Quality assurance programs, in health care, have always monitored the quality of services delivered to patients retrospectively.

Now in HMO's, over time, QA and UR functions have evolved from primarily reactive systems (checking out claims) to proactive programs (screening of PPO members).

The National Committee for Quality Assurance (NCQA), an independent nonprofit organization founded in 1979, is a major influence on HMO's quality management programs. Has published practice guidelines which Many HMOs and PPOs are adopting.

NCQA PRACTICE GUIDELINES

REPORTING

Health Data Information Set 2.0 (HEDIS), released by NCQA in November 1993. The HEDIS database includes 60 performance measures ranging from financial indicators to clinical outcomes.

At this time HEDIS and outcome measurement (The Health Data Information Set 2.0) measures include one performance measure specific to eye care which may affect ODs: the annual rate of diabetic retinal exams.
NCQA PRACTICE GUIDELINES

CREDENTIALING

NCQA Guidelines:

- A current, valid license to practice
- Graduation from an appropriate school and perhaps completion of residency
- Proof of board certification and board eligibility
- Diagnostic pharmaceutical certification
- Therapeutic pharmaceutical certification (if applicable)
- Work history
- Malpractice coverage
- Professional liability claims history
- Statements regarding physical and mental health status, lack of impairment due to chemical dependence/substance abuse, and history of loss of license and/or felony convictions

FACILITY REVIEW

- Physical accessibility (handicap accessible, etc.)
- Physical appearance
- Safety (from fire and other hazards)
- Adequacy of waiting room and exam space
- Adequacy of space for record filing
- Appointment systems and availability of appointments
NCQA PRACTICE GUIDELINES

PREAUTHORIZATION REQUIREMENTS

- To control use of specialty providers and to maximize use of cost-efficient providers (primary).
- Gatekeeper and must authorize referrals to all other specialty providers and inpatient institutions.
- May specifically outline required referrals (limiting your scope)

UTILIZATION REVIEW

- Retrospective analysis of services provided.
- Collected by the HMO during the claims process
- Looking at the # and type of exams and their results

RECORD KEEPING

- Will require your records to meet guidelines developed by the plan
- Requirements that each individual have his or her own chart, that there is complete documentation of services provided and recommendations and the patients health history.
- Organized system for record storage and retrieval. Managed care plans typically conduct audits of patient records once every two or three years.
ACCESS AND PATIENT SATISFACTION SURVEYS

- Frequently used by managed care plans to measure quality of care from the patient viewpoint.
- You may be asked to allow managed care staff to survey patients in your office.

USE OF STANDARDS

Established guidelines for eye exams

- Objective and subjective refraction
- Muscle balance testing/binocular assessment
- Aided and unaided visual acuities at distance and near
- Pupil evaluation
- Extraocular muscle function
- Applanation tonometry or non-contact tonometry
- Slit lamp biomicroscopy
- Dilated fundus evaluation

- Additional screening, when appropriate, including but not limited to visual field screening and color vision screening