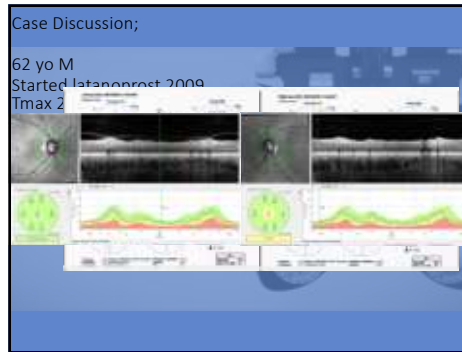
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Case Discussion;

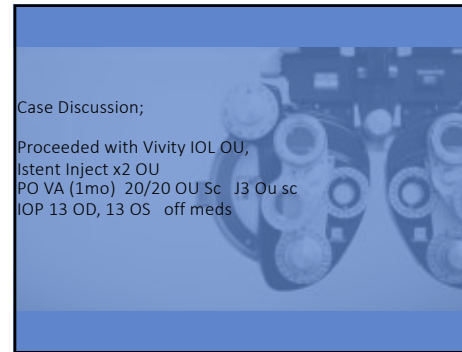
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