TRANSITION OF CARE: WHY? WHEN? HOW?
An AAP-sponsored workshop

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None of the panelists have financial interests in the material in this presentation
TRANSITION OF CARE-EXAMPLES FROM PEDIATRICS

• Complex congenital heart disease
  – Improved survival
  – Adult cardiologists with no experience

• Pediatric cancer
  – Long-term survivors
  – Late effects clinics
A BYPRODUCT OF SUCCESS

- Complex patients
  - Down syndrome
  - Congenital heart disease
  - Developmental delay

- Need for system-wide implementation of programs
THE ACADEMIC APPROACH: FORMAL CONCEPTS - SIX CORE ELEMENTS

1. Transition policy (12-14 years)
2. Transition tracking
3. Transition readiness
4. Transition planning
5. Transfer of care (18-21 years)
6. Transition completion
WHY IS OPHTHALMOLOGY DIFFERENT?

- Single organ system
- Adult specialists often care for pediatric patients
- Many pediatric ophthalmologists care for patients with complex ocular disorders
### DISORDERS THAT PEDIATRIC OPHTHALMOLOGISTS MANAGE

<table>
<thead>
<tr>
<th>Disorder</th>
<th>% of respondents who manage</th>
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</thead>
<tbody>
<tr>
<td>Ptosis and anterior orbital lesions</td>
<td>68%</td>
</tr>
<tr>
<td>Cataracts</td>
<td>49%</td>
</tr>
<tr>
<td>Uveitis</td>
<td>38%</td>
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<tr>
<td>Retinopathy of prematurity</td>
<td>25%</td>
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<tr>
<td>Glaucoma</td>
<td>19%</td>
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<tr>
<td>Retinoblastoma</td>
<td>7%</td>
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</tbody>
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BVOM (in press)
FOR MOST OF US

• Doesn’t need to be that complicated

• Why is ophthalmology different?
  – Single organ system
  – Adult specialists often familiar with pediatric eye diseases
  » Many care for all ages
IN A NUTSHELL

1. Make patients and families aware of your policy a few years before the transition
2. Identify willing providers
3. Transfer care
4. Provide a lifeline
ISSUES TO CONSIDER

• Different types of pediatric ophthalmology practices
  – Private practice vs academic
  – Competition

• Availability of providers
  – Comprehensive vs specialists
  – OD vs MD

• Children with special needs
POTENTIAL BARRIER - FINDING A WILLING PROVIDER

• Sometimes difficult
  – Practices too busy
  – Don’t want to deal with pediatric problems
POTENTIAL BARRIER-
FAMILIES MAY NOT WANT TO LEAVE YOUR PRACTICE

• Discuss this a few years before

• Remind families prior to last visit

• Frame it as a good thing
  – Sign of maturing
POTENTIAL BARRIER-HEALTH INSURANCE

• Currently young adults can be on parents’ insurance plan until age 26

• Medicaid coverage varies
  – Usually more difficult to get coverage when older
OK to limit type of care as long as:

- No discrimination or violation of ADA
- No contractual obligations

If patient physician relationship established must notify when no longer provide care:

- Oral, handout, written letter
MEDICO LEGAL

• Pediatric patients with complex conditions
  – Formal handoff recommended
  – Coordinate in advance of transfer
  – Send information to new MD
  – Few but DIFFICULT
THINGS YOU MIGHT NOT THINK ABOUT: 18 YEARS OF AGE

• Patients are considered adults
  – Can make their own health decisions

• HIPAA rules start to apply at age 18
Specialized Eye Care for Special Needs Patients: Why it’s Important, Why Everyone Wins, and What to Do When Your Patients Age Out of Pediatric Care

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Emory University
AAPOS/AAP Workshop: Transition of Care - Why? When? How?
AAPOS 48th Annual Meeting - New York, NY
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None – except for an interest in the cost of airfare between Philadelphia and Atlanta.

Objectives
Report the:
- Demographics
- Types and prevalence of visual/ocular pathology
For patients seen in Emory’s outpatient eye clinic patients with disabilities
Discuss:
Why dedicated eye care is important for individuals of all ages with disabilities
Who should do it
How it can be done in both university-based and private practice settings

Background
How caring for residents at a residential facility for individuals with disabilities in the Philadelphia suburbs morphed into an eye clinic for patients with disabilities at the Emory Eye Center in Atlanta…

- Multispecialty ophthalmology practice in suburbs of Philadelphia from 1992-2021
- Woods Services
- Residential facility for individuals of all ages with disabilities of any type, congenital or acquired
- In suburbs of Philadelphia
- 600-800 residents
- Annual eye exam mandated by PA law
- Clinic there once/month from 1996-2019

Invited to join the pediatric ophthalmology team at Emory University in Atlanta and happily accepted to set up a clinic for individuals of all ages with disabilities because I loved and had experience working with this patient population and…

. . . truth be told, a great way to visit my kids and grandkids who lived in Atlanta on a regular basis

Why have a dedicated clinic for patients with disabilities at all?

- Intellectual disability due to congenital rubella
- Entered residential facility December 1985 at age 22
- Always hungry
First Eye Exam
- Yearly eye exams from 1/24/86 by same examiner
- No IOP or dilated fundus exam documented for 12 years until...
- Different examiner 4/2/98:
  - VA LP OD, 20/200 OS
  - +APD OD
  - Tap 42 OD, 22 OS
  - DFE: total cup OD, increased cupping OS
- Blind OD - glaucoma

Sarah – just needed a little food
- Was wearing -5.75 + 1.50 X 175 OD; VA 20/200 Allen chart
- Cycloplegic refraction OS: -11.50 +2.00 X 165; VA 20/40+3 Allen chart
- Glaucoma now managed by glaucoma specialist with topical medication: VA LP OD but no apparent further progression OS
- Glaucoma keeps snacks on hand for her - Combos are her favorite. Has never needed an EUA.
- 2019 exam: VA OS 20/40+ without correction, IOP's well controlled

Lynn
- 52 year-old with history of CP due to asphyxia at birth
- Cared for by mother until age 50, when she died
- Wheelchair bound
- Cannot walk, talk, or care for her needs in any way
- Communications by moving head toward pictures on lap based on her wheelchair
- Presented January 2015 to Emory Eye Center clinic for individuals with disabilities with aide, who stated she did not think Lynn saw very well until things were close
- Has never worn glasses
- Last eye exam was sometime in early childhood

Cycloplegic Retinoscopy:
OD: -16.50 +1.00 X 80
OS: -15.00 +1.00 X 85

Lynn
If all you can do is sit in your wheelchair and look at the world around you, imagine how much better your quality of life would be with glasses when you’re a -15.00 myope!
Lynn loved her new glasses... Imagine if she had them since childhood.

Emory Eye Clinic for Individuals with Disabilities
Created to fill the void of specialized eye care for this specialized patient population

Concept at outset for this clinic: Win – Win – Win situation
- A win for the patients of all ages with disabilities who get an eye care service that anticipates their needs and schedules ample time for examination
- A win for eye care providers whose busy clinic schedules are structured around non-challenging patients who can easily converse and follow directions
- A win for residents who get specific training for how to examine this demographic.
Regardless of ultimate ophthalmic specialty, will need this skill set to examine difficult patients encountered in their careers.

So, why have a dedicated clinic for patients with disabilities?
Because: There is a high prevalence of visual impairment and ocular pathology in a large cohort of patients who, for the most part:
- Cannot verbalize if there is any problem
- Cannot be easily examined
- Cannot be followed by ordinary testing

Examinations are challenging in this patient population, yet services and eye care professionals willing or able to provide them are scarce.

So, how did we do? Was it worth the effort?
Did we really help anyone?

Three years after its inception,
- Patients and their families welcomed a clinic that suited their needs,
- Colleagues utilized this resource for difficult cases, and
- Our ophthalmology residents had the resource available to develop the skill set needed for challenging examinations.

What we did not know was how much we were helping our patients.
A complete exam was possible in the vast majority of cases:

- **SLT lamp-exam:** Achieved in 177/178 (99.4%) could not achieve in 1 patient due to cooperation.
- **Cycloplegia refraction:** Achieved in 177/178 (99.4%) could not achieve in 1 patient due to cooperation.
- **Dilated fundus exam:** Achieved in 177/178 (99.4%) could not achieve in 1 patient due to cooperation.
- **IOP:** Tonometry achieved in 175/178 (99.4%).

The most and least number of ocular diagnoses...

### New Ocular Diagnoses (n=178)

- **Glaucoma:** Overall, 6/178 (3.3%)
- **Cataract:** Newly diagnosed in 31/178 (17.4%)
- **Retinal Detachment:** Diagnosed in 1/178 (0.6%)
- **Macular Degeneration:** Diagnosed in 3/178 (1.7%)
- **Strabismus:** Diagnosed in 4/178 (2.2%)
- **Dilated fundus exam:** Achieved in 177/178 (99.9%)

### Total Number of Patients with Disabilities Included in This Study

- Total of 178 patients

### Methods

- **Study population:** Overall (n=178)
- **Exams performed:** All were performed in their entirety by the same pediatric ophthalmologist (SJM)
- **Methods:** Dilated fundus exam

### Overview of Results for Visual/Ocular Diagnoses: n=178 Patients

- **Overall results:**
  - 38/178 (21.3%) had a normal exam
  - 148/178 (85%) had pathology or refractive error requiring glasses
  - 169/178 (95%) had pathology requiring glasses or pathology

- **Other patient with pathology:**
  - 32/178 (18.1%) had another ocular diagnosis
  - 32/178 (18.1%) had only new ocular diagnoses
  - 169/178 (95%) had pathology requiring glasses or pathology

- **Overview of Results for Visual/Ocular Diagnoses:**
  - Total of 188 patients seen at 293 visits
  - Ability to obtain examination data in a full eye exam
  - Full details of the methods are in the handout for how data was obtained, including:
  - Definition of "treatable" vs. "non-treatable" conditions
  - Visual acuity
  - Intracranial pressure
  - Alignment
  - Cycloplegia
  - Refraction

- **Results:** Study Population

- **Total of 178 patients seen at any time:**
  - 119/178 (66.9%) were newly diagnosed
  - 59/178 (33.1%) had pathology or refractive error requiring glasses
  - 123/178 (69.1%) did not need glasses but had pathology

- **Description:**
  - Sex
  - Age at first visit
  - Nonverbal
  - Coexisting conditions
  - Communication
  - Medicaid

- **Data Analysis:**
  - Descriptive statistics were calculated for demographics, visual acuity, visual/ocular diagnosis, non-ocular diagnosis, refractive error, and achievable examination data.

- **Conclusions:**
  - Together, 132 patients with treatable ocular diagnoses and 14 patients with non-treatable ocular diagnoses were included in this study (27.5%) study patients with a treatable ocular condition.
Why? When? How?

2/3 (66.7%) Overall (n=178) 4 (2.3%) Are we diagnosing new problems or confirming those we already know exist?

2/2 (100%) Do our patients have conditions that are mostly treatable or non-treatable?

30 Do most patients just need glasses and otherwise have normal exams?

Results of this study justify the recommendation that

0/2 (0%) As deinstitutionalization moves those with disabilities into the community, the need for outpatient resources for their eye care increases.

2/2 (100%) Discussion: Who Should Perform These Exams and in what Setting?

18 (10.1%) Discussion: Who Should Perform These Exams?

TREATABLE DIAGNOSES

4/5 (80.0%) What responsibility do we have for our patients with disabilities once they become adults?

35

TREATABLE DIAGNOSES

2 (1.1%)

εικόνα του λεπτομερούς εαυτού του μαθητή.

34

33

32

31

29

28

26/85 (30.7%) patients had a significant refractive error

86/85 (47.8%) patients had a significant refractive error + only non-treatable ocular pathology.

Significant refractive error + at least 1 treatable ocular diagnosis

Significant refractive error only (no other ocular diagnosis)

OPHTHALMIC DIAGNOSES Overall (n=178) New Diagnosis

NON-TREATABLE DIAGNOSES

Cortical visual impairment 25 (14.0%)...

Lens subluxation 2 (1.1%) 2/2 (100%)

Chalazion 1 (0.6%) 0/1 (0%)

Photophobia intense 1 (0.6%) 1/1 (100%)

Discussion: Who Should Perform These Exams?

• An institutionalization of medicine with disabilities into the community, the need for outpatient resources for their eye care increases.

• Results of this study justify the recommendation that individuals with disabilities should have routine comprehensive ophthalmic examinations.

• A complete ophthalmic examination is able to be achieved in the vast majority of patients with disabilities.

• The essential elements are having both the time and expertise to perform such exams.

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Since there is no standard definition of “significant” refractive error, for purposes this study, we define significant refractive error as

• Refractive error was not only common, but frequently accompanied by other treatable conditions.

• Significant refractive error is at least +1.00 diopters in one eye, or +2.00 in both.

• Photophobia intense

• Chalazion

• Keratoconus

• Glaucoma suspect, narrow angles

• Ptosis

• Glaucoma suspect, ocular hypertension

• Torticollis, ocular

• Nasolacrimal duct obstruction

• Corneal Pathology (non-keratoconus)

• Amblyopia (≤17yo)

• Strabismus

• Coloboma, chorioretinal

• Ophthalmoplegia

• Visual field deficit

• Retinal pigmentary dystrophy

• Phthisis/microphthalmia

• Retinal detachment; chronic, total

• Amblyopia (>17yo)

• Retinal abnormality

• Nystagmus

• Nystagmus

• Cortical visual impairment

• Transition of Care

• Transition of Care

• Transition of Care

See handout for details of refractive error data

• Dissociated Vertical Deviation

• Convergence Insufficiency

• Amblyopia (>17yo)

• Strabismus

• Coloboma, chorioretinal

• Ophthalmoplegia

• Visual field deficit

• Retinal pigmentary dystrophy

• Phthisis/microphthalmia

• Retinal detachment; chronic, total

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• Retinal abnormality

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• Nystagmus

• Cortical visual impairment
What responsibility do we have for our patients with disabilities once they become adults?

As pediatric ophthalmologists, don't we have a responsibility to ensure the special needs patients we have followed through childhood have the resources of adequate eye care when they become adults?

Recommendations: University-based setting

We suggest that in a university-based setting, a dedicated eye clinic for individuals with disabilities staffed by experienced ophthalmology physicians provides a desirable environment for examination because:

- The needs of this patient population are anticipated,
- Adequate time is factored into the schedule, and
- It provides the opportunity to teach ophthalmology residents the skills necessary to perform challenging examinations they undoubtedly will encounter in their careers.

Recommendations: Private Practice

In a private practice, setting aside dedicated clinic time for individuals with disabilities is advantageous—every 30 minutes/month:

- Smart scheduling: more time allotted per patient than in a regular clinic setting
- Physician and staff anticipate special needs
- Helps prevent running behind when a difficult patient is scheduled in the middle of a busy everyday clinic

Recommendations: University-based setting

Call center and schedulers must be aware that ONLY patients with disabilities can be scheduled in this clinic.

IMPORTANT: For all new patients, schedulers must write comment of some sort in the appointment list regarding the type of disability (Down syndrome, autism, etc.)

Depending on schedulers' turnover rate or knowledge of your clinic, mistakes can be made, so be sure you or a designated person checks the schedule ahead of time for these comments to assure patients are correctly scheduled. Those without a disability will need to be rescheduled to a different clinic. (ROP, strabismus, sickle cell disease/trait, cataracts are not disabilities in end of if/mawork.)

Recommendations: Private Practice

Patients are scheduled every 30 minutes. Yes, you really need all that time.

At every 30 minutes, you want to minimize your no-show rate, so appointments should be confirmed in advance.

Keep a waiting list, if possible, to fill cancellation spots.

Review appointments beforehand (I usually do this 2 weeks in advance)

- To assure each patient scheduled does have a disability or is someone you can be prepared. (It's sometimes hard to keep up with the newer identified genetic mutations and any possible associated eye findings.)

Recommendations: University-based setting

Patients are referred from within the university by:
- Ophthalmology, neurology, genetics, neurosurgery, neuro-ophthalmology
- Primary care/pediatric physicians
- Neurology
- Specialty centers

Patients referred from outside the university by:
- Primary care/pediatric practices
- Schools
- Specialty centers: Autism, brain injury, other facilities/homes for individuals with disabilities
- Word-of-mouth

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How this works in a university setting

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How this works in private practice

Patients are referred from within your practice:
- Solo practitioner: schedule your patients with disabilities and others who have challenging or time-consuming exams.
- Multi-specialty practice: Patients referred from your associates
- Identify who is good with this patient demographic
- Affiliates: Patients referred from your associates
- Other facilities/homes for individuals with disabilities

Patients are referred from outside your practice:
- Primary care pediatric practices
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How this works in both university-based and private practice settings:

- Be familiar with resources available for those with disabilities in your community:
  - Who handles vision services for preschool and school age children?
  - Early intervention services for children with developmental delays
  - Services available for visually impaired adults
  - Visual requirements for a driver’s license in your state
  - Your local facilities/centers for children and adults with autism
  - Your local facilities/centers for those with traumatic brain injuries

Importance for this patient population:

Results of our study highlights the importance of eye examinations in individuals with disabilities. While the underlying non-ocular conditions of these patients may not be curable,

- We can present additional disability through diagnosis and treatment of vision-threatening disorders and
- We can eliminate the disability of diminished eyesight by providing glasses when significant refractive errors are detected.

Why have a clinic for individuals with disabilities?

- We owe it to the Sarahs out there so they don’t go blind because they were difficult to examine.
- We owe it to the Lynns out there so they don’t have the additional disability of poor vision because nobody realized they simply needed glasses.

Acknowledgements

Many thanks to this study’s co-investigators:
Alcides Fernandes, MD
Laura Ward, MSPH

Supplementary slides with data and results from study


Methods – Data Collection

What Constituted “Treatable” vs. “Non-Treatable” Conditions?

- Conditions for which treatment by an eye care physician is customarily available to provide resolution or improvement were designated as “treatable.”
- Ocular conditions that were not treatable and non-ocular visual problems were designated as “non-treatable.”
- In an effort to delineate amblyopia in children from long-standing amblyopia in older individuals, an age criterion of ≤17 years was chosen to divide the diagnosis into “treatable” vs. “non-treatable” groups based on previously published results from the Pediatric Eye Disease Investigator Group (PEDIG).*


Methods – Visual Acuity

- Visual acuity measured using Lea, HOTV, or Snellen charts in patients who could cooperate verbally.
- If non-verbal but could cooperate, matched distance Lea or HOTV characters to a lap card.
- For patients unable to cooperate for such measurement, fixation and following were assessed by response to visual stimuli. The presence of a fixation preference was determined by preferred eye in those with strabismus and by base down prism testing when strabismus was not present.

Methods – Intraocular Pressure

- IOP first attempted by iCare, with multiple measurements taken if necessary to document repeatability.
- If unsuccessful or results questionable, Goldmann tonometry was then utilized.
- Finger tension estimate of IOP was documented if unable to be measured by either Goldmann tonometry.
Methods – Alignment
- Alignment assessed with cover-uncover and alternate cover testing.
- Fixation or cooperation precluded such assessment, alignment was evaluated by corneal light reflexes, measuring with prisms when possible when strabismus was present.

Methods – Slit Lamp Exam
- Slit lamp examination was achieved using portable or standard equipment.

Methods – Cycloplegia/Dilation
- Adults: phenylephrine 2.5% and tropicamide 1%
- Children without history of seizures: combination phenylephrine 2.5%/tropicamide 1%/cyclopentolate 1% drop or tropicamide 1% and cyclopentolate 1%
- Children with history of seizures: phenylephrine 2.5% and tropicamide 1%, repeated once in 10 minutes

Methods – Refraction
- Refractive error was ascertained by cycloplegic streak retinoscopy, recorded in plus cylindrical notation, and classified as “significant” if it met the age-related criteria defined in previously published guidelines.

Controversy
Point of controversy: What is a “significant” refractive error?
- Other studies have reported a high prevalence of significant refractive errors in patients with disabilities, but there is no clear definition of what this means.
- Before calculating descriptive statistics for refractive error, we felt it was important to define what “significant” meant for the purposes of this study.
- Since there is no standardized designation for both children and adults, as needed for our patient population, the thresholds for “significant” refractive error were selected from previously published guidelines set for automated preschool screenings, since they were delineated by type of refractive error and could be applied to various ages.
- Adhering to a clearly defined standard for classifying refractive errors is a strength of this study, but one weakness is that it likely underestimates the number of patients with significant refractive errors since, for example, the threshold set for hyperopia as >3.5D is probably too high for adults.

Methods – Dilated Fundus Exam
- Indirect ophthalmoscopy performed using 20D lens
- Direct ophthalmoscopy performed if further assessment needed
- If no fundus view was possible and cooperation permitted, B-scan ultrasonography was obtained

How well could our patients see? and How often did they need glasses?
Refractive Error by Cycloplegic Retinoscopy

- Spherical equivalent >+5D in 7/330 (2.1%) eyes
- 6/31 (19.3%) hyperopic patients

Astigmatic Refractive Error by Cycloplegic Retinoscopy

- Astigmatism ranged from 0 to 8.50D
- Spherical equivalent in diopters (D) range:
  - ≥+.25 to <1.50
  - ≥+1.50 to <+3.00
  - ≥+3.00 to <+6.00

Highlights of what we learned about strabismus in patients with disabilities in our study:

- >55% of our patients had strabismus, our most common oculardisorder diagnosis
- 45% of patients with strabismus had other visual/ocular pathology, 49% with treatable problems
- 93% of patients with strabismus had esotropia or exotropia, evenly divided
- There was a high prevalence of strabismus in the 6 disabilities that comprised 95% of our patients:
  - Autism, Down syndrome, Cerebral Palsy, Intellectual Disability, Neuropathology, Genetic disorder

What did we learn?

- Patients with disabilities have a high prevalence of ocular pathology, often treatable and previously unrecognized.
- Strabismus is the most common ophthalmic diagnosis
- Refractive errors are common, frequently accompanied by other treatable conditions.
- Trained providers such as pediatric ophthalmologists can achieve a complete ophthalmic examination in the vast majority of these patients.
Transitions of care can be difficult

Transition of practice

In 2008, Krista Heidar, MD and I made the difficult decision to leave our practice and venture out on our own.

At the time, there were less than 10 pediatric ophthalmologists in Washington State.

We chose to move to a suburb of Seattle about 12 miles from the Seattle office at which we practiced. This was partly our decision and partly because of restrictive covenants, which are enforceable in WA.

Now, 15 years later, Dr. Heidar is transitioning again, moving to New Mexico.

I'll be covering two types of care transition:
1. Transition of care due to changing/moving/leaving practice
2. Transition of care from pediatric age to adult age
What are your obligations when changing practices?

Both the individual ophthalmologist and the practice have obligations:
- Steps need to be taken to ensure continuity of care, to prevent allegations of abandonment, and to make sure all involved ophthalmologists have access to records in the event that care is called into question.
- You must also abide by your contract, state and federal laws.

https://www.omic.com/leaving-practice-toolkit/

Things to consider in transition

- Decide when to stop performing surgery
- Notify patients about the physician’s departure
- Take over care from the departing physician
- Protect the medical records
- Review your professional liability insurance policy
- Notify third parties

Decide when to stop performing surgery

- What is best for the patient should drive this decision, not what is best for the practice or you financially.
- Complex patients need more complex care following surgery: will there be someone available to do this care?
- Is there someone in the practice who can take over care of the departing physician’s patients?
- Does the practice have a shared post-operative care protocol?
- Be sure to inform the patient if post-operative care is to be shared!

Notify patients about the physician’s departure

- Depending on your situation, this could be amicable or could be a point of contention: a joint letter from the practice and the departing physician is ideal.
- Patient abandonment occurs when a physician fails to provide necessary medical care to a current patient without adequate justification.
- High-risk, active and inactive patients may require different types of notification; use the OMIC toolkit for examples.
- There may be state laws that require certain types of notifications; check with your state medical board.

Key points in your letter to patients

- Explain options when the departing physician will not be locally available for ongoing care.
- Explain options when the departing physician will be locally available for ongoing care.
- Explain how to get a copy of the medical record.
- Inform the patient of any fees for copying and sending the record.
Take over care from the departing physician

- Make sure you have someone in your practice to take over care, or a community physician when you can refer these patients.
- Especially for those with high-risk diagnoses.
- Review charts of patients you are taking over before seeing the patient or treat each of these patients as new patients and workup thoroughly.
- Exercise caution when discussing previous care or diagnoses.
  - "I was not involved with your care at the time, so I don’t have all the information."
  - "There are several ways to treat your condition."
  - "I would like to try a different treatment now."

Protect the medical records

- Practices need to work in good faith with the departing ophthalmologist to provide access to his/her former patients’ medical records as allowed by law.
- There are many federal and state laws to pay attention to with regard to patient records.
- If possible, have a written agreement on medical records.
- Make sure your patients have access to a records release and understand there may be a cost for this.
- Prioritize patient care and safety over all else.

Review your professional liability insurance policy

- You need to make sure you have coverage for any claims that arise from your old practice: “tail” coverage.
- You will also need to set up coverage for your new practice location and situation.

Notify third parties

- Reach out to referring doctors and practices with your new information.
- Contact insurance and managed care companies, CMS, Medicaid, etc. to initiate new contracts and terminate old ones.
- This takes 6 or more months—do this as soon as you know!
- Notify your state medical board, local county or city organizations, DEA, etc.
- Change your information with local hospitals and emergency departments.
- Resist the urge to badmouth your former practice and colleagues.

Transitioning from Pediatrics to Adult

Why is this change so hard?
In a word: trust.
Concerns about transition: colleagues

- Will our colleagues take as much care with them as you have?
- Will they pay attention to all the details and understand the subtleties?
- Will they just use the autorefractor for your patient’s refraction?

Concerns about transition: retinoscopy

Never fear: you’ve done your job!

- You’ve spent years making sure this patient can see as best as possible for his or her situation.
- You’ve done your job.
- You can be proud of your work, your relationship with the patient and family, and it’s time for them to move to the next step in their lives.
- Pick good colleagues and make specific recommendations based on your knowledge of the family.

What age to make the change?

- If you are part of a large system (hospital, university, etc.) you may have no choice.
- If you can make the decision, consider what’s best for your patients:
  - Having a set age (e.g. 18 years) doesn’t fit well with life at that age.
  - Consider using a life change point in time: graduation from high school, college, transition program, etc.

Prepare the family

- Start talking about the transition a few years prior.
- The year before, remind the family about the transition.
- The year of transition, hold their hand through the process.
  - Give the family the name of an adult colleague near where they live.
  - Review how to get records transferred to the new provider.
  - Remember that the family is going through more than just this transition.
  - Kid off to college, trade school, etc.
  - Changing pediatricians.
Prepare your office

- Have a written policy the staff can follow.
- Allow some flexibility with the policy.
- Emergencies
- Insurance issues
- Empower the staff to make decisions with regard to whether the patient is seen again or not.
- Make sure that staff know that emergencies or other visits are okay until they have established care with the adult colleague to whom you’ve referred them.

Prepare yourself

- It’s bittersweet to have to say goodbye after following a patient for so long.
- You may see them back in the future with their children!
- Each situation is different: try to read the social dynamics and match how the patient is feeling.

Summary

- Transitions of care are hard and some attention to detail is needed.
- It’s important to remember that what is best for the patient should drive each decision.
- Help prepare your patient and family for the bittersweet “graduation” from your office by talking about it early.
Transition of Care: Ethics Challenges
Alex V. Levin, MD, MHSc, FRCSC
Adeline Lutz - Steven S.T. Ching, M.D. Distinguished Professorship in Ophthalmology
Chief, Pediatric Ophthalmology and Ocular Genetics, Flaum Eye Institute
Chief, Clinical Genetics, Golisano Children’s Hospital and
University of Rochester Medical Center

I. Duty to Care
   A. Moral Foundations
      Non maleficence (do no harm)
      Beneficence (do the best for the patient)
   B. What are our obligations? The spectrum…
      Good Samaritan
      Contracted care
      Choice to care
      We choose…
      Our specialty
      Our subspecialty
      Our sub sub specialty…
   C. Can we ever say no? Absolutely!
      As long as…
      Nondiscriminatory (e.g., Morgentaler case)
      No abandonment
      Not malicious
      Especially if…
      Non maleficence (do no harm)
      Beneficence

II. Transition of care
   A. Uphold…
      Ethics
      Non maleficence
      Beneficence
      Policy (e.g. no one over a certain age)
      Law (e.g. HIPAA)
   B. What if options are sub optimal?
      Special policy (e.g. extending age limits for certain disorders)
      Create resources thru training and advocacy
      Systemic response (e.g. adult cystic fibrosis service)
      Personal response (e.g. continued consultation/availability)

III. International Care
   A. Many considerations
      Financial incentives and medical tourism
      Other conflicts of interests (e.g. personal, academic)
      Ongoing care at home (non-maleficence)
      Consent (language AND understanding)
      Cultural sensitivity (“When in Rome…”)
      Unrealistic expectations
Transition of Care
In the Context of International Service

Daniel J Karr MD FAAO FAAP
Oregon Health and Science University
Casey Eye Institute
International Service Experience

• Extremely popular altruistic “Mission” for ophthalmologists
• Ophthalmology resident and fellow applicants-essential part of CV
• Ophthalmology skill sets are highly productive in international setting
• Services provided limited local availability and life-changing for patients
International Service Concerns

• Short-term one-time vacation project
• Procedures performed which would not be performed in home country
• Training experience, often unsupervised, for medical students residents etc.
• No regulation by host country or interaction with local medical community
• Unregulated research projects
• No documentation of services provided
Medical Tourism

• Major benefit may be for the doctor rather than the patient
• May undermine or compete with local caregivers-risk of long-term service
• May not adequately consider long-term care and complications
International Service Requirements

• Current license and active practice
• May need to meet with medical board
• Malpractice coverage
• Declaration of proposed scope of service
• Identification of local sponsor
International Service Considerations

• What is in the purpose-goal of the trip?
• Partnership with established organization HCP, SEVA
• In country organizations to consider: Rotary Lions
• What services will be provided. Infrastructure available?
• What happens to your patients after you leave?
• Long-term care for Glasses, PCO, Glaucoma, RD, Infection?
Transition of Care

• Integration with local doctors and clinics from pre trip to completion
• Careful selection of patients
• Education of local providers for both performing procedures and handling potential complications
• Providing infrastructure with equipment and medications
• Providing post trip support through video conferencing photos and ongoing training
• Consider training of host country doctors in your facility
• Consider established organizations which have transition of care built into their program
So You Want to Work Overseas?

AAO CME course

Johns Hopkins University Blumberg School of Public Health

David S. Friedman, MD, PhD, MPH

Alfred Sommer, MD, MHS

Bishop R, Litch JA. Medical tourism can do harm. BMJ. 2000;320:1017
