QUALITY ASSURANCE IN OPTOMETRIC HEALTH CARE PRACTICE

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Introduction

As with any branch of health care, optometric practitioners want to provide the best, most appropriate care to their patients. The quality of health care is important not only to patients and doctors, but also to the population as a whole, to the bottom line of the practice or facility, to insurers, investors, and regulators. As quality increases so do a multitude of other factors that can and will have a significant impact on the success of your practice of optometry. Whether you work on your own or as part of a larger organization, the overall quality of the care you provide is crucial. Quality improvement (QI) and assurance are cornerstones of being successful in a very competitive marketplace.

This chapter is written both from the perspective of a newly minted optometrist beginning his or her career, and alternatively from the view of an established optometrist already in practice. Please keep in mind that the topics covered apply to both situations. In this chapter we will examine several components of the goal of “quality” and investigate how to measure, achieve and maintain this goal. We will discuss the “how’s” and “why’s” of this amorphous component of being an optometrist. We will look at how the medical record of your patients is used in QI activities and why that is the most important document that you will produce. This chapter will examine how your education, experiences, and qualifications (“credentialing and privileging”) are examined by potential employers and vice versa when you may wish to add another OD to your practice. We will also learn how patient satisfaction yields repeat patients and how to measure and analyze whether or not you are meeting your patients’ needs, both clinically and in other ways. Finally, we’ll speak about how and why regulations to the profession come into play and how best to stay aware of what you need to be doing to keep up with them.

Objectives

Upon completing this chapter, the reader should be able to:

1. Explain why quality assurance and improvement are important for public health.
2. Describe the most common methods for quality assurance.
3. List which individuals have interest in quality assurance by detailing who pays for and receives health care.
4. Describe the characteristics of a good health care record.

Who Is the Health Care Customer – Who Cares About Quality?

Individuals receiving care want the best and proper care for their own good health and longevity. The typical lay person does not know how to diagnose or best treat their ailments. They rely upon the education and judgment of their doctor and the processes and procedures imposed by other entities such as accreditation bodies like the Joint Commission and insurance companies through approval and payment mechanisms – all designed to foster quality.

Employers provide health care for nearly two thirds of the non-elderly American working population (19-64), though this number has been declining in the past decade.¹ This can be a large proportion of their employee benefits costs. Employers are making a sizeable investment in their employees through health insurance. Their interest in providing high quality health care is two-fold: that the cost is worth the outcome and the investment ultimately maintains employee health and productivity in the workplace.

Health insurance companies are balancing premium pricing with the dollars out flowing to doctors, hospitals, other care providers for services, drugs and other devices. Since premiums and available coverage are market competition points, they strive to improve the quality and availability of services while controlling costs. Also, the good health of each insured individual reduces their own future health care costs and thus the burden to the insurance company.

The government is interested in the overall quality of health care from several different perspectives. First and foremost, governments work for the betterment of the health of their citizens. For most countries’ economies, the productivity of the workforce is a basic driver of their economy. The United States government provides health insurance through social welfare programs such as Medicaid for millions of people who meet certain income criteria. Additionally, Medicare covers Americans 65 and over. These programs are very large investments in health by the federal government and affect tens of millions of people. The government strives to push improvements in health care that will improve health and, ultimately, control future costs.

Expenditures on health care are a significant part of all countries’ GNP. In the United States, health care accounted for 16% of the gross national product in 2008.² The percentage is expected to grow to 20% by 2017; these expenditures are a significant part of the US economy. This investment, however, has not resulted in an overall improvement in the health of US citizens. Several versions of managing care have been attempted yet have not achieved the goal of overall cost control and better health outcomes. Private and public payers, through several mechanisms, move us to improve health care quality for the dollars spent by providing the right care at the right time.
There is a stake in health care quality improvement from virtually any angle you look. Individuals, employers, health insurance companies and local, state, and federal government all share in the goal of improved health.

**Methodologies for Quality Assurance**

**Structure**

Although each state’s regulations may differ, there are some minimal compliance issues that your practice must address. Some are discussed below in this section.

Access to your building and office must be in compliance with the Americans with Disabilities Act. This means you must be accessible to those with difficulty walking, seeing, hearing, etc. Your staff should be trained in dealing with patients who are handicapped or require additional assistance so that these patients are treated no less efficiently or professionally than any other individual. Aside from legal compliance with federal and state statutes, it is simply the right thing to do from an ethical and customer service prospective.

Most states also set parameters for how patients in need of urgent care should be accommodated. For optometrists in an office setting, you will likely have standard hours of operation and may not see patients presenting with urgent care needs. In this situation simply communicating your office hours and providing a way for patients to leave voicemails should be sufficient. You should consider including in your outgoing voicemail message, however, instructions on how to seek urgent care should the need arise for one of your patients.

Clinic or hospital settings are generally subject to more extensive requirements for treating urgent care patients. These vary by state but generally include a way for patients to receive treatment during “off hours”, or at least a health care professional who is qualified to triage patients and arrange for their care at another facility.

Additionally, most state optometry boards, vision plans and health insurance providers maintain a list of minimal necessary equipment and policies and procedures for an optometrist to possess in order to serve patients. Appendix A is a sample list which would be used by third party payors or regulatory bodies to ensure that facilities treating patients are properly following quality care guidelines such as safety, access, equipment, infection control and physical appearance. These are representative of standard requirements for optometry and you and your practice should score a high mark on all metrics. Developing a tool such as this one is straightforward and can provide an excellent mechanism to measure your compliance.
CREDENTIALING AND PRIVELEGING

One of the most important aspects of running a safe and successful optometric practice, whether in a smaller office setting or a larger organization, is the proper credentialing and privileging of new providers in your group. This is just as important when you may wish to join an existing group or facility and will need your own credentials verified (this section applies to both situations). Regulations surrounding credentialing and privileging standards exist at the state and federal levels and must be followed to ensure that only qualified practitioners are treating patients. Most states have laws and regulations relating to credentialing and privileging, and you are wise to be fully informed of them. These regulations are set up to protect the public and help ensure quality health care practitioners whose skill sets have been examined and verified and are applicable to the care they are giving.

Credentialing is a process in which four main parameters are verified: licensure, training, competence, and ability to perform the clinical procedures requested. The first step is verification of current licensure – this should be accomplished prior to the granting of any privileges and certainly prior to any hands-on interaction with patients. Licensure should match with all relevant state and federal laws, as well as the requirements of your own organization. Verification of the practitioner’s clinical skill set, knowledge and competence demonstrates that the individual has undergone appropriate training for the type of privileges being requested. All documents related to credentialing and privileging should be maintained in the Medical Staff Office if your organization has one, or with the Human Resources department.

Unfortunately in today’s climate, identity theft and misrepresentation are common. Virtually all industries have mechanisms to prevent this and health care is no different. While it is mandatory to verify an independent practitioner’s reported credentials, it must be done in most cases where possible using “primary source verification”. Primary source verification is: “Verification of an individual health care practitioner’s reported qualifications by the original source or an approved agent of that source. Methods for conducting primary source verification of credentials include direct correspondence, documented telephone verification or secure electronic verification from the original qualification source, or reports from credentials verification organizations…” This means that whenever possible, your organization needs to verify credentials, education, licensure, work experience, etc. directly from the reported source of each. For example, to verify that a potential new doctor’s degree in optometry was granted in 1992 from the Illinois College of Optometry in Chicago, Illinois you would be required to contact the College directly through one of the secure methods described in the citation above, and then document this verification and the route through which it was obtained. The same process would be necessary to verify licensure at the state level, work experience at the level of the institution where the work was performed, etc.
In some cases you may not be able to or may choose not to take the time and resources to verify with the primary source; however it must still be done. In these cases organizations called Credentials Verification Organizations (CVO) can do the verification for you for a fee. In compliance with all regulations and statutes, they will verify all necessary information and return the information to you. CVOs can be a good choice for larger practices that may have higher practitioner turnover, whereas smaller practices may choose to do the verification in-house, but both options are available to all practices regardless of size.

Once the credentials of a new practitioner have been verified appropriately you and the practitioner must agree, based on the information gleaned from the credentialing process, on what clinical procedures the practitioner will be permitted to carry out in your organization. These designations are called “privileging” and are a delineation of what the practitioner can and cannot do in his or her role as an optometrist in your organization. In general, the applicant will request certain privileges that are in-line with their licensure, education, and experience, and it is then up to you to decide if the information obtained during credentialing supports that request. At this step it is highly recommended that you request peer references and reviews from the applicant. These will give you a first-hand impression of the quality of the applicant’s work and outcomes. Although peer review may or may not be mandated by your state’s laws, we cannot recommend it strongly enough. The same reasons that any type of business would take into account personal recommendations of an applicant apply to optometry just as easily.

Examples of identity theft or misrepresentation of qualifications abound in healthcare. Perhaps the most well-known is that of “Doctor” Gerald Barnes who lost his pharmaceutical license in the 1970s due to Medicaid fraud but went on to “practice” medicine as an MD in several facilities in Southern California before being repeatedly sent to prison. He was found responsible for the death of a patient in 1979 and is currently in prison until 2018. What is teachable in this story is that he was employable even after his first conviction and release from prison when those tasked with proper credentialing and privileging did not pick up on his history. With excruciating attention to detail and proper primary source and peer verification “Dr Barnes” would likely never have found residence on another medical staff after the first time (see CNBC American Greed available online at: http://www.cnbc.com/id/1933047).

Virtually all licenses, medical, optometric, DEA, etc… have expiration dates. For the smaller practice with a few Optometrists on staff this can be easily tracked on your calendar, but for larger practices and organizations it is important that the Medical Staff or Human Resources office implement a system to monitor when licenses need to be renewed and obtain a copy of the current license. It is also important to make sure your applications for National Provider Numbers (Medicare and Medicaid), as well as a
DEA number are current and active. These will be part of the many components checked in a credentialing and privileging process.

The credentialing and privileging process you choose to implement in your practice should be given careful and extensive thought. No matter which role an employee plays in your organization, their past qualifications, degrees, training and experience are paramount. In the case of those providing hands on eye care, you want to be 100% sure you’re getting in person what you see on paper. This is best accomplished by using primary source verification and peer review as your cornerstones to a strong practice foundation.

Process

Credentialing and privileging are processes which occur under the quality assurance subject of structure. Process as a quality assurance vehicle is separate. Structure is facilities and methods in place before a doctor-patient relationship exists. Process is the comparison of actual care given with the standard of care. The standard of care may be set in structure (state statues which have minimum requirements for an eye exam, insurance companies which dictate tests and procedures to meet a billing code level, or practice guidelines set by professional organizations). The process is comparing patient care with the standard.

The most common quality assurance process is record reviews. An auditor will sample a practice’s records and assess the proportion of records which meet preset standards. A less common method is patient care observation by the auditor or even secret “patient” visits. For patient visits, subjects with a known health status present themselves as a patient to an office, receive an exam, and later perform an audit on the practice.

Outcomes

Quality improvement measurement includes collection and dissemination of statistics which can give an indication of the overall health of a population as well as demonstrating evidence – positive or negative – of how a particular healthcare profession overall or a particular facility is doing. These aggregate data are used as benchmarks against individual providers. Two examples directly related to optometry are discussed below.

Diabetic retinopathy is the most frequently encountered diabetic eye disease with between 12,000 and 24,000 new cases of blindness attributed to the disease each year. Diabetic retinopathy is a condition that is well-studied and outcomes are tracked through various mechanisms; one is the Physician Quality Reporting Initiative (PQRI) which will be discussed later in this chapter. Between 53% and 61% of insured
Americans (commercial, Medicaid, Medicare) aged 18-75 with diabetes are screened by an eye care provider. For commercial and Medicaid patients these percentages have been rising over the past six years. Unfortunately, Medicare patients have seen a decrease in the percentage screened over this time period, but they are still the group with the highest overall percentage being screened of the three.\(^4\)

Glaucoma afflicts nearly 2.2 million Americans 40 years and older with some degree of vision impairment and of those about 10\% will lose some or all of their vision.\(^5\) For African Americans, glaucoma is eight to nine times as prevalent.\(^6\) Many people do not know they have early stage glaucoma, which is detected through a routine eye exam, as the disease initially is painless and the vision loss mild and slow to develop. Quality improvement activities to examine how well this patient population is being cared for suggest that currently about 6 of 10 Medicare patients are being properly screened for evidence of the disease. However, over the past six years screening rates have dropped nearly two percentage points.\(^7\)

Many other examples have been used for outcome data such as proportion of children screened for amblyopia by pediatric providers, the proportion of monocular patients prescribed high impact spectacle lenses, the frequency by which contact lens wearers disinfect or replace their lenses.

We would have no way of intelligently debating if we are meeting these patients’ needs sufficiently without knowing the hard data. The data show what they show… it is in the interpretation of the data where meaningful change can come. Is it appropriate to screen only 60\% of patients for glaucoma; should that number be higher or lower? These types of debates are without merit without the information quality improvement research and monitoring provides.

**COMPLIMENTS AND COMPLAINTS:** Listen to your patients

Whatever the motivation for a student to pursue a career in optometry, a fundamental truth is that the patients we treat are also the customers of our business: the science and art of eye health and helping people to see well. While a primary goal for optometrists is to manage our patients’ eye care and eye disease appropriately and effectively, we are also in business to serve the public health, advance the reputation of optometry and last but not least create a living for ourselves and our families. To this end, we must remember the old adage: “The customer is always right…. even when they’re not.” For many optometrists, competition in the marketplace of eye care is intense. If patients are not happy with the care they received from you, they very likely have other options before them, just as with any product or service a customer would seek. Patient satisfaction can be the lifeblood of continuing success in your career.

In addition to economic reasons for a robust patient satisfaction program to enhance your practice’s market position, healthcare accreditation entities such as the
Joint Commission (which is increasingly accrediting ambulatory and physician office care settings) expect that a patient satisfaction program will be in place. This program would address the complaint resolution process at the organization, as well as contain a mechanism for assessing patient perceptions of quality of care. Most importantly, a process to turn the data gathered from the patient satisfaction program into meaningful and evident positive change would be assessed, for without that final and all-important step, the data you collect will not be useful.

Increasingly, health care-related data are being found online for customers to review in making a choice as to where to receive care. It’s becoming easier and easier for patients to compare healthcare facilities and make their decision based on more than which facility may be closest to their home or work. This means that positively differentiating your practice from others is crucial to success. Moreover, it is not just the quality of healthcare facilities that is increasingly available to consumers, but also forums for publicly listing complaints against health care providers and facilities. One example is the “Complaints Board” [www.complaintsboard.com] where disgruntled patients can anonymously post their virtually always negative reports of interactions with healthcare providers. As the internet’s reach and accessibility continue to expand to include an ever-growing section of the population, complaints can find a loud voice that can be heard in ways it was not previously. While many of the complaints listed on sites like Complaints Board are without strong merit, in the realm of customer perceptions this becomes far less important than ferreting out the truth and thus should be of great concern to your practice. It is valuable to make the distinction between a patient complaint website and a complaint that is reported to your state’s board of professional regulation. These complaints, unlike those not monitored for accuracy on public forums, are followed up on and investigated thoroughly and can have serious implications for your licensure. These types of investigations will stay on your public record as a health care provider for many years.

Perhaps the best way to avoid complaints and foster an environment of excellent customer service is to implement a patient satisfaction program. There are various kinds of patient satisfaction programs, as different in scope and reach as are the varied ways and settings in which optometric care is delivered, but each contain several commonalities crucial to a successful and meaningful program which yields actionable results. Once you have set up a program what you do with the results can translate into increased patient satisfaction scores. Higher patient satisfaction levels generally lead to patient loyalty and longevity, positive word of mouth, happier customers and employees…all of which create the potential for and likelihood of increased growth and revenue for your practice – a situation where everybody wins.

The main objective of any patient satisfaction program should be to effectively capture a sampling of your patients’ perceptions of the quality of the care and service they received from you. This means actively soliciting their opinions and then actively
listening to their responses. Compliments and complaints are two of the most common avenues to get an idea of how your patients think you’re doing as their primary eye health care giver. It goes without saying that an appreciable imbalance between the two is a good indicator one way or the other. However, just knowing that you have received five compliments to every complaint is not enough information from which to make meaningful decisions.

The type of patient satisfaction program you institute should be a good fit for the type of practice in which you work. Practices as small as a single optometrist in an office to a larger ambulatory care center with tens of thousands of annual patient visits and multiple physicians on staff to everything in between these two extremes need to be treated differently in terms of effective patient satisfaction programs. Let’s examine the two ends of the spectrum independently.

Larger institutions serving a higher volume of patient visits may opt for a vendor to administer the patient satisfaction program. This includes: sampling patient records, contacting patients, and receiving and processing survey responses. There are numerous companies that offer this service; these types of companies will do most of the work for you and present you with detailed analysis of the returned surveys. Most programs will also provide bench-marking comparison data against other similar organizations.

For optometrists in smaller practices, it may not be cost-advantageous to hire a vendor to run your program. Instead, it is certainly possible to develop, implement and carry out a smaller-scale program on your own. The primary recommendation is to make sure your patients know that you have a listening ear and that you are genuinely interested in their opinions. This could include posting professional looking signs in your waiting area, leaving copies of a brief survey out and encouraging patients to respond. An old fashioned Suggestion Box should have a place of prominence in your office. You may also want to consider a dedicated phone line with voice mail so that patients can leave a message and do so anonymously if they so desire. If you have the financial resources and a small enough monthly patient volume, consider sending all patients a survey within a period of a few weeks after their visit. In short, the easier you make it to communicate their feelings to you, the more likely you are to receive the feedback.

For any type of practice – large or small – complaint resolution is paramount to high patient satisfaction. A happy and satisfied customer may tell a couple people about their experiences, but an unsatisfied customer will tell ten or more; people who are displeased are far more vocal. When complaints come to your attention, and they will, dealing with them in a prompt, professional manner is the sure way to calm a distressed individual and keep them as your patient. The complaint resolution process should include a way for the complaints to reach you as soon as possible, a way for them to be discussed and dealt with, a way to communicate with the patient and a
tracking mechanism to, over time, get a picture of what patients are complaining about. In general, a complaint should be responded to as soon as you are able, certainly no longer than a week. You, or you with your partners, need to address every complaint and, before you have contacted the patient, have a good knowledge of their case, their complaint and at least a rough idea of how you plan to address it. Most patients are willing to discuss their dissatisfaction and appreciate that you care. In the setting up of your patient satisfaction program, this must be taken into account.

Keeping aware of your patients’ perceptions of the quality of their care, listening to their concerns and complaints and acting on this information is a key component of running a successful, high quality optometric practice that benefits both patients and doctors alike. Time invested in this endeavor is time well spent.

Measures of Quality

The Medical Record

Of the many forms you will fill out, forward, store and review in your career as an optometrist, the patient’s actual medical record is without equal in its importance and value. The medical record (MR) is the document that proves you have provided care and the specifics of that interaction. It is a legal document which must be created, modified, treated and maintained with the greatest care and respect. The MR demonstrates the success of your and your staff’s depth of knowledge of optometric care, information management system, and compliance with applicable local, state and federal statutes. In short, it is the most important piece of information you produce as a result of the care of your patients.

The medical record should be documented legibly and completely. While transition to electronic health records (EHR) is ongoing (and, as EHR adoption becomes more wide-spread, concerns over handwriting legibility will decrease), the majority of health care facilities and practices continue to use paper records. This means that a human being will enter most data into the MR by hand and in many cases, more than one individual will make entries to the chart. As handwriting styles can differ substantially from one person to another, it is paramount that all entries to the medical record be legible. Uncertainty as to the information contained in the MR can lead to errors or omissions in the care of your patients. For this reason it is wise to have in place a system whereby recently completed medical records are checked for legibility and any discrepancies are immediately cleared up while the patient’s care is still fresh in the mind of the provider. Entries to the MR should be in ink and there should never be erasures or white-out used on a medical record for any reason – in most states these are legal requirements. Instead, when for whatever reason alterations to the MR need to be made, they should either be noted as additional information along with the initials
of the scriber, or a single line strike out with the corrected information directly adjacent also with the scriber’s initials and date of the correction. This prevents any suspicion that an entry to the record was expunged which is against the law in most, if not all, parts of the United States. All practitioners who make an entry into the medical record, no matter how small, need to be identifiable – there should never be any question as to who made an entry into a patient’s record.

Although it is unfortunate, medical malpractice suits are increasingly common. In virtually all cases the medical record of the patient will be a central document in any litigation involving a patient complaint. It is of the utmost importance that what you and/or your staff did to the patient be recorded clearly, completely, succinctly and legibly so that you as a provider can strongly defend your position. Medical records that are incomplete, un-locatable, error prone, illegible or contain erasures or apparent omissions will not help your case; in fact they will support the plaintiff’s case by demonstrating sub-par record keeping and documentation on your part. If your care is challenged in a legal forum and you are not able to produce a credible record of the exact care you provided you will suffer in the proceedings. It is wise to note that in the eyes of the law: if it does not appear in the medical record, you didn’t do it. Record everything you do, say and discuss with your patients. It is always better to record more rather than less, and a good habit to get into. Again, if it’s not recorded in the medical record, it did not happen – the familiar adage applies here: “Get it in writing”.

On the positive side, a healthy respect for medical malpractice litigation – some might call it a healthy fear of not getting sued! – can and does lead to increases in quality. While we do not encourage practicing what is termed “defensive medicine” (the ordering of extra medical care to cover one’s backside so to speak), it is appropriate in all cases to order the tests and complete the procedures that are necessary to diagnose and treat your patient. It is wise to keep in mind areas where you could face liability, but at the same time, ordering superfluous tests and procedures drives up the cost of health care for all and has not been shown to result in better outcomes for your patients. In fact, this type of medicine places an enormous burden on the health care delivery system overall. If your attention to the quality of your care on all levels is close and on-going you will not need to worry as much about legal ramifications…you will know you’re providing high quality care.

Medical malpractice should be considered as a “last resort” in the pursuit of quality because it can only monetarily compensate a patient for damage already done. Indeed, health care reform currently under consideration in the U.S. Congress seeks to unburden the health care system of lawsuits as a result of defensive medicine by incentivizing advances in communication and documentation. These include electronic medical records which would be available to any and all providers, regardless of where that provider was based. In theory this would mean that every health care provider would have access to the patient’s complete medical record. Imagine what this could
do: no more repeated or missed tests because you’re unsure about the patient’s recollection of their medical history, fewer drug interactions, enhanced opportunity for collaboration on the care of the patient. And, of interest to us in this chapter, greatly enhanced and expanded abilities to collect quality improvement data.

Medical records reflect the care that you have provided, and can and should be used as an on-going as well as retroactive tool for quality improvement activities. The medical record can be used by private insurance companies as well as Medicare in reimbursement decisions. Most, if not all, state boards of professional regulation and/or licensure for health care providers have minimal medical record documentation requirements; you are wise to check with your state’s Board for this information. Pay for Performance determinations are usually based in large part of medical record review activities. Moreover, many optometrists participate in programs which examine adherence to clinical practice guidelines (which will be discussed below) and the medical record is always the source for these comparisons. The federal government, through CMS’ Physician Quality Reporting Initiative [http://www.cms.hhs.gov/pqri/], offers physicians several opportunities for increased reimbursement in return for information on the quality of care provided to patients – all of which is found thru proper coding and medical record review. There are many measures that are directly relevant to optometry and we encourage optometrists to take advantage of the PQRI program to increase quality as well as reimbursement. Accreditation bodies use medical records to determine the overall quality of care delivered and base their accreditation decisions in large part on this. Additionally, larger practices may frequently mandate medical record review for internal quality improvement activities and/or provider oversight. Active and meaningful participation in these programs – whether compulsory or voluntary – leads to increases in the quality of care delivered which can lead to better outcomes for your patients. Better outcomes can lead to enhanced reimbursement, greater patient satisfaction and thus increased revenue for your practice or facility.

The medical record is the singular record of the quality of care and how your patient care practices compare with what are considered “best practices” – clinical practice guidelines. The American Optometric Association (AOA) publishes detailed practice guidelines for optometric care. From the AOA:

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Optometric Clinical Practice Guidelines (OCPGs) are recommendations for patient care which are developed through a formal process. They combine the best available current scientific evidence and research with expert clinical opinion to recommend appropriate steps in the diagnosis, management, and treatment of patients with various eye and vision conditions. Each of the optometric practice guidelines has been developed by a consensus panel of optometrists who were selected for their knowledge and experience in that area. The guidelines have gone through extensive review processes within AOA and represent a broad consensus on guidelines for current optometric care.
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Quality Improvement Activities
Adherence to clinical practice guidelines allows for both the freedom of professional decision making in patient care, as well as the alignment of care across the spectrum of optometry and as such following them is highly recommended.

The patient’s medical record is of the utmost importance for myriad reasons. It is a legal document recording the care currently being provided, a historical document of care provided in the past, a roadmap towards future care, a communication bridge between providers of different disciplines and/or facilities, and a resource for external as well as internal quality improvement activities. For these reasons, you are wise to devote sufficient resources to ensuring your documentation and management of your patients’ medical records is a paramount concern for your practice or organization. There are few things more important in healthcare.

CASE STUDY

The ABC Vision Care center is an optometric practice in a large metropolitan area staffed with 20 Optometrists and also serves as a teaching satellite site for a college of optometry. ABC also employs optometric residents who are recent graduates from colleges of optometry. ABC sees nearly 50,000 patient visits annually, and treats patients presenting with the full spectrum of optometric conditions. They sell glasses and contact lenses and see a payor mix of about 1/3 Medicare, 1/3 Medicaid and 1/3 everything else including private insurance and self-pay. There is an urgent care service available 24/7.

At a recent meeting of Attendings and Residents, there were several questions about referring patients to other facilities/providers for care that was not available at ABC. This discussion led to the conclusion that no one seemed to know who to refer to, what happened to the patients who were referred, how the recipients of these patients treated them (or felt about being referred to by ABC), or how the patients themselves felt about the care they received at ABC and the next provider of care. One thing that was agreed on was that ABC would like to treat as many patients as possible on site, rather than refer out.

This is a problem with myriad components, but all relate back to ensuring quality in your practice. Let’s see how ABC handled this challenge to glean knowledge of how a quality improvement project can be undertaken at your facility or office.

First, we need the raw numbers. Leadership appointed Dr Smith as Lead on the project. Dr Smith first gathered information on the number of patients who were referred to other facilities in the past 12 months (she picked a time frame that would provide meaningful data but not be too large as to be unwieldy). She then wanted to
know “who” these patients were. Were there any characteristics that united them? Were they all in a single payor group? Were they all diabetic? Were most of them older, younger, spoke a foreign language? She discovered that most patients who were referred out had complications from diabetes. She also noted that most of the referrals took place after 6pm on weekdays and on the weekends, even though on the weekends there were “normal” operating hours on both days. Furthermore, Dr Smith realized that for most of these patients there was little mention in their chart of what happened after they were referred elsewhere. Finally, she noted that more than half of these patients did not return to ABC in the 9-12 months since the referral even though many of them had been patients for years; it appeared they were losing patients! The chart and record review was labor intensive (even using sampling methods which limit the sheer number of charts to review), but it produced actionable data to improve the service ABC provides. Remember, ABC competes with other providers of optometric care in their city and wants to provide the finest health care to the greatest number of patients possible.

Dr Smith then assembled a team of stakeholders to discuss what she had uncovered. The team included doctors, residents, students, quality/compliance staff and customer service associates – each with their own unique perspective on the issue. Getting input from various members of your team is essential. What you don’t see, someone else does, and vice versa.

The team concluded that the following were areas of concern that needed to be addressed:

1. Why was there confusion about the referral process among staff?
2. Why were most referrals happening after hours or on the weekend and why did having complications from diabetes correlate so well with being referred?
3. How could ABC find out what happened after the patient left?
4. How could ABC better treat these patients in house rather than refer them out which is a burden on the patient and a loss of revenue for ABC?

Here is what ABC did, point by point:

1. The confusion was a result of the fact that there was no standardized process for referrals, despite there being a form for it that was being used. Some doctors knew other providers well and referred to them, some didn’t. Some Residents were confident enough to ask the Attendings, others felt like it was bothering them to do so. There wasn’t a central location with names and phone numbers. This resulted in patients experiencing the “luck of the draw” when being referred. If the doctor had a relationship and knowledge of what specialist to refer to, the
patient received good care. If not, the referral was made from a list of specialists reprinted from the phone book or to a local teaching hospital where the resident on call saw them.

a. Dr Smith gathered the names of the doctors and facilities that ABC referred patients to and then personally contacted each of them to let them know ABC was formalizing their referral process. She asked for their permission to be included on the list and also told them ABC’s expectations for providers they refer to. All agreed to terms which were communicated to the entire ABC staff and posted.

2. ABC kept a smaller staff as many facilities do on the evenings and weekends. Since there were few regular appointments scheduled during these times most patients were walk in urgent care. Fewer Attendings were on staff during these hours, with ABC relying more on their residents. It turns out that the same issue with confidence and not wanting to bother the Attending from #1 played into this part of the problem. Moreover, a query of the Residents indicated they were not as comfortable with diabetic patients as they should be. When they were unsure about treatment they would resort to referring out to another provider rather than bother someone or make a mistake.

a. Dr Smith knew there were not sufficient resources (nor justification) to fully staff ABC at all times. Thus, she appointed an Attending to serve on-call and made it clear to that person and ALL the residents that on-call meant you COULD call the doctor without worry.

b. Dr Smith also saw an opportunity for enhanced clinical education of the Resident staff for diabetic patients.

3. Dr Smith faced her toughest challenge with trying to learn about the patient’s outcome after they’d been referred to another facility and why many of them did not return to ABC for routine or follow up care. Once the patient is physically gone, and without wide-spread electronic medical records, it is work to find out what happened to them…it takes time and money ultimately. Dr Smith, like all health care providers, was on a tight budget and had limited staff. But she decided that retaining these patients in the future was the right thing to do from a financial as well as patient satisfaction standpoint, and that investment in this would yield a positive return for ABC.
a. Dr Smith instituted a system where ALL referrals were recorded in a searchable format. The patient's name, medical record number, presenting diagnosis, reason for referral, referral name and contact information and date were noted. She then assigned an individual to monitor this list once a week, and contact the patients by phone to “follow up” on their care after they left ABC, ask them if they have any questions, and offer to schedule a follow up appointment at ABC. In cases where the patient could not be reached or their information was unreliable, ABC would contact the referral directly to inquire about the care. Updates to the patient's chart were made under the ‘Correspondence’ section so that all other providers who might see the patient at ABC in the future would know what care was provided at the referral facility. This meant a redistribution of responsibilities for some folks, but this is certainly possible in any practice, even with limited resources.

b. Dr Smith also instituted a system whereby the Attending or Resident who referred the patient was updated on their care. At first this information was sent to them unsolicited, but as the culture began to change it was information that the providers at ABC sought out on their own.

4. Ultimately ABC wanted to treat their patients in house whenever possible and appropriate (keeping the relationship with the patient intact).

a. ABC also knew their limits of care and wanted to be sure they had a good and dependable network of facilities and other doctors to refer to when necessary. By establishing relationships and keeping lines of communication open internally as well as between themselves and their referral facilities they made sure there was never a problem or confusion with referrals.

b. Clinical education was offered to the Residents on diabetic patients and over time their knowledge base grew. Attendings were also encouraged to attend seminars to keep abreast of new developments.

c. By taking the time to contact the referred patients shortly after their referral, ABC demonstrated to these people that they cared about their health. This went a very long way, with ABC hearing time and again how appreciative (and surprised!) patients were to have been called. It turned out that the referral process itself left many patients feeling negative and unsure about the quality of care from ABC’s doctors and staff. This
outreach from ABC to the patient resulted in a reduction in the percentage of patients referred out who never returned and thus an increase in revenue.

This example demonstrates the importance of: record keeping and review, communication, professional relationship building and maintenance, clinical education, patient satisfaction, re-apportionment of duties and team work – all essential components of a quality improvement program that will yield results for your practice.

**Take Home Conclusions**

1. Quality improvement and assurance are extremely important aspects of any health care practice and optometry is no different. Quality does not come without work, planning, evaluating, listening and doing.
2. Quality improvement efforts include concentrations on: the competency of the doctors and staff in your practice, the quality of the medical record of your patients, your knowledge of and adherence to clinical standards, and how much attention is paid to your patients’ satisfaction to name just a few.
3. Things that get measured get done. If you track quality in your practice you will see an increase in it. If you don’t, you’ll likely see a decrease which can express itself in myriad negative ways.

**Study Questions**

1. What types of data or resources would you look at to determine if your comprehensive eye exams take more or less time than other optometrist offices?

2. What would be the best way to check your office’s medical records for completeness? How would you track this on an on-going basis?

3. Why is it important to have a patient satisfaction program?

4. If you have concerns about a new practitioner you’re considering hiring, how would you find out about his or her background and experience?

5. How would you as an O.D. deal with a patient who was dissatisfied with their care and threatened to become very vocal about it?

**Endnotes**


3. The Joint Commission; *2009 Standards for Ambulatory Care*.


Appendix A.
Sample Facility Audit Questions

Accessibility/Facility Appearance:

- Handicapped access
- Reasonable seating availability in waiting rooms
- Parking or public transportation access
- Appointment times/Office Hours posted
- Privacy in exam rooms
- Licenses posted
- Cleanliness of facility

Hygiene/Safety:

- Hand washing – observed by patient
- Clinical equipment cleaned properly – observed by patient
- Food and medicines stored separately
- CLs and CL solution disinfected and stored properly
- Expired meds disposed of properly
- Fire-fighting equipment recently checked to code
- Meds and prescription pads secure
- First aid kit available and stocked properly

Required Equipment (sample list, not complete):

- Phoropter
- Retinoscope or Autorefrator
- Slit lamp
- Stereopsis and Color Vision Testing
- Lensometer
- Keratometer or Topographer
- Tonometer
- Direct and Binocular Indirect Ophthalmoscope

Record Keeping:

- Medical record storage and handling is HIPAA compliant
- Policy/procedure for destruction of PHI in place
- Records located easily and are kept for state minimum
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