New Retina Radio: Are Today's Protocols Tomorrow's Routines?

Selected excerpts from a recent edition of *New Retina Radio*.

INTERVIEW BY JOHN W. KITCHENS, MD; WITH MURTAZA ADAM, MD; DAVID R.P. ALMEIDA, MD, PHD, MBA; AND CHRISTINA Y. WENG, MD, MBA

As the host of New Retina Radio's *COVID-19 coverage, I've had the opportunity to speak with a number of leaders in our field about the present and future challenges the COVID-19 pandemic presents. I am curious whether, in some ways, we are witnessing the future of retina in our present moment.*

Protocols have changed significantly during the COVID-19 pandemic. Which of those procedures are here to stay and which will disappear as the pandemic subsides? To find out, I invited three of retina's rising leaders—Murtaza Adam, MD; David R.P. Almeida, MD, PhD, MBA; and Christina Y. Weng, MD, MBA—to New Retina Radio *to discuss which changes implemented in 2020 might become permanent fixtures in retina practice.*

Portions of our discussion are presented here, edited for brevity and clarity.

You can find audio of this episode (and others in the series) in the New Retina Radio *podcast feed. Just navigate to the podcast in your preferred app, subscribe, and listen.*

—John W. Kitchens, MD

PRACTICE LAYOUT

John W. Kitchens, MD: Describe how you normally see patients and then how you have modified that during COVID-19.

David R.P. Almeida, MD, PhD, MBA: We were lucky that our practice setup was already prepared to handle the COVID-19 crisis. Our practice has two floors. The pre-COVID routine saw patients interacting with physicians on the first floor, where diagnosis, imaging, and a treatment plan occurred. Treatment was administered on the second floor, which had a negative pressure system with multiple lanes.

During the pandemic, we have obviously adjusted waiting rooms, PPE requirements, and masking protocols. And we've tried to minimize contact opportunities. Luckily, our layout required patients who needed treatment to head directly to the second floor, and for most of our patients that's what we're doing. They come in for their injection and then they leave.

Dr. Kitchens: And are you doing more or fewer treatments now compared with before the pandemic?

Dr. Almeida: We're providing the same level of care. Our injection clinic was already set up, and so, other than extending intervals for a few patients, we're sticking to pre-pandemic treatment regimens. We use the first-floor imaging stations for selected patients, but the injection clinic is running at full tilt.

Dr. Kitchens: Dr. Weng, can you walk me through the hypothetical first visit for a patient with wet age-related macular degeneration (AMD)? Tell me what your protocols were before the pandemic so we have a basis for comparison.

Christina Y. Weng, MD, MBA: Our pre-pandemic check-in process required a technician to gather patient history, assess vision, and administer imaging. All of this was performed before the patient and the physician interacted.

Before the pandemic, we imaged any referred patients with OCT and occasionally fluorescein angiography to confirm diagnosis. I asked that a family member join the patient, if possible, so that another listening ear can absorb the information I'm delivering. At that point, I usually had the patient initiate therapy on their next visit because I needed pre-authorization to start injecting in most cases.

Now, our policy at Baylor does not allow patients to bring family members to appointments, unless that family member is there to assist with something like translation or a physical handicap. We try to streamline patient intake, too, which minimizes the number of surfaces a patient touches and the number of rooms that need to be turned over between patients. Many of our patients only receive OCT testing; ancillary testing such as fluorescein angiography and fundus photography are performed only if it will change clinical management.

I see patients in the same room where they are worked up, and I'm often administering treatment on the same day to eliminate the need for a return visit. I'm not sure how sustainable this is from a financial and insurance perspective, but it's what we're doing at Baylor now.

AT A GLANCE

- Some protocols implemented during the COVID-19 era may stay in place after the pandemic subsides.
- In an interview with *New Retina Radio*, three retina specialists share what's happening at their clinics, explain why some new processes may become permanent fixtures, and discuss which therapies and technologies in the pipeline would be particularly useful to have right now.

Murtaza Adam, MD: Dr. Weng's description of a *lean* facility is easier to implement in a smaller practice, and kudos to her team for thinking on their feet and adjusting quickly in the university setting. Luckily, at Colorado Retina, we had a lean system in place, and our adjustments looked more like Dr. Almeida's.

In the past, we didn't have to think about such high levels of safety measures in the clinic. Gone are the days of only wiping alcohol on an applicator to address contamination. Our entire framework has shifted.

PATIENTS AND BILLING

Dr. Kitchens: If we reserve imaging for only those patients whose disease management may be altered after the results, as Dr. Weng has described, then some patients may feel like we're not providing a full workup. Is that your experience, Dr. Adam?

Dr. Adam: Not at all. In fact, most of my patients are appreciative of getting in and out so quickly. Injection-only visits take about 30 minutes—a far cry from some of our previous turnaround times. For patients who report visual change, we check visual acuity and perform imaging. I wonder how we'll transition back after the pandemic's intensity is reduced.

Dr. Almeida: Have you run into difficulty with billing? Payers sometimes want to see vision checks or pressure checks on an assessment.

Dr. Adam: We don't bill for visits during injection-only visits. We bill only for the injection and, if needed, the OCT.

Dr. Kitchens: Drs. Adam and Almeida are in private practice. Does their experience with injection-only visitation mirror your experience at Baylor, Dr. Weng?

Dr. Weng: We check vision and pressure in all of our patients, and the vast majority of our patients receive OCT imaging. Our wet AMD patients are on treat-and-extend regimens, and we use that imaging to guide treatment. Luckily, OCT images are quickly acquired, so they do not disrupt our processing flow as long as they are ordered correctly.

TELEMEDICINE

Dr. Kitchens: How have you engaged with patients via telemedicine during the pandemic?

Dr. Adam: The day before a patient is scheduled for an in-person visit, we call them to gather information usually acquired during their in-person intake. History, medications, review of symptoms—all of that is included in their chart. When their visit starts, they get their pressure checked and then I see them immediately. I think we'll continue with this model even after the pandemic.

Dr. Kitchens: Telecommunication with some of our patients can be challenging.

Dr. Adam: Agreed. Sometimes it's a matter of getting a family member to help them with technology. Not uncommonly, the patient has trouble hearing you. It's not a perfect system—I would say it works for 50% to 60% of my patients. Still, it does lend itself to increased efficiency in the clinic.

Dr. Almeida: We use the same system that Dr. Adam just outlined. We gather as much information as possible over the phone before bringing patients in, and then we instruct them to visit our injection clinic for treatment visits. Telehealth, in that way, creates a quick and safe visit for our patients. But we have not done anything like video conferencing. We haven't had the need yet.

Dr. Weng: We have the ability to videoconference with patients via our EHR system, but I've found it challenging. It can be useful for triaging patients, and some patients find it reassuring to know a doctor is listening to their symptoms. But when a patient reports a change in vision, I can't say, "Oh, I don't think it's really anything," without the aid of an OCT or a dilated examination.

Dr. Kitchens: Are there any technologies that you wish you had?

Dr. Weng: Home OCT is something that would revolutionize retina. If we had that, we could tell patients with accuracy how quickly they need to be seen.

Dr. Kitchens: Agreed. Home OCT would be a game-changer. We have the Amsler grid, obviously, and we also have the ForeseeHome device (Notal Vision). Dr. Almeida, has your practice used the ForeseeHome?

Dr. Almeida: Our practice covers such a huge area that we have chosen to concentrate on efficiency and on supporting our local referral base. Unfortunately, we don't have the bandwidth for something like ForeseeHome.

Dr. Adam: My practice also hasn't embraced ForeseeHome, or any home-based monitoring system for that matter. Has your practice looked into these, Dr. Kitchens?

Dr. Kitchens: We're believers in it. We were in the HOME study, which evaluated the ForeseeHome device's efficacy. About 70% of my patients can use it, and they love it; the other 30% have difficulty with it. We have found it an effective monitoring tool for patients.

A Return to In-Person Meetings?

In-person education is one of the jewels of retina, and a dynamic of the job that many physicians miss. What concerns do you have about the resumption of in-person meetings, which will presumably happen in 2021?

Murtaza Adam, MD
Colorado Retina Associates
It's going to take a lot to convince me that in-person meetings should be resumed. I need to see evidence of a nationwide paradigm shift on how travel and business is conducted before I can comfortably attend a convention.

David R.P. Almeida, MD, MBA, PhD
Erie Retinal Surgery
It's tricky. Obviously, I want to go and see my colleagues and learn about their research. But I also don't want to acquire the virus while traveling, become an asymptomatic carrier, and then pass it along to my patients.

Christina Y. Weng, MD, MBA
Baylor College of Medicine-Cullen Eye Institute
Our facility requires people who visited certain states to quarantine for 14 days. Even if I visit a state that isn't on the list when I leave, I would be required to quarantine if that state is added to the list while I'm there. I must consider this when traveling to any potential events.

DRUG CHOICE

Dr. Kitchens: Has the pandemic affected your choice of drug—say, allowing more steroid use in patients with diabetic eye disease, or using a different anti-VEGF agent for wet AMD patients?

Dr. Adam: Before the pandemic, we had plenty of patients who received bevacizumab (Avastin, Genentech) and were happy to come in every 4 or 5 weeks for an appointment. Now, given that every appointment is a risk of exposure, our practice has shifted our anti-VEGF agents of choice, particularly for patients in long-term care facilities, as they are at the greatest risk for complications should they contract COVID-19.

Dr. Weng: Drug durability was already a hot topic, and now it's even more important. Longer-duration drugs could allow us to avoid a situation like we had at the beginning of the pandemic, when we had to strictly enforce social distancing and decide which patients we were able to see. Technology that could get us to quarterly intervals or longer would be great. That is part of the reason the Port Delivery System (PDS, Genentech) excites me so much. Regarding steroid use, I am generally a proponent of it, but given that it may also be harder for patients to return to our clinic if there is an IOP spike, it is important to select patients carefully.

Dr. Kitchens: Are you switching anti-VEGF agents?

Dr. Weng: I've considered it. Some patients with wet AMD experience longer duration of effect if they receive aflibercept (Eylea, Regeneron), for example. And of course, now there is brolucizumab (Beovu, Novartis). The patients I've started on brolucizumab have responded wonderfully, and many have moved to quarterly treatments. Given the safety considerations around brolucizumab, however, I think a lot of doctors are hesitant to start patients on this agent, especially during this time.

Dr. Almeida: With respect to neovascular AMD, we have significant experience with longer duration of effect and stable efficacy intervals with aflibercept, although we use all the available anti-VEGF agents. We started using brolucizumab in November 2019. When some safety concerns arose, we revised our consent process and monitor those patients closely.

THE FUTURE OF RETINA

Dr. Kitchens: Some of the changes we made will be here for the long term. Others will fade away with time. Does the panel have any ideas about which protocols will stay in place?

Dr. Weng: Cleaning practices and hygiene routines will probably stick around for a while. It's hard to justify going back to a less-clean workplace. I think that wiping down rooms with bleach and wearing masks will be around for a while. Forever, maybe.

Dr. Adam: Creating a less-clean practice—that's going to be a hard sell.

Dr. Almeida: As someone who loves staying involved with clinical trials, I look forward to enrolling patients and gathering data. We have a completely separate area for our clinical trials division, which facilitates pandemic preparedness in research patients. I can see this division of clinical roles (eg, imaging, diagnosis, treatment, research, etc.) remaining for the long term.

Dr. Adam: The challenge with recruiting for clinical trials at the moment is that patient volume is down. Patient enthusiasm is still present, which is key. But, in Colorado, our referrals fell sharply when optometry offices closed. ■

MURTAZA ADAM, MD
- Physician, Colorado Retina Associates, Denver, Colorado
- madam@retinacolorado.com
- Financial disclosure: Allergan/AbbVie, EyePoint Pharmaceuticals, Genetech, Novartis, Regeneron

DAVID R.P. ALMEIDA, MD, MBA, PHD
- Vitreoretinal Surgeon, Erie Retinal Surgery, Erie, Pennsylvania
- drpa@pm.me; Twitter: @davidalmeidaMD
- Financial disclosure: Allergan/AbbVie, Alcon, Alimera Sciences, Bayer, Genentech, Novartis, Regeneron

JOHN W. KITCHENS, MD
- Partner, Retina Associates of Kentucky, Lexington, Kentucky
- Editorial Advisory Board Member, *Retina Today*
- Host, *New Retina Radio* COVID-19 Coverage
- jkitchens@gmail.com
- Financial disclosure: None

CHRISTINA Y. WENG, MD, MBA
- Associate Professor of Ophthalmology; Fellowship Program Director, Vitreoretinal Diseases and Surgery; Baylor College of Medicine-Cullen Eye Institute, Houston
- Director, Medical Student Clinical Elective Ben Taub General Hospital, Houston
- christina.weng@bcm.edu
- Financial disclosure: Allergan/AbbVie, Alcon, Alimera Sciences, DORC, Novartis, Regeneron, RegenxBio