



SUMMA HEALTH SYSTEM

Department of Ophthalmology Resident Handbook

2010-2011

Reviewed and Approved by Faculty Committee 12-17-2010



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DEPARTMENT OF OPHTHALMOLOGY

MISSION STATEMENT

The Department of Ophthalmology, as a component of Summa Health System, is dedicated to the provision of quality vision care services to the community, the education of future health care professionals and to enhance knowledge through ongoing vision research.



DEPARTMENT OF OPHTHALMOLOGY

ORGANIZATION OF DEPARTMENT PERSONNEL

ADMINISTRATION

- Thomas Strauss, Chief Executive Officer
- Joseph Zarconi, M.D., System Vice President, Medical Education, Chief Academic Officer
- Dana Ash, RN, Administration Director of Outpatient Network
- Deepak P. Edward, M.D., F.A.C.S., Department Chair/Program Director of Ophthalmology
- Hiroshi Nakamura, M.D., Ph.D., Scientific Director of Ophthalmology Research

INTRODUCTION TO STAFF

Ophthalmology Administration

- Jaki Mills, Sr. Admin. Secretary

Ophthalmology Center Staff

- Dee Hopkins, COT, Clinical Coordinator (Full time)
- Patty Scalia, Business Office Coordinator (Full time)
- Carolyn Hobbs, RN, PCOS, Program Coordinator Ophthalmology Services
- Linda Caldwell, RN, (Full time)
- Jerrine King, COA (Full time)
- Teresa Whitmer, OA (Part time)
- Barbara Monaco, OA (Full time)
- Christa Klein, COA (Part time)
- Dina DePerro, COA (Per Diem)
- Heather Fisher, OA (Per Diem)
- Leanne Clay, Medical Office Associate (Full time)
- Melissa Eisele, Medical Office Associate (Full time)
- Barbara Jost, Medical Office Associate (Full time)

Ophthalmology Research

- Rachida Bouhenni, PhD.
- Jeff Dunmire, BA
- Sarah Scott, MS
- Dawn Pamer, AB, Administrative Research Coordinator
- Marianne A. Wiest, COT, BS, Clinical Trials Coordinator

All residents are expected to be on time for scheduled clinics. Delays must be communicated to the Ophthalmology Center staff (preferably, the Clinical or Business



Office Coordinator) and should be at a minimum because of regard for our patients and their time.

Requests for any unscheduled days/time out of the clinic are subject to approval by the Chief Resident and communicated to the Business Office Coordinator, ASAP. (A two (2) week notice is preferred). When canceling/rescheduling patients, the resident should:

1. View his/her panel of patients for disposition.
2. Determine if a scheduled patient(s) should be seen by another physician.
3. Provide clarification, as to how soon patient(s) should be rescheduled.



DEPARTMENT OF OPHTHALMOLOGY

GENERAL PROGRAM DESCRIPTION

A. DESCRIPTION OF OPHTHALMOLOGY CENTER & POLICIES

The staff is comprised of:

- (1) Program Coordinator – Ophthalmology Services
- (1) Business Office Coordinator (full-time)
- (1) Clinical Coordinator, Ophthalmic Technician (full-time)
- (1) Registered Nurse (4-days /week)
- (6) Ophthalmic Technicians / Assistants (full / part-time mix)
- (3) Medical Office Associates (clerical)

Definition: Summa Health System's Ophthalmology Center is a faculty-directed, multi-specialty ophthalmology group practice consisting of six (6) Ophthalmology Residents, community-based Attending Physician Faculty, as well as Facility-based Attending Physician Faculty. The practice is staffed with RN / Ophthalmic Technician / Assistants, in addition to clerical support personnel.

Facilities: The Ophthalmology Center (Residency-based office practice) & Ophthalmology Diagnostic Center and Laser Labs share space located in the North Professional Building, 75 Arch St., Suite # 202 adjacent to Summa Health System Hospital. The Center occupies 6,396 square foot of 2009-renovated space. In addition, Suite 204, connected via an interior corridor to Suite 202, serves as the private office practice for the Residency Program Director and partner.

There is one Business Office, a Reception / Registration waiting room, a Dilating / waiting room, two Manager's offices, two nursing / technician workstation. The physician workspace provides computerized, individual workstations for each of the six (6) Residents in a private area, adjoining the conference room/library space. The Conference room is equipped with computerized access to diagnostic results (Digital Imaging & OCT), to enhance Attending / Resident case discussion. The physical layout avails a separated technical assessment area (3 technician assessment lanes) in close proximity to the dilation area, with diagnostic testing areas and an auto-refract area,



strategically placed, while the physician exam lanes are located in close proximity to the physician workroom. The physical layout facilitates the patient flow patterns; also a flag system is in place to assist with communicating the status of patient readiness for exam and location of staff / physicians throughout the daily operations of the office practice. An overhead paging system is available for the entire combined space of Suite 202 & 204 via any phone within the suites.

Equipment: There are eight (8) physician exam rooms available. Each of the patient examination rooms are fully equipped with all necessary examination equipment including instruments for visual acuity testing, a patient examination chair, and an equipment stand with a slit lamp biomicroscope, keratometer, and phoropter. In addition, complete trial lens sets are available, as well as, lenses for gonioscopic examination, exophthalmometry measurements, color and stereo acuity vision testing, and Amsler Grid testing. **Two of the exam / assessment lanes avail wheelchair-friendly accessibility.**

Equipment should remain in the assigned examination rooms. Equipment should not be taken from one room to another, nor should it be taken from the Ophthalmology Center to the Emergency Room, an inpatient unit, or another hospital. Please report missing or broken equipment immediately to the Clinical Coordinator. Equipment location is consistent within examination rooms. A "Call Bag" is also available for on-call coverage. The on-call equipment includes a portable indirect ophthalmoscope, portable slit lamp, and TonoPen. Items missing from the Call Bag should be brought to the immediate attention of the Clinical Coordinator.

The exam rooms may be utilized for lid laceration repairs, chalazion excisions, minor plastics procedures, lacrimal probing, and other procedures that do not require the full services of an operating room. However, a minor procedure / surgery room is located within the Suite to enhance performance of in-office procedures. The procedure room is equipped with a surgical bed, overhead surgical lighting, a surgical microscope, and various supplies and instrumentation for minor procedures.

In addition, seven (7) rooms contain Ophthalmic Diagnostic & laser equipment to support the diagnostic / laser needs of the residency practice:

- Fluorescein Angiography & Fundus photography / Digital Imaging *
- Neuro-testing (EOG/ERG) *
- Visual Field (2- Humphrey & 1-Goldmann)
- A/B Scan (Ultrasound)
- Corneal Topographer
- Tuneable Dye (Argon) Laser
- YAG Laser
- OCT (Optical Coherence Tomography)

Administration: The Medical Director and Program Coordinator oversee the operation of the clinical operations of the Ophthalmology Center including organization, Attending



physician staffing, Resident scheduling systems and templates, finances, policy setting and implementation, marketing, patient recruitment, and contracting. The Clinical Coordinator and the Business Office Coordinator oversee the daily operations of the Ophthalmology Center; these individuals are responsible for staff management, staff scheduling, and managing day-to-day operational issues.

All technical staff report to the Clinical Coordinator, while all clerical staff report to the Business Office Coordinator. The clerical staff is responsible for answering phones, scheduling appointments, patient registration, obtaining results of laboratory tests and patient related data, medical records management, processing facility charges and managing correspondence. The Business Office Coordinator over-sights and manages surgery scheduling. The technical staff performs triaging of patient calls to assist in appropriate patient scheduling and facilitation of patient / physician communication.

During patient office visits the technical staff is responsible for performance of patient assessment, including lensometry, visual acuity measurement, and for preliminary screening evaluations pertinent to the visit. As well, the technical staff is trained and skilled in performance of the various diagnostic testing performed within the Ophthalmology Center. In addition, they assist physician with performance of minor procedures and patient instruction.

Referral Sources: The Ophthalmology Center provides the ONLY Ophthalmology residency program in the greater-Akron area. Therefore the Ophthalmology Center serves as provider of Ophthalmologic care for a large radius of the surrounding geographical area.

The following serve as major referral sources:

Internal Medicine Center – SHS*

Family Practice Center – SHS*

Internal Medicine Center – Akron General Medical Center (Health Plan eligible)

CARE Center of SHS* (HIV Clinic)

Women's Center of SHS* (OB/GYN Clinic)

POB (Prevent Blindness Ohio)

Area Lion's Clubs and GALEP (Greater Akron Regional Eye Care Program)

Veteran's Administration

Akron Community Health Resource Center

Medina Community Resource Center

New Destiny Treatment Center Barberton Rescue Mission Haven of Rest Ministries

Info Line

Area on Aging

Oriana House (Substance Abuse Center)

Area Optometrists

*SHS=Summa Health System



Waiting Times for Appointments: Typically, NEW, non-emergent patients can be easily accommodated with an appointment within 1-4 week timeframe. Any emergent appointments can be accommodated, same-day consistent with triage information.

Scheduling Systems: The appointments for the Ophthalmology Center are accommodated in accordance with residency practice rotational templates. The basic building block for the current appointment system is based upon 15-minute increments, ranging from 15 minutes to 1-hour appointments, based upon physician requirement / request. The Center's appointment books are templated for an AM session (8:45-10:30) on Monday, Tuesday, Wednesday, & Thursday AND a PM session (12:30-16:30) 5-days / week (Friday PM, generally starts @ 12:00 noon). Every effort is made to assure a satisfactory mix of patients for the residents.

The majority of AM clinic sessions are General Ophthalmology, with possibility of accommodating neuro, glaucoma, cornea, and retina appointments on some occasions, as the Attending specializing in these areas staff AM clinic sessions; the sub-specialty clinics are interspersed, as follows (see Attending Staffing Schedule template, attached):

RETINA- 1st, 3rd & 5th Tuesday PM AND 2nd Monday PM (The Retina Group- Attending coverage) AND occasionally some Thursday AMs (Charles Peter, M.D., Retina Interest-Attending coverage).

GLAUCOMA – 1st, 3rd, & 5th Monday AM & 4th Tues AM & 5th Thurs and Fri PMs (Deepak Edward, M.D.- Attending coverage) AND 3rd Friday PM (Deepak Edward, M.D. or other Glaucoma specialist.- Attending coverage), AND 1st, 3rd, & 5th Monday PM & 4th Thursday PM (Todd Woodruff, M.D. – Attending coverage).

CORNEA- 2nd Monday AM (Marc Jones, MD-Attending coverage), 3rd Tues AM (Lawrence Lohman, M.D- Attending coverage), 1st Wednesday PM (William Yeakley, M.D.- Attending coverage), AND 3rd Wednesday PM (Daniel Mayer, M.D.- Attending coverage).

NEURO- 2nd Fri PM, 3rd Wednesday PM, & 4th Monday – ALL Day (James Bates, M.D. - Attending coverage).

PLASTICS- 3rd Thursday PM (Plastics Specialist. - Attending coverage) AND 5th Wednesday PM (Todd Beyer, D.O. - Attending coverage).

CONTACT LENS- 2nd Thursday PM (James A. Cannatti, M.D. - Attending coverage).

All attending physician schedule changes (cancellations or additions) are conveyed to the Ophthalmology Services Program Coordinator, in advance of the scheduled clinic session. Alternate coverage is elicited via email and / or phone contact of other



teaching staff to arrange cross-coverage, if the Attending physician has not arranged a “trade” with another physician or made other arrangements for said coverage of the Clinic session.

Patients requesting new or return appointments schedule appointments by contacting the Ophthalmology Center’s appointment scheduling line at 330-375-4831.

Residents are encourage to strive to make each patient’s visit as pleasant, expedient, uninterrupted and thorough, as possible.

Patient satisfaction is the highest priority.

W K	AM- GLAUC/GEN Dr. Edward	AM- GENERAL Dr. Awender	AM- GENERAL Dr. Donthi	AM- GENERAL Dr. Awender	AM RESIDENT CONF.
	PM- GLAUC/GEN Dr. Woodruff	PM- RETINA TRG- Dr. Hull	PM- CORNEA/GEN Dr. Yeakley	PM- GENERAL Dr. Starkey	PM- GENERAL Dr. Donthi
W K	AM- COR/GEN Dr. Jones	AM- GENERAL Dr. Awender	AM- GENERAL Dr. Repko	AM- GENERAL Dr. Awender	AM RESIDENT CONF.
	PM- RETINA TRG- Dr. Tsai	PM- GENERAL Dr. Cingle	PM- GENERAL Dr. Awender	PM- CL / GEN Dr. Cannatti	PM- GEN/NEURO Dr. Bates
W K	AM- GLAUC/GEN	AM- COR/GEN	AM- GENERAL	AM- GENERAL	AM



	Dr. Edward	Dr. Lohman	Dr. Donthi	Dr. Dash-Modi	RESIDENT CONF.
3	PM- GLAUC/GEN Dr. Woodruff	PM- RETINA Dr. Lamkin	PM- GEN/NERUO Dr. Batesx8/x4(/Mayer/ Donthi) PM- CORNEA Dr. Mayer	PM- PLASTICS Plastics Specialist	PM- GLAUC/GEN Dr. Edward / Glauc Specialist
w K	AM- GEN/NEURO Dr. Bates	AM- GLAUC/GE N Dr. Edward	AM- GENERAL Dr. Donthi	AM- GENERAL Dr. Awender	AM RESIDENT CONF.
4	PM- GEN/NEURO Dr. Bates	PM- GENERAL Dr. Awender	PM- GENERAL Dr. Awender	PM- GLAUC/GEN Dr. Woodruff	PM- GENERAL Dr. Davis(o) / Johnston(e)
w K	AM- GLAUC/GEN Dr. Edward	AM- GENERAL Dr. Awender	AM- GENERAL Dr. Donthi	AM- GENERAL Dr. Awender	AM RESIDENT CONF.
5	PM- GLAUC/GEN Dr. Woodruff	PM- RETINA Dr. Lamkin	PM- PLASTICS Dr. Beyer	PM- GENERAL Dr. ?????? DPE / RRE	PM- GENERAL Dr. ?????? DPE / RRE

At the time of the visit, patients who are uninsured will be advised of the federally funded Care Assurance Program and Charity Care application process. All billing questions should be directed to the Business Office Coordinator. Under no circumstances should any resident make arrangements to not bill a patient for services. All patients will be billed for each visit, as negotiated by the individual health insurance plans.

Out-Patient Surgery: Assigned clinical staff will schedule all surgeries at a participation ambulatory surgery center (ASC) or hospital surgical suites, as appropriate. Scheduling requests should be conveyed on the Surgery Order Sheet, one or more CPT codes should accompany the request. Faculty and residents are notified of the date by the scheduler. Since postoperative visits are always necessary, they



should be scheduled when surgery is scheduled. Postoperative visits should not be overbooked at the last minute.

Patient Retention: Patients seen in the Ophthalmology Center are not a “captive” group. Many may obtain their care anywhere. Therefore, all residents should provide service of the highest caliber, in a timely fashion. Every effort should be made to see patients on time, keep overbooking to a minimum, and be sensitive to each patient’s financial concerns. Be sure to address each patient’s presenting problem or chief complaint. Residents on specialty rotations must not attempt to address only specialty-related problems while ignoring the presenting complaint of a patient. Do not request unnecessary laboratory tests. No patients are to be “sold” or “pressured” into procedures or treatments for which they are not seeking help or treatment.

To reduce the complaint frequently voiced by patients that they are seen by different physicians each time they visit, the Resident will see their own respective patients and will follow his/her panel of patients throughout his/her time in the residency program unless a referral is made. A referral should be made for procedures and consultations that are necessary and require the skill of a particular service. What would be considered the standard of care in the community should dictate referrals within the Ophthalmology Center.

Residents are encouraged to keep return visits at the minimal level necessary and in the best interest of patient care. Excessive follow-up will impair a resident’s ability to see new patients.

Patient Evaluations: All patients must be “encountered” at the front registration desk. There is no exception to this policy. Once encountered, they will be directed to the waiting room. If they are new patients, or if they have been given glasses at another facility, the technician will measure their prescription on a Lensometer and may perform an auto-refraction. From the Pro-Fee Billing perspective, patients who have not been seen for three years will be considered new patients and be charged the new patient fee.

Prior to examination, a technician will perform a preliminary examination, including dilation, if requested by the physician. Technicians are responsible for seeing that all appropriate historical and screening blanks on the patient work-up sheet are filled in. The patient’s eyes will not be dilated, unless so directed by the physician. Abnormal findings will be documented by the technician for the resident’s for verification. Allergies and any medication, including eye drops administered to the patient, must be documented in the patient’s record.

Universal precautions are policy at Summa Health System. Residents are responsible for understanding and practicing proper universal precaution policies and procedures. Residents are responsible for performing a complete Ophthalmological examination on every new patient, and an appropriate evaluation is performed on return patients. If a



new patient is scheduled to see a resident on a specialty service, the patient must receive a comprehensive evaluation, not just a specialty-related brief evaluation. A comprehensive ophthalmologic evaluation on a new patient consists of:

- chief complaint
- history of ophthalmic and major medical problems
- the current systemic and ophthalmic medications
- Snellen distance visual acuity with best correction and if <20/40, a pinhole visual acuity
- allergies
- social history
- family history
- review of systems (10 systems)
- near visual acuity with best correction
- complete external evaluation of the face, eyelids, adnexa, and anterior segments
- manifest refraction or cycloplegic refraction, as indicated
- pupillary examination
- confrontation visual field examination
- motility examination
- slit-lamp biomicroscopic examination of the eyelids, lashes, conjunctiva, corneas anterior chambers, irises, lenses and anterior vitreous cavities
- gonioscopy, as indicated
- Intraocular pressure (different methods of measurement)
- a dilated fundus examination including biomicroscopic evaluation of the disc and macula, and indirect ophthalmoscopy of the retinal periphery and scleral depression, as indicated.

At least once per year, returning patients should receive an assessment of refractive error and a dilated examination. The results of the evaluation should be written clearly on new patient/full-assessment medical records form.

The American Academy of Ophthalmology Preferred Practice Patterns (PPPs) will be considered the standard of care unless circumstances warrant deviation from the recommendations (view PPPs at <http://www.aaopt.org/ppp>).

Based on the physician orders/plan of care, the clerical staff schedules necessary additional testing or surgical procedures. Only under faculty recommendation should referrals be made for subspecialty clinic consultation.

A consult form should be completed for consultation to a Summa Health System-based source (i.e. IMC, FPC). All referrals must be clearly documented in the patient's chart. A signed Release of Information should be used to receive or send medical records outside of the SHS Network.

At the conclusion of the visit and after the patient's chart has been signed by an Attending Physician, the chart and Superbill are routed to the "check-out" area for the



Business Office staff to schedule. Surgical procedures should be included in the plan of care and require completion of Surgery Order Sheet; coding of the procedure should be submitted for authorization and scheduling.

Documentation: All patient charts must be complete and legible. Only the most widely accepted abbreviations may be used (see SHS approved abbreviations list); all other entries must be written in full. Upon completion of examination and documentation and before the patient leaves, the patient must be presented to the attending ophthalmologist for approval and signature. All signatures must be legible. Attending physician's name must be printed or stamped.

Telephone messages from patients to residents will be placed in the residents' mailbox along with the patient's chart. The resident must write a response to each phone call on the medical record. **All phone calls with patients should be documented in writing.** Inpatient charts may be requested, if necessary, but may take 24-48 hours to arrive. **Records should not be removed from any facility.** If a chart must be taken out of the area, a removal card must be completed and placed in an "out-guide" and inserted in place of the chart.

The New Patient or Established/Follow-up patient, Health Assessment and history forms, as applicable, are used to record the patient's medical history, visual acuity and the findings of the eye examination.

A requisition must be completed for an external diagnostic test and/or photographic procedures.

An "ocular history/flowsheet" is placed on the medical record for each new patient and is to be maintained, updated throughout patient's association with the Ophthalmology Center to "catalog" via timeline, an overview of the diagnostic and laser therapy and cataract surgery experienced by the patient,

Correspondence: Before the end of the day, on all "referred" patient visits, the resident must either complete an eye referral feedback form or dictate, through the hospital transcription service, reports on all visits with copies to the referring physicians, including outside physicians and primary care physicians (PCPs). Without exception, these reports must be dictated within 10 working days after the visit. To access and use the SHS transcription service, dial 330-375-4664 (in-house x54664), written instructions should be followed.

The need will arise periodically to correspond with referring physicians regarding a patient's planned evaluation and management. It is each resident's responsibility to see that correspondence is dictated in a timely fashion.

Every attempt should be made to respond to patient's request for information. If a patient asks for a summary letter describing his condition, this should be provided. If a



school or employer asks for information regarding a patient's condition, this should be provided with the patient's written permission. All correspondence that is deemed appropriate should be dictated on the SHS transcription service, with the exception of Bureau of Disability Determination (BDD). The BDD dictation should be phoned to the BDD's teledictation service, which in turn will be transcribe and returned for review/editing/signature and will convey payment for physician services of providing a dictated report. The payment is deposited to the Resident Education Research Foundation Fund to be used for resident book credit.

Services Provided: The Ophthalmology Center provides comprehensive and specialty ophthalmic care and contact lens services. This care is provided by residents with direct full-time or community-based, Summa Physician's Inc. (SPI)-contracted faculty supervision.

The majority of patients seen in the Ophthalmology Center have problems of a general or comprehensive nature. A new patient calling with such a complaint will be given an appointment with the first available resident on the patient's preferred visit day. When an established patient calls to schedule an appointment, the clerical staff will make every effort to determine if the patient has a problem that falls into a specialty area or if the physician's plan of care indicates return to a specific clinic. If so, the patient will be scheduled to see the resident-of-record, in the appropriate specialty, on his preferred day.

If a resident is not fully booked with patients who have specialty problems, they will be assigned patients who have general or comprehensive problems. These patients must be given a thorough, comprehensive evaluation even if they are seen during a specialty service timeframe. Again, residents on specialty rotations must avoid performing an evaluation limited to their specialty rotation. In addition, no patient should be pressured into specialty-related evaluations and procedures if this is not part of their ophthalmic complaint. (It is certainly within the scope of good care to relay problems that are evident on examination, and if these problems happen to fall within the realm of the specialty rotation, all the better.)

Resident Attendance: Regular attendance for clinical and educational activities by residents is mandatory. Resident rotations have been carefully coordinated with the Residency Program Director so that no other professional activities will conflict. All residents must submit requests for vacation time or leave for professional meetings at least 10 weeks in advance, so that patient appointments can be blocked. No last-minute changes in patient scheduling can be accommodated, except in unusual circumstances of real urgency which require the approval of the Residency Program Director. **Any resident who anticipates arriving late to patients must notify Residency Program Director and Clinical/Business Office Coordinators.**

B. DIAGNOSTIC TESTING



All patients requiring ancillary testing must have a laboratory requisition completed and requesting physician must be identified. All patients are referred to the Front Desk for checkout, scheduling of follow-up visits, ophthalmic tests and insurance authorization issues.

OPHTHALMIC PHOTOGRAPHY

Definition

The Ophthalmic Photography Unit conducts requested test on clinic patients and referred patients from any privileged ophthalmologist/physician. These tests include

- (a) Slit-lamp or external camera views of ocular adnexa
- (b) Ocular motility photographs
- (c) Standard and wide-angle fundus photographs
- (d) Fundus fluorescein angiography
- (e) OCT – Optical Coherence Tomography, or OCT, is a noncontact, noninvasive imaging technique

Scheduling

Ophthalmic photography is open during regular business hours at 330-375-4831. The physician requesting photographs must complete the Ophthalmic Photography Request form. The patient's eye cannot be dilated unless this form is completed.

Note: Slit Lamp photography equipment is also available in Lane ---. This equipment can be used by residents to take photographs that may be used for presentation/rounds or other educational activities.

FLUORESCEIN ANGIOGRAPHY

Patient Evaluation in Fluorescein Angiography

Fluorescein Angiography is performed according to standard photographic procedures in conjunction with an intravenous injection of 5cc of 10% fluorescein sodium solution in a 3 to 5 second period. The injection will be administered by a registered nurse or a resident or attending physician,

Standard photographic procedures provide for identification of a primary area of clinical interest and secondary or tertiary areas of clinical interest, as appropriate, by the physician requesting the fluorescein angiography.

In every case, unless modified by physician instructions, limitations of mydriasis, or other factors, photographs are obtained as presented on the Ophthalmic Photography Request form. (See attached)



In patients with choroidal neovascular membranes, additional frames with fixation target should be included during early, middle and late phases or the eye of interest. An example of the photograph request form is attached in the appendix

Interpretation and reporting

All fluorescein angiograms are interpreted and reported by the resident and an attending physician. Diagnostic impressions constitute the basis for the fluorescein angiography registry for retrieval and collation for teaching and research.

Resident responsibilities include

- a. a review of digital images, fluorescein angiogram
- b. interpretation and reporting of fluorescein angiography on patients **within two working days**
- c. Selection of studies for presentation at Fluorescein Angiography Conference or Department of Ophthalmology Clinical Case Conference
- d. selection of studies for the teaching collection on fluorescein angiography
- e. attendance at Fluorescein Angiography Conference

Faculty responsibilities include

- a. review, amends if indicated, and approves fluorescein angiography reports prepared by the resident, within two working days of completion of interpretation
- b. selection of studies for presentation at Department of Ophthalmology Clinical Case Presentation
- c. selection of studies for teaching collection of fluorescein angiography
- d. attendance at Fluorescein Angiography Conference

Ophthalmic Photographer responsibilities include

- a. provision of photographs in orderly sequence (with the requisition and billing slip) via digital imaging system and requisition with requesting physician to be available for interpretation and reporting on day of fluorescein angiography
- b. provision for a Teaching Collection in which copies of designated studies are available for use by Ophthalmology residents and faculty
- c. prompt notification of appropriate resident about an emergency ("stat") study

Fluorescein Angiography File

Files maintained by the Ophthalmic Photography Coordinator provide for a diagnosis and retrieval system. Each fluorescein angiography study will include the following materials:



- a. color fundus photographs representative of all color photographs obtained on the patient
- b. original negatives of red-free and black-and-white angiography photographs
- c. proof sheet of red-free and black-and-white angiography photographs
- d. copy of the report

OPHTHALMIC ULTRASONOGRAPHY

Definition

Ophthalmic ultrasonography is a sophisticated diagnostic examination technique using high frequency sound waves to detect, differentiate, and measure ocular and orbital disease processes. Two modes in clinical use, the A-scan and the B-scan, measure different parameters and are used to provide optimal information regarding pathologic processes. Ophthalmic ultrasonography is particularly valuable where opacities of the media preclude direct ophthalmoscopic visualization of the posterior segment of the eye.

The Ophthalmology Diagnostics evaluates patients referred from the Department of Ophthalmology and outside physicians.

Procedures performed include:

- a. standardized diagnostic ophthalmic echography:
 - 1) A-scan (ocular and orbital)
 - 2) B-scan (ocular and orbital)
- b. axial length measurements
- c. intraocular lens power calculations

Available instrumentation includes

- a. E-Z scan AB5500 model (combined standardized A, B, high resolution and biometry)

Scheduling

The referring physician should write an order on the progress note to initiate scheduling.

It is important that the technician performing the examination have basic information about the patient, such as clinical history, prior eye surgery, eye to be examined, and visual acuity. Each physician (Attending & Resident) will perform a B-scan for their respective patient. The resident physician shall perform A-scans on their respective patients until 20 procedures and/or competency has been achieved by the PGY IV. As competency is established, the technician staff will assume performance of A-scan per physician order.

For intraocular lens power calculation, an old and current refraction and visual acuity are assessed. Formulas used for calculating lens power require an A-constant corresponding to the lens planned for each patient.

Indications

Indications for ophthalmic ultrasonography are as follows:

- A. Ocular Indications:

1. Opacities in the ocular media precluding direct visualization of posterior structures, including:
 - a. corneal opacities
 - b. dense cataract
 - c. vitreous opacification
 - 1) Vitreous hemorrhage
 - 2) Vitreous membranes
 - 3) Cellular vitreous opacification
 - 4) Suspected endophthalmitis
 - d. suspected retinal detachment in cases where direct visualization is not possible.
 - e. leukocoria
 2. Intraocular mass lesions
 3. Atypical retinal detachment, including
 - a. bullous detachment without detectable breaks
 - b. detachment with shifting fluid
 - c. exudative detachment, possibly secondary to intraocular neoplasm
 - d. retinal detachment with turbid subretinal fluid
 4. Ocular trauma
 - a. associated with opacities in the ocular media
 - b. possibly affecting integrity of globe
 - c. involving intraocular foreign bodies
 5. Axial length measurement
 - a. to determine intraocular lens power
 - b. in cases of pseudoproptosis
 - c. myopic or hyperopic shift
- B. Orbital Indications:**
1. Proptosis from any cause, including
 - a. orbital eoplasm, primary or metastatic
 - b. orbital extension of periorbital neoplasm
 - c. orbital inflammatory process, such as cellulitis or pseudotumor
 - d. suspected Graves' Ophthalmopathy
 - e. orbital mucocele
 - f. vascular malformation and varices
 - g. suspected arteriovenous fistula
 2. Detection and localization of orbital abscess
 3. Unexplained strabismus with diplopia

Interpretation and reporting

All ultrasounds interpretation and reporting is the responsibility of the ordering physician.

Ultrasound Technician responsibilities include



- a. provision of photographs of ultrasonography and requisition for final interpretation and reporting no later than the fifth working day after test, and
- b. distribution of ultrasonography testing results to outside physicians, medical records, and ophthalmology diagnostic files in the specified manner.

VISUAL FIELD AND OTHER OPHTHALMIC PROCEDURES

Definition

Visual Field and other ophthalmic procedures include:

- a. visual field examinations (Humphrey and Goldmann, perimetry,)
- b. Corneal pachymetry measurement
- c. endothelial cell count
- d. potential acuity meter (PAM)
- e. corneal topography

Scheduling

Ancillary testing is open during regular business hours at 330-375-4832. The physician requesting visual fields and other ophthalmic procedures must complete the proper request form.

Interpretation and reporting

All visual fields interpretation is the responsibility of the ordering physician.

Technician responsibilities include:

- a. provision of visual fields or other test results and requisition for interpretation no later than the fifth working day after test, and
- b. distribution of test result/print-out to outside physicians, medical records, and Diagnostic files in the specified manner.

ELECTROPHYSIOLOGIC TESTING

Definition

Electrophysiological testing includes electroretinography dark adaptation.

Dark adaptation testing quantifies night vision impairment and reveals the kinetics of cone and rod recovery from bleaching.

Electro-oculograms or electroretinograms may help establish a diagnosis in cases of panretinal functional disturbance involving the retinal pigment epithelium, receptor layers, and bipolar cell layer. Focal electroretinograms aid in the identification and diagnosis of macular dysfunction.



These tests may be obtained to evaluate drug toxicity, macular function, optic atrophy, and optic neuritis.

Scheduling

The laboratory requisition form (attached) must be completed in advance for scheduling. Schedule laboratory appointments at 330-375-4831. Detailed information on findings of the clinical examination (e.g. visual acuity and appearance of the macular and optic discs) and the presumptive diagnosis is necessary for the technicians to conduct an appropriate evaluation and for results to be interpreted by the neuro-ophthalmologist, accurately.

Consultation/Interpretation

All interpretations for electrophysiological testing are provided via consultative process to the neuro-ophthalmologist on staff. The neuro-ophthalmologist will bill a professional fee to the patient's insurance/coverage for these services in addition to a Facility charge being billed by Summa Health System's Ophthalmology Center.

THERAPEUTIC LASERS

DYE LASER

Definition

The therapeutic argon laser is done using the Coherent Tuneable Dye Laser. This laser is used in therapeutic intervention of diabetic retinopathy, repair of retinal tear/hole, glaucoma, ALTP, iridotomy, iridoplasty, and laser suture lysis following trabeculectomy and following cataract surgery.

Scheduling

Privileged/credentialed staff may schedule in advance the use of the laser during normal business hours by contacting the Ophthalmology Center at 330-375-4832.

Laser Surgery Preparation & Documentation

The patient's preparation (pre-op assessment) will be completed by technical staff, in accordance with physician written/standing orders for the specific laser treatment scheduled. A written verification of patient consent for laser surgery will be acquired from the patients by the assessing party.

Documentation of the laser procedure and attestation of the treating physician on the laser treatment record is the responsibility of the treating physician. The laser treatment record/consent for treatment is attached (see Appendix).

YAG LASER



Yag laser services are available via a Zeiss Yag Laser III Plus delivery system. This laser is utilized for:

- a. posterior capsule opacity
- b. iridotomy
- c. vitreous strand lysis
- d. release of suture S/p shunt

Scheduling

Privileged/credentialed staff may schedule in advance the use of the laser during normal business hours by contacting the Ophthalmology Center at 330-375-4832.

Laser Surgery Preparation & Documentation

Patient's preparation (pre-op assessment) will be completed by technical staff, in accordance with physician written/standing orders for the specific laser treatment scheduled. A written verification of patient consent for laser surgery will be acquired from the patients by the assessing party.

Documentation of the laser procedure and attestation of the treating physician on the laser treatment record is the responsibility of the treating physician. The laser treatment record/consent for treatment is attached (See Appendix).

B. IN PATIENT CONSULTATION

The Ophthalmology Consultation Service at all hospitals provides faculty-supervised consultation for inpatients.

- A. During normal working hours, 0800-1700 (8 A.M. to 5 P.M) Monday through Friday; ophthalmology inpatient consultations should be directed to ACH Requests for consultations during the day at Akron Children's Hospital may be communicated either directly to the resident on call or to the office of the attending pediatric ophthalmologist on call, who will then forward this to the on.
- B. Requests for consultation for retinopathy of prematurity at Akron Children's Hospital should be referred to The Retina Group of Northeast Ohio at 330-434-1185 or Dr. Locastro at 330-374-5666.
- C. After hours, consultation service is administered by the resident on call, with backup from the Faculty or attending ophthalmologist on call. Every effort should be made to bring consultation patients to an eye lane for the best possible examination. Only if a patient cannot come to an eye lane should the resident go to the floor to evaluate the patient.
- D. When a patient is seen, an original examination sheet should be placed in the chart. All consultations should be seen with the faculty member assigned to consults that day or the faculty member whose specialty the consult involves before recommendations are made. If the consultation is to a particular attending, that attending needs to be contacted to see if he/she would like to see the consult; if not, it would default to Dr. Awender or any other attending covering



consults. If appropriate, the requesting physician should be notified by phone of findings and of further diagnostic or therapeutic recommendations, if appropriate.

SEE POLICY ON RESIDENT SUPERVISION IN SEPARATE AREA OF THE HANDBOOK

INSTRUCTIONS

The instructions that follow are general guidelines for writing ophthalmology consultation notes. Some of the information that is included in the consultation note is vital for obtaining reimbursement, so please adhere to these guidelines as much as possible. All consult notes should include the following information: name of examining physician, department of ophthalmology, patient name, medical record number, date of consultation, requesting attending physician.

The body of the text should follow the ophthalmology template and begin with the following, for example: "HISTORY OF PRESENT ILLNESS: 77-year-old white woman who was admitted to ACH on DATE, with a diagnosis of WHATEVER." At this point, give in detail the reason for the hospitalization and the pertinent workup to date, particularly if it has a bearing on the reason for the consultation. Then proceed to describe specifically the reason for consultation and the patient's eye complaints. In this section provide pertinent details of the ocular history and the name of the patient's private ophthalmologist, if any. The remainder of the consultation note should include the following headings:

MEDICAL HISTORY (past medical; past ocular; past surgical;

SOCIAL HISTORY (must be present to bill at level 3 or above)

FAMILY HISTORY

REVIEW OF SYSTEMS (must contain at least 10 items to bill at a level 3 or above; or state that they have been reviewed and documented in the chart).

CURRENT MEDICATIONS (if pertinent)

OPHTHALMOLOGIC EXAMINATION REVIEW OF DATA (if appropriate)

IMPRESSION RECOMMENDATIONS

If laboratory studies – such as head CTs, MRIs or carotid angiographic studies – relevant to the patient's visual complaint have been done or reviewed, please include a comment under the heading of LABORATORY STUDIES before the IMPRESSION. Always specify follow-up, if any is necessary, in the RECOMMENDATIONS. If no follow-up is necessary, please state something to that effect.



Under "IMPRESSION" list the diagnoses in numerical order. Begin with the refractive error followed by an anatomic walk-through of the eye from the lids to the optic nerve, then by systemic illnesses that affect the eye, and then by systemic illnesses that do not affect the eye. Such a list might read as follows:

IMPRESSION

1. Myopia, OU
2. Presbyopia
3. Staphylococcal blepharitis, OU
4. Pterygium, OS
5. Nuclear sclerotic cataracts, OU
6. Glaucoma suspect secondary to increased cup-to-disc ratio
7. Type II diabetes mellitus with background diabetic retinopathy
8. History of central nervous system lymphoma
9. History of hydrocephalus, S/P ventriculoperitoneal shunt

At the end, note that the patient was seen and/or discussed with (Name of faculty member). Then send copies of the note to the patient's private ophthalmologist, if any, and to the attending physician of record.

All consultations must be discussed with the attending before the resident leaves the unit, and the resident must ensure that the attending places a note on the chart within 24 hours. For all serious conditions, the attending must examine the patient promptly.



D. CHILDREN'S HOSPITAL MEDICAL CENTER OF AKRON

Children's main campus in downtown Akron houses regional centers for genetics, fetal treatment, cancer and blood disorders, heart, palliative care, orthopedics, pediatric trauma, pediatric intensive care, and level III neonatal intensive care, among others. Children's is also one of only two pediatric hospitals in the country that operates a burn center for both adults and children. Akron Children's is a major teaching affiliate of Northeastern Ohio Universities College of Medicine and Pharmacy, a consortium comprising The University of Akron, Kent State University, Youngstown State University and a Basic Medical Sciences Campus in Rootstown, Ohio, as well as 17 community hospitals. CHMCA offers 11 subspecialty fellowship training programs and is accredited by the Accreditation Council for Graduate Medical Education.

The Pediatric Ophthalmology service is located at the Children's Vision Center as part of the Children's Hospital Medical Center of Akron, located at 300 Locust Street, Suites 486 and 490, Akron, OH 44302

Children's Hospital Medical Center of Akron is dedicated to providing:

- medical care to infants, children, adolescents and burn victims of all ages, regardless of ability to pay
- multi-level professional education for residents and students of medicine, nursing, and the various allied health professions
- basic and clinical research into the causes, treatment and cure of childhood illness and burn injury
- community service intended to improve health status through lay education
- child and family advocacy efforts to improve the status of children and adolescents in our region of service
- continuing medical education to facilitate and encourage the process of lifelong learning for physicians and other health care providers involved in the care of children

Objectives and Goals

The Vision Center at CHMCA is a place where clinicians, scientists, students, residents, fellows, doctoral and post-doctoral students, using modern technology, provide a combination of expert clinical and diagnostic services and perform high level academic research and organized educational activities related to the developing visual and ocular motor systems.

- a. To Provide Expert Pediatric Ophthalmic Care
- b. To Provide Diagnostic Services For Referring Professionals
- c. To Provide Consultations For Referring Professionals



- d. To Promote Staff Scientist Independent and Cooperative Clinical Research
- e. To Educate Students, Residents, Doctoral and Post-Doctoral Candidates

Support and Structure Personnel

1. Hospital Administration
2. Director/Chief of Pediatric Ophthalmology
3. Clinicians – On Site
 - Full time Pediatric Ophthalmologists (3)
 - *Richard W. Hertle, MD, Robert Burnstine, MD, Anthony Locastro, MD*
 - Fellow in Pediatric Ophthalmology
 - 1 – Starting 2011-2012
 - Dedicated (10-12 weeks) Rotating Residents in Ophthalmology
 - 1-2 SUMMA
 - Consulting Ophthalmologists (Cornea, Plastics, Retina)
 - 3 From the community
4. Scientists (Staff)
 - Provides supervision of special testing and diagnostic services, independent research, and educational support.
 - 1 – Donsheng Yang, PhD
5. Students (Undergraduate, Medical, Graduate)
 - 1-2 As part of required or elective curriculum
6. Post-Doctoral Candidate
 - 1-2 Each under the supervision and mentorship of staff scientist in coordination with local university graduate programs
7. Clinical - Technicians
 - 3 Full Time Technicians Hospital Eye Service
8. Clerical, Administrative and Support Staff
 - 2 Administrative Assistants
 - 2 Patient Registrants

Demographic Service Participation



Clinical

1. Fellow-Resident Service – 5 Outpatient Sessions Week
2. Fellow-Resident Service – 3-4 Diagnostic/Special Testing Sessions Week
3. SUMMA Department of Ophthalmology – 1 session week Adult Motility Clinic
4. CHMCA and SUMMA NICU – ROP Service
5. CHMCA – Pediatric Surgery 15-18 Surgical Cases Week
6. SUMMA-Wellness Center – Adult Surgery 3-5 Cases Week
7. Emergency and Inpatient Consultation – Resident-Fellow - 25-30 Week

Research

1. Vision Center
 - Laboratory of Visual and Ocular Motor Physiology (see below)
2. University of Akron Graduate Education Program Bioengineering
3. Bioinnovation Collaboration
4. The Jaeb Center for Health Research (Tampa, FLA) – PEDIG Studies

Services

1. Clinical Care Diagnosis, Consultation, Medical and Surgical Treatments
 - a. Primary Care-Self Referral
 - b. Hospital Consultation
 - c. Tertiary Referral
 - d. Emergency Room Consultation
 - e. Disease Specific
 - Adult Ocular Motility Service at CHCMA
 - Adult Ocular Motility Service at SUMMA
 - f. Research
 - a. Collaborative - Industry
 - b. Independent – NEI RO1, DOD Grants
 - c. Clinical – PEDIG Collaboration and Electrophysiology Research
2. Teaching and Education
 - a. Graduate - Post-Doctoral Program
 - b. Medical Student – local, National and International Elective
 - c. Resident/Fellow – AAPOS Approved Pediatric Fellowship, SUMMA Resident Rotation
 - d. Undergraduate – Bioengineering Student Projects

Vision Center (Fellow-Resident Access) Equipment and Space

Equipment

1. Clinical Examinations
 - a. Five Examination Lanes (Diagnostic equipment and supplies for 5 examination lanes)

- b. Computers (1 in each exam room, 1 for check in, 1 for the technician, 1 for the fellow, 1 for the resident)
- 2. Laboratory of Visual and Ocular Motor Physiology and Special Testing
 - a. Electroretinography Recording Systems
 - b. Visual Evoked Stimulus and Recording Systems
 - c. Visual Field Evaluation Systems
 - d. Behavioral Visual Acuity Testing Systems
 - e. Color Vision Testing Systems
 - f. Ophthalmic Ultrasound Evaluations
 - g. Remote Video/Infrared Eye Movement Recording System
 - h. Scleral Search Coil Eye Movement Recording System
 - i. Computerized Vision Testing
 - j. Video Recorder
 - k. Fundus Camera
 - l. Anterior Segment Camera Space
- 1. Clinical Space – Five Examination Lanes (Suites 485-490)
Examination Lanes (diagnostic equipment and supplies)
5 Complete lanes (Slit lamp, phoropter, indirect and direct ophthalmoscopes, muscle light, retinoscope, trial lens set, worth 4 dot, color plates, stereo plates, M&S computer vision testing system, indirect lenses, biomicroscopic lenses, optokinetic drum, examination speculums, prism set, occluders, etc.)
- 2. Three Rooms Dedicated to Special Testing and Laboratory of Visual and Ocular Motor Physiology to Include
 - a. 2 Eye Movement Rooms (Each 100-120 sq ft)
 - b. ERG/VER/Photography/Behavioral+Field Testing (120 sq ft)
- 3. Administrative Space
 - Scientist Office
 - Fellow/Resident Office Work Space
 - Ophthalmic Technician Work Space
- 4. Clerical
 - a. Administrative Assistant Office/Desk
 - b. Receptionist-Check In-Phone – Work Space
- 5. Patient Waiting/Reception

Conclusions

The goals of the Vision Center and Division of Pediatric Ophthalmology are to meet the research and clinical vision embodied by CHMCA and SUMMA educational systems. We hope to create an environment where clinicians, scientists and students, using the latest technology, will provide the most sophisticated diagnostic capabilities, expert medical and surgical treatments of pediatric eye disease and ocular motility disorders in adults. We hope to perform ground breaking research on the developing visual and ocular motor systems. In addition, and in parallel with the goal of education, we will also



provide a graduate/post graduate program that will train future clinical and laboratory scientists.

Clinic Hours – M-F 8:30 am-4:30 pm

Operating room

Akron Children's Hospital performs more pediatric surgeries than any other hospital in northeast Ohio (more than 10,000 each year). Surgical Services at Akron Children's Hospital performs general and specialized surgical procedures, from uncomplicated tonsillectomies to open heart surgery and neurosurgery. Children's has twelve state-of-the-art operating rooms or surgical suites. Two are dedicated to minimally invasive surgeries and feature a voice-activated system and ceiling-mounted booms to hold all the equipment. There is space, personnel and equipment dedicated to the ophthalmology service where residents have the opportunity to participate in 15-18 procedures each week, including those on the lids and orbit, anterior segment, cornea, lens and those for glaucoma, strabismus, vitreo-retinal disease and complete examination under anesthesia with photographic documentation. Over 90 percent of surgeries are done on an outpatient basis, which has proven to be not only medically safe but psychologically beneficial for children.

Emergency Department

Pediatric board-certified doctors, along with nurses and technicians with additional training in pediatric emergency medicine, treat about 70,000 children and teens per year. The ED is staffed by 19 Pediatric Emergency Medicine physicians, three urgent care Pediatric attending physicians, two nurse practitioners and six Pediatric Emergency Medicine fellows. This core team is backed by a strong nursing team, child life workers, psychologists, radiologists, respiratory therapists, social workers and a variety of other disciplines that respond to all the patients' needs. The Emergency Department's carefully developed triage system, an organized method of identifying and directing patients according to the urgency of care they require, is designed to provide efficient, timely care to all patients who come to the ED. Akron Children's Hospital is verified as a pediatric trauma center by the American College of Surgeons. Through their interaction with the emergency department the residents in ophthalmology are exposed to, and become experienced in, the care of all varieties of patients, from those with orbital and eye trauma, to those with ocular manifestations of systemic diseases.



E. SURGERY CENTERS

a. Description of Four Surgery Centers participating in Residency training

- Common ophthalmic equipment at all surgery centers

Surgery Center	Address	Hours of operation	Distance from Akron City Hospital	Operating rooms #	Specialized equipment	Emergency surgery including trauma	Joint Commission accredited	Surgery Center Medical Director	Supervising Faculty	Annual review by PD	Program Letters of agreement
Davis Eye Center	789 Graham Rd., Cuyahoga Falls, OH 44221 (330) 923-7636	6a-2pm Mondays; Wednesdays (occasionally)	8.7 miles	2	VISX Laser for LASIK	Yes, but limited to working hours and complexity	YES	Charles Davis DO	Charles Davis, DO	YES	On file
Novus Clinic	518 West Ave., Tallmadge, OH 44278 (330) 630-9699	8a-5pm M-Fri 2 Tues / mo 2 Weds / mo * Fri –12p-4p reserved for Plastics	4 miles	2	NIDEK & VISX Laser for LASIK	Yes, but limited to working hours and complexity	YES	Todd Beyer, MD	-Todd Beyer, DO - James Johnston, DO	YES	On file
Parkwest Surgery Center	One Park West Boulevard Ste. 260 Akron, OH 44320 (330) 864-6000	6:30a-5pm (Mon – Fri)	8.5 miles	2	None	Yes, but limited to working hours and complexity	YES	Richard Ellison , MD	-Richard Ellison , MD -Anita Dash Modi, MD -J. Starkey, MD -James Canatti, MD -Thomas A. Repko, MD -Nancy Awender, MD	YES	On file
St. Claire Surgery Center	4441 Hudson Dr., Stow, OH 44224 (330) 920-4500	7a-6pm (Mon – Thurs) * Friday reserved for LASIK	8.7 miles	2	VISX Laser for LASIK	Yes, but limited to working hours and complexity	YES	Lawrence Lohman, MD	-Lawrence Lohman, MD -Marc Jones, MD -Kimberly Cingle, MD -Nancy Awender, MD	YES	On file

- Resident Rotations: less than 1 month per resident per year at each center



- Patients are examined at Akron City Hospital; pre operative assessments done there include informed consent and patient education
- All surgeries supervised by attending physician faculty
- Post operative care at Akron City hospital or attending physician faculty private office
- High risk complex cataract cases are scheduled at Akron City Hospital OR

F. PROGRESSIVE PATIENT RESPONSIBILITY POLICY FOR RESIDENTS

This document is intended to provide guidance for hospital personnel with regard to procedural competencies of ophthalmology residents. If any questions arise regarding a resident's competency to perform a procedure, the supervising attending physician may be contacted for clarification. Progressive responsibilities for patients are outlined in the document and will serve as the policy. Additional responsibilities are outlined in the Goals and Objectives.

PGY-2 Resident

The following activities can be performed unsupervised:

History taking
Dilation of pupils
Eye examination
Slit-lamp examination
Tonometry
Ophthalmoscopy

All surgical activities must be supervised by designated faculty

PGY-3 Resident

PGY-2 Residents will take an online Ophthalmology Review Test to determine their medical knowledge.

The following activities can be performed unsupervised:

All activities listed above as in PGY-2 resident activities
Corneal foreign body removal
Chalazion I&D
Repair of simple lid lacerations on call

The following activities must be supervised by designated faculty

Any surgery or part of surgery as deemed appropriate by the attending faculty



Any laser procedure as deemed appropriate by the attending faculty

PGY-4 Resident

The following activities can be performed unsupervised:

All activities listed above as in PGY-3 resident activities

Laser treatments as deemed appropriate by faculty

The following activities must be supervised by designated faculty

Any surgery or part of surgery as deemed appropriate by the attending faculty

G. RESIDENT SUPERVISION POLICY

ACGME-accredited programs must provide appropriate supervision for all residents that are consistent with proper patient care, the educational needs of residents, and the applicable Program Requirements. Residents must be supervised by teaching staff in such a way that the residents assume progressively increasing responsibility according to their level of education, ability, and experience. On-call schedules for teaching staff must be structured to ensure that supervision is readily available to residents on duty. The teaching staff must determine the level of responsibility accorded to each resident.

PROGRAM POLICY

Supervision of Residents

1. The general Institutional Policies for resident's supervision are outlined in the Summa Health System's Graduate Medical Education Policies and Procedures manual.
2. All patient care is directly or indirectly supervised by qualified faculty. The program director ensures, directs, and documents adequate supervision of residents at all times. Residents are provided with rapid, reliable systems for communicating with supervising faculty
3. Faculty schedules are structured to provide residents with continuous supervision and consultation.
4. Faculty and residents are educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects.

PROGRAM PROCEDURES

General

1. Qualified faculty, approved by the Program Director and Chairman of the Department, supervises all patient care, including clinics, inpatient consultations and operating room and subspecialty clinics.
2. The residents will be given graduated levels of experience based on their year of training and feedback received from faculty evaluations. The levels of responsibility would include patient care in the clinic, in the operating room and on call and are defined in the curriculum.
3. The written curriculum defines the level of residents' supervision by faculty members in all patient-care activities.
4. The role of the Chief residents in supervision is outlined in the residency handbook.
5. The Program Director ensures adequate supervision of residents at all times.
6. Residents are provided with rapid, reliable systems for communicating with supervising faculty.
7. Faculty schedules are structured to provide residents with continuous supervision and consultation.

RESIDENT SUPERVISION IN CLINIC

1. All patients seen by residents must be directly supervised by an attending when patients are in the clinic
2. Under unusual circumstances where the attending faculty is busy in the clinic with another resident with a complex problem or with a minor procedure or laser procedure, and the patient has to leave, indirect supervision is acceptable with the attending being on site and is left to the judgment of the attending faculty physician supervising the clinic.

RESIDENT SUPERVISION FOR CONSULTS

1. All consults seen by residents must be directly supervised by an attending when patients are in the clinic
2. Consults after hours: Direct supervision is available by phone with the attending physician on call or if the patient is a private patient of an attending faculty physician that attending should be contacted if necessary. Consults should be followed up in the ophthalmology clinic at the hospital or the private office of an attending faculty physician.

RESIDENT SUPERVISION FOR ON-CALL

Attending physician faculty may be Direct or Indirect on call.

1. Direct Supervision: The supervising physician is physically present with the resident and patient.
 - a. The presence of the supervising Ophthalmology attending on call onsite with the resident will be determined after the resident on call communicates with the attending on call.
 - b. In other instances the ER attending faculty will provide direct supervision on call for patients in the ER.
2. Indirect Supervision:
 - a. Direct supervision immediately available – The supervising physician is physically within the confines of the site of patient care, and immediately available to provide Direct Supervision
 - o This scenario is not applicable to residents in Ophthalmology on call.
 - b. Direct supervision available- The supervising physician is not physically present within the confines of the site of patient care, is immediately available via phone and is available to provide Direct Supervision.
 - o This is the default method of supervision for Ophthalmology attending and direct supervision being available onsite with the resident and patient is left to the judgment of the physician. It is however expected that any patients needing an emergency

procedure or in instances of an emergency where the diagnosis or management is complex, direct supervision with the physician onsite with resident and patient is carried out.

OTHER CALL POLICIES

1. The PGY-4 residents are expected to accompany the PGY-2 resident on call during the entire month of July.
2. After July, each PGY-2 resident on call is covered by a PGY-4 who can be called, if needed. However, the senior resident has to be called for any surgical issues.
3. The Department and hospital follow an escalation policy if the attending on call is unavailable. This includes contacting the Assistant Program Director, Program Director and Chair or designee and then the Hospital Administrator on call in that order,
4. All patients seen on call are discussed or followed up by the appropriate attending or at morning report.
5. All residents are provided with a call-roster giving the names and telephone/pager/cell phone numbers of all residents, attending physicians, Program Director and the Chair.
6. Both resident and attending call schedules are available on the Ophthalmology Department website and on Summa's On-line Directory.

Operating Room Supervision

1. All surgical procedures performed in the Operating rooms of the Hospital or surgical centers must be supervised by an attending physician on staff.

Evaluation and monitoring resident supervision

1. The Program Director will monitor the timeliness and level of supervision of residents by feedback from the clinic staff and the residents.
2. The quality of resident supervision will be evaluated during discussion with the residents during their semi annual evaluations and also through the annual confidential evaluations of the faculty by the residents.



DEPARTMENT OF OPHTHALMOLOGY

EDUCATION COMMITTEE – COMPONENTS & FUNCTION

Resident Education Committee

Functions

1. Advise and assist Dept Chair in developing, reviewing and modifying resident rotations schedule
2. Advise regarding surgical rotations and experience
3. Advise and Assist in formulation of lecture schedule and other departmental educational meetings
4. Advise and help formulate policies on research for residents
5. Advise in resolution any issues/problems that may arise regarding residents
6. Review any specific issues related to resident competencies and recommend corrective action to the Program Director/ Chair
7. Review and approve residency related documents as needed

Meeting how often: 3-4 times a year

Members:

Todd Woodruff, MD
Nancy Awender, MD
Jeff Lamkin, MD
James Cannatti, MD
Thomas Repko, MD
Charles Davis, DO
Richard Hertle, MD
Deepak Edward, MD
Chief Residents
Jaki Mills/Admin Assistant (Invited)
Carolyn Hobbs, PCOS (Invited)



DEPARTMENT OF OPHTHALMOLOGY

COMPETENCY BASED GOALS & OBJECTIVES OF THE OPHTHALMOLOGY PROGRAM

Goals & Objectives by Year and by Specialty

The following set of guidelines provides a plan for a standard curriculum of the ophthalmology residency training. The program is constructed based on a three-year training curriculum.

These guidelines are inclusive of both didactic knowledge acquisition and acquired skills transfer, and are, set forth in broad terms, and on a subspecialty by subspecialty basis.

Resident learning and development is provided through a combination of lectures, supervised patient care, graduated hands-on procedural and surgical experience, research and independent study. The goal of the curriculum is to train ophthalmologists who are capable of providing 'state of the art' comprehensive ophthalmologic care and to help interested residents prepare for additional fellowship training. Ideally, graduates of such a curriculum should possess the knowledge and experience necessary for membership in the American Board of Ophthalmology.

General Objectives:

CURRICULUM FOR RESIDENT EDUCATION

OVERALL EDUCATIONAL OBJECTIVES

The principal objective of the program is to train excellent clinical ophthalmologists. The residency training program over a three-year period is organized to provide a stable, well-coordinated, and progressive educational experience in the entire spectrum of ophthalmic diseases and ocular surgery, so that residents may develop diagnostic, therapeutic, and manual skills, as well as sound judgment in the application of such skills. Each resident has major technical and patient care responsibilities in order to provide an adequate base for a comprehensive ophthalmic practice that includes: optics, visual physiology, and corrections of refractive errors; retina, vitreous, and uvea; neuro-ophthalmology; pediatric ophthalmology and strabismus; external disease and cornea; glaucoma, cataract and anterior segment; oculoplastic surgery and orbital diseases; and ophthalmic pathology.

- The following set of guidelines provides a plan for a standard curriculum of ophthalmology residency training.

- The program is constructed based on a three-year training curriculum. These guidelines are inclusive of both didactic knowledge acquisition and acquired skills transfer, and are set forth in broad terms and on a subspecialty by subspecialty basis.
- Resident learning and development is provided through a combination of lectures, supervised patient care, graduated hands-on procedural and surgical experience, research and independent study.

GOAL:

- The goal of the curriculum is to train ophthalmologists who are capable of providing ethical comprehensive ophthalmologic care and to help interested residents prepare for additional fellowship training. Graduates of the curriculum should possess the knowledge and experience necessary for membership in the American Board of Ophthalmology.

COMPETENCY BASED OBJECTIVES BY RESIDENT YEAR OF TRAINING

Competencies addressed:

- Patient care
- Medical knowledge
- Professionalism
- Practice-based learning and improvement
- Interpersonal and communication skills
- Systems-based practice

I. General Objectives:

1. To provide supervised direct patient care experience which allows the resident to:
 - a. Master ophthalmologic examination skills,
 - b. Formulate and work up differential diagnoses,
 - c. Manage clinical problems of increasing complexity,
 - d. Develop and exercise clinical and ethical decision making abilities,
 - e. Develop patient communication techniques, and
 - f. Work effectively as a member of the medical care team.
2. To provide graduated supervised procedural and surgical experience including:
 - a. Modern cataract surgery and other anterior segment techniques,
 - b. Strabismus surgery
 - c. Anterior and posterior segment laser surgery, and
 - d. Exposure to all areas of subspecialty surgery.
3. To develop a broad fund of basic science and clinical knowledge through lecture, reading, and interactive conference and review sessions.



4. To provide residents with exposure to research, to teach them to knowledgeably assess research results and to motivate residents to pursue research projects.
5. To develop teaching skills as part of education.
6. To prepare for American Board of Ophthalmology exams.

II. Objectives by Year

PGY-2

1. To develop a core knowledge base through attendance of a basic science lectures **[Medical Knowledge]**
2. To use the American Academy of Ophthalmology Basic and Clinical Science Course, and attendance at clinical conferences including pathology lecture series and grossing of enucleated specimens. **[Medical Knowledge, Patient Care, Systems-Based Practice]**
3. To acquire history taking skills and communicating with patients from diverse settings in ophthalmology **[Interpersonal & Communication Skills, Patient Care, Professionalism]**
4. To learn basic anterior and posterior segment examination skills. **[Medical Knowledge, Practice-Based Learning Improvement]**
5. To learn and acquire skills in diagnostic ophthalmology, including tonometry, slit lamp examinations, indirect ophthalmoscopy, refraction, etc. **[Medical Knowledge, Practice-Based Learning Improvement]**
6. To manage uncomplicated general ophthalmologic disorders, including refractive errors, external inflammations, minor trauma, uncomplicated uveitis and glaucoma. **[Medical Knowledge, Patient Care, Practice-Based Learning Improvement, System-Based Practice]**
7. To acquire ophthalmic examination techniques and management of basic problems in the subspecialty areas of glaucoma, cornea, ophthalmic plastics, retina and neuro-ophthalmology. **[Patient Care, Practice-Based Learning Improvement]**
8. To develop capabilities to examine and diagnose most ophthalmic emergencies via emergency room coverage and provide compassionate care in a professional manner **[Patient Care, Practice-Based Learning Improvement, System-Based Practice, Professionalism]**
9. Complete a wet lab course learning basic operating room skills **[Medical Knowledge, Interpersonal & Communication Skills, System-Based Practice]**
10. To learn elementary refraction and contact lens fitting techniques. **[Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Interpersonal & Communication Skills]**
11. To perform minor surgical procedures (i.e. chalazion excision, etc.). **[Medical Knowledge, Patient Care]**
12. To develop an understanding of special diagnostic techniques – ultrasound, fluorescein angiography, electroretinography, visual field testing, etc. **[Patient Care, Medical Knowledge, Practice-Based Learning Improvement]**
13. To provide opportunities for teaching medical students in the clinic. **[Medical Knowledge, Professionalism]**

14. To help identify areas of research interest and pursue an original project with faculty guidance. **[Medical Knowledge, Practice-Based Learning Improvement]**
15. Understand the care of indigent patients and mechanisms available to provide the best and compassionate care to these patients. **[Interpersonal & Communication Skills, Professionalism, Patient Care]**
16. Learn the informed consent process and communication with the OR and surgery centers. **[Patient Care, Professionalism, Interpersonal & Communication Skills]**
17. Learn how to examine pediatric patients with strabismus and perform strabismus surgery. **[Patient Care, Medical Knowledge, Interpersonal & Communication Skills, Practice-Based Learning Improvement; Professionalism]**
18. To perform anterior segment lasers and panretinal photocoagulation. **[Patient Care, Professionalism, Interpersonal & Communication Skills]**

PGY-3

1. To develop a core knowledge base through attendance of a basic science lectures, use of American Academy of Ophthalmology Basic and Clinical Science Course, and attendance at clinical conferences and participate in discussions during the lecture series. **[Medical Knowledge, Professionalism, Interpersonal & Communication Skills]**
2. To attend pathology lecture series and grossing of enucleated specimens. **[Medical Knowledge, Patient Care, System-Based Practice]**
3. To participate in an increasing clinical decision making in management of general clinic and emergency patients using a process of using evidence based medicine, using information technology to access information and performing self reflection during the learning initiative. **[Patient Care, Practice-Based Learning & Improvement, Professionalism, Interpersonal & Communication Skills]**
4. To extend and expand diagnostic skills and management techniques in more complicated ophthalmologic disorders. **[Medical Knowledge, Patient Care]**
5. To acquire and develop skills and techniques for providing consultation to other medical services. **[Interpersonal & Communication Skills, System-Based Practice]**
6. To learn and acquire skills in subspecialties of ophthalmology – glaucoma, neuro-ophthalmology, oculoplastics, etc. **[Medical Knowledge, Practice-Based Learning & Improvement]**
7. To perform simple surgical procedures such as pterygium excision, tarsorrhaphy and lacrimal probing. **[Patient Care, Interpersonal & Communication Skills, Practice-Based Learning & Improvement]**
8. To develop an understanding of the indications for and uses of low vision aids. **[Medical Knowledge, Patient Care]**

9. To develop interpretative skills in assessing diagnostic tests such as fluorescein angiograms, radiologic images, etc. **[Medical Knowledge, Patient Care, System-Based Practice]**
10. To provide ophthalmic consultations in a general medical hospital and emergency room and learn communication with patients, families and consultants **[Patient Care, Practice-Based Learning & Improvement, Interpersonal & Communication Skills, System-Based Practice]**
11. To perform extraocular surgery, principally strabismus surgery and laser procedures, including panretinal photocoagulation, laser iridotomies, argon laser trabeculoplasty, and YAG capsulotomy. **[Patient Care, Professionalism, Interpersonal & Communication Skills]**
12. To develop a complete understanding of intraocular (cataract) surgery and participate in some of the surgical steps. **[Practice-Based Learning & Improvement, Systems-Based Practice]**
13. Perform extracapsular cataract surgery **[Patient Care, Interpersonal & Communication Skills]**
14. To assist in supervision and teaching of PGY-2 ophthalmology residents. **[Interpersonal & Communication Skills, Professionalism, Medical Knowledge]**
15. To work research project that is to be completed prior to graduation. **[Medical Knowledge, Practice-Based Learning & Improvement]**

PGY-4

1. To develop a core knowledge base through attendance of a basic science lectures, use of American Academy of Ophthalmology Basic and Clinical Science Course, and attendance and presentation at clinical conferences. **[Patient Care, Medical Knowledge, Practice-Based Learning Improvement, Interpersonal & Communication Skills]**
2. To master the art of diagnosis and treatment of complicated eye diseases **[Medical Knowledge, Practice-Based Learning Improvement, Interpersonal & Communication Skills, Patient Care].**
3. To develop competency in intraocular surgery and pre and post operative management of these conditions (cataract surgery, glaucoma surgery, retinal detachment procedures, major ocular trauma, etc.) and in complicated ophthalmic plastic procedures such as orbital fracture and tumor resection. **[Patient Care, Medical Knowledge, Practiced-Based Learning Improvement, Interpersonal & Communication Skills, Systems-Based Practice]**
4. To be able to manage intraoperative complications of surgery. **[Medical Knowledge, Patient Care, Interpersonal & Communication Skills, Professionalism]**
5. To develop skills and acquire experience in preoperative evaluation and postoperative management. **[Patient Care, Medical Knowledge, Interpersonal & Communication Skills]**

6. To develop competency in medical and surgical management of ocular trauma ***[Patient Care, Medical Knowledge, Practice-Based Learning Improvement, Interpersonal & Communication Skills, Systems-Based Practice]***
7. To develop interpretative skills in fluorescein angiography and ultrasound examination. ***[Patient Care, Medical Knowledge, Practice-Based Learning Improvement]***
8. To acquire skills of current modern practice management techniques. ***[Medical Knowledge, Systems-Based Practice, Professionalism, Interpersonal & Communication Skills]***
9. To assist in the teaching and supervision of PGY-2 and PGY-3 ophthalmology residents. ***[Medical Knowledge, Professionalism, Interpersonal & Communication Skills]***
10. To complete a research project started in PGY2 or 3 year ***[Medical Knowledge, Practice-Based Learning Improvement]***
11. To understand some of the principles of contract negotiations and practice management issues through didactic lectures. ***[Systems-Based Practice, Practice-Based Learning Improvement, Interpersonal & Communication Skills]***

**OVERALL LEARNING ACTIVITIES BASED ON COMPETENCIES FOR
COMPREHENSIVE OPHTHALMOLOGY**

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Comprehensive GME Core Curriculum	X	X	X	X	X	X
Didactic lectures		X			X	X
Grand rounds	X	X	X	X	X	
Morning reports	X	X	X	X	X	
Journal Club	X	X		X	X	X
Comprehensive Clinic	X	X	X	X	X	X
Performance Quality Improvement Conference	X		X	X	X	X



M&M conferences	X	X	X	X	X	X
Resident group discussion with supervision		X	X	X		X
Video vignettes/		X		X	X	X
Research Project		X	X			X



**OVERALL EVALUATION TOOLS FOR COMPETENCIES FOR COMPREHENSIVE
OPHTHALMOLOGY**

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Evaluation by Faculty	X	X	X	X	X	X
Semi Annual Evaluation by PD	X	X	X	X	X	X
Evaluation by Staff	X			X	X	
Evaluation by Patients	X			X	X	
Evaluation by Peers	X	X	X	X	X	X
On call evaluation tool	X	X	X	X	X	X
Cataract evaluation	X	X	X		X	
OCEX	X	X	X	X	X	X
Patient Surveys	X			X	X	X
Portfolios			X	X	X	
Procedures Log	X	X	X		X	X
Self Evaluations			X		X	X

RETINOSCOPY AND REFRACTION

These skills are learned and evaluated through the 36 months of residency

PGY2 [Medical Knowledge, Patient Care, Practice-Based Learning & Improvement]

1. To describe the major types of refractive errors
2. To perform elementary refraction techniques (e.g., myopia, hyperopia, accommodative add)
3. To perform objective and subjective refraction techniques for simple refractive error
4. To describe the basic ophthalmic optics and optical principles of refraction and retinoscopy
5. To perform retinoscopy for detecting simple refractive errors
6. To describe the indications for and to use the trial lenses or a phoropter for simple refractive error
7. To describe the basic use of a trial frame and trial lens set for simple refractive error
8. To describe the basics principles of a keratometer

PGY3 (in addition to Basic) [Medical Knowledge, Patient Care, Practice-Based Learning & Improvement]

1. To describe more complex types of refractive errors including post-operative refractive errors
2. To perform more advanced refraction techniques (e.g., astigmatism, complex refractions, asymmetric accommodative add)
3. To perform objective and subjective refraction techniques in more complex refractive errors including astigmatism and post-operative refractive error
4. To describe the more advanced ophthalmic optics and optical principles of refraction and retinoscopy (e.g., post-keratoplasty, post-cataract extraction)
5. To perform more advanced techniques of retinoscopy for detecting simple and complex refractive error
6. To describe and use more advanced techniques using trial lenses or the phoropter for more complex refractive errors including modification and refinement of subjective manifest refractive error
7. To describe and perform more advanced use of a trial frame and trial lens set for more complex refractive errors (e.g., advanced and irregular astigmatism, vertex distance)
8. To use the keratometer for detection of more advanced refractive error

PGY4 (in addition to Basic and Standard) [*Medical Knowledge, Patient Care, Practice-Based Learning & Improvement, Professionalism, System-Based Practice*]

1. To describe the most complex types of refractive errors including post-operative refractive errors, post-keratoplasty, and refractive surgery
2. To perform the most advanced refraction techniques (e.g., irregular astigmatism, pre and post refractive surgery)
3. To perform objective and subjective refraction techniques in the most complex refractive error including astigmatism and post-operative refractive error (one should be more complex the other should be most complex)
4. To describe the most advanced ophthalmic optics and optical principles of refraction and retinoscopy including higher order aberrations
5. To perform the advanced techniques of retinoscopy for detecting simple and complex refractive errors including post-keratoplasty and refractive surgery
6. To understand patient complaints related to complex refractive errors and communicate options available to them.
7. To perform the most advanced techniques using the trial lenses or the phoropter for more complex refractive errors including modification and refinement of subjective manifest refractive, cycloplegic retinoscopy and refraction, and post-cycloplegic refraction
8. To perform the advanced use of a trial frame and trial lens set for the most complex refractive error including astigmatism, post-keratoplasty, and refractive surgery cases
9. To use the keratometer for detection of subtle or complex advanced refractive error
10. To use more advanced refraction instruments and techniques (e.g., distometer, automated refractor, corneal topography).

Other skills applicable to all levels of training

1. Learn how to take a refractive history from the patient [*Patient Care, Medical Knowledge, Interpersonal & Communication Skills*]
2. Be able to interpret patients symptoms [*Medical Knowledge, Practice-Based Learning, Improvement, Interpersonal & Communication Skills*]
3. Communicate with the optical shops [*Interpersonal & Communication Skills, Systems-Based Practice*]
4. Educate patients on various optical options available [*Practice-Based Learning Improvement, Professionalism, Interpersonal & Communication Skills*]



RETINOSCOPY AND REFRACTION LEARNING ACTIVITIES BASED ON COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Didactic lectures		X			X	X
Grand rounds	X	X	X	X	X	
Morning reports	X	X	X	X	X	
Journal Club	X	X		X	X	X
Comprehensive Clinic	X	X	X	X	X	X
Performance Quality Improvement Conference	X		X	X	X	X
M&M conferences	X	X	X	X	X	X
Resident group discussion with supervision		X	X	X		X

RETINOSCOPY AND REFRACTION EVALUATION TOOLS FOR COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Evaluation by Faculty	X	X	X	X	X	X
Semi Annual Evaluation by PD	X	X	X	X	X	X
Evaluation by Staff	X			X	X	
Evaluation by Patients	X			X	X	



Evaluation by Peers	X	X	X	X	X	X
On call evaluation tool	X	X	X	X	X	X
Cataract evaluation	X	X	X		X	
OCEX	X	X	X	X	X	X
Patient Surveys		X		X	X	
Portfolios						
Procedures Log	NA	NA	NA	NA	NA	NA
Self Evaluations	X	X	X			

**SUMMARY OF SPECIALTY AREA
LENS & CATARACT**

WHERE:

1. Akron City Hospital; Lens & Cataract continuity clinic for 36 months of residency (see rotation schedule for assignments)
2. Private Practices of Dr's (see rotation schedule for assignments and location)
3. Surgery at Akron City Hospital and (4) Surgery Centers with above preceptors and supervisors

PRECEPTORS:

1. Awender, Beyer, Cannatti, Cingle, Dash-Modi, Davis, Ellison, Johnston, Jones, Lohman, Repko, and Starkey.

GOALS and OBJECTIVES: SEE BELOW

ROTATION EVALUATION:

1. Through New Innovations Systems
2. Through cataract evaluation
3. Through OCEX in clinic
2. Annual Feedback from Staff



3. Patient surveys

LENS AND CATARACT

OBJECTIVES

1. To describe the normal anatomy, embryologic development, physiology, and biochemistry of the crystalline lens [**Medical Knowledge**]
2. To identify congenital anomalies of the lens [**Patient Care, Medical Knowledge**]
3. To distinguish types of congenital and acquired cataracts [**Patient Care, Medical Knowledge**]
4. To describe the association of cataracts with aging, trauma, medications, and systemic and ocular diseases [**Patient Care, Medical Knowledge**]
5. To appropriately evaluate and manage patients with cataract and other lens abnormalities [**Patient Care, Medical Knowledge**]
6. To explain the principles of cataract surgery techniques and associated surgical technology [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement**]
7. To develop an appropriate differential diagnosis and management plan for intra-operative and postoperative complications of cataract surgery [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice**]
8. To identify special circumstances in which cataract surgery techniques should be modified and develop appropriate treatment plans [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice**]

LENS AND CATARACT LEARNING ACTIVITIES BASED ON COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice



Comprehensive GME Core Curriculum						
Didactic lectures		X			X	X
Grand rounds	X	X	X	X	X	
Morning reports	X	X	X	X	X	
Journal Club	X	X		X	X	X
Comprehensive Clinic	X	X	X	X	X	X
Performance Quality Improvement Conference	X		X	X	X	X

LENS AND CATARACT EVALUATION TOOLS FOR COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Evaluation by Faculty	X	X	X	X	X	X
Semi Annual Evaluation by PD	X	X	X	X	X	X
Evaluation by Staff	X			X	X	
Evaluation by Patients	X			X	X	
Evaluation by Peers	X	X	X	X	X	X
On call evaluation tool	X	X	X	X	X	X
Cataract evaluation	X	X	X		X	



OCEX	X	X	X	X	X	X
Patient Surveys						
Portfolios						
Procedures Log						
Self Evaluations						



SUMMARY OF ROTATION OPTICS & CONTACT LENSES

WHERE:

1. Akron City Hospital; Optic & Contact Lenses clinic for 36 months of residency (see rotation schedule for assignments)

PRECEPTORS:

1. Dr. Cannatti

GOALS and OBJECTIVES: SEE BELOW

ROTATION EVALUATION:

1. Through New Innovations Systems
2. Annual Feedback from Staff
3. Patient surveys

OPTICS & CONTACT LENSES

OBJECTIVES

1. To outline the theory and terminology of physical optics [**Medical Knowledge**]
2. To discuss the clinical and technical relevance of such optical phenomena as interference, coherence, polarization, diffraction, and scattering [**Medical Knowledge**]
3. To review the basic properties of laser light and how they affect laser-tissue interaction [**Medical Knowledge**]
4. To outline the principles of light propagation and image formation and work through some of the fundamental equations that describe or measure such properties as refraction, reflection, magnification, and vergence [**Medical Knowledge**]
5. To explain how these principles can be applied diagnostically and therapeutically [**Patient Care, Medical Knowledge**]
6. To identify optical models of the human eye and how to apply them [**Patient Care, Medical Knowledge**]
7. To define the various types of visual perception and function, including visual acuity, brightness sensitivity, color perception, and contrast sensitivity [**Patient Care, Medical Knowledge**]

8. To summarize the steps for performing streak retinoscopy [**Patient Care, Medical Knowledge**]
9. To summarize the steps for performing a manifest refraction using a phoropter or trial lenses [**Patient Care, Medical Knowledge**]
10. To describe the use of the Jackson cross cylinder [**Patient Care, Medical Knowledge**]
11. To describe the indications for prescribing bifocals and common difficulties encountered in their use [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice**]
12. To review the materials and fitting parameters of both soft and rigid contact lenses [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice**]
13. To explain the optical principles underlying various modalities of refractive correction: spectacles, contact lenses, intraocular lenses, and refractive surgery [**Medical Knowledge**]
14. To discern the differences among these types of refractive correction and how to apply them most appropriately to the individual patient [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice**]
15. To discuss the basic methods of calculating intraocular lens powers and the advantages and disadvantages of the different methods [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice**]
16. To describe the conceptual basis of multifocal IOLs and how the correction of presbyopia differs between these IOLs and spectacles [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice**]
17. To recognize the visual needs of low-vision patients and how to address these needs through optical and nonoptical devices and/or appropriate referral [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice**]
18. To describe the operating principles of various optical instruments in order to use them more effectively [**Patient Care, Medical Knowledge**]

OPTICS & CONTACT LENS LEARNING ACTIVITIES BASED ON COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Comprehensive GME Core Curriculum						
Didactic lectures		X			X	X
Grand rounds	X	X	X	X	X	
Morning reports	X	X	X	X	X	
Journal Club	X	X		X	X	X
Comprehensive Clinic	X	X	X	X	X	X
Performance Quality Improvement Conference	X		X	X	X	X
M&M conferences	X	X	X	X	X	X
Resident group discussion with supervision		X	X	X		X

OPTICS & CONTACT LENS EVALUATION TOOLS FOR COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Evaluation by Faculty	X	X	X	X	X	X



Semi Annual Evaluation by PD	X	X	X	X	X	X
Evaluation by Staff	X			X	X	
Evaluation by Patients	X			X	X	
Evaluation by Peers	X	X	X	X	X	X
On call evaluation tool	X	X	X	X	X	X
OCEX	X	X	X	X	X	X
Patient Surveys						
Portfolios						
Procedures Log						
Self Evaluations						

**SUMMARY OF ROTATION
CORNEA AND EXTERNAL DISEASE**

WHERE:

1. Akron City Hospital; Cornea and External Disease clinic for 36 months of residency (see rotation schedule for assignments)

PRECEPTORS:

1. Dr. Lohman
2. Dr. Jones
3. Dr. Mayer
4. Dr. Yeakley

GOALS and OBJECTIVES: SEE BELOW

ROTATION EVALUATION:

1. Through New Innovations Systems

2. Annual Feedback from Staff
3. Patient surveys

CORNEA AND EXTERNAL DISEASE

OBJECTIVES

[The area of competency that each objective meets is given in parentheses after each objective]

1. To describe the anatomy and molecular biology of the cornea [**Medical Knowledge**]
2. To explain the pathogenesis of common disorders affecting the eyelid margin, conjunctiva, cornea, and sclera [**Patient Care, Medical Knowledge**]
3. To recognize the distinctive signs of specific diseases of the ocular surface and cornea [**Patient Care, Medical Knowledge**]
4. To describe how the environment can affect the structure and function of the ocular surface [**Patient Care, Medical Knowledge**]
5. To outline the steps in an ocular examination for corneal or external eye disease and choose the appropriate laboratory and other diagnostic tests [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice**]
6. To summarize the developmental and metabolic alterations that lead to structural changes of the cornea [**Medical Knowledge**]
7. To identify topographic changes of the cornea and describe the risks and benefits of corrective measures [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice**]
8. To assess the indications and techniques of surgical procedures for managing corneal disease, trauma, and refractive error [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice**]
9. To apply the results of recent clinical research to the management of selected disorders of the conjunctiva and cornea [**Patient Care, Medical Knowledge**]



10. To integrate the discipline of corneal and external eye disease into the practice of ophthalmology [***Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice***]

CORNEA & EXTERNAL DISEASE LEARNING ACTIVITIES BASED ON COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Comprehensive GME Core Curriculum						
Didactic lectures		X			X	X
Grand rounds	X	X	X	X	X	
Morning reports	X	X	X	X	X	
Journal Club	X	X		X	X	X
Comprehensive Clinic	X	X	X	X	X	X
Performance Quality Improvement Conference	X		X	X	X	X
M&M conferences	X	X	X	X	X	X
Resident group discussion with supervision		X	X	X		X

CORNEA & EXTERNAL DISEASE EVALUATION TOOLS FOR COMPETENCIES



	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Evaluation by Faculty	X	X	X	X	X	X
Semi Annual Evaluation by PD	X	X	X	X	X	X
Evaluation by Staff	X			X	X	
Evaluation by Patients	X			X	X	
Evaluation by Peers	X	X	X	X	X	X
On call evaluation tool	X	X	X	X	X	X
Cataract evaluation	X	X	X		X	
OCEX	X	X	X	X	X	X
Patient Surveys						
Portfolios						
Procedures Log						
Self Evaluations						

**SUMMARY OF ROTATION
REFRACTIVE SURGERY**

WHERE:

1. Akron City Hospital; Refractive Surgery clinic for 36 months of residency (see rotation schedule for assignments)



PRECEPTORS:

1. Dr. Lohman

GOALS and OBJECTIVES: SEE BELOW

ROTATION EVALUATION:

1. Through New Innovations Systems
2. Annual Feedback from Staff
3. Patient surveys

REFRACTIVE SURGERY

OBJECTIVES

1. To explain the contribution of the cornea's shape and tissue layers to the optics of the eye and how these components are affected biomechanically by different types of keratorefractive procedures [**Medical Knowledge**]
2. To outline the basic concepts of wavefront analysis and its relationship to different types of optical aberrations [**Medical Knowledge**]
3. To review the general types of lasers used in refractive surgeries [**Patient Care, Medical Knowledge**]
4. To describe the role of the FDA in the development and approval of ophthalmic devices used in refractive surgery [**Patient Care, Medical Knowledge**]
5. To outline the steps—including medical and social history, ocular examination, and ancillary testing—in evaluating whether a patient is an appropriate candidate for refractive surgery [**Patient Care, Medical Knowledge**]
6. For incisional keratorefractive surgery (radial keratotomy, transverse keratotomy, arcuate keratotomy, and limbal relaxing incisions), review the history, patient selection, surgical techniques, outcomes, and complications [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice**]
7. To list the various types of corneal onlays and inlays that have been used for refractive correction [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice**]
8. For photorefractive keratotomy (PRK) and laser subepithelial keratomileusis (LASEK), review patient selection, epithelial debridement, laser calibration and techniques, refractive outcomes, and complications [**Patient Care, Medical**]

Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice]

9. To describe the different methods for creating a LASIK flap using a microkeratome or a femtosecond laser as well as instrumentation and possible complications associated with each [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice]**
10. To review patient selection, surgical techniques, outcomes, and complications for laser in situ keratomileusis (LASIK) [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice]**
11. To explain recent developments in the application of wavefront technology to PRK and LASIK [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice]**
12. For conductive keratoplasty, provide a brief overview of history, patient selection, and safety issues [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice]**
13. To discuss how intraocular surgical procedures, including clear lens extraction with IOL implantation or phakic IOL implantation, can be used in refractive correction, with or without corneal intervention [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice]**
14. To discuss the different types of IOLs used for refractive correction [**Patient Care, Medical Knowledge]**
15. To explain the leading theories of accommodation and how they relate to potential treatment of presbyopia [**Patient Care, Medical Knowledge]**
16. To describe nonaccommodative and accommodative approaches to the treatment of presbyopia [**Patient Care, Medical Knowledge]**
17. To discuss considerations for, and possible contraindications to, refractive surgery in the setting of preexisting ocular and systemic disease [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice]**
18. To list some of the effects of prior refractive procedures on later IOL calculations, contact lens wear, and ocular surgery [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice]**

REFRACTIVE SURGERY LEARNING ACTIVITIES BASED ON COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Comprehensive GME Core Curriculum						
Didactic lectures		X			X	X
Grand rounds	X	X	X	X	X	
Morning reports	X	X	X	X	X	
Journal Club	X	X		X	X	X
Comprehensive Clinic	X	X	X	X	X	X
Performance Quality Improvement Conference	X		X	X	X	X
M&M conferences	X	X	X	X	X	X
Resident group discussion with supervision		X	X	X		X

REFRACTIVE SURGERY EVALUATION TOOLS FOR COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Evaluation by Faculty	X	X	X	X	X	X



Semi Annual Evaluation by PD	X	X	X	X	X	X
Evaluation by Staff	X			X	X	
Evaluation by Patients	X			X	X	
Evaluation by Peers	X	X	X	X	X	X
On call evaluation tool	X	X	X	X	X	X
Cataract evaluation	X	X	X		X	
OCEX	X	X	X	X	X	X
Patient Surveys						
Portfolios						
Procedures Log						
Self Evaluations						



SUMMARY OF ROTATION GLAUCOMA

WHERE:

1. Akron City Hospital; Glaucoma continuity clinic for 36 months of residency (see rotation schedule for assignments)
2. Private Practices of Dr's Woodruff and Edward (see rotation schedule for assignments and location)
3. Surgery at Akron City Hospital with above preceptors and supervisors

PRECEPTORS:

1. Todd Woodruff, MD
2. Deepak P. Edward, MD

GOALS and OBJECTIVES: SEE BELOW

ROTATION EVALUATION:

1. Through New Innovations Systems
2. Annual Feedback from Staff
3. Patient surveys

GLAUCOMA

OBJECTIVES

1. To identify the epidemiologic features of glaucoma, including the social and economic impacts of the disease [**Patient Care, Medical Knowledge**]
2. To summarize recent advances in the understanding of hereditary and genetic factors in glaucoma [**Patient Care, Medical Knowledge**]
3. To outline the physiology of aqueous humor dynamics and the control of intraocular pressure (IOP) [**Patient Care, Medical Knowledge**]
4. To review the clinical evaluation of the glaucoma patient, including history and general examination, gonioscopy, optic nerve examination, and visual field [**Patient Care, Medical Knowledge**]
5. To describe the clinical features of the patient considered a "glaucoma suspect" and indications of treatments of these patients and cost effectiveness of treatment [**Patient Care, Medical Knowledge; system based Practice**]
6. To recognize and understand the clinical features, evaluation, and therapy of primary open-angle glaucoma and normal-tension glaucoma [**Patient Care,**

Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice]

7. To list the various clinical features of and therapeutic approaches for the primary and secondary open-angle glaucomas [**Patient Care, Medical Knowledge**]
8. To explain the underlying causes of the increased IOP in various forms of secondary open-angle glaucoma and the impact these underlying causes have on management [**Patient Care, Medical Knowledge**]
9. To review the mechanisms and pathophysiology of primary angle-closure glaucoma [**Patient Care, Medical Knowledge**]
10. To review the pathophysiology of secondary angle-closure glaucoma, both with and without pupillary block [**Patient Care, Medical Knowledge**]
11. To outline the pathophysiology and therapy of infantile and juvenile-onset glaucoma [**Patient Care, Medical Knowledge**]
12. To differentiate among the various classes of medical therapy for glaucoma, including efficacy, mechanism of action, and safety [**Patient Care, Medical Knowledge**]
13. To compare the indications and techniques of various laser and incisional surgical procedures for glaucoma [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice**]
14. To describe cyclodestructive treatment for refractory glaucoma [**Patient Care, Medical Knowledge**]

GLAUCOMA LEARNING ACTIVITIES BASED ON COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Comprehensive GME Core Curriculum						
Didactic lectures		X			X	X

Grand rounds	X	X	X	X	X	
Morning reports	X	X	X	X	X	
Journal Club	X	X		X	X	X
Comprehensive Clinic	X	X	X	X	X	X
Performance Quality Improvement Conference	X		X	X	X	X
M&M conferences	X	X	X	X	X	X
Resident group discussion with supervision		X	X	X		X

GLAUCOMA EVALUATION TOOLS FOR COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Evaluation by Faculty	X	X	X	X	X	X
Semi Annual Evaluation by PD	X	X	X	X	X	X
Evaluation by Staff	X			X	X	
Evaluation by Patients	X			X	X	
Evaluation by Peers	X	X	X	X	X	X
On call evaluation tool	X	X	X	X	X	X



Cataract evaluation	X	X	X		X	
OCEX	X	X	X	X	X	X
Patient Surveys						
Portfolios						
Procedures Log						
Self Evaluations						

SUMMARY OF ROTATION

NEURO-OPHTHALMOLOGY

WHERE:

1. Akron City Hospital; Neuro-Ophthalmology continuity clinic for 36 months of residency (see rotation schedule for assignments)
2. Private Practices of Dr. Bates (see rotation schedule for assignments and location)
3. Surgery at Akron City Hospital with above preceptors and supervisors

PRECEPTORS:

1. James Bates, MD

GOALS and OBJECTIVES: SEE BELOW

ROTATION EVALUATION:

1. Through New Innovations Systems
2. Annual Feedback from Staff
3. Patient surveys

NEURO-OPHTHALMOLOGY

OBJECTIVES

1. To describe a symptom-driven approach to patients with common neuro-ophthalmic complaints in order to formulate an appropriate differential diagnosis [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement**]
2. To select the most appropriate tests and imaging, based upon symptomatology, to diagnose and manage neuro-ophthalmic disorders in a cost-effective manner [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice**]
3. To review anatomic structures relevant to the neuro-ophthalmologist (including the skull and orbit, brain, vascular system, and cranial nerves) in order to localize lesions [**Patient Care, Medical Knowledge**]
4. To assess eye movement disorders and the ocular motor system [**Patient Care, Medical Knowledge**]
5. To describe the association between pupil and eyelid position and ocular motor pathology [**Patient Care, Medical Knowledge**]
6. To review the pathophysiology and management of diplopia and central eye movement disorders [**Patient Care, Medical Knowledge**]
7. To identify the effects of systemic disorders on visual and ocular motor pathways [**Patient Care, Medical Knowledge**]
8. To explain the possible systemic significance of ophthalmic disorders [**Patient Care, Medical Knowledge**]
9. To communicate with the neurologist and radiologist and other referral sources and explain findings in a patient with neurophthalmic disease [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice, Communication skills, Professionalism**]

NEURO-OPHTHALMOLOGY LEARNING ACTIVITIES BASED ON COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Didactic lectures		X			X	X



Grand rounds	X	X	X	X	X	
Morning reports	X	X	X	X	X	
Journal Club	X	X		X	X	X
Comprehensive Clinic	X	X	X	X	X	X
Performance Quality Improvement Conference	X		X	X	X	X
M&M conferences	X	X	X	X	X	X
Resident group discussion with supervision		X	X	X		X

NEURO-OPHTHALMOLOGY EVALUATION TOOLS FOR COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Comprehensive GME Core Curriculum						
Evaluation by Faculty	X	X	X	X	X	X
Semi Annual Evaluation by PD	X	X	X	X	X	X
Evaluation by Staff	X			X	X	
Evaluation by Patients	X			X	X	
Evaluation by Peers	X	X	X	X	X	X
On call evaluation tool	X	X	X	X	X	X
Cataract evaluation	X	X	X		X	



OCEX	X	X	X	X	X	X
Patient Surveys	X			X	X	X
Portfolios	X	X	X		X	X
Procedures Log	X		X			
Self Evaluations			X	X	X	



SUMMARY OF ROTATION OPHTHALMIC PATHOLOGY AND INTRAOCULAR TUMORS

WHERE:

1. Akron City Hospital; Ophthalmic Pathology and Intraocular Tumors continuity clinic for 36 months of residency (see rotation schedule for assignments)
2. Private Practices of Dr. Edward (see rotation schedule for assignments and location)

PRECEPTORS:

1. Deepak P. Edward, MD

GOALS and OBJECTIVES: SEE BELOW

ROTATION EVALUATION:

1. Through New Innovations Systems
2. Annual Feedback from Staff
3. Patient surveys

OPHTHALMIC PATHOLOGY & INTRAOCULAR TUMORS

OBJECTIVES

1. To describe a structured approach to understanding major ocular conditions based on a hierarchical framework of topography, disease process, general diagnosis, and differential diagnosis [***Patient Care, Medical Knowledge; PBLI***]
2. To summarize the steps in handling ocular specimens for pathologic study, including obtaining, dissecting, processing, and staining tissues [***Medical Knowledge;PBLI***]
3. To explain the basic principles of special procedures used in ophthalmic pathology, including immunohistochemistry, flow cytometry, molecular pathology, and diagnostic electron microscopy [***Medical Knowledge***]
4. To communicate effectively with the pathologist regarding types of specimens, processing, and techniques appropriate to the clinical situation [***Patient Care, Medical Knowledge, Systems-Based Practice, Professionalism, Interpersonal & Communication Skills; PBLI***]
5. To summarize the histopathology of common ocular conditions [***Patient Care, Medical Knowledge***]

6. To correlate clinical and pathological findings [***Patient Care, Medical Knowledge***]
7. To list the steps in wound healing in ocular tissues [***Patient Care, Medical Knowledge***]
8. To summarize current information about the most common primary tumors of the eye [***Patient Care, Medical Knowledge;PBLI***]
9. To identify those ophthalmic lesions that indicate systemic disease and/or are potentially life-threatening [***Patient Care, Medical Knowledge***]
10. To provide useful genetic information to families affected by retinoblastoma and other ocular tumors [***Patient Care, Medical Knowledge, Professionalism, Interpersonal & Communication Skill;PBLI***]
11. To assess current and new treatment modalities for ocular tumors in terms of patient prognosis and ocular functioning [***Patient Care, Medical Knowledge;PBLI***]

**OPHTHALMIC PATHOLOGY AND INTRAOCULAR TUMORS LEARNING
ACTIVITIES BASED ON COMPETENCIES**

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Comprehensive GME Core Curriculum						
Didactic lectures		X			X	X
Grand rounds	X	X	X	X	X	
Morning reports	X	X	X	X	X	
Journal Club	X	X		X	X	X
Comprehensive Clinic	X	X	X	X	X	X
Performance Quality	X		X	X	X	X



Improvement Conference						
M&M conferences	X	X	X	X	X	X
Resident group discussion with supervision		X	X	X		X

OPHTHALMIC PATHOLOGY AND INTRAOCULAR TUMORS EVALUATION TOOLS FOR COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Evaluation by Faculty	X	X	X	X	X	X
Semi Annual Evaluation by PD	X	X	X	X	X	X
Evaluation by Staff	X			X	X	
Evaluation by Patients	X			X	X	
Evaluation by Peers	X	X	X	X	X	X
On call evaluation tool	X	X	X	X	X	X
Cataract evaluation	X	X	X		X	
OCEX	X	X	X	X	X	X
Patient Surveys	X			X	X	X
Portfolios	X	X	X		X	X
Procedures Log	X		X			



Self Evaluations			X	X	X	
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**SUMMARY OF ROTATION
OCULOPLASTICS & ORBITAL SURGERY**

WHERE:

1. Akron City Hospital; Oculoplastics & Orbital Surgery continuity clinic for 36 months of residency (see rotation schedule for assignments)
2. Private Practices of Dr's Locastro and Beyer (see rotation schedule for assignments and location)
3. Surgery at Akron City Hospital with above preceptors and supervisors

PRECEPTORS:

1. Todd Beyer, DO
2. Anthony Locastro, MD

GOALS and OBJECTIVES: SEE BELOW

ROTATION EVALUATION:

1. Through New Innovations Systems
2. Annual Feedback from Staff
3. Patient surveys

OCULOPLASTICS & ORBITAL SURGERY

OBJECTIVES

1. To describe the normal anatomy and function of orbital and periocular tissues
[Medical Knowledge]
2. To identify general and specific pathophysiological processes (including congenital, infectious, inflammatory, traumatic, neoplastic, and involuntional) that affect the structure and function of these tissues **[Patient Care, Medical Knowledge]**
3. To choose appropriate examination techniques and protocols for diagnosing disorders of the orbit, eyelids, and lacrimal system **[Patient Care, Medical Knowledge, Practice-Based Learning & Improvement]**
4. To select from among the various imaging and ancillary studies available those that are most useful for the particular patient **[Patient Care, Medical Knowledge]**

Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice]

5. To develop appropriate differential diagnoses for disorders of the orbital and periorbital tissues [**Patient Care, Medical Knowledge**]
6. To compare the indications for enucleation, evisceration, and exenteration [**Patient Care, Medical Knowledge**]
7. To communicate informed consent of all procedures undergoing surgery **Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice, Communication skills, Professionalism]**
8. To distinguish between functional and cosmetic indications in the surgical management of eyelid and periorbital conditions [**Patient Care, Medical Knowledge**]
9. To outline the principles of medical and surgical management of conditions affecting the orbit, eyelids, and lacrimal system [**Patient Care, Medical Knowledge**]
10. To recognize the major postoperative complications of orbital, eyelid, and lacrimal system surgery [**Patient Care, Medical Knowledge, Practice-Based Learning & Improvement]**

OCULOPLASTICS & ORBITAL SURGERY LEARNING ACTIVITIES BASED ON COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Comprehensive GME Core Curriculum						
Didactic lectures		X			X	X
Grand rounds	X	X	X	X	X	
Morning reports	X	X	X	X	X	

Journal Club	X	X		X	X	X
Comprehensive Clinic	X	X	X	X	X	X
Performance Quality Improvement Conference	X		X	X	X	X
M&M conferences	X	X	X	X	X	X
Resident group discussion with supervision		X	X	X		X

OCULOPLASTICS & ORBITAL SURGERY EVALUATION TOOLS FOR COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Evaluation by Faculty	X	X	X	X	X	X
Semi Annual Evaluation by PD	X	X	X	X	X	X
Evaluation by Staff	X			X	X	
Evaluation by Patients	X			X	X	
Evaluation by Peers	X	X	X	X	X	X
On call evaluation tool	X	X	X	X	X	X
Cataract evaluation	X	X	X		X	
OCEX	X	X	X	X	X	X



Patient Surveys	X			X	X	X
Portfolios	X	X	X		X	X
Procedures Log	X		X			
Self Evaluations			X	X	X	



SUMMARY OF ROTATION PEDIATRIC OPHTHALMOLOGY & ADULT STRABISMUS

WHERE:

1. Children's Hospital Medical Center of Akron; Pediatric Ophthalmology & Adult Strabismus continuity clinic for 36 months of residency (see rotation schedule for assignments)
2. Private Practices of Dr's Burnstine, Locastro and Hertle (see rotation schedule for assignments and location)
3. Surgery at Children's Hospital Medical Center of Akron and Akron City Hospital with above preceptors and supervisors

PRECEPTORS:

1. Robert Burnstine, MD
2. Anthony Locastro, MD
3. Richard Hertle, MD

GOALS and OBJECTIVES: SEE BELOW

ROTATION EVALUATION:

1. Through New Innovations Systems
2. Annual Feedback from Staff
3. Patient surveys

PEDIATRIC OPHTHALMOLOGY & ADULT STRABISMUS

OBJECTIVES

1. To describe evaluation techniques for young children that provide the maximum gain of information with the least trauma and frustration [***Patient Care, Medical Knowledge; Professionalism; Communication skills***]
2. To outline the anatomy and physiology of the extraocular muscles and their fascia [***Patient Care, Medical Knowledge***]
3. To explain the classification, diagnosis, and treatment options for amblyopia [***Patient Care, Medical Knowledge, Practice-Based Learning & Improvement***]
4. To describe the commonly used diagnostic and measurement tests for strabismus [***Patient Care, Medical Knowledge, Practice-Based Learning & Improvement***]

5. To classify the various esodeviations and exodeviations and describe the management of each type [***Patient Care, Medical Knowledge***]
6. To identify vertical strabismus and special forms of strabismus and formulate a treatment plan for each type [***Patient Care, Medical Knowledge***]
7. To list the possible complications of strabismus surgery and describe guidelines to minimize them [***Patient Care, Medical Knowledge, Practice-Based Learning & Improvement; Professionalism***]
8. To understand the informed consent for surgery in a pediatric patient [***Patient Care, Medical Knowledge, Practice-Based Learning & Improvement; Professionalism; Communication skills***]
9. To differentiate among various causes of congenital and acquired ocular infections in children and formulate a logical plan for the diagnosis and management of each type [***Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice***]
10. To list the most common diseases and malformations of the cornea, lacrimal drainage system, anterior segment, and iris seen in children [***Patient Care, Medical Knowledge***]
11. To describe the diagnostic findings and treatment options for childhood glaucoma [***Patient Care, Medical Knowledge, Practice-Based Learning & Improvement***]
12. To identify common types of childhood cataracts and other lens disorders [***Patient Care, Medical Knowledge***]
13. To outline a diagnostic and management plan for childhood cataracts [***Patient Care, Medical Knowledge, Practice-Based Learning & Improvement***]
14. To identify appropriate diagnostic tests for pediatric uveitis [***Patient Care, Medical Knowledge, Practice-Based Learning & Improvement***]

PEDIATRIC AND ADULT STRABISMUS LEARNING ACTIVITIES BASED ON COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based	Interpersonal & Communication	Professionalism	Systems-Based
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			Learning & Improvement	Skills		Practice
Comprehensive GME Core Curriculum						
Didactic lectures		X			X	X
Grand rounds	X	X	X	X	X	
Morning reports	X	X	X	X	X	
Journal Club	X	X		X	X	X
Comprehensive Clinic	X	X	X	X	X	X
Performance Quality Improvement Conference	X		X	X	X	X
M&M conferences	X	X	X	X	X	X
Resident group discussion with supervision		X	X	X		X

PEDIATRIC AND ADULT STRABISMUS EVALUATION TOOLS FOR COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Evaluation by Faculty	X	X	X	X	X	X
Semi Annual Evaluation by PD	X	X	X	X	X	X
Evaluation by Staff	X			X	X	



Evaluation by Patients	X			X	X	
Evaluation by Peers	X	X	X	X	X	X
On call evaluation tool	X	X	X	X	X	X
Cataract evaluation	X	X	X		X	
OCEX	X	X	X	X	X	X
Patient Surveys	X			X	X	X
Portfolios	X	X	X		X	X
Procedures Log	X		X			
Self Evaluations			X	X	X	

**SUMMARY OF ROTATION
RETINA**

WHERE:

1. Akron City hospital; Retina continuity clinic for 36 months of residency (see rotation schedule for assignments)
2. Private Practices of Dr's Tsai, Lamkin and Hull (see rotation schedule for assignments and location)
3. Surgery at Akron City Hospital with above preceptors and supervisors

PRECEPTORS:

1. Jeff Lamkin, MD
2. Thomas Tsai, MD
3. Thomas Hull, MD
4. Charles A Peter, MD

GOALS and OBJECTIVES: SEE BELOW

ROTATION EVALUATION:

1. Through New Innovations Systems
2. Annual Feedback from Staff
3. Patient surveys

VITREORETINAL DISEASES

OBJECTIVES

1. To describe the basic structure and function of the retina and its relationship to the vitreous and choroids [***Patient Care, Medical Knowledge***]
2. To recognize specific pathologic processes that affect the retina or vitreous [***Patient Care, Medical Knowledge***]
3. To choose appropriate methods of examination and ancillary studies for the diagnosis of vitreoretinal disorders [***Patient Care, Medical Knowledge, Practice-Based Learning & Improvement***]
4. To incorporate data from major prospective clinical trials in the management of selected vitreoretinal disorders [***Patient Care, Medical Knowledge, Practice-Based Learning & Improvement***]
5. To understand the informed consent for surgery for various vitreoretinal procedures and communication with the patient [***Patient Care, Medical Knowledge, Practice-Based Learning & Improvement; Professionalism; Communication Skills***]
6. To explain the principles of medical and surgical treatment of vitreoretinal disorders [***Patient Care, Medical Knowledge, Practice-Based Learning & Improvement***]

UVEITIS

OBJECTIVES

1. To outline the immunologic and infectious mechanisms involved in the occurrence and complications of uveitis and related inflammatory conditions, including acquired immunodeficiency syndrome (AIDS) [***Patient Care, Medical Knowledge***]
2. To identify general and specific pathophysiological processes that affect the structure and function of the uvea, lens, intraocular cavities, retina, and other tissues in acute and chronic intraocular inflammation [***Patient Care, Medical Knowledge***]

3. To choose appropriate examination techniques and relevant ancillary studies
[Patient Care, Medical Knowledge, Practice-Based Learning & Improvement]
4. To develop appropriate differential diagnoses for ocular inflammatory disorders
[Patient Care, Medical Knowledge, Practice-Based Learning & Improvement]
5. To describe the principles of medical and surgical management of uveitis and related intraocular inflammation, including indications for and complications of immunosuppressive agents
[Patient Care, Medical Knowledge, Practice-Based Learning & Improvement, Systems-Based Practice]
6. To describe criteria that can be applied to differentiate the masquerade syndromes from true uveitis
[Patient Care, Medical Knowledge, Practice-Based Learning & Improvement]

VITREORETINAL DISEASE/VEITIS LEARNING ACTIVITIES BASED ON COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Comprehensive GME Core Curriculum						
Didactic lectures		X			X	X
Grand rounds	X	X	X	X	X	
Morning reports	X	X	X	X	X	
Journal Club	X	X		X	X	X
Comprehensive Clinic	X	X	X	X	X	X
Performance Quality Improvement Conference	X		X	X	X	X
M&M conferences	X	X	X	X	X	X
Resident group discussion with supervision		X	X	X		X

VITREORETINAL DISEASE/VEITIS EVALUATION TOOLS FOR COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Evaluation by Faculty	X	X	X	X	X	X



Semi Annual Evaluation by PD	X	X	X	X	X	X
Evaluation by Staff	X			X	X	
Evaluation by Patients	X			X	X	
Evaluation by Peers	X	X	X	X	X	X
On call evaluation tool	X	X	X	X	X	X
Cataract evaluation	X	X	X		X	
OCEX	X	X	X	X	X	X
Patient Surveys	X			X	X	X
Portfolios	X	X	X		X	X
Procedures Log	X		X			
Self Evaluations			X	X	X	

**SUMMARY OF ROTATION
LOW VISION REHABILITATION**

WHERE:

1. United Disabilities Services/Low Vision Services; Low Vision Rehabilitation continuity clinic for 36 months of residency (see rotation schedule for assignments)
2. Private Practices of Cheryl Reed, OD (see rotation schedule for assignments and location)

PRECEPTORS:

1. Cheryl Reed, OD

GOALS and OBJECTIVES: SEE BELOW

ROTATION EVALUATION:



1. Through New Innovations Systems
2. Annual Feedback from Staff
3. Patient surveys

LOW VISION REHABILITATION

OBJECTIVES

1. To describe the various methods of optical and other rehabilitation methods for patients who are visually impaired in a caring and empathetic manner (***Patient Care, Medical Knowledge, Systems Based Practice; communications skills; Professionalism***)
2. To recognize the significant co-morbidities that impact low vision rehabilitation. (***Patient Care, Medical Knowledge, Systems Based Practice; Professionalism***)
3. To discuss the different types of low vision devices used for refractive correction (***Patient Care, Medical Knowledge; PBLI***)
4. To identify the locations of special needs services for visually impaired patients (***Patient Care, Systems Based Practice, Professionalism***)
5. To understand and recognize the needs of a visually impaired patients so that appropriate therapy may be offered to the patients (***Practice Based Learning, Systems Based Practice, Professionalism; Communication Skills; Professionalism***)

LOW VISION LEARNING ACTIVITIES BASED ON COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Comprehensive GME Core Curriculum						
Didactic lectures		X			X	X
Grand rounds	X	X	X	X	X	
Morning reports	X	X	X	X	X	
Journal Club	X	X		X	X	X
Comprehensive Clinic	X	X	X	X	X	X



Performance Quality Improvement Conference	X		X	X	X	X
M&M conferences	X	X	X	X	X	X
Resident group discussion with supervision		X	X	X		X

LOW VISION EVALUATION TOOLS FOR COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Evaluation by Faculty	X	X	X	X	X	X
Semi Annual Evaluation by PD	X	X	X	X	X	X
Evaluation by Staff	X			X	X	
Evaluation by Patients	X			X	X	
Evaluation by Peers	X	X	X	X	X	X
On call evaluation tool	X	X	X	X	X	X
Cataract evaluation	X	X	X		X	
OCEX	X	X	X	X	X	X
Patient Surveys	X			X	X	X
Portfolios	X	X	X		X	X
Procedures Log	X		X			



Self Evaluations			X	X	X	
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SUMMARY OF ROTATION OPHTHALMIC PRACTICE

WHERE:

1. Akron City Hospital; Ophthalmic Practice continuity clinic for 36 months of residency (see rotation schedule for assignments)

GOALS and OBJECTIVES: SEE BELOW

ROTATION EVALUATION:

1. Through New Innovations System
2. Annual Feedback from Staff
3. Patient surveys

OPHTHALMIC PRACTICE

1. To describe the fundamentals and principles of medical ethics in ophthalmology (e.g., patient care decision-making, informed consent, competency issues, ethics of inter-collegial relations risk management [***Practice Based Learning, Systems Based Practice, Professionalism; Communication Skills; Professionalism***])

2. To describe the basics of ophthalmic practice management (e.g., contractual negotiations, hiring and supervising employees, financial management, working with associates, billing) [***Practice Based Learning, Systems Based Practice, Professionalism; Communication Skills; Professionalism***]

3. To describe the basics of the health care system and reimbursement, as appropriate to the local, regional, and national market of the trainee (e.g., third party payers, managed care, Medicare (USA), medical documentation, Medicaid (USA), private insurance, nationalized health care systems (UK, Canada) (Course taken by residents using UIC GME curriculum on competencies) [***Practice Based Learning, Systems Based Practice***])

4. To describe and apply principles of medical ethics (e.g., life and death patient care decision-making, ethics of optometric relations, documentation requirements, claims in risk management) [***Practice Based Learning, Systems Based Practice, Professionalism; Communication Skills; Professionalism***]

5. To describe and apply the more advanced aspects of practice management (e.g., business models, documentation requirements and coding, privacy requirements, dealing with patients or employees with disabilities) [***Practice Based Learning, Systems Based Practice, Professionalism;***]



Communication Skills; Professionalism]

6. To describe and apply the more advanced aspects of health care reimbursement (e.g., physicians' role in managed care organizations, administrative role, third party reimbursement, capitated programs) **[Practice Based Learning, Systems Based Practice, Professionalism; Communication Skills; Professionalism]**

OPHTHALMIC PRACTICE LEARNING ACTIVITIES BASED ON COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	Systems-Based Practice
Comprehensive GME Core Curriculum						
Didactic lectures		X			X	X
Grand rounds	X	X	X	X	X	
Morning reports	X	X	X	X	X	
Journal Club	X	X		X	X	X
Comprehensive Clinic	X	X	X	X	X	X
Performance Quality Improvement Conference	X		X	X	X	X
M&M conferences	X	X	X	X	X	X
Resident group discussion with supervision		X	X	X		X

OPHTHALMIC PRACTICE EVALUATION TOOLS FOR COMPETENCIES

	Patient Care	Medical Knowledge	Practice-Based	Interpersonal & Communication	Professionalism	Systems-Based
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			Learning & Improvement	Skills		Practice
Evaluation by Faculty	X	X	X	X	X	X
Semi Annual Evaluation by PD	X	X	X	X	X	X
Evaluation by Staff	X			X	X	
Evaluation by Patients	X			X	X	
Evaluation by Peers	X	X	X	X	X	X
On call evaluation tool	X	X	X	X	X	X
Cataract evaluation	X	X	X		X	
OCEX	X	X	X	X	X	X
Patient Surveys	X			X	X	X
Portfolios	X	X	X		X	X
Procedures Log	X		X			
Self Evaluations			X	X	X	



B. GOALS & OBJECTIVES BY LEARNING ACTIVITIES

1. Interpersonal & Communication Skills

Goals and Objectives

During training through the Summa Health Systems Ophthalmology residency program the residents:

- Must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, patients' families, and professional associates.
- Are expected to create and sustain a therapeutic and ethically sound relationship with patients
- Use effective listening skills, be elicited and provide information using effective nonverbal, explanatory, questioning, and writing skills
- Work effectively with others as a member or leader of a health care team or other professional group

Learning activities (complete one activity of 1 or 2 AND others to be completed during residency)

Didactic activities

1. Structured Journal club discussing communication skills as a group
2. Completion of a self learning online module administered by the UIC

Graduate Core Curriculum

- a. 101 Medical Professionalism
- b. 103 Leading the Health Care Team
- c. 107 Teaching Skills
- d. 108 Managing a Successful Practice
- e. 111 Communication Skills
- f. 112 Medical & Clinical Ethics
- g. 113 Medicine and Culture

The modules have pre and post tests that monitor improvement in this competency. The course progress is monitored by the Program Director or a designated individual. These must be completed prior to graduation.

Experiential learning activities

1. At Akron City Hospital, Akron Children's Hospital, and Surgery Centers
 - a. Learn how to effectively communicate with patients, especially the uninsured and those with limited coverage, and explain the options available. Learn these skills by obtaining history, obtain informed consent for surgical

- procedures, communicating on the telephone with attendings, present a case in the clinic, writing or dictating consultation notes to consulting physicians, and explaining the details of a diagnosis and therapeutic plan to patients and families.
- b. Learn to communicate with the clinic staff and social workers to ensure that care is provided to these groups of patients.
 - c. Learn to communicate with individuals in the clinic who liaison with pharmaceutical companies that provide medication assistance and other agencies that provide free glasses.
 - d. Learn communication with non-English speaking patients and those from diverse ethnic backgrounds
 - e. Learn communication with patients who have hearing impairments through sign language, interpreters and families.
2. The expectations and duties of Chief resident at the Summa Health System are outlined in the resident handbook. This activity during residency designates the resident as part of a healthcare team that will work effectively with others.

Medical Records Completion

1. See policy for medical record completion in residency handbook

Methods of Evaluation

1. Online evaluation by new innovations system during each rotation
2. Annual evaluations from patient surveys and on-the-spot patient surveys
3. Annual evaluations from technical staff
4. Medical Chart audits for legibility
5. OCEX tool
6. Communication from medical records for timely completion
7. Semi annual evaluations by Residency program director

2. Practice Based Learning Improvement

Goals

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

Objectives

Residents are expected to:

- Analyze practice experience and perform practice-based improvement activities using a systematic methodology (**Self-improvement project**)

- Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems (**journal club; case presentation and rounds**)
- Obtain and use information about their own population of patients and the larger population from which their patients are drawn (**journal club; case presentation and rounds**)
- Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic **effectiveness (journal club, case presentations)**
- Use information technology to manage information, access on-line medical information; and support their own education (**journal club, case presentations**)
- Facilitate the learning of students and other health care professionals (**case presentations (see below)**)

Activities

1. Residents must, with the guidance of the Program Director, develop a learning activity which requires the resident to analyze and improve his or her own practice behaviors. The assignment will be made annually by the Chief Resident
The process should include:
 - a. Identification of any problems which may surface based on self-reflection or through feedback from evaluations and the discussion of identified problems with the faculty and/or Program Director.
 - b. The resident is to provide a summary of the issues identified, as well as, a written plan for addressing the issues.
 - c. If applicable, the resident is to quantify the problem (using numbers or percentages)
 - d. Document the process
 - e. Document outcome in numbers or percentages (if applicable) after a finite period. Include final results with self-evaluation and discuss with Program Director at semi-annual evaluation
2. Learning of evidence based medicine skills
 - a. Grand round or case presentations will include evidence based data whenever applicable.
 - b. Journal clubs to be used for this activity
 - c. Resident presentation assessed using evaluation form which includes evaluation of the use of evidence based data
 - d. Knowledge and use of evidence based data also reviewed by Program Director during semi-annual evaluation
 - e. All residents must complete a self directed online learning module #106 titled "Life Long Learning and Evidence Based Medicine" administered by

the UIC GME curriculum that serves as a didactic learning activity and teaches residents the basis of this activity. The course progress made by residents is monitored by the Program Director or a designated individual. This online structured process provides feedback to the Program Director or Faculty. The progress on completion is evaluated by the Program Director on a semi-annual basis.

3. Quality improvement project
 - a. Development of a project in which at least 2-3 residents participate
 - b. Quality issue to be identified. (typically at Performance Quality Improvement meeting)
 - c. Project should have faculty supervisor and involve techs and administrator
 - d. QI improvement project should be measurable. Examples: percentage reduction in waiting time in clinic; improvement in performance scores
 - e. Project results presented at forum such as QI meeting; faculty meeting or elsewhere
4. Teaching skills
 - a. Development of Resident teaching skills is an important part of the education process.
 - b. Activities include:
 - **Case presentations, grand rounds, M&M, and journal clubs:**
 - **Small group interactive discussions** in the resident clinics and self-study sessions.
 - **Teaching medical students and other residents** rotating through the ophthalmology service.
 - **Teaching residents on** other services such as internal medicine and emergency medicine.
 - A **self-directed online learning module course 107** titled "Teaching Skills for the Physician Educator" offered by the UIC GME core curriculum. All residents are required to complete this module that includes evaluation through a pre and post test that is monitored by the Program Director.
5. Residents teaching opportunities include:
 - a. Teaching patients/families during every patient encounter, with direct observation of their teaching skills by faculty. Formative evaluation of some of these skills is documented using OCEX tool.

- b. Teaching members of the faculty, medical students, and allied health staff during unit Performance Quality Improvement (Unit) conferences throughout the year and via various clinical presentations, grand rounds, journal clubs and conferences.
- c. Teaching residents in other specialties and medical students through lectures on the red eye and eye emergencies.

EVALUATION AND FEEDBACK

Residents will **receive feedback about their teaching effectiveness** so that they can incorporate this feedback into their daily practice through:

1. Formative evaluations after patient encounters from senior residents and faculty
2. Written feedback from journal club and case presentation using a form that evaluates their presentation
3. Feedback through New Innovations systems during rotation evaluation
4. Written or oral feedback from Program Director or Chairs of other departments where residents make presentations.
5. Written feedback using an evaluation tool from medical students rotating through Ophthalmology.
6. Feedback from patients and family from office initiated patient surveys.

3. Professionalism

Goals

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Objectives

Residents must

- Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development.
- Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- Demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities

Learning Activities

1. Morning report
2. Annual Review of Karl Golnik Professionalism CD
3. Lecture on Professionalism by Dr. Charles A. Peter, MD

4. Completion of UIC GME Core Curriculum Modules
 - 101 Medical Professionalism
 - 106 EBM and Life-long Learning
 - 108 Managing the Medical Practice
 - 112 Medical & Clinical Ethics
 - 113 Medicine and Culture

These modules have pre and post tests that monitor improvement in this competency. The course progress is monitored by the Program Director or a designated individual. These must be completed prior to graduation.

5. **Reading of** “Your Guide to Service Excellence at Summa Health System: Standards of Behavior.” All faculty staff and residents are required to attest that they will abide by these standards of behavior while at the institution. The text of the document provides sensitivity training.

Methods of Evaluation

Online evaluation utilizing the New Innovations system during each rotation

1. Annual evaluations from patient surveys and spot patient surveys
2. Annual evaluations from technical staff
3. OCEX tool
4. Formative feedback from Faculty Chief Residents and Technical Staff
5. Semi-annual evaluations by Residency program director

See Summa Handbook for Residents for further information regarding policies and procedures related to dealing with lapses in professional behavior by residents.

4. Systems Based Practice

Goals

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as, the ability to call effectively on other resources in the system to provide optimal health care.

Objectives

Residents are expected to:

- Work effectively in various health care delivery settings and systems relevant to ophthalmology
- Coordinate patient care within the health care system relevant to ophthalmology



- Incorporate considerations of cost awareness and risk-benefit analysis in patient care and/or population-based care as an appropriate advocate for quality patient care and optimal patient care systems
- Work in inter-professional teams to enhance patient safety and improve patient care quality
- Participate in identifying system errors and in implementing potential systems solutions.

Learning Activities

Didactic

1. Cost containment lecture
2. Attending coding seminar in the Department or at the AAO meeting
3. Completion of UIC GME Core Curriculum Modules
 - 102 Evolution, Organization & Finance
 - 103 Leading the Health Care Team
 - 104 Quality, Cost, & Resource Mgmt.
 - 105 Regulatory Systems & Agencies
 - 108 Managing the Medical Practice
 - 111 Communication Skills
 - 115 Patient Safety

These modules have pre and post tests that monitor improvement in this competency. The course progress is monitored by the Program Director or a designated individual. These must be completed prior to graduation.

Experiential

1. Participation in Performance Quality Improvement meetings.
 - a. Monthly meeting will be attended by Administrator, Technicians, Residents, Program Director, Faculty and Office staff
 - b. System based issues will be discussed including system problems or errors
 - c. Root cause analysis of Systems errors or problems are conducted with active resident participation
 - d. Plans for improvement decided using team approach and including implementation with time lines
 - e. Process of improvement documented using a structured checklist maintained by department secretary
2. M & M conferences may also identify system based errors and will document any such errors along with a plan for correction.



Methods of Evaluation

1. Online evaluations utilizing the New Innovations system during each rotation
2. Completion of activity related to systems based error identified during Performance Quality Improvement Conference in which active resident participation was documented in the minutes
3. Annual evaluations from patient surveys
4. Annual evaluations from technical staff
5. Formative feedback from Faculty Chief Residents and Technical Staff
6. Semi- annual evaluations by Residency program director

DEPARTMENT OF OPHTHALMOLOGY

RESIDENT RESPONSIBILITIES

A. OUTPATIENT CLINICS & SUPERVISION

Most ophthalmic care is provided on an outpatient basis. Patients expect and deserve to be seen promptly at the time of a scheduled appointment. Please do not schedule patients when such responsibility clearly cannot be fulfilled. Patients also expect and deserve to be seen repeatedly by the same resident physician and by the same attending physician. Proper scheduling of return visits will facilitate such continuity of care.

Each resident physician is assigned an examining room. Please assume responsibility and take pride in the appearance and function of the equipment in that room. Remember the importance of patient confidentiality and note that voices tend to carry in the clinic. Doors to examining rooms must be locked at all times when the clinic is not occupied. Patients' charts must be finished promptly and returned to the clinic receptionist daily.

Scheduled outpatients take priority over non emergent inpatient examinations, unscheduled outpatients, and surgery outside of regularly scheduled times. The authority for determining priority of responsibility rests with the clinic coordinator. Patient screening by ophthalmic nurses and technicians is a privilege. **ALL** histories taken by nurses and technicians should be verified and amplified. Technical data should be reviewed and measurements repeated if unexpected results have been obtained.

New PGY2s should have manifest refractions double checked by one of the technicians, senior resident or attending especially if the patient is in the clinic primarily for a glasses prescription. This should be done for at least 3 months.

RESIDENT SUPERVISION

- 1. All patients seen by residents must be directly supervised by an attending when patients are in the clinic**
- 2. Under unusual circumstances where the attending faculty is busy in the clinic with another resident with a complex problem or with a minor procedure or laser procedure, and the patient has to leave, indirect supervision is acceptable with the attending being on site and is left to the judgment of the attending faculty physician supervising the clinic.**

Technician duties: The ophthalmic technicians and nurse are primarily present in the clinic to assist with the examination of the patient. The primary responsibility of patient care and documentation in the record lies with the resident. If the clinic

is short of ophthalmic technicians or the technicians for some reason are busy with other duties, it is the responsibility of the resident to work up the patient so that patient flow is maintained and patients are seen in a timely fashion.

In order to support the residency educational initiative, a higher degree of technical support is afforded the PGY IIIs & PGY IVs, while the assessment performed for a PGY II is more "restrictive. The patient assessment routinely performed by the Tech/RN is, as follows:

PGY II's (1st 6 months) - Assist with triage assessment including medical history, medications and visual acuity.
(2nd 6 months) – Same, but include lensometry, check pupils, extraocular muscles and confrontational fields.

PGY IIIs & IVs – same as above including IOP check, refraction and dilation.

Note other responsibilities related to patient examination are that of the resident assigned care of the patient. Also it is the responsibility of the resident to cross check all information obtained by the technician;

B. INPATIENT AND AMBULATORY SURGERY & SUPERVISION

Each patient will have a history and physical examination. A complete eye examination must be performed and recorded by the resident physician involved in the surgical or medical care of the patient.

A faculty-attending physician is required for all patients admitted to any affiliated hospital and **MUST** be notified at the time of admission in all instances. Home telephone numbers for attending faculty physicians at each hospital are listed in this document and available in the eye clinic.

Informed consent is required for all surgical procedures. Usually considerable discussion will have occurred between the patient and the attending physician, but it is the responsibility of the resident physician to review the patient's understanding of the risks and benefits of the proposed procedure if the consent has not been signed. The operation is described best on the operative permit in lay terms (e.g., "repair detached retina"). Patient or guardian must sign the operative permit and the act of signing must be witnessed.

Consultations requested by other services will be performed on the day requested in all instances.

The responsibility of the consulting ophthalmologist is to provide a complete and thorough consultation rather than merely to perform certain tests, which might have been requested by the physician requesting the consultation. If a consultation request is considered inappropriate by the ophthalmology resident, it should be performed cheerfully but reported later to the chief resident. Hospitalized patients should be brought to the clinic for examination whenever possible to provide the best possible ophthalmic examination. All inpatient consults brought to the clinic should be seen by an attending physician that day. **Please see section on inpatient consults for additional details**

RESIDENT SUPERVISION

1. All consults seen by residents must be directly supervised by an attending when patients are in the clinic

2. Consults after hours: Direct supervision is available by phone with the attending physician on call or if the patient is a private patient of an attending faculty physician that attending should be contacted if necessary. Consults should be followed up in the ophthalmology clinic at the hospital or the private office of an attending faculty physician.

C. OPERATING ROOM RESPONSIBILITIES, POLICIES & SUPERVISION

A resident physician should be in the operating room/holding at least 20 minutes prior to the scheduled start of surgery. The resident physician will ascertain that all preoperative orders, H&P and consent have been completed and will begin to prepare the patient for surgery. The resident physician will attend any patient receiving general anesthesia from the time of induction until the time of delivery to the recovery room. Resident physicians not directly involved in any surgical procedure will observe procedures whenever possible.

All surgeries that a resident physician participates in have to be recorded in the online ACGME surgical log. The residents are responsible for ensuring that their surgical logs are up to date and entries within two weeks after the surgical procedure.

D. RELATIONSHIP TO ATTENDING PHYSICIAN

The care of all patients, whether in the hospital or in the clinic, is the ultimate responsibility of an attending physician. Resident physicians work at all times under the direction of an attending physician and benefit from his/her guidance while the patient benefits from his/her prior experience. In most cases the attending physician is required to document involvement in patient care through appropriate entries in the patient's record in order to ensure that payment will be made for hospital and professional services.

E. MEDICAL RECORDS AND TRANSCRIPTION

Prompt and accurate completion of medical records is an essential part of patient care. Hospital charts are not to be removed from the premises.

All patient-related dictation should be completed by transcription services at the hospital where the patient has received care. **Operative records must be completed promptly on the day of the surgical procedure at ACH and at the surgery centers. NO EXCEPTIONS.** Samples of operative reports of commonly performed procedures are attached in the appendix. Discharge summaries must be completed on the day of hospital discharge.

Feedback on completion is provided directly by Medical Records and through the Program Director if delinquent.

F. AFTER HOURS ON CALL & SUPERVISION

ALL CALL IS HOME-CALL. Night and weekend call coverage is as follows:

Resident On Call begins at 7:00 am and call ends the next day at 6:59 AM. A PGY-IV resident will be available at all times to assist during the first 4 weeks of the academic year. For the first 4 weeks the PGY-IIIs are expected to discuss every patient that they see on call with a senior resident for any reason including being called to more than one hospital at the same time.

Pagers will be carried by the resident on-call at all times. Each resident is responsible for his/her pager and will arrange for prompt repair service with Summa's Telecommunication Department on the ACH Campus in cases of malfunction.

Changes to the On Call schedule are the responsibility of the resident on call. The Residency Program Coordinator must be informed in writing of any changes made to the published call schedules at Summa and at Children's Hospital Medical Center of Akron.

Resident supervision

- a. Attending physician faculty may be Direct or indirect on call**
- b. Direct Supervision: The supervising physician is physically present with the resident and patient**
 - The presence of the supervising Ophthalmology attending on call onsite with the resident will be determined after the resident on call communicates with the attending on call.
 - In other instances the ER attending faculty will provide direct supervision on call for patients in the ER
- c. Indirect Supervision:**
 - i. Direct supervision immediately available – The supervising physician is physically within the confines of the site of**

patient care, and immediately available to provide Direct Supervision

- **This scenario is not applicable to residents in Ophthalmology on call.**
- ii. **Direct supervision available – The supervising physician is not physically present within the confines of the site of patient care, is immediately available via phone, and is available to provide Direct Supervision**
 - **This is the default method of supervision for Ophthalmology attending**

Other policies on call

1. If a patient who previously has been cared for by an attending faculty physician in their private practice presents with an emergency to the Emergency Room, the resident should attempt to first inform that attending faculty and then determine the course of action. If the primary attending faculty was unavailable by phone or pager, the attending physician on call should then be notified and the course of action determined
2. The Department and hospital follow an escalation policy if the attending on call is unavailable. This includes contacting the Assistant Program, Director, Program Director and Chair and then the Hospital Administrator on call in that order.

G. OPHTHALMOLOGY CHIEF RESIDENT DUTIES

1. The senior residents (PGY-4) will serve as Chief Residents concurrently for 6 months or together with duties split as determined by the two residents.
2. The Chief Resident will be assigned several key duties:
 - a) To assure that there is timely and adequate preparation for Friday educational and intramural Basic Sciences meetings. This involves assignment of duties to the other residents in an equitable manner. Additionally, the Chief is ultimately responsible to record the content of the Category 2 Friday conferences for the program's recordkeeping. The Chief should coordinate this information and any media needs with the Program Director's secretary.
 - b) To assure resident coverage of all required and expected clinical duties. The Chief needs to proactively look at clinical and surgical coverage issues as they relate to call/vacations/conferences/holidays/weekends in coordination with the clinic Administrator, Program coordinator and Residency Program Director.
 - c) To assure resident attendance at required residency clinical and educational programs. The Chief can assign extra duties or call to

residents for chronic tardiness or absence. (Friday AM conferences, Pediatric, Basic Science, Unit Conference, Cleveland Ophthalmology Society, Post-Graduate Day are required.)

- d) To be the primary arbitrator of conflicts between residents, between the residency teaching staff and the residents, and between the Clinic/Diagnostic Center staff and the residents. The Chief will be the first person called when a teaching staff member has a difficulty with any resident. The Chief has the power to objectively investigate the complaint, make a decision and action plan, and then respond to the staff who lodged the complaint. If an acceptable compromise is reached, the Chief is then empowered to enforce the action.
If there is an unresolved conflict between the two senior residents or a resident and the Chief, a meeting of all the residents should be called to decide what is best and equitable for the residents and the residency. If the conflict cannot be solved after this, then the Chief will need to consult with the Program Director for direction.
- e) To be the role model for the junior residents in work ethic, professionalism, punctuality, and relationships to patients and health professionals. The Program Director will expect the Chief to achieve a high standard of performance and if not, will be relieved.

H. SUBSPECIALTY ROTATIONS

It is the resident's responsibility to show up on time at subspecialty rotations. It is also the resident's responsibility to notify the subspecialist if going to be late or unable to attend rotation.

Subspecialty Rotations

Low Vision	Thursday PM	Cheryl Reed, OD
Retina	Monday AM Wednesday PM Friday PM	Thomas Tsai, MD Thomas Hull, MD Jeffrey Lamkin, MD
Plastics	Monday All Day	Anthony Locastro, MD
Neuro	Wednesday AM or PM	James Bates, MD
Cornea OR	Wednesday AM Thursday AM	Lawrence Lohman, MD Marc Jones MD



Glaucoma	Tuesday PM Tuesday PM	Deepak Edward, MD Todd Woodruff, MD
CHMCA	Tuesday AM Thursday AM	Richard Hertle, MD Anthony Locastro, MD

I. RESIDENT DUTY HOURS AND THE WORKING ENVIRONMENT

Principles

Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. The residents must ensure that the learning objectives of the program are not comprised by excessive reliance to fulfill service obligations. Didactic and clinical education must have priority in the allotment of resident's time and energies. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

1. Duty Hours

a. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

b. ***Duty hours must be limited to 80 hours per week, averaged over a four-week period***, inclusive of all in-house call activities.

c. ***Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, education, and administrative activities.***

2. On-Call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal workday when residents are required to be immediately available in the assigned institution.

a. In-house call must occur no more frequently than every third night, averaged over a four-week period.

- b. ***Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, maintain continuity of medical and surgical care, transfer care of patients, or conduct outpatient continuity clinics.***
- c. No new patients may be accepted after 24 hours of continuous duty, except in outpatient continuity clinics. A new patient is defined as any patient for whom the resident has not previously provided care.
- d. ***At-home call (pager call) is defined as call taken from outside the assigned institution.***
 - 1) ***The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.***
 - 2) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
 - 3) The program director and the faculty will monitor the demands of at-home call in their program and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

3. Oversight

The Ophthalmology program has written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Monthly monitoring of duty hours is required with frequency sufficient to ensure an appropriate balance between education and service.

4. Violation of Duty Hour rules

If the resident, having tracked their duty hours, foresees a duty hour violation, they are to contact the Residency Director and/or Chair of the Department of Ophthalmology as soon as possible to 1) submit a duty



hour variance report for approval with justification or 2) to be removed from duty as soon as possible. ***A variance request must be well supported and be exceptional.***

5. Timely reporting of Duty Hours

Residents are personally responsible for tracking their own hours and providing truthful and accurate written documentation on provided cards. The preceding month's cards are due by the 5th or the Monday following the 5th of the next month. If they are not received by then, the resident will be removed from all duties until received. Any repeated violation of this deadline will result in reporting to the Department of Medical Education.



Residency in Ophthalmology Duty Hour Variance Request

Date/Time_____

Resident_____

Variance Request and Applicable Duty Hours rule

Resident Signature_____

Approved_____ Disapproved_____

Signature of Department Chair or Program Director



Summa Health System/Dept of Medical Education

VIOLATIONS OF WORK HOUR RULES

- 1st Offense: Written warning, placed in resident file.
- 2nd Offense: Probation, two months. Subsequent violation during probation may lead to further disciplinary action.
- 3rd Offense: Suspension, two weeks, without pay. May prolong training.
- 4th Offense: Meet with Residency Director and Vice-President of Medical Education. Consideration of dismissal.

FAILURE TO SUBMIT TIME RECORDS

Same penalties.

J. FATIGUE

The **SAFER** (Sleep, Alertness, and Fatigue Education) from the American Academy of Sleep Medicine. Powerpoint presentation will be available and presented on a yearly basis.

Annual Review of this PowerPoint presentation is mandatory for the residents.

K. CASE LOG ENTRIES

- a. The resident case log system was created by the Accreditation Council for Graduate Medical Education (ACGME) and its use by all ophthalmology training programs is mandated by the Ophthalmology Residency Review Committee (RRC), a branch of the ACGME.
- b. All procedures must be documented and must be completely regularly and updated at least every two weeks
- c. Education on the use of the online case Log Entry will be provided by the Program Director or person designated to provide the education. Any issues relate to how a procedure should be logged should be discussed with the Program Director
- d. The Residency Program Director will review the Case Logs every two months
- e. Annual comparative data from ACGME will be shared with the faculty and the residents.

DEPARTMENT OF OPHTHALMOLOGY

EDUCATIONAL ACTIVITIES

Definition

An overview of the continuing education programs (i.e., Journal Clubs, Basic Science, Grand Rounds, etc.) offered to Summa Health System residents, faculty and staff, community, and visiting ophthalmologists is summarized in the following sections. Schedules are distributed and posted on a web calendar by the residency coordinator on a monthly basis with location and scheduling information given for current programs. Each resident is required to attend all sessions unless in surgery or handling an emergency and their responsibilities are assigned on a yearly basis.

Description

The rotations and curriculum of Summa Health System's Ophthalmology Residency Program is designed to fulfill the requirements set forth by the Residency Review Committee (RRC) for Ophthalmology.

Attendance is taken for all conferences and logged on the Google Calendar's Documentation site. Any unexcused absence will result in mandatory 'academic remediation.'

Unexcused absences include:

- Arrival more than 15 minutes after the scheduled start of the conference
- Departure before the scheduled conclusion of the conference
- Scheduled patient care

All excused absences must be approved by the Residency Director and may include:

- Vacation
- Fellowship interviews
- Away conferences
- Family emergencies
- Illness
- Urgent patient care or in operating room for an urgent procedure in which the resident had primary care of the patient



- Unusual/uncommon surgical procedure by an attending where resident has participated in patient care and has made an advance request to be present at the procedure

Mandatory Educational Activities

A. INTRAMURAL

Ophthalmology Basic and Clinical Science Course: Conducted as a series of lectures by members of the resident staff and faculty, this instructional program is based on the Ophthalmology Basic and Clinical Science published by the American Academy of Ophthalmology and is instituted as a core lecture group and repeated on a yearly basis. The lecture titles will be reviewed by the members of the Resident Education Committee. Lectures are given either on Friday mornings, which is assigned for resident education, or as previously determined by the Program Director and the lecturing physician

Ophthalmology Clinical Case Conference/Morning Report: This session reviews patient care activities of the Ophthalmology Department. This conference takes place each Friday at 7 A.M. from July through June. In addition, other operational issues within the department will be discussed with the residents. Each week, patient cases will be presented that represent some of the following: common and unusual diagnoses, problems related to diagnosis, problems related to management, and interesting and unusual findings.

Grand Rounds: Grand Rounds are held every 3- 4 months. The timing of such rounds will be determined by the attending physician conducting the rounds. Each resident is required to be present and will be assigned to participate as necessary throughout the year. Outside speakers will also be invited to present at grand rounds on topics determined by the faculty.

Post Graduate Day: Held the first Monday in June each year. Resident Research Day offers an opportunity for the residents to present reports of their research. Each resident is required to present one time during their three years in the residency program. A dinner to honor our graduating residents is held at the end of the Academic Year.

Other Regular Meetings

Morbidity and Cataract Conference is held bi-annually as an opportunity for residents to present complications of cataract surgery, system based errors or issues surrounding other surgical procedures.

Fluorescein Angiography Conference: Arranged by the Retina Service, the Fluorescein Angiography Conference is convened monthly to review current angiograms representing disease entities, unusual abnormalities, and controversial interpretations of angiographic findings. The Conference is attended by the residents, retina faculty members, other faculty members and medical students.

Journal Club: The subspecialty directed Journal Club, with a faculty member serving as host, meets quarterly as scheduled to discuss scientific material published in current issues of the major ophthalmology journals. Articles are assigned on a rotating basis to residents, who are required to participate in this educational activity. Invited guests also may participate.

Resident Case Presentation: Two residents per month are scheduled to present a case presentation.

B. REGIONAL & NATIONAL CONFERENCES

1. Cleveland Clinic Cole Eye Institute: Programs in Ophthalmology held on a Saturday, once a month.
2. Cleveland Ophthalmological Society: A half-day education conference held four times a year.
3. AAO Meeting: Senior residents attend the Annual American Academy of Ophthalmology Meeting
4. ARVO/ASCRS: Any resident whose paper/poster is accepted by ARVO or ASCRS may attend that conference.
5. Will's Course: 2nd year residents attend the Wills Eye Institute's Annual Ophthalmology Review Course
6. Harvard Medical School's Intensive Cataract Surgical Training Conference: 2nd year residents attend.
7. Orbital Anatomy/Dissection Course: Location TBA. 1st year residents attend.

DEPARTMENT OF OPHTHALMOLOGY

PUBLICATIONS & RESEARCH

The participation of residents in research projects and is meant to provide an academic and scholastic experience to the resident in training.

The research protocol includes review of relevant literature, formulation of a hypothesis, IRB or IACUC training, and consultation with a statistician; submission of a project to the IRB or animal committee followed by execution of the project.

To help with the orientation process, an introductory lecture covering the concepts and requirements for research at Summa is provided by the Department of Research.

Completion of one research project is mandatory for a resident to graduate with results being presented as stated below. It is preferred that the planning process be completed at the latest by late in the PGY2 year and work on the project completed by the end of the PGY3 year.

Funds may be available using a grant application process through the Summa Foundation to help with costs incurred in research projects. These activities are supervised by one of the faculty members who serve as a mentor during the process.

It is expected the results of the research project be presented at resident research day and/or a regional or national meeting and also, hopefully, would result in a publication in a peer reviewed journal

DEPARTMENT OF OPHTHALMOLOGY

VACATION/LEAVE POLICY

1. Three weeks vacation time per year with no carry-over. One week must be taken before January 1.
2. All vacation requests must be submitted to the Chief Resident for approval, then to the Department Secretary. Requests for vacation time will be on a seniority basis and are due by **July 15** for the first half of the academic year and **December 15** for the second half.
3. No vacation time in July or the last 2 weeks of June.
4. Vacation may be taken no longer than one week at a time, unless approved by Residency Director.
5. Two residents can take vacation time at the same time as long as issues related to clinic and call coverage are adequate as determined by the clinic supervisor. A minimum of three residents are to be present to cover the clinic at every clinic session.
6. **Vacation must be taken in consecutive workday intervals. Senior residents may split one (1) week vacation time, if needed, to pursue employment/fellowship opportunities.**
7. Decisions of Program Director will be final as to scheduling of vacation time
8. Priorities to be considered are:
 - a. Welfare and safety of the patients of the Ophthalmology Center and patients of Summa Health System.
 - b. Effect on educational program.
9. Senior Residents may be granted five (5) days to pursue practice or fellowship positions. Written requests for these days should be made at a minimum of two weeks in advance and submitted to the Chief Resident, then submitted to the Program Coordinator who in turn will convey to the Department Secretary. Any additional time will be deducted from the resident's vacation time.
10. There will be three (3) days paid for a death in the immediate family and three (3) days paid for Paternity Leave. Refer to Summa Health System's policies regarding medical, family, maternity, and personal leave. Any leave greater than

6 weeks may necessitate extension of resident's training period in order to fulfill the requirements of the residency, specialty board or state licensing board.

11. Graduating resident's final day will be June 30th and to leave earlier is at the discretion of the Chair. This change is being implemented to meet RRC requirements regarding resident surgical minimums.
12. If a resident has secured a fellowship position that requires him/her to start fellowship training orientation sooner than this policy would allow, written documentation from the fellowship director must be submitted to the residency director and Vice President, Medical Education & Research. In this instance, unpaid days off may be granted to achieve this request.
13. **Unscheduled time off**
Requests for any unscheduled days/time out of the clinic are subject to approval by the Program Director/Chief Resident and communicated to Business Office Coordinator/Program Coordinator ASAP. (Scheduling office needs 4 weeks to clear schedule) and will only be allowed for exceptional circumstances.

When canceling/rescheduling patients, the resident should:

1. View his/her panel of patients for disposition.
2. Determine if a scheduled patient should be seen by another physician.
3. How soon patient can be seen.



**SUMMA HEALTH SYSTEM
OPHTHALMOLOGY RESIDENTS**

VACATION/CONFERENCE/LEAVE REQUEST FORM

NAME _____ DATE SUBMITTED _____

VACATION _____ CONFERENCE _____ PRACTICE/FELLOWSHIP _____

OTHER _____

FROM _____ TO _____
First Day Off Last Day Off

REQUIRED SIGNATURES

CHIEF
RESIDENT _____ DATE _____
(Home Department)

OPHTHALMOLOGY CENTER
BUSINESS
OFFICE _____ DATE _____

RESIDENT PROGRAM DIRECTOR/
DEPARTMENT CHAIRMAN
_____ DATE _____

MEDICAL EDUCATION OFFICE
(Terri Robinson)
_____ DATE _____

In case of an emergency during my absence, I can be reached at



RETURN THIS FORM TO YOUR DEPARTMENT. A COPY WILL BE SENT TO TERRI ROBINSON, MEDICAL EDUCATION OFFICE, SO THE INFORMATION MAY BE NOTED ON THE MONTHLY CALL SCHEDULE.

DEPARTMENT OF OPHTHALMOLOGY

MOONLIGHTING POLICY

The Department of Ophthalmology does not allow resident moonlighting.

Residents are paid an established stipend by the System, and may not accept any other fee for services rendered as a hospital physician except in accordance with policies related to in-hospital services. Residents may not conduct a separate practice outside the hospital, nor may they engage in other gainful employment without written permission from their residency director.

By signing the resident Agreement at the beginning of each year of training at Summa Health System, residents agree to abide by the following condition:

“The RESIDENT shall not engage in remunerative activities, other than those performed pursuant to this Agreement, without obtaining the prior consent of the residency director. If the RESIDENT is granted permission to participate in outside work, the RESIDENT does so subject to his own legal responsibility, and is functioning outside the scope of this Agreement and his/her residency program at the System.”

DEPARTMENT OF OPHTHALMOLOGY

EVALUATION OF RESIDENTS, PROGRAM & FACULTY

Evaluation of Resident Performance

1. New Innovations system are used for most evaluations
2. Residents will be evaluated on competency-based objectives after each rotation. The residents will be able to view these evaluations electronically.
3. The residents will be evaluated by patients to patient surveys which will be made available for review to the residents at the performance quality improvement meetings are in the clinic
4. The residents will be evaluated on an annual basis by the technical and office staff confidentially.
5. Evaluation of case presentations, grand rounds journal clubs, M&M conferences, morning report
6. Semi-annual evaluations will be performed by the program director based on written and verbal feedback from various sources.
7. Summative evaluations at the completion of residency.

Evaluation of the Program performance

1. The program will be evaluated by the residents based on the ACGME annual resident survey
2. A confidential and anonymous evaluation of the program annually by the faculty
3. Feedback from the Designated Institutional Officer based on surveys sent by the graduating residents

Evaluation of Faculty

1. The residents will evaluate faculty on an annual basis in a confidential and anonymous manner using the new innovations system. Aggregate feedback for be provided to the faculty by the program director. Any significant issues that might be discovered will be addressed by the program director after discussion with the department chair.
2. The residents will also evaluate the faculty teaching using lecture evaluation forms at each lecture.
3. The program director evaluates and provides feedback to the teaching faculty annually using a checklist.