Continuing Competence Program Practice Visit Report

Part 2 – Patient Chart Scoring Rubric

Name of Practitioner Being Reviewed		**Practitioner Registration Number**	
Office Name			
Office Address			
	Address	**City**	**Postal Code**
Office Phone Number			
Office Fax Number			
Name of Reviewer			
Date of Review			

The ACO Continuing Competence Program Practice Review is 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. Part A assesses documentation completeness and Part B assesses clinical decision-making abilities and record accuracy.

Part A – Chart Documentation

Comprehensive Eye Exams

- A minimum of eight (8) patient charts will be chosen at random from patients who received a comprehensive eye exam within the past six (6) months.
    - A complete cross-section of patient/case types should be assessed whenever possible (ex: pediatric, adult, senior, contact lens patients).
    - Contact lens charts should have follow up charts included.
- The minimum of eight (8) charts may be assessed if the practitioner exhibits a consistent and appropriate recording of eye exam procedures and test results on all eight patient charts that were assessed. Space for up to twelve (12) primary care chart assessments is available if additional information is needed.
- A minimum of two (2) patient charts must be photocopied and attached to this report.
- For each chart assessed:
    - Mark a "✔" if all information was recorded completely
    - Mark a "✚" if the information was partially recorded
    - Mark a "✖" if the information was not recorded or recorded with an unacceptable level of detail

Patient Number	1	2	3	4	5	6	7	8	9	10	11	12
Patient Initials												
Patient Age												
Date of Exam												
Patient Name and Demographics, Exam Date, & OD Name - on Chart												
Chief Complaint												
Self Ocular and Medical Health History												
Family Ocular and Medical History												
Medications and Allergies												
Verification of Current Rx and Aided and/or Unaided Entrance VA												
Distance and Near Binocular Assessment												
Objective and Subjective Refraction with VA												
External Ocular Health including Pupils												
Internal Ocular Health including IOP (as appropriate)												

Are the charts reviewed deemed legible, complete, and understandable records (by a reasonable person)?	Do the charts contain sufficient information so that another practitioner is able to understand and assume the patient's care?
☐ YES ☐ NO	☐ YES ☐ NO

Part B – Clinical Decision Making

Section 1.1: Comprehensive Eye Exams

- In this section, for each of the patient charts reviewed in Part A:
  - Carry forward the patient initials from Part A.
  - Mark a "✔" if the information was recorded accurately and completely and the practitioner behaved in an appropriate manner
  - Mark a "✚" if the information was partially complete and accurately recorded and/or the practitioner mostly performed in an appropriate manner
  - Mark a "✖" if the information was incomplete and/or inaccurately recorded, and/or recorded with an unacceptable level of detail, and/or if the practitioner did not perform in an appropriate manner
- Case types can be listed with the following abbreviations: adult (A), child (C), senior (S), or contact lens (CL)

1	Patient Initials	Was the testing regimen and diagnosis appropriate to the presenting complaint and exam findings?	Was the treatment or referral plan appropriate to the diagnosis?
Case Type:			
	Additional Comments:		
	Improvements:		

2	Patient Initials	Was the testing regimen and diagnosis appropriate to the presenting complaint and exam findings?	Was the treatment or referral plan appropriate to the diagnosis?
Case Type:			
	Additional Comments:		
	Improvements:		

3	Patient Initials	Was the testing regimen and diagnosis appropriate to the presenting complaint and exam findings?	Was the treatment or referral plan appropriate to the diagnosis?
Case Type:			
	Additional Comments:		
	Improvements:		

4	Patient Initials	Was the testing regimen and diagnosis appropriate to the presenting complaint and exam findings?	Was the treatment or referral plan appropriate to the diagnosis?
Case Type:			
	Additional Comments:		
	Improvements:		

5	Patient Initials	Was the testing regimen and diagnosis appropriate to the presenting complaint and exam findings?	Was the treatment or referral plan appropriate to the diagnosis?
Case Type:			
	Additional Comments:		
	Improvements:		

6	Patient Initials	Was the testing regimen and diagnosis appropriate to the presenting complaint and exam findings?	Was the treatment or referral plan appropriate to the diagnosis?
Case Type:			
	Additional Comments:		
	Improvements:		

7	Patient Initials	Was the testing regimen and diagnosis appropriate to the presenting complaint and exam findings?	Was the treatment or referral plan appropriate to the diagnosis?
Case Type:			
	Additional Comments:		
	Improvements:		

8	Patient Initials	Was the testing regimen and diagnosis appropriate to the presenting complaint and exam findings?	Was the treatment or referral plan appropriate to the diagnosis?
Case Type:			
	Additional Comments:		
	Improvements:		

9	Patient Initials	Was the testing regimen and diagnosis appropriate to the presenting complaint and exam findings?	Was the treatment or referral plan appropriate to the diagnosis?
Case Type:			
	Additional Comments:		
	Improvements:		

10	Patient Initials	Was the testing regimen and diagnosis appropriate to the presenting complaint and exam findings?	Was the treatment or referral plan appropriate to the diagnosis?
Case Type:			
	Additional Comments:		
	Improvements:		

11	Patient Initials	Was the testing regimen and diagnosis appropriate to the presenting complaint and exam findings?	Was the treatment or referral plan appropriate to the diagnosis?
Case Type:			
	Additional Comments:		
	Improvements:		

12	Patient Initials	Was the testing regimen and diagnosis appropriate to the presenting complaint and exam findings?	Was the treatment or referral plan appropriate to the diagnosis?
Case Type:			
	Additional Comments:		
	Improvements:		

Section 2: Treatment, Referral and/or Co-Management Exams

- Assess at least ten (10) different charts (than those assessed in Part A) from patients who required care such as diabetic assessment, emergency care, pharmaceutical treatment, glaucoma workup, referral (ex. cataract, retina, cornea, binocular vision, vision therapy), or in-office treatment (ex: low vision, vision therapy).
    - A variety of conditions should be chosen.
    - Examination dates should ideally be within the past six (6) months, but due to referral times, charts up to one (1) year old can be used.
    - For referral charts, please include the chart, initial referral letter, and the letter back.
    - A minimum of two (2) patient charts must be photocopied and attached to this report.
- In this section, for each of the charts reviewed:
    - Mark a "✔" if the information was recorded accurately and completely and the practitioner behaved in an appropriate manner
    - Mark a "✚" if the information was partially complete and accurately recorded and/or the practitioner mostly performed in an appropriate manner, or
    - Mark a "✖" if the information was incomplete and/or inaccurately recorded, and/or recorded with an unacceptable level of detail, and/or if the practitioner did not perform in an appropriate manner
- Case types can be listed with the following abbreviations: binocular vision (BV), cataract (C), diabetes (DM), dry eye (DE), emergency care (E), glaucoma (G), cornea (K), neuro (N), lids (L), low vision (LV), retinal conditions (R), therapeutic pharmaceuticals prescribed (TPA), or write out in full if other.

1	Patient Initials	Patient Age	Date of Exam	Subjective	Objective	Assessment	Plan
Case Type:							
	Additional Comments:						
	Improvements:						

2	Patient Initials	Patient Age	Date of Exam	Subjective	Objective	Assessment	Plan
Case Type:							
	Additional Comments:						
	Improvements:						

3	Patient Initials	Patient Age	Date of Exam	Subjective	Objective	Assessment	Plan
Case Type:							
	Additional Comments:						
	Improvements:						

4	Patient Initials	Patient Age	Date of Exam	Subjective	Objective	Assessment	Plan
Case Type:							
	Additional Comments:						
	Improvements:						

5	Patient Initials	Patient Age	Date of Exam	Subjective	Objective	Assessment	Plan
Case Type:							
	Additional Comments:						
	Improvements:						

6	Patient Initials	Patient Age	Date of Exam	Subjective	Objective	Assessment	Plan
Case Type:							
	Additional Comments:						
	Improvements:						

7	Patient Initials	Patient Age	Date of Exam	Subjective	Objective	Assessment	Plan
Case Type:							
	Additional Comments:						
	Improvements:						

8	Patient Initials	Patient Age	Date of Exam	Subjective	Objective	Assessment	Plan
Case Type:							
	Additional Comments:						
	Improvements:						

9	Patient Initials	Patient Age	Date of Exam	Subjective	Objective	Assessment	Plan
Case Type:							
	Additional Comments:						
	Improvements:						

10	Patient Initials	Patient Age	Date of Exam	Subjective	Objective	Assessment	Plan
Case Type:							
	Additional Comments:						
	Improvements:						

Extra	Patient Initials	Patient Age	Date of Exam	Subjective	Objective	Assessment	Plan
Case Type:							
	Additional Comments:						
	Improvements:						

Extra	Patient Initials	Patient Age	Date of Exam	Subjective	Objective	Assessment	Plan
Case Type:							
	Additional Comments:						
	Improvements:						

Extra	Patient Initials	Patient Age	Date of Exam	Subjective	Objective	Assessment	Plan
Case Type:							
	Additional Comments:						
	Improvements:						

All areas of the Practice Visit Report (above) must be completed before practitioner and reviewer signatures are applied.

Dated this _____ day of _____, 20_____.

Signed:

_____	_____
Reviewer Name	Practitioner Name
_____	_____
Reviewer Signature	Practitioner Signature

SUMMARY OF FINDINGS

Based on the ACO's Standards of Practice, Guidelines, Clinical Practice Guidelines, and Established Standards

Please reference the applicable document(s) for exact wording / clarification.

Reference	Details	# of Repeated Errors from Part A	# of Repeated Errors from Part B
SOP 1.2.1	Optometrists must make and maintain a **legible, complete, and understandable record** of their care for each patient.		
GL 1.2.1b	Optometrists have a duty to ensure that paper and electronic **patient records contain, as a minimum the following information**: (see document for complete list, but common ones are – family history, meds, allergies, examination findings, diagnoses, prescriptions, counseling, co-management arrangements, treatments administered, referrals made, recommended recall date)		
GL 1.2.1c	**Interpretation** of any additional testing performed such as visual fields, laser scanning or photographic imaging, etc. must be recorded on the patient chart.		
GL 1.2.1f	Optometrists shall ensure that the patient record contains **sufficient information so that another practitioner is able to understand and assume the patient's care** at any point in the course of diagnosis, monitoring, co-management, treatment, or referral without loss of patient care or continuity. A patient record is considered **legible if both the optometrist and a reasonable person are able to read the record.**		
SOP 1.2.2	Optometrists must collect, protect, maintain, use, correct, amend and disclose health information in an appropriate, lawful, and confidential matter. *More specific guidelines are written in regards to **custodian agreements** (GL1.2.2b,1.2.2n) and **information manager agreement** (GL 1.2.2l).*		
SOP 1.5.9	Patient **recall** should be based on the **type and severity** of optometric or medical condition.		
CPG 2.1.1	An examination and **assessment plan shall be designed in order to obtain the information necessary to achieve a proper diagnosis at the highest level of specificity**, and develop appropriate treatment and management plans. *GL 2.1.1a Optometrists shall use their professional discretion and judgment to determine which tests and procedures are best suited for that particular patient at that particular time and be able to justify the inclusion or exclusion of any test.*		
CPG 2.1.2	The examination, assessment, treatment and/or management plan shall be **progressively and appropriately modified on the basis of findings.** (*re: defaults & carry forwards)*		
CPG 2.1.3	Consideration shall be given to the relative importance or urgency of the presenting problems and examination findings.		
CPG Contact Lenses Summary	General Guidelines: the patient's refraction, binocular status, ocular and physical health, mental status, occupational requirements, leisure requirements, wearing environment and other findings **must be considered when determining the most appropriate contact lens specifications.** All contact lens specifications must include (see document for complete list, but common ones listed): • Brand name of contact lens • Base curve, diameter, and power • Replacement schedule		

	• Type of contact lens solution The optometrist's responsibility for the fitting and dispensing of contact lenses includes (see document for complete list): • Having an appropriate discussion on contact lens options and associated costs • Verifying and assessing the contact lenses on the patient's eye for physical fit, physiological response, and visual performance before the lenses are supplied to the patient • Instructing the patient in contact lens wear, insertion and removal, lens care and replacement frequency, monitoring the contact lens performance, ocular health and patient adherence to wearing and maintenance regimen on a regular schedule.		
CPG Diabetes Summary	An annual, comprehensive eye and fundus examination with dilation is recommended for all diabetic patients with consideration given for more frequent assessments when appropriate. Optometrists should communicate with other health practitioners involved in the patients care as per section 1.8 of ACO SOP. The following specific history / procedures **should be performed and documented** for patients who are at risk or showing early signs of developing diabetes (see document for complete list): • Type and onset of diabetes • Measure of blood sugar control (recent blood sugar and/or HbA1c readings) • Current medications and compliance with treatment • Name of physician monitoring diabetic care • Visual acuity, EOMs, pupils, IOP • Assessment of cornea, tear film, iris, anterior chamber for neovascularization • Assessment of retina and optic nerve (dilation is standard of care) • Scanning laser imaging of macular area for detection of macular edema • Retinal photography for future monitoring and/or referral purposes. Optometrists should take an active role in the assessment, diagnosis, co-management, on-going care, treatment and referral of patients with diabetes – specifically educating them on healthy lifestyle choices, possible current and future complications of diabetes, chronic nature of the disease and need for constant, daily monitoring, and the need for annual, comprehensive eye examinations with dilation.		
CPG Glaucoma Summary	Co-management of glaucoma requires the following: • Agreement and discussion of protocols from both practitioners • Appropriate sharing of test results • Appropriate communication of any changes to the management, glaucoma status, complications, or advice to patient • Agreement on follow-up frequency Specific history / procedures **should** be performed and documented when deemed necessary for patients who are **at risk,** or showing early signs of developing glaucoma: • Family / personal health history • Assessment of risk factors • Data from previous assessments • VAs, pupils • Central corneal thickness • Applanation IOP including time of day (Goldmann or Perkins is considered current standard of care and is **required** for all		

	glaucoma suspects and glaucoma patients) • Assessment of anterior chamber angle and anterior uvea (gonioscopy is considered the current standard of care) • Assessment of retina and optic nerve (dilated fundus examination is considered the current standard of care) • Computerized **threshold** visual fields • Stereoscopic optic nerve head photography (preferred) or standard fundus photography • Scanning laser imaging of the optic nerve and macula including analysis of the RNFL • ***Any other supplemental testing as per discretion and judgment of optometrists appropriate to that specific patient.*** Depending on the type, severity, and progression of glaucoma, the following procedures **should be** performed and documented when deemed necessary on glaucoma patients on a **regular basis as part of regular monitoring:** • if using IOP lowering meds, confirm and document time of last dose, compliance, and any adverse reactions • Corrected VAs, pupils • Applanation IOP (Goldmann or Perkins) including time of day • Anterior chamber angle (gonioscopy standard), • Assessment of retina and optic nerve (DFE standard of care) • Computerized threshold VFs • Stereoscopic optic nerve photos or standard fundus photography • Scanning laser imaging of optic nerve and macula including RNFL • Other supplemental testing as per discretion and judgment of optometrist appropriate to that specific patient. In order to be successful in managing glaucoma patients, optometrists **should** communicate with the patient's family doctor, consult with certified optometrist or ophthalmologist when appropriate, and continue to educate and instruct the patient to ensure maximum compliance with the therapeutic regimen.		
CPG BV Summary	When deemed therapeutically beneficial for the patient, the **suitability of additional binocular, oculomotor, accommodative, fusional, perceptual and/or sensory testing, management and treatment should be considered**. Prior to proceeding, optometrists must explain the type of services that are recommended for that patient, the expected timeline for treatment and expected costs for all recommended services. Optometrists who do not provide this type of optometric care must refer patients to an appropriately trained optometrist or ophthalmologist. Optometrists who perform these additional assessments must have **additional specialized testing and treatment equipment** dependent on and appropriate for the severity and type of disorder or anomaly. Optometrists who provide testing, management, and treatment services for learning related problems as part of a multi-disciplinary team shall **communicate and coordinate care** with patients, parents, and/or legal guardians, classroom teachers, and any other professionals involved in the patient's care.		
CPG Optometric Treatment Procedures Summary	The following specific history / guidelines should be performed and documented for patients who will undergo any treatment procedures to the eye and/or adnexa area: • Name of treatment procedure, patient consent form (when deemed necessary) • Pre-treatment consultation that includes the discussion of any contraindications, consultation with other health care providers		

	as well as the provisions of any required additional tests • Date, time and type of treatment performed • Documentation of any adverse effects • Recommended post-treatment care and follow-up. Optometrist is responsible for the safety of all staff and patients in treatment area; for the appropriate service and maintenance of all equipment; creating an office procedures and protocols manual in the event of equipment failure and/or emergency situation; the appropriate use of protective eyewear and other PPE when deemed necessary. List of treatment procedures: removal of a foreign body, D&I, I&R of punctual plugs, treatment of corneal abrasion or erosion, epilation of eyelashes, treatment of chalazia via warm compresses, massage and possible pharmaceutical prescription, IPL and radiofrequency (see detailed list of appropriate purposes).		
Other:			
Other:			
Other:			
Other:			
Other:			
Other:			
Other:			

RECOMMENDATIONS

Based on consensus of the ACO Competence Committee

Name of Practitioner Being Reviewed		Practitioner Registration Number	
Date of Review			

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 this practitioner receive:

- ☐ 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 specific 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

Notations and Comments: