MICHIGAN CENTER FOR RURAL HEALTH

IMPROVING DIABETIC EYE EXAM RATES:

A PRACTICAL GUIDE FOR RURAL HEALTH CLINICS

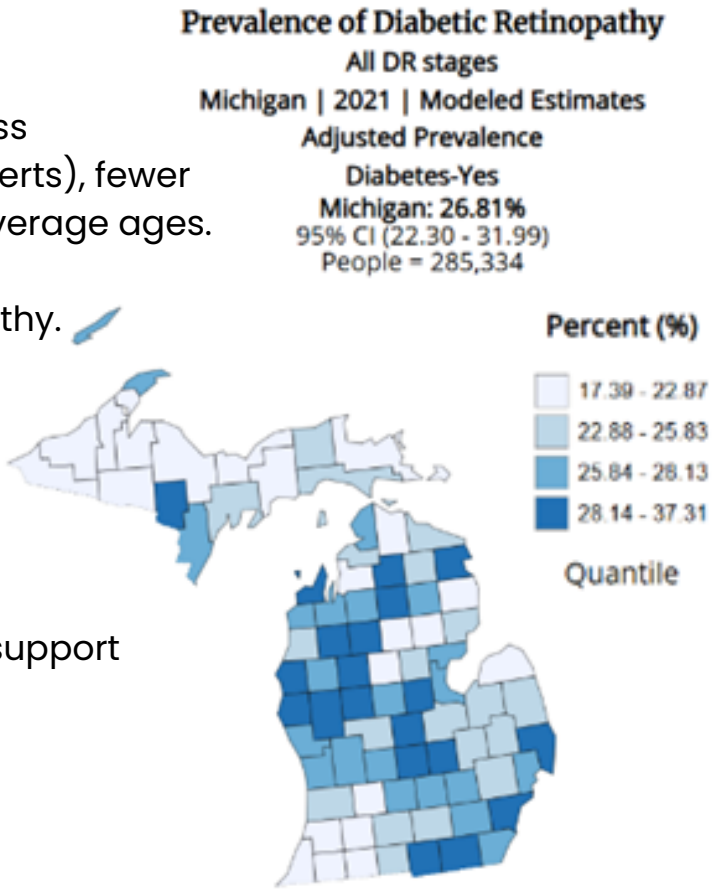
JUNE 2026

TABLE OF CONTENTS

INTRODUCTION

Diabetic retinopathy (DR) is a leading cause of blindness among working-age adults in the U.S.—and often progresses without symptoms until advanced stages. That is why timely screening and early intervention are so essential. Improving DR screening rates in rural primary care settings not only aligns with clinical quality goals but also protects patients' long-term eye health and quality of life.

Statistically, rural populations face higher rates of type 2 diabetes due to complex factors like limited access to fresh, affordable foods (food deserts), fewer recreational facilities, and higher average ages. More diabetes directly translates to a higher baseline risk for retinopathy.



This guide offers strategies to strengthen workflows, reduce missed opportunities, and ensure more patients receive the care they need. This guide was developed to support Rural Health Clinics (RHCs) in increasing DR screening rates and reducing preventable vision loss among patients with diabetes.

Created through the MI 23-0020 – Diabetes Health Equity Advancement in Diabetes Management and Prevention Work Plan, in partnership with the Michigan Department of Health and Human Services (MDHHS), it offers actionable strategies and practical tools tailored for rural clinical settings.

Vision & Eye Health Surveillance System (VEHSS), Centers for Disease Control and Prevention, Vision Health Initiative, [online] [accessed Jun 17, 2026]. URL: https://www.cdc.gov/visionhealth/vehss/project/index.html

HOW TO USE THIS GUIDE

This guide is designed to be clear, easy to use, and supportive of RHCs at any stage—whether you're just getting started with diabetic eye screening or looking to strengthen existing workflows. It provides tools and strategies to help your care team deliver high-quality, guideline-based care. The workflow outlined in this guide shows how primary care teams can identify at-risk patients, streamline referrals, address access barriers, and ensure timely follow-up and documentation. By applying these steps, RHCs can improve care coordination, support early detection of diabetic retinopathy, and ultimately improve health outcomes. The guide is flexible; use it as a starting point, focus on one section at a time, or follow it as a full implementation roadmap.

Note: This guide is not meant to be a checklist, but rather a collection of practical approaches to help you design a process that works for your team and your patients.

ADA Recommendations for Diabetic Retinopathy Screening

To support consistent, high-quality screening practices, the American Diabetes Association (ADA) provides evidence-based recommendations that help guide when and how patients should be screened. Understanding and implementing these guidelines is a key step in improving outcomes and preserving vision for individuals with diabetes.

1. Initial Screening:

- Type 1 Diabetes: Begin screening within 5 years of diagnosis.
- Type 2 Diabetes: Begin screening at the time of diagnosis, since disease onset is often earlier than diagnosed.

2. Follow-Up Exams:

- If no signs of retinopathy are found, screen every 1–2 years.
- If any level of retinopathy is present, screen at least annually. More frequent exams may be needed based on severity.

3. Pregnancy & Diabetes:

- Women with pre-existing diabetes should have an eye exam before pregnancy or during the first trimester, and be monitored each trimester and for 1 year postpartum, as pregnancy can worsen retinopathy.

4. Screening Methods:

- A comprehensive dilated eye exam by an ophthalmologist or optometrist is preferred.
- An in-house option can include programs that use retinal photography with remote reading or the use of U.S. Food and Drug Administration–approved artificial intelligence algorithms to improve access to diabetic retinopathy screening. These programs need to additionally provide pathways for referrals for a comprehensive eye examination when indicated.

5. Treatment Referral:

- Patients with vision-threatening retinopathy (e.g., proliferative diabetic retinopathy or macular edema) should be promptly referred to an eye care professional for treatment.

For detailed guidance on treatment and visual rehabilitation, readers are encouraged to review the the American Diabetes Association Guidelines: **Standards of Care in Diabetes | ADA Clinical Guidelines**. The Retinopathy standards are in section 12.

The field of diabetes care is rapidly changing as new research, technology, and treatments that can improve the health and well-being of people with diabetes. Throughout the ADA's Standards, there is a consistent emphasis on person-centered, team-based care. That same collaborative, interprofessional approach should be applied when planning and implementing diabetic retinopathy screening.

Laying the Groundwork for Success

Roles and Responsibilities

A well-structured process for DR screening starts with clearly defined roles and responsibilities across the care team. This includes everything from identifying patients due for screening, scheduling appointments, closing referral loops, documenting results, and providing patient education. Clinics should have a written plan that outlines staff responsbilities at each step to support smooth coordination and consistent follow-through.

Example DR Team Roles & Responsibilities

Workflow Step	Key Responsibility	Primary Staff Role
Patient Identification	Track and identify diabetic patients due or overdue for their annual DR screening.	Medical Records / Quality Improvement Staff
Scheduling	Outreach to patients to schedule the screening appointment or coordinate it during a routine visit.	Front Desk / Scheduling Coordinator
Patient Education	Explain the importance of the screening, what to expect, and answer initial questions.	Medical Assistant (MA) / Nurse
Referral Loop Closure	Track outbound referrals to eye care specialists and ensure the specialist's report is received back.	Referral Coordinator
Documentation	Log the screening results accurately into the patient's Electronic Health Record (EHR) for consistent follow-through.	Provider / Clinical Informatics Staff

When writing your official plan, replace the "Primary Staff Role" column with the actual names or specific titles used in your clinic to ensure absolute accountability.

Diabetic Retinopathy Screening Workflow

The following sections outline each step of the screening process, beginning with identifying patients due for screening and ending with documented follow-up.

Identify Patients Who Need Screening

The first step in improving DR screening rates is making sure no eligible patients are missed. Use your EHR and care team workflows to flag patients with diabetes who are due or overdue for an eye exam. Early identification allows for timely referrals and follow-up.

Tips to get started:

- Use EHR alerts and health maintenance reminders to prompt screening.
- Make sure the EHR and referral process is set up to close the gap in care.
- Stratify patients by risk level to prioritize outreach efforts.
- Use Scripting: phone calls, texts, or portal messages to remind patients.
- Train staff to flag gaps during chart prep and morning huddles.
- Include patient education during visits to explain the importance of screening.
- Use Chronic Care Management (CCM) programs to regularly engage high-risk patients.

Remove Barriers

Removing barriers is just as important. Staff should routinely assess and help address transportation, financial constraints, scheduling challenges, language needs, and patient motivation. Using strategies like motivational interviewing, social support referrals, flexible scheduling, and cost transparency can improve follow-through. Clinics are also encouraged to monitor screening rates by race, ethnicity, and other demographics to identify and address inequities, partnering with patients to understand and resolve root causes. Together, these practices ensure DR screening efforts are equitable, effective, and patient-centered. *See Section Reduce Barriers That Keep Patients from Being Screened for more details.*

Make Referrals Simple and Reliable

To help more patients complete their eye exams, it's important to have a clear and consistent referral process. Whether your clinic uses electronic or manual referrals, the goal is the same: reduce confusion, track progress, and make sure results come back and get documented.

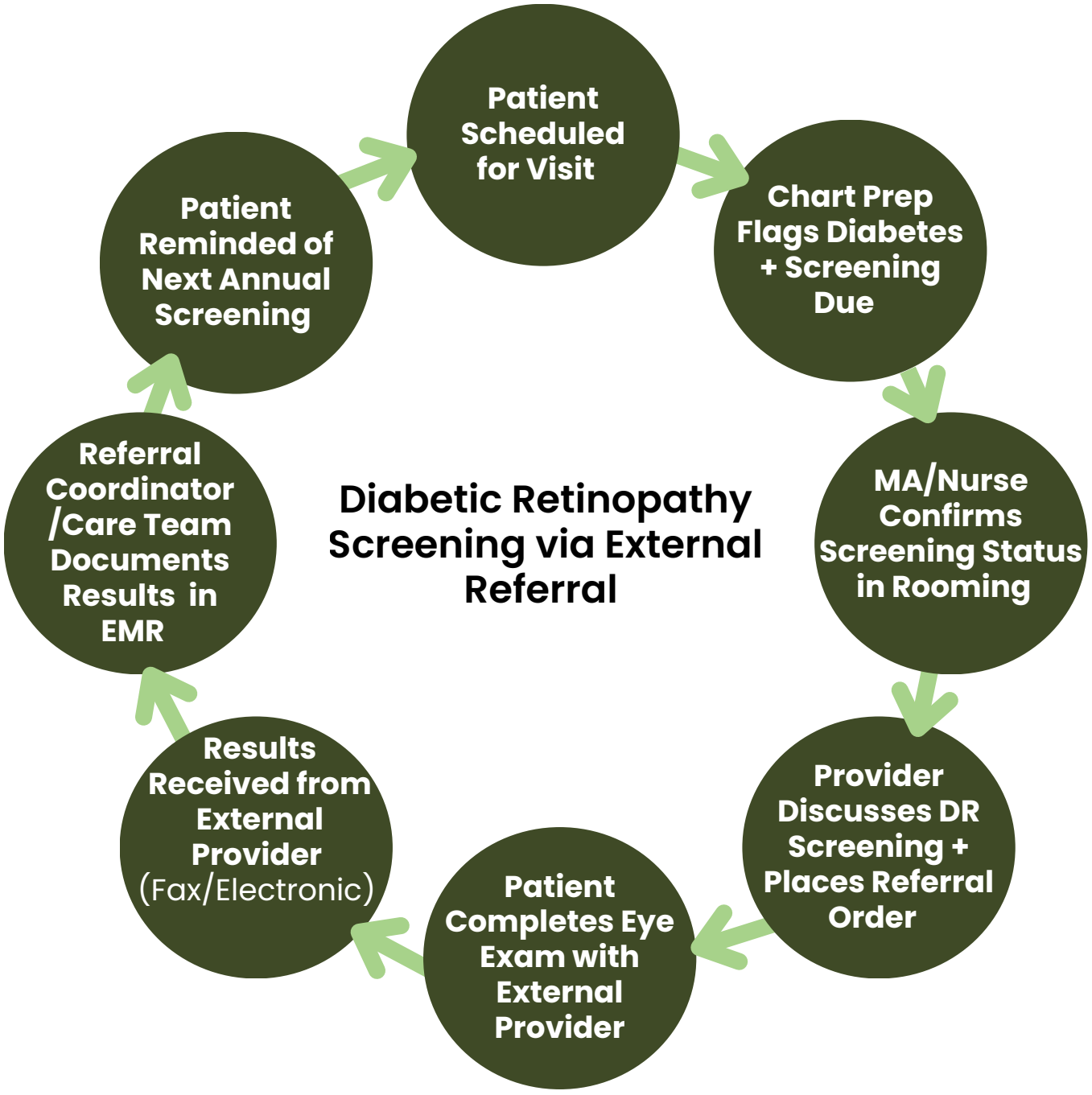
Key strategies

- Use your EHR to place and track referrals whenever possible. If not, create a manual process that works just as well.
- Standardize your workflow so staff know exactly how to document, follow up, and close the loop.
  - Make sure the EHR and workflow are set up to close the gap in care. i.e.) referrals are for “diabetic eye examination” vs “ophthalmologic eye examination”
  - Ensure direct chart prep is happening for diabetes patients.
- Assign a team member to manage referrals from start to finish, including scheduling help and result tracking.
- Keep in touch with vision providers to ensure smooth communication and timely return of results.
  - Build relationships with local eye care providers who allow your clinic to book appointments directly for patients.
  - Utilize a Referral Form/Retinal Screening Form that the vision provider can send back easily.
- Support patients with navigation help, like scheduling, transportation, or understanding the next steps.
  - Keep up to date with available local and insurance-based transportation.

A strong referral process helps patients stay on track and gives your team confidence that nothing slips through the cracks.

Sample Workflow for External Referrals

For clinics without an on-site fundus camera, external referrals remain a common and effective approach to diabetic retinopathy screening. The key to success with this model is ensuring a smooth, consistent process from patient identification through result documentation. This **sample workflow** outlines each step involved in referring patients to an outside eye care provider, helping clinics minimize delays, reduce missed follow-ups, and close screening care gaps efficiently.



Connect with Local Eye Care Providers

Many RHCs rely on outside optometrists and ophthalmologists for diabetic eye exams. When results don't make it back to the clinic, it's tough to close the care gap and missed documentation means missed credit for screenings. One of the best ways to improve this is by building and maintaining a list of trusted community vision providers. Additionally, clinics should actively build and cultivate establish and maintain collaborative relationships local optometrists and ophthalmologists.

Gather Details

- Do they perform diabetic eye exams?
- How do they send results back?
- Do they accept Medicaid and other common insurances?
- What's the cost for uninsured patients?
- Do they offer follow-up for abnormal results and/or referrals to an ophthalmologist for treatment, if needed?

Make Things Easier

- Create an internal Google Map with these providers for staff to reference.
  - **Google My Maps**
- Develop a patient-facing handout with key contact information, accepted insurances, and any helpful tips.
- Equip your front desk or MA team with a script or information packet to walk patients through their referral options.
- For health systems: consider sharing information about eye specialists with other clinics in the area or create a master list.

During your research, when calling each office directly -be specific. Make sure you mention "diabetic eye exam", "dilated exam" or "retinal imaging." Optometrists typically use the term "diabetic eye exam" not screening.

Reduce Barriers That Keep Patients from Being Screened

Many patients face challenges that make it hard to complete their diabetic eye exam. These can include cost, transportation, health literacy, or just not understanding why it matters. Addressing these issues head-on helps make care more accessible, equitable, and patient-focused.

Ways to Help Reduce Barriers

- **Cost and Coverage**: Help patients understand what their insurance covers and offer guidance on financial assistance if needed.
  - Make sure patients know how to contact their insurance if they have questions about coverage.

- **Incentives**: Some health plans offer gift cards or other rewards to patients for getting screened. Check annually and include these incentives in your outreach. A simple message like: "You're due for your diabetic eye exam—and [Health Plan Name] is offering a $25 gift card if you complete it this month. Call us today to schedule!" can go a long way in boosting participation.

- **Education and Support**: Explain why diabetic eye exams are important and offer support for those feeling anxious or overwhelmed about it.
  - Set an Action Plan
  - Reframe Patient Thinking
  - Use a Referral Postcard

- **Transportation:** Investigate local programs, ride-share options, or Medicaid-covered transportation to help patients get to appointments.
  - Note: Driving may be difficult for several hours while the eyes are dilated. Clinic staff can communicate this to the patient and prepare them to request transportation if needed.

More ways your clinic can help on the next page!

Reduce Barriers That Keep Patients from Being Screened

More Ways to Reduce Barriers:

- **Clear Communication**: Provide materials at a 4th - 6th -grade reading level and in multiple languages when appropriate—even if language needs are rare in your area, it's good to be prepared.
- **Care Coordination**: Use care managers or coordinators to help patients with appointment scheduling, follow-ups, and removing roadblocks.
- **In-Clinic Screenings:** If your clinic has the capability, offer same-day screenings to remove the need for external referrals.
- **Scheduling Flexibility**: Offer appointment times outside of traditional hours and consider mobile or community-based screening options for easier access.

Make Screening Part of the Visit

Having a Camera On-Site

If your clinic has a fundus camera, offering in-house diabetic eye exams during routine visits is one of the easiest ways to boost screening rates. It eliminates the need for patients to schedule a separate appointment, helps avoid no-shows, and keeps care convenient.

- **Offer Same-Day Screenings:** Use the fundus camera during regular primary care visits—patients are already there, so it's a great opportunity.
- **Determine a space**, if needed: some fundus cameras require a dark room. Determine what existing space in your clinic will best accomodate this exam.
- **Update Rooming Protocols**: Add a quick DR screening check to your rooming or chart prep process so patients due for screening aren't missed.
- **Standing Orders**: Put standing orders in place so staff can perform the screening without waiting for provider approval.
- **Use EHR Prompts**: Set up alerts in your EHR to flag when a patient is due for screening so staff can take action during the visit.
- **Train Your Team**: Make sure medical assistants, nurses, or other trained staff know how to use the camera properly and capture good-quality images.
- **Document Right Away**: Build a workflow that allows for immediate documentation of results—and referrals if needed—to keep things moving and close the loop quickly.

Use Data to Stay on Track

Regular data review is important to keep diabetic retinopathy screening efforts on course. Data reviews helps your team see what's working, spot where patients might be falling through the cracks and make smart improvements that stick. Here's how to make data part of your workflow:

- **Use EMR Dashboards**: Run regular reports to monitor screening rates, flag gaps, and follow up on missed referrals.
- **Check Coding Accuracy:** Work with billing and EHR staff to make sure diabetic eye exams are coded using Centers for Medicare & Medicaid Services (CMS) and Healthcare Effectiveness Data and Information Set (HEDIS) approved codes (like CMS 131 and HEDIS EED). Mistakes or missing codes can cause underreporting.
  - See the **Quality Cheat Sheet**
- **Backcode When Needed**: If completed exams weren't coded correctly, go back and fix them. This alone can boost your performance rates.
- **Keep Data Clean**: Assign someone to check that screenings are showing up correctly in reports, results from outside providers are entered in the right fields, and tools like RetinaVue are fully captured.
- **Audit Quartely**: Review diabetic patient charts quarterly to make sure exams are documented, referrals are closed, and all results are filed in the medical records where they should be. At minium perform chart audit every 6 months, but move to monthy or weekly when the clinic is actively working quality improvement
  - Refer to the **Chart Audit Procedure Document**
- **Track Referral Follow-Through**: Monitor the number of completed referrals within 30 days & look for patterns that may slow things down.
  - See the **Referral Log**
- **Share Results**: Keep your team in the loop. Share screening data regularly to celebrate wins, troubleshoot issues, and keep everyone invested in improving outcomes.

Making data part of your routine helps ensure no patient gets missed and your clinic gets credit for the good work being done.

Getting Started and Gaining Momentum

Improving diabetic retinopathy screening doesn't have to mean overhauling everything at once. Small, focused steps can go a long way in building momentum and closing care gaps. Here are some quick wins to help your clinic get started:

- **Begin with Chart Prep:** Train MAs or nurses to flag patients due for their annual eye exam during pre-visit planning.
- **Run a Baseline Report:** Use your EHR to see which patients haven't had a documented screening in the past year.
- **Pick One Referral Partner:** Build a relationship with a local eye care provider and streamline the referral and result-return process.
- **Use Standing Orders:** Empower trained staff to perform screenings without waiting for provider approval, especially if you have a camera on-site.
- **Tap into Existing EHR Tools**: Turn on care gap alerts or build prompts into rooming workflows to catch screening opportunities.
- **Act Same-Day When You Can:** Try to schedule or complete screenings during the visit whenever possible to avoid losing patients to follow-up.
- **Assign a Point Person:** Designate someone to keep an eye on referral completions and documentation so nothing falls through the cracks.
- **Celebrate Progress:** Share small wins at team huddles to keep the energy up and show your efforts are paying off

With a few intentional changes and a team-based approach, your clinic can start making meaningful progress right away.

Sustained Improvement Through PDSA Cycles

Small, targeted changes are often the key to long-term success.

Plan-Do-Study-Act (PDSA) cycles give clinics a structured way to test new ideas, evaluate their impact, and make adjustments before scaling more broadly. This approach is especially helpful when refining multi-step workflows such as chart prep, referrals, or result follow-up for diabetic eye exams. **Examples of PDSA Focus Areas:**

- **Chart Prep:** Pilot a process where MAs flag overdue eye exams during morning huddles or chart reviews. Track how many patients are flagged and followed up each week.

- **Referral Process:** Test a workflow where MAs or nurses schedule vision appointments before the patient leaves the clinic.

- **Result Follow-Up:** Assign a staff member to monitor and follow up on open referrals or missing results on a weekly basis.

Sample PDSA Cycle:

- **Plan**: An MA begins using a new referral script for patients flagged as overdue for an eye exam.
- **Do**: The script is tested over two days during all diabetes-related visits.
- **Study**: Staff track the number of referrals scheduled before the patient leaves.
- **Act**: Based on the outcome, the clinic refines the script and expands the workflow to other team members.

- **Schedule regular check-ins with staff to review progress, identify challenges, and share small wins.**
- **Using a simple visual tracker (like a whiteboard or EMR dashboard) can help keep teams engaged and motivated.**

Acknowledgments

This guide was developed by the Michigan Center for Rural Health (MCRH) in collaboration with the Michigan Department of Health and Human Services (MDHHS) as part of the MI 23-0020 – Diabetes Health Equity Advancement in Diabetes Management and Prevention work plan.

We extend our sincere thanks to the Rural Health Clinics and clinical partners who shared their experiences, challenges, and best practices. Their input played a key role in shaping the practical strategies outlined in this resource. This guide reflects our shared commitment to expanding access to diabetic retinopathy screening, reducing health disparities, and supporting better eye health outcomes in rural communities across Michigan.

Appendix: Tools and Templates

This section includes sample materials and tools to help Rural Health Clinics implement diabetic retinopathy (DR) screening improvements more efficiently. Each item can be adapted to fit your clinic's staffing, EMR system, and workflow.

Patient Education and Tools

- Use flyers with language at 4th - 6th-grade reading level; available in English and Spanish.
  - **Flyers/ What is Diabetic Retinopathy**
    - One Pager:
      - National Eye Institute One-page flyer
      - National Eye Institute One-page flyer in Spanish
    - MDHHS Office Flyers:
      - More than meets the eye flyer
      - Other MDHHS Flyers and Messages
    - Flip Chart: Diabetes Eye Health Flip Chart
    - Annual Exam Packet:
      - Eye Health Annual Exam Packet
      - Eye Health Annual Exam Packet in Spanish
  - **Action Plans**
    - Action Plan: Kaiser Permanente Self Help Action Plan
  - **Other Education**
    - Reframe Patient Thinking:
      - 12 Reframes to Help with Diabetes Distress
      - 12 Reframes to Help with Diabetes Distress in Spanish
    - Visit Summary: ADA Visit Summary
    - Learning about the Eye: Parts of The Eye Flyer
    - Protect Your Vision Handout: MCRH Protect Your Vision Handout
    - External Referral Postcard: Referral Postcard
      - Have patients take this to their eye doctor
- **Social Media**
  - NIH Social Media Toolkit
  - Other MDHHS Flyers and Messages

Appendix: Tools and Templates

Staff Resources

- **Staff Scripting Message**s(including incentive messaging)
  - Diabetic Eye Exam Staff Scripting
- **Reminder and Referral Information:** Retinopathy Exam Referral Reminder
- **Talking to Patients:** learn how to talk with patients about diabetes-related eye complications without sparking fear or judgement
  - Let's Talk: Diabetes & Eye Health - dStigmatize
- **ADA Eye Health Resources:** ADA Eye Health Resources

Insurance and Transportation Tools

- **Patient and Provider Benefits Incentives**
  - Patient and Provider Benefits and Incentives
- **Insurance Coverage Worksheet -** specific for medication and continuous gloucose monitoring, but can be modified for Diabetic Eye Exam
  - MCT2D Insurance Coverage Worksheet
- **Use your google Map of Eye Care Providers**
  - Google My Maps

In-Office Workflow Tools

- **Sample Referral Tracking Log**
  - Simple spreadsheet to track referral date, provider, result status, and follow-up.
  - Helps close the loop and avoid missed results.
  - Molina Referral Tracking Log
- **Camera Protocol** (for clinics with on-site imaging) – **Coming soon!**
  - Step-by-step guide for capturing and storing images, cleaning the equipment, and uploading results to the EMR.
  - Includes troubleshooting tips and quality control checklist.
- **Chart Prep**
  - Chart Preparation for Patients with Diabetes

Appendix: Tools and Templates

In-Office Workflow Tools

- **Chart Audit**
  - Chart Audit for Patients with Diabetes
  - RHC Quality Collab's DRE Tooklit Chart Audit
- **Standing Order Template**
  - Editable document authorizing MAs or RNs to perform or initiate DR screening (e.g., fundus imaging or referral) for eligible patients with diabetes.
  - Includes patient eligibility criteria and documentation steps.
  - Standing Order for Diabetes Care- This includes overall care for diabetes including retinopathy
- **Tip Sheets**
  - Screenshot-based reference showing how to set up or locate:
    - Health maintenance alerts for diabetic eye exams
    - Care gap flags
    - Referral order pathways
    - Structured fields for documenting receipt of external results
    - Example: ASPIRE EPIC Tip Sheets
- **Quality Cheat Sheet:** Quality Measure Cheat Sheet
- **Sample Workflow:** External Referral Workflow
- **Patient Communication Workflow:** ADA Patient Communication Referral
- **Finding Optometrists and Ophthalmologists**
  - Optometrists: Find a doctor of optometry | AOA
  - Ophthalmologists: Eye Health - American Academy of Ophthalmology
- **Google My Maps:** to create the map with providers for staff to reference
  - Google My Maps