

Contact lens co-management & other schemes



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Schemes

- None

Other schemes

- None at time of publication

And on the CD ROM

- Contact lens presentation

Contact lens schemes

Summary

Contact lenses

Summary

For some medical conditions, contact lenses are the only possible or practicable method of sight correction. In conditions such as:

- keratoconus
- aphakia
- anisekonia
- irregular astigmatism
- high refractive error
- contact lenses are the preferred option for sight correction. They may also be used as bandage lenses and for:
- anterior segment damage due to trauma
- albinism

The fitting of contact lenses in such clinical situations is currently undertaken, if at all, within the secondary sector i.e. in hospital-based clinics which are often staffed by part-time, contact lens practitioners, and following a consultant access appointment. These practitioners, because they have a special interest in contact lenses, usually offer the same or similar service from their community based practices on a private basis i.e. to non-NHS patients. It seems difficult to justify the allocation of relatively expensive, hospital-based specialist clinics, for this purpose, when community optometrists can provide the service.

Basing such services in the community, where premises, equipment and skills are already established, offers patients the advantages of convenience and continuity, as well as the potential of a cost efficient service to the provider.

As with all co-management, planning needs to be undertaken in a multi-disciplinary forum, ensuring that the interests of the patient are central to the delivery system. This section does not cover the fitting of artificial eyes.

Contact lens schemes

Overview

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Overview

There appear to be no figures available on the number of contact lens patients fitted within the HES, and no centrally available data on where and how these services are provided.

In hospitals where there is a full time optometrist the supply of contact lenses may be undertaken efficiently and with great expertise. Hospital optometrists may build up considerable skill and experience in the fitting of some of the more esoteric designs used for abnormal conditions such as keratoconus. However this situation does not apply in many hospitals, where the fitting of contact lenses is more likely to be via itinerant fitters, who may be optometrists or dispensing opticians. It is also routine, when there are no hospital optometrists, for the supply of contact lenses to be undertaken through a tendering process, which may obtain the lowest per capita cost but may prove not to be the most effective route to supply a satisfactory clinical service of high quality.

The supply of contact lenses for medical reasons can be provided adequately through the primary sector, thus relieving the secondary sector (HES) of this burden. It is the view of the Government that wherever possible care should be provided in the community, via the primary sector. This policy fits well with the supply of contact lenses.

Most practices supply contact lenses, although increasingly this is restricted to straightforward soft lenses, which have a minimum of different parameters. This approach is not conducive to medically indicated contact lenses, so optometrists who wish to be considered for this type of co-management are likely to be involved in the fitting of gas permeable, toric and bifocal contact lenses. In most cases the fitting of contact lenses as part of the medical care of patients will be within the capabilities of such practitioners.

As with all co-management schemes, the wide availability of the service may not ensure that each practitioner has sufficient volume of fittings to guarantee the maintenance of adequate expertise in this specialist area of optometry. It would therefore be necessary to plan the service based on the number of patients who are likely to be seen, and the geographical distribution of available and interested optometrists.

Currently some medical contact lenses are supplied through the community by the issuing of an HES (P) form to the patient, who takes it to the contact lens fitter of their choice, or by patients being instructed to take it to a specific practice. Neither of these approaches would appear to produce an efficient, cost effective, high quality contact lens service provided throughout the community.

Contact lenses - development

The development of a contact lens co-management scheme

Overview

Every scheme will have to develop to suit local need, and so will be unique. As with all co-management, no scheme can be developed without first assessing the need. In contact lens care this assessment will investigate the number of potential recipients of the service within the catchment area, which is likely to be different to (more than) the number of those currently being provided for. The aim is to improve on the service (if any) already in operation. This will need to take into account the likelihood that some existing long standing contact lens wearers do not have satisfactory aftercare.

The next stage will be to examine how this service is currently being provided, for example:

- where is the service provided and by whom?
- how often are clinics held?
- is the service convenient for users?
- what is the procedure for introduction into the service?
- are there adequate recall facilities, with systems in place to identify non-compliance?
- has the service been provided consistently?
- has it been audited?
- who is paying?

Having established the current usage levels, the potential demand and the quality of service delivery a start can be made on planning a better service. The aim should be to deliver contact lens care for those persons who require them for medical reasons in an efficient manner, ensuring high standards of clinical care, cost effectively and as conveniently as possible for the patient. There will need to be compromises in these aims, some of which may be mutually exclusive. For example the most efficient way may be to expand an existing HES based service, even though this is not as convenient for users as a community based service.

It is self evident that there is no point in deciding that a community based service would be the most appropriate if there are few optometrists in the area who are able and willing to provide this. The LOC should undertake a survey of local optometrists to determine the availability of optometrists to provide a contact lens care facility. This should determine the experience level of those who indicate interest, and whether or not they would be prepared to undergo further training in the techniques required for fitting specialist lenses (such as keratoconus). It is quite likely that not all practitioners will want to fit the whole spectrum of medical contact lenses, for example paediatric aphakia patients.

The team approach

Contact lens co-management planning will involve fewer clinical groups than some other schemes (e.g. diabetes and low vision), but successful schemes must include those who are currently, and will in the future, be associated with the service. A list should be produced which includes all of those who are party to the present arrangements, and those who will be affected by any change. This group will contain ophthalmologists and optometrists, but will also require managerial input from the secondary sector and possibly the PCT if they are to provide the funding. Patient involvement may also be seen as beneficial. It should also be noted that some users of medical contact lenses may have low vision and so their service may need to be integrated into the overall low vision care.

Contact lenses - development

The General Medical Practitioner

Most GPs are very happy to move to a community management system. It is probable that they will have little involvement in the delivery of this service.

The ophthalmologist

Some ophthalmologists are enthusiastic about contact lenses, but most do not have any real role in the day to day management of patients. In most cases it will be the ophthalmologist who refers the patient into the service, and who will retain overall clinical management of the patient in many of these. Thus it may be that for the keratoconic patient the ophthalmologist will retain a close interest in the clinical care of the patient, but in the case of a long established aphake there may be no involvement at all. This will need to be planned into the access and continuing care arrangements.

The optometrist

It is sometimes ironic that the wearer of medical contact lenses may be attending a community optometrist contact lens practitioner for “routine” eyecare and the provision of spectacles. By involvement in this scheme the optometrist gains considerably in the overall management of the patient. This not only enhances the clinical role of the optometrist, but reinforces the perception of the patient that the optometrist is the community based eyecare specialist.

The optometrist should be part of the planning process, with input at every stage in the implementation of a new system, and in the ongoing management of the scheme. Adequate feedback to all concerned is part of this process.

The fee for the optometrist’s consultations can be generated either by a “work sheet” which is processed monthly (cf. GOS vouchers), or automatically by an additional copy of the reports being sent to the hospital administrative department. The contract can be on a per-case, per-visit or block purchase arrangement.

The advantages of using optometrists are:

- graduate professional
- primary healthcare specialist
- trained to examine the eye to detect abnormal ocular conditions, general health problems & defects of eyesight
- economic & effective
- give advice on all eyecare-related matters
- under-utilised healthcare resource
- have the necessary communication skills
- committed to CET/ clinical audit/ clinical governance
- likely to be more available in throughout the community
- well equipped practices
- established recall systems
- flexible appointment times

The advantages to the patient are:

- improved access to the service
- delivery of the service in convenient and familiar surroundings
- continuity of care

Contact lenses - development

Paperwork

The optometrist should inform the hospital of the outcome after each visit, and should be able to identify when patients do not attend.

Training

Training should be an integral part of any scheme, as the essential clinical skills of the optometrist to fit specialist lenses may require enhancement compared with those normally expected in community contact lens practice. It is essential that all optometrists are well acquainted with procedures as well as guidelines, and they are aware of the activities of all of the other participants.

Accreditation

It is likely that in a system which relies on a more advanced usage of the skills of optometrists some form of accreditation will be necessary, with individual optometrists (not practices) being accredited once the training programme has been completed. Provision needs to be made to train and accredit optometrists moving into the area.

Audit

Audit is an essential ongoing feature of the schemes. Initial audits will discover any procedural problems which can be discussed with the management team. Later audits will identify clinical problems, and fine tuning issues. Participants must be aware that they may be identified as not measuring up to the levels of performance required which will suggest changes to the accreditation or training, or in severe cases removal from the list of participating optometrists.

Funding

None of the participants should expect any of the other participants to undertake additional tasks, unless these are adequately funded. The source of funding for optometrists needs to be identified at an early stage in the planning process, and should be part of the agenda. The actual fees to be paid should be discussed once the work patterns are agreed. Many GPs, ophthalmologists and administrators are ignorant of the funding of optometric activities, and erroneously anticipate that additional activities can be funded from the GOS contract.

Protocols

Due to the diversity of the type of service which will be delivered, strict clinical protocols may not be appropriate, but there should be written guidance on which groups of patients will be supplied with the service, the frequency of visits, procedures for reassessment in the HES when necessary and reporting measures.