

**Frequently Asked Questions
Ophthalmology**

Question	Answer
Institutions	Sponsoring Institution
<p>Can you clarify the following requirement? [Program Requirement I.A.]</p> <p>The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.</p>	<p>The Review Committee has not set a minimum time or amount of resources needed for the position of program director, and recognizes that this will vary with the program and the individual. While typical time requirements nationally range from 10-30%, the Committee seeks to know that both the program director and the residents feel the program allows the program director sufficient time and resources to complete the job adequately.</p>
Institutions	Participating Sites
<p>What is meant by “opportunity for continuity of care?” [Program Requirement I.B.4.]</p>	<p>Continuity of care comprises a variety of different concepts, each of which is enabled by the ability of the residents to examine patients at multiple points along their disease or treatment course. For example, residents should have the opportunity to follow patients through their pre-operative assessment, their surgical intervention, and their post-operative course. Residents should have the opportunity to follow patients at various points through the course of a disease process, both for acute conditions (e.g., conjunctivitis, cornea abrasions, hyphema) and chronic conditions (e.g., glaucoma, amblyopia), so that they may assess effects of medical or surgical interventions, as well as become familiar with the natural history of a disease. While a continuity of care clinic would provide these opportunities for residents, where this is not possible, rotations should be structured such that residents have the ability to participate in sustained patient follow-up.</p>
<p>What sort of arrangements should be made for residents on away rotations that preclude their attendance at conferences at the parent institution? [Program Requirement I.B.5.]</p>	<p>Possible alternatives including real-time teleconferencing or Web conferencing, or making the presentation and any materials distributed during the lecture available to residents either electronically or by hard copy. A DVD or CD of the lecture that the residents could view at their leisure would also suffice.</p>

Question	Answer
<p>Can surgical cases performed on international rotations be counted toward the minima? Does it make a difference if program faculty members are also on an overseas trip and supervising the residents during a surgery? [Program Requirement I.B.7.]</p>	<p>While some educational goals may be met during international rotations, surgical cases performed during these rotations may not be counted toward the surgical minima required by the Review Committee, even if a program faculty member accompanies the resident, because the ancillary resources, local standard of care, and medical systems employed on these rotations cannot be evaluated by the Committee.</p>
Program Personnel and Resources	Program Director
<p>When or under what circumstances can the Review Committee change a program's review cycle period? [Program Requirements II.A.4.m.]</p>	<p>Following any review, the Review Committee has the authority to determine the length of time before the next review. Additionally, if the Review Committee becomes aware of significant changes in a program that could affect resident education (e.g., closure of a facility, departure of significant faculty), the Committee may recommend an earlier review.</p>
<p>What is the process to follow when a particular resident needs additional time beyond the 36-month program period to successfully complete his/her residency education? [Program Requirement Int.B.3. & II.A.4.r.]</p>	<p>Whenever this is considered necessary, the program director should notify the Review Committee promptly, and should provide a detailed account of all reasons explaining why additional time has been recommended, the program designed for the resident, and what steps will be taken to ensure it does not negatively impact the education of other residents in the program. The Review Committee will review such cases on an individual basis, and work with the program director to address the concerns mentioned above. The program director should not make any agreement or contractual arrangement with a resident without Review Committee approval.</p>
<p>What is the responsibility of the program director when residents need to be on extended leave (up to six months)? What is the program director's responsibility if a resident is required to remain in a program beyond his/her expected graduation time, either to make up lost time, or for educational remediation? [Program Requirement Int.B.3. & II.A.4.r.]</p>	<p>In both cases, the program director must notify the Review Committee promptly, and provide an explanation of why any modifications to program length are necessary. Both extended residents absences and a temporary resident complement increase may affect the other residents in the program. The program director must evaluate the effects any such modifications may have on remaining residents in the program, and outline what steps have been made to protect and balance their educational and service needs, i.e., to make sure their educational program is not hindered by either excessive service or dilution of resources.</p>
<p>Do required online education modules count as lecture hours even though they are not face-to-face? [Program Requirement II.A.4.t.]</p>	<p>If online teaching modules are required and the program can document satisfactory completion of these modules, they may count as lecture hours and should be included in the Program Information Form.</p>

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What is considered “current diagnostic equipment?” [Program Requirement II.D.1.]	In all locations where patients are seen, standard “current diagnostic” equipment would include devices to measure visual acuity and obtain refractive data, slit lamps, direct and indirect ophthalmoscopes, and appropriate diagnostic lenses. In pediatric or adult motility clinics, prisms and tests to measure binocular function (e.g. Titmus, Worth 4 dot) should be present. Ready access to fluorescein angiography, ophthalmic photography and echography, visual fields, and retinal/optic nerve fiber analysis should be easily available for treating patients. Less commonly used tests such as visual evoked potential systems (VEP), electroretinography (ERG), electrooculography (EOG), should be available at least on-site for program use.																						
Educational Program	ACGME Competencies - Patient Care																						
Does a temporary tarsorrhaphy count on the surgical logs, or does it have to be permanent? [Program Requirement IV.A.5.a.]	A temporary tarsorrhaphy can count and should be entered in the surgical logs.																						
What are the minimum operative numbers? [Program Requirement IV.A.5.a.(5)]	<table border="1" data-bbox="747 795 1566 1260"> <thead> <tr> <th data-bbox="747 802 1033 867">Procedure</th> <th data-bbox="1041 802 1566 867">Current Minimum Requirement (*Surgeon; **Surgeon and Assistant)</th> </tr> </thead> <tbody> <tr> <td data-bbox="747 873 1033 906">Cataract*</td> <td data-bbox="1041 873 1566 906">86</td> </tr> <tr> <td data-bbox="747 912 1033 945">Strabismus*</td> <td data-bbox="1041 912 1566 945">10</td> </tr> <tr> <td data-bbox="747 951 1033 984">Corneal Surgery*</td> <td data-bbox="1041 951 1566 984">3</td> </tr> <tr> <td data-bbox="747 990 1033 1023">Refractive Surgery**</td> <td data-bbox="1041 990 1566 1023">6</td> </tr> <tr> <td data-bbox="747 1029 1033 1062">Glaucoma *</td> <td data-bbox="1041 1029 1566 1062">5</td> </tr> <tr> <td data-bbox="747 1068 1033 1101">Glaucoma Laser*</td> <td data-bbox="1041 1068 1566 1101">9</td> </tr> <tr> <td data-bbox="747 1107 1033 1140">Retina/Vitreous**</td> <td data-bbox="1041 1107 1566 1140">10</td> </tr> <tr> <td data-bbox="747 1146 1033 1179">Other Retinal*</td> <td data-bbox="1041 1146 1566 1179">25</td> </tr> <tr> <td data-bbox="747 1185 1033 1218">Oculoplastics/Orbit*</td> <td data-bbox="1041 1185 1566 1218">28</td> </tr> <tr> <td data-bbox="747 1224 1033 1256">Globe Trauma*</td> <td data-bbox="1041 1224 1566 1256">4</td> </tr> </tbody> </table> <p data-bbox="747 1266 1906 1328">* Operative minimums per class of procedures are now established only for cases where the resident is the <i>primary surgeon</i></p> <p data-bbox="747 1334 1906 1390">** Operative minimums per class of procedures are established for cases where the resident is either the <i>primary surgeon and/or the assistant</i></p>	Procedure	Current Minimum Requirement (*Surgeon; **Surgeon and Assistant)	Cataract*	86	Strabismus*	10	Corneal Surgery*	3	Refractive Surgery**	6	Glaucoma *	5	Glaucoma Laser*	9	Retina/Vitreous**	10	Other Retinal*	25	Oculoplastics/Orbit*	28	Globe Trauma*	4
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	Residents are expected to input surgeries on which they are the first assistant as well as cases on which they are the primary surgeon. This is necessary for the program to show a progressive graduated and broad surgical experience. At least 364 total procedures (surgeon + assistant) should be completed at the end of the residency.
How were the minimum operative numbers determined? [Program Requirement IV.A.5.a.(5)]	In 2006 the Review Committee revisited the minimum operative numbers. As a surgical subspecialty, ophthalmology requires the development of competence in key surgical procedures and at least familiarity in others. While the Review Committee recognizes that achievement of minimum operative numbers does not assure individual competency, the minimums serve as a surrogate for measurement of adequacy of surgical volume offered by a program to its residents. The new minimums were set at the 20th percentile of procedures performed nationwide by residents. On review the past 2 years the Review Committee has decided not to change the minimums even though the numbers of surgeries nationwide has increased according to the Resident Case Log System.
Why have surgical categories with a very low minimum (e.g. 3 or 4)? [Program Requirement IV.A.5.a.(5)]	We recognize that residents will not achieve <i>competency</i> after only performing a handful of procedures in a particular discipline, but we require that residents do have <i>familiarity</i> with the procedures in each subspecialty. Familiarity can be defined as the ability to perform a procedure with assistance. The program director and faculty are the final arbiters for the assessment of a resident's competency for a procedure.
Does each resident have to meet the minimum operative numbers to graduate? [Program Requirement IV.A.5.a.(5)]	No. The program's per resident average should meet each minimum operative number. However, each resident must demonstrate sufficient competence to enter practice without direct supervision. In addition, the program director should ensure that residents have equivalent educational experiences (in general, there should not be wide variations in residents' surgical numbers). The program should also have a broad range of surgical experience, a progressive, graduated surgical experience (residents should assist on most procedures before acting as primary surgeon), and have appropriate supervision in surgery. A program may be cited for non-equivalent experience, lack of breadth of surgical experience, lack of a progressive, graduated experience, and inappropriate supervision despite meeting the minimum operative numbers. <u>and</u> there must be an assessment of surgical competency.

Question	Answer
Educational Program	ACGME Competencies - Medical Knowledge
Residents should have documented experiences in practice management, ethics, advocacy, visual rehabilitation, and socio-economics. What exactly is meant by "advocacy"? [Program Requirement IV.A.5.b).(2)]	According to the American Academy of Ophthalmology (AAO) publication, <i>The Profession of Ophthalmology</i> , advocacy is a duty of the physician and requires that he/she support, defend, and protect his/her patients and the profession. Commitment to advocacy can empower one to directly affect legislation, regulation, policy, and public and professional opinion on patient care, patient's rights, access to health care, research funding, scope of practice, liability issues, and device and medication development. Residency programs should provide formats where residents can be exposed to and participate in these issues. Examples include the AAO's Advocacy Day and Mid-Year Forum, local legislative meetings and events, FDA conferences, or observation or service on an Institutional Review Board or other committee that protects patients' rights.
Educational Program	ACGME Competencies - Practice-based Learning and Improvement
Documentation for self assessment and reflection [Program Requirement IV.A.5.c.]	<ul style="list-style-type: none"> • Document a structured process for reflection in which a faculty advisor guides the resident in using feedback and evaluations to inform the self assessment process • Documentation of the semi-annual evaluation meetings in which these processes are demonstrated and provide evidence that this requirement is being addressed
Documentation for EBM-related skills [Program Requirement IV.A.5.c.]	<ul style="list-style-type: none"> • Document structured evidence-based medicine activities such as a journal club presentation, critical appraisal of a topic, or educational prescription with appropriate faculty oversight and formal assessment of skills • Additional documentation would be the written goals and objectives for this learning activity and how residents are assessed
Documentation for quality improvement [Program Requirement IV.A.5.c.(4)]	<ul style="list-style-type: none"> • Document the written project description of a full PDSA cycle in which an individual resident or group of residents actively participated with appropriate faculty oversight and formal assessment of skills, or proceedings from events in which quality improvement projects were presented orally
Documentation for teaching skills [Program Requirement IV.A.5.c.(8)]	<ul style="list-style-type: none"> • Document the written goals and objectives for this learning activity and how residents are assessed • Additional documentation should include evidence for structured teaching opportunities, feedback from learners such as medical students, or patient perceptions of the clarity of residents' explanations

Question	Answer
Educational Program	ACGME Competencies - Interpersonal and Communication Skills
Documentation for communicating with patients and families [Program Requirement IV.A.5.d.]	<ul style="list-style-type: none"> • The learning activity must include both a didactic component and an experiential component • Learning activities might address written communication (e.g., orders, history and physical examination, progress note, transfer note, discharge summary, operative reports, diagnostic reports), oral communication (e.g., presentations, transfer of care, interactions with patients, families, colleagues, members of the health care team) and/or non verbal skills (e.g., listening, team skills) • These should be structured learning activities (not just “on-the-job” training) with faculty oversight and feedback
Documentation for teamwork [Program Requirement IV.A.5.d.(3)]	<ul style="list-style-type: none"> • Documentation should include the written goals and objectives and curriculum (didactic and experiential) • Demonstrate that faculty actively engage the learners in developing these skills • Document that team member communication is bidirectional rather than unidirectional
Documentation for medical records [Program Requirement IV.A.5.d.(5)]	<ul style="list-style-type: none"> • Additional documentation (not required) might include a written policy for the completion of comprehensive, timely and legible medical records that includes monitoring, evaluation and feedback to residents
Educational Program	ACGME Competencies - Professionalism
Documentation for professionalism [Program Requirement IV.A.5.e.]	<ul style="list-style-type: none"> • This activity should be structured, should demonstrate active faculty involvement (not just passive role modeling) and timely feedback to residents, and should include a mechanism for collecting evaluations (including routine multi-source assessment) • Additional documentation is provided by the written goals and objectives for this learning activity (must be available for site visitor review) and how residents are assessed
Documentation for promoting professionalism behavior [Program Requirement IV.A.5.e.]	<ul style="list-style-type: none"> • Approaches may include role modeling by program leadership, ongoing interactive conversations involving both faculty and residents about the elements of professionalism, particularly in the context of every day practice, policies regarding lapses in professionalism, and processes to address lapses when they occur
Documentation for remediation in professionalism [Program Requirement IV.A.5.e.]	<ul style="list-style-type: none"> • Approaches may include provision of immediate feedback, development of a plan specific to the behavior in question, monitoring for behavior change, decisions based on specified outcomes, and consequences that are aligned with the gravity of the lapse or breach if expectations are not achieved

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Educational Program	ACGME Competencies - Systems-based Practice
Documentation for systems-based practice [Program Requirement IV.A.5.f]	<ul style="list-style-type: none"> Documentation should include the written goals and objectives for this learning activity, curriculum (didactic and experiential) that demonstrates the elements of systems-based practice, and assessment of resident outcomes
Documentation for system errors [Program Requirement IV.A.5.f.(6)]	<ul style="list-style-type: none"> Important elements include identified faculty to guide the activity, mechanism to ensure active engagement by each resident, and evidence of experiential learning (not just passive presence at conferences or meetings) in which residents participate in identifying a system problem or error and contribute to a potential solution Additional documentation includes the written goals and objectives for this learning activity and how residents are assessed Aggregated resident outcomes may be in the form of percentage of residents that completed a patient safety or other systems-based practice project by the end of training, annual list of improvements that resulted from such projects, etc.
Evaluation	Resident
If our program evaluates residents electronically, and they sign off on the electronic evaluation, do we need to provide hard copies and have the residents sign in ink for a site visit? [Program Requirement V.A.]	Access to these evaluations must be available to the site visitor. Electronic accessibility could be acceptable provided it is not too time-consuming for the site visitor, and it is uncomplicated to verify that a full evaluation occurred and was reviewed with and acknowledged by the resident. However the program director should be prepared to quickly print a hard copy.
What methods of evaluation should Ophthalmology programs use? [Program Requirement V.A.1.e.]	<ul style="list-style-type: none"> Direct Observation: Tools: Ophthalmic Clinical Exam (OCEX) or other structured assessment of a resident-patient interaction 360 Degree Evaluation: Tools: Ophthalmology specific evaluation forms for peer, patient, supervisor, self, etc. Portfolio: Tools: Ophthalmology specific portfolio with documentation of self improvement project, quality improvement and PDSA or other structured systems-based project, chart audit, learning plan, etc. Written/Oral Examinations: Tools: Ophthalmic Knowledge Assessment Program (OKAP), ABO pass rate, AAO self assessment exams, etc.

Question	Answer
Resident Duty Hours in the Learning and Working Environment	Supervision of Residents
<p>What is the difference between direct and appropriate supervision? [Program Requirement VI.B.1.]</p>	<p><u>Direct supervision</u> connotes that a faculty member has specifically discussed a patient's history and exam findings with the examining resident, as well as having personally examined the patient him/herself. The faculty member notes appropriate corrections or additions to the resident's findings and signs off on the resident note.</p> <p><u>Appropriate supervision</u> can include, but does not <i>require</i>, direct supervision. The concept of residents' graduated level of responsibility be commensurate with their individual skill level and abilities is key. The level of supervision needed for a resident in a given situation is at the discretion of the program director and program faculty members.</p>
<p>How should we confirm or document that at least 1,000 patients have been seen by residents with direct faculty supervision? [Program Requirement VI.B.1.]</p>	<p>Possible examples include: review of clinic charts for a defined period of time with extrapolation over 36 months; review of billing records; and query of faculty members regarding their procedure and subsequent review of clinic appointment schedules.</p>
Resident Duty Hours in the Learning and Working Environment	Duty Hours
<p>How should a program with home call interpret the following program requirement? "Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call." [Program Requirement VI.D.3.]</p>	<p>If residents are on home call, the rest period does not apply, but programs must continue to monitor for signs of excessive fatigue. Only the requirement that hours spent in the hospital, while on call from home, must be counted toward the 80-hour limit.</p>

Question	Answer
Resident Duty Hours in the Learning and Working Environment	On-call Activities
<p>How do the 80 hour and 1/7 rules apply to residents on home call? If they come in to the hospital during the night, how does this affect what their schedule should be the next day? [Program Requirement VI.E.4.]</p>	<p>Hours on night call spent on duty (not at home reading or resting) should be applied toward the 80 hour limit. The 1/7 day off rule is separate from rules governing home call, and during that day off, the resident cannot have any clinical responsibilities.</p>

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