

# DOCUMENT A

## GENERAL PROTOCOLS FOR SHARED CARE INVOLVING OPTOMETRISTS

### *Introduction*

Within a shared care arrangement, patient care is provided by two or more practitioners, each practicing within their sphere of expertise. Shared care allows continuing involvement of the optometrist in the care of the patient and aims to co-ordinate patient care to provide high quality integrated care that is readily accessible and convenient to the patient and cost effective for all parties involved.

Communication and clear demarcation of roles and responsibilities are essential for effective shared care.

### *Ethical & Legal Obligations Associated with Shared Patient Care*

Optometrists participating in shared care must be competent to collect data according to set protocols, and must ensure they have the equipment, expertise and skills required to perform their role safely and effectively. This includes a complete understanding of the Board's Guidelines and Protocols. An appropriate level of professional indemnity insurance is compulsory.

Optometrists must act in the best interest of the patient at all times. The decision of where/when to refer the patient must be based on the needs and requirements of the patient rather than the interests of the optometrist.

The patient should be informed of alternative treatments, surgeons and centres. An optometrist may participate in fee splitting arrangements with ophthalmologists provided that such arrangements are not secret and the patients are fully aware of the arrangement before embarking on the procedure. Fees must be based on the services provided by each participant. Optometrists must not receive any financial reward (kickbacks) for referring patients for any types of care.

### *Roles & Responsibilities in Shared Patient Care*

Within a shared care arrangement, it is essential that the roles and responsibilities of the optometrist and the medical practitioner are clearly defined and continue to be redefined as training of the two parties changes and as the clinical circumstances of the patient(s) change.

For optimal patient care, both the optometrist and medical practitioner should have similar treatment philosophies. Which responsibilities are given to each practitioner depends upon the experience and confidence each professional has in the other, but professional relationships between providers will often evolve over time by understanding and sharing of a common treatment approach.

### ***Communication in Shared Patient Care***

Communication is the lynch pin of effective shared care, and open discussion and communication is paramount to ongoing success. Participating practitioners and their patients must clearly understand which practitioner is responsible for providing the various aspects of care.

To avoid repetition and confusion, each party must have a clear understanding of:

- the other's diagnoses, treatment(s) and ongoing recommendations to the patient
- what information they need to forward to others involved in the patient's care,
- time frames in which this information should be forwarded
- the preferred format for this information.
- who is responsible for ongoing patient care and the follow up of patients who miss scheduled appointments
- the roles and responsibilities of each person participating in the shared care.

The use of standardised protocols and forms are recommended to clarify responsibilities and facilitate the transfer of information and communication between practitioners involved in shared care. Such systems may involve standardised forms used by all parties participating in the shared care arrangement, or may be a less regimented (but stated) agreement that each party will forward a report to others after each patient consultation.

As a minimum requirement, practitioners sharing patient care should have a clear understanding of which tests should be completed during review appointments. Ongoing discussion between the optometrist and medical practitioner should review these protocols and make any changes necessary over time to ensure optimal patient care.

All practitioners involved in shared care of patients should receive a copy of the results of any review appointments the patient attends.

### ***Patient Involvement in Shared Care***

In a shared care arrangement, patients must be clearly informed of who maintains responsibility for their primary eye care and when they are required to attend reviews with each practitioner. Patients must be provided the opportunity to choose whether they wish their care to be shared between the ophthalmologist and their optometrist. Similarly, the patient reserves the right to seek a second opinion if they so choose. Written information for patients regarding shared care may prove a useful adjunct to verbal discussions with their optometrist.

## **DOCUMENT B**

# **GUIDELINES FOR SHARED CARE OF GLAUCOMA PATIENTS**

### ***Introduction***

Under these guidelines suitably trained optometrists who are approved to use therapeutic drugs in their practices and who have adequate professional indemnity cover will be able to co-manage glaucoma patients in a shared care arrangement with an ophthalmologist.

Management of glaucoma patients typically includes:

- evaluation of intraocular pressures, visual fields and ocular structures;
- instigation of the necessary therapeutic and/or surgical treatment at the appropriate time;
- ongoing review to monitor for any changes in ocular status (including progression of the disease and/or side effects of treatment); and
- alteration to treatment strategies if required (this may include changes in medication regimens, surgical intervention or other alterations).

Once the diagnosis of glaucoma is confirmed by the ophthalmologist and a treatment plan is in place for the patient the optometrist can perform ongoing reviews to monitor the patient and prescribe topical drugs providing that:

- periodic review demonstrates the treatment to be effective
- changes to management are only initiated after the approval of the managing ophthalmologist.

### ***Initial Referral to Ophthalmologist***

An optometrist who makes a provisional diagnosis of glaucoma is to refer the patient to an ophthalmologist for confirmation of the diagnosis and the development of a management plan to allow for the patient's ongoing treatment.

Where clinically important delays are expected before the patient's first review by an ophthalmologist, the optometrist should seek interim advice from the ophthalmologist by telephone on the patient's management, and arrange an appointment with the ophthalmologist as soon as possible.

The patient's consent is to be obtained by the ophthalmologist and the optometrist for all aspects of the management plan, including to the sharing of care between the two practitioners.

### ***Patient Management Plan***

The management plan should specify in writing the following:

1. All the agreed components of treatment including any drug therapy.
2. Target pressures and any action to be taken if target pressures are not achieved within a specified time frame.
3. An agreed approach to monitoring visual fields and optic disc imaging and the action to be taken following changes in visual fields.
4. What changes in visual function and/or ocular status will trigger referral for more immediate ophthalmologic review. (This might include guidelines for referral based on IOP levels, visual fields, optic nerve head appearance and/or other risk factors.)
5. Likely side effects from agreed treatment and the action to be taken to address those side effects.
6. An agreed schedule for patient review by both the ophthalmologist and the optometrist, designating who is responsible for ensuring the patient attends agreed follow up visits. (In most cases a patient will have a review by an ophthalmologist at least once per year, however practitioners may agree to a longer review interval in certain clinical circumstances.)
7. Who is responsible for performing each of the required tests (including visual fields and mydriatic disc examination) and how frequently these tests must be done.
8. How clinical findings are communicated between parties, including General Practitioners, and mechanisms employed to ensure ongoing, open communication between all the practitioners involved.

Ophthalmologists must be available for consultation by the treating optometrist and for consultation by the patient where that consultation has been recommended or requested by the optometrist.

### ***Repeat Prescriptions for Patients***

From time to time, patients will present to an optometrist requiring an updated script. These may be visitors to the Northern Territory town in question, or local patients managed entirely by ophthalmology unable to secure an appointment with the local ophthalmologist before their Rx runs out. In such circumstances, the indicated tests should be performed ( IOP, Fields, Gonio and Disc Assessment) where appropriate. The managing Specialist may need to be contacted for written (faxed or emailed) confirmation of the current regimen, and for passing on any findings of the current examination. A duplicate prescription can then be written or amended for the patient as per written instruction from the managing specialist.

# DOCUMENT C

## A SAMPLE MODEL FOR GLAUCOMA SHARED CARE

### *Introduction*

This model has been developed to assist practitioners participating in the shared care of patients with glaucoma (and glaucoma suspects). It is not intended to imply that other models of glaucoma shared care are not equally valid. The Board recognises that both criteria for referral and treatment stratagems employed in the management of such patients may vary according to both the patient's presentation and the skills and clinical judgment of the practitioners involved.

### *Minimum standards of equipment*

To effectively diagnose and review glaucoma patients (and suspects), minimum standards of equipment would include:

- Applanation tonometer
- Computerised Perimeter
- Binocular nerve head analysis (preferably a 90D lens or the equivalent)
- Gonioprism

Where possible, baseline disc imaging (photography or tomography images) provide additional information that will assist practitioners in identifying early signs of glaucomatous change and documenting progression of neural tissue loss. Similarly, imaging of the nerve fibre layer may prove a useful adjunct in the identification and documentation of such change.

### *Clinical Guidelines*

#### **Target Pressures**

Setting a target intra-ocular pressure is an essential step in glaucoma management as it provides a baseline against which the efficacy of both pharmaceutical and surgical treatment modalities may be assessed.

While the setting of target IOPs will obviously vary according to the individual patient's age, history and disease state, the following may prove a helpful guide:

- *In Chronic Open Angle Glaucoma,*

Aim for target IOPs of 18 mmHg or less for people <70 years old, 15 mmHg for people >70 years old.

• *In Low Tension Glaucoma,*

Aim for a 30% decrease or IOPs <12 mmHg, whichever is less

It is essential that reviews be conducted at appropriate time frame to determine whether the patient is achieving target IOPs with their current treatment and also monitor for any side effects of the treatment. Should a patient consistently fail to achieve target IOP, they should be reviewed (in consultation with the co-managing ophthalmologist) to determine whether there is a need to alter the treatment strategy.

**Review Schedules**

To ensure optimal care of the glaucoma patient, a review schedule should be developed by the co-managing practitioners and communicated to the patient.

It is essential that all parties have a clear understanding of who is responsible for performing these reviews, and following up patients who fail to attend scheduled reviews.

Each time a practitioner sharing the care of a glaucoma patient performs a review, the results of this should be forwarded to the other practitioner(s) involved in this patient's care to encourage active participation by all parties.

While review schedules will be set according to the patient's needs/circumstances and may also vary between individual practitioners, the following provides some general guidelines to assist in the formulation of review schedules:

• *General Reviews*

Ocular hypertensives (OHT) / glaucoma suspects (GS):	12 months
Early glaucoma (EG):	6 months
Advanced glaucoma (AG):	3 months
Low Tension Glaucoma (LTG):	3-12 months

If there are a number of high risk factors present, more frequent review may be required. In order to determine if low tension glaucoma is progressive, frequent reviews are required early in the course, becoming annual after stability has been established.

• *Stereoscopic Optic Nerve inspection (and disc imaging, if available)*

Ocular hypertensives, Glaucoma suspects,	
Early Glaucoma and stable Low Tension Glaucoma:	once a year
Advanced Glaucoma:	twice a year
Low Tension Glaucoma:	twice a year until stability established, then annually.
Stable on meds:	9-12 months

- *Frequency of Visual Field Testing*

Ocular hypertensives, Glaucoma suspects,	
Early Glaucoma and stable Low Tension Glaucoma:	1/yr
Advanced Glaucoma:	2/yr
Low Tension Glaucoma:	4/yr until stability established, then annually.
Stable on meds:	12-18 months

### **Visual Field Assessment & Criteria for Field Progression**

Visual Field Assessment is a key tool in both the diagnosis and ongoing management of glaucoma, however significant variability can be seen in glaucoma patients which can make change difficult to detect with a reasonable level of reliability.

In assessing visual fields, it is extremely important that repeat visual fields be performed to confirm the reliability of results. As guideline, it is suggested that repeat fields be performed no sooner than two weeks and no later than 6 weeks after the initial test. Furthermore, it is essential that fields are repeated in the same format from test to test

At least 4 or 5 visual field tests may be required to establish stability/progression. Practitioners need to show at least twice that an unaffected area is now affected or has definitely changed, hence two fields are needed to establish baseline and two are needed to confirm progression. Practitioners monitoring advanced glaucoma or low tension glaucoma will need to use a test pattern that can identify threats to fixation.

- *If initial visual fields testing suggests a 10 dB loss in 3 adjacent points, the patient should be reviewed in 2-6 week and visual fields repeated.*

If at review,

3x15 dB loss was found => refer for ophthalmological opinion  
3x10-15 dB loss => borderline suspicious and keep reviewing (6-12 weekly) until worsens (3x15 dB loss) or gets better.

- *The development of repeatable loss in an area of previously normal field (3 points each with > 10 dB loss) should also be considered as progression.*
- *Two neighboring points adjacent to an existing scotoma that decline by > 10 dB or the deepening of 2 adjacent points in an existing scotoma by > 10 dB is sufficiently sensitive to be useful for referral, especially if these are not edge points.*

Such changes signal a need for re-appraisal of the clinical findings and treatment strategy, and consultation with the co-managing ophthalmologist.