Practice management in the era of anti-VEGF therapy

Identifying the bottlenecks that are preventing effective management of neovascular AMD

Highlights from an expert roundtable meeting on practice management in the era of anti-VEGF treatment
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Introduction

“Practice management is the adaptation of the clinic organization and/or team structure regarding screening, diagnosis, treatment and patient care. Its purpose is to improve patient flow, treatment efficiency and outcomes while maintaining or improving the quality of the clinical work for both the patient and staff. This will lead to optimized utilization of resources and measurably improve outcomes.”

The past 12 months has witnessed the launch of anti-VEGF therapy across the world as well as in Europe to treat neovascular AMD, creating excitement amongst the retinaology community as well as a dramatic shift in practice patterns. Now, almost all subtypes of the disease in its various stages are treatable with this new class of therapy, as opposed to previously, when only a portion of patients qualified for verteporfin therapy. But what does this really mean for the retina specialist and why are we highlighting the importance of practice management?

Simply stated, each retina specialist can now expect a dramatic increase in the number of patients seeking diagnosis, treatment and counselling.

To add to the complexity of today’s situation, not only are all existing active neovascular AMD patients now eligible for treatment, but the prevalence of the condition is on the increase; as the baby boomer age, the number of patients with AMD will continue to escalate. The true extent of this phenomenon can only be truly realised when we take a closer look at some statistics. For example, today, there are an estimated 50,000 new cases of neovascular AMD per year in Germany2 and approximately 26,000 in the UK,3 escalating the need for each retina specialist to devise a treatment plan that incorporates screening, diagnosis, consultation, follow-up and counselling for each patient. Taking all stages of the patient journey into account, it is clearly estimated that specialists could witness an approximately six-fold increase in patient volume4 This is no easy task and will require careful planning prior to the introduction of anti-VEGF treatment.

In addition to considering frequency of therapy, specialists must also now consider how to devise a treatment plan that incorporates screening, diagnosis, consultation, follow-up and counselling for each patient. Taking all stages of the patient journey into account, it is currently estimated that specialists could witness an approximately six-fold increase in patient volume.4 This is no easy task and will require careful planning prior to the introduction of anti-VEGF treatment.

Retina specialists are attuned to the fact that changes lie ahead and for those who have already introduced anti-VEGF therapy into their clinics, this estimated six-fold increase in patient numbers is already becoming a reality. In fact, it is thought that this figure may even be an underestimation as it fails to account for those who have not been diagnosed.

In February 2007, a European panel of retina specialists participated in a roundtable meeting to address the issues that will soon be facing their European colleagues in the era of anti-VEGF treatment. The objective was to identify the bottlenecks to efficient patient flow that now exist along a single patient’s journey, from initial screening, right through to discharge and post-treatment rehabilitation (see Figure). The aim was to use this knowledge to advise on how to tackle each bottleneck thus allowing effective management of the increasing workload, whilst also maintaining high standards of care. The ultimate goal: to reach a consensus on recommendations for best practice.

“We need to pre-empt these problems and put measures in place today so that we can be best prepared to deal with them tomorrow,” urged roundtable meeting moderator, Florian Sutter-Adler, MD.

So now we begin the first part of the journey by taking a look at initial screening and referral.

The Panel

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Practice management in the era of anti-VEGF therapy

Identifying the bottlenecks that are preventing effective management of neovascular AMD

1 GO screening & referral

According to recent market research, there are currently between 55 and 70% of late- and early-stage AMD sufferers who have yet to be diagnosed, which clearly indicates an inadequacy in current screening and referral methods. It was generally agreed by all meeting participants that people over the age of 50, especially smokers and those who have relatives with AMD, should be screened periodically either by a general ophthalmologist (GO) or an optometrist. Fundus examination, patient history, visual acuity (VA) testing, Amsler grid screening and photographic imaging of the central retina were recommended screening tools. Optical Coherence Tomography (OCT) was not deemed necessary at this stage.

Public disease awareness and education was identified as a key bottleneck to adequate diagnosis and referral. “I find that one of the main reasons for late referrals and hence, failed treatments, is that people learn to compensate for a bad eye with the good eye. I think this is a fundamental problem in ophthalmology overall — it starts with a squint and ends with AMD,” said Norbert Schrage, MD. There is, therefore, an urgent need to address public awareness and education.

“Do you think a public campaign using various media, including television, would be useful?” questioned Dr Sutter. “I think the public should have easy access to low-cost vision monitoring tools such as the Amsler grid, with advice on how to perform a self-examination. If symptoms are apparent, the card should advise on next steps and open channels that bypass the usual waiting lists. There is a severe shortage of GOs in Germany, hence, patients who are able to self-examine would compensate a little for this. After all, if we can administer treatment early, we are in a fortunate position not only to prevent further vision loss, but we may also improve it,” enthused Dr Schrage. He continued, “We need to publish the wonderful fact that improvement in vision is possible with the latest treatments.”

Public education was therefore highlighted as an important aspect of good screening and referral practice. However, so too was education of the GO. “Admittedly, we are faced with a big problem in that, more often than not, patients do not understand the severity of their condition and will not complain if they are added to a long waiting list to see the GO. It is not unreasonable, however, to also assume that ophthalmologists who have not often seen patients with neovascular AMD are not fully versed in the recent developments that have been taking place in AMD treatment. I think we need to train the people who are performing public screening so that they are aware, not only of what to look out for, but also, of the benefits of early referral. I cannot emphasize enough the importance of early referral. In Italy, delays in referral create a big bottleneck in good patient flow and practice management,” insisted Costantino John Trombetta, MD. Martine Mauget-Fajssé, MD agreed, “Sometimes the system falls apart: if the urgency of the patient’s condition is incorrectly evaluated during screening or if the patient does not realise the seriousness of his case and does not insist on a quick appointment with the GO, it will result in a late referral and ultimately a poor treatment outcome.”

Unsurprisingly, incorrect referrals are also a big problem. “The lack of GOs in the northern region of Denmark, in which I operate, means many referrals are made by general practitioners (GPs) who have limited experience and instrumentation required for AMD screening. This leads to incorrect diagnosis and poor judgement of referral urgency,” said Lars Loumann Knudsen, MD.

“I think that with every new treatment, retinal specialists should take the opportunity to educate GOs, optometrists, GPs and the public. We need to educate professionals, in particular, to refer within one week of seeing a suspected case of AMD. Then I think things will improve,” said Winfried Amoaku.

2 Retina specialist diagnosis

Moving along to stage two of the patient’s journey (the patient has been referred to the specialist), the issue of diagnostic tests roused similar opinions amongst all participants, with fluorescein angiography (FA) being accepted as a necessary diagnostic test in all new patients, along with a complete ophthalmic evaluation including VA measurement, fundus examination, intraocular pressure (IOP) and OCT tests. The main reason is to ensure an accurate diagnosis. The general consensus amongst all participants was therefore to recommend a routine angiogram in all new patients, unless there is a good reason for not doing so. “At present, we are all still on a very steep learning curve. We may find, in the future, that FA may not be necessary upon initial presentation, however for now, we would recommend this test,” said Dr Sutter.

Theoretically, it should be possible to perform FA within 15 minutes, however, it was agreed that the number of angiograms upon initial presentation, do not represent a bottleneck to efficient practice management. Rather, the definition of roles and an efficient team structure is crucial to ensure smooth running. “All diagnostic examinations should be performed by predefined personnel in a predefined order to ensure smooth patient flow, supported by optimal hardware...
setup. As a result, several members of staff will be involved in the diagnostic procedure, thereby necessitating a systematic and repetitive education to ensure diagnostic uniformity. Weekly decision conferences could ensure clarity in the diagnostic process,” recommended Dr Knudsen.

The panel agreed that FA should be performed by a specialist, whilst opinions on the level of experience required for all other tests varied. Depending on the available resources, further diagnostic tests are currently performed by either nurses, junior doctors, technicians or the retina specialist. “In my clinic, we try to build a strong team, where well-trained technicians, who are not qualified doctors, play an important role. These technicians measure the VA, IOP, and perform the OCT testing. We have managed to increase patient volume significantly with this approach,” said Dr Stutter.

3 Administration & preparation
Upon completion of the diagnostic tests and the decision to initiate anti-VEGF therapy has been made, the process of administration and preparation begins. The complexities of this aspect of the patient journey vary from country to country in Europe, particularly because of the differences in healthcare regulations, reimbursement policies and legal requirements.

In this instance, it is essential that sufficient information is provided to the patient to enable informed consent. It is also agreed that timing is important here; a patient should not be supplied with a lot of new information and asked to sign a consent form unless they feel certain that they have understood what is involved and are happy for the retina specialist to proceed with treatment. “Same day consent and treatment is possible, however, I think this should be avoided, because patients need to fully understand the nature of the treatment and potential complications,” said Dr Trombetta. It was generally agreed that 24 hours between the provision of information and consent was acceptable. In contrast, Mr Amoaku felt that a 24 hour wait was unnecessary and time-consuming, particularly for those patients that had long distances to travel.

“The first consultation with the patient takes quite a long time, I would say around 20 minutes. During this time, we inform the patient of the nature of the disease, using illustrative aids, and we tell them exactly what we are planning, with regards to treatment, re-treatment and follow-up. They also have the opportunity to ask questions. I feel a lengthy initial consultation is necessary to allay any concerns the patient may have, to save time during future consultations and, importantly, to build a good relationship with the patient,” said Dr Stutter.

Dr Schrage interjected, “We have begun using an informed consent interactive computer to educate the patient before the initial consultation. The educational system takes the patient, step-by-step, through a number of pages, which explain the disease and treatment. At the bottom of each page, the patient must answer whether they did or did not understand that page, before progressing to the next. They are then presented with a printout of their results, which they bring along to the consultation.” He continued, “We are currently piloting this programme to establish whether this method enhances information retention by the patient. Eventually, we hope that this will reduce consultation time.”

In most clinics, once the initial consent is given, patients are not asked to consent again for subsequent injections, unless the treatment protocol changes from that initially described. However, Dr Schrage disagreed with this approach and insisted on the provision of a signature before each anti-VEGF injection, if anything, so that all angles are covered should a legal case be filed. “I think asking for another signature would cause a break in the relationship with the patient; they may view this as a sign of mistrust,” countered Dr Sutter.

“I believe that multiple informed consents can be avoided by wording the initial consent form in such a way as to cover multiple treatments,” suggested Mr Amoaku.

“It is true to say that legal cases are initiated when a patient is unhappy. Shouldn’t the most important protection against legal action therefore be to make sure the patient is happy?” questioned Dr Sutter. He continued, “I think, in general, one must consider the likelihood of legal action being initiated versus the time you spend on gaining one or multiple informed consents.”

The issue of insurance and payment for anti-VEGF treatment stimulated a mixed response from the panel, with Dr Schrage and Mr Amoaku particularly highlighting a bottleneck to smooth practice management at this step. According to Mr Amoaku, the paperwork involved in applying for anti-VEGF therapy significantly increases his workload. At present, only a few primary care trusts in the UK are paying for selected patients to receive anti-VEGF treatment. “In recent weeks, however, two private insurance firms in the UK have agreed to pay for this treatment, so I do see others following suit,” said Mr Amoaku.

Dr Schrage, on the other hand, experiences problems once the initial letter requesting treatment payment is sent to the insurers. “Although only one letter is

### recommendations

**Administration & preparation**
- Provision of adequate processes and materials to aid informed consent
- Healthcare regulators need to facilitate access to anti-VEGF therapy

**Treatment**
- Trained personnel to administer intravitreal anti-VEGF therapy
- Sterile technique and sterile field more important than the type of treatment room environment
- Antibiotics should be used watchfully as part of the overall patient and procedure evaluation
- Outsourcing injections not recommended
required, we have a problem with receiving payment from the insurers because no system is in place as yet, which dictates the regularity of payments, or responsibility for them. Our time is wasted chasing the insurers as well as answering unnecessary questions. This creates around 10% more work for us,” he said.

In order to overcome this bottleneck it was agreed that, not only should healthcare authorities be updated on AMD and recognize the importance of anti-VEGF therapy for AMD patients, thus allowing easier access to the treatment, but a system needs to be put in place which advises on responsibility for treatment payment and reimbursement of ophthalmologist time and resources.

4 The treatment

Once the administration process has been completed, the patient is now ready to receive anti-VEGF therapy, but how can treatments be organized efficiently whilst maintaining or improving quality of care?

The panel agreed that the intravitreal injection itself should be administered by a trained ophthalmologist, not necessarily the consultant retina specialist, but someone who has been fully trained in the correct technique for administering intravitreal injections, such as a junior doctor. The reason for this being that, as more intravitreal procedures are performed in the future, the need for fully trained professionals who are able to administer intravitreal injections will escalate. There was less uniformity, however, on the subject of the treatment room.

“Should we administer therapy in a clean room or an operating theatre?” questioned Dr Sutter. The decision was split amongst all participants, with half of attendees suggesting an operating theatre set-up versus advocates of the clean room setting. Mr Amoaku informed the panel that he performed his injections in a clean room. His patients do not change clothes and he prepares himself by wearing a gown, mask and sterile gloves, after washing his hands. Dr Sutter supported Mr Amoaku’s approach and added that he believed the important issue was the actual technique employed rather than the treatment environment. “We must all be employing a sterile technique, ensuring a sterile field around the eye to be treated. So, rather than arguing about what room we should be performing the injection in, I think we need to teach the next generation how to do it correctly,” insisted Dr Sutter.

It seemed, however, that Dr Trombetta and Dr Schrage were bound by regulations, which insisted that the treatment be performed in a full operating theatre. Dr Mauget-Fayssé and Dr Knudsen also agreed with this approach to treatment. “We should perhaps move it to a semi-sterile room but I am bound by regulations right now,” Dr Schrage admitted.

It transpired that moving the treatment from the operating room into a semi-sterile setting, would halve the time needed to inject each patient, taking it from a 17 to 20 minute procedure in the operating room, to a seven to eight minute procedure. Thus 10 minutes could be gained simply by changing the treatment environment. “I agree that the operating room presents us with a big bottleneck, however, we must follow our guidelines which insist on this form of treatment environment. I do, however, feel that these guidelines may be unreasonable and are limiting our ability to instil good clinical management when trying to optimize patient flow,” said Dr Trombetta.

Dr Mauget-Fayssé admitted to employing a rather unconventional approach during the injection procedure, in that she also employs the assistance of a psychiatrist, in order to induce hypnosis in patients, particularly for their first treatment. “I find this relaxes my patients. They are, however, free to choose whether to accept this mode of relaxation therapy or not,” she said.

When the subject of outsourcing the injection to outside the clinic in order to facilitate patient flow was suggested, all agreed that this was a bad idea. “I think outsourcing will take the involvement I have with my patient; the best part of my job is to see people healed. If somebody else is administering treatment, I would feel as though my soul as a medical doctor would also be taken from me,” said Dr Schrage.

The subject of antibiotics also stirred a passionate debate amongst all participants, with each specialist amongst the panel employing a different method in their practices. Opinions varied significantly, with Dr Mauget-Fayssé preferring to administer antibiotic drops two days before the injection and then for three days afterwards. Meanwhile, both Dr Sutter and Dr Knudsen recommended against antibiotics. “I do not believe we cause a significant break in ocular tissue to necessitate antibiotic use. We must be very careful with over-using antibiotics, particularly with fluoroquinolones,” urged Dr Sutter.

All agreed that injection technique was crucial here, so too was the use of povidone iodine for disinfection. All-in-all it was accepted that preparing the patient and the eye for treatment should take at least five minutes.

The number of injections that could be performed each day does vary significantly, depending on how a
Patient-self monitoring essential

GO involvement recommended

Monitor long-term rehabilitation & treatment

Follow-up monitoring & re-treatment

- GO involvement recommended
- Full examination, including FA, to be performed after third injection
- Patient self-monitoring for VA essential between treatments

Long-term rehabilitation & monitoring

- GO involvement recommended
- Patient self-monitoring essential in the long-term follow-up after treatment course

Post-treatment exam

When the subject of immediate post-treatment examination was discussed, it was felt that only a minor examination should be performed immediately after treatment. Both Dr Sutter and Dr Knudsen were in agreement in not performing post-injection tests, however, a fundus examination was recommended by all other participants. Of course, this does depend on the patient. Mr Amoaku admitted that, of his last 500 patients, he has not witnessed any postoperative complications, hence he feels immediate postoperative testing is probably unnecessary. He has abandoned IOP checking but he insists on checking the fundus.

Dr Sutter clarified that the panel did not feel that postoperative examination presented a bottleneck to good patient management, rather he urged those administering treatment to think, “I feel that no examinations are necessary immediately after treatment in the vast majority of cases, however, many examinations may be needed in a minority of our cases. Ophthalmologists must learn to judge this for themselves,” he said.

In Dr Schrage’s clinic, patient discharge follows very shortly after a brief examination of IOP and funduscopy followed by a short period of being seated outside of the treatment room. “During this time I organize my communication to the patient’s GO advising on reaction to treatment,” said Dr Schrage, who insists on a close relationship with the referring GO throughout the course of patient treatment and follow-up.

Dr Knudsen has a different approach, “Our patients are contacted by telephone the day after injection and recalled to the clinic in the event of unexpected complaints (which are also registered by the Danish National Board of Health). The GO has not been included so far, though this may be advantageous in the future.”

If, however, the patient is receiving a second treatment, such as cataract surgery, both Dr Trombetta and Mr Amoaku recommend performing the cataract surgery on a different day to the injection, whereas Dr Schrage will administer anti-VEGF therapy soon after performing cataract surgery as the eye is already prepared and stable.

With regards to administration of multiple AMD treatments, such as verteporfin therapy in conjunction with anti-VEGF, Mr Amoaku, Dr Trombetta and Dr Mauger-Fajssé preferably administer both treatments on the same day. Dr Schrage, however, disagreed with this and advised that he pre-treated those patients with verteporfin therapy around three to four weeks in advance of anti-VEGF treatment so that, even if negotiation for funding of anti-VEGF treatment was necessary with insurance firms, he had already initiated therapy. Dr Sutter, on the other hand, said that patient flow would be interrupted in his clinic if both treatments were administered on the same day, in light of the way his clinic is currently organized. He therefore prefers to administer verteporfin therapy in a separate clinic altogether.

Follow-up monitoring & re-treatment

With regards to follow-up monitoring, Dr Schrage is a strong believer in including the referring GO at every step of the patient’s treatment journey. “Once I administer treatment, I will refer the patient back to the GO, who will act as their first point of contact should the patient have any problems following treatment,” advised Dr Schrage. He continued, “I try to involve the GO, firstly because I do not want them to feel that I am taking their patients from them and, secondly, because they act as supervisors of my therapy so, not only do I make everything I do completely visible, but I also rely on them for support.”

In general, the panel were united on the issue of FA during follow-up, with each participant stating that an angiogram was not necessary at each stage of follow-up to help them reach a decision on re-treatment. Overall, the panel advised that VA and OCT tests be given every month and a full examination, including angiogram, be performed one month after the third injection, hence four months after the very first treatment.

Dr Schrage, however, stated that FA is not routinely performed in his clinic if OCT reveals no observable oedema and there is a major visual improvement. As part of his treatment protocol, he will administer his first three anti-VEGF treatments without performing any examinations, unless the patient informs him there is a problem, “I do not feel it is necessary to perform any full exams unless the patient is unhappy with something. At the moment, this only equates to around 5% of my patients,” he said.

“Admittedly, I perform ETDRS chart VA measurement, near VA and OCT tests every single time a patient comes to me for their treatment. For me, however, this largely has an academic focus because I would like to collect as much data as possible so that I can learn from the treatment. However, maybe this is something that I need to alter because we do spend time gathering this data and it may be that, as my patient numbers continue to grow, this is something that will be abandoned,” said Dr Sutter.

Patient self-monitoring was highlighted as a crucial part of the monitoring and follow-up process. Not only would this go towards reducing unnecessary appointments made by concerned patients, but it would also alert the patient to potential problems between appointments.

Dr Sutter reassured the panel that self-monitoring materials can be simple and inexpensive, by referring to his own patient monitoring forms, one of which provides instructions to the patient of their treatment and contact details for the clinic. The second form is a VA test with instructions on how to perform the test and what to look out for. “We rely on patient self-monitoring and find these forms very effective. I do think, however, that maybe we should also involve the referring GO at this stage of the process,” conceded Dr Sutter.

Overall, it was agreed that there may be a future role for the GO in treatment monitoring, provided they were fully equipped with the necessary tools and knowledge to monitor patients. Hence outsourcing follow-up was a possibility, though only a reality in the

Patient Self-Monitoring

- Instructions on how to perform the test
- What to look out for

Outsourcing Follow-up

- Potential role for the GO in treatment monitoring
- Full equipment and knowledge for monitoring patients

Follow-up Monitoring & Re-treatment

- GO involvement recommended
- Full examination, including FA, to be performed after third injection
- Patient self-monitoring for VA essential between treatments
clinics of Dr Schrage and Dr Mauget-Fajyse thus far. Monthly VA and OCT exams were also deemed potentially unnecessary by some, though all specialists, apart from Dr Schrage, still perform these tests at each appointment as routine. Meanwhile, investing some time into developing simple patient self-evaluation forms could save time but could also highlight problematic cases in the long-run.

7 Long-term rehabilitation & monitoring

Looking further ahead, it was difficult for the panel to provide concrete guidance on treatment cessation and long-term monitoring, simply because anti-VEGF therapy has only been available for a short period of time. “I have not officially discharged any of my patients yet, I have instead opted to lengthen the intervals between follow-up appointments” stated Mr Amoaku. He conceded that this would pose a significant management problem if he continues to manage his patients in this way, however, he confirmed that, once more experience is gained with anti-VEGF treatment and discharge, his approach will change.

Dr Schrage advised that approximately half of his patients so far present a dry lesion after the initial three anti-VEGF injections. If his patients demonstrate improved VA, the OCT shows no oedema and perhaps an angiogram demonstrates no leakage, he assumes the lesion is dry. On this assumption, his patients are then provided with adequate self-monitoring materials and referred back to the GO who will review their progress every three months.

Dr Sutter did not fully agree with this approach and instead recommended prolonging duration of follow-up with the patient. “I admit that we are slightly in limbo at the moment with regards to the best way to go about long-term patient follow-up. Right now I do follow my patients closely, although this might just be an academic drive to gain good information,” Dr Sutter conceded. Dr Schrage is currently testing a new scheme, which involves patients who are self-monitoring to enter their data into a system on the Internet, which in turn is sent to him. Whilst currently only around 25% of Dr Schrage’s patients have Internet access and can therefore use this system, he is continuing to test the validity of this approach in nursing homes. “Although there is a problem currently with self-examination, this will improve over the coming years as our new patients come to us with improved computer skills,” said Dr Schrage. It was agreed that long-term follow-up did present a bottleneck to good practice management at the moment, with the idea of involving the GO and promoting self-examination being accepted by all as a viable solution.

Organizing the clinic

The final issue for discussion related to the organization of the clinic in general. Specifically, which approach works best: the production line or the integrated team approach? Certainly, this will depend largely on whether the specialist opts to screen, consult and treat their patients all on the same day or whether they opt to reserve days for certain components, for example, a day of injections.

All agreed that it is preferable to perform all components of treatment within the same day, the best approach being to optimize both patient and team satisfaction by adopting the team approach, i.e. for the patient to be seen by the same team on each visit, if possible. Dr Schrage advised that he had considered performing all injections on one day by asking that patients queue in line outside of the operating theatre. “Although this may have increased the efficiency of my clinic, I would be very disappointed and unhappy if I had to perform my job in this way,” he admitted.

Dr Sutter voiced the opinions of all when he expressed his three reasons for preferring the integrated small team approach, “Firstly, I do not feel that it is necessarily less efficient than the production line method, if it is organized well. Secondly, the patient will appreciate this approach; they always want a good relationship with the team. Thirdly, it makes the team happier: if you have someone only performing OCT every day, they will quit their job very quickly. It is all about working towards the end result together. This makes our jobs far more satisfying and rewarding.”

When discussing the main differences between teaching hospitals and private clinics that administer anti-VEGF therapy, it became apparent that clinics without an OCT would face a further bottleneck to good patient flow, because some patients would need to be referred elsewhere for accurate diagnosis. “At the moment, most district hospitals in the UK do not have an OCT, thus they are precluded from providing anti-VEGF services,” added Mr Amoaku.

In closing

At the conclusion of the meeting, the panel agreed that the first steps had been taken to addressing the very important challenge of neovascular AMD practice management. “Two years ago, I used to say I felt like a priest, because my job primarily involved comforting unhappy AMD patients, now, the vast majority of my patients are happy,” enthused Dr Sutter. Dr Schrage added, “This message needs to be transmitted to those who are responsible for referring patients but, more importantly, the message needs to be heard by healthcare regulators and insurers. At the moment, everyone is concentrating on the economics of treatment. This is the wrong message. What we have learned is that a formerly untreatable disease can now be treated. Thus we face a situation whereby we need more resources to adequately treat our patients.”

The team also agreed that more attention needed to be paid to defining a role for the GO, defining the perfect injection technique rather than promoting an operating theatre-style environment and encouraging patient self-assessment. These measures, it was accepted, would go some way towards alleviating the bottlenecks that today’s retina specialist faces.

“I was speaking with a colleague recently about practice management and I asked her how a clinic should be organized in order to cater for more patients and to perform more injections. She answered, ‘Is there a smart solution to an un-smart problem?’” said Dr Mauget-Fajyse. Although it is evident that different bottlenecks exist in different countries, largely related to regulations, the panel have made the first steps towards identifying the common obstacles and providing some very useful suggestions for securing a clinic that instils good practice management in the era of anti-VEGF therapy.

More attention needed to be paid to defining a role for the GO, defining the perfect injection technique rather than promoting an operating theatre-style environment and encouraging patient self-assessment

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recommendations

Clinic organisation

❚ The team approach preferable to the production-line

References

3. AMD Alliance UK. Left to pay their own way. October 2006.
4. On file at Novartis Ophthalmics