ASCRS EYEWORLD SUPPLEMENT TO EYEWORLD AUGUST 2020

Turning the Lights Back On

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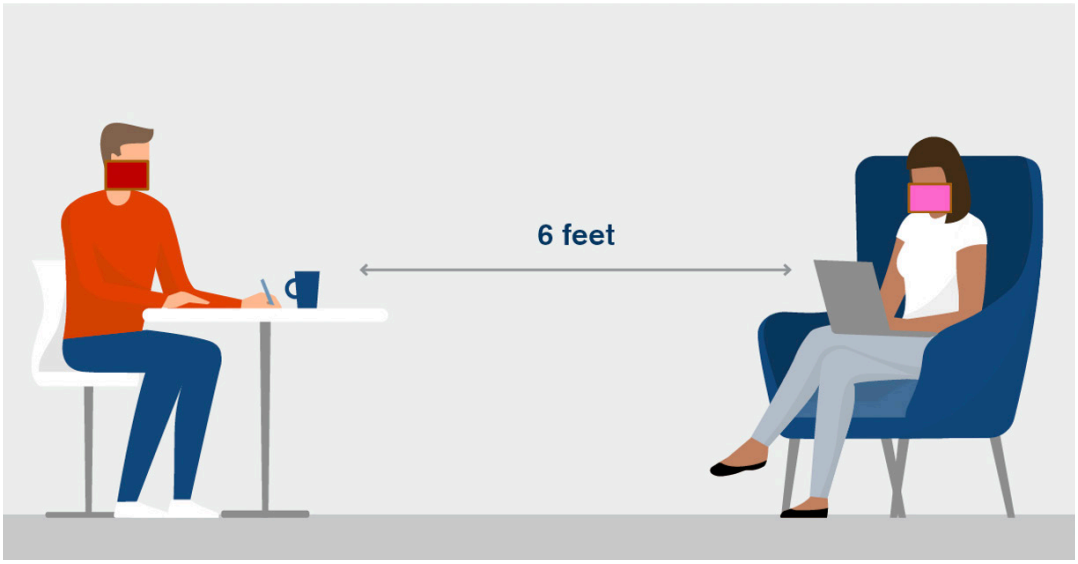
Ophthalmology as a medical specialty has been hit hard in the COVID-19 pandemic, and ophthalmic practices have just started to regain their sea legs, figuring out how to steady themselves amid the safety concerns, financial hardships, and other unknowns.

The 2020 ASCRS Virtual Annual Meeting, which took place May 16–17, featured a two-part special session, Turning the Lights Back On supported by Alcon, to specifically address the unique challenges and opportunities the COVID-19 pandemic presents to ophthalmology. This resource features key content from this session and additional thoughts from notable physicians.

Bringing back refractive cataract surgery

by Vance Thompson, MD



Spacing out or blocking chairs in the waiting room and during counseling is one way to help reduce potential exposure among patients and staff.

Source: Vance Thompson, MD, screenshot from the 2020 ASCRS Virtual Annual Meeting

Presbyopia patients, even in this COVID-era environment, want to hear about all of the solutions for implant technology during cataract surgery. In fact, they seem, in my experience, to be even more interested now.

We've been amazed at our practice because since reopening for elective surgery, the adoption rate for premium implants has actually been higher than pre-COVID. People seem eager to invest in themselves and their true desires, so they've been open to premium implants, and refractive surgery has been quite popular.

Since the ASCRS Virtual Annual Meeting in May, we've seen a significant return in volume. We're back to about 90% of normal, pre-COVID patient volume, and that happened faster than I predicted. Will it be sustainable? That's what we all wonder.

While we haven't changed how we counsel patients or how we present them with premium IOL options, there is no question, some elements of "normal" clinic practice have changed—they had to.

In the new "normal," patients are very open to remote telemedicine and consults, enabling the doctor to educate them about cataracts and options using existing educational resources. Advanced testing and the examination, of course, can't currently be done remotely. Patients just want you to do your best. Explain what you can do remotely and explain what you can't.

The patient journey at our practice has shifted somewhat. Before the pandemic, information was mailed to patients prior to cataract consultations. They were encouraged to watch an informational video, which many didn't do ahead of time. Now, in order to even set up a telehealth cataract consult, patients have to watch the video. The technician gathers information from the referring doctor for this telehealth visit, preparing a chart for the doctor as they would have if they had been in the office. If a decision is made for an IOL type during the telehealth visit, patients are reminded that this IOL selection could change on surgery day based on certain factors.

With so much happening remotely, by the time we get to the surgery day, we're just double checking the numbers, doing the exam and final counseling, then going into surgery.

Enhanced safety measures for in-office and OR visits

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Turning the Lights Back On

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don't have to be a barrier to the patient experience; it can be a great opportunity to show your patient how much you care. Get rid of the coffee station (and snacks, if they were offered before), space chairs adequately in a waiting room and between patients and staff, and require that all patients and staff wear masks. A lot of our waiting room is now in our parking lot vs. our lobby.

But we still want a great experience. We still use our form to know Mrs. Johnson in the brown coat is sitting in which chair, and we can walk right up to her. Even with social distancing and masks, we're still smiling, providing eye contact, addressing patients by name.

Often, the missing link keeping some practices from reaching their fullest potential is the big E: the patient experience.

With all the new considerations during this time, why work on increasing refractive cataract surgery at this time? You want to make patients happy. What follows patient satisfaction is an increase in the financial health of the practice.

For example, a practice that does 5% premium cataract surgeries in 500 eyes (25 premium IOLs/year) could translate into a $50,000 net profit for the clinic. A practice that performs premium cataract surgery in 40% of its patients (200 premium IOLs out of 500 patients, for example) could see a net profit of $400,000.

As with before the pandemic, we still have to educate our patients to the point of: What type of cataract surgery would they want if they had my knowledge and experience? That's the goal—to educate them to that extent. These patients need to learn that if they are going for a postoperative result as close to plano as possible, a

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Staff training and protocols in the clinic and OR

Daniel Chambers, MBA, COE, and Regina Boore, MS, BSN, discussed considerations for reopening the clinic and ASC, respectively, during the Turning the Lights Back: Part 1 session.

Both discussed the importance of staff communication and training for new policies and procedures. Mr. Chambers stressed a calm, firm, positive approach to communications.

To address concerns of staff and patients, extra housekeeping measures should be implemented around the practice, and patient flow and volume should be adjusted with tiered increases, he said. Mr. Chambers shared how patients and staff are screened and questioned before entering the practice, and patients wait in the parking lot until their appointment time. The practice also established drive-thru IOP checks, offered telemedicine visits, and suggested hybrid, diagnostic-only visits with a remote telemedicine call with the doctor afterward.

At ASCs, Mr. Chambers suggested avoiding overlapping surgeons in block scheduling.

Essential guidance sources for ASCs, Ms. Boore said, include the federal government, CMS, CDC, OSHA, state departments of health, accrediting organizations, and other professional societies. PPE and disinfection have always been a staple in operating rooms but to a greater extent now amid the pandemic.

"Universal masking is the standard of care in this COVID period," Ms. Boore said, adding that the N95 respirator masks are only required during general anesthesia and aerosol generating medical procedures (AGMP), such as bronchoscopy, upper endoscopy, etc.

She also mentioned that disinfectants need to be EPA-approved against SARS-CoV-2.

Policies and procedures that should be addressed, at a minimum, Ms. Boore said, include those involving:

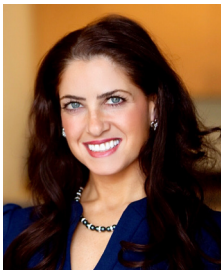
- visitors
- surgery scheduling
- universal masking
- appropriate use of PPE
- disinfection of non-patient care environment in the ASC
- patient COVID-19 screening
- a post-exposure plan
- social distancing
- a respiratory protection program if performing general anesthesia or AGMP

ASC staff need to be trained in all new and revised policies and procedures (which should be updated in response to current COVID-19 trends).

"Any time you launch new policies and procedures, you have a need for new staff training and in service," Ms. Boore said. She added that some training elements should include infection control at the facility, PPE management, scheduling procedures, social distancing measures between staff members as well as between staff and patients, and updates to the employee handbook. Ms. Boore also said ASCs should conduct an updated hazard vulnerability analysis, a new infection control risk assessment, and consider new cleaning products, scheduling changes, and staffing changes.

Editors' note: Mr. Chambers is the executive director at Key-Whitman Eye Center in Dallas/Fort-Worth, Texas. Ms. Boore is a principal and senior vice president at BSM Consulting and is based in San Diego, California.

Implementing tele-ophthalmology during (and after) the COVID-19 pandemic



by Ranya Habash, MD

How has telemedicine changed our practice amid the pandemic? In February our institution had three telehealth visits. By the end of May, we had nearly 4,000.

Initially, it may have seemed difficult to apply telemedicine to ophthalmology, but we've now seen the proof; not only is it applicable, but there is a vast range of services we can offer our patients.

This is a Darwinian moment for all of us. It's a time when we have to adapt to survive, so it's very important for us to think creatively, think outside the box, and to have some practical solutions. In fact, it's a great opportunity to spur medicine forward.

CMS expansions during the COVID-19 pandemic were a game changer for us in terms of truly getting telehealth off the ground in ophthalmology. Medicare started reimbursing for telehealth services at the same rate as regular, in-person visits. Prior authorization requirements were suspended. HIPAA requirements were relaxed to allow interactions to take place on consumer-based technology. Time-based billing became the norm for physicians; this is total physician time (time reviewing medical records, time talking to the patient, time documenting, and time coordinating care afterward). Phone calls became reimbursable at the same rate as video and E/M visits. All of these factors enabled the widespread use of telehealth and gave our patients the access to care they've always needed.

In terms of the types of visits that can be conducted

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Telehealth best practices

1. Engage office staff. This has been the No. 1 factor that has helped us spur our telehealth offerings tremendously.

2. Structure your office line to allow for telehealth triage. Allow patients to request telehealth visits and be routed accordingly.

3. Be proactive. Go through existing schedules to see who is amenable for telehealth visits, high-risk patients who should be kept out of the clinic, etc. Identify these patients and label them for telehealth visits.

4. Add a telemedicine consent to your patient registration forms. This way the patient always has a telemedicine consent on file. This must be updated annually.

5. Develop templates for telemedicine encounters. Documentation should include consent obtained, patient location, mode of communication used, and time spent.

6. Follow your same standard operating procedure. Stick to how you would run a clinic visit in person as much as you can remotely; this includes your technician and your scribe helping you with the visit.

7. Market your offerings. Announce that your practice is offering telehealth visits during the pandemic and beyond.

8. Keep it simple. Telehealth is easy to overcomplicate, and the simpler we can keep it, the better.

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monofocal implant will maintain or worsen the presbyopia that they might already have and that a multifocal implant, for example, gives them near vision similar to someone in their 30s. One of my recent studies with trifocal IOLs found 99.2% of patients who received this lens said they would get it again, while 89% in the monofocal control group said they would get that option again.

Both options can make patients happy, but patients deserve a choice.

Editors' note: Dr. Thompson is the founder of Vance Thompson Vision. He practices in Sioux Falls, South Dakota.

Keys to bringing back refractive cataract surgery

1. Realize patients still want lens options.
2. Explain what can and can't be done remotely to the patient.
3. Educate patients on what premium IOLs offer.
4. Provide a safe environment in your center.
5. Create a quality patient experience.

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via telehealth, at Bascom Palmer Eye Institute we are performing a whole array of telehealth services for new, follow-up, and post-op patients. These include urgent care/triage visits, doctor-to-doctor consults, virtual counseling, second-opinion consults, hybrid televisits, drive-thru IOP checks, resident/ER tele-staffing, and remote slit lamp exams.

One of my most successful telehealth visits has been discussions about cataract surgery and advanced technology IOLs. We use this tele-counseling time to talk about the kind of outcome patients are expecting and how they want to see. They're at home and in front of their computers, and the really precise patients will tell me, "I'm 16 inches from my computer screen now," as they come to understand what their "intermediate" vision would be with an advanced technology IOL. You really get to see them and the way they work in their home environments. They seem more relaxed in these visits; I'm more relaxed in these visits. Oftentimes, their family is there in person or we invite them to join the video call; they participate, too. It becomes a completely different conversation, and I can't tell you how successful this has been.

I think if you're going to do cataract surgery, you should try to give patients the best visual outcome you can. It's about giving patients the freedom to see the price tag when they're shopping in the grocery store then being able to drive home, about seeing the menu in a restaurant without having to bring out the phone's flashlight but still recognizing a friend waving from across the room. That's all so important to our patients.

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Business planning and tax policy changes

To say that medical practices have had to adjust to survive as a business through the pandemic is an understatement.

In the Turning the Lights Back On: Part 2 session, Bruce Maller discussed what practices should be doing now not just to survive but to "hopefully get to the point where we can be paid a fair wage … while also seeing some return on the risk many of you assume as business owners."

"There are a few things I want to emphasize that will give you that feeling of control," Mr. Maller said.

These include understanding the value of forecasting, employing greater rigor in decision making, and learning how to more effectively align economic incentives.

When thinking about how to manage a business through a crisis, Mr. Maller broke it into three phases.

Phase 1: This is a time of survival, when the depth and breadth of the situation are unknown, Mr. Maller said. It's a time to engage staff, monitor daily/weekly cash flow, shore up your balance sheet, and size your cost structure appropriately.

Phase 2: This phase is when you wake to a new reality with a new mindset. At this point, Mr. Maller said it's important to determine what your new normal is in terms of breakeven. Create a 2020 forecast, refine your cost structure to align with your new reality, and find your footing, Mr. Maller said.

Phase 3: Shine a light on the future and begin to think ahead.

Mr. Maller said it's important to create a model for each line of business, look at historical results, calculate monthly averages, build your revenue forecast, review each line item or expense (forget historical norms and start at zero; identify things that are essential and non-essential), align cost structure to the new reality in terms of revenue, find your breakeven point, and model "what if" scenarios.

The federal government also made changes to help businesses through this challenging time. Jeffrey Kimbell gave an update on these efforts from Washington, D.C., including several tax provisions within the CARES Act to help businesses remain viable and retain employees.

Tax credits for idle workers: Businesses impacted by the pandemic can receive a tax credit for keeping idle workers on their payroll equal to half of what they spend on wages (up to $5,000 per worker). This tax credit, Mr. Kimbell explained, applies to businesses whose operations were fully or partially suspended due to a government order, a COVID-19 outbreak, or a significant decline in gross receipts. Mr. Kimbell also noted that employers cannot take part in this tax credit in combination with SBA/Treasury-backed loans.

Deferral of payroll taxes: The 6.2% employer payroll taxes can be deferred until the end of the year. Deferred employment taxes must be paid back over the following 2 years, with half of the amount due by Dec. 31, 2021, and the other half due by Dec. 31, 2022.

Net operating losses and other credits: Net operating losses arising in tax years beginning in 2018, 2019, or 2020 can be carried back to 5 years, Mr. Kimbell presented. The taxable income limitation has been temporarily removed to allow net operating losses to fully offset income.

Editors' note: Mr. Kimbell is the president and CEO of Jeffrey J. Kimbell & Associates and is based in Washington, D.C. Mr. Maller is the founder and CEO of BSM Consulting and is based in Incline Village, Nevada.

Reframing clinic flow in the age of social distancing

by Elizabeth Yeu, MD

It goes without saying that there has been significant trial and error with clinical protocols during the COVID-19 pandemic. Since the moratorium on elective care was lifted, we have steadily reinstated clinic volume and are now seeing about 80–90% of the pre-pandemic volume.

My cataract surgical volume is about 90% of pre-pandemic levels. The adoption rate to advanced technologies in my practice has been relatively stable, with about 40% of new patients adopting advanced technology IOLs. I've had a small percentage of patients who could not adopt an advanced technology IOL due to the economic changes of the pandemic. This has been offset by patients who were increasingly frustrated by the constraints of their declining, suboptimal vision and have the financial means to opt for more spectacle freedom.

At this time, social distancing and patient protection are our main goals, and how to accommodate this while increasing clinic volume is challenging. Additionally, we are trying to accommodate

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"Telehealth in ophthalmology, a specialty so dependent on high-quality imaging and in-person testing for diagnostics, does require a change in thinking about how to help patients."

—Ranya Habash, MD

I'm now devoting one full day to a telehealth-only clinic.

Hybrid televisits have been a game changer for us. We've designed a workflow where patients come in for a very targeted, focused exam. We contact them later with the results and discuss the plan virtually. This strategy keeps our staff employed and keeps necessary patients minimally exposed. It is also helpful for the post-COVID return-to-work backlog. Using hybrid visits, we're able to see patients in multiple locations on the same day. Our patients can now choose their most convenient location and have a visit within a more efficient timeframe, instead of having to wait for the limited days per month that we visit that location.

Lately, we've been using a video slit lamp adapter that allows the remote staffer to see the entire exam. This adapter was relatively inexpensive and has been a big help in our emergency room and during hybrid visits. There is also a drone slit lamp, which is technology that enables the patient to sit at a slit lamp that a doctor logs into remotely. They are able to see the images and control the slit lamp from any location.

For helping patients decide whether they should go to the ER or not during the pandemic, our urgent care telehealth clinic has been supremely helpful. We were able to triage patients and help roughly 70% of them virtually, while expediting patients who did need to come in. We were also able to identify those who needed immediate help who might not have sought it in time were it not for telehealth. One such visit involved a patient who seemed unable to see things on her left side during a virtual Amsler grid test. She was asked to come in immediately and an acute stroke was identified. That telehealth visit may have saved her life.

Telehealth in ophthalmology, a specialty so dependent on high-quality imaging and in-person testing for diagnostics, does require a change in thinking about how to help patients. I've found you can learn a lot about what's going on just by talking to the patient and by observing. That's more what telehealth is about. It's more about triaging patients; it's more about counseling patients than doing every single element on the exam.

This is like a Renaissance age for medicine. It's going to change the way we care for patients from here forward.

Editors' note: Dr. Habash is the medical director of technology innovation and an assistant professor of ophthalmology at Bascom Palmer Eye Institute, University of Miami Health System, Miami, Florida.

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our work family. We have a reduced staff, and some doctors have chosen to not return full time. Thus, we are trying our best to accommodate the patients who want to be seen.

These are just a few pearls for reframing your clinic flow in the new age of social distancing.

Pearl 1: Prepare patients for their visit. When we think about what our patients experience and think about eyecare and elective medical care, they're nervous. When we queried our internal patients, a sample of 5,500 patients among different locations, 25–50% said they were not ready to come in for a visit. Of all elective surgery patients who had surgery put on hold but as of May 1 were cleared, two-thirds wanted to wait on rescheduling at that time.

Contact and communicate with patients so they know ahead of time that things will (and must) look different. Set their expectations for what their experience will be like at their appointment. We created a video to help educate and prepare patients for what the exam will look like now and the safety measures that are being taken. Having these expectations expressed in a phone call, email, and letter is helpful. Patients need info about what they should bring to the office and when they should be arriving.

Pearl 2: Reduce face-to-face time in the office. We need to shorten appointments and try to automate the process, whether in remote or virtual visits. We had tried to split up new patient evaluations, which can take upward of 3 hours, with the patient's health and safety in mind. Unfortunately, this did not work out for most of our patients because it was more difficult to find transportation and support for two shorter visits than to come in for one longer visit.

I think we can change the frequency of follow-up appointments, especially for stable examples like glaucoma and dry eye. We've increased our telehealth offerings, but are finding these, in many cases, difficult to manage. Our specialty of medicine is difficult to shift follow-up appointments to virtual visits, and we have not been able to expand this to follow-ups beyond routine POD 1 for cataract surgery and some routine dry eye and glaucoma follow-up appointments. Surprisingly, post-surgical cataract patients have embraced virtual visits for the POD 1 appointment, and this has worked out well. There have been no undue surprises at their postop week 1 in-person visit. We adjusted our cataract surgery perioperative kit to include acetazolamide 250 mg dose in the recovery room and brimonidine 0.2% BID x1 to the operative eye.

Perform questionnaires and temperature checks before patients even enter the clinic.
Source: Elizabeth Yeu, MD, screenshot from the 2020 ASCRS Virtual Annual Meeting

Pearl 3: Observe the 6-feet distancing rule. Distance equipment and chairs in the waiting room. Separate the check-in and check-out locations (consider even having a satellite tent outside for check-in with automatic check-in freestanding stations). Ask that family and caregivers wait in the car to minimize bodies in the clinic.

Pearl 4: Prevent COVID-19 spread. Wear face masks at all times and have all clinic members and staff members answer questionnaires. At our clinic all patients and staff are getting their temperature checked. Patients are instructed to arrive no more than 10 minutes prior to their scheduled appointment.

With regard to surgery, we can consider PCR testing of all surgical patients. Avellino has a rapid PCR test where we can get results within 4–7 hours. My practice is not doing antibody or PCR testing, but all patients are rinsing their mouth with a povidone-iodine solution, which SARS-CoV is extremely susceptible to. Lastly, we're considering doing some immediate sequential bilateral cataract surgery to meet the needs of patients who have not been able to be cared for, particularly as the demand increases.

Pearl 5: Take care of your work family and promote goodwill. Clinic members are anxious as well and it may be

difficult for some to return to work, especially those who might have childcare or other issues. It's important that we have routine communication with them. We made more than 1,000 cloth face masks, and these kinds of small measures of goodwill carry a lot of weight.

Keeping our staff and work family safe is of utmost importance because without them none of the clinic flow is going to happen. Do everything possible to distance patients, make sure the balance of the patient volume coming in isn't too much, avoid traffic jams in the clinic, and make sure they have the protection they need as well. Everyone on our staff has at least two cloth face masks. If you have direct contact with patients, you need the N95 face mask. To reiterate, it's important to query patients, making sure you're not letting anyone in who may be symptomatic or may have had exposure. Limit those coming in from hospitals or nursing homes.

Editors' note: Dr. Yeu is an assistant professor at Eastern Virginia Medical School and practices at Virginia Eye Consultants, Norfolk, Virginia.

PPE and other safety considerations

Personal protective equipment (PPE) is essential in returning to and maintaining a safe ophthalmic practice for staff and patients alike. In the Turning the Lights Back On: Part 1 session, Francis Mah, MD, described the most basic of PPE for COVID-19, a respiratory virus: the face mask.

"Any face mask is better than no face mask," he said, discussing the different types of masks and face coverings that could be used, from cloth masks to surgical masks to N95 respirator masks.

"The reason we're wearing face masks … is because it does reduce spread," Dr. Mah said, from both symptomatic and asymptomatic patients. Dr. Mah also explained that while wearing a face mask doesn't protect one from getting infected (unless it's a properly worn N95 respirator mask), it does reduce efficiency of viral spread.

Patients should be encouraged to wear even a cloth face covering, if a surgical mask is not available, while doctors and staff should aim for having N95 masks and surgical masks.

Other strategies Dr. Mah discussed to prevent COVID-19 spread included limiting exposure by creating a new check-in process, making adjustments to the waiting room (if patients are allowed to stop and wait there at all), resituating staff work stations, and limiting talking within the exam room. Before sitting down at the slit lamp, Dr. Mah said doctors should tell patients they will not be talking during that portion of the exam and ask patients to refrain from talking during that close contact as well.

Matthew McCarthy, MD, who also spoke during the session, was among the first COVID-19 attendings at his hospital in New York City.

"I was on the ground floor figuring out best practices and figuring out how we were going to try to save people," he said.

At the time of the 2020 ASCRS Virtual Annual Meeting in May, Dr. McCarthy said he doesn't wear an N95 mask. He wears a surgical mask, eye shield, and gloves.

"The N95 mask is only recommended for aerosol generating procedures," he explained. "That being said, an ophthalmologist is going to be right in the patient's face for a long period of time, so it would not be unreasonable to wear an N95 mask and an eye shield."

Unless you have point-of-care testing where you can receive a result within 5 minutes of admitting patients to your clinic as to whether they have COVID-19, Dr. McCarthy said you should take universal precautions, assuming that every patient has it for the time being so that you are protecting yourself and your staff.

Dr. McCarthy discussed the different types of testing available and the challenges with them. Antibody testing, for example, tells you if you've been exposed to the virus, not if you are immune. That should be kept in mind if considering this as a factor for returning to work.

For a vaccine, Dr. McCarthy said he's skeptical that one will be available by early 2021, as some have suggested. Most vaccines take years to develop, he said, noting the special challenges with creating vaccines for RNA viruses, like coronavirus.

Editors' note: Dr. Mah is the director of the Cornea Service and co-director of the Refractive Surgery Service at Scripps Clinic, La Jolla, California. Dr. McCarthy is an assistant professor of medicine at Weill Cornell, New York, New York.

ASCRS EYEWORLD

Our journey together to help people see brilliantly continues. It connects us as an ophthalmic community and anchors us in tumultuous times. We are all in this together.

No matter where you are in the recovery process, Alcon is here to support you and your patients.

That's why we've created a new online resource with information and tools to help navigate these challenging times. We hope this helps on your journey to recovery so you can focus on the possibilities that lie ahead.

Steady As We Go

professional.myalcon.com/covid19-resource-center

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