

# Ophthalmology Resident Manual

Academic Year 2011-2012

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## **I. Statement of Purpose**

The primary purpose of ophthalmology residency is to train compassionate, ethical ophthalmologists who are knowledgeable and skilled in the medical and surgical care of the eye, orbit, and visual system.

## **II. Statement of Ethics**

The following statement reflects the philosophy and goals of the University of Missouri-Kansas City Department of Ophthalmology Residents (hereafter the “Residents”). The mission of the Residents is as follows:

To preserve the fundamental principle of “do no harm” while acquiring the knowledge and skills required to effectively practice ophthalmology independently by ensuring the following:

- Maintaining a professional environment that encourages open communication between the Residents and faculty
- Approaching unfamiliar or complex ophthalmic disease processes or surgical procedures by first engaging in self-directed learning and skill development before seeking assistance

To provide the vital function of ophthalmic care and surgical intervention of ophthalmic diseases, to a traditionally underserved portion of society in a manner that achieves the following:

- Equity
- Respect of patient autonomy
- Compassion

To pursue the following educational goals:

- Development of clinical and surgical skills that are necessary to provide for the population at large
- Education of attending physicians, residents-in-training in all fields, medical students, and other healthcare professionals
- Education of the public regarding their eye conditions and the impact of overall health on their eyes

## **III. Core Competencies**

The educational program derives its foundation from the Core Competencies published by the ACGME (Accreditation Council for Graduate Medical Education). These objectives define core values of the learning environment and seek to provide meaningful goals in the areas of patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-

based practice. All of the Core Competencies are addressed in this resident manual and will be designated by abbreviation as follows throughout. All residents are to know and understand what is expected of them in each of these areas:

### **Patient Care (PC)**

Upon conclusion of the training program, each resident will:

- Demonstrate the ability to acquire essential and accurate patient information
- Diagnose and manage medical and surgical disease of the eye and visual system at a level acceptable for the general ophthalmologist
- Demonstrate effective patient and family counseling while showing sensitivity to relevant socio-cultural circumstances
- Demonstrate the effective use of information technology to facilitate continuous improvement in patient care skills

### **Medical Knowledge (MK)**

Upon conclusion of the training program, each resident will:

- Demonstrate the ability to understand and apply established and evolving areas of clinical and basic science within the field of ophthalmology
- Demonstrate a level of medical knowledge sufficient to engage in a safe and effective clinical practice
- Demonstrate the ability to evaluate new information critically

### **Practice-Based Learning and Improvement (PBLI)**

Upon conclusion of the training program, each resident will:

- Demonstrate the ability to appraise and assimilate scientific evidence and improvement in patient care
- Show evidence of self-directed learning as a basis for continuous improvement in patient care skills

### **Interpersonal and Communication Skills (ICS)**

Upon conclusion of the training program, each resident will:

- Show a commitment to the professional responsibilities of practicing physician
- Demonstrate adherence to the ethical and moral standards of the profession
- Show respect for the physician-patient relationship through appropriate conduct in all patient encounters
- Demonstrate sensitivity when interacting with a diverse population of patients

### **Professionalism (P)**

Upon conclusion of the training program, each resident will:

- Show a commitment to the professional responsibilities of a practicing physician
- Demonstrate adherence to the ethical standards of the profession
- Show respect for the physician-patient relationship through appropriate conduct in all patient encounters
- Demonstrate sensitivity when interacting with a diverse population of patients

### **Systems-Based Practice (SBP)**

Upon conclusion of the training program, each resident will:

- Demonstrate an awareness of the role of the ophthalmologist in the context of complete patient care
- Demonstrate the ability to use skill-building resources in order to provide optimum patient care
- Practice medicine in a safe, efficient, and cost-effective manner
- Practice medicine in a way that consistently advocates the patient's best interest

## **IV. Ophthalmology Specific Objectives**

A specific educational program for ophthalmology can be formulated within the general framework of Core Competencies.

Faculty Directors are designated by the Department Chairman and Program Director to develop and coordinate the instructional courses and case presentation conferences. Documentation of resident attendance at all conferences is maintained by the Residency Coordinator and overseen by the Program Director. The current curriculum encompasses the following broad areas:

### **Instruction in the Basic and Clinical Sciences**

#### **Didactic Lectures (MK)**

- Lens and Cataract
- External Disease and Cornea
- Intraocular Inflammation and Uveitis
- Retina and Vitreous
- Glaucoma
- Oculoplastics
- Neuro-ophthalmology
- Ocular Oncology
- Pediatric Ophthalmology and Strabismus
- Ocular Pathology
- Ocular Electrophysiology
- Optics, Refraction, and Contact Lenses

- Refractive Surgery
- Low Vision
- Ethics, Moral and Legal Issues in Ophthalmology
- Ophthalmic Coding
- Advocacy
- Residents as Teachers Series (Core Lecture Series)

**Ethics/Practice Management Lecture Series (PBLI, ICS, P, SBP)**

The Program Director provides a lecture series (one hour, alternating months) for the discussion of ethical, legal, and moral issues in the field of ophthalmology and the practice of medicine. The Department Chairman provides a lecture series (one hour, alternating months) on exploring physician contracts, practice development, business management, managed care, and other issues of interest to the new physician.

Topics include:

- Choosing the practice that's right for you: practical considerations
- Coding and documentation for the ophthalmologist
- Confidentiality
- Conflict of interest issues
- Do's and Don'ts when dealing with difficult patients
- Financing a practice start-up
- Understanding financials in a group setting
- Fraud and Abuse regulatory overview
- Introduction to personal finance
- Malpractice 101
- Measuring physician performance
- Medical records documentation: in office, surgical, and consultations
- Medicare/Medicaid 101
- Navigating through the managed care maze
- Patient and Physician safety
- Physician employment contracts: what you need to know
- Resident intimidation
- Sleep deprivation: our life and our work
- Thriving through residency: the resilient resident
- Understanding clinical trials
- What you should know about gifts to physicians from industry
- Addictions/impairment: recognition and resources

**Case Conferences (PC, MK, PBLI, ICS, P, SBP)**

- Lens and Cataract
- External Disease and Cornea
- Intraocular Inflammation and Uveitis
- Retina and Vitreous
- Glaucoma
- Oculoplastics
- Neuro-ophthalmology
- Ocular Oncology

- Pediatric Ophthalmology and Strabismus
- Ocular Pathology (Clinico-pathologic conference)
- Ocular Electrophysiology
- Optics, Refraction, and Contact Lenses
- Refractive Surgery
- Low Vision
- Ethics, Moral and Legal Issues in Ophthalmology
- Ophthalmic Coding
- Advocacy

**Additional Conferences/Lectures (PC, MK, PBLI, ICS, P, and SBP)**

- Journal Club
- Grand Rounds
- Mortality and Mortality Conference
- Visiting Professorship Lectures
- Faculty Development Lectures
- On Call Assessment Tool Conference (OCAT)
- Annual Department Symposium

**Clinical Experience (PC, MK, PBLI, ICS, P, and SBP)**

- Outpatient clinics
- Surgery: elective, urgent, and emergent
- Hospital-based consultations

**Clinical and Basic Science Research and Scholarly Activity [PC and MK]**

- Resident research participation and requirements are detailed subsequently in this Resident Manual.

**Professionalism (PC, PBLI, ICS, P, and SBP)**

Values and standards are difficult to evaluate, but common sense dictates certain behavioral expectations for any serious student and physician. Residents are required to be on time and appropriately prepared for all scheduled educational sessions, and complete assigned tasks in all areas of training in an appropriate and timely manner. Residents must always behave courteously, tactfully and empathetically towards patients and their families. Similarly, they should be cooperative and supportive to staff, fellow residents, paramedical staff, patients and others. Proper dress, grooming and deportment are expected when in patient care areas. TMC residency policy stipulates no nail polish, no open-toe shoes, no written statements on clothing, and no suggestive jewelry or attire. Socks or nylons worn must be worn at all times. Residents are expected to provide appropriate medical and surgical care, according to the level of skills, and to communicate with the staff about patient care so that appropriate and necessary supervision and guidance may be provided. Continuity of care must be ensured with both staff and fellow residents for any patient for which the resident is responsible.

Accurately written patient records must be maintained. Each encounter with a patient must be documented in the patient record, accurately and thoroughly. Residents are expected to adhere to the published rules and regulations of the Academy of Ophthalmology and familiarize themselves with the AAO Code of Ethics. Residents are all encouraged to join actively as resident members of the American Academy of Ophthalmology. Finally, residents are expected to communicate in an honest and candid manner with staff. This is fundamental to the kind of relationship that is necessary to both education and patient care in our department. Residents are to behave with respect and courtesy towards one another, and to share their wisdom and expertise with each other in a collegial manner. Team building and thoughtful concern for one another at all times is expected.

## **V. Organization**

One of the major strengths of the three-year rotation is the opportunity for residents to participate in a full range of subspecialty services where state-of-the-art care is provided, to work directly with the attending staff, and to participate in clinical research and preparation of manuscripts for publication. Each year is divided into three 4-month blocks. Residents are assigned to the following affiliated teaching locations:

- Truman Medical Center - Hospital Hill (TMC-H)
- Truman Medical Center - Lakewood (TMC-L)
- Children's Mercy Hospital (CMH)
- St Luke's Hospital - Plaza (SLH)
- Research Medical Center (RMC)

Truman Medical Center - Hospital Hill is the parent institution. The typical resident complement at each institution is as follows:

- Truman Medical Center - Hospital Hill:
  - 2 third-year residents
  - 1 second-year resident
  - 3 first-year residents
- Truman Medical Center - Lakewood:
  - 1 third-year resident (to include contact lens and refractive surgery rotation)
- Children's Mercy Hospital:
  - 1 second-year resident (to include low vision CCVI rotation)
  - 1 first-year resident doing introductory rotations on a part-time basis
- St Luke's Hospital:
  - 1 second-year resident (to include contact lens, retina, glaucoma, ocular oncology, and neuro-ophthalmology clinics; and four half days per month of protected research time)

- Research Medical Center:  
1 second-year resident (same resident as SLH rotation) for consult service

### **Resident Rotations [PC, MK, PBLI, and SBP]**

The year academically begins July 1<sup>st</sup> and ends June 30<sup>th</sup>. Each year is divided into three 4-month blocks. Hospital time allocations are as follows:

**First Year:** 12 months at TMC-H, including 2 two-month introduction to ophthalmic surgery rotations (3 days per week: Tuesday, Wednesday, and Thursday), neuro-ophthalmology clinic Friday mornings, contact lens clinic one half day per month, and CMH clinic four half-days per month.

**Second Year:** 4 months at TMC-H, 4 months at CMH, and 4 months at SLH (including SLH and RMC daytime consults, and at least four half days per month protected research time)

CMH rotation includes exposure to retinopathy of prematurity (ROP): Premature babies being screened for retinopathy of prematurity are not examined by residents in the clinic. These examinations are stressful for both the infants and parents. ROP experience will occur in the NICU during assigned surgery week where the babies are monitored and active disease more frequently observed.

**Third Year:** 8 months at TMC-H and 4 months at TMC-L. TMC-L rotation includes Refractive Surgery rotation one half day per week (Wednesday mornings) and contact lens clinic (Wednesday afternoons).

## **VI. Resident Development [MK, PBLI, and P]**

### **First Year**

The goal of the first-year rotation in ophthalmology is to introduce the resident to the examination of the eye and visual system in both children (while at CMH rotation) and adults. In general, first-year residents are expected to show evidence of increasing knowledge derived from a continuous program of reading to supplement their learning in the clinics and lectures. The first-year resident should make every effort to collect as much information as possible during their patient examination. Initially, first-year residents will understandably be limited in their ability to perform a complete examination of a patient and be expected to obtain assistance along the way with more senior residents and the attending staff. During the course of the first year, it is expected that less assistance with the exam will be necessary. As the rotation progresses, the first-year resident should become increasingly competent in the following areas:

- Ophthalmic history taking
- Retinoscopy and refraction, lensometry, spectacle prescribing, visual acuity measurement

- Pupil testing, confrontation visual fields
- External eye exam, slit lamp exam
- Tonometry and gonioscopy
- Color vision and stereo testing
- Keratometry and pachymetry
- Ocular ultrasound and biometry
- Detailed motility examinations and the general ophthalmic examination
- Removal of foreign bodies from the surface of the eye
- Schirmer's testing
- Detailed retinal drawings
- OCT and GDx testing and interpretation
- Full neuro ophthalmic examination (to be taught by staff neuro- ophthalmologist)
- Pediatric examination (to be taught by staff pediatric ophthalmologists)
- Familiarization with basic surgical instrumentation and equipment to be taught while rotating through our ophthalmic surgical department with various attendings. (During a 4-month introduction to ophthalmic surgery rotation, each resident spends 4 half-days per week assisting staff ophthalmic surgeons in surgery. Testing regarding names and proper usage of ophthalmic surgical equipment and instruments will occur during the biannual wet lab sessions. Refer to the surgical skills manual for more details.)
- Supervised introduction to periocular anesthesia to begin during the first year surgery rotation. Proper technique will be taught and overseen by attending staff to residents regarding peribulbar and retrobulbar anesthesia
- Basic ophthalmologic diseases and complex problems will be encountered and should be supplemented with daily self -directed reading on the part of the resident
- Beginning residents examine patients in the clinic, perform extraocular procedures, and perform selected laser procedures under direct attending staff supervision
- One half-day session per week is spent at Children's Mercy Hospital Eye Clinic during one 4-month block to gain exposure to pediatric ophthalmology
- Twelve months of the first year are spent at TMC-H eye clinic rotation
- Wet lab suturing per month
- EYESI simulator lab: introduction to phaco first year for 2 hours per month
- Explore research topics of interest
- Research projects will be encouraged to start at the beginning of the first-year rotation. Residents are encouraged to meet with Dr. Koulen and visit his lab to enhance their knowledge about the process and explore research opportunities
- Phaco practice lab time will be introduced, and residents will be encouraged to pair up with more senior residents. Three-to-four formal mandatory multi-station surgery practice labs will be utilized by all residents, with oversight by the Residency Program Director and other attending physicians
- Begin laser PRP, SLT, and YAG laser treatments after their initial six months of training are successfully completed
- Begin performing oculoplastics cases after six months of training are successfully completed

## **Second Year**

The second-year rotation is designed to further enhance the skills and clinical/surgical responsibilities learned during the first-year rotation. In addition, the second-year resident will learn to treat many of the surgical disorders that occur in ophthalmology, including intraocular surgery. While some of the surgical procedures will be outside the scope of a second-year resident, the knowledge to be learned from these procedures is not. It is expected that at the end of the rotation, the resident will be comfortable evaluating and treating as many of the eye conditions facing today's comprehensive ophthalmologist, as well as subspecialty disease areas.

Residents spend 4 months at TMC-H, 4 months at SLH, and 4 months at CMH eye clinics. The four-month rotation at TMC-H features concentrated training in retinal and vitreoretinal surgical cases, perform a significant number of retinal lasers, and interpret fundus photographs and fluorescein angiograms. Corneal, glaucoma, oculoplastics, and oncology clinic patients occur as well during the TMC-H rotation on a weekly basis. During the 4 months at St Luke's Hospital, the resident spends time at the private subspecialty clinics including neuro ophthalmology, retina, glaucoma, cornea, and contact lens/low vision clinics. While on the St Luke's rotation, the resident will also be responsible for daytime consult duties covering Research Medical Center. The resident also performs in patient hospital consultations under supervision of attending faculty staff at St Luke's (SLH) and Research Medical Center (RMC). By the end of the second year, each resident will:

- Demonstrate an increased level of competence in the medical and surgical evaluation and treatment of adult and pediatric patients
- Perform diligent work on research projects as a priority during second year rotation
- Mandatory monthly time spent practicing surgical skills will be monitored in the resident practice lab. Feedback will be given by the oversight faculty along the way. Residents are encouraged to work one on one with Dr. Walline initially.
- Correctly interpret diagnostic tests such as OCT, GDX, visual fields, B Scans, ERG's, photos, and fluorescein angiograms
- Demonstrate an acceptable level of skill in performing cataract surgery and other selected intraocular procedures
- Achieve competence in performing common ophthalmic laser procedures (e.g. YAG, PRP, SLT)
- Recognize conditions that warrant low vision and contact lens specialty referral and become familiar with these areas. This includes ½ day per month experience at CCVI while on their CMH rotation. This experience includes working with social workers and occupational therapists.

## **Third Year**

Residents attain maximum proficiency during their third year, as they prepare to graduate and begin fellowship training or a career in comprehensive ophthalmology. Medical and surgical skills are sharpened through intensive clinical exposure and higher levels of responsibility for major surgical and complex medical cases. Senior residents are expected to provide ongoing leadership and guidance to more junior residents, medical students, and family practice and internal medicine residents rotating on the ophthalmology service.

Residents rotate for a period of 8 months through TMC-H and four months at TMC-L. While assigned to TMC-L, each resident also spends one half-day per week at the Eye Foundation Refractive Surgery Clinic observing and performing procedures, as well as learning patient evaluation and postoperative care. The privilege of performing refractive surgery is based on overall total performance up to that point in residency, as well as good understanding of equipment and surgical technique. Attending staff retain the right to perform all cases on a given 4-month rotation if the resident doesn't demonstrate appropriate progression of understanding and competence. Third year residents also spend one half-day per week in contact lens clinic. This time is utilized to train and educate senior residents further regarding the fitting and management of contact lenses. By the end of the third year, each resident will:

- Demonstrate full competency in the medical evaluation and treatment of adult and pediatric patients
- Demonstrate acceptable skills and safe techniques in performing all surgical and laser procedures within the domain of the general ophthalmologist
- Complete departmental research requirements
- Demonstrate an ability and willingness to practice medicine according to the ethical standards of the profession

The **Chief Resident** is a senior resident selected by the faculty and senior staff of the Department of Ophthalmology each year to act as a liaison between the department leadership and the residents. The Chief Resident begins his or her tenure in May of the second year and is charged with the following duties:

- Create and maintain the resident call schedule, time off, and coordinate with attending call schedule
- Assist the Residency Program Director in developing the teaching conference schedule, academic weekly and monthly calendar
- Assist the department in resolution of any internal resident concerns or disputes
- Participate in the Resident Education Committee and Department Managers Meetings
- Assist in proper set up and clean up of departmental surgical labs utilizing pig eyes in a fair and equitable manner. Program director of the residency will arrange all such labs in advance.

Throughout the residency, **faculty physicians assume ultimate responsibility** for ensuring proper patient care is provided. Staff physicians are always available in clinic

for direct supervision and in the operating rooms. Residents are expected to carry out the recommendations of attending staff in all patient care, including surgery.

## **VII. Levels of Supervision**

The ACGME recognizes several levels of faculty supervision of residents involved in patient care.

### **Direct Supervision (DS)**

Faculty directly supervises all clinic and surgical procedures for first, second, and third year residents during regular clinic hours and after hours. The only exception is that minor procedures may be performed by first, second, and third year residents when competency has been demonstrated and skills manual completed in the appropriate skills area. Examples include simple lid laceration repair, removal corneal/conjunctival foreign body, and anterior chamber paracentesis. Faculty also directly supervises all clinic exams of beginning first year residents.

### **Indirect Supervision with Direct Supervision Immediately Available (IS/DSIA)**

Faculty indirectly supervises with immediate availability in the clinic all clinic exams for first, second, and third year residents during regular clinic hours.

### **Indirect Supervision with Direct Supervision Available (IS/DSA)**

Faculty indirectly supervises with direct supervision availability during regular clinic hours (for subspecialty, inpatient, or emergency room consultation) and after hours. Faculty responds as needed/requested for direct supervision for first, second, and third year residents.

### **Oversight (OS)**

Faculty provides oversight of all patient encounters for which no examination is performed. First, second, and third year residents are required to document in patient charts and/or phone logs each telephone encounter with patients and physicians. These encounters are reviewed with faculty at OCAT conferences.

## **VIII. Duty Hours and Moonlighting [PC and P]**

### **Duty Hours**

The resident duty hour policy of the University of Missouri-Kansas City School of Medicine is adopted verbatim from the following Common Program Requirements for All Core and Subspecialty Programs, effective July 1, 2011:

Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energies. Duty hour

assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

Duty hours are defined as all clinical and academic duties related to the residency program (e.g. inpatient and outpatient care, 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 also include any time spent outside of the hospital completing direct patient care activities (e.g. charting and dictation). Duty hours *do not* include reading and preparation time spent away from the duty site.

Duty hours must be limited to 80 hours per week, averaged over a four-week period.

Ophthalmology residents never take in-house call and instead always take call from home (pager call). Home call is not subject to the every third night limitation of in-house call put forth by ACGME but must not be so frequent as to preclude rest and reasonable personal time for each resident.

Residents must be provided with one day in 7 *free* from all educational and clinical responsibilities, averaged over a four-week period. *One day* is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities. It is expected that this 24 hour period begins with the resident awakening outside of the hospital and continues for 24 hours.

Adequate time for rest and personal activities must be provided. This should consist of a ten hour period between all daily duty periods.

Residents should become well versed in recognition of signs of fatigue, and adopt proactive solutions to prevent and counteract its potential negative effects. Adequate time for rest and personal time must be balanced by each resident. Residents experiencing significant fatigue are to communicate this to their attending faculty, chief resident, and program director in a timely manner in order to be excused from patient care responsibilities. There is an on-call room available at TMC HH available for rest, if necessary. It is located on 5th floor, room number 3.

There are two circumstances in which exceptions to Duty Hours Policies may be allowed. A resident may, on their own initiative, stay to provide continuity care to a patient that is critically ill or unstable, a patient that offers an academically important experience, or a patient or family in need of emotional support at a time of crisis. Residents in their final year of training, may, on occasion, have less than eight hours between duty periods. This would be most commonly expected to occur when the third year residents provide supervision to junior residents and participate in emergent surgical procedures.

### **Moonlighting**

Moonlighting is strictly prohibited by the department of ophthalmology for all residents. Ophthalmic residency is a full time endeavor, mandating 100% commitment from each resident.

### **IX. Resident Responsibilities [PC, MK, ICS, and P]**

Formal lectures are provided to the residents covering every subspecialty area of ophthalmology. The Residency Curriculum for the 2011/2012 Academic Year contains an outline of subject material and required reading. Lecture topics are made available to residents prior to presentation to allow for individual preparation/review.

Although a considerable amount of information is presented in formal lectures, independent in-depth self-study of texts and journals is mandatory to supplement this material. The ability to critically read and evaluate the ophthalmic and basic science literature is necessary to the continuing education of an ophthalmologist.

Providing high-quality medical and surgical eye care is a priority of the department of ophthalmology at UMKC School of Medicine/Eye Foundation of Kansas City, and participation in this care is essential during all three years of residency training. Most surgery falls within the scope of residency training, and participation is largely determined by the skill of the resident. Development of technical skills and surgical judgment is supported by practice labs taught by attending staff and by independent practice on a regular basis using the EYESi surgical simulator and donor eyes.

### **Lecture Attendance and Clinical Duties [PC, MK, and P]**

**Monday through Friday: 7:30 a.m. to 8:30 a.m. faculty lecture:** Attendance is mandatory, and residents must sign the attendance sheet located on the podium to receive credit for attendance. Non-emergent surgical procedures are to be attended by residents AFTER lecture is over. Emergent medical and surgery care take precedence over attendance at lecture unless otherwise directed by the faculty surgeon. Communication should occur with faculty whenever lecture is missed, reason stated why it was missed, and completed test questions that are to be turned into Sandra (program coordinator).

Residents are required to attend conferences and lectures given by attending staff at the Eye Foundation, SLH, and Children's Mercy Hospital. All third year Lakewood rotation residents are responsible for preparing and giving one introduction to Ophthalmology lecture per month to the family medicine residents. This is in effort to supplement resident knowledge and education within various basic topics in ophthalmology. All third year Lakewood rotation residents are to attend the noontime family medicine conferences given by non-ophthalmic physicians as well, in effort to enhance their overall residency education. Clinical obligations are excused since teaching conferences supersede clinical responsibilities for the residents. Attending staff must excuse your absence, should it occur for any reason, in advance of the situation (except for true emergencies). Please be on time for all meetings. The faculty spends a great deal of time preparing lectures. Arriving late is unacceptable and should only occur under

extenuating circumstances. Documentation of the title and subjects covered by faculty should be input by the residents onto sign-in sheet daily.

**Grand Rounds/Visiting Professorships** are held monthly from August through May at the Eye Foundation of Kansas City Auditorium. The purpose is many-fold, not the least of which includes the opportunity to discuss unusual ophthalmic cases and to present case histories and physical findings concisely along with a critical review of the literature pertinent to the patient's diagnosis. Whenever possible, the involved patient is brought in prior to grand rounds so that physicians can personally examine and evaluate their particular situation. This is done in effort to enhance better patient, resident, and faculty understanding of each case. Residents will present either two longer cases or three short cases when held at the Eye Foundation. Healthcare matrix is to be input to at least one case per month and discussed at the conclusion of the case along with pre and post-test questions for the other case.

Residents are responsible to present a **core lecture** to the department staff and residents monthly, representing an in-depth review of an assigned topic. Faculty members are available for advice on preparation of the core lecture as needed. Residents are expected to seek their advice and assistance from faculty in advance.

**Monday through Friday clinic schedule:** TMC-H clinics begin promptly at 8:30 am (8:00 am on mornings with no conference) and continue until noon. TMC-L and SLH clinics begin promptly at 9 a.m. and continue until noon. All afternoon sessions start at 1 p.m. and continue until 5 p.m. CMH clinic starts and finishes at the discretion of the faculty. Some clinics may begin earlier or end later, depending on unique patient situations/needs. Residents are to make every effort to be on time to clinics. Please courteously communicate if you are running behind and reason why to clinic supervisor and RIC (resident in charge). RIC is designated as senior in clinic per half day.

#### **Approach to Resident Clinic [PC, MK, PBLI, ICS, P, and SBP]**

Residents should thoroughly examine patients before the attending sees them wherever possible. To make the most of your experience, it is your responsibility to take the initiative. Do not wait to be handed a chart or to be asked to examine a patient. Begin by introducing yourself to the patient and family members present. Explain that you work with the attending that will be seeing the patient. Do not dilate any patient before he/she has been presented to the attending in neuro-ophthalmology or pediatric clinics. It is not possible to accurately evaluate pupils, motility, alignment, binocular vision, or acuity in pre-verbal patients when the patient has already been dilated. In contrast, all retina patients are all routinely dilated. Except in post-operative patients, every element of the external exam should be performed and documented (pupils, confrontational fields, etc.) before dilation. Before presenting the patient, have your findings ready. Formulate a preliminary working diagnosis and differential with management plan, even if you are uncertain. If and when an attending's assessment and plan is different than that of a resident, it is the responsibility of the resident to proceed with exactly what the attending has instructed them to do in a positive manner. Any concerns in this regard should be taken promptly to the Program Director for further discussion and clarification.

Residents are sometimes asked to return patient phone calls. Be sure to document the phone call in the patient's chart. This includes the name of the caller, time, date, reason for inquiry, your thoughts on situation, and your recommended resolution of situation.

Residents are to be certified in BLS which will be reimbursed by the program once successfully completed. ACLS, however, will not be covered.

### **Testing [MK, PBLI, and SBP]**

Mandatory oral and/or written examinations will be held on a monthly basis covering the following areas:

- Glaucoma
- Ophthalmic pathology
- Cataract, Lens and Uveitis
- Pediatric and Adult Strabismus
- Orbit, Eyelids, and Lacrimal System
- External Diseases of the Eye and Cornea
- Neuro Ophthalmology
- Retina and Macular Diseases/Fluorescein Angiography
- Optics, Refraction, and Contact Lenses
- Ethics and Professionalism in Ophthalmology

A grade of pass, fail, or outstanding will be given. A grade of fail may require a retake at a later date using a new test. If failed a second time, competency and medical knowledge of the resident may be questioned at the Education Committee. Remediation and further assistance may appropriately ensue. All residents sit together as a group for the entire examination process in an effort to maximize learning during the oral exam process. OKAP (ophthalmic knowledge assessment) exams are mandatory and are administered in April each year. Year-round self-study is highly recommended. In March and April, faculty will provide focused OKAP review sessions to supplement self-study. As with all lectures and conferences, attendance is mandatory.

### **Assignments [PC, MK, ICS, and P]**

The department of ophthalmology has provided their faculty and residents with access of the O.N.E. network established and maintained by the American Academy of Ophthalmology. Residents will be required to visit the website regularly to complete educational and surgical assignments as required by the department, faculty or rotation.

### **Clinical and Basic Science Research Activities and Scholarly Projects [PC, MK, and P]**

Active participation in clinical research resulting in at least two manuscripts is a graduation requirement for all residents. Regular departmental research meetings are

held every other month, and each resident is expected to show adequate progress on their project(s) throughout the academic year. Residents are encouraged to submit research posters to various national meetings (e.g. APOS, ARVO, AAO, etc). Residents will be reimbursed for travel and related expenses when poster(s) are expanded to a completed manuscript and submitted for publication to a major ophthalmology journal.

Residents will develop a working knowledge of the basic principles and techniques of clinical and basic science research. Areas of emphasis include project design, data collection and analysis, and preparation of results for presentation and/or publication.

Each resident must complete at least two manuscripts by the end of training. These should include one clinical case report and one clinical study. The clinical study may be either a prospective trial or a chart review. Procedures for project approval are described in the departmental research policy. Resident research is supervised by a faculty mentor and by a faculty director appointed by the Department Chairman. Progress towards meeting research requirements is monitored during the resident evaluation process.

### **Resident Surgery [PC, MK, PBLI, and SBP]**

Performing surgery is a privilege. Residents should be fully versed on the procedure(s) they will be observing, assisting, or performing, including the indications, anatomy, and potential complications and management of those complications. Residents who are not prepared will not be able to perform surgery. It is expected that residents will have studied a particular surgical procedure prior to seeing it and/or performing it. Resident surgeons should know the contents of the patient charts prior to surgery. Resident surgeons are expected to provide surgical care of the same quality they would expect to receive as patients. Many attending faculty appreciate the resident communicating to them 1-2 days in advance of surgical cases to alert them in advance. While this is not mandatory with all faculty, it remains greatly appreciated by all. Residents should practice suturing on two practice eyes per month and work with the EYESi simulator lab. Suture practice on a regular basis is important to continually train surgical hands, which should show steady improvement. Residents who do not choose to spend 2 hours per month with the simulator and wet lab per month will have all elective surgical cases removed from the schedule for 2 weeks. The department arranges phaco practice labs twice a year for the residents. Various stations include suturing, phacoemulsification, extracapsular cataract extraction, trabeculectomy, tube shunt, iris hooks, capsular tension rings, and insertion of silicone intraocular lenses. These sessions are mandatory and are announced well in advance to allow all residents opportunity to participate. Faculty volunteer their time to provide one on one teaching during these sessions. Each resident will reach a level of skill in ophthalmic surgery and laser treatment to allow him or her to function independently as a competent ophthalmologist. Areas of surgical experience will include cataract, cornea, other anterior segment surgery, strabismus, glaucoma, retina/vitreous, globe trauma, oculoplastics/orbit, laser/cryo procedures of the anterior and posterior segments, and refractive surgery. The minimum number of procedures in each category is specified by the residency review committee of the ACGME.

**Inadequate preparation for surgery will result in the attending physician performing the resident cases in the best interest of the patient.**

**Resident Surgical Logs [PC, MK, PBLI , and P]**

Surgical logs are mandatory, and each resident is responsible for maintenance of an individual surgical log. Logs will be monitored by surgical staff on a regular basis. Specific operative minimums where the resident acts as primary surgeon must be met in order to graduate from the residency program. Class I and III are no longer used. Residents are expected to enter all surgeries into the surgical log where they act as primary surgeon or first assistant. This is necessary to show a progressive, broad surgical experience. At least 364 total procedures (surgeon + assistant) should be completed by the end of residency. It is suggested that a surgical log be purchased the first week of residency, which can then be periodically entered into an accepted Microsoft excel spreadsheet template.

Surgical logs should be turned into the residency coordinator for review and further documentation. Log information will be uploaded to the ONE network by the residency coordinator. Surgical numbers will be reviewed by the Program Director, department faculty, and the Residency Review Committee for Ophthalmology with ACGME.

Current operative minimums for ophthalmic residents as primary surgeon upon graduation are as follows (subject to change by the ACGME):

Cataract	86
Strabismus	10
Corneal Surgery/Refractive Surgery	3
Glaucoma Filtering	5
Glaucoma Laser	9
Retina/Vitreous	0
Other Retinal	25
Oculoplastics/Orbit	28
Globe Trauma	4

The stated minimum number of listed surgical procedures for ophthalmology residency education reflects the minimum clinical volume of these procedures which is acceptable per resident for program accreditation. Achievement of the minimum number is not tantamount to achievement of competence of an individual resident in a particular listed procedure, and a particular resident may need to perform more than the minimum number to be deemed competent. This requirement also does not supplant the requirement that upon the resident's completion of the program, they must demonstrate sufficient professional ability, compassion, and knowledge to practice competently and independently.

## **Basic Surgical Log Principles [PC and PBLI]**

To be recorded as the surgeon, a resident must be present for all of the critical portions and must perform the majority of the critical portions of the procedure under appropriate faculty supervision. Involvement in the preoperative assessment and the postoperative management of that patient is an important element of that participation. Only the first assistant (not the second or third) may record a procedure as assistant. A resident may only record a case as assistant if the resident is first assistant to: (1) faculty member performing the procedure or (2) another resident performing the procedure under faculty supervision. Also, one resident cataract case must be recorded onto DVD and submitted in each resident's file prior to graduation.

### **Clarifications of Surgical Log Principles**

- If a resident completes ONE side of a bilateral procedure, the resident can count that as one case as primary surgeon.
- If a resident completes BOTH sides of a bilateral procedure, this still counts as one case as primary surgeon.
- If two residents EACH do one side of a bilateral procedure, each resident can record the procedure as the primary surgeon, provided that each fulfills the stated criteria for performance as surgeon on one side.
- If a resident completes an operation that involves multiple procedures, the resident may record all the procedures as separate cases, provided that the resident performs the majority of the critical portions of the cases (e.g. phacoemulsification with trabeculectomy). However, if the multiple procedures all fall within the same subspecialty category (e.g. cataract, cornea, strabismus, retina/vitreous, glaucoma, oculoplastics/orbit, globe trauma), then only one case may be recorded.
- If an operation involves multiple procedures, more than one resident may be recorded as the surgeon, provided that the resident performed the majority of the critical portions of one or more of the procedures.

Example 1: Resident performs a combined procedure involving trabeculectomy and cataract extraction. The resident may record both procedures as primary surgeon.

Example 2: Resident performs bilateral medical rectus muscle recessions and anterior transposition of the right inferior oblique muscle on a patient. The resident may record only one procedure as primary surgeon.

Example 3: Resident performs a scleral buckle procedure combined with a pars plana vitrectomy. The resident may record only one procedure as surgeon.

Example 4: Resident performs bilateral blepharoplasty combined with bilateral ptosis repair. The resident may record only one procedure as primary surgeon.

Example 5: During pars plana vitrectomy combined with phacoemulsification, one resident performs the pars plana vitrectomy while another resident performs the cataract extraction. Each resident may record the procedure he or she performed as primary surgeon.

### **On Call Responsibilities [PC, ICS, and SBP]**

During normal eye clinic hours of 8:30 am until 5:00 pm, emergencies will be handled by the normal contingent of physicians staffing the clinic. Residents will be responsible for seeing and evaluating emergency room eye patients and emergency consults. Coverage will provide the residents with invaluable experience in phone triage and patient exposure that is necessary for any physician to practice. The full-time staff physicians will be able to be reached on their own pagers and expect to be notified of ANY and ALL noteworthy patient/resident conversations or encounters. This is especially true for any patient who has recently undergone surgery. Discuss the problem with the patient and tell them you will contact their attending surgeon/doctor. It is most imperative that residents communicate directly to the on call attending regarding the need for same day attending evaluation, in other words an emergent or urgent staff patient examination. For postoperative patients, first attempt to call the attending that performed the surgery. If that attending is not available, contact the attending on call. Discuss your thoughts, impressions, and plan of action. Residents are on call for TMC-H, TMC-L, SLH, CMH, and RMC. Pagers are to be worn at all times while on call for easy accessibility. All phone calls are to also be documented at all times and a record kept by the resident physician. Third Thursday of the month OCAT conferences (7:15am Eye Foundation Library) will review all on call, phone, and surgical encounters to enhance patient care and understanding.

First call duties are taken from home and rotate between first and second year residents, each of whom share weekend call Friday/Saturday/Sunday. Weeknight call for first on call is nightly rotated so as not to be consecutively longer than one night at a time. Weekend first call typically goes from Friday night to Monday morning. Second call duties are assigned to third year residents, who likewise are to rotate call one week at a time. Second call is allowed to take call from home for non surgical cases, however must be able and willing to come in when asked by the first call resident to assist in assessing particular situations. Any changes needed along the way in your call rotation are to be cleared through the chief resident and program director.

First year residents will be excused from call for the first 2 weeks, and excused from taking weekend call for the first 6 weeks. When starting to take call, the first year residents are to contact the senior resident on call regarding each and every patient. At first, the senior resident should assess each patient on all but the most uncomplicated

cases (e.g. corneal abrasion). As the first year resident gains experience, he or she may handle uncomplicated patient care without assistance.

A junior resident should never hesitate to call the senior resident for advice or request their presence when seeing a patient. If questions remain upon completion of the consultation, the attending physician on call should be contacted. The first call resident on call should neither be intimidated nor reluctant to contact the senior resident, regardless of the hour. Likewise, the senior resident on call should neither be intimidated nor reluctant to contact the attending, regardless of the hour.

The process of contacting the senior resident can start at the onset of the patient encounter or any other time there are questions or concerns regarding examination or management of the patient. When there is any ambiguity regarding the examination or proper management of a patient, the senior resident must directly examine the patient. The senior resident on call must examine every patient thought to require surgical management. It is incumbent on the senior resident to exercise good judgment by directly assessing the patient and contacting the attending on call when necessary. The attending physician on call is always available, and the senior resident on call is encouraged to contact the attending physician at any time for advice, direction, direct assessment, or when surgical management is required. In almost all cases, it is preferable that the attending be contacted AFTER the initial assessment is complete. Depending on the severity of the situation communicated, all attending physicians or their designated backup must assess patients seen on call either immediately or within 24 hours. A charge voucher should be prepared by the resident physician. The attending should confirm the accuracy of the voucher and sign it. Residents take call at all training institutions (TMC-H, TMC-L, RMC, SLH and CMH).

A prompt response to ER requests is mandatory, saves time, saves sight, and maintains a standard of excellence. When involving a TMC-H, TMC-L, CMH, SLH, or RMC patient, there is NEVER a time that is appropriate to hesitate or refuse to see a patient when requested to do so by another physician regardless of how trivial the consult may seem. Furthermore, it is never appropriate to call a senior resident or attending to see if it is necessary to see a patient when asked to do so by another service. The answer is always yes. If unusual circumstances arise along the way, it should be communicated immediately to the attending on call for further clarification. All other outside requests, phone calls, requests for 'curbside' advice or transfer, are to be initially handled by the faculty on call, and should be faculty to faculty driven.

The SLH resident will cover research and SLH consults up to 5:00 pm on weekdays. The CMH resident will cover CMH up to 5:00 pm even on days when there is no clinic at CMH. For consults/clinic please review guidelines with the Pediatric Ophthalmology Fellow and Dr Olitsky, chairman of pediatric ophthalmology at CMH.

If a difficulty arises regarding a consult, the patient should be seen and treated appropriately, and the attending contacted *afterward*. Under no circumstances should the resident attempt to rectify the problem without attending involvement. Put the patient's

best interests and needs first. Whenever possible, defer to the “faculty to faculty” objective in unusual circumstances that may arise.

### **After-Hours On-Call Patient Encounters [PC, P, and SBP]**

Established Truman postoperative and clinic follow-up patients can only be examined/evaluated at the EFW facility during normal clinic hours. This is for the safety and protection of each resident. Outside normal clinic hours, these patients may otherwise be examined in the first-floor exam room of EFW only if a TMC security guard has been called by the resident and agrees to remain present during the entire patient encounter. Saturday morning post-op and follow-up exams may occur between 8:30-10:00 a.m. on the first floor of the Eye Foundation. TMC-H has agreed to provide security for that timeframe on a routine basis. Each visit must be fully documented. There is an after-hours folder available containing medical record forms and charge vouchers. A charge voucher must be completed on each patient. The medical documentation for the visit and the charge voucher should be placed inside the same folder after completion. Eye Foundation personnel will remove completed documents and restock the folder the next business day. New ambulatory patients must be seen at the emergency room to ensure safety, allow registration, reduce liability, guarantee access to testing and hospital services, and allow for proper documentation of the visit.

### **On Call Surgery [PC, P, and SBP]**

All surgery performed in the operating room must be done under the supervision of an attending and is typically performed by the more senior resident on call.

First call residents are required to assist the more senior resident in patient prep for surgery (e.g. H&P, contacting the OR and anesthesia department, consent process, and any other logistics for surgery). In addition, first-call residents are to stay for the duration of all surgery cases that are done unless directed otherwise by the attending physician. Each trauma is unique, and a great deal can be learned by each physician participating in the surgical experience. Exceptions may arise if other patient emergencies or on call responsibilities occur simultaneously, in which case first-call residents are excused to handle those situations. First call residents are otherwise expected to stay and learn/observe/participate in each on call trauma to maximize learning and experience.

Minor surgery may be done in the ER with permission from the attending on call (e.g. repair of simple lid laceration.)

### **On Call Facilities**

The ophthalmology department has an on-call room on the 5<sup>th</sup> floor of Truman Medical Center that can be used 24/7 if needed by the on-call resident. The ophthalmology room is #3. Food is also available at TMC for one on-call resident after hours and on weekends.

## **Hospital Consults and Inpatient Follow-up [PC, MK, P, and SBP]**

Whenever possible and appropriate, residents should have in-house patients brought to the clinic (TMC-H, TMC-L, or SLH) for full consultation during the day. Research Hospital and St. Luke's Hospital consults are to be seen by the St Luke's second-year resident. If a consult is a true ocular emergency, the resident should inform the attending and will be excused from clinic to assess the patient. All non-emergent consultations can be seen by the daytime resident after morning or afternoon clinic is over with the attending in that particular clinic. Emergency after-hours consultations go to the resident on call, as detailed above. The same general guidelines apply to inpatient consultations as to ER consultations in terms of communication with the senior resident and faculty member. A charge voucher should be prepared by the resident physician. The attending will verify the accuracy of the charge voucher and sign it. Attending staff must see hospital consults with the resident in a timely manner, based on communication by the resident. Emergency consultations should be seen as soon as possible. Routine consultations must be seen within 24 hours. Any difficulties encountered with the consultation process are to be directed to either Dr. Komal Desai if at SLH or Dr. Cassell if at RMC. The Program Director can also be contacted for clarification at anytime.

All inpatients on the ophthalmology service are to be seen by the resident on call over the weekends. Residents will be responsible for reviewing all emergency consults with full time staff on a daily basis. The examination notes or consult sheets should be left at the front desk of the eye clinic with the supervisor. Each resident will be active in providing inpatient and outpatient consultations during the course of training.

Proper medical records documentation of all phone calls with patients, physicians, and staff members is mandatory. Residents are encouraged to bring this documentation back to the original patient record (when appropriate) and have it placed in the patient's chart. It is suggested that a separate copy be kept by the resident for the purpose of Thursday monthly morning OCAT conference. Patients having no chart in which to file this information will have a new chart created by the staff at TMC eye clinic.

The second year resident on the St. Luke's rotation will cover SLH and Research Medical Center inpatient and ER consultations during daytime hours (until 5 pm). Attendings at SLH will staff daytime consults as able. After-hours SLH and RMC consults will be covered by the resident(s) and attending on call. RMC patients requiring transfer to another facility for surgical intervention should initially be stabilized and assessed by the resident prior to transfer. These patients will be transferred only under the direction of the attending. The hospital consult service is overseen by Dr. Komal Desai with the assistance of the Program Director.

## **Requests for Time Off**

All time off for vacations, holidays, fellowship interviews, courses, presentations, resident fatigue, and illness must be communicated in a timely fashion, in writing, to the chief resident. As a first step, all requests for planned time off (e.g. vacations, interviews,

and conferences) will be considered by the request for time off committee, which meets on a monthly basis to oversee proper coverage of surgery and clinics. Members of this committee include the chief resident, director of clinics, director/administration of the EF, coordinator, surgical scheduler at EFW, director of eye surgery, and the program director. All requests made will be considered in a fair and responsible manner. In urgent situations (e.g. family emergency), the chief resident and program director should be consulted immediately and will grant requests expediently. Time off for illness must be claimed in writing upon return to duty. Time off requests for extreme fatigue should be directed to the chief resident and program director, and are mandatory in nature for patient and physician safety.

### **Chain of Command/Help [P and ICS]**

In any instance of personal/professional or ethical dilemma or conflict among residents/faculty or clinic staff the resident is advised to follow the chain of command for assistance in resolve the matter as follows:

- 1) Chief Resident, Mouhammed Abuattieh, MD (507-319-4644)
- 2) Faculty involved in the situation (if possible)
- 3) Assigned faculty mentor
- 4) Program Director, Jean Hausheer, MD, FACS (daytime office at 816-404-1780, daytime at 816-522-3030, or after-hours at 816-587-1633)
- 5) Chairman, Nelson Sabates, MD, FACS (daytime office at 816-404-1780)
- 6) Associate Dean St Lukes Hospital, Diana Dark, MD (816-932-3408)
- 7) Associate Dean UMKC, Jill Moormeier, MD (816-404-4375)
- 8) Eve Medlock (GME Office)

### **Assigned Reading [PC and MK]**

The faculty has provided a reading list for each subspecialty area that is critical to the development of one's fund of knowledge (see Residency Curriculum). It is expected that this list will be completed at the appropriate time in one's training. Although extensive, it is not complete. This should be considered the MINIMUM reading required. Residents are expected to take the opportunity to learn whenever and wherever possible. In addition to this required reading, residents are expected to pursue an aggressive independent course of reading texts and journals. Residents should regularly read the major journals and demonstrate a progressive ability to critically evaluate the general directions of ophthalmic inquiry and the specific attributes of individual presentations. Reading should most assuredly include basic scientific journals as well, to enhance research knowledge and basis. Attending staff will regularly hold journal club sessions covering retina/macula, corneal/refractive/lenticular surgery, ocular oncology, neuro-ophthalmology, oculoplastic surgery, glaucoma/uveitis, and pediatric/adult strabismus.

### **Available Resident Funding and Finances**

- Each PGY-2 and higher resident is given a \$1000 allowance for each academic year. This begins each July 1<sup>st</sup> and ends June 30<sup>th</sup> of the following year. Funding is to be used for equipment, textbooks, and expenses associated with ARVO and AAO meetings/attendance.
- Additional GME funds are available through the UMKC School of Medicine. Please review their policies for preapproval at least 30 days before attending a conference.
- The department utilizes earmarked funds for resident education to cover expenses related to graduation, the annual symposium, phaco practice lab, textbooks, etc. This funding is not available for use by individual residents.

### **Curriculum [PC, MK, and PBLI]**

Curriculum development and oversight are the responsibility of the Residency Education Committee, a group composed of the Residency Program Director, Assistant Residency Program Director, and other key section leaders. The entire curriculum is revised annually to determine its usefulness and effectiveness in achieving the goals and desired objectives of the training program. Each resident provides written input by means of annual program evaluation; however, timely input throughout the year is greatly appreciated. Further feedback is then encouraged annually during group resident year-end review, as well as during quarterly individual resident evaluations with the Residency Program Director.

### **Curriculum Assessment**

Didactic courses and case presentation conferences are assessed annually for educational relevance and overall quality. Modifications are made as needed based on feedback from residents and staff physicians.

### **X. Assessment of Resident Performance**

Outpatient statistical data from each institution is reviewed by the Department Chairman on a monthly basis. Surgical activity and complications of each resident are also tracked monthly and reviewed at the department managers meeting. Copies of operative reports are directed to the ophthalmology administrative office at the parent institution. Pertinent information is entered into a computer database by the residency coordinator. Printouts are generated monthly for comparison to surgical logs maintained by each resident. Corrections to the central database are made as needed and any missing operative reports are recovered. Resident and institution-specific data is reviewed periodically by the Department Chairman and Program Director. Surgical volume and teaching quality are assessed at the annual review, and monthly throughout the year.

The clinical performance and surgical skills of each resident are evaluated by faculty members and appropriate leadership staff informally at the Department Manager's Meeting each month, and every four months with formal written evaluations. Written evaluations can be viewed online through New Innovations. Written evaluations are reviewed at the Department Manager's meeting, and grades and comments are assigned

with the leadership of the Department Chairman and Program Director. The Department Chairman, Program Director, Associate Program Director, and other involved faculty meet with each resident privately to discuss any remedial actions that may be required. The Program Director meets with each resident privately for feedback on these confidential reviews. Cumulative annual results are compiled anonymously and then presented and discussed at a group meeting with the Program Director and/or Department Chairman at the conclusion of each academic year.

Core competencies are evaluated throughout ophthalmology residency using various assessment tools. Assessments are compiled by Core Competency and confidentially maintained by the Program Director and Program Coordinator in a **RESIDENT MILESTONES PORTFOLIO** throughout the three years of residency. Many assessment tools evaluate multiple competencies; all competencies are evaluated quarterly with Rotation Evaluations as well as 360 Degree Evaluations. Additional examples of assessments by specific Core Competency include:

#### **Patient Care**

Observed Patient Encounter and Evaluation (OCEX)  
Skills manual  
Surgical Log  
Wet lab and surgical simulator attendance record/scores

#### **Medical Knowledge**

Didactic lecture and conference attendance record  
Monthly subspecialty oral examinations  
Pre- and post-test questions for didactic lectures and conferences  
OKAP examinations  
ABO Written and Oral examinations

#### **Practice-Based Learning and Improvement**

Grand Rounds presentation  
Mortality and Morbidity conference presentation  
Core Lecture presentation  
Journal Club presentation  
ONE Network modules/examinations

#### **Interpersonal Communication Skills**

Patient surveys

#### **Professionalism**

Patient surveys  
Completion of UMKC/TMC facility online training (HIPPA, disaster preparedness, diversity, ethics/professionalism, etc)

#### **Systems-Based Practice**

OCAAT conference attendance record  
Clinic and surgery chart review

**Please refer to the Ophthalmology Specific Assessment Tools: The Essentials, The Second Tier, and The Third Tier in the appendix of this Resident Manual. Please refer online for rotation evaluations (New Innovations).**

## Ophthalmology Specific Assessment Tools

### THE ESSENTIALS

Important Criteria for an assessment system:

- Use multiple assessment methods
- Use multiple evaluators
- Obtain multiple observations

<b>Assessment Methods</b>	<b>Competency</b>	<b>Evaluator</b>
Global Performance Rating (Rotation Evaluations)*	PC, MK, PBLI, ICS, P, SBP	Faculty members, Program Director
OKAP (Written Examination)	MK	AAO, Program Director
ABO Written and Oral Examinations	MK	ABO, Program Director
360 Degree Evaluations -Self Assessment -Fellow Residents -Professional Associates	PC, MK, PBLI, ICS, P, SBP	Resident, Residents, Fellows, Staff, Nurses, Technicians, Coordinator, Other Healthcare Professionals
Patients Surveys	ICS, P	Patients
Portfolios	PC, MK, PBLI, P, SBP	Program Director, Faculty Member, Resident
Procedural Skill Assessment (Surgical Skills Manual)	PC, MK	Faculty Member, Fellows, Volunteer Faculty, Program Director
Surgical Case Log	PC, MK	Program Director, Resident

\* Rotation evaluations are available online at New Innovations

## Ophthalmology Specific Assessment Tools

### THE SECOND TIER

Important Criteria for an assessment system:

- Use multiple assessment methods
- Use multiple evaluators
- Obtain multiple observations

<b>Assessment Methods</b>	<b>Competency</b>	<b>Evaluator</b>
Oral Examinations	MK	Faculty Members
Observed Patient Encounter and Evaluation (OCEX)	PC, MK, PBLI, ICS, P, SBP	Faculty Members, Fellows, Volunteer Faculty, Program Director
On Call Assessment Tool (OCAT)	PC, MK, SBP	Faculty Member, Program Director
Journal Club Tool	PBLI, ICS	Faculty Member, Program Director
Eye Surgical Skills Assessment Tool (ESSAT)	PC, MK	Faculty Member, Program Director
Objective Assessment of Skills in Intraocular Surgery (OASIS)	PC, MK	Faculty Member, Program Director
Global Rating Assessment of Skills in Intraocular Surgery (GRASIS)	PC, MK	Faculty Member, Program Director

## Ophthalmology Specific Assessment Tools

### THE THIRD TIER

Important Criteria for an assessment system:

- Use multiple assessment methods
- Use multiple evaluators
- Obtain multiple observations

<b>Assessment Methods</b>	<b>Competency</b>	<b>Evaluator</b>
Chart Simulated Recall	PC, MK	Faculty Members, Program Director
Objective Structured Clinical Examination (OSCE)	PC, MK, ICS, P	Faculty Members, Program Director
Simulations and Models (Surgical Simulators)	PC, MK	Program Director, Simulator
Record Review	PC, PBLI	Faculty Member, Program Director

**Subject: Resident Supervision**

**Originator: Chief Medical Officer**

Approval Date: February 8, 2006

Approved By: \_\_\_\_\_

Mark T. Steele, M.D., Chief Medical Officer

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**Policy:** Residents and fellows in training in the hospital shall not normally hold membership on the medical staff. The residents and fellows shall be permitted to function clinically in accordance with the following guidelines:

**Procedure:**

- I. Inpatient and outpatient care rendered by resident physicians shall be rendered under faculty supervision.
- II. Patient care is ultimately the responsibility of the attending physician and involved consultants.
- III. Program faculty directly responsible for the supervision of patient care services provided by resident physicians should be available to participate in that care as if residents were not involved and program faculty must be available to participate in a patient's care when requested by a resident physician.
- IV. When allowing care of their patients by residents, attending physicians do not relinquish their rights or responsibilities to: examine and interview, admit or discharge their patients; write orders, progress notes, and discharge summaries; obtain consultations; or to correct resident medical record entries deemed to be erroneous or misleading by crossing through the erroneous statement or correcting the statement and initialing the change.
- V. When a resident is involved in the care of a patient, it is the resident's responsibility to communicate effectively with their supervising physician regarding the findings of their evaluation, physical examination, interpretation of diagnostic tests, and intended interventions on a continuous basis.
- VI. The attending physician and consulting physicians shall review entries made by the residents in the medical record and make any necessary corrections in the entries, initialing all changes.

VII. Residents shall notify the appropriate attending or consulting physician upon patient admission, if there is any significant change in a patient's condition or prior to initiating significant changes in a patient's treatment including patient discharge.

VIII. Residents may perform history and physical examinations and consultations without the attending physician being physically present. It is the responsibility of the resident to discuss their findings with the attending physician upon completion of their examination. Admitting history and physical examinations shall be countersigned by the attending physician.

IX. Residents may act as consultants under the direct supervision of a medical staff member and they must see any patient if on-call for consults when requested by a medical staff member. All outpatient consultations seen by residents or fellows must be discussed with and/or seen by the attending physician at the time of the patient's clinic visit. All routine inpatient consultations must be seen by the supervising attending physician within 24 hours of the request. Urgent or emergent requests for inpatient consultations seen by a resident must be discussed with the attending physician within the required time frames (1 hour emergent; 4 hours urgent) and personally seen by the attending physician within 24 hours of the request in instances where on-site consultations are routinely provided. Physician-to-physician contact is required for urgent or emergent consultation requests.

X. Residents may evaluate patients and write daily progress notes without the attending physician being physically present. It is the responsibility of both the resident and the attending physician to discuss their findings and treatment plans documented in the progress note on a daily basis, or more often as described above, when a patient's condition changes, or prior to initiating changes in a patient's treatment.

XI. Residents may write daily orders on patients for whom they are participating in the care. These orders will be implemented without the co-signature of an attending or consulting physician. It is the responsibility of the resident to discuss their treatment plans with the attending or consulting physician. Attending and consulting physicians may write orders in the patient's chart on all teaching cases.

XII. Outside the Operating Room and Labor and Delivery, residents will be supervised by the physical presence of the attending physician or a senior resident during all procedures for which the resident has not achieved independent proficiency as verified by the residency program director. If, at any time, a resident is called upon to perform one of the specified procedures which he is not verified to perform independently, the patient's attending physician must be notified before informed consent is obtained from the patient or the appropriate individual representing the patient.

XIII. Each residency program director will develop a list of procedures that their residents may be allowed to perform without supervision. Once competency has been documented in any of these specific procedures by the program, the resident may perform these procedures without direct supervision but with the permission of the attending physician. Such list will be developed with input from members of the appropriate

department or service, and will be submitted to the Office of Graduate Medical Education. Each residency program director will review such list on an annual basis.

XIV. Except in rare emergency situations, surgical residents will be supervised by the physical presence of the surgical attending physician in the operating room suite during all operating room cases from the time of initial incision through completion of all significant portions of the case.

XV. Program specific written descriptions of resident roles, responsibilities, and patient care activities shall be distributed by program directors to their program faculty supervising residents in-training. These descriptions shall include identification of the mechanisms by which the resident's supervisors and program director make decisions about each resident's progressive involvement and independence in specific patient care activities.

XVI. The UMKC Graduate Medical Education Committee chair will report to the Medical Executive Committee annually concerning resident performance, patient safety and quality of care issues and related educational and supervisory needs of the residents. These reports will be forwarded by the Chief Medical Officer to the Joint Conference Committee of the TMC Board.

Authority: The Chief Medical Officer (or designee) is responsible for the implementation of this policy.

Original Approval Date: 7/1/2002

Revised Date: February 8, 2006

Revised Date: \_\_\_\_\_

Revised Date: \_\_\_\_\_

Reviewed Date: \_\_\_\_\_

Initials: \_\_\_\_\_

Reviewed Date: \_\_\_\_\_

Initials: \_\_\_\_\_

Reviewed Date: \_\_\_\_\_

Initials: \_\_\_\_\_

**Subject: PATIENT TRANSFERS FROM AND TO TRUMAN MEDICAL CENTERS**

**Originator:** Robert E. Myers, RN, MPA, CNA, CHE, Nursing Division  
Venus M. Buckner, R.N., BSN, Interim Corporate Patient Safety  
Manager

**Approval Date: August 12, 2005**

**Approved By:** \_\_\_\_\_  
**Mark T. Steele, M.D., Chief Medical Officer**

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**Policy**

For the purpose of ensuring coordination for patient safety and quality of care, this policy will outline the criteria for acceptance of patients to Truman Medical Centers (TMC), and describe its responsibilities when transferring patients to other facilities. Any variance from this policy may be considered a potential EMTALA (Emergency Medical Treatment and Labor Act) violation and the Corporate Patient Safety Manager and the nursing supervisor will be contacted immediately for clarification and investigation. TMC has an obligation to report to Centers for Medicare Medicaid Services (CMS) or the state agency when there is a reason to believe TMC has received a transfer in violation of EMTALA within a specific period of time, which is 72 hours. The Corporate Patient Safety Manager will be responsible for the reporting of potential violations.

**Procedure**

**Transfers of Patients from Truman Medical Centers to Another Institution**

When it is determined that a patient will be transferred to another facility, the following will be accomplished:

- A. An individual who comes to TMC for treatment of a condition that is not within its treatment capability and/or capacity may be transferred to another facility capable of providing additional levels of care and/or bed availability. TMC will provide the required medical screening examination and stabilizing treatment within its capability prior to transfer.
- B. When a patient specifically requests a transfer, an appropriate transfer will be arranged by TMC in compliance with COBRA/EMTALA Federal Regulations.
- C. The Transfer Form will be initiated and completed by the Transferring Physician.
- D. The patient is informed of benefits and risks related to the transfer by the physician and the physician documents this information on the Transfer Form.
- E. The patient consents to transfer and signs the Transfer Form.
- F. The physician certifies the need for the transfer by signing the Transfer Form. Physician to physician contact with the other facility must be made and documented on the Transfer Form for acceptance of the patient.

G. The receiving facility must also acknowledge capability and capacity to care for the patient's needs. The acceptance of the patient by the receiving facility must be documented on the Transfer Form.

H. The physician determines the appropriate method of transport of the patient to the accepting facility and documents the type of transport on the Transfer Form.

I. Copies of all records regarding the medical condition will accompany the patient to the accepting facility. Documentation of the medical records sent would be made on the Transfer Form, which accompanies the patient being transferred.

J. Patient condition at the time of the transfer shall be documented upon the Transfer Form.

K. Nursing will call a patient report and document the name of the appropriate care provider at the receiving facility who accepts the report. Documentation is made on the Transfer Form.

L. The nursing documentation will include:

1. Medical records copied.
2. Report called to receiving facility and identification of the individual receiving report.
3. Method of transfer.
4. Time of departure.

M. A copy of the Transfer Form will be retained in the patient's medical chart. The other copy will be sent to the office of the Corporate Patient Safety Manager.

N. A central log will be maintained in the Emergency Department.

### **Patient Transfers from Another Institution to Truman Medical Centers**

All transfer requests will be directed to phone number 1-800-462-8623 (1-800-GO2-TMC3). The caller will be provided with a choice of three options:

**Option 1 for Trauma Activation Transfer**

**Option 2 for Truman Medical Center Hospital Hill**

**Option 3 for Truman Medical Center Lakewood**

If transfer criteria have been met, the DSO will contact the appropriate staff physician to validate patient acceptance through the Emergency Department or inpatient.

#### A. Transfer request from another facilities' Emergency Department.

TMC recognizes its obligation to accept transfer requests from other facilities' Emergency Department if TMC has the capability and capacity, regardless of the patient's ability to pay. TMC expects requesting facility to meet its transfer obligations as required by the EMTALA regulations.

**NOTE:** According to EMTALA interpretive guidelines, a "dedicated emergency department" generally would include obstetrical and psychiatric department, as well as hospital based urgent care centers.

1. The accepting physician and the Director of Shift Operations (DSO) will accept a transfer request from another facility's "dedicated emergency department" when it is determined that TMC has the capability and capacity to treat the patient.

2. TMC will require that the requesting facility report and provide copies of all documentation regarding treatment and stabilization initiated on the said patient. It may include:

- Patient specifically requests transfer.
  - The transfer request is medically necessary. A certification is required that medical benefits of transfer outweigh medical risks.
  - The requesting facility does not have the capability and/or capacity to continue treatment.
3. Upon the arrival of the patient, the accepting physician is responsible for the patient's final disposition.

4. TMC may not refuse an appropriate transfer under the provisions of the EMTALA if TMC has the capability and capacity to treat the patient. For clarification, the staff will contact the Corporate Patient Safety Manager or the nursing supervisor.

5. **Trauma patients referred from another facility's Emergency Department or Operating Room will be accepted by the ED Attending through 1-800-462-8623 (1-800-GO2-TMC3) trauma activation option.** The ED Attending will page the Chief Surgery Resident on call to notify him of the pending transfer. Upon the patient's arrival he/she will be placed in a Trauma Resuscitation room unless the Chief/Attending Surgeon has determined that the patient should be taken directly to the operating room. Trauma transfers will be activated as a "**Type B Activation**" at a minimum for the patient's initial evaluation unless the patient meets criteria for a "Type A Activation" then they should be activated as such.

B. Transfer from a Referring Health Care Agency.

TMC will not authorize the acceptance of an **inpatient** transfer of a patient unless the referring facility is incapable of providing care for the patient and TMC is capable and has the capacity of providing such care and the patient requests transfer to TMC. Any patient transfer from inpatient status must be accepted by an attending physician and screened for appropriateness of transfer. Patients must be medically stabilized to the capability of the originating facility prior to transfer.

1. The DSO is TMC's designated agent to accept transfer requests based on TMC's capability and capacity. Any physician contacted by an outside facility for the purpose of inpatient transfer will direct the caller to the 1-800-462-8623 number prior to any patient acceptance. If inpatient transfer criteria have been met, the DSO will direct the Patient Access staff to communicate with the admitting office of the referring facility regarding payment plan and /or payment source for this admission.
2. If the patient is accepted by the staff physician and cleared by the DSO and Patient Access, the DSO will direct the accepting staff physician to complete an admit authority and execute the transfer based on bed availability.
3. The DSO will instruct Patient Access to release a bed assignment to the referring facility.

Patient Access will obtain the following information:

- a. Patient's Name
- b. Patient's Address of Legal Residence
- c. Patient's Age
- d. Patient's Sex
- e. Patient's Date of Birth
- f. Patient's Admitting Diagnosis
- g. Patient's Medicare, Medicaid number or insurance policy name and number

4. Any requests for transfers to TMC from an in-patient facility whose patient resides outside of Kansas City and Jackson County must provide a verified payment source or make arrangements for payment.
5. The referring facility will fax a copy of their admitting face sheet to Patient Access as verification of address of residence and payment source.
6. After obtaining confirmation of acceptance of the patient at Truman Medical Center by the DSO, the referring facility will call nursing report to the assigned patient unit and the patient should be transported by the method clinically indicated. Truman Medical Center does not assume responsibility for transportation of the patient from the referring facility.
7. In the event that the patient arrives with a diagnosis or condition not anticipated, the accepting service is responsible for the patient's disposition and to coordinate appropriate consultation or treatments.

Original Approval Dates:

Policy: Accepting Patient Transfers to Truman Medical Center, December 2003

Policy: Transfer of Patient to Another Institution, September 2002

Date Due To Be Reviewed / Revised: August 2007

Revised Date: \_\_\_\_\_ Initials: \_\_\_\_\_

Reviewed Date: \_\_\_\_\_ Initials: \_\_\_\_\_

Reviewed Date: \_\_\_\_\_ Initials: \_\_\_\_\_

## **Disciplinary Action Policy and Procedure**

**Purpose:** To establish a uniform policy and procedures that adhere to due process for use in investigating and responding to academic or behavioral performance by a resident that does not meet expected standards.

**Scope:** This policy and procedure applies to all residents and fellows in ACGME accredited programs sponsored by UMKC School of Medicine. Each program or department may have additional policies intended to further define the required procedures, however, the guidelines provided in this policy must be followed.

### **Definitions:**

**Academic Performance** includes the knowledge, skills, and attitudes necessary to achieve competence in the core areas of medical knowledge, patient care, communication, professionalism, practice-based learning and systems-based practice.

**Behavioral Misconduct** includes improper behavior; intentional wrongdoing; violation of a law, standard of practice, or program, hospital, or university policy. Examples include dishonesty, plagiarism, false documentation, discriminatory or harassing behavior, and being unfit for duty.

### **Procedures:**

#### **1. Failure to Meet Academic Expectations.**

A. Education Committee. Each training program will have an Education Committee, composed of selected faculty members from the specialty. At the program's discretion, other personnel (housestaff, administrative staff) may also participate in the Education Committee. The Education Committee is responsible for monitoring and reporting on the academic performance of each of the program trainees.

B. Problem Identification. Deficiencies in academic performance will be identified and evaluated by the Education Committee of the training program. These deficiencies are typically identified in the course of routinely reviewing the formal evaluations of resident performance, including end of rotation evaluations, performance on standardized tests or in structured patient contacts, patient satisfaction surveys, 360 degree evaluations and all other formal resident performance evaluations. Unsolicited and informal evaluations of resident academic performance will be accepted by the Education Committee, but disciplinary action will not be considered without substantiation of the concerns through at least one formal evaluation mechanism.

C. Performance Feedback. It is expected that all learners will receive routine, structured feedback. If it is deemed that the deficiency is serious enough to warrant additional action, the Education Committee may decide to issue a formal Letter of Academic Deficiency. This letter should include the following: a specific description of the deficiency including examples, a remediation plan with expected timeline for remediation, performance goals with appropriate methods to assess accomplishment, and consequences of either meeting or not meeting the expected goals. The letter should be signed by the program director. It is expected that in addition to the written warning, the resident or fellow will receive initial and ongoing mentoring by faculty, to give the resident every opportunity to remediate his or her deficiency. Progress through the remediation plan will be monitored by the Education Committee. The learner that successfully meets the goals and expectations outlined in the Letter of Academic Deficiency will receive a letter confirming successful completion of the remediation plan.

D. Failure to Remediate. If a resident or fellow fails to successfully achieve the goals set in the Letter of Academic Deficiency, the Education Committee may consider additional action. At this time, the Education Committee may recommend another Letter of Academic Deficiency, or may recommend a more serious disciplinary action including probation, extension of training, election not to promote, non-renewal of contract or dismissal. With each of these actions, the resident or fellow should receive a letter outlining the proposed action and including all of the elements required in a Letter of Academic Deficiency (except for instances of proposed dismissal, where the remediation plan and performance goals are not relevant). The letter must also notify

the resident or fellow of their right to request review of the decision and the processes and timeline of the review request.

E. Request for Review. The resident or fellow has the right to request review of any disciplinary action that has the potential to adversely affect the course of his or her training or career (including probation, extension of training, election not to promote, non-renewal of contract or dismissal). The resident or fellow must request this review within 14 days of receipt of the decision of the Education Committee. The request for review should be submitted to the program director. This review must be conducted by an individual or group of individuals independent of the training program's Education Committee. The review should include a comprehensive assessment of resident or fellow performance, a report (verbal or written) from the Education Committee, and an opportunity to meet and interview the resident or fellow. The resident or fellow must have the opportunity to present their perspective to the reviewer(s). A legal or advisory representative may be present during the interview acting in an advisory capacity to the resident or fellow but may not otherwise actively participate in the proceedings. In preparation for this presentation, the resident or fellow must have access to all of the information provided to the reviewer(s) a minimum of five days prior to the review. After consideration of all available information, a final decision will be submitted to the Education Committee and the resident or fellow.

F. GME Committee Review. It is the program director's responsibility to submit to the GME Committee the summary of any disciplinary action resulting probation, extension of training, election not to promote, non-renewal of contract, dismissal, or any other action that could adversely affect the course of training of the resident or fellow. The GME Committee will review the case file to confirm that this policy has been followed and that the trainee has had appropriate opportunities for remediation and due process.

G. Employer Review. In some situations, a final review by the trainee's employer may be allowed. The resident can confer with the GME office if this issue becomes relevant.

## **2. Behavioral Misconduct**

A. Problem Identification. Behavioral misconduct may be identified through the formal training program evaluation system, but will often be identified by informal, or incident, reports to the program administration.

B. Initial Investigation. Upon receipt of a report of behavioral misconduct, through formal or informal channels, an investigation of the complaint should be undertaken. This investigation may be directed by the program director, or may be assigned to another faculty member. At a minimum, this investigation must include review of the complaint and a discussion with the accused resident or fellow. If there is insufficient information to conclude that misconduct may have occurred, no further action will be taken. If there is evidence suggesting possible sexual harassment, the GME office is to be notified immediately. For all other areas of behavioral misconduct, the matter will be referred to the Education Committee for review.

C. Education Committee Review. The Education Committee will review the submitted complaint, the evidence gathered by the initial investigation, and meet with the accused resident or fellow. The Education Committee may also collect additional information, independent of the initial investigation. The resident or fellow must have the opportunity to formally answer to the submitted accusation before any disciplinary action is considered. In order to fairly respond to the submitted accusation, the resident or fellow must have access to all information provided to the Education Committee.

If the inquiry by the Education Committee finds that no misconduct occurred, no action will be taken and the case will be closed. If the committee finds that behavioral misconduct did occur, the following disciplinary actions may be considered: a verbal or written warning, referral to an appropriate educational or treatment program (e.g. Missouri Impaired Physicians program), probation, extension of training, election not to promote, non-renewal of contract, or dismissal. Written notification of the Education Committee decision will be sent to the resident or fellow.

D. Request for Review. The resident or fellow has the right to request review of any disciplinary action that has the potential to adversely affect the course of his or her training or

career (including probation, extension of training, election not to promote, non-renewal of contract or dismissal). The resident or fellow must request this review within 14 days of receipt of the decision of the Education Committee. The request for review should be submitted to the program director. This review must be conducted by an individual or group of individuals independent of the training program's Education Committee. The review should include a complete review of the entire case file, a report (verbal or written) from the Education Committee, and an opportunity to meet and interview the resident or fellow. The resident or fellow must have the opportunity to present their perspective to the reviewer(s). A legal or advisory representative may be present during the interview acting in an advisory capacity to the resident or fellow but may not otherwise actively participate in the proceedings. In preparation for this presentation, the resident or fellow must have access to all of the information provided to the reviewer(s) a minimum of five days prior to the review. After consideration of all available information, a final decision will be submitted to the Education Committee and the resident or fellow.

E. GME Committee Review. It is the program director's responsibility to submit to the GME Committee the summary of any disciplinary action resulting probation, extension of training, election not to promote, non-renewal of contract, dismissal, or any other action that could adversely affect the course of training of the resident or fellow. The GME Committee will review the case file to confirm that this policy has been followed and that the trainee has had appropriate opportunities for remediation and due process.

G. Employer Review. In some situations, a final review by the trainee's employer may be allowed. The resident can confer with the GME office if this issue becomes relevant.

**Reportable Actions.** Reportable actions are those actions that the training program or GME administration must disclose to others upon request, including future employers, privileging hospitals, and licensing or specialty boards. A final disciplinary decision that results in extension of training, election not to promote, non-renewal of contract, or dismissal is considered a reportable action.



**March 20, 2008**

**GME Administration and Program Support during a Disaster  
Policy and Procedure**

**Purpose:** To insure continued, high quality educational experiences for our residents and fellows during a time of disaster affecting UMKC School of Medicine or one of its affiliated hospitals or training sites.

**Scope:** This policy and procedure applies to all residents and fellows in ACGME accredited programs sponsored by UMKC School of Medicine.

**Definitions:**

**Disaster:** An event that causes significant alteration in the educational experience in one or more GME training programs.

**Procedures:**

1. **Individual Communication.** It will be the responsibility of the GME Office to maintain accurate, complete contact information for all program directors and housestaff. This contact information, as often as possible, should include multiple potential lines of communication (residential phone, cell phone, mobile pager, university and personal e-mail addresses). The program coordinators will be responsible for reviewing this information on a scheduled basis and confirming its accuracy. Reports detailing the contact data will be electronically distributed to the program directors on a regular basis, for use in an emergency situation.
2. **Group Communication.** Campus-wide communication regarding disasters will occur through the UMKC Alert! Mass notification system, as outlined in the UMKC Business Interruption Policy (December 10, 2007), as well as through the School of Medicine, Campus and System web pages.
3. **ACGME Communication.** It will be the responsibility of the DIO (Designated Institutional Official, in most instances the Associate Dean for Graduate Medical Education) to notify the ACGME of a disaster potentially affecting the course of training of residents or fellows in one or more UMKC School of Medicine sponsored programs.
4. **Institutional Impact Assessment.** The affiliated hospital Associate Deans will be responsible for assessing the impact of the disaster on their individual organization's ability to provide uninterrupted and ongoing graduate medical education. The assessment will include determination of general capacity (common facilities and services), as well as individual program capacity for ongoing training. If at all possible, this assessment should be completed within 72 hours of the occurrence of the disaster. If the disaster limits the capacity of an affiliated institution to provide GME training, it will also be the

affiliated hospital Associate Dean's responsibility to determine if and when the full, pre-disaster training experience can be resumed at their institution.

5. **Individual Impact Assessment.** The program directors will be responsible for contact with each of their housestaff. The program directors will ascertain the health and safety of the residents or fellows and determine their capacity and desire to continue training. If at all possible, this assessment should be completed within 72 hours of the occurrence of the disaster.
6. **Training Capacity Determination.** Upon receipt of reports from the hospital Associate Deans and the Program Directors and with their input and guidance, the Associate Dean for Graduate Medical Education will determine the capacity of each individual training program to provide ongoing, high quality graduate medical education to each of its residents or fellows. The Dean of the School of Medicine will be informed of these decisions by the Associate Dean for Graduate Medical Education.
7. **Transfer of Training Experience.** If one or more training programs cannot provide an adequate educational experience for some or all of its residents or fellows, it will be the Program Director and the Associate Dean for Graduate Medical Education to either: a) Arrange for temporary transfers to other programs or institutions until such time as the UMKC program can provide an adequate educational experience for each of its residents or fellows, or b) Assist the resident in permanent transfer to another training program. If more than one training opportunity is available, every effort will be made to follow the preference of the trainee in the location of the temporary or permanent transfer. It will be the responsibility of the hospital Associate Deans to assist in the transfer of Medicare cap reimbursement to the temporary or permanent training site.
8. **ACGME Requirements.** Within ten days of disaster declaration by the ACGME, the DIO or Associate Dean for Graduate Medical Education will contact the ACGME to discuss due dates that the ACGME will establish for the programs to: a) submit program reconfigurations to the ACGME, and b) To inform each program's residents or fellows of transfer decisions. The due dates for these submissions are expected to be no later than thirty days after declaration of the disaster, unless extensions are approved by the ACGME.
9. **Ongoing Communication.** It is the responsibility of the program director to notify each transferring resident of the expected minimum and actual duration of any temporary transfer. The program director must also maintain ongoing contact with all temporarily transferred residents, keeping them informed of expected times of transfer back to the UMKC campus. The program director is also expected to provide any information reasonably expected to be necessary to the accepting program director, including individual resident educational experiences, performance and expected needs. Finally, it is the program director's responsibility to obtain, from the accepting institution, a report of the academic progress for each resident that has to be temporarily transferred. This report should be sufficient detail to allow the UMKC program director to determine if the resident has met the training requirements of the appropriate specialty board and the RRC for the specialty.
10. **Program Oversight.** The Associate Dean for Graduate Medical Education will be responsible for regular reporting to the GME Committee on the status of each program affected by the disaster. Upon review of the impact of the disaster, the GME Committee may recommend an increase in the intensity of

program oversight for affected programs, including additional internal reviews.

**Follow-up Responsibility:** Director, Graduate Medical Education Operations.

**Revision Date: March 20, 2011**

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