Public health 101 - NALHN

Background

Optometry substitution clinic commenced 1st April 2019

Role

- 1-2 days a week
- Morning clinic: 4-6wk cataract post-op clinic
- Afternoon clinic: new patients
  - Diabetic screening, medication toxicity screening, stable glaucoma, DED, cataract pre-operative (non-urgent or semi-urgent patients)
- Collating data throughout the last 12months
  - Some unexpected findings with some interesting lessons learnt

Northern Adelaide Local Health Network - NALHN

- Modbury Ophthalmology moved from Lyell McEwin approx. 2 years ago
  - At GP plus prior to that
  - Same waiting list but larger catchment area for referrals at Modbury
  - Current Ophthalmology team
    - Dr Sudha Cugati
    - Dr Swati Sinkar
    - Dr Tim Gray
    - Dr Neena Peter
    - Dr Andy Simpson
  - Please send named referrals whenever possible

Modbury Ophthalmology OPD

- Make sure you are aware of the operations/scope of practice of your local public hospital
  - Modbury “General Ophthalmology”
    - 1x Consultant/ 1x Registrar 4-5days a week
    - Services take place in the outpatient department

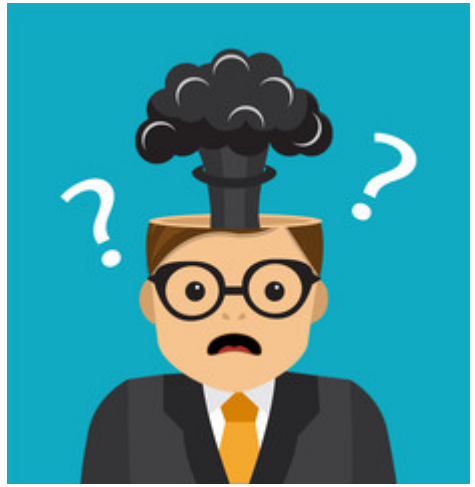
  - At present services do **NOT** include vitreo-retinal and paediatrics*
    - Urgent fl/fr patients are better to be sent straight to RAH
    - ERM/VMT and macular holes can be assessed/monitored at Modbury
      - Px would require referral to RAH if deemed suitable for surgery

Modbury Ophthalmology OPD

- How are referrals triaged?
  - Referrals received by bookings team and a triaging slip attached
  - All referrals passed to Consultants who triage appropriately
  - One of four outcomes
    - **Urgent**: An appointment arranged for the patient within a week
    - **Semi-Urgent**: Referral added to the semi-urgent waitlist – can be **12-18 months** before appointment available for patient
    - **Non-Urgent:** Referral added to the non-urgent waitlist – some patients waiting 6-8 years for an appointment
    - **Referral rejected:** Insufficient information to appropriately triage. Referral is sent back with the request for further information

Current waitlist numbers

- Currently over 2900 people on the waitlist
- Close to 250 new referrals every month
  - Approximately 90% of referrals come from Optometrists
- How does a non-urgent patient get an appointment?
  - Good question!! Will cover in more detail later



Pilot data – lessons learnt

- The impression of the waitlist prior to the start of the pilot was that it was GP referrals, which should've been sent to Optoms, that were clogging the waitlist
- Quickly determined this was incorrect:
  - Over 90% of referrals from Optometry
  - 50% discharge rate of patients from Optometry substitution clinic back to community optometry
    - Where is community optometry going wrong?

Reasons for discharge

- Incorrect diagnosis of ocular health e.g.
  - Cataracts commonly misdiagnosed when underlying pathology was DED or Dry ARMD
- Conditions better monitored by community Optometry e.g.
  - Stable diabetics with minimal-no diabetic retinopathy
  - Dry eye disease
- Patient already under private Ophthalmology care

NOT practising full scope Optometry

- Patient is discharged back to community Optometry for one of the following reasons:
  - Incomplete testing performed on patient
    - “Tick and flick” approach to Optometry
    - Can’t assume that for a patient with decrease BCVA with a cataract that the cataract is the sole cause of vision drop
    - Regularly seeing referrals with no:
      - Dry eye workup
      - Posterior pole examination!! (preferable DFE)
      - VF when px’s presenting complaint being trouble with driving
  - **Does the level of cataract correlate with decrease BCVA??**
    - **No? Look further!!**

Inadequate px communication and follow up

- Keep in mind waitlist times when referring to the public health system
  - Duty of care to the patient
  - Ensure to arrange appropriate review schedules to monitor patient despite placing patients on Modbury waiting lists.
    - Patient may develop a secondary pathology in the meantime which needs to be seen urgently
    - Make sure patient in aware of the importance of this – your duty of care

Inadequate px communication and follow up

** **Update referral when change in ocular health of BCVA is noted**

- No point in referring a 6/7.5, 6/9 cataract with the thought that “it will be worse by the time they get to the top of the waitlist”
- This patient will be triaged as non-urgent and in the present climate will not move due the appointments being taken by semi-urgent/urgent patients
- Best way to move up the waitlist is to provide updated information of worsening condition
  - Will be triaged again

Lack of inter-optometry referrals

- As an industry we are not utilising this as much as we should
  - Complicated by corporate pressures and concern with losing patient
  - Need to develop relationships/understanding with local optom network
  - If cost of further testing an issue, then utilise Elizabeth Eye Care
    - No cost for OCT etc

- At a minimum:
  - Discuss atypical cases with fellow Optoms before referring
  - If a patient is discharged and you don't feel comfortable managing/monitoring refer to another Optom before referring back to the hospital

Cataract patient pathway

- Referral received and triaged appropriately
  - **Non-urgent** in most cases, **semi-urgent** if close to driving standards, CF/LP or density of cataract is affecting the ability to manage/treat posterior pathology, **urgent** if bilaterally blind
  - First appointment: Preoperative assessment
    - Px assessed for suitability for cataract surgery, confirm that VA drop is solely from cataracts and no other underlying pathology
    - If suitable px is placed on surgical waitlist in one of the following categories:
      - CAT 1: Surgery within 30days
      - CAT 2: Surgery within 90days
      - CAT 3: Surgery within a year
  - Biometry is performed on the same day or if the clinic is busy, they are booked in on another day

Cataract patient pathway

- Day surgery at Modbury Hospital
  - Local anaesthetic, no general (unless indicated)
  - Patient needs to be able to lie flat for 30-45mins
  - Teaching hospital – hence surgeries are performed by the training registrars
  - Should expect to be at the hospital for half the day
  - Px returns to OPD the following morning for 1day post-op
  - Uses Pred Forte 1% QID, Chlorsig 0.5% QID for 4/52
  - 4-6wk post-op appointment
    - If other eye requires surgery, they are placed back on surgical waitlist
    - Actively discharging patients who have had both eyes done whenever possible
- **Know the cost of private cataract surgery with your local Ophthals – ensure patients are aware of this cost before sending them to the public system**

How can community Optometry help?

Contact local private Ophthalmologists

- Know the price of cataract surgery without private health
- Consider referrals for YAG laser capsulotomy, iridotomy, retinal laser, removal of lumps and bumps etc to the local ophthalmologists
- What is the GAP for initial consult? Ophthalmologists can always refer to public if patient cannot afford treatment privately
- Ensure you are offering patient all the options
    - Surprisingly some patients will willingly pay for surgery especially if vision affects their quality of life
- If you suspect any sight threatening disease like GCA, please pick up the phone and discuss with the ophthalmologists

Future directions

Case Based examples

Case 1

Referral received with the following information:

- Routine eye examination of patient noted a decrease in BCVA LE from 6/4.8 to 6/9
- Patient a diabetic
- External examination noted cataracts NO2NC2 C1 OU
- Internal examination noted LE cystoid macula oedema on OCT
    - Image of OCT was not included

Case 1

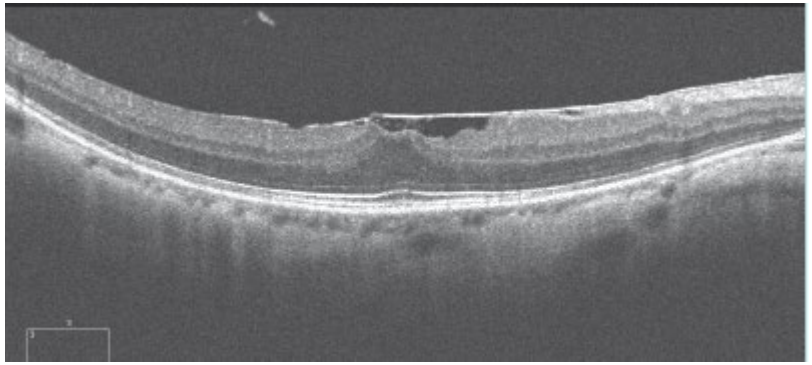
Is this enough information to appropriately triage?

What else would you include?

- Patient's refraction and/or any refractive change
  - Changes to refractive error can link with pathology
- Amsler
  - Any metamorphopsia present?
- Further information on DM and systemic health
  - Type? BSL? Controlled? Treatment? Other DM complications? Etc
- Macular appearance on fundus examination
- Copy of OCT image

Case 1

- No change to refraction
- Type 2, onset 2 yrs ago, latest Hba1c 6.2%, currently treated with metformin and HT/HC medications. No DM related complications to date.
- Amsler showed mild central LE metamorphopsia
- LE fundus examination showed an ERM with mild traction
- OCT image:



Case 1

Patient is suffering from an LE ERM

- More appropriately triaged as semi-urgent
  - Important to ensure you are confident interpreting imaging
  - Make sure referrals are detailed to ensure patient is correctly triaged

Referral essentials

Ensure to always include:

- What referral is for i.e. Cataract assessment
- Patient's DOB
- Relevant history information
- Visual acuity (or change in acuity/pin hole)
- Refraction (or change in refraction)
- Screening tests where applicable (i.e. pupils in neuro)
- External ocular health
- Internal ocular health
- Any additional tests or imaging

Referral essentials

More specifically:

Glaucoma:

- Ensure a full glaucoma workup is done before referral
  - Include all information i.e. risk factors, IOPs, CCT, angles, disc assessment, VF and OCT (if applicable)

AMD

- Remember patients with dry AMD noticing a sudden change in vision need an OCT
  - If this is sent it will aid in triaging
  - If OCT not available investigate inter-optometry referral or ensure an amsler and detailed fundus examination is done prior to referral

Please note: Chalazia, conjunctival cysts are better referred to private due to the long waiting in public hospitals. They can be performed as outpatient procedures.

- In addition lid surgeries like ectropion & entropion can be performed as outpatient procedures in the clinics and can be referred to private to avoid waiting time.