COMANAGEMENT

Grand Canyon 2018

Regional Ophthalmology Meeting

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OPHTHALMIC MUTUAL INSURANCE COMPANY

Risk comes in many forms

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Disclosures

- Dr. Briceland and Linda Harrison have no financial interests to disclose.
- We will not be discussing off-label use

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Risks of poorly comanaged patients

- Delay in diagnosis or treatment
- Failure to follow-up
- Patient confusion
- Lawsuits

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Communication Breakdown

Communication

- 3rd most frequently identified root cause of sentinel events in medical errors (Joint Commission study, 2015)
- At least **50% of these occur during "hand-offs"**

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Objectives

After participating in this presentation, ophthalmologists will be better able to:

- Develop guidelines for comanagement
- Communicate needed information during patient hand-offs
- Manage patient expectations

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Comanagement

- Federal statutory guidelines regarding comanagement fee structure
- Fee guidelines dictate shared care responsibilities

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Comanagement

- STATE REGULATIONS
  - State board regulations of professional behavior: medical and optometric
  - Referral behavior and expectations

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Case 1: Bilateral Blepharoplasty

- 12/3/15: visit with Ophthalmologist #1:
  - 1-mo hx swollen upper lids; interfered with ability to see/perform at job
  - Medical hx: depression, anxiety, smoker, hypertension, high cholesterol, diabetes, acid reflux, sleep apnea
  - Significant surgical hx: cholecystectomy, knee replacement, hysterectomy

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Case 1: Bilateral Blepharoplasty

- 12/3/15: visit with Ophthalmologist #1 (cont'd)
  - Dx: dermatochalasis; bilateral cataracts; increased IOP (24 OS; 22 OD); bilat ocular hypertension
  - Discussed dx with patient: etiology of condition, effect on visual field, risks & benefits of sx.
  - Rec: sleep apnea study; blepharoplasty

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Case 1: Bilateral Blepharoplasty

- 12/28/15, eval for bleph, ophthalmologist #2
  - Screening & VF tests
  - Corrected vision 20/25 OD, 20/25 OS
  - Bilateral 3+dermatochalasis, normal eyelids; ocular hypertension; current meds include 81mg aspirin daily
  - Did not measure IOPs
  - Dx: bilateral dermatochalasis upper lids; referred to ophthalmologist #3 for bleph eval

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Case 1: Bilateral Blepharoplasty

- 1/27/16: consult with ophthalmologist #3.
- Pt. c/o heavy eyelids and blocked vision
- VF test suggests peripheral vision loss due to dermatochalasis
- Noted daily 81 mg aspirin
- Discussed dx with patient
- Rec: bilateral upper eyelid bleph with fat excision
- Asked patient to discuss with her MD whether to halt aspirin pre-op

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Case 1: Bilateral Blepharoplasty

- 3/16/16 : Pre-op exam; noted patient on aspirin.
- Patient expectations, risks and complications, post-op care, outcomes discussed with patient.
- Reviewed anticoagulant status
- Patient signed consent
- Surgery scheduled for 4/6/16

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Case 1: Bilateral Blepharoplasty

- 4/6/16: outpatient surgery
- Pre-op note: no meds taken that day.
- Surgery uneventful
- Post op: some diplopia; no pain
- No aspirin until next day; Erythromycin ophthalmic solution 2x day
- Call surgeon re: excessive bleeding, drainage, any problems
- Post-op appointment scheduled: 4/13/16

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Case 1: Bilateral Blepharoplasty

- 4/6/16, evening, patient's neighbor calls; OD on call:
  - profuse bleeding “most of the day” from suture line, OS; lid swollen; nausea and vomiting. Patient could see & open left eye; denied proptosis; no pain
  - Neighbor texted photo of eye to OD
  - OD speaks to surgeon & texts photo

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Case 1: Bilateral Blepharoplasty

- Dr asks OD to confirm that patient can see, move, and open eye, and no pain; pt confirmed
- Dr asks OD to advise patient to contact if pain, loss of vision, proptosis, increased swelling, inability to move or open eye
- Use ice packs; Phenergan for nausea/ vomiting.

- 4/8/16: Patient called & asked to be seen: eye swollen shut and bloody.
  - Seen by OD: no pain; unable to open eye for exam; use ice; sent home
  - OD calls Dr to report findings

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Case 1: Bilateral Blepharoplasty

- 4/8/16: Surgeon asks patient to come in ASAP
  - NLP L eye
  - Performs canthotomy and cantholysis; IOP=44 after procedures
  - Diamox; IOP drops to 24
  - No hemorrhage seen
  - Left afferent papillary defect noted
  - Some light and movement from OS
  - Eye drops and Diamox
  - Impression: angle closure glaucoma or potential PION

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Case 1: Bilateral Blepharoplasty

- 4/9/16: surgeon sees patient
- No pain or nausea. Minimal bleeding at canthotomy site. Mild discomfort looking up. Able to open L eye 5mm. IOP 24 OS; pupil defect remained.
- IOP 24. continue drops, Diamox increased.

- 4/11/16: OD sees patient, NLP OS; IOP 18 OS.
- Dx: Ischemic optic neuropathy, discussed w/ surgeon.
- Offered steroids, but patient declined
- OD called Dr to report findings; texted photo of L eye

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Case 1: Bilateral Blepharoplasty

- 4/12/16: exam by same OD.
  - No change, NLP OS. IOP 16 OS
  - OD called Dr to report findings & texted photo
- 4/13/16: exam by Dr.
  - no change; still NLP
  - Discussed ION with patient
  - referred to neuro-ophthalmologist; patient seen same day
  - Dx: unexplained optic neuropathy 2* short posterior ciliary artery compromise from elevated orbital pressure.
  - Diff Dx: retrobulbar optic neuritis
  - RX: steroids x 3 days; orbital MRI; brain MRA

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Case 1: Bilateral Blepharoplasty

- 4/14—4/27: seen by OD and MD
  - No pain, NLP OS; swelling less OS
  - Patient requested 3rd opinion; referred
- 4/29/16: MRI & MRA.
  - MRI = moderate small vessel ischemic change of uncertain age
  - MRA = possible occlusion distal L mid cerebral artery may represent CVA of uncertain age

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Case 1: Bilateral Blepharoplasty

- 4/29/16: patient texts photos to Dr
  - Patient c/o swelling below L eye after crying
  - Dr reassured patient; call if any problems
- 5/4/16: last visit with MD
  - Discussed MRI and MRA findings
  - f/up with PCP
  - Unlikely to regain vision OS
- 5/7/16: Patient at ER, concerned re: infection OS.
  - Dx: periorbital cellulitis OS; IV antibiotics given. Discharged on Keflex.

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Case 1: Bilateral Blepharoplasty

- 5/13/16: neuro-ophthalmology consult at Wake Forest
  - Patient claimed she had pain immediately post-op
  - Bleeding began 1.5 hours post-op
  - Dx: ischemic optic neuropathy; irreversible
- Patient lost to follow up
- Damages:
  - Initial demand: 1.2M

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Case 1: Bilateral Blepharoplasty

- Issues with care > plaintiff experts:
  - Aspirin should have been stopped prior to surgery
  - Surgery should not have occurred due to aspirin therapy
  - Aspirin caused retrobulbar hemorrhage
  - Post-op care below SOC
  - Vision loss due to:
    - Post-op bleeding that developed into
    - Retrobulbar hemorrhage

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Case 1: Bilateral Blepharoplasty

- Issues with care > defense experts:
  - Mixed SOC opinions
  - Post-op care within SOC
  - OK to continue aspirin, if don't remove excess fat
  - Imaging delayed
  - No evidence earlier intervention would have changed outcome
  - Causation: retrobulbar hemorrhage vs. PION

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Case 1: Bilateral Blepharoplasty

- Claim outcome?
- A B C D

Case 1: Bilateral Blepharoplasty

- Verdict range: 700-900K, Settlement range 600-750K
- Surgeon dismissed
- Claim against group/entity

Risk Management Principles

- Challenges when multiple providers involved
- Documentation
- Oral consent for comanagement with OD
- Protocol for post-op calls from patients
- Surgeon's responsibility to patient

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Case 1: Bilateral Blepharoplasty

- Claim outcome?
- A B C D

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Case 2: Comanaged LASIK

- 38 year old myopic female with astigmatism presented for LASIK evaluation
- Optometrist noted dry eyes
- Punctal plugs declined by patient

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Case 2: Comanaged LASIK

- Two days later, bilateral LASIK performed without complications. No pre-op evaluation by surgeon of dry eyes.
- Postoperative day 1:
  - Seen by optometrist.
  - C/o dry eyes and poor vision.

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Case 2: Comanaged LASIK

- PO day 7, patient c/o dry eyes and poor vision; using artificial tears, not driving.
- PO day 13, patient c/o dry eyes and poor vision; using artificial tears every 30 minutes.
- 4 weeks post-op, c/o dry eyes and poor vision; still using artificial tears.
- 3 months post-op, c/o dry eyes and poor vision; lower eyelid punctal plugs.

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Case 2: Comanaged LASIK

- 5 ½ months post-op: c/o dry eyes and poor vision; using artificial tears.
- 6 months post-op: c/o dry eyes and double vision; upper eyelid collagen punctal plugs
- 6 ½ months post-op: refuses to be seen by O.D.; demands to be seen by surgeon.

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Case 2: Comanaged LASIK

- Seven months post-op, surgeon examines patient:
  - Dry eyes with double vision.
  - Reinserts collagen punctal plugs.
  - Returns patient to comanaging optometrist without long-term plan.

Case 2: Comanaged LASIK

- Two weeks later, patient c/o dry eyes and poor vision; using artificial tears.
  - sent to a new comanaging O.D.
- Three weeks later (8 ½ months post-op)
  - c/o dry eyes and poor vision –
  - planned visit with surgeon – **but did not occur**

Case 2: Comanaged LASIK

- Six weeks later:
  - c/o dry eyes, poor vision; not driving or working
- Three weeks later (10 ½ months post-op):
  - c/o dry eyes and poor vision
  - **declines further follow up** (bad sign).
- Last visit BCVA OD 20/70 OS 20/80

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Case 2: Comanaged LASIK

- **Patient files suit**
- Plaintiff expert:
  - needed better preoperative evaluation of tear film
  - detailed informed consent
- Defense expert:
  - dry eye known complication

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Case 2: Comanaged LASIK

- **Poor communication with patient regarding:**
  - Persistent dry eyes
  - response to treatment
  - plan and prognosis

Poor communication with comanaging optometrist

Case 2: Comanaged LASIK

Plaintiff allegations:

- No initial evaluation by surgeon
- No inspection of care
- Minimal active intervention post operatively
- **Poor Outcome**

Case 2: Comanaged LASIK

- Claim outcome?
- A B C D

Case 2: Comanaged LASIK

- Claim outcome?
- A B C D

Risk Management Principles

- Independent pre-op eval by surgeon
- F/up of documented concerns
- Oral informed consent re: comanagement
- Protocol with comanaging OD

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Case 3: Comanaged Cataract Surgery

- Cataract surgery and IOL in 80 y/o male by MD
- PO day 1: No complications; care transferred to OD
- PO day 6: seen by comanaging OD; c/o pain. Increased steroids. Return 2 weeks

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Case 3: Comanaged Cataract Surgery

- Two days later (PO day 8), patient's daughter asks surgeon to see her father. Surgeon diagnoses endophthalmitis and starts antibiotics.
- Next day, improved, so surgeon referred patient back to OD in 2 days
  - Recall same OD had missed diagnosis

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Case 3: Comanaged Cataract Surgery

- Next day (PO day 10), patient called surgeon to report pain.
- Told to use Motrin and eye drops.
- Called back later same day to report improvement.
- Told to follow-up with OD, who saw him that day.

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Case 3: Comanaged Cataract Surgery

- PO day 15: to ED with c/o poor vision and pain – retained cortex, **increase steroids**.
- Seen that day by optometrist who noted improvement; no dilation.
- PO day 17, saw retina specialist, VA HM, pseudomonas endophthalmitis.
- Final outcome: VA HM

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Case 3: Comanaged Cataract Surgery

- **Patient files suit**
- Alleges surgery contraindicated with history of blepharitis
- Delay in diagnosing endophthalmitis by OD
- Negligent management of endophthalmitis by ophthalmologist

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Case 3: Comanaged Cataract Surgery

- **DEFENSE**
- Poor communication between surgeon and optometrist.
- Initial complaints misdiagnosed
- F/U complaints and ER visit
- Surgeon should have reviewed f/u plan – dilation.
- Surgeon should have followed patient with endophthalmitis

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Case 3: Comanaged Cataract Surgery

Plaintiff'allegations:

- Poor communication
- No active or continued dialogue
- No comanaging protocol
- Poor oversight

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Case 3: Comanaged Cataract Surgery

- Claim outcome?

A B C D

Case 3: Comanaged Cataract Surgery

- Claim outcome?

A B C D

Risk Management Principles

- Vetting external comanaging ODs
- Establish protocol and expectations
- Written consent by patient for comanagement
- Physician responsibilities

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Case 4: Comanaged Glaucoma

- 60 year old female with DM evaluated by OD in group
- Diagnosis: Cataracts, diabetic macular edema, rubeosis iridis, and narrow angles.
- Refer to M.D. in group in 2 months.

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Case 4: Comanaged Glaucoma

- Patient no show for 2 month follow-up.
- MD indicates f/u on “next available date”
- Four months after initial visit, patient presents emergently with pain
- VA LP, IOP 76 OS.
- MD notes neovascular glaucoma, angle closure, PDR, hyphema.

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Case 4: Comanaged Glaucoma

- **Expert Opinions:**
- MD and OD below SOC
- Optometrist should have referred immediately
- Physician should have reviewed chart and seen immediately after missed appointment

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Case 4: Comanaged Glaucoma

- Claim outcome?
- A B C D

Case 4: Comanaged Glaucoma

- Claim outcome?
- A B C D

Risk Management Principles

- Office protocol for no-shows
- Assure competence and training of ODs
- Set expectations for ODs in group
- Active dialogue and participation in care
- Review and inspect care

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Time Check…
One more case?

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Case 5: Glaucoma-Retina

- GLAUCOMA EVALUATION
- 66 y/o female
- 25-year hx advanced uncontrolled chronic angle closure glaucoma
- 10 degree islands

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Case 5: Glaucoma-Retina

- Trabeculectomy performed OS
- PO day 4: IOP mid teens
- A/C formed but diffusely shallow
- Referred to retina with ? diagnosis of aqueous misdirection (malignant glaucoma)

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Case 5: Glaucoma-Retina

- RETINA EVALUATION
- VA 20/30 OD, CF OS
- IOP 14 OD, 16 OS
- Filtered eye (OS) diffuse bleb
- Anterior chamber moderately shallow
- Ultrasound: Diagnosis ? choroidal detachment

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Case 5: Glaucoma-Retina

- RETINA
- Lensectomy/vitrectomy to reverse aqueous misdirection
- Operative note: found choroidal detachment
- Surgery stopped due to suprachoroidal hemorrhage
- Final outcome: Enucleation

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Case 5: Glaucoma-Retina

Plaintiff's allegations:

- Glaucoma specialist (non-OMIC) and retina specialist (OMIC) BOTH SUED for misdiagnosis and unnecessary surgery

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Case 5: Glaucoma-Retina

- PLAINTIFF EXPERT CONTENTIONS:
- Glaucoma made wrong diagnosis: problem was over-filtering
- Retina should have known that choroidal detachment common after filtration surgery. Performed unnecessary surgery
- Surgical complications led to enucleation

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Case 5: Glaucoma-Retina

- RETINA DEFENSE EXPERT OPINIONS:
- Initially supportive, later felt wrong diagnosis by glaucoma expert
- Sympathetic on deferral to glaucoma expertise, and desire to save vision
- If choroidal detachment, need to wait due to bleeding risk
- "…caught between a rock and a hard place"

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Case 5: Glaucoma-Retina

- OTHER PROBLEMS:
- Missing operative report
- Letters to glaucoma had information and dates inconsistent with other records
- When record found, stated pre-op deep anterior chamber, mild choroidal detachment
- Credibility issues

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Risk Management Principles

- Retina relied on Glaucoma's dx
- Dx inconsistent with Retina's exam
  - Insufficient assessment?
- Poor documentation of events
- Missing op report
- Credibility and Defensibility

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Case 5: Glaucoma-Retina

- Claim Outcome?
- A B C D

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Risk Management Summary

- The independent duty of the ophthalmologist
- Vet the OD and establish guidelines
- Informed consent from patient (oral vs. written)
- Hand-offs: internal and external
- As always: thorough documentation
- Office protocols:
  - no-shows, post-op complications
- OMIC document
  - https://www.omic.com/comanagement-after-eye-surgery/
- AAO document
  - https://www.aao.org/ethics-detail/guidelines-comanagement-postoperative-care

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Thank You!

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