SUPPLEMENTARY MATERIAL

Title

Diabetic Disease of the Eye in Canada: Consensus Statements from a Retina Specialist Working Group

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SUPPLEMENTARY MATERIAL 1

Table S1: Full-text articles reviewed by Working Group members prior to the virtual workshop

Theme	Literature citation
Disease	Aiello, 2015 [1] ; Akil, 2019 [2]; Antonetti, 2021 [3]; Bansal, 2015 [4]; Bressler, 2019 [5]; Noma, 2021 [6]; Russell, 2019 [7]; Ryan, 2006 [8]; Sartore, 2013 [9]; Sharma, 2022 [10]; Simo-Servat, 2019 [11]; Singh, 2017 [12]; Virgili, 2015 [13]; Zhao, 2014 [14]
Patient	Amoaku, 2020 [15]; Park, 2019 [16]; Petrella, 2012 [17]; van Leiden, 2002 [18]; Xie, 2017 [19]; Yu, 2021 [20]
Management	Antoszyk, 2020 [21], Cheung, 2018 [22], Elman, 2015 [23], Flaxel, 2020 [24], Glassman, 2020 [25], Glassman, 2020 [26], Maturi, 2021 [27], Schmidt-Erfurth [28], 2017, Virgili, 2017 [29]
Collaboration	Cheung, 2019 [30]; Das, 2021 [31]; Pearce, 2018 [32]; Simo-Servat, 2019 [11]

SUPPLEMENTARY MATERIAL 2

Survey questions for Working Group members (each question corresponds to a consensus statement)

1. All diabetic patients require the following disease criteria assessed/documented for optimal ophthalmic care and decision making (please check all criteria that apply, if any).
    a. Type 1 or Type 2
    b. Insulin usage
    c. Duration of diabetes
    d. Nephropathy status (any one of the following e.g.)
        i. Verify if being followed up by a nephrologist
        ii. Check creatinine in the system
        iii. Subjective reporting of kidney status
        iv. Completion of nephropathy screening (annual urinary microalbumin:creatinine ratio) with primary care and reported results
        v. Dialysis schedule – Peritoneal or Hemo
    e. Systemic Hypertension status (any one of the following e.g.)
        i. Ambulatory BP evaluation
        ii. Usage of anti-hypertensives
        iii. Subjective patient reporting
    f. Dyslipidemia status (any one of the following e.g.)
        i. Using statin or Fibrate
        ii. Previous reported cholesterol levels
    g. Presence of primary care physician for systemic diabetic management
    h. List of all MDs involved with care
    i. Status of diabetic control (any one of the following e.g.)
        i. Random clinic CBGM
        ii. Assessment of prior conducted blood work
        iii. Asking re: HgbA1c status and patient's knowledge of control parameters
        iv. Assessment of compliance to medical appointments
    j. Systemic Medications used (any one of the following e.g.)
        i. List by pharmacy

ii. Subjective report by patient

iii. Consult report by referring physician

k. Smoking status

l. Other (please list):

2. An assessment of the retinal perfusion status through dye-based or non-dye-based angiography is an essential component in the evaluation of the degree of progression/severity of systemic diabetes mellitus.

   a. Agree

   b. Disagree (please elaborate):

3. All diabetic patients with vision worse than 20/30 require an OCT scan of their macula to assess for diabetic macular edema and to evaluate its centricity.

   a. Agree

   b. Disagree (please elaborate):

4. All diabetic patients on anti-VEGF therapy require serial OCTs with each visit to assess for progression/regression of the macular edema.

   a. Agree

   b. Disagree (please elaborate):

5. Intravitreal anti-VEGF agents are a safe treatment option/choice for the control of proliferative disease in diabetic females of child-bearing age.

   a. Agree

   b. Disagree (please elaborate):

6. All diabetic patients require the following personal criteria assessed/documented for optimal ophthalmic care and decision making: (please check all criteria that apply, if any).

   a. Comorbid systemic disease

   b. Possible Obstructive sleep Apnea· Floppy eyelids on exam· Neck and body configuration· Prior positive sleep study

   c. Obesity

   d. Pregnancy (in females of childbearing age)

7. Indications for cataract extraction in patients coping with DDE would include: (please check all criteria that apply).

   a. Vision worse than 20/40 in both eyes without other explanatory pathology

   b. Inability to visualize posterior segment

c. Non-neovascular intraocular pressure elevation due to primary angle closure or open angle glaucoma

d. Other (please elaborate):

8. Cataract extraction can be performed safely in diabetic patients when: (please check all criteria that apply).

    a. Proliferative disease is controlled and stable (or non-proliferative retinopathy severity) and maculas are dry

    b. While undergoing active Anti-VEGF therapy (for whatever indication)

    c. Only in setting of controlled proliferative disease (or non-proliferative retinopathy status) but regardless of macular status

    d. Only in setting of controlled macular edema with tolerance of DR status up to LR-PDR

    e. Never

    f. Other (please elaborate):

9. Multifocal IOLs represent a safe and convenient long-term intraocular lens option for DDE patients.

    a. Agree

    b. Disagree (please elaborate):

10. What constitutes long term success of vision care over the lifetime of diabetic patients?

    a. Maintenance of at least one eye with better than reading vision throughout life

    b. Maintenance of vision stability; the reduction/prevention and subsequent treatment of visually significant diabetic complications

    c. Best binocular attainable central vision and perimetry at all stages in life

    d. The attainment of long-term vision goals in diabetic patients is not the exclusive responsibility of the ophthalmologist, and involves a compliant patient within a dedicated care team

    e. Other (please elaborate):

11. Regarding NPDR (without DME), do you feel there is any individual or collective value in the widespread implementation/adoption of diabetic interventions to limit progression to proliferative disease (whether continuous anti-VEGF or PRP)?

    a. Yes

    b. No (please elaborate)

12. The presence or absence of macular ischemia has no impact on my threshold to initiate anti-VEGF for diabetic macular edema.

    a. Agree

b. Disagree (please elaborate):

13. Regarding DME + NPDR structural - In the context of 20/30 vision or worse, one should start anti-VEGF therapy when OCT findings indicate.
    a. Qualitative foveal involving edema on B-Scan cut (Foveal depression not preserved)
    b. A quantitative predetermined CMT (or FMT) cut-off on OCT topography
    c. Physician determined structural threshold based on OCT technology in use
    d. Other (please elaborate):
14. Regarding DME + NPDR functional - Treatment-naïve diabetic patients with OCT structural changes consistent with CI-DME, and with non-proliferative retinopathy findings, should only be started on anti-VEGF therapy IF there is an associated functional decline (20/30 or worse).
    a. Agree
    b. Disagree (please elaborate):
15. Regarding CI-DME (no PDR) - Intravitreal anti-VEGF therapy is my primary treatment intervention for threshold CI-DME.
    a. Agree
    b. Disagree (please elaborate):
16. When would you use steroids for the management of diabetic macular edema.
    a. Alternative first line therapy. Offered to all treatment naïve pseudophakic diabetic patients
    b. If CI-DME is refractory to the loading phase of anti-VEGF (with or without addition of macular laser) i.e. after 3-6 monthly doses
    c. All diabetic macular edema is controllable by anti-VEGF. Switching to steroids is not necessary – the edema will respond with persistent administration of Anti-VEGF
    d. One may combine steroids with ongoing Anti-VEGF therapy for resistant/refractory/recurrent/chronic DME with favorable structural results
17. The following steroid formulations are available to me under my provincial coverage plan (please check all formulations that apply, if any).
    a. Ozurdex (Allergan)
    b. Triessence (Novartis)
    c. Off label Kenalog
18. Pars plana vitrectomy is a valuable tool in the management of resistant/refractory/recurrent/chronic DME diabetic macular.
    a. Agree

b. Disagree (please elaborate):

19. Regarding CSME (non-central) - The ETDRS criteria continue to inform my decisions regarding thresholds of intervention with macular laser for non-center involving edema.
    a. Agree
    b. Disagree (please elaborate):
20. Regarding CI-DME (no PDR) - Additional macular laser, as used in the RISE/RIDE and VIVID/VISTA trials, is an important addition to anti-VEGF therapy for threshold CI-DME when diabetic macular edema is refractory/recurrent.
    a. Agree
    b. Disagree (please elaborate):
21. Regarding CSME (non-center-involving) - In the setting of clinically significant, non-center involving macular edema, my practice preference is to:
    a. Treat the non-center involving CSME with macular laser as per ETDRS
    b. Observe and treat with Anti-VEGF only if progression to center involving
    c. Treat all OCT based thickening outside of center with macular laser – grid (or focal treatment of leaking microaneurysms)
    d. I haven't done a macular laser in decades
22. Regarding the agent - Anti-VEGF agents available today have negligible clinical differences in their effect on diabetic macular edema.
    a. Agree
    b. Disagree (please elaborate):
23. A loading phase of at least 5/6 anti-VEGF doses administered monthly at the initiation of therapy improves long term diabetic macular edema control (overall duration of therapy and number of injections needed in year 2 and 3).
    a. Agree
    b. Disagree (please elaborate):
24. My algorithm of treatment for anti-VEGF for CI-DME is:
    a. Fixed treatment interval as per VIVID/VISTA, RISE/RIDE, etc.
    b. Treat and Extend (No different from ARMD)
    c. PRN with fixed appointment schedules (BOLT)
    d. Personalized plan incorporating loading followed by a modified treat and extend approach (Non-evidence based)
    e. Other (please elaborate):

25. Monitoring of diabetic retinopathy status by means of clinical examination is necessary while patients receive anti-VEGF therapy for macular edema (especially with treatment discontinuation or treat and extend algorithms of care).
    a. Agree
    b. Disagree (please elaborate):
26. If you selected agree for the previous question (question #25), when should this be done?
    a. Every visit
    b. Q12 weeks
    c. Based on patient's retinopathy grading prior to initialization of anti-VEGF
    d. Other (please elaborate):
27. Assessment of patient's retinal perfusion status is necessary prior to the initialization of anti-VEGF or PRP therapy (dye based or non-dye-based angiography).
    a. Agree
    b. Disagree (please elaborate):
28. Regarding PDR (no CSME or CI-DME) - My threshold to intervene in PDR is based on:
    a. Results of the DRS Trial i.e. High Risk Proliferative Diabetic Retinopathy (HR-PDR)
    b. Low Risk Proliferative Diabetic Retinopathy (LR-PDR)
    c. Perfusion status through advanced imaging tools (Widefield OCT-A, Fluorescein Angiography)
    d. Patient factors (compliance, availability of care, etc.) independent of proliferative threshold for retinopathy status (Severe NPDR and worse)
    e. Other (please elaborate):
29. Regarding PDR (no CSME or CI-DME) - PRP (with PRN add-on therapy) represents the only permanent therapy for control of proliferative diabetic retinopathy.
    a. Agree
    b. Disagree (please elaborate):
30. Regarding PDR and DME - In the setting of threshold proliferative diabetic retinopathy AND threshold CI-DME, my treatment preference is for:
    a. Start anti-VEGF therapy to control DME and continue indefinitely with anti-VEGF to stabilize the proliferative disease
    b. Start both PRP and anti-VEGF on treatment initiation and then continue with anti-VEGF only for DME

c. Personalized treatment based on patient's preferences and individual treatment plans formulated to each patient's visual goals

d. Start anti-VEGF therapy for rapid control of DME and PDR then add PRP while ongoing anti-VEGF therapy (NB at what treatment interval would you add PRP – end of loading, before 12 week extension, etc.)

31. Regarding PDR and DME - In the presence of both proliferative diabetic disease and CI-DME, I would intervene when:

    a. Either CI-DME or PDR meets my threshold for intervention

    b. AT THE EARLIEST opportunity, regardless of whether high risk criteria/perfusion criteria for PDR or structural/functional CI-DME criteria are met

    c. Other (please elaborate):

32. Regarding non-resolving diabetic vitreous hemorrhage (no visible clinical or echographic detachment) - A vitrectomy would be indicated when: (please select all criteria that apply)

    a. Vision loss from persistent VH for more than 4-6 months

    b. Diabetic vitreous hemorrhage in only seeing eye – regardless of duration

    c. Inability to visualize or assess posterior segment for presence/absence of retinal detachment (No B Scan, non-compliant patient, etc.)

    d. At onset of vitreous hemorrhage in a type 1 diabetic

    e. All of the above

    f. None of the above/other (please elaborate):

33. Regarding tractional detachment (no rhegmatogenous component) - A vitrectomy is necessary for:

    a. Foveal involving tractional detachments

    b. Macula involving tractional detachments

    c. All retinal tractional detachments regardless of location

    d. Variable threshold (please elaborate):

34. Regarding combined detachment (tractional and rhegmatogenous) - All combined detachments require retinal stabilization by means of a pars plana vitrectomy.

    a. Agree

    b. Disagree (please elaborate):

35. My treatment preference for post-operative CME in a diabetic patient is:

    a. Anti-VEGF

    b. Topical steroids

c. Combination of topical steroid and topical NSAID

d. Topical NSAID only

e. Periocular/intraocular steroid

f. Observation

g. Other (please elaborate):

36. Differentiating post-op CME from DME requires:

    a. OCT imaging only

    b. Fluorescein angiography

    c. Clinical examination

    d. This differentiation is clinically unnecessary - management is the same

37. Regarding vision rehab - Timely referral to vision rehabilitation centers is an important management strategy for assistance with adaptation to advanced vision loss.

    a. Agree

    b. Disagree (please elaborate):

38. Regarding collaborative management - Should the Working Group seek to establish a minimum communication standard for diabetic patient ophthalmology consultations, to inform the multidisciplinary care team, what would you feel would be the essential information to communicate and at what interval? (open-ended question)

    a. Answered

    b. Skipped

39. Regarding compliance and responsibilities - In addition to managing the ocular complications of DDE, what do you feel are the responsibilities, if any, of the treating ophthalmologist towards a) the diabetic patient and b) the broader multidisciplinary team?

    a. The diabetic patient

    b. The broader multidisciplinary care team

40. Regarding screening - Please list any currently active screening programs within your geography from which your practice receives referrals. (If present, information regarding the screening program, tools used for screening and validation literature, etc. would be helpful if known). (open-ended question)

    a. Answered

    b. Skipped

41. Regarding screening - Please list any current efforts regarding the establishment of diabetic screening programs that you may be engaged in or aware of. (open-ended question)

a. Answered

b. Skipped

SUPPLEMENTARY MATERIAL 3

Table S3: Consensus statements reference list

No.	Statements *Legend (for 6 responses): All = 6, Most = 3 to 5, Some = 3, Few = 1 to 2, None = 0*	Section
1	• Most respondents noted that the following clinical criteria were important determinants of DDE care and required inquiry and documentation: diabetes type, duration of diabetes, nephropathy status, systemic hypertension status, dyslipidemia status, diabetic control status, insulin use, systemic medication usage, smoking status, and the presence/coordinates of primary care physician. • Few respondents noted that the presence of a sleep apnea diagnosis should also be evaluated.	Diagnosis and Monitoring
2	• Most respondents stated an assessment of retinal perfusion status through dye-based or non-dye-based angiography is an essential component in the evaluation of disease progression and severity. • Few respondents noted that angiography is only required in cases with clinically evident retinopathy.	Diagnosis and Monitoring
3	• All respondents agreed that diabetic patients with vision worse than 20/30 require an OCT scan of their macula to assess for DME and evaluate its centricity. In addition, subclinical central DME can present with vision better than 20/30; in that case, an OCT scan is also recommended at screening to determine intervals of follow-up and subsequent treatment planning or functional worsening.	Diagnosis and Monitoring
4	• Most respondents agreed that patients on anti-VEGF therapy require OCT scans with each visit to evaluate disease progression or regression. • Few respondents recommended less frequent OCT scans, such as after every 2-3 anti-VEGF treatments and at the end of treatment.	Diagnosis and Monitoring
5	• Most respondents disagreed that anti-VEGF agents were safe for the control of proliferative disease in diabetic females of child-bearing age. Their opinions were largely based on the lack of current data and the potential for DR to worsen during pregnancy.	Pregnancy & Lactation
6	• All respondents stated that diabetic patients require comorbid systemic disease to be assessed and documented to inform ophthalmic decision making. • Most respondents also recommended assessments/documentation of possible obstructive sleep apnea (OSA), obesity, and pregnancy.	Systemic Comorbidities
7	• All respondents noted that an indication for cataract extraction in DDE patients was the inability to visualize the posterior segment. • Most respondents noted that an indication was unexplained vision worse than 20/40 in both eyes. • Few respondents noted an indication of non-neovascular intraocular pressure elevation due to primary angle closure or open-angle glaucoma.	Cataract
8	• All respondents noted cataract extraction can be safely performed when proliferative disease is controlled or stable and maculas are dry. Most respondents also felt that it was safe to perform surgery while patients were undergoing active anti-VEGF therapy. • Some respondents reported only performing surgery in settings of controlled macular edema with tolerance of DR status up to low-risk PDR. • Few respondents reported they would perform cataract extraction in patients with controlled proliferative disease, regardless of macular status.	Cataract
9	• All respondents disagreed with the statement that multifocal IOLs are a safe or convenient long-term option. The reasons for disagreement included decreased contrast sensitivity, increased risk of maculopathy, and the inability to complete PRP. They noted that perhaps an extended depth-of-focus-type lens may be more appropriate in this setting.	Cataract
10	• Few respondents defined long-term, lifetime success of vision care as the maintenance of vision stability; few defined it as best attainable binocular central vision and perimetry at all stages of life; and few defined it as maintenance of at least 1 eye with better-than-reading vision throughout life. • Few respondents added that the attainment of long-term vision goals in diabetic patients is not the exclusive responsibility of the ophthalmologist; it also requires a compliant patient and a dedicated care team.	Treatment Goals
11	• Most respondents stated they did not feel there was currently any individual or collective value to the widespread adoption of anti-VEGF intervention to limit progression to proliferative disease.	NPDR Management
12	• Most respondents agreed that the presence or absence of macular ischemia has no impact on their threshold to initiate anti-VEGF therapy for DME.	DME Without PDR

No.	Statements *Legend (for 6 responses): All = 6, Most = 3 to 5, Some = 3, Few = 1 to 2, None = 0*	Section
	• In the presence of macular ischemia, few respondents noted they would initiate 3 injections and then reassess, stopping if there was no improvement. • Few respondents noted that the absence of macular ischemia would only have an impact on their threshold for anti-VEGF therapy implementation in cases of unexplained vision loss or decline.	
13	• Most respondents stated that in the context of 20/30 vision or worse, an anti-VEGF should be initiated in DME/NPDR patients when OCT findings are at the physician-determined structural threshold based on the OCT technology being used. • Few respondents noted initiating anti-VEGF when OCT findings indicate qualitative foveal-involving edema on B-scan cut. • Few respondents noted leveraging a quantitative predetermined CMT (or foveal minimum thickness) cut-off on OCT topography.	DME Without PDR
14	• All respondents agreed that in treatment-naïve patients with OCT structural changes consistent with center-involved DME and with non-proliferative retinopathy findings, anti-VEGF should only be started if there is an associated functional decline.	DME Without PDR
15	• All respondents agreed that intravitreal anti-VEGF therapy is the primary treatment intervention for center-involved DME without PDR.	DME Without PDR
16	• Most respondents stated they would use steroids for the management of DME if disease was refractory to the loading phase of anti-VEGF. • Few respondents stated they would use them in patient cases with resistant or recurrent or refractory or chronic DME.	DME Without PDR
17	• Few respondents stated that the steroid formulation dexamethasone implant (Ozurdex®) was available under their provincial coverage plan, and few noted that triamcinolone acetonide injectable suspension (Triesence®) was available under their plan. • All respondents stated that off-label Kenalog® was available under their plan.	DME Without PDR
18	• Most respondents agreed that pars plana vitrectomy was a valuable tool in the management of resistant or recurrent or refractory or chronic DME.	DME Without PDR
19	• Some respondents agreed with the ETDRS criteria to inform their decisions for macular laser intervention for non-center-involving CSME. • Some respondents noted that they rarely used macular laser and followed the DRCR Network Protocol I to monitor non-center CSME. • Few respondents reported that they used laser similarly to ETDRS and applied it beyond the foveal avascular zone.	DME Without PDR
20	• Most respondents agreed that macular laser in addition to anti-VEGF therapy (as per the RISE/RIDE [33] and VIVID/VISTA [34] protocols) was an important option for refractory or recurrent DME.	Current anti-VEGF treatment landscape
21	• Few respondents noted that in the setting of clinically significant non-center-involved DME, their practice preference was to treat with macular laser as per ETDRS. • Few respondents noted a preference to observe and treat with anti-VEGF only if the disease progresses to center-involved DME. • Few respondents noted a preference to treat all OCT-based thickening outside of center with macular laser-grid (or focal treatment of leaking microaneurysms).	Current anti-VEGF treatment landscape
22	• Regarding anti-VEGF agents, most respondents agreed that options available today had clinically different effects on DME. • Few respondents referenced Protocol T [35] and the Cochrane review [29] to support their belief that aflibercept is superior.	Current anti-VEGF treatment landscape
23	• All respondents agreed that a loading phase of 5-6 doses would improve long-term DME control.	Current anti-VEGF treatment landscape
24	• Most respondents noted their algorithm of treatment for anti-VEGFs for DME was a personalized plan with loading followed by a modified treat-and-extend approach. • Few respondents reported that their algorithm was treat-and-extend, and few reported that their algorithm was fixed treatment interval.	Current anti-VEGF treatment landscape

No.	Statements *Legend (for 6 responses): All = 6, Most = 3 to 5, Some = 3, Few = 1 to 2, None = 0*	Section
25 and 26	• All respondents agreed that monitoring of DR status via clinical examination is necessary while patients receive anti-VEGF therapy for DME. • Some respondents stated this should be done at every visit; others said that frequency should be based on the patient's retinopathy grading prior to anti-VEGF initiation.	Current anti-VEGF treatment landscape
27	• Most respondents agreed that assessment of retinal perfusion status is necessary prior to initiating anti-VEGF or focal/grid laser therapy. Perfusion status affects the safety of application of macular laser and the assessment of macular ischemia (which can affect functional gains with anti-VEGF therapy); it also provides baseline DR status to inform future treatment decisions. • Few respondents disagreed, stating that perfusion status does not prognosticate the anti-VEGF response.	Current anti-VEGF treatment landscape
28	• Few respondents noted that their threshold to intervene in PDR was based on low-risk PDR. • Few respondents noted a threshold to intervene based on results from the DRS Trial (i.e., high-risk PDR). • Few respondents noted a threshold to intervene based on patient factors independent of the proliferative threshold for retinopathy status.	Proliferative Diabetic Retinopathy
29	• All respondents agreed that PRP represents the only permanent therapy for control of PDR.	Proliferative Diabetic Retinopathy
30	• For patients with threshold PDR and threshold center-involved DME, most respondents stated that their preferred treatment would be to start an anti-VEGF therapy for rapid control, then add PRP while continuing anti-VEGF therapy. • A few respondents stated that they would use a personalized treatment based on the patient's preference and visual goals.	Proliferative Diabetic Retinopathy
31	• In instances where both sub-threshold PDR and sub-threshold center-involved DME are present, some respondents said that they would intervene when either DME or PDR met their threshold. • Some respondents said they would intervene at the earliest opportunity regardless of risk criteria.	Proliferative Diabetic Retinopathy
32	• In cases of non-resolving diabetic VH with no detachment, all respondents stated that a vitrectomy would be indicated when vision loss from VH persists for more than 1-3 months [36]. • Most respondents stated that early vitrectomy would be indicated for VH in the only seeing eye. • Some respondents stated it would be indicated with an inability to visualize or assess the posterior segment for presence or absence of retinal detachment. • Some respondents stated it would be indicated at the onset of VH in a patient with type 1 diabetes. • Some respondents noted that all 4 reasons above indicate a need for vitrectomy.	Vitreous Hemorrhage
33	• Most respondents stated vitrectomy was necessary for macula-involving tractional detachments. • Few respondents noted it was necessary only for foveal-involving tractional detachments.	Tractional +/- Rhegmatogenous Detachment
34	• All respondents agreed that retinal stabilization by means of a pars plana vitrectomy should be conducted in all cases of combined TRD/RRD.	Tractional +/- Rhegmatogenous Detachment
35	• All respondents stated that their preferred treatment for post-operative CME in diabetic patients was a combination of topical steroid and topical non-steroid anti-inflammatory drugs.	Cystoid Macular Edema (CME)
36	• To differentiate post-operative CME from DME, some respondents would use FA. • Some respondents would use only OCT imaging. • Some respondents noted differentiation was unnecessary as clinical management was the same.	Cystoid Macular Edema (CME)
37	• All respondents agreed that timely referral to vision rehabilitation centers was an important management strategy for assistance with adaptation to advanced vision loss.	Interdisciplinary Collaboration
38	• Most respondents believed the Working Group should seek to establish a minimum communication standard for ophthalmology consultations to inform the multidisciplinary care team. • The Working Group specified that the key information to communicate is visual acuity, intraocular pressure, macular status, DR status, interventions performed, the recommended treatment plan, and the current follow-up schedule with periodic updates based on change in the diabetic status.	Interdisciplinary Collaboration
39	• All respondents noted that key responsibilities of the treating ophthalmologist were to educate patients about the importance of diabetes control, DDE, treatment compliance, and potential	Interdisciplinary Collaboration

No.	Statements *Legend (for 6 responses): All = 6, Most = 3 to 5, Some = 3, Few = 1 to 2, None = 0*	Section
	complications; to provide emotional support to the patient; and to establish a lifelong relationship with the patient. • All respondents felt responsibility towards the broader multidisciplinary care team.	
40	• Most Working Group respondents noted there were currently no active screening programs in their region. • Few respondents noted that Ontario Community Health Centers have a Diabetes Eye Screening Program [37], or that Edmonton uses the secure diagnostic imaging (SDI) System to help screen remote Northern Alberta communities.	Interdisciplinary Collaboration
41	• Most respondents named current efforts regarding the establishment of diabetic screening programs.	Interdisciplinary Collaboration

Abbreviations: CME: cystoid macular edema; CMT: central macular thickness; CSME: clinically significant macular edema; DDE: diabetic eye disease; DME: diabetic macular edema; DR: diabetic retinopathy; DRCR: diabetic retinopathy clinical research; DRS: Diabetic Retinopathy Study; ETDRS: Early Treatment of Diabetic Retinopathy Study; FA: fluorescein angiography; IOL: intraocular lens; NPDR: non-proliferative diabetic retinopathy; OCT: optical coherence tomography; PDR: proliferative diabetic retinopathy; PRP: pan-retinal photocoagulation; RRD: rhegmatogenous retinal detachment; TRD: tractional retinal detachment; VEGF: vascular endothelial growth factor; VH: vitreous hemorrhage

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