



American Optometric Association
PRACTICE REVIEW EDUCATION PROGRAM

INTRODUCTION

The **Practice Review Education Program--PREP** is designed to give you, the practicing optometrist, guidance in the self evaluation of your practice. The purpose of the evaluation is to:

- o Acquaint you with the concepts of record review, credentialing, and privileging
- o Assist you in demonstrating the quality of care provided to your patients
- o Prepare you for managed care requirements.

The greatest difficulty with optometric practice review is that many practitioners lack an understanding regarding the procedures. **PREP** addresses this problem by providing you a nonthreatening method to evaluate your practice through self assessment.

In the absence of generally accepted standards for optometric office review, the PREP cannot provide the practitioner with every conceivable review requirement, and does not imply approval by an accrediting body. However, it can provide valuable information to the practitioner prior to undergoing a managed care review.

PROGRAM INSTRUCTIONS

How to use the PREP review forms:

PREP uses three separate review forms to assess quality of care in the following categories:

1) environment of care, 2) clinical records of care, and 3) patient perception of care. Assessment criteria have been selected to represent a broad range of quality indicators, and no practitioner is expected to meet all that are listed. The important thing is to establish baseline scores as an initial step in a quality improvement program.

Step one:

Make one copy of the Office Review Form (see Attachment A) and answer the 20 questions as objectively as possible as you walk through your office.

Step two:

Make 10 copies of the Record Review Form (see Attachment B), randomly select 10 recent patient records (comprehensive exams), and again, as objectively as possible, answer the 20 questions for each record.

Step three:

Send a copy of the Patient Survey letter (copied onto your own letterhead) and a self-addressed, stamped envelope, to each of the 10 patients (see Attachment E).

If you remain objective in your self assessment, you may uncover areas for potential improvement. If you implement a quality improvement program, these same three forms will serve as a useful outcome assessment tool. This is one type of quality improvement cycle that managed care organizations must document for their own accreditation. Panel members who can facilitate this process may be more highly valued by MCOs than those who cannot.

OFFICE REVIEW FORM

Review Date: _____ Practice Site: _____

Patient Access and Services Offered

Yes No

- Is the office easy to find and access?
 Is the office clean, well-maintained, and comfortable?
 Is it easy to determine whether services go beyond basic refractive care?
 Do services include diagnosis and treatment of disease?

Total marked "Yes" _____

Credentials

Yes No

- Does the doctor display a current practice license?
 Does the doctor have diagnostic drug education certification?
 (either pre- or postgraduate as required by that state)
 Does the doctor have therapeutic drug education certification?
 (either pre- or postgraduate as required by that state)
 Does the doctor accumulate enough CE hours to receive the AOA Optometric Recognition Award?

Total marked "Yes" _____

Equipment/Instrumentation

Yes No

- Does the doctor have clean and fully operational refraction equipment?
 (e.g., chair, stand, phoropter, acuity chart, etc.)
 Does the doctor have basic disease diagnostic/management equipment?
 (e.g., slitlamp, biomicroscope, gonioscope, etc.)
 Does the doctor have specialized disease diagnostic/management equipment?
 (e.g., threshold autoperimeter, fundus camera, etc.)
 Are all pharmaceuticals current (not beyond the expiration date)?

Total marked "Yes" _____

Office Safety

Yes No

- Is the office equipped and prepared for fire hazards?
 (e.g., emergency exit(s) diagram, fire extinguishers, emergency numbers by telephones, etc.)
 Does the office meet minimum safety standards?
 (e.g., no obvious risks to employees and patients)
 Does the office have wheelchair access?
 Is the office equipped for infectious disease standard precautions?
 (e.g., sinks in exam rooms, latex gloves, eye protection, face masks, sharps disposal as needed for level of practice observed)

Total marked "Yes" _____

Office Procedures

Yes No

- Is there adequate backup/afterhours coverage for level of practice observed?
 Is there a written delineation of clinical functions performed by technicians and office assistants?
 Is there evidence of a system for spectacle verification prior to dispensing?
 Is there a specific procedure for handling patient grievances?

Total marked "Yes" _____

RECORD REVIEW FORM

Chart #: _____ **Date of Examination:** _____ **Review Date:** _____

Clinician Name _____ **Practice Site** _____

Records Management

Yes No

- Is this record legible?
 Is the responsible doctor clearly identified?
 Is patient name and date of examination clearly recorded?
 Overall, is this record well organized for quality care review, including a problem list?
 (See Attachment C)

Total marked "Yes" _____

Subjective

Yes No

- Is the reason for this office visit easy to determine?
 Was there adequate pursuit of the patient's chief complaint?
 (e.g., onset, course, subjective reliability)
 Was there adequate review of personal health history (including ocular)?
 Were current medications and allergies listed?

Total marked "Yes" _____

Objective

Yes No

- Are visual acuities (entering and best corrected) and tonometry recorded?
 Is it obvious that the visual system analysis was adequate for presenting symptoms?
 Is it obvious that external and internal examinations were adequate for this patient's needs?
 Did diagnostic or therapeutic procedures avoid inappropriate risk to the patient?
 (See Attachment D)

Total marked "Yes" _____

Assessment

Yes No

- Is the diagnosis (or diagnoses) clearly stated (i.e., easy to code)?
 Is the diagnosis (or diagnoses) logical on the basis of findings?
 Are symptom(s) and abnormal findings adequately assessed?
 Overall, does this assessment effectively summarize the patient's eye care needs?

Total marked "Yes" _____

Plan

Yes No

- Is there a specific treatment plan or disposition for this patient?
 Is the plan logical on the basis of assessment?
 Is this treatment plan clear enough that you could easily understand and implement it for the doctor?
 Is there documentation of adequate patient/family health education for patient's needs?

Total marked "Yes" _____

Diagnostic and Therapeutic Patient Risk Examples

The following examples of possible diagnostic and/or therapeutic patient risks were taken from the American Optometric Association's Optometric Clinical Practice Guideline pamphlets. These examples were chosen to give the practitioner an idea of procedures and/or actions that could put the patient at risk.

Overdosage and/or the selection of the incorrect cycloplegic agent for infants, toddlers, and children with certain conditions, such as Down's syndrome, cerebral palsy, trisomy 13 and 18 and other central nervous disorders. (AOA Optometric Clinical Practice Guideline, "Pediatric Eye and Vision Examination", Section II, A 3 c, page 10).

Not discussing the importance of protective eye wear and regular monitoring of amblyopes, with the amblyopic patient and/or parent. (AOA Optometric Clinical Practice Guideline, "Amblyopia", Section II, B 3, page 22.)

Not accessing the anterior chamber angle depth of patients at risk for angle closure prior to administering dilating agents. (AOA Optometric Clinical Practice Guideline, "Primary Angle Closure Glaucoma", Section I, C 3, page 10.)

Dear _____

(Remove this portion)

I'd like to know your impression of the eye care services you received in my office on _____ . Your response on this questionnaire will help me develop ways to improve my services to patients. If you will, please take a minute to rate your impression on the following five aspects of your eye examination.

	Excellent	Good	Fair	Poor	Unacceptable	Not Applicable
Thoroughness of the examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information or advice about the health of your eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal attention from the doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall promptness in scheduling the appointment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality of services and materials received	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please return this completed questionnaire to me in the self-addressed, stamped envelope. If you prefer to remain anonymous, just remove the top part of the page where your name appears.

Thank you for helping me better serve you.

Sincerely,