CHAPTER 24

Quality Assurance

Roger Kamen

Quality is never an accident; it is always the result of intelligent effort.
John Ruskin

A health care system consists of three key components: quality, access, and cost. This chapter explores the quality issue of health care. The goal of every practitioner is to provide the best care to his or her patients. Many practitioners assume that their patients are receiving the best care in their practices, but this may not always be true as evidenced by increasing malpractice claims and dissatisfaction expressed by patients. Additionally, with the increasing role of third-party payers, optometrists can no longer practice in isolation without outside scrutiny. Practitioners can no longer proclaim that they provide quality care but now must provide evidence that such is the case. Quality assurance has gained primary prominence in the delivery of health care. Practitioners need to understand this and embrace it by establishing quality assurance programs in their practices. The dividend of all this activity is to provide the highest level of patient care possible, increase patient satisfaction, decrease risk and liability exposure, and increase practice revenues. This chapter is limited in scope, focusing only on quality assurance in the optometric office and the development of a quality assurance plan for the practice.

QUALITY ASSURANCE IN THE OPTOMETRIC PRACTICE

Each practice, even the solo practitioner, needs to develop and implement a quality assurance program for his or her office. The major components of the program include the following:

- Credentialing and privileging
- Documentation and record review
- Patient satisfaction
- Utilization management
- Risk management

Credentialing and Privileging

Credentialing is the act of verifying the reliability of, confidence in, or believability of information about an individual. The solo practitioner may not appreciate the need for credentialing, although it is a requirement of third-party payers, managed care organizations (MCOs), and hospitals. A leading quality organization is the National Committee for Quality Assurance (NCQA). NCQA is a private, not-for-profit organization dedicated to improving the quality of healthcare in the United States. Although the accreditation of health plans (primarily MCOs) is voluntary, the NCQA "seal of approval" is the gold standard for quality for health plans. Many large employers will only use accredited health plans for their employees. Five categories of standards are used for evaluation: access and service, qualified providers, staying healthy, getting better, and living with illness. The Health Plan Employer Data and Information Set (HEDIS), a comprehensive set of measures of a health plan's performance, includes dilated eye examinations for diabetic patients and Consumer Assessment of Health Plans (CAHPS), a standardized survey of patient experiences with the health plan. These data are required for accreditation and therefore are very important to the health plan. The optometrist will be required to collect these data for any health plans in which he or she is a participating provider, as well as being credentialed by the health plan.

Some of the information required for credentialing includes personal data, education (schools attended and degrees received), optometric state licenses and certifications obtained, professional experience, and professional liability carrier information. Box 24-1 contains the complete list of required information according to the American Optometric Association (AOA) credentialing standards. The process of credentialing is time consuming and may take anywhere from 60 to 180 days to complete.

Privileging is the act of granting certain rights to an individual or group of individuals and withholding certain rights from other individuals or groups of individuals based on an individual's professional license, experience, ability, and competence. Before the optometrist is granted any hospital privileges he or she must be credentialed and privileged. While the solo practitioner will not be privileged in their own practice, practitioners in larger clinics, academic clinical centers, and Armed Forces and Veteran Affairs clinics will have to apply for and be granted clinical privileges. Table 24-1 contains the AOA Guidelines for Delineation of Clinical Privileges for Optometry and includes the Privilege List Approach to clinical privileging. The optometrist requests specific privileges based on his or her education, training, experience, and competence. The hospital or clinic

BOX 24-1

American Optometric Association: Recommended Credentialing Standards for Optometrists

- Personal (name, address, social security number, etc, as required on application)
- Practice information, including:
  - Federal tax identification number
  - Primary office address
  - Office hours and provisions for after-hours care
- Education and training: requires verification of highest level attained, professional school attended, year of graduation, residency training if applicable, etc. Graduation must be from an accredited college or school of optometry whose graduates are recognized as candidates for licensure by the regulating authority issuing the license.
- Graduation can be confirmed by the state licensing agency if the agency conducts primary source verification of this credential.
- Licensure: must hold valid, current license. Application must include history of licensure in all jurisdictions. Verification comes directly from state licensing agency.
- Drug Enforcement Administration (DEA), Controlled Dangerous Substances (CDS), or state equivalent, if applicable, certificate and number.
- Work history: curriculum vitae, resume, or statement regarding practice history. Any work history gap of 6 months or more will require clarification.
- Malpractice history and listing of all sanctions or penalties imposed by licensing boards, government entities, and managed care organizations: required on the application and obtained from the malpractice carrier, Medicare/Medicaid cumulative sanctions report, or National Practitioners Data Bank (NPDB).
- Hospital affiliations or privileges, if applicable
- Listing on application of any voluntary or involuntary relinquishment of privileges to practice in a facility or jurisdiction
- Current malpractice insurance coverage
- Attestation statement by the provider (adapted from the National Committee for Quality Assurance's credentialing standards):
  - Reasons for any inability to perform the essential functions of the position, with or without accommodation
  - Lack of present illegal drug use
  - History of loss of license and felony convictions
  - History of loss of or limitation of privileges or disciplinary activity
  - The correctness and completeness of the application
  - Authorization for health benefit plan to collect any information necessary to verify the information in the credentialing application

RECREDENTIALING

- The optometrist's delivery of care during the 2 or 3-year interval between credentialing and recredentialing is further documented and maintained in the managed care organization's (MCO's) credentialing files through the following data:
  - Member complaints and their resolution by the provider
  - Information from MCO quality improvement activities
  - Utilization management (UM) data on the provider
  - Patient satisfaction surveys
  - Chart review results, if required
- Site visits to the optometrist's office, if required. Possible MCO action may be taken when there is documented evidence of problems or issues with the delivery of care. These actions may extend to the following:
  - Required participation in continuing education
  - Supervision requirements
  - Written improvement plans from the provider
  - Documented evidence of improvements in practice protocols
- Termination from participation of all plans in which they participate, as well as their own office privacy and confidentiality processes found in their written compliance programs
- UM processes may also play a role in protecting patients from medical errors and adverse outcomes. Automated UM systems have the capability of flagging unexpected events that may be indicators of a problem in the quality of health care delivery. This alert may prompt a review of the patient's file by a case management nurse or physician.
- Notify the optometrist of the decision within one calendar day of receiving the precertification request.

then would grant specific privileges, deny specific privileges, or require monitoring before the granting of the privilege.

DOCUMENTATION AND MEASUREMENT OF QUALITY

The framework for measuring healthcare quality resides within three key components: structure, process, and outcome. A quality assurance program needs to incorporate all three of these aspects into the program. For each of these areas, indicators should be developed to document and measure the level of success obtained.

Structure is the environment of the practice and includes: number of personnel, equipment, licensing and privileging of the providers, orientation of new personnel, and clinic policies. Sample structure indicators include the following:

- Annual cardiopulmonary resuscitation (CPR) certification for optometrist and technical staff
- Availability of medical records for follow-up

Process is the appropriateness of care provided to the patient during his or her visit to the practice. Evidenced-based sources for appropriate care include the published AOA Clinical Guidelines. Sample process indicators include the following:

- Diabetic eye examination includes dilated fundus examination
- Amsler grids provided to patients with age-related macular degeneration (AMD)

Outcome measures the final results of the care provided. Sample indicators include the following:

- Patient satisfaction with optometrist care
- Referring diagnosis agrees with consultant's diagnosis
- Ophthalmic eyewear satisfaction and quality

TABLE 24-1

American Optometric Association Guidelines for Delineation of Clinical Privileges for Optometry

PRIVILEGE LIST APPROACH (SAMPLE)

R	PROCEDURE	C	M	G	D	MODIFIED
( )	Admitting privileges	( )	( )	( )	( )	_____
( )	Burns	( )	( )	( )	( )	_____
( )	Co-management of ocular conditions with other physicians	( )	( )	( )	( )	_____
( )	Comprehensive eye health and vision examination	( )	( )	( )	( )	_____
( )	Conjunctival/ocular irrigation	( )	( )	( )	( )	_____
( )	Corneal epithelial debridement	( )	( )	( )	( )	_____
( )	Corneal micropuncture for recurrent corneal erosion	( )	( )	( )	( )	_____
( )	Developmental and perceptual vision evaluation and treatment	( )	( )	( )	( )	_____
( )	Diagnosis and management of conditions of the visual system	( )	( )	( )	( )	_____
( )	Diagnosis, treatment and management of diseases and conditions of the eye, orbit, and adnexa (visual system)	( )	( )	( )	( )	_____
( )	Dilation and irrigation of lacrimal apparatus	( )	( )	( )	( )	_____

This list is representative of possible optometric consultative, diagnostic, and treatment services that could be applied to optometrists in any state. However, the list is not all inclusive and should not be used as a means of limiting or restricting an optometrist's scope of practice; nor is the list applicable in its entirety to all optometrists.

R	PROCEDURE	C	M	G	D	MODIFIED
( )	Electrodiagnostic testing	( )	( )	( )	( )	_____
( )	Fluorescein angiography	( )	( )	( )	( )	_____
( )	Incision and drainage of abscess	( )	( )	( )	( )	_____
( )	Incision and drainage of lacrimal gland or sac	( )	( )	( )	( )	_____
( )	Laser (specify)	( )	( )	( )	( )	_____
( )	Low vision evaluation and related services	( )	( )	( )	( )	_____
( )	Medical laboratory tests: order and interpret	( )	( )	( )	( )	_____
( )	Minor procedures of the eye and adnexa	( )	( )	( )	( )	_____
( )	Ocular microbiology laboratory tests: order and interpret (specify)	( )	( )	( )	( )	_____
( )	Ophthalmic ultrasonography: A and B scans	( )	( )	( )	( )	_____
( )	Punctal occlusion	( )	( )	( )	( )	_____
( )	Radiological imaging tests	( )	( )	( )	( )	_____
( )	Repair of superficial ocular laceration	( )	( )	( )	( )	_____
( )	Utilization of injectable ophthalmic therapeutic pharmaceutical agents	( )	( )	( )	( )	_____
( )	Utilization of oral legend drugs	( )	( )	( )	( )	_____
( )	Utilization of oral narcotic pharmaceutical agents	( )	( )	( )	( )	_____
( )	Utilization of topical ophthalmic pharmaceutical agents (specify)	( )	( )	( )	( )	_____
( )	Vision therapy/orthoptics related services (specify)	( )	( )	( )	( )	_____

Legend
R = Privilege Requested
C = Category (level of training or experience required for this privilege)
M = Monitoring required (monitoring by another optometrist or physician is required for a specific time before privilege is granted)
G = Privilege granted
D = Privilege denied
Modified = Designate if any limitations to the privilege are indicated

Medical Records

Medical records are a critical source of data for documenting quality care provided. The preferred record system is the problem-oriented record system (PORS). This system includes four components: adequate data base, master problem list, management plan for problem, and progress notes utilizing the SOAP (Subjective, Objective, Assessment, Plan) format. Chapter 16 includes a detailed explanation of this record system. The audit of the medical record is a key component of any quality assurance program and should be reviewed on a regular basis.

Figure 24-1 is a sample of a record review form used for auditing primary care examinations. Ten records of patients who have had had a primary care examination could be pulled at random to audit. For each patient, the 24 indicators in AU8 Figure 24-1 should be completed and scored as indicated by

Review and Delineation of Clinical Privileges for:

_____

In accordance with the Guidelines for Delineation of Clinical Privileges for Optometry and on the basis of my education, training, experience, and competence, I hereby request the specific privileges in the Department of _____ as identified on the preceding pages.

_____ _____
Signature of Applicant Date

_____ _____
Signature of Department Chair Date

_____ _____
Signature of Credentials Committee Chair Date

Table 24-1 continued

PRIMARY CARE EXAMINATION

RECORD REVIEW AUDIT

Patient name	Age	Exam date	1 Personal eye history	2 Personal medical history	3 PSFH (family medical Hx and patient social Hx)	4 ROS (review of systems)	5 Patient identifying information recorded	6 Date of most recent PHI and if change/no change	7 Chief complaint	8 History of present illness (HPI)	9 Entrance visual acuity	10 Cover test	11 Visual field screening	12 Pupillary evaluation	13 Tonometry (IOP and time)	14 Habitual Rx	15 Refractive analysis	16 Two other diagnostic tests	17 EOM evaluation (versions)	18 Biomicroscopy	19 Ophthalmoscopy	20 Assessment	21 Management plan	22 Master problem list	23 Patient education/advice	24 Signatures	Score	Goal	Percent	Intern network number	Dr. network number
																												70			
																												70			
																												70			
																												70			
																												70			
																												70			
																												70			
		Score																													
		Goal	10	10	10	10	10	10	10	10	30	50	20	30	40	30	50	20	10	50	70	50	60	40	40	30					
		%																													

_____ _____
Date Reviewer Record review audit criteria 092308

FIGURE 24-1 Primary care examination record review audit.

BOX 24-2

Record Review Audit Criteria

PATIENT HEALTH INFORMATION (PHI)

Note : **All** questions, tables, and check boxes **must** be completed.

- — 1 pt Personal eye history
- — 1 pt Personal medical history
- — 1 pt Past patient and family medical and patient socialhistory (PSFH)
- — 1 pt Review of systems (ROS)

All boxes checked with "yes" must be explained or commented on.

PRIMARY CARE EXAMINATION

- — 1 pt Patient identifying information completed at the top of the front page on the examination form
- — 1 pt Intern reviews PSFH and ROS and records date of most recent PHI form, indicating "No change" or "Changes noted above" on primary care examination form
- — 1 pt Chief complaint (CC)
- — 1 pt History of present illness (HPI)

Entrance Visual Acuity (aided or unaided): 3 pts

- — 1 pt Monocular distance
- — 1 pt Monocular near
- — 1 pt Method of testing indicated

Cover Test (MUST indicate with or without prescription [Rx]): 5 pts

- — 2 pts Distance
- — 2 pts Near
- — 1 pt Testing with or without Rx indicated

Visual Field Screening: 2 pts

- — 2 pts Confrontations or Frequency Doubling Technology (FDT) (Amsler grid is optional, where appropriate)

Pupillary Evaluation: 3 pts

- — 1 pt Pupil size and shape
- — 1 pt Pupillary reactions
- — 1 pt Afferent Pupillary Defect (APD) indication

Tonometry: 4 points

- — 2 pts Goldmann or another method
- — 2 pts Time performed

Habitual Rx: 3 points

- — 2 pts Habitual Rx recorded or "None" written if patient does not wear Rx
- — 1 pt Indicating the purpose of wearing the habitual Rx (distance, near)

Refractive Analysis: 5 points

New Patient

- — 2 pts Objective method results (1 pt) with visual acuity (VA) (1 pt)
- — 1 pt Method of objective testing indicated
- — 2 pts Subjective refraction results (1 pt) with VA (1 pt) or indication of inability to perform and reason (2 pts)

Established Patient Objective and/or subjective (3 pts for methods and findings)

- — 2 pts VA(s)

Other Diagnostic Tests

Other tests not in highlighted areas, one of these two being an accommodative test (facility, lag, Amplitude of Accommo dation (AA), Binocular Cross Cylinder (BCC), Negative Relative Accommodation (NRA)/Positive Relative Accommodation (PRA), add determination, etc.) 2 points

- — 1 pt Accommodative test
- — 1 pt One additional diagnostic test

Extraocular Muscles (EOM) Evaluation (Versions) 1 pt

Biomicroscopy: 5 pts

- — 1 pt For every 2 boxes for both eyes checked as within normal limits (WNL) or written description if not checked

Ophthalmoscopy: 7 pts

- — 1 pt Drug(s) administered by name, concentration, dosage, eye or both eyes (OU), and if no Dilated Fundus Examination (DFE) , reason why patient was not dilated
- — 1 pt Method(s) of ophthalmoscopy recorded
- — 1 pt For every 2 boxes checked (for both eyes checked as WNL or written description if not checked)

Assessment: 5 pts

- — 5 pts Diagnosis(es), signs, or symptoms consistent with and addressing CC, HPI, and examination findings

Management Plan: (6 pts)

- — 4 pts A specific management plan is recorded for each diagnosis, sign, or symptom; primary diagnosis should be the first plan, secondary diagnosis the second plan, etc.
- — 2 pts Written Rx with expiration date or "None" written if there is no Rx for the patient

Master Problem List: 4 pts

- — 4 pts List each diagnosis, sign, or symptom as a separate problem with a separate management plan

Patient Education/Advice: (4 pts)

- — 2 pts Patient education or advice for each diagnosis, sign, or symptom
- — 2 pts Return to clinic (RTC) date recorded

Signatures (must be legible): (3 pts)

- — 1 pt Doctor signed bottom of side 1 of examination form with ID number, indicating review of most current history form
- — 1 pt Intern signed bottom of side 2 of examination form
- — 1 pt Doctor signed bottom of side 2 of examination form and initialed Master Problem List

criteria in Box 24-2 . For each indicator a point total for all 10 records is summed at the bottom of the sheet, and a percentage score is calculated. This can be used to analyze how the practice as a whole is performing on each of the indicators. Additionally, the point totals of the 24 indicators for each patient are totalled, and a percentage score is calculated. These data can be used to analyze how each doctor is performing on a patient-by-patient basis. Other audit forms, such as a progress note audit form, could be developed to audit other services (Figure 24-2).

FOLLOW-UP or EMERGENCY VISIT

Record Audit Form

Patient name	1 Reason for follow-up/chief complaint	2 Follow-up form dated	3 PFSH and ROS reviewed	4 HPI addressed	5 Diagnostic data	6 Dx consistent with recorded findings	7 Tx consistent with diagnosis	8 Patient advice/education	9 Recall/RTC	10 Signatures/legibility	TOTAL	Goal	Percent	Intern network numbers	Dr. network numbers
												20			
												20			
												20			
												20			
												20			
												20			
												20			
												20			
												20			
												20			
Score															
Goal	20	20	20	20	20	20	20	20	20	20					
Percent															

Date _____ Reviewer _____

FIGURE 24-2 Follow-up or emergency visit record audit form.

PATIENT SATISFACTION

Patient satisfaction is very important to the success of the optometric practice and also an important parameter of quality care assessment. Many health plans require patient satisfaction surveys of their members (patients). Patients are asked to rate their overall satisfaction and perceived quality of the eye care examination by describing how they were treated during the visit. This would include an evaluation of the doctor, staff, the facilities (including parking), etc. Figures 24-3 and 24-4 are examples of patient satisfaction surveys.

An important outcome indicator for optometrists is the patient's satisfaction of the eyewear that was dispensed by the practice. Dispensing eyewear can be a major source of revenue for the optometric practice and weighs heavily in the patient's opinion of the practice and the optometrist. The quality assurance program should include sending a followup survey to the patient a few weeks after dispensing new eyewear. A phone call asking a few questions can quickly determine if the patient is satisfied with their eyewear. If the patient is not satisfied, then the patient should be scheduled back into the practice for an appointment with either the optician or optometrist, depending on the type of problem.

A disgruntled patient could quickly spread negative words about the practice to many others. Figure 24-5 is an example of an eyewear telephone follow-up satisfaction survey. Patients should be informed of their rights and responsibilities, which should be posted in the reception area of the office. Box 24-3 is a sample of the patient's rights and responsibilities.

UTILIZATION MANAGEMENT

Utilization management is the process that attempts to assure the appropriate use of resources and services to provide quality care in a cost-effective manner. Proper utilization management is required by many health plans with which an optometrist may have a contract to provide services, and it can also have an effect on practice revenues. Either overutilization or underutilization of services is inappropriate. An example of underutilization is not providing a dilated fundus examination for a diabetic patient at least annually. An example of overutilization would be having a patient return to the office an excessive number of times for unnecessary medical follow-up visits. A good source of data for analysis of utilization management is the medical record.

UNIVERSITY EYE CENTER

Patient Satisfaction Survey

Your feedback about our services to you is important.

Please circle your level of agreement with the following statements:

1 = Strongly Disagree
2 = Disagree
3 = Neither
4 = Agree
5 = Strongly Agree

	SD	D	N	A	SA
1. The optometry student was courteous.					
2. The optometry student was professional.					
3. The optometry staff were courteous.					
4. The optometry staff were professional.					
5. My questions were answered thoroughly.					
6. I was provided enough privacy during my exam.					

(If you disagree, please explain.)_____
_____

7. My examination was outstanding.

8. I would refer others to this clinic.

9. Is this your first visit to this clinic? (Please circle.)

Yes No

10. Do you wear contact lenses? (If yes, answer #11.)

Yes No

11. On a scale of 1 to 10, which is more important regarding contact lenses: the inexpensive cost of contact lenses or the improved safety of the new state-of-the-art contact lenses? (Please circle the appropriate number.)

Cost Safety

1 2 3 4 5 6 7 8 9 10

12. On a scale of 1 to 10, which is more important regarding the eye exam: the highest quality of exam possible or the shortest length in time for an eye exam? (Please circle the appropriate number.)

Highest Quality Shortest Time

1 2 3 4 5 6 7 8 9 10

13. I will return to the clinic as a patient again? (Please circle.)

Yes No, explain_____

14. How did you hear about us? (Please circle.)

Bulldog Bonanza Friend Newspaper TV Radio Mailing Phone book

Other_____

FIGURE 24-3 Sample patient satisfaction survey.

Patient Satisfaction Survey

Please take a few minutes to fill out this survey to let us know how we are doing. Circle the best answer that describes your experiences. If the question does not pertain to you, please skip and go to the next question. Thank you very much for your time.

1. Did you know that we changed our name to the University Eye Center? Yes No

2. How did you hear about our services? Radio Flyers Newspaper

Television Friends/co-workers Other_____

3. How long ago did you schedule your appointment?

1 Week 2 Weeks 3 Weeks 4 Weeks or more

4. Was this amount of time acceptable to you?

Did not meet expectations	Poor	Fair	Good	Exceeded expectations
1	2	3	4	5

Please rate the following:

Check In:	Did not meet expectations	Poor	Fair	Good	Exceeded expectations
	1	2	3	4	5

1. Overall satisfaction 1 2 3 4 5

2. Courtesy and professionalism of staff 1 2 3 4 5

3. Waiting time before your exam 1 2 3 4 5

Eye Examination:	Did not meet expectations	Poor	Fair	Good	Exceeded expectations
	1	2	3	4	5

1. Courtesy and professionalism of staff 1 2 3 4 5

2. Communication of the staff 1 2 3 4 5

3. Staff listened to your needs and concerns 1 2 3 4 5

4. Received information about condition and treatment options 1 2 3 4 5

1 2 3 4 5

Dispensary:	Did not meet expectations	Poor	Fair	Good	Exceeded expectations
	1	2	3	4	5

1. The selection of eyewear 1 2 3 4 5

2. Competitiveness of prices 1 2 3 4 5

3. Courtesy of staff 1 2 3 4 5

Dispensary:	Did not meet expectations	Poor	Fair	Good	Exceeded expectations
	1	2	3	4	5

1. Courtesy and professionalism of staff

General Comments:

What were you most impressed with?_____

What were you least impressed with?_____

How could the University Eye Center improve?_____

Recommendations made to patient:_____

Date of phone call: Attempt #1_____ Attempt #2_____ Attempt #3_____

Date postcard sent (if unable to reach by phone):_____

FIGURE 24-4 Sample patient satisfaction survey.

Aspect of Care: Quality of Ophthalmic Eyewear Phone Call Follow-Up

Patient Name:_____

Age:_____

Home Phone Number:_____

Rx Date:_____

Date Dispensed:_____

1. Is the patient pleased with the frame dispensed?	Yes or No
2. Is the patient pleased with vision for driving- or reading-type tasks while wearing new glasses?	Yes or No
3. Did the patient feel that they received the glasses in a reasonable amount of time?	Yes or No
4. Does the patient need an adjustment of new glasses and/or a follow-up?	Yes or No
5. Did the patient have any questions as to:	
• When to wear Rx?	Yes or No
• Care of Rx?	Yes or No
• Adaptation to Rx?	Yes or No

6. How could our service be improved for you?_____

_____

FIGURE 24-5 Sample follow-up phone call survey.

BOX 24-3

Patient's Bill of Rights

The Michigan College of Optometry at Ferris State University presents these patient rights as part of our effort to provide you with effective patient care. We believe that our patients will be more satisfied when they understand their rights and what they can expect from those who provide their care.

You as a patient should know:

- You have a right to receive adequate and appropriate care, and to receive, in terms you can understand, information regarding your treatment including the risks, benefits and expected duration, alternate course of treatment, if any, and your prospects for recovery. There are only rare exceptions to this when the doctor determines that sharing such information with his/her patient is medically contraindicated.
- You also have a right to refuse treatment to the extent allowed by law and to be informed about the consequences of that refusal.
- You have a right to know in advance about any experimental
- treatment proposed for you and can refuse to participate in the experiment without jeopardizing your right to receive continuing treatment in any way.
- Students in clinical training may observe the delivery of health care to you. If you object, no students except those involved in your care will be present during any procedure, examination, or consultation.
- Your medical records are confidential and will not be disclosed to a third party, except in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and Michigan state law. As stated in HIPAA, we will not obtain a signed patient authorization for treatment, payment, or health care operation.
- You have a right to inspect your medical records or to receive a copy upon reasonable notice and payment of a reasonable per page copying charge.
- You will not be denied appropriate care on the basis of race, religion, national origin, sex, age, handicap, marital status, sexual preference or source of payment.

RISK MANAGEMENT

Risk management is the process that the practice uses to minimize or eliminate potential harm or injury to patients, staff, visitors, and the practice itself. A good risk management program is central to quality assurance. For an in-depth analysis of risk management, see Chapter 23.

QUALITY ASSURANCE PLAN

Each practice should have a quality assurance plan. A good model to follow is the 10-step quality assurance plan proposed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), commonly known as the Joint AU8 Commission. Founded in 1951, the Joint Commission is

an independent, not-for-profit organization that provides accreditation for health care organizations including hospitals, nursing homes, and long-term care facilities. This is a major undertaking for these organizations, and any optometrist involved with such organizations will be expected to provide information as needed. Following this 10-step model will help ensure that the optometrist is in compliance with the Joint Commission guidelines. The plan is applicable to small optometric practices, as well as large clinics. Many other quality assurance organizations and health plans have adopted this plan for their quality assurance programs. The 10-step quality assurance plan is as follows:

1. *Assign responsibility.* Identify the individual who is responsible for the overall quality assurance program. In the typical optometric practice, this is usually the optometrist.
2. *Scope of practice.* Identify diagnostic and therapeutic services provided by the practice.
3. *Identify important aspects of care and services.* Identify services which are most frequently performed and have the highest potential of risk to the patients, for example:
    - Appropriate diabetic eye care
    - Proper referral of patients
4. *Identify indicators.* Measure the quality and appropriateness of care provided; indicators may reflect structure, process, and outcomes criteria as discussed above.
5. *Establish thresholds for evaluation.* Define the level of performance desired for each indicator. A threshold of 80% to 95% is typical but may be 100% for some indicators (e.g., current CPR certifications for providers).
6. *Collect data.* Sources for data include the following:
    - Medical records
    - Patient satisfaction surveys (see Figures 24-3 and 24-4)
    - Patient referral logs
    - Prescription remake lists
    - Optical dispensary follow-up phone call surveys (see Figure 24-5)
7. *Evaluate data.* Analyze data to assess areas where problems or opportunities to improve care exist.
8. *Take action.* Develop a plan with assigned responsibility and action to be taken.
9. Assess action taken. Determine if corrective action has resolved the problem.
10. Communicate. Share with all individuals the findings, conclusions, recommendations, action taken and results.

It is imperative that all office personnel be involved in developing a quality assurance program. It should be stated clearly that the nature of the program is not punitive but rather a helpful tool in providing high-quality care for the patients of the office. Communication is the key to a successful program. Quality assurance is an ongoing process.

CONCLUSION

Quality assurance is the key to a successful practice and to delivery of high-quality patient care. The practitioner needs to develop a viable quality assurance program for his or her practice. Additionally, all staff members need to participate fully in the quality assurance program for it to be a successful endeavor.

BIBLIOGRAPHY

Al-Assaf AF, Schmele JA: *Total quality in healthcare,* Delray Beach, FL, 1993, St Lucie Press.

American Optometric Association: AOA *recommended credentialing standards for optometrists,* St. Louis, 2002.

American Optometric Association: AOA *guidelines for delineation of clinical privileges for optometry,* St. Louis, 2002.

Benson DS: *Measuring outcomes in ambulatory care,* Chicago, 1992, American Hospital Publishing.

Newcomb RD, Marshall EC: *Public health and community optometry,* Boston, 1990, Butterworth-Heinemann.

Norden LC: *Quality Assessment and improvement: a manual for optometric practices,* St Louis, 2002, American Optometric Association.

Websites

www.aoa.org. Website for the American Optometric Association.

www.jointcommission.org. Website for the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

www.ncqa.org. Website for the National Committee for Quality Assurance.