Eye Care Interprofessional Communication Protocol

Scenario 1: Communication Regarding Individuals with Known Diabetes

**Diabetes Care Professional** (Primary care clinician or endocrinologist)

**Person with Diabetes** (Two-way communication, education, and shared decision-making)

**Primary Eye Care Professional** (Optometrist or ophthalmologist)

**Report: No DR/DME or Other Retinal or Nonretinal Ocular Complications That Require Specialist Care**
(Manage any existing conditions per guideline recommendations)

**Report and Referral: Evaluate and Treat DR/DME and/or Other Retinal or Nonretinal Ocular Complications That Require Specialist Care**

**Referral: Perform Dilated and Comprehensive Eye Examination**

**POC Screening in Diabetes Care Provider Office**

**Patient Self-Referral (or Direct Access): Perform dilated and comprehensive eye examination**

**Retina Specialist or Ophthalmologist with Retina Expertise** (Provide close monitoring and ongoing treatment, as needed)

**OR**

**OR**

**OR**

DR, diabetic retinopathy; DME, diabetic macular edema
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1. The diabetes health care professional (HCP; primary care clinician, endocrinologist, or diabetologist) either
A) makes a referral to the primary eye care professional (ECP; optometrist or ophthalmologist) for a
dilated and comprehensive eye examination or B) performs point-of-care (POC) screening using retinal photography with
remote reading or a validated assessment tool.

If option A, the referral can go to a patient’s existing ECP (if applicable) or to an HCP-recommended ECP.
The referral should include:
- HCP’s name and contact information
- Date of referral and date of next scheduled HCP visit
- Patient’s name, date of birth, and last reported eye examination
- Reason for referral (e.g., routine annual examination, ocular/visual symptoms, positive result on remote
  screening, preconception evaluation, or pregnancy-related eye care)
- Pertinent diabetes history: diabetes type and duration, most recent and target A1C, most recent and target
time in range (if applicable), diabetes-related medications, and comorbidities

If option B, the HCP informs the patient of the POC screening results.

- If POC screening indicates no more than mild to moderate diabetic retinopathy (DR) and no other ocular
  conditions requiring specialist care,* the HCP refers the patient to an ECP as described above for option A.
- If the patient has diabetic macular edema (DME), moderate to severe nonproliferative diabetic retinopathy
  (NPDR), any signs of proliferative diabetic retinopathy (PDR), or any other ocular manifestation of diabetes
  requiring specialist care,* the HCP refers the patient to a specialist as described in step 6 below.

At a Glance

🔗 Refer: Diabetes health care professional (HCP) refers patient to primary eye care professional (ECP) for a
dilated and comprehensive eye examination (or performs point-of-care screening and monitors or
refers based on findings).

🔍 Examine: ECP performs the eye examination.

☐ Report: ECP reports findings to HCP.

💰 Treat: If no specialty care is needed, ECP provides eye care and the cycle repeats as needed.

🔗 Refer: If specialty care is needed, ECP refers to a specialist.

🔍 Examine: Specialist performs an examination.

☐ Report: Specialist reports to the HCP and primary ECP.

💰 Treat: Specialist provides treatment as needed.

🔗 Maintain: Specialty treatment, with reports to HCP and primary ECP, continue as needed.

🔗 Communicate: All encounters should include discussion and collaboration between the professional and
the patient.
2. Ideally, the HCP’s clinic staff schedules an appointment with the ECP at the time of referral. If this is not possible, the patient should receive contact information for the ECP’s clinic and a date by which to schedule an appointment. (Some patients make appointments with an ECP on their own, without a referral from their diabetes HCP or have direct access for eye examinations via a managed care organization. In these instances, post-examination communication proceeds in the same manner, as described in detail below.)

3. At the appointment, the ECP performs a dilated and comprehensive eye examination, including both retinal examination and assessment for possible nonretinal ocular manifestations of diabetes.

4. After the examination, the ECP reports findings back to the HCP. This report should avoid jargon and abbreviations commonly used among ECPs that may be unfamiliar to the HCP. It should include:

- ECP’s name and contact information
- Reference to the referral from the HCP
- Patient’s name and date of birth and date of the eye examination
- Findings of dilated retinal examination, including absence/presence and stage of DR (i.e., none; mild, moderate, or severe NPDR; or PDR), DME (none, non–center-involved, or center-involved), or other retinal conditions (e.g., hypertensive retinopathy or arteriosclerotic retinopathy) and recommended treatment
- Findings of any nonretinal ocular manifestations of diabetes (e.g., cataract, glaucoma, ocular surface disease, and cranial nerve palsy) and recommended treatment
- Recommended follow-up surveillance interval
- Summary of any referral for specialist care of DR/DME or other diabetes-related ocular complications, including the specialist’s name and contact information

If the patient has no DR/DME or other ocular conditions that require specialist care,* this cycle repeats at a follow-up interval recommended by the ECP based on clinical findings, comorbidity status, pregnancy status, glycemic control, and/or other risk factors.

5. If the patient has any DR/DME or any other ocular manifestation of diabetes that requires specialist care,* the ECP sends the HCP a report as described above and also refers the patient to a specialist for further evaluation and treatment. When available, this referral would be to a retina specialist for conditions involving the retina. When access to a retina specialist is limited or when the condition prompting referral is nonretinal in nature, this referral could be to another ophthalmologist with requisite expertise. This referral should include:

- ECP’s and HCP’s names and contact information
- Patient’s name and date of birth
- Date of eye examination
- Findings of dilated retinal examination, including absence/presence and stage of DR (i.e., none; mild, moderate, or severe NPDR; or PDR), DME (none, non–center-involved, or center-involved) or other retinal conditions (e.g., hypertensive retinopathy or arteriosclerotic retinopathy) and recommended treatment
- Findings of any nonretinal ocular manifestations of diabetes
- Other pertinent clinical information (e.g., pregnancy status)
- Recommended follow-up interval with the specialist and treatment recommendations

6. Ideally, the ECP’s clinic staff schedules an appointment with the specialist at the time of referral. If this is not possible, the patient should receive contact information for the specialist’s clinic and a date by which to schedule an appointment.
7. After the ophthalmologist with retinal expertise has completed an evaluation and developed a treatment plan, a report should be sent to both the primary ECP and HCP. This report should include:

- Specialist's, primary ECP's, and HCP's names and contact information
- Patient's name and date of birth
- Date of specialty care appointment
- Diagnosis or diagnoses and recommended treatment(s)
- Recommended follow-up treatment interval for specialty care
- Recommended schedule to resume primary ECP follow-up visits

8. Interprofessional communication among the HCP, primary ECP, and ophthalmologist with retinal expertise (when applicable) should continue on a regular basis, as needed, including whenever there are changes in DR management, treatment of nonretinal ocular manifestations, or when the next dilated and comprehensive retinal examination is needed. For a patient receiving specialty care, the HCP and primary ECP should be alerted of any follow-up/treatment appointment nonattendance and also when the patient's retinal status is sufficiently stable to resume ongoing general eye care.

9. At all encounters, two-way communication between the provider and the patient should occur to keep the patient fully informed about his or her eye health, risk factors, and treatment; provide diabetes and eye health education; engage in shared decision-making with regard to risk reduction strategies and treatment options; and review the dates for upcoming appointments and/or the need to make referral appointments. These discussions should take a person-centered, collaborative approach and provide information in plain language, avoiding medical jargon and abbreviations that may not be familiar to the patient.

*Specific recommendations about when and to whom to refer patients with ocular complications of diabetes differ among various professional organization guidelines. The American Academy of Ophthalmology recommends referral to an ophthalmologist when there is any evidence of DR and for follow-up for potentially reversible vision loss from conditions such as cataracts, glaucoma, or refractive changes. The American Diabetes Association recommends prompt referral of patients with any level of DME, moderate or worse NPDR, or any PDR to an ophthalmologist knowledgeable and experienced in the management of diabetic retinopathy. The American Optometric Association recommends that patients with severe or very severe NPDR, early PDR with risk of progression, high-risk PDR, central-involved DME, or persistent DME after laser and/or anti-vascular endothelial growth factor therapy, as well as those with vitreous hemorrhage, traction retinal detachment, macular traction, or an epiretinal membrane should be referred to an ophthalmologist experienced in the management of diabetic retinal disease. The American Society of Retina Specialists recommends referral for all diabetic retinal disease for evaluation and potential treatment to prevent irreversible vision loss for conditions such as diabetic macular edema and proliferative diabetic retinopathy to a retina specialist (i.e., a board-certified ophthalmologist with specific fellowship training in retina).
Eye Care Interprofessional Communication Protocol

Scenario 2: Communication Regarding Individuals with Suspected Prediabetes or Diabetes

Referral: Screen for Prediabetes or Type 2 Diabetes

Primary Eye Care Professional
(Ophthalmologist or optometrist)

Patient
(Two-way communication, education, and shared decision-making)

Primary Health Care Professional
(Physician, nurse practitioner, or physician associate)

Report: No Prediabetes or Diabetes
(Monitor)

OR

Report: Prediabetes or Diabetes
(Treat and refer back for dilated and comprehensive eye examination at guideline-recommended intervals)
Scenario 2: Communication Regarding Individuals with Suspected Prediabetes or Diabetes

At a Glance

- **Refer:** Eye care professional (ECP) refers patient to primary care professional (PCP) for diabetes screening.
- **Screen:** PCP screens patient and assesses risk factors.
- **Report:** If no prediabetes or diabetes is identified, PCP reports this finding to ECP.
- **Report and Treat:** If prediabetes or diabetes is diagnosed, PCP reports this to ECP, and initiates treatment.
- **Refer:** PCP refers patient back to ECP for eye examinations (or performs point-of-care screenings) at guideline-recommended intervals.
- **Maintain:** ECP and PCP continue sharing information about eye care and diabetes care as needed.
- **Communicate:** At all encounters, discussion and collaboration should occur between the professional and the patient.

1. Having noticed signs or symptoms of possible prediabetes or type 2 diabetes during routine eye care, the ECP (ophthalmologist or optometrist) refers the patient to a primary care professional (PCP; physician, nurse practitioner, or physician associate) for diabetes screening. This referral can be to a patient's existing PCP, if applicable, or to an ECP-recommended PCP. This referral should include:
   - ECP's name and contact information
   - Patient's name and date of birth
   - Date of eye examination
   - Relevant eye examination findings suggestive of prediabetes or diabetes
   - Expected interval for follow-up eye care

2. Ideally, the ECP's clinic staff schedules an appointment with the PCP at the time of referral. If this is not possible, the patient should be advised to contact his or her PCP or be given contact information for an ECP-recommended PCP to schedule an appointment.

3. At the appointment, the PCP conducts diabetes screening per American Diabetes Association guidelines and an assessment of risk factors.

4. If no prediabetes or diabetes is found, the PCP reports this finding back to the ECP.

5. If prediabetes or diabetes is diagnosed, the PCP initiates appropriate treatment, reports back to the ECP. The HCP should refer the patient back to the ECP for subsequent dilated and comprehensive eye examinations (or perform point-of-care screenings using retinal photography with remote reading or a validated assessment tool) at guideline-recommended intervals.

6. At all encounters, two-way communication between the provider and the patient should occur to keep the patient fully informed about his or her eye health, risk factors, and treatment; provide diabetes and eye health education; engage in shared decision-making with regard to risk reduction strategies and treatment options; and review the dates for upcoming appointments and/or the need to make referral appointments. These discussions should take a person-centered, collaborative approach and provide information in plain language, avoiding medical jargon and abbreviations that may not be familiar to the patient.

The Eye Care Interprofessional Communication Protocol is not intended to be an official statement of medical standards applying to all situations. Health care professionals, including diabetes and eye care professionals, must make their own judgments about the propriety of the care they provide and the requisite interprofessional communication that should occur around that care. Development of this protocol was a collaboration among the American Academy of Ophthalmology, the American Diabetes Association®, the American Optometric Association, the American Society of Retinal Specialists, and the National Eye Institute and was sponsored in part by the Focus on Diabetes™ initiative. The partner organizations disclaim any and all liability for injury or other damages of any kind for any claims that may arise out of the use of this protocol or any recommendations or other information contained herein.