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			

Notes from the Review of Part 1

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)?												
◯ YES ◯ NO												
Do the charts contain sufficient information so that another practitioner is able to understand and assume the patient's care?												
◯ 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 should be listed with 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:		

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:		

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:		

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:		

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:		

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:	AP	☐ ☐ ☐	☐ ☐ ☐
	Additional Comments:		

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:		

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:	EP	☐ ☐ ☐	☐ ☐ ☐
	Additional Comments:		

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:	SS	☐ ☐ ☐	☐ ☐ ☐
	Additional Comments:		

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:		

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:		

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:		

Extra Comments for Section 1.1:

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 (Li), low vision (LV), retinal conditions (Ret), therapeutic pharmaceuticals prescribed (TPA), or write out in full if other.
    - Also indicate whether the case was treated in-office (I), co-managed (Co), or referred (R)

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

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

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

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

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

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

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

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

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

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

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

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

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

Extra Comments for Section 1.2:

The practitioner and reviewer acknowledge that the practice review has been performed and documented in good faith by both parties.

Da**ted this _____ day of _____, 20_____.**

Signed:

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