CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Welcome

Pharmacy Diabetes Learning Collaborative | October 29, 2024

Care Transformation Collaborative of RI

Agenda

Topic *Presenter*	Time
Welcome *Susanne Campbell, RN, MS, PCMH CCE, Sr. Program Administrator, CTC-RI*	**5 min**
Diabetic Eye Disease, Identifying and Closing Care Gaps *Stephen M. Montaquila, O.D., F.A.A.O., Jad Osmanski, OD*	**20 min+** **10 min Q&A**
Practice Updates (~5 mins / practice): **Coastal** **MARI (Bristol & East Providence)** **RIPCPC** • **Matt Rocheleau, DO** • **Herman Ayvazyan, MD** **Clinica Esperanza** **Rhode Island Free Clinic** *Kelley Sanzen, PharmD, PAHM, CDOE, Clinical Pharmacist, Pharmacy Quality Improvement Facilitator*	**35 min**
Data Summary *Steve Kogut, PhD, MBA, RPh & Carolyn Karner, MBA*	**15 min**
Next Steps	**5 min**

Diabetic Eye Disease, Identifying and Closing Care Gaps

Presentation for the Care Transformation Initiative / Rhode Island Department of Health

- Jad Osmanski, OD
- Stephen M Montaquila, OD, FAAO

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Diabetic Eye Disease

- **Agenda**

- Defining the disease
- Screening recommendations
- Evidence based treatment options
- Care gaps in the diabetic population
- Offering solutions to close care gaps

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Diabetic Eye Disease

- **Jad Osmanski, OD**
  - New England College of Optometry Graduate with Honors
  - Member of BSK (International Optometric Honor Society)
  - Former US Army Optometrist
  - Private practice
  - Staff Optometrist Providence VAMC
  - Adjunct Professor at ICO, MCPHS, NECO, Salus/PCO, UHCO

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Diabetic Eye Disease

- Type 1 diabetes
  - Autoimmune disease where body's immune system attacks the pancreas' insulin-producing cells, preventing pancreas from making insulin
  - Type 1 accounts for about 6% of diabetics in the United States

- Type 2 diabetes
  - Much more common and is not an autoimmune disease
  - Insulin deficiency = the pancreas produces less insulin
  - Insulin resistance = the body becomes resistant to insulin

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Impacts of Diabetic Eye Disease

- Refractive error changes = glasses changes
- Ocular motility
- Cornea – reduced sensitivity and wound healing
- Iris – depigmentation, neovascularization (NVI), glaucoma (NVG)
- Cataracts
- Retina – diabetic retinopathy (DR) and macular edema (DME)
- Optic nerve – papillopathy, ischemic optic neuropathy, open angle glaucoma

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Types of Diabetic Retinal Disease

- Non-proliferative (NPDR)
  - Damaged blood vessels in the retina may leak fluid
  - Patients typically asymptomatic or have mild symptoms
  - NPDR can be categorized as mild, moderate, severe, or very severe
- Diabetic Macular Edema (DME)
  - Complication of DR where blood vessels in the macula leak
  - Leads to blurry vision and swelling of the macula
- Proliferative (PDR) Diabetic Retinopathy
  - Advanced stage of diabetic retinopathy
  - New blood vessels grow (neovascularization) in the retina and into the vitreous
  - New blood vessels can leak easily and/or break causing severe vision loss

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Diabetic Eye Disease

- Percentages diabetic retinopathy
  - In the US an estimated 40% of diabetics over 40 years old have DR
  - Over 8% of diabetics in the US have severe/very severe NPDR, DME, or PDR
- NPDR
  - 20-30% of diabetics have NPDR
- PDR
  - 4% of patients withing the first 10 years develop PDR
  - Rates double every 10 years with up to 16% of diabetics developing PDR

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Ocular Examination Recommendations

- Type 1
  - Eye exam at puberty or within 3-5 years of DM diagnosis, whichever comes first
  - Follow ups as directed by eye doctor
- Type 2
  - Eye exam at time of diagnosis as diabetes may have gone undiagnosed for years
  - Follow ups as directed by eye doctor

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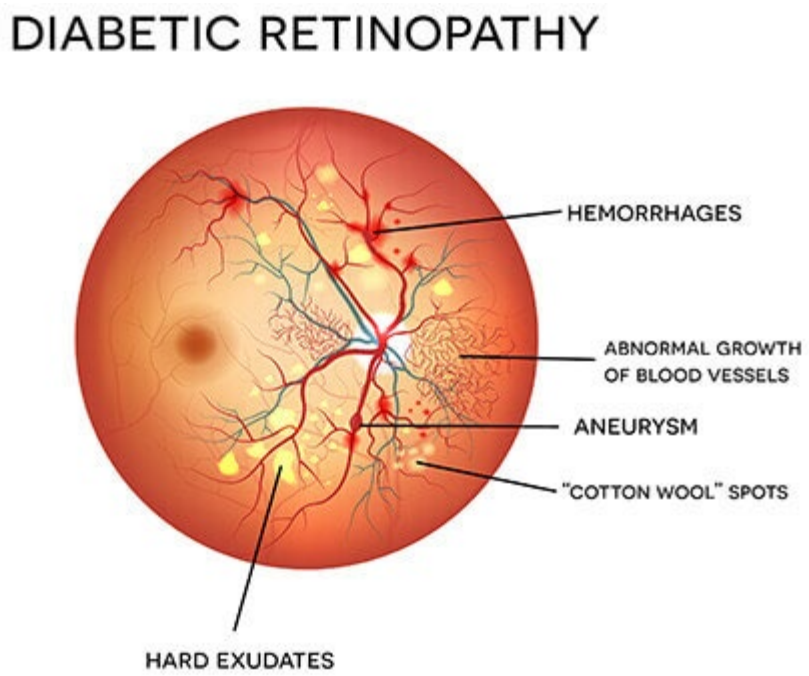
Diabetic Eye Disease

Treatment Options

- Injections
  - Anti-VEGF (Vascular Endothelial Growth Factor)
  - Corticosteroids
- Laser Photocoagulation
- Eye Surgery = Vitrectomy
- Cryotherapy



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Diabetic Eye Disease

Clinical Decision Making

- Detailed information contained in American Optometric Association clinical practice guidelines: Eye Care for the Patient with Diabetes Mellitus, 2nd Edition
- Clinical practice guidelines explain the disease, treatment options, and also recommended screening intervals

AOA Clinical Practice Guidelines

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Diabetic Eye Disease

Members of the care team

- Optometrist
  - DOCTORS OF OPTOMETRY (OD) examine, diagnose, treat, and manage diseases, injuries, and disorders of the visual system, the eye, and associated structures as well as identify related systemic conditions affecting the eye.
  - Optometrists provide 77% of all first time eye care visits and 66% of all eye care on an ongoing basis.
- Ophthalmologist
  - An MD or DO level practitioner who has gone on after general medical internship to complete a residency in advanced procedures in eye care.
  - Most commonly they specialize in advanced surgical techniques including cataract, glaucoma, and retinal surgery

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Diabetic Eye Disease

- **Stephen M Montaquila, OD, FAAO**

  - West Bay Eye Associates, Warwick, RI
  - Diplomate, American Board of Optometry, Fellow American Academy of Optometry
  - Chair, Rhode Island Primary Care Physicians Corporation Eye Care POD
  - Immediate past Chair American Optometric Association Third Party Center Executive Committee
  - Member American Optometric Association Federal Relations Committee
  - Chair Rhode Island Optometric Association Legislative Committee

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Diabetic Eye Disease

System challenges:

Health Plans vs Vision Benefit Administrators

- Health Plans
  - Coverage for medical eye care services
  - May also cover “well eye care” visits
  - Improved data collection
  - Integrated access point for patient care
  - Facilitates care coordination and collaboration

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System Challenges:

Health Plans vs Vision Benefit Administrators

- Vision Benefit Administrators
  - Self selected “add on” to medical benefit package
  - Marketed in the “Ancillary Benefit” space

  - 1 in 4 employees choose not to enroll in their employer’s vision plan

- Often utilize different provider panel than medical eye care panel
- Barrier to data collection and sharing

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Care gaps

- What options are available to the health care delivery system to improve access and close care gaps?

- Benefit design
- Data loss
- Care team make up, organization, education
- Communication

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- Vision benefit administrators create a barrier to care coordination and data collection and sharing.
  - Many times, due to poor benefit design, patients pressure providers to bill visits to vision benefit administrators even though they are diabetic due to higher out of pocket costs with medical plans
  - VBA's do not effectively collect and report data
- Communication
  - It is possible that care is being delivered at higher rates than is reported
  - Communication between providers is difficult in the current health care delivery environment
- Direct standard protocol has not been effective
  - Added steps outside of normal workflow

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PRIMARY CARE

Closing care gaps with improved access

- The RIPCPC experience
  - We formed the Eye Care POD specifically to address care gaps in diabetic eye care.
  - We recruited like minded optometrists and ophthalmologists and through a care compact, we have developed a working collaboration between the eye care community and RIPCPC's network of physicians
  - We focused on having all of our clinicians practice to top of license and improving patient flow by ensuring that patients have access to timely interventions
  - Approximately 50 optometrists and 20 ophthalmologists

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The RIPCPC experience

- Though our collaborative efforts we achieved increased access and adherence to recommended yearly comprehensive eye examinations for diabetics in both the commercial and Medicare populations
- Rates increased by 5-13% approaching 80% of diabetic insured lives being seen (national average is <50%)
- This represents our proof of concept

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Diabetic Eye Disease

What does success look like?

- RIPCPC
  - Teams of clinicians working in concert with RIPCPC as coordinator
  - Optometrists are primary eye care, entry point for diabetic patients into the health care delivery system
  - Ophthalmology referrals are made for those patients who need tertiary care
  - Careful use of resources
  - Care compact ensures timely access and consistent reporting

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Diabetic Eye Disease

Go forward recommendations

- Focus on comprehensive integrated care not disassociated tests to check boxes (eg: photo screeners)
- Foster teams of clinicians practicing to top of license working together to ensure increased and appropriate access
- Work closely with optometrists, ophthalmologists, other members of the care team (nurses, nutritionist, care navigator, pharmacist, etc)
- Work towards more uniform reporting standards
- Care compact with primary care and endocrinology and eye care
  - Use of networks of providers such as RIPCPC Eye Care POD
- Coordinating organization
  - RIDOH, RIPCPC, ? others

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Physician Reimbursement

- The state must act to ensure that RI is able to attract and retain the best and brightest clinicians!

- Regional payment disparity must be addressed here in RI if we are to achieve the goal of increasing access to the highest quality of care, improving the patient and clinician experience, and meaningfully impacting population health outcomes.

"I'm right there in the room, and no one even acknowledges me."

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Diabetic Eye Disease

Contact us:

- Jad Osmanski, OD
  - jadosmanski@gmail.com
- Stephen M Montaquila, OD, FAAO
  - smontaquila@gmail.com

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Next Steps

- Kidney health evaluation
  - Past albuminuria
    - Referral to nephrology
    - Appropriate pharmacotherapy (RAAS, SGLT2, +/- GLP-1, MRA)
  - Prioritize patients with history of albuminuria and reduced eGFR
  - Standing orders? Chart screening/flagging?

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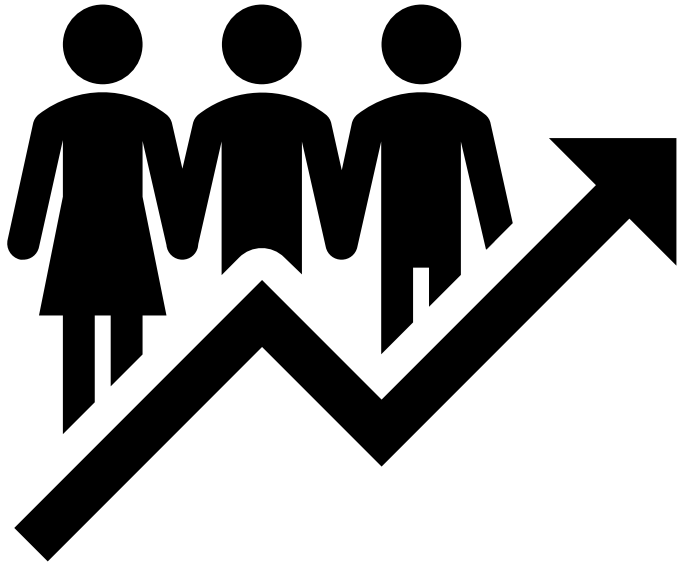
Data Summary

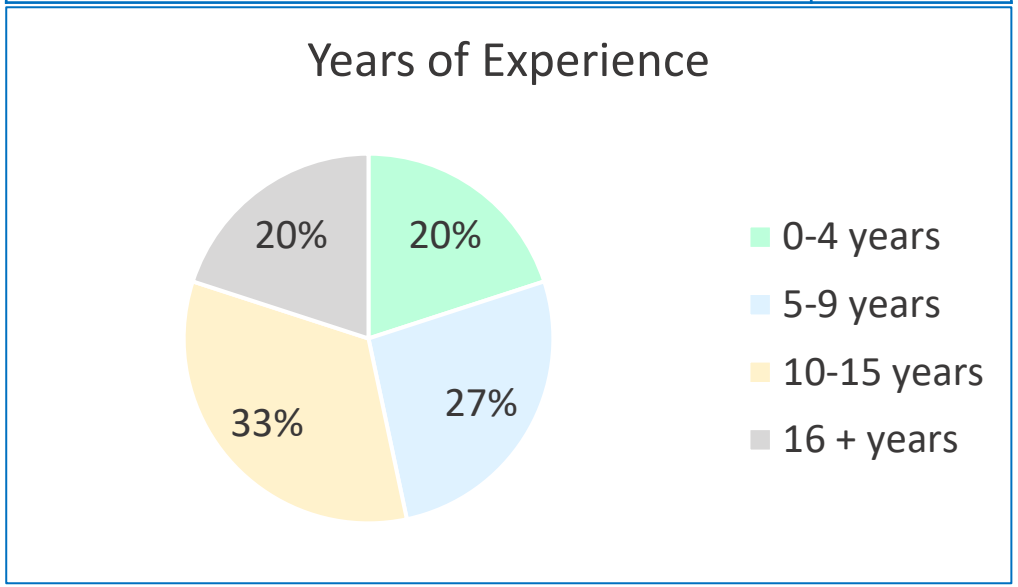


Baseline Survey of Care Team Members (n =21)

Sept.-Oct. 2024

Role	n
Pharmacist	7
Nurse	5
Physician	4
Executive leadership/management	2
Nurse care manager	1
Patient care navigator	1
Quality specialist	1

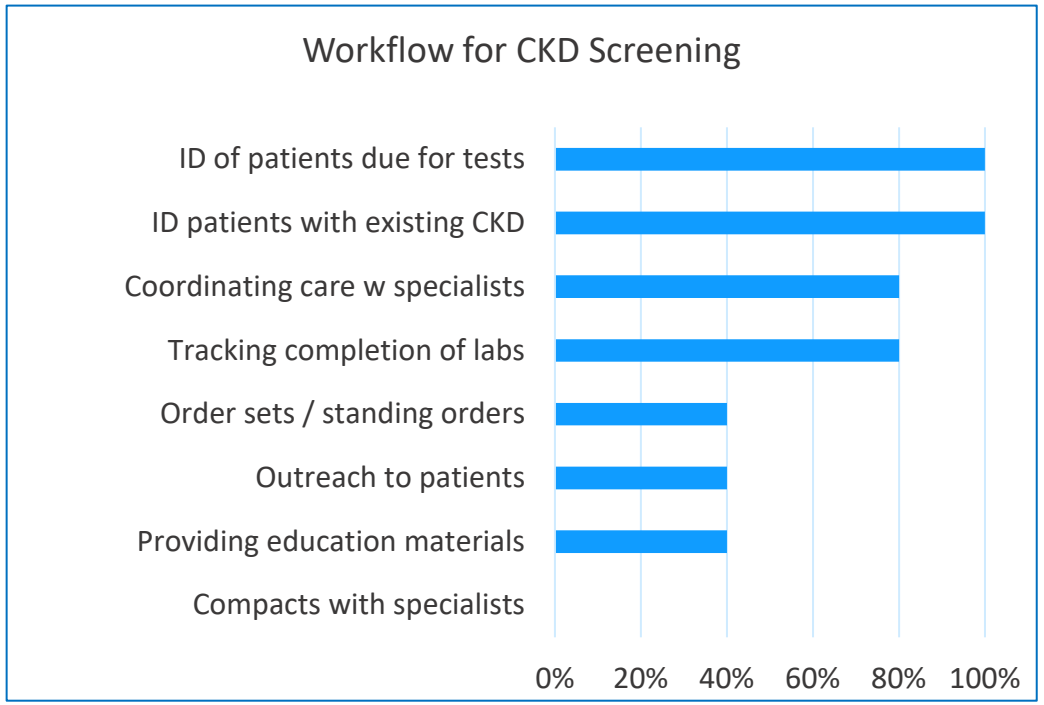
Site	n
Coastal Hillside	12
Clinica Esperanza	2
Medical Associates of RI (Bristol)	2
RIPCPC (Warwick)	2
RI Free Clinic	2

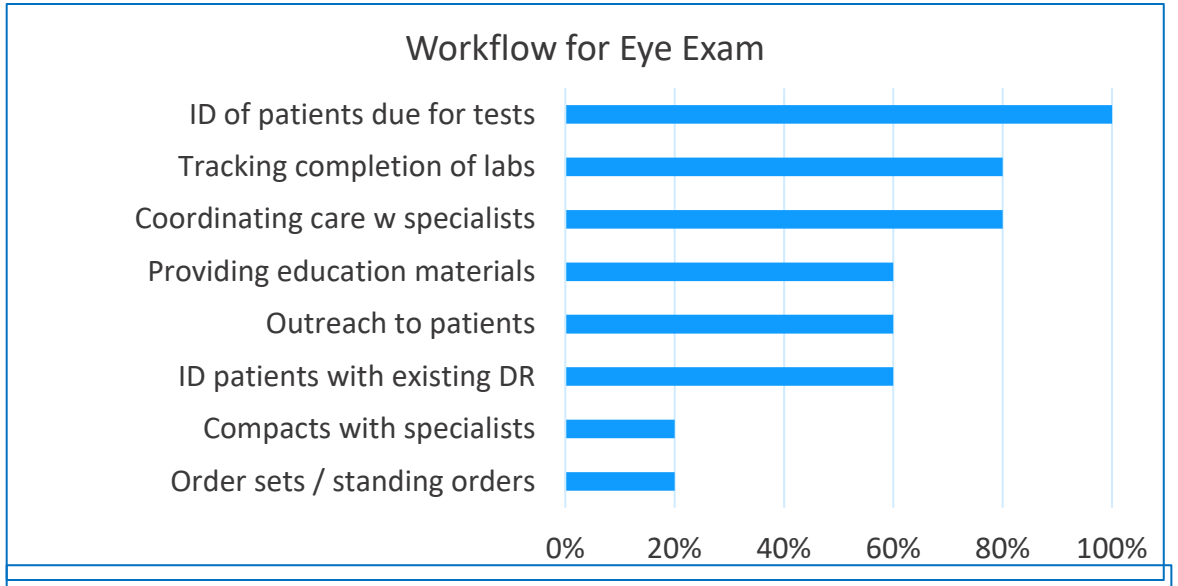


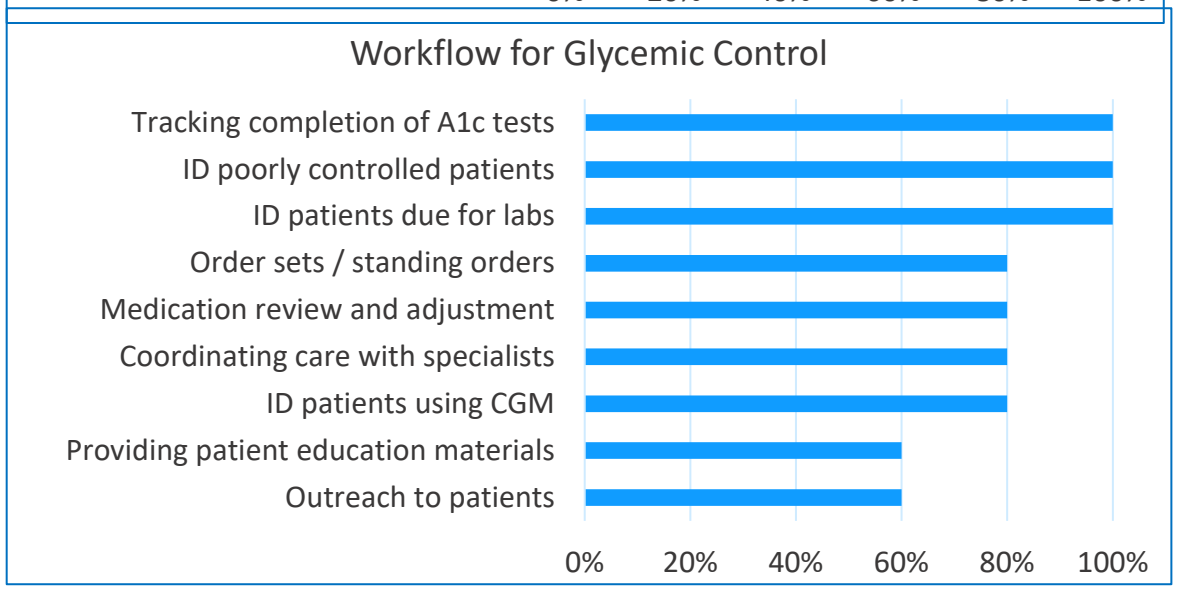
Clinic Workflow

Sample: MD or lead RPh respondent from each site

% of 5 sites indicating the process exists:

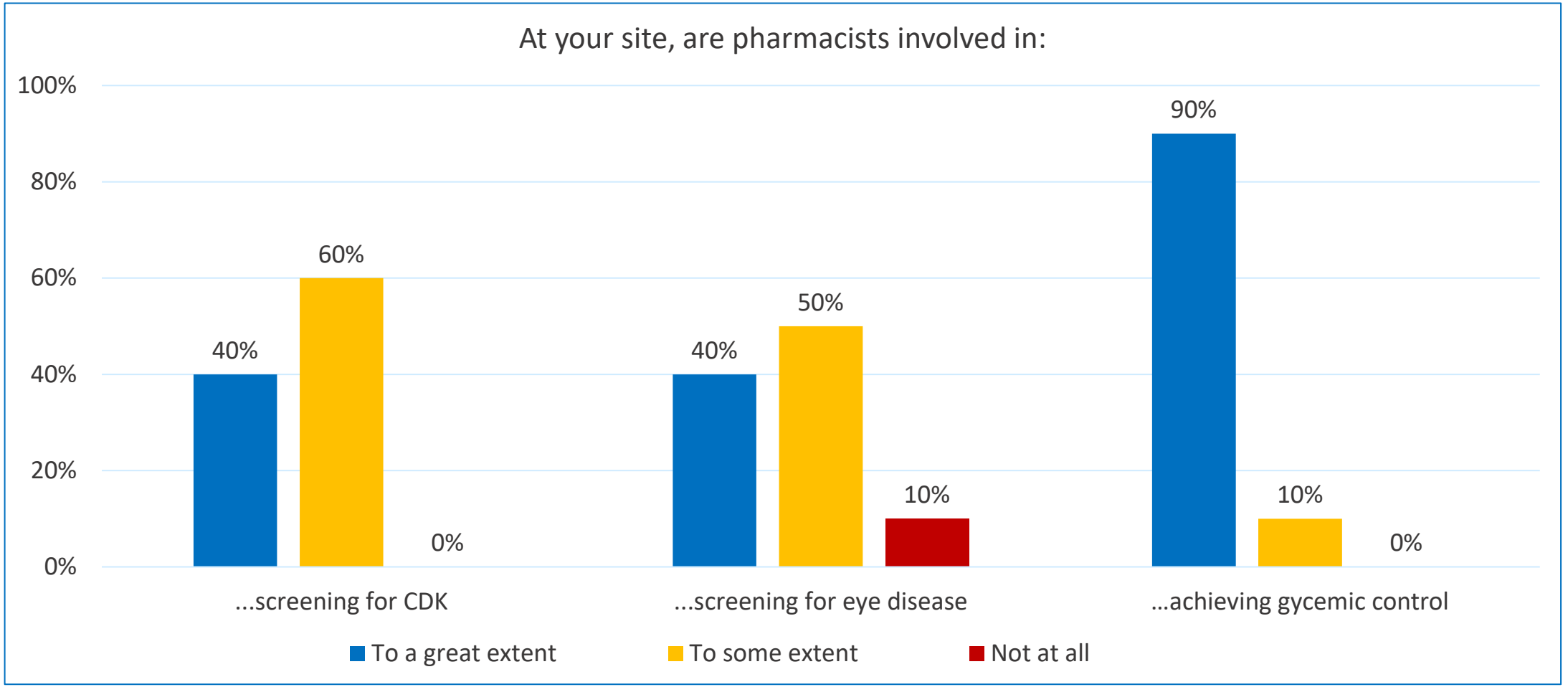




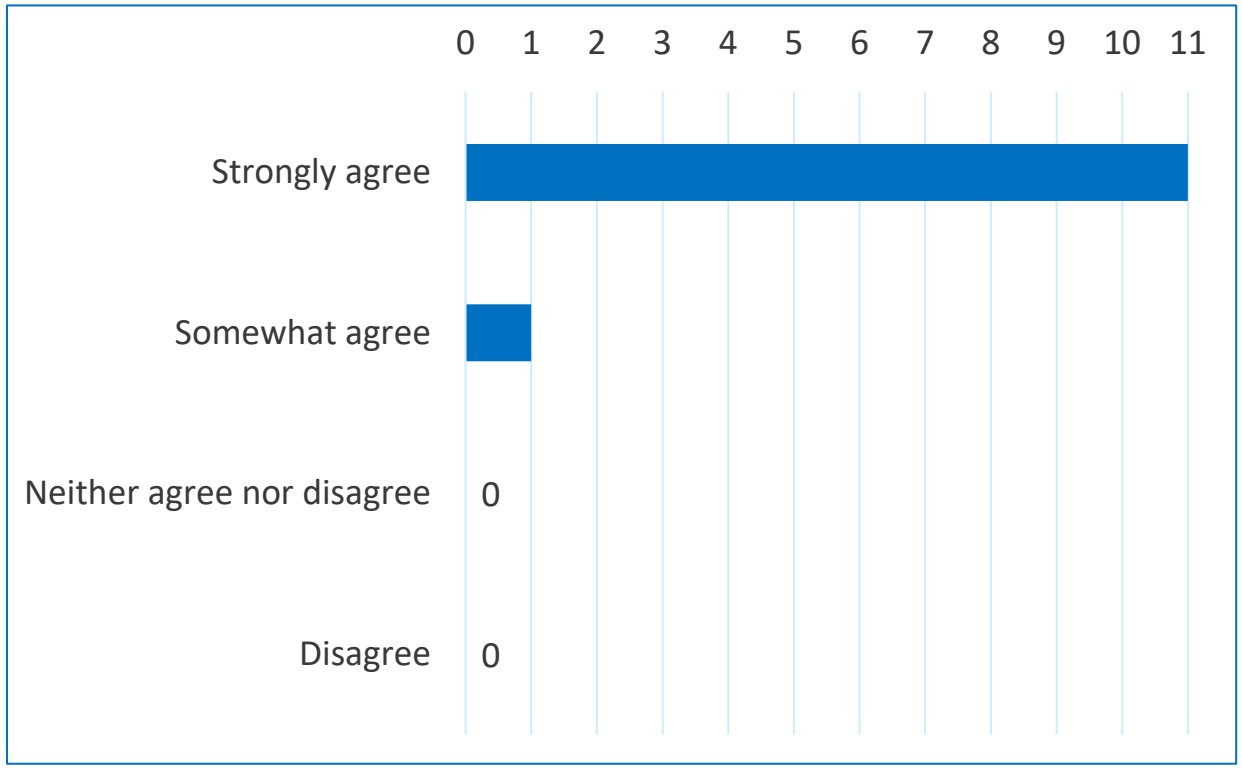


Pharmacist Involvement in Diabetes Care Activities

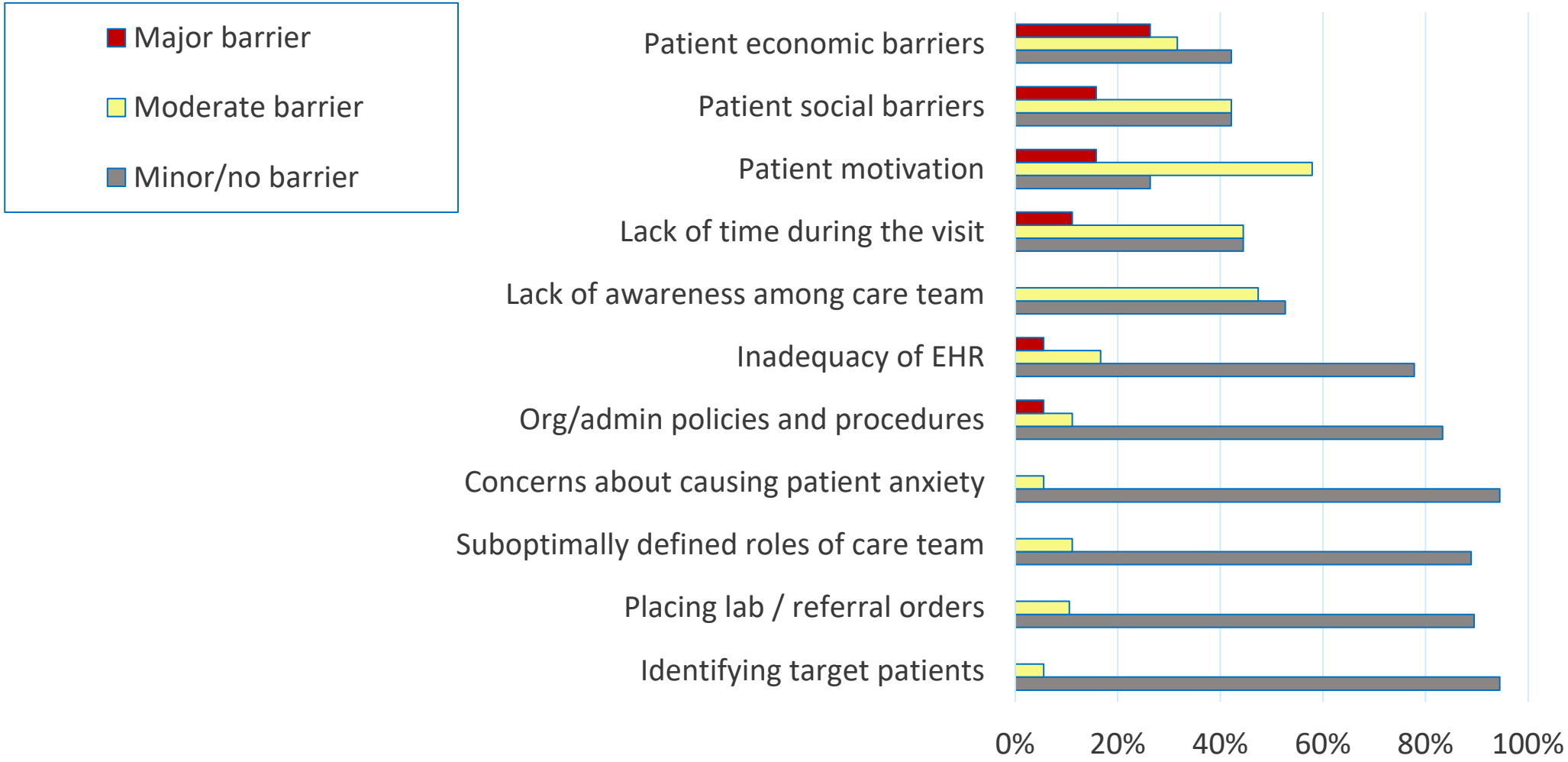
(sample: 2 physician or pharmacist respondents per site)



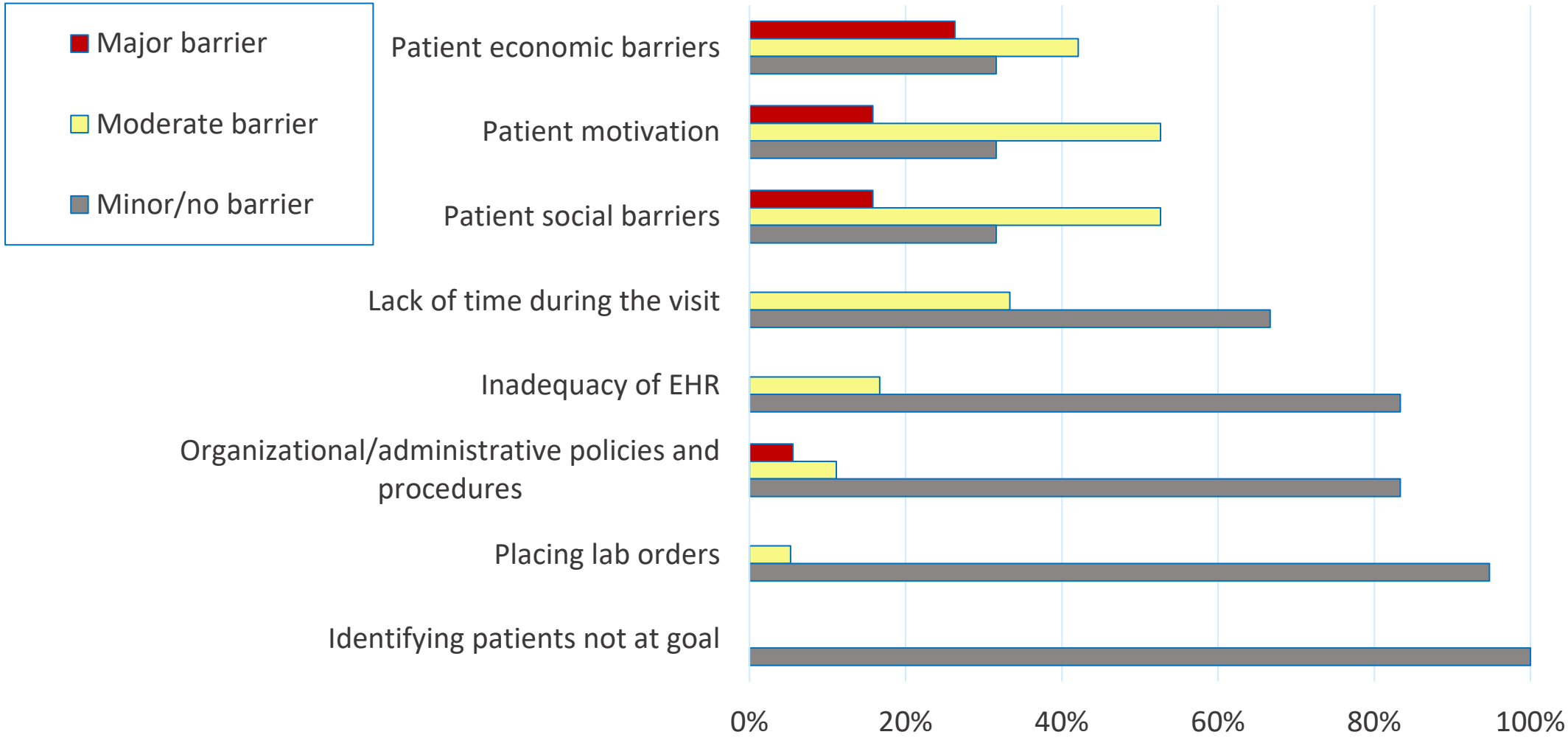
Q. *Pharmacist involvement in the management of patients with diabetes has positively impacted the wellbeing of our care team* (sample: all non-pharmacist respondents, n = 12)



Barriers to Screening (sample: all respondents with data, n=19)



Barriers to Glycemic Control (sample: all respondents with data, n=19)



What is the top barrier to achieving higher CKD screening rates in your practice?

Care team awareness/understanding of the updated guidelines
Have an automated checklist of diabetes labs that need to be completed and have set up to do at visit with provider (portal reminder, written reminder, checklist for MA's to set up)
Having the personnel to consistently track data
Lab orders being placed prior to visits and patients completing the labwork timely.
Lab orders not being placed at guideline recommended intervals --> therefore, screening recommendations not being communicated to patients
Lack of patient follow-through on UACR
MAKING SURE THE PROPER ORDERS ARE PLACED WHEN NEEDED AND PAYING ATTENTION TO THE DUE DATES IF WITHING SAME CALENDAR YEAR PLACING THE ORDERS AND PTS KNOWING WHAT NEEDS TO BE DONE. PATIENTS ALSO BEING PROACTIVE IN THEIR CARE AND COMPLETING THE ORDERS
Not having labs completed at in house lab while at appointments
Patient engagement | Patients actually getting the screening done
Patients getting uACR screening simultaneously with the BMP. Often times patient's will only get their eGFR drawn and won't complete their uACR in order to be compliant in the KED measure.
The greatest barrier is cost associated with the lab tests. Many of our patients have difficulty completing labs at Brown Health because of barriers to completing the free care application, transportation, and other factors. We have increased our capacity to provide on-site testing, but because we are not reimbursed for services provided, our capacity to offer these tests is limited.
Workflows, and barriers placed by IS and lab administration. Clinical team members do not have the necessary permissions to place or pend orders. Lab staff routinely cancel orders if the patient cannot complete the test, rather than leaving them in the system for patients to complete later.

What is the top barrier to achieving higher screening rates for DM retinopathy in your practice?

In your view, what is the top barrier to achieving higher screening rates for diabetic retinopathy in your practice?
$$$, Patients can't afford and may not be educated on the importance of this exam
Actually recording the eye exams that were already done in a systematic way that is able to be tracked
Compliance; also Cost and time
Coordination of care with endocrinology offices and ophthalmology offices to receive results. Often times if the patient is followed by endocrinology they are the providers who are making the diabetic retinopathy initial referral and will automatically be CC'd on the results. Enhancing workflows to best optimize time management strategies and not contacting specialist offices multiple times.
Difficulty tracking, obtaining, and organizing eye exams; feels like we are always chasing these reports down. Would be nice to have this automated into system - could patients upload or self-report information on patient portal?
Lack of access to screenings, further testing, and specialists/outside practices. Patients are uninsured and many don't fully qualify for FreeCare, which can pose major economic barriers. The referral process to outside practices for screenings can be extremely slow.
Lack of volunteer ophthalmologist/optometrist and for our RetinaVue, the cost per test can be prohibitive.
Limited time during office visits to complete all necessary screenings. We have held clinics in the past, but there has been limited engagement/interest on the part of the patient. Recently made the operational decision to cancel subscriptions to retina screening devices that supported multiple practices. Few team members are trained on how to perform retinal screen in PCP setting.
Not having screening completed while patient in office
patient engagement | Patient follow through with appointments. | Patient motivation to find eye doctor.
patients getting the screening done
PATIENTS STAYING ON TOP OF THEIR PREVENTATIVE CARE AND TAKING ACTION WHEN NEEDED. HAVING IN OFFICE OPTIONS AT TIMES OF VISIT WHEN DUE OR IN OFFICE SCHEDULING FOR THEM TO COMPLETE EYE EXAMS. I FEEL PATIENTS BEING ABLE TO SET UP APPS AND COMPLETE AT TIME OF VISITS MAKE LESS TRIPS AND REMEMBERING OF APP'S WHICH ALSO MAY BE AN ISSUE. HAVING MANY DOCTORS/SPECIALTIES MAKE IT ALOT MORE FOR PTS TO UPKEEP WITH AND MAY SIMPLY BE OVERWHELMING

What is the top barrier to achieving higher rates of glycemic control in your practice?

$$, Medications are very expensive and "healthy" foods are expensive. Also, If patients are not having known complications from uncontrolled diabetes, they may not put the effort or funds into better control.
Access to affordable/free medications for diabetes
Compliance | Cost of medications, patient motivation/social barriers
Improper follow up interval for noncompliant A1cs
Inconsistent A1c checks and patient motivation/follow through on completing labs.
Lack of routine patient follow up - patients often going longer than the recommended 3 month follow up period. This is largely due to patients canceling and no showing appointments, however, sometimes patients are also booked for a 6-12 month follow up intentionally, despite guidelines recommending 3 month follow up. This results in less frequent monitoring of A1c values and less frequent adjustment to diabetes care plan. Would love to see a work flow at the office level for patients who cancel or no show appointments!
Patient accountability and wanting to actively participate in their care. Understanding the diabetes disease state and how disease progression causes many comorbidities and risk of hospitalization. An additional barrier is coordination of care with endocrinology who is medication managing the patient and ordering all follow-up labs.
Patient education about taking medications consistently and calling before they run out. Diet and exercise are barriers as well and much of that is tied to SDOH factors including poverty and lack of sustainable work.
patient engagement with their health
PATIENTS KNOWLEDGE AND FOLLOWING THROUGH ON HEALTHY HABITS AND EATING VERSUS RELYING SOLELY ON MEDICATION. ALSO STAYING ON TOP OF PREVENTIVE TESTING TO KEEP EYE ON THE CONTROL OF DIAGNOSIS
Socioeconomic status of our patients is typically why they struggle to achieve glycemic control.

Eye Exam for Patients with Diabetes

RI All Payer Claims Data (2021)

Population: Type I or II diabetes, age 18-75
Exclusions: Nursing home, use of hospice

$$\frac{24{,}570}{52{,}440} = 46.9\%$$

Demographic Factors Associated with Lacking an Eye Exam

	Odds Ratio	95% low	95% high	p < 0.05
Age				
65+	Reference			
<65	1.74	1.67	1.81	y
Gender				
Female	Reference			
Male	1.24	1.19	1.28	y
Insurance				
Commercial	Reference			
Medicare	0.94	0.89	0.98	n
Medicaid	0.99	0.96	1.04	n
Zip Code				
mid	Reference			
High poverty	0.98	0.93	1.03	n
Low poverty	1.03	0.98	1.07	n
Any ED Use				
No	Reference			
Yes	1.65	1.45	1.87	y

Next Steps

Deliverable	Timeframe Due Dates
Monthly practice facilitation meetings	June 2024-May 2026
Quarterly learning collaboratives	October 29, 2024 **January 28, 2025** April 29, 2025 July 29, 2025 October 28, 2025 January 27, 2026 April 28, 2026
Submit PDSA, and aggregate results for HEDIS measures. - Kidney Health Evaluation (2 measures) - Eye Exams - A1C < 8%	Baseline measure results: (July 1, 2023-June 30, 2024) submitted by August 16, 2024. Submit quarterly updates on: October 11, 2024 (initial PDSA plan due) **January 17. 2025** April 18. 2025 July 12, 2025 October 17. 2025 January 16, 2026 April 17, 2026
Review open gaps for each of the measures. Strategies include but are not limited to: - Conducting chart reviews - Interviewing patients and conducting SDoH screening - Categorizing reasons for not meeting the measure - Collecting demographic data - Evaluating for co-morbidities	One measure must be completed by October 11, 2024. All measures prior to April 18, 2025.
Using internal data, identify providers and conduct academic detailing for up to 85% of targeted providers (PCP, endocrinologists, nephrologists, ophthalmologists). Review list of specialist providers with practice facilitator prior to any outreach to ensure a coordinated approach. Measure and report impact of academic detailing initiatives.	November 2024- February 2026

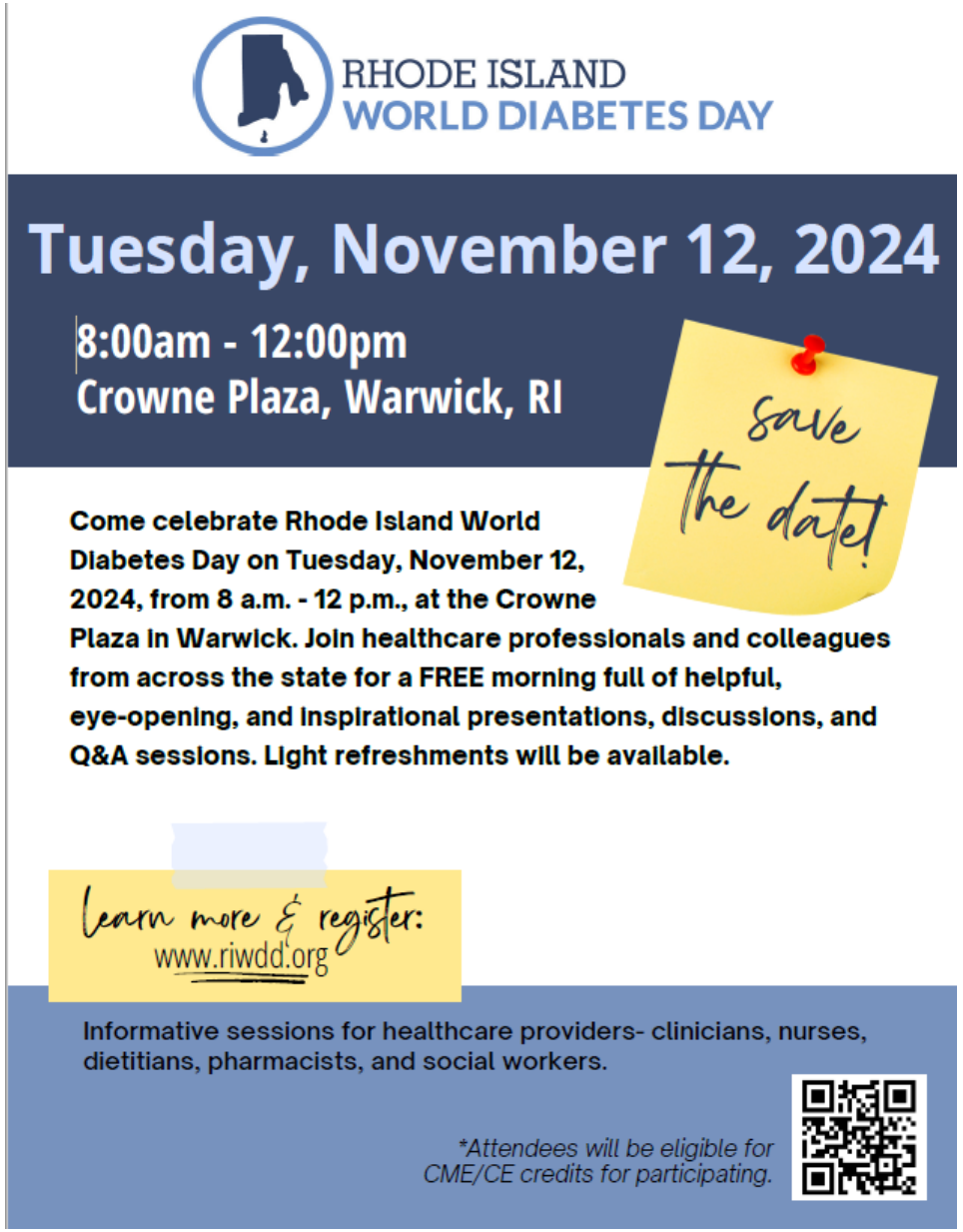
Next Steps (continued)

Deliverable	Timeframe Due Dates
Survey care team members (survey instrument to be provided by CTC-RI)	Baseline (Within 3 months of kickoff) and at Completion (May 2026)
Stratify patients at risk by race, ethnicity, and payer all others are optional. (Consider the following) A1C/GMI - Presence of medical comorbidities - Presence of behavioral health comorbidities - Language preference - CKD Stage - # of specialists involved in care for patient - Other to be determined by practice	Determine which other variables to collect during months 1-4. Submit plan for high-risk priority population by July 12, 2025.
Submit and implement plan for spread/ sustainability	January 16, 2026
Final storyboard submission	May 2026

Announcements

Learn more and register:

www.riwdd.org



thank you
danke
格雷西
ngiyabonga
આભાર
teşekkür ederim
gracias
tapadh leat
mochchakkeram
go raibh maith agat
dziękuję
obrigado
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terima kasih
eskerrik asko
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شكرا لك
ありがとう