Continuing Competence Program
Practice Visit Report

Part 2 – Patient Chart Scoring Rubric

Name of Practitioner Being Reviewed:

_____ **Registration No.:**_____

Type of Practice Visit: **[ ] Regular** **[ ] 180 Day Follow-Up**

Name of Reviewer(s):_____

Date of Review: _____

Name or Office Location of Practice Visit_____

Address:

_____

[Postal Code]

Office phone number: [ ] _____ Fax: [ ] _____

The ACO Continuing Competence Program is evolving from a simple patient chart review (check to see if the practitioner filled in all required test procedures boxes) to a Performance Assessment that ascertains whether the practitioner acted in a skilled, knowledgeable and competent manner. As such, this Scoring Rubric is designed to assist the reviewer and the Competence Committee in making fair, repeatable, objective, reasonable and logical decisions on Practice Visits.

All scores assigned via this Scoring Rubric will be verified and confirmed by the entire ACO Competence Committee before any Practice Visit decision is finalized.

Patient Chart Scoring Rubric Rationale

As mentioned above, recent advances in competence assessments and research in various quality assurance programs have required the on-site Practice Visit component of the ACO Continuing Competence Program to evolve from a simple patient chart review into a comprehensive Performance Assessment. This innovative advancement has necessitated a modification of the ACO Practice Visit Report Form.

The new Report Form has been revised to clearly differentiate possible documentation issues from clinical decision making issues. As such, Part A will assess and record documentation concerns and Part B will assess and record clinical decision making concerns.

Part A – Documentation on Patient Charts

- It is recommended that you assess a minimum of six (6) patient charts chosen at random from patients who received general optometric care (comprehensive or regular eye exams) within the past six (6) months. Additional columns are available if the reviewer deems it worthwhile to include additional chart audit information.
- You will use the exact same patient charts to fill out this part (Part A) and the 1st part of Part B (Clinical Decision Making).
- We also request that you photocopy a minimum of three (3) patient charts and attach to the Scoring Rubric. The reason for including photocopied patient charts to your report is twofold:
    - The charts will give the entire Competence Committee the ability to review practitioner documentation.
    - Should the practitioner request an appeal of the Competence Committee decision, the only evidence presented to Council is Part 1 and Part 2 of the Practice Visit Form as well as all photocopied patient charts. Council reviews the photocopied patient charts to determine whether the Competence Committee arrived at a fair and reasonable decision. If we do not include an adequate number of photocopied charts, the Council does not have adequate evidence to make an informed decision.

Part B – Clinical Decision Making

- This section is the most important part of the on-site Practice Visit as it assesses patient care in more “high risk” areas.
- The previous contact lens assessment area has been incorporated into this area; however, we request that you only assess three (3) contact lens charts in order to spend more time on higher risk files such as independent glaucoma, in-office emergencies and retinal referrals.
- If a pattern of “not performing in an appropriate manner” emerges, an additional page has been added to this section to allow you to continue the Performance Assessment in these higher risk areas.
- Again, as noted above, a minimum of three (3) patient charts should be photocopied and included with this report. We also ask that if a referral letter is photocopied, that the response letter is also photocopied as this gives an independent verification of the practitioner’s competence.

Part A – Documentation on Patient Charts

General Primary Care Comprehensive Eye Exams

- It is recommended that you assess a minimum of six (6) patient charts chosen at random from patients who received general optometric care (comprehensive or regular eye exams) within the past six (6) months. Please attach a minimum of three (3) photocopied charts to this report.
- Additional columns have been added for those reviews where you deem it necessary to include an audit of additional charts.
- **In this section, you will mark a "2" if the practitioner performed in an appropriate manner, a "1" if the practitioner mostly performed in an appropriate manner or a "0" if the practitioner did not perform in an appropriate manner.**
- The Total Score is determined by adding up all the numbers that were recorded for the patient charts that were assessed and dividing by the total number possible. Therefore, practitioners will have a possible max total score of 132 for 6 charts assessed or 220 for 10 charts assessed.

Patient Initials, Age and Date of Exam										
Patient demographics, OD name on chart										
Chief Complaint										
Ocular Health, Family History and General Medical History										
Drugs and Allergies										
Verification of Current Rx and Aided and/or Unaided Entrance Acuities										
Are Records Legible										
Distance and Near Binocular Assessment										
Objective and Subjective Refraction with acuities										
External Ocular Health Exam including pupil assessment										
Internal Ocular Health Exam including tonometry if required										

Total Score = /

Part B – Clinical Decision Making

1. **General Primary Care Comprehensive Eye Exams**
   - **In this section, you will use the exact same patient charts reviewed during your general primary care comprehensive exam assessment in Part A. You will mark a "2" if the practitioner performed in an appropriate manner, a "1" if the practitioner mostly performed in an appropriate manner or a "0" if the practitioner did not perform in an appropriate manner.**
   - Patient initials will therefore stay the same as recorded for Part A.
   - The Total Score is determined by adding up all the "2's" that were recorded for the patient charts that were assessed and dividing by the total number possible. Therefore, we would have a possible max total score of 24 for 6 charts assessed or 40 for 10 charts assessed.

Patient Initials										
Was testing regimen and diagnosis appropriate to presenting complaint and exam findings										
Was treatment or referral plan appropriate to diagnosis										

Total Score = /

Additional Comments on General Primary Care Comprehensive Eye Exams Clinical Decision Making Process

2. In-Office Treatment, Referral and/or Co-Management Examinations

- Assess twelve (12) different patient charts (than those assessed in Part A) that are chosen at random from at least three separate days. The reviewer will attempt to audit a cross-section of conditions normally encountered in optometric practice such as: in-office contact lens fitting (required 3 charts with one chart being a new CL wearer), emergency care, pharmaceutical treatment, referral to another practitioner (such as a cataract referral, retinal referral or a binocular vision or vision therapy referral), diabetic, in-office glaucoma workup, in-office vision therapy, in-office low vision workup, etc.
- If a practitioner provides independent glaucoma diagnosis and treatment, at least three (3) charts in this section must be for glaucoma patients.
- Attach at least three (3) photocopied patient charts to this report. For the referral to another practitioner cases, please photocopy the referral letter and the response letter as well as the patient chart.
- **In this section, you will mark a "2" if the practitioner performed in an appropriate manner, a "1" if the practitioner mostly performed in an appropriate manner or a "0" if the practitioner did not perform in an appropriate manner.**
- **The following page contains an area to list the factors that were considered in assigning the score to each patient. For example – not measuring the entrance VA or missing other minor documentation for a patient that presented with a red eye might result in a scoring of a 1 rather than a 2.**
- We will only add up the total score for each case individually – not for the total section. This will serve as a guideline to assist on the practitioner's final decision.

Patient Age, Initials and Date of Exam												
Subjective												
Objective												
Assessment												
Plan												
Score for each case												

Additional Comments on each Patient for In-Office Treatment, Referral and/or Co-Management Examinations:

a) **Patient # 1 – Patient Initial -**

b) **Patient #2 – Patient Initial -**

c) **Patient #3 – Patient Initial -**

d) **Patient #4 – Patient Initial -**

e) **Patient #5 – Patient Initial -**

f) **Patient #6 – Patient Initial -**

g) **Patient #7 – Patient Initial -**

h) **Patient #8 – Patient Initial -**

i) **Patient #9 – Patient Initial -**

j) **Patient #10 – Patient Initial –**

k) **Patient #11 – Patient Initial –**

l) **Patient #12 – Patient Initial –**

Additional Comments on In-Office Treatment, Referral and/or Co-Management Examinations

General Comments and Practice Impressions of the Reviewer

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Dated this _____ day of _____20_____

Signed: _____
[Signature and Printed Name of Reviewer]

_____
(Signature and Printed Name of Practitioner)

All areas of the Practice Visit Report must be completed before the member signs this form above.

RECOMMENDATIONS

To be completed by the Competence Committee as a Whole

Name of Practitioner Being Reviewed:

_____

Registration Certificate Number: _____

Upon completion of Parts 1 & 2 of the ACO Practice Visit Report and review of a limited number of patient charts, it is the recommendations of the Competence Committee that:

[ ] Letter #1 - **Satisfactory Review**.

[ ] Letter #2 - **Satisfactory Review -** With minor notations.

[ ] Letter #3 - **Satisfactory Review -** Practitioner will make immediate changes and send written confirmation to the ACO office within 30 days that the specified changes were made.

[ ] Letter #4 - **Unsatisfactory Review –** Practitioner must undergo a 180 day follow up.

[ ] Letter #5 - **Unsatisfactory Review -** Referral to the ACO Complaints Director.

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Practice Visit Comment Form

Comments from the Practitioner Being Reviewed (if so desired).

[This page is to be removed from this package if the practitioner wishes to provide his/her comments after the review has been completed. It must be forwarded directly to the Alberta College of Optometrists (ACO) office by the practitioner who was reviewed within 10 working days following the date of the practice visit.]

Member to: Fax to: (780) 466-5969
- or-
Mail to: #102, 8407 Argyll Rd., NW, Edmonton, AB T6C 4B2

Name: (please print)
_____

Facility Name, Office Location or Street Address where practice visit took place:
_____

_____
[postal code]

Date of Practice Visit: _____

Name of Reviewer: _____

COMMENTS

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Signed: Dr. _____

Date: _____