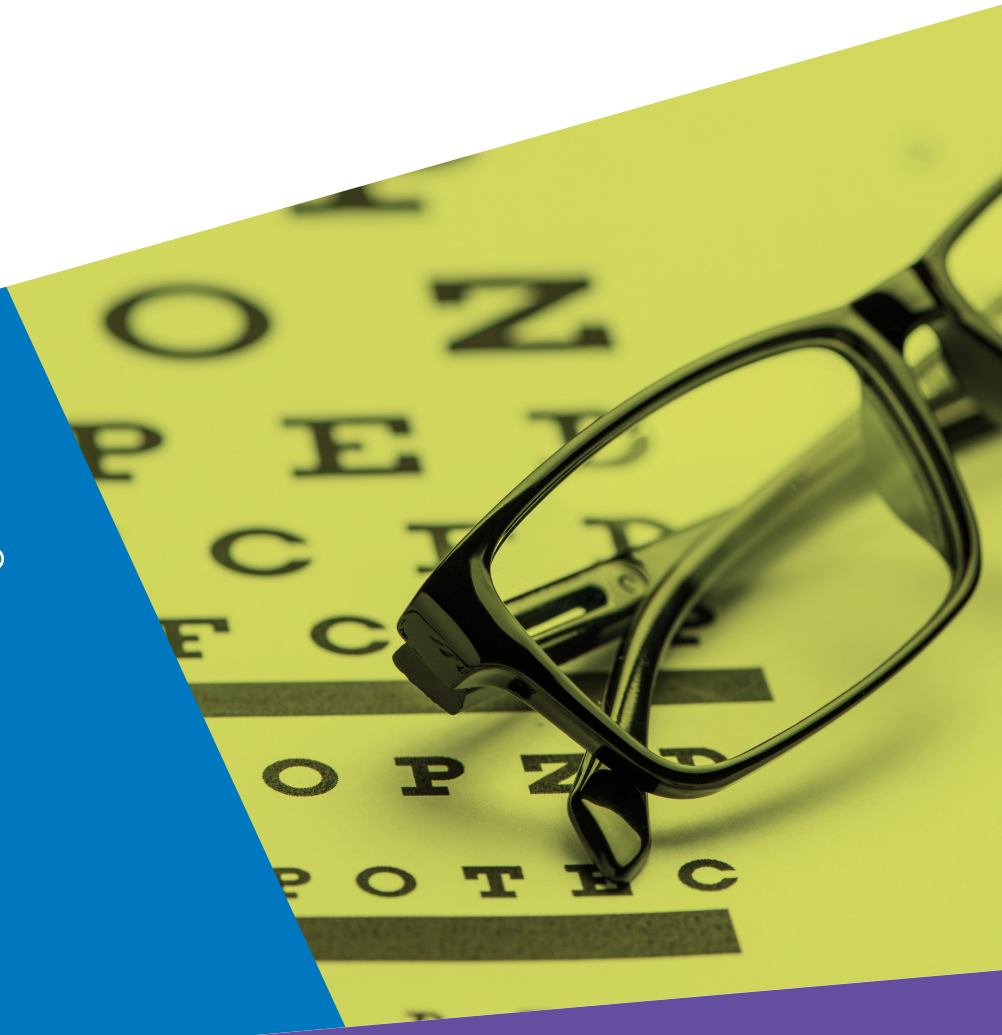
AMGA
Advancing High Performance Health

Together 2 Goal
AMGA Foundation

Together 2 Goal® Innovator Track Eye Care Cohort Case Study



Prevea Health

Organizational Profile

Founded in 1996, Prevea Health is a multispecialty group serving northeastern and western Wisconsin. The organization serves 90,000 patients a year at its six hospitals and 78 health centers. Prevea employs 253 physicians, more than 275 allied health providers and over 1,600 staff members. Its corporate headquarters are located in Green Bay, Wisconsin.

Executive Summary

According to the 2020 National Diabetes Statistics Report from the Centers for Disease Control and Prevention (CDC), more than 34 million Americans have diabetes, with up to 95% of those having Type 2 diabetes.[1]

Diabetes is the leading cause of new cases of blindness in adults, and diabetes-related blindness costs the United States about $500 million annually.[2] The American Diabetes Association (ADA) recommends that people with diabetes get an eye exam following their diagnosis and at regular intervals every one to two years following.[3] Despite these recommendations, a significant portion of patients with diabetes are not meeting the recommended screening guidelines.[4]

AMGA convened the Together 2 Goal® (T2G) Innovator Track Eye Care Cohort (Eye Care Cohort) to address this problem by allowing groups to explore ways to increase eye exam rates for people with diabetes.

Prevea joined the Eye Care Cohort in order to improve its diabetic retinopathy (DR) screening rates by focusing on improving the completion of DR screening exams and capturing the results within Prevea's electronic medical record (EMR). The team at Prevea also worked to improve patient education within its clinics to better convey the importance of diabetes eye exams. In addition, Prevea conducted outreach to patients missing their DR screening exams.

The interventions Prevea implemented during the Eye Care Cohort resulted in nearly 1,200 additional patients with a documented retinopathy screening.

Program Goals and Measures of Success

The primary measure of the Eye Care Cohort was the proportion of Type 2 diabetes patients in the T2G Cohort with a documented screening for diabetic retinal disease. This measure, selected by the Eye Care Cohort Advisory Committee, was based on an adapted version of the HEDIS 2018 Technical Specifications for Physician Measurement: Comprehensive Adult Diabetes Care: Eye Exam Numerator (see Appendix).

Prevea focused on two main goals during the collaborative: improving data capture within the EMR for external DR screening exams and improving educational resources on DR screening for patients and clinical staff.

Existing Diabetes Population and Care Structure

Prevea cares for over 5,500 patients that have Type 2 diabetes. The care team for these patients includes primary care providers, endocrinologists, care managers, dieticians, ophthalmologists, and optometrists.

Prior to the Cohort, the main people involved in the care of patients with diabetes were primary care and endocrinology providers with support from care managers and dieticians as needed. Prevea has a diabetes workflow in primary care that providers and staff follow; this workflow takes into consideration whether a patient is a new or existing patient with diabetes and whether their hemoglobin A1c (A1c) is at goal. Patients with diabetes are referred to care management or endocrinology based on criteria (e.g., a patient that has an A1c > 8 for over six months would be referred to endocrinology). Patients that are referred to care management follow standardized intake and education.

Health maintenance (HM) items, such as urine micro albumin, A1c testing, and DR screening exams, are addressed in chart prep and annual appointment rooming according to standard workflow. This helps Prevea staff proactively discuss these items with the patient during the rooming process and provider visit.

Interventions

Prior to the Eye Care Cohort, Prevea did not have a standard way throughout the organization to handle eye exams for patients with diabetes. There were differences in how eye exams were requested, how they were reviewed, and how patients were educated about DR. Prevea's Eye Care Department was able to share patient education materials that were used in their department for patients that were being screened for retinopathy.

During the Eye Care Cohort, Prevea used multiple strategies to standardize how DR screening exams are handled. One of those strategies was that care managers in the clinics became the primary contact to review incoming exams from external eye care locations. These individuals review results, ensure that the problem list reflects the appropriate diagnosis, and note if the exam is positive or negative prior to sending it for entry into the EMR. Care managers and clinical staff also use a fax-back form (see Appendix) when patients with diabetes are due for an eye exam and see a provider outside of Prevea. Prevea educated clinical departments, specifically care managers, on the workflow and process when an external eye exam is received. The organization also fostered a collaboration between clinical departments and the Document Scanning Department—the group that scans DR screening exams received from external eye care providers—to ensure that these departments were aware of the process for exams. The Scanning Department provided follow-up when documents were received and the workflow was not followed, which provided opportunity for re-education on a one-on-one basis.

Prevea created a fax-back form that included the Prevea logo along with a main fax number (see Appendix). This form was used in an outreach campaign where the Prevea team contacted diabetes patients without a current DR screening exam on file via mail and patient portal. Letters that were mailed included the fax-back form for patients to have completed and returned to their primary care provider's office. Patients seen in the office were given a printed copy of the fax-back form during their office visit if they had not completed their eye exam; they were encouraged to take the fax-back form to their eye care provider when having their eye exam so that the provider could fax the completed form back to the clinic following the exam. Patients were also asked to let staff know if they had an up-to-date eye exam so staff could send the fax-back form to the clinic where the eye exam was completed for updated records.

Though the Prevea Eye Care Department utilized existing materials on DR screening prior to the Cohort, the project team created additional materials during the Cohort on DR screening and exam capture. One of these materials—an educational insert addressing the importance of diabetic eye exams—was included in the DR screening outreach campaign letters. Care managers provide education to patients with diabetes in both primary care and endocrinology; the newly created materials help them discuss retinopathy and the importance of early and routine screening with patients (see Appendix).

Outcomes and Results

Prevea improved rates of documented screening for diabetic retinal disease by 20.5% during the Eye Care Cohort (see Appendix). This was a 45% relative increase from baseline.

The Prevea team felt that the efforts to educate staff, providers, and patients had the greatest impact on results. A large increase in completed eye exams occurred following the outreach campaign to patients missing a documented eye exam, as 26% of patients contacted either completed eye exams within the Prevea system or sent an external record to be evaluated and uploaded into Prevea's EMR.

Lessons Learned and Ongoing Activities

During the Eye Care Cohort, Prevea learned the importance of gaining buy-in from departments that will affect or be affected by workflow and process changes. Prior to initiating changes within the organization, the Prevea team met with the Eye Care Department to discuss both their involvement and targeted improvements. The Eye Care Department was engaged and willing to help with any identified gaps. As the project team worked to modify different processes in the clinic, they identified and engaged other departments that would also be affected by the forthcoming changes.

Another lesson that Prevea learned during the Cohort was the importance of leveraging existing resources. Engaging eye care staff and providers allowed Prevea to provide education to primary care staff and providers on DR screening.

One of the challenges that Prevea encountered during the Cohort was the delay caused by the involvement of the Information Technology Department. Prevea overcame this challenge through communication, but additional time was needed to ensure that updates in the EMR would be working appropriately prior to implementation.

References

1. Centers for Disease Control and Prevention. 2020. National Diabetes Statistics Report, 2020 (Rep.). Retrieved from cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf.

2. Centers for Disease Control and Preventions. n.d. Diabetic Retinopathy. Retrieved from cdc.gov/visionhealth/pdf/factsheet.pdf.

3. Solomon, S. D., Chew, E., Duh, E. J., Sobrin, L., Sun, J. K., VanderBeek, B. L., Wykoff, C.C., Gardner, T. W. (2017). Diabetic Retinopathy: A Position Statement by the American Diabetes Association. *Diabetes Care*, 40(3), 412-418. doi:10.2337/dc16-2641.

4. Garg, S. & Davis, R. (2009). Diabetic Retinopathy Screening Update. *Clinical Diabetes,* 27(4), 140-145; doi: 10.2337/diaclin.27.4.140.

Eye Care Cohort Measure

Measurement is a cornerstone of all facets of the T2G campaign, including the Innovator Track. During the Eye Care Cohort, groups measured rates of documented screening for diabetic retinal disease among the T2G Cohort with Type 2 diabetes and tracked improvement.

In keeping with AMGA Foundation's philosophy to measure improvement using existing industry-standard measures when possible, the denominator for the Eye Care Cohort was defined to be the same as the T2G Cohort for the campaign (i.e., patients with Type 2 diabetes who meet the T2G campaign criteria to be included in the four individual core components and the diabetes bundle measure). This denominator is broadly defined as patients age 18–75 with:

- Two or more eligible ambulatory encounters with an eligible primary care, endocrinology, cardiology, or nephrology provider in the last 18 months **AND**
- At least one Type 2 diabetes on a claim or problem list in that same 18-month period.

For complete denominator measure specifications with inclusion and exclusion criteria, see Together 2 Goal® Campaign Measurement Specifications (v3, April 2019).

The numerator for the measure was determined to be those T2G Type 2 diabetes patients who met the criteria for HEDIS 2018 Technical Specifications for Physician Measurement: Comprehensive Adult Diabetes Care: Eye Exam Numerator.

Screening or monitoring for diabetic retinal disease was identified by electronic data or medical record review and included:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year;
- A negative retinal exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year; or
- A bilateral eye enucleation anytime during the patient's history through the end of the measurement period.

Eye Care Cohort participants were provided detailed measure specifications and relevant HEDIS value sets.

Prevea Fax-Back Form

Patient Name _____ Patient's Date of Birth _____

Patient's Primary Care Physician _____ Date of Eye Exam _____

Retinal Exam: ❑ Dilated ❑ Non-Dilated

Visual Acuity: _____ Right Eye _____ Left Eye

Check all that apply:

	Right	Left	Not identified
Retinopathy:			
• Mild background retinopathy present:	❑	❑	❑
• Severe background retinopathy present:	❑	❑	❑
• Proliferative retinopathy present:	❑	❑	❑
• Clinically significant macular edema present:	❑	❑	❑
Cataracts:	❑	❑	❑
Glaucoma:	❑	❑	❑

If Glaucoma is identified, is it:

	Right	Left
NOT CONTROLLED	❑	❑
CONTROLLED	❑	❑

Recommended Plan:

Progress evaluation suggested in _____ weeks / months / years *(circle one)*

Type of treatment planned: _____

Referred back to primary care physician: ❑ Yes ❑ No

Referral needed for futher evaluation: ❑ Yes ❑ No

_____
Ophthalmologist/Optometrist Signature

_____
Please Print Name

Please fax completed form to Prevea Health:

11/18

PREVEA health

Prevea Retinopathy Screening Education

Five things you should know about diabetic eye disease

If left untreated, diabetes can cause vision loss or blindness. Here are five things to know about diabetic eye disease from the National Eye Institute.

Diabetic retinopathy is the leading cause of blindness in adults ages 20-74 in the United States

1. **A series of eye problems are associated with diabetes.** They include; cataract, glaucoma and diabetic retinopathy.
2. **There are no symptoms or pain** in the early stages of diabetic retinopathy. A person may not notice vision changes until the disease advances.

Between 40 and 45 percent of those diagnosed with diabetes have some degree of diabetic retinopathy

3. **Anyone with diabetes is at risk of developing diabetic retinopathy.** The longer someone has diabetes, the more likely he or she will get this eye disease.
4. **Continue the plan laid out by your doctor** when it comes to prescriptions, weight management and physical activity.
5. **Get a dilated eye exam** at least once a year. Diabetic eye disease can be detected early and treated before noticeable vision loss occurs.

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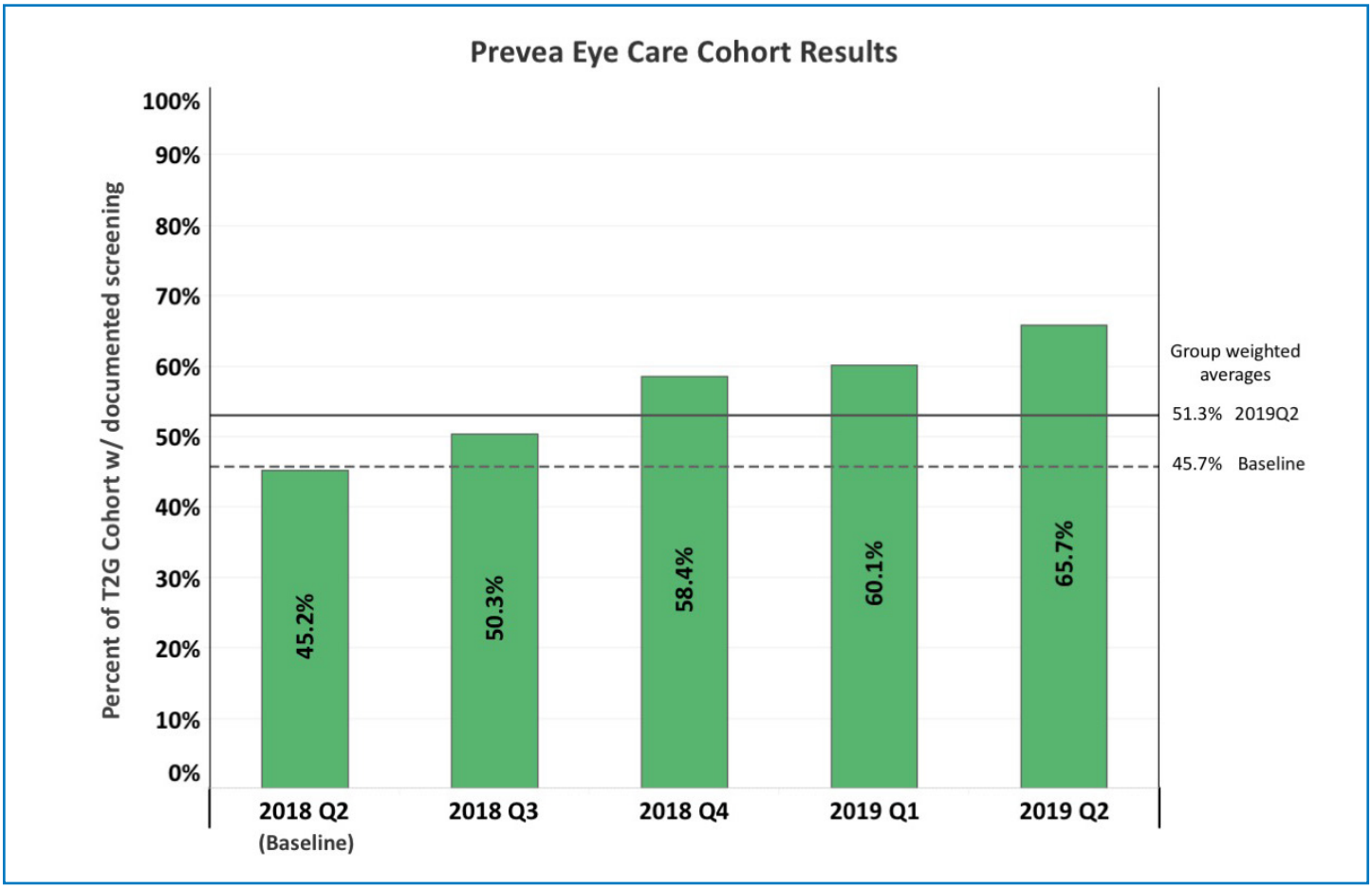
Source: National Eye Institute

Prevea Eye Care Cohort Results



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