Clinical & Patient Care Services

A Guide for Clinical Operations
Indiana University School of Optometry

Atwater Eye Care Center
744 East Third Street
Bloomington, Indiana 47405
(812) 855-8436

Indianapolis Eye Care Center
501 Indiana Avenue, Suite 100
Indianapolis, Indiana 46202
(317) 321-1470
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Introduction

Professional practice involves proficiency in both the “science” of practice, for which the foundation has been laid in the studies preceding the clinic, and in the “art” of practice which can best be established by patient interaction and practical application of the student’s optometric education. This manual contains information to serve as a guide to meet these standards and objectives. All individuals connected with the Indiana University School of Optometry Eye Care Centers (students, faculty, and staff) are required to read and understand the contents of this manual.

The Association of Schools and Colleges of Optometry (ASCO) has established functional standards for optometric education. In order to graduate, each student must meet these standards, along with criteria established by the Indiana University School of Optometry (IUSO). The functional standards for optometric education require that each graduating student possesses appropriate abilities in the following areas:

- **Observation**
  Student interns must be able to acquire a defined level of knowledge as presented through lectures, laboratories, patient interaction and self-study.

- **Communication**
  Student interns must be able to communicate effectively, efficiently and sensitively with patients and their families, peers, staff, clinical faculty and other members of the health care team.

- **Sensory and Motor Communication**
  Student interns must possess the sensory and motor skills necessary to perform an eye examination, including emergency care.

- **Intellectual-Conceptual, Integrative and Qualitative Abilities**
  In order to be an effective problem-solver, the student intern must be able to accurately and efficiently utilize such abilities as measurement, calculation, reasoning analysis, etc.

- **Behavioral and Social Attributes**
  The student intern must possess the necessary behavioral and social attributes for the study and practice of optometry.

One of the roles of the clinical faculty is to assist students in meeting these standards. In the process, the faculty member will exercise educated judgment in evaluating and grading student performance in all of the areas listed above.

The Indiana University School of Optometry Eye Care Centers (ECCs) are designed to provide optometry students essential professional training for the practice of Optometry.

**Indiana University School of Optometry Mission Statement**

The mission of the Indiana University School of Optometry is to protect, advance, and promote the vision, eye care, and health of people worldwide by preparing individuals for careers in optometry, the ophthalmic industry, and vision science and by advancing knowledge through teaching, research, and service. This is accomplished through the Doctor of Optometry, Optician/Technician, Residency, and Graduate Programs.

To fulfill our mission, the School must ensure that students demonstrate satisfactory knowledge and skills in the provision of optometric care.

**Indiana University School of Optometry Vision Statement**

The vision of the Indiana University School of Optometry is to be on the leading edge of vision care for the people of the world.
General Policies and Procedures

The following policies and procedures are designed to familiarize clinical interns, faculty, and staff, with basic clinical protocols and intern expectations.

Clinic Course Grading

The faculty of the Indiana University School of Optometry (IUSO) is committed to the quality of your clinical education by providing a supervised, well-organized environment for patient care. The goals of the Clinical Program include not only the enhancement of your clinical skills, but also the development of your communication skills as you interact with patients, other professionals, and clinic staff/faculty.

Course Grade Determination

1. A written Mid-term Intern Evaluation will be completed by each faculty member. The purpose of the Mid-term Intern Evaluation is to provide timely formal feedback. The intern will receive a copies of the Mid-term Evaluations completed by each faculty member through the Meditrek system. Third year interns receive their Mid-term Evaluations after four (4) weeks of their eight (8) week clinical rotation. Fourth year interns receive their Mid-term Evaluations after six (6) weeks of their twelve (12) week clinical rotation.

2. A graded written Final Intern Evaluation will be completed by each faculty member. The final grade will be weighted by the number of patient encounters with each faculty member, as reported by the intern at the end of the rotation on the Patient Log Sheet Census Form. The intern will receive a copy of the Final Evaluation forms completed by each faculty member through the Meditrek system.

It is unavoidable that the grading of clinical performance includes some degree of subjectivity on the part of faculty members. It is understood by the faculty members that your clinical performance often will be affected by the amount of clinical experience you have had prior to your assigned IUSO clinic. Whenever possible, these aspects of grade determination are taken into account in your final clinical grade determination.

The following guidelines are utilized in your final clinical grade determination:

<table>
<thead>
<tr>
<th>Performance Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>“A” Level (A+, A, A-)</td>
<td>Intern exhibits a high level of clinical performance.</td>
</tr>
<tr>
<td>“B” Level (B+, B, B-)</td>
<td>Intern exhibits an average clinical performance.</td>
</tr>
<tr>
<td>“C” Level (C+, C) (C-)</td>
<td>(C+, C): Intern exhibits a below average level of clinical performance. (C-): Intern exhibits a below passing level performance</td>
</tr>
<tr>
<td>“D” Level (D+, D, D-)</td>
<td>Intern exhibits a level well below passing clinical performance standards.</td>
</tr>
<tr>
<td>“F” Level</td>
<td>Intern exhibits grossly unacceptable clinical performance.</td>
</tr>
</tbody>
</table>

If performance deficiencies are noted during the course, the clinical faculty will proactively identify and address these deficiencies as effectively as possible. This is done in a timely manner, and the intern is fully informed at each juncture. A receptive attitude on the part of the intern to the recommendations of the clinical faculty will contribute positively to the intern’s educational experience.
Grading Process

• Third Year Interns

Throughout your clinical rotations in Bloomington, your clinical performance is continually evaluated. Each clinic day, your clinical consultant evaluates your clinical skills for each exam that you performed using the Daily Intern Skills Assessment Form shown in the Appendix. This evaluation is intended primarily as a tool to provide you with feedback in order to improve your clinical skills. The assessment forms will be a factor when it is time to consider your final grade. Note, however, that your grade is not a composite of your Daily Intern Skills Assessment Form grades.

• Fourth Year Interns

Unlike your experience in third year clinic you are not given an individual Daily Intern Skills Assessment Form for each patient examination you perform. Instead, you will receive a mid-term grade and a final grade. It is expected that if a consistent deficiency in your clinical performance is noted, your clinical consultant will bring this to your attention in a timely manner.

It should be noted that fourth-year interns performing a rotation at one of the IUSO Eye Care Centers must receive a passing grade in each sub-clinic (e.g. Ophthalmic Disease Clinic, Contact Lens Clinic, Binocular Vision/Pediatric Clinic, Low Vision Clinic, etc.) to receive a passing grade for the rotation.

Patient Log Requirements

In accordance with Accreditation Council of Optometric Education (ACOE) guidelines, all third and fourth year students are required to document all of their clinical patient contacts. The School provides a web-based patient log (located at www.opt.indiana.edu under the “Students” section) where students can easily record this information. Additionally, you are required to keep a written copy of the log as backup in the event that the computer log should fail. Each patient encounter must be entered into the log no more than two weeks after the encounter and the log must be complete by the final class day of the semester or rotation. The patient log report should be signed by the coordinator of the externship program the student has attended, and turned in to the office of the Director of Clinics. Failure to do so will result in an incomplete grade being recorded for the appropriate course.

Clinical Instructor Evaluation Requirement

Each session, optometry student interns are required to evaluate faculty who have supervised them in clinic. Each student enters an instructor evaluation via the Meditrek system for each faculty who has served as his/her clinical consultant during the semester or clinical rotation. The evaluation is anonymous and is intended only to provide feedback to the individual clinical faculty member. The surveys are collected by an assistant to the Associate Dean for Clinical & Patient Care Services and forwarded to the individual faculty member for their review.

Clinical Remediation Policy

The IU School of Optometry’s clinical remediation policy is based on the following concept: Clinical education is an interactive process, and successful clinical performance requires the full participation of the student. A student who has difficulty in areas of clinical performance is expected to seek help, to identify and understand the problem, and to take an active role in correcting it. Faculty will provide intense supervision at the student’s request; ultimately, however, the success of remediation depends on the student.

Student Interns who receive a grade of C- or lower in a clinic rotation will not pass that rotation. A clinic remediation plan must be completed satisfactorily, and the failed rotation repeated.

Please consult the current School of Optometry Bulletin (accessed on the ISUO Home Page) for the official remediation policy under the section entitled “Academic Standing”.

Professional Misconduct

Proven violation of the policies, procedures and protocols of either Indiana University or its School of Optometry constitutes professional misconduct. Professional misconduct may include (but is not limited to) dishonesty involving clinic patient records such as alteration or fabrication, forgery of signatures, excessive unexcused absences, or use of the clinic for financial gains, i.e., practicing Optometry without a license and/or receiving a fee for services rendered or materials ordered. Patient endangerment or abandonment also
represents professional misconduct. Any form of professional misconduct is strictly prohibited, and is grounds for immediate dismissal from the School of Optometry.

Please consult the current School of Optometry Bulletin for further information on professional misconduct.

**Attendance Policy**

All students are responsible for prompt attendance in the clinic they have been assigned. You must remain in your assigned clinic (e.g., Primary Care, Contact Lens Research Clinic, Ocular Disease Clinic, etc.) at all times during your shift until all patients have been examined and your consultant releases you.

If you need to leave the clinic floor during your assigned time you must obtain permission from a faculty consultant and notify the front desk of your whereabouts.

Failure to comply with any portion of the Attendance Policy will result in a failing grade (“F”) for the day.

**Third Year Interns**

Attendance for third year optometry interns is mandatory. There are no days allotted for professional or personal leave. Each absence must be made up. Failure to make up an absence will result in a failing grade for that day. Extreme circumstances will be considered on a case-by-case basis.

If unforeseen circumstances make an absence necessary, you must notify the clinic front desk, your clinic consultant, and the Chief of that particular service Director of as far in advance as possible.

**Fourth Year Interns**

Professional leave is a benefit that fourth year interns can use for activities that further their professional (i.e., optometric) career, such as seminars and interviews.

Fourth year interns may be granted a maximum of two (2) professional leave days during their Bloomington rotation and an additional two professional leave days during their IECC rotation (if applicable). Professional leave days cannot be “banked” and/or carried over.

**How to Request Professional Leave Days**

Interns who wish to use professional leave time must submit a *Professional Leave Request Form* (see Appendix). The completed form must be submitted at least two (2) weeks in advance of the requested time off to the Director of Clinics office (or Ann Michael/Dr. Sutton if at IECC). Leave requests will be approved on a case-by-case basis.

Interns are asked to notify their consultant(s) about any professional leave days they have been granted.

If a student experiences an unforeseen absence (e.g., illness, injury, or death in the family) the student must call the school in advance (when possible) to report the situation and complete a *Professional Leave Request Form* upon return.

**Schedule Swapping (Third and Fourth Year Interns)**

Third and fourth year interns who wish to make a schedule switch must submit a *Clinic Swap Form* (see Appendix). The completed form must be submitted at least two (2) weeks in advance of the requested swap. Schedule swap requests will be approved on a case-by-case basis.

Failure to appropriately complete a *Clinic Swap Form* will result in a failing grade (“F”) for the day for each intern involved in an undocumented swap. Once a schedule swap has been approved, all attendance policies must be adhered to by each swap participant.

**Inclement Weather**

If you must miss clinic due to inclement weather you are responsible for immediately contacting the clinic, as well as the consulting faculty member and/or the Chief of that service.

IUSO clinics remain open as scheduled, even on days of inclement weather. However, you will not be penalized for absences due to extreme weather conditions. In the event of multiple legitimate absences due to extreme weather conditions, you may be required to “make-up” that time.
Before attempting to travel, contact the Indiana State Police at 812-332-4400 or 317-897-6220. Unless weather conditions are extreme, it is preferred that you attempt the trip before missing clinic.

**Dress Code Policy**
This Dress Code Policy applies to all faculty, residents, students, staff, and work studies whenever on the clinic premises. If you enter any of our clinics for any reason ie, research, discussion, checking on schedules, looking for classmates or colleges, etc, you must conform to the clinic dress code. Student violation of this policy may result in dismissal from clinic resulting in an “unexcused” absence (“F” for the day and make-up time required).

**Name Tags**
All faculty, residents, students, staff and work studies must be identified by a name tag while on the clinic floor. The name tag should be kept current.

**Lab Jackets/Coats**
- General Comments: lab coats should be clean and pressed at all times and are required during patient care activities unless climate control problems are present in the clinic. The shirt worn beneath the lab coat should be appropriately modest.
- Faculty: A lab coat (long length, white).
- Interns and Optician/Technician Students: a lab jacket (short length, white).
- Clinic Staff, hourly and workstudy: Scrubs or short white lab coat are required when present in the clinic.
- Dispensary Staff: No lab coat is required but all dispensary personnel are required to dress in professional office attire.

**Proper Attire:** Good common sense and professionalism should dictate daily attire.
- Be attentive to all aspects of your personal hygiene.
- Hair should be clean and well groomed. Long hair should be tied back. Dramatic styles are not appropriate. Do not come in with wet hair.
- Shoes should be appropriate. Closed toe shoes are strongly recommended. Sport tennis shoes are not considered appropriate.
- Jewelry should be kept to a minimum. Jewelry in the brow, nose, lip or tongue is not considered appropriate.
- Clothing styles and fit should be appropriately modest, clean and pressed. T-shirts under cardigan sweaters are not considered appropriate. Sweatshirt material is not considered appropriate. Baggy “sagging” pants are not appropriate.

Women:
- Make-up should be kept light.
- Dress slacks, Dress blouses or tailored shirts are appropriate. The blouse or shirt should be appropriately discreet.
- Dresses, skirts and dress walking shorts should be of modest length (no more than 2 inches above the knee) and should be worn with appropriate shoes. Mini-skirts, and revealing necklines, exposed midriffs and spaghetti straps are not appropriate.

Men:
- Dress slacks, dress shirts and ties are appropriate. Casual shirts are not considered appropriate, even when worn with a tie.

**24-hour On-Call Service**
**Bloomington**
Any individual with an after hours ocular emergency who calls either AECC or CECC will be directed where to call to activate the pager.
- Primary On-Call Intern
The primary on-call intern will be scheduled from 5:00 PM on Friday until 5:00 PM the following Friday, including the weekend. The primary on-call intern is responsible for wearing his/her pager at all times or having it in close proximity. It is the intern’s duty to use the pager only for its intended clinical use. Any unprofessional conduct while on-call will not be tolerated.

The primary on-call intern will be paged by the doctor on-call if a patient emergency occurs. The pager will display the phone number where the intern can reach the doctor for further instructions (patient’s status, when and where to meet, etc.) After being paged, the intern should contact the doctor within 15 minutes.

• Secondary On-Call Intern
The secondary on-call intern will be scheduled from 5:00 PM on Friday until 5:00 PM the following Friday, including the weekend. The secondary on-call intern will not have a paging system. The duty of the secondary on-call intern is to serve as a back-up to the primary on-call intern in instances where the primary on-call intern must go out of town or is indisposed (in such cases, the primary on-call intern may hand-off the paging system). The secondary on-call intern is contacted if the primary on-call intern cannot answer his/her page or if there is a pager malfunction. This does not mean that the secondary on-call intern must sit by the phone every night, but should remain accessible if needed.

• On-Call Doctor
The on-call doctor can be reached by pager by dialing 812-323-5592. After you hear three beeps, enter the number where you can be reached, press the “#” symbol, and hang up.

IECC
On-call service is staffed by faculty only.

Patient Medical Records
Legal Aspects
A patient’s medical record is a legal and historic document. It serves as a record of all data collected, services delivered, advice and recommendations made, materials provided, and fees charged and collected. As a legal document, it is the property of the Clinic. Copies may only be released at the discretion of the Clinic Administration upon proper request from the patient or their guardian.

Signatures
All records must be completely documented and signed and dated by the appropriate student, faculty consultant, or staff personnel. Unsigned records, order forms, etc., will automatically bring procedures to a halt until a proper signature is attained. Forgery of a signature or initials is grounds for dismissal and a failing grade. All signature must be legible.

Record Legibility
All patient record entries must be legible. If an auditor cannot read record entries, they will assume that the procedure or examination had not been performed. Be sure that all entries are legible so that any person reading the chart can decipher the information.

Confidentiality
In 1996 the Health Insurance Portability and Accountability Act (HIPAA) was passed. The Administrative simplification provisions of this act are clinically significant in that they address the security and privacy of health data and serve to protect individually identifiable patient information.

Patient files contain confidential information about the patient which may not be released without the patient’s consent. To ensure ethical and legal patient care, it is imperative that confidentiality is maintained. No one should have access to a patient file that does not have legitimate reasons to see the file. No discussion of information contained within the record should be held in public areas of the clinic, such as the waiting area, the payment areas, the front desk areas, staff, with other patients or students or faculty who are not involved in the care of the specific patient. Consultation with the faculty consultant should be held in a closed examination room or the consultant’s office. Failure to maintain confidentiality jeopardizes the Clinic’s legal position and can lead to suspension or dismissal of a student from the Clinic.

Failure to comply with the privacy portion of this act may result in civil penalties up to a maximum of $100 per violation and $25,000 annually for similar violations. Intentional misuse of Protected Health Information (PHI) is subject to criminal penalties including $50,000-$250,000 in fines and/or 10 years in jail.
For further information on HIPAA, see “HIPPA Basics” and “IUSO Commitment of Confidentiality” which are attachments to this manual (Attachments 1 & 2), or please go the following websites: http://cms.hhs.gov/hipaa/

Record Storage
Under no circumstances are patient records to be removed from the Clinic. Failure to abide by this rule will lead to suspension from the Clinic.

Patient records are filed numerically in our paper file system and alphabetically in our computerized file system. Active records are defined as records of patients who were seen in the last four years.

Active records are filed on the clinic floor. Inactive records four years or older are placed in storage. Students or faculty should not remove patient records from storage. If an archived record is needed, please consult the records service staff member.

When a record is removed from a file, an out card should replace it. Out-cards should contain the name of the patient, the date, the faculty consultant’s name and the student intern’s name to whom the patient had been assigned. At the end of the day, returned records can be checked against these out-cards. Failure to return a record at the end of each will be brought to the Clinic Director’s attention.

Request for Patient Records
No information, including eyeglass or contact lens prescriptions, can be released without a signed consent from the patient or their legal guardian. An Indiana University School of Optometry consent form can be mailed to the patient’s address if the patient is unable to sign a consent form at the Clinic. These forms are available at the front desk.

CPR/AED Certification; Immunizations
No one can see patients in clinic until verification is provided of training in cardio-pulmonary resuscitation and automated external defibrillation, and of compliance to immunization policies.

Because of direct patient contact during your time in clinic you are required to provide the IUSO proof of CPR/AED certification. Please bring a copy of your current certification to the office of the Director of Clinics in room 306 before the start of your third year clinic.

Courses in CPR/AED are regularly offered at the IU School of Optometry, local Red Cross chapters, and other locations.

All interns must have had annual testing for TB and Hepatitis B prior to any patient care activities. For immunization policies, consult the IUSO Bulletin found on the IUSO home page.

Occupational Injuries
The following policy applies to all faculty, staff, and students working in one of the IUSO Eye Care Centers. It is taken directly from Indiana University Personnel Policy 7.2 – Injury on the Job.

1. Employees must report immediately any and all on-the-job injuries to their consultant, supervisor or designee, regardless of whether medical attention is sought. Failure to report an injury on the same day of occurrence—or in the case of cumulative trauma, when the employee becomes aware of the symptoms—may result in denial of a claim by Risk Management.

2. The consultant, supervisor or designee must report the injury on the Occupational Injury/Illness Report form and forward it to Risk Management within 24 hours regardless of whether professional medical attention or lost time is indicated.

3. The university has the choice of the attending physician for treatment of on-the-job injuries. If the employee believes that treatment is needed, the employee must go to the IU Health Center, 600 N. Jordan, for treatment of the injury. If the Health Center is closed or it is an emergency situation, the employee must go to the Bloomington Hospital Emergency Room. At IU Eye at Carmel, the employee should report to Occupational Health Services, located in Coleman Hall at 1140 N. Michigan Street (317-274-5887)
An employee may not be entitled to Worker's Compensation benefits and university-provided injury leave if she/he:

a. Does not seek medical treatment for an injury that results in lost time
b. Seeks treatment from a source other than the IU Health Center, or if appropriate, from the Bloomington Hospital Emergency Room

4. Before leaving the treatment location, employees must obtain and provide to their consultant or supervisor, a physician’s statement regarding the employee’s return-to-work status. 5. In cases where an employee is exposed to another person’s tissue, blood, or fluid, the employee should contact University Human Resources and the Biosafety Officer of the Biosafety Committee on the Bloomington campus regarding the procedure to follow.

a. The employee is required to take (in person) one copy of the Occupational Injury-Illness Report form to the IU Health Center (or Bloomington Hospital if the Health Center is closed) within two hours of exposure.
b. If a sample of the source of contamination can be obtained, the employee should take it to the Health Center or Bloomington Hospital for testing.
c. The supervisor is to send a copy of the Occupational Injury-Illness Report form to the Biosafety Officer, Biosafety Committee, IU Research Park, Room 109, IUB.

6. All employees’ lost time as a result of on-the-job injury must be reported to Risk Management.

7. Questions regarding this procedure should be directed to Risk Management.

Clinic Security and Safety
Policy against Workplace Harassment and Violence

1. Purpose and scope

a. It is the goal of Indiana University to promote a safe, respectful, and productive work environment in which to deliver quality academic programs and administrative services. To this end, the university will not tolerate, condone or ignore workplace harassment or violence as described in this policy.
b. Each department head, manager, supervisor, and employee is responsible for keeping the workplace free of harassment and violence. This includes intimidating, hostile, threatening, or violent behavior by employees or non-employees (vendors, job applicants, visitors, spouses, etc.) against self, others, university property, or property on university premises belonging to others.
c. This prohibition covers all university premises and university-sponsored events as well as off-campus sites should an incident occur that is shown to have an adverse impact on the university.

2. Existing related law and policy

a. Federal and state law, as well as university policy, prohibits discrimination as identified in the university's Equal Opportunity/Affirmative Action policy. Those who believe they are victims of or have observed such discrimination are strongly urged to contact their campus affirmative action office.
b. The university policy on firearms and weapons prohibits employees from unauthorized possession of firearms or other items deemed by the campus police department to be dangerous on university premises or events.
c. Certain violence-related behavior is prohibited under criminal or civil law. When appropriate, the university will refer such cases for criminal or civil prosecution.

3. Descriptions of workplace harassment and violence

No form of intimidating, hostile, threatening, or violent behavior will be tolerated. Such behavior includes but is not limited to the following:
a. Intimidating or hostile behavior includes language or action that disrupts the work environment, causes undue emotional distress to another, or creates a reasonable fear of injury to a person.
b. Threatening behavior includes physical actions without physical contact or injury, and general or implied threats to people or property.
c. Violent behavior includes any physical assault with or without weapons, throwing objects, destroying property, and specific or expressed threats to inflict harm to people or destruction to property.

Reporting and Investigating Workplace Harassment or Violence

1. Any employee who experiences, observes or has knowledge of actual or threatened workplace harassment or violence has a responsibility to report the situation as soon as possible.
   a. In the case of an actual or imminent act or threat of violent behavior, call the campus police department.
   b. In all other cases, the report should be made to the employee’s supervisor or department head and to campus Human Resources office.

2. All reports of workplace harassment or violence will be investigated promptly and impartially and as confidentially as possible.

3. Employees are required to cooperate in any investigation. A timely resolution of each report should be reached and communicated to all parties involved as soon as possible.

4. Any form of retaliation against employees for making a bona fide report concerning workplace harassment or violence is prohibited; therefore, such retaliation must also be reported.

Telephone Numbers – Bloomington

In the case of an emergency, contact the IUB Police Department: 911

In the case of a non-emergency, contact the IUB Police Department: 812-855-4111

Telephone Numbers – Indianapolis Eye Care Center

In the case of an emergency, call: 9-911

In the case of an emergency, contact the IUPUI Police Department: 9-274-7911

In the case of a non-emergency, contact the IUPUI Police Department: 317-274-7971

Emergency Disaster Plan – General Information

The following policies are based upon policies included in the IU and IUPUI Staff and Faculty Emergency Procedures Handbooks.

On their first day in clinic, all new faculty, staff, and interns should be introduced to emergency procedures including evacuation routes, safe locales and assembly points, as well as the location of fire alarms, fire extinguishers and emergency lighting.

For all emergencies the following general protocol should be kept in mind:

1. Identify the emergency type
2. Notify the appropriate authorities/emergency responders
3. Move to a place of safety or evacuate
4. Move to the designated assembly point and account for all faculty, staff, interns, patients, and family.
5. Follow the directions of emergency responders.

All phone calls from IECC must be preceded by a “9” to get an outside line.
Emergency Disaster Plan – Severe Weather
In the case of severe weather, listen to local radio, television or the National Oceanic and Atmospheric Administration (NOAA) weather radio for latest National Weather Service bulletins.

The Bloomington National Weather Service station is WXM78 on a frequency of 162.450 MHz
The Indianapolis National Weather Service station is KEC74 on a frequency of 162.550 MHz.
Note that a special NOAA Weather Radio receiver or scanner is necessary to pick up the National Weather Service station – it can not be tuned in on an AM/FM radio.

Definitions and Procedures

1. Severe Thunderstorm Watch
   A possibility of severe thunderstorms exists. Continue normal activities but monitor the situation.

2. Tornado Watch
   A possibility of tornados and severe thunderstorms exists.
   Continue normal activities but monitor the situation.

3. Severe Thunderstorm Warning
   A severe thunderstorm has been identified by spotters and/or radar.
   Be prepared to move to a place of shelter. Keep people indoors and away from windows until the severe storm passes.
   Call 911 (or 9-274-5887 in Indianapolis) to report injuries and damage and then notify your departmental administrative office.

4. Tornado Warning
   An actual tornado has been identified by spotters and/or radar.
   If in the warning area, seek shelter immediately. Stay clear of glass windows, exterior doors, and shelving such as those containing patient records. In high rise buildings, go to interior small rooms or hallways. Basements, interior hallways on the lower floors (canal level) and small interior rooms on the lower floors offer the best shelter.
   If in a vehicle, get out and seek shelter in a sturdy building. If a building is not available, a depression such as a ditch or a ravine offers some protection.
   Call 911 to report injuries and damage and then notify your departmental administrative office.
   After the all clear, leave badly damaged buildings and do not return to the buildings unless directed to do so by University Police. Move to the designated assembly point. Do not attempt to turn utilities or equipment on or off.

Emergency Disaster Plan – Fire
Report potential fire hazards or address fire prevention questions to the Department of Environmental Health and Safety at 812-855-6311 (Bloomington) or 317-274-2311 (Indianapolis).

Fire Evacuation Procedure - AECC

1. Upon discovering a fire, explosion or smoke in the building, activate the fire alarm system.

2. After sounding the alarm, dial 911 and give the following information:
   a. That you are reporting a fire.
   b. Location of the fire, including building name, floor, and room number.

3. If possible, notify the School of Optometry’s administrative office.
4. When a fire alarm sounds, complete evacuation is required. Never assume that an alarm is a false alarm.

Walk, do not run, to the nearest stairway exit and proceed to ground level. Close doors and windows as you leave, but do not lock them. DO NOT USE ELEVATORS DURING A FIRE EMERGENCY. If the alarm stops, continue the evacuation and warn others who may attempt to enter the building after the alarm stops.

Once you have exited the building move away from it, leaving walks and drives open for arriving firefighters. Proceed to the designated assembly point.

5. Follow the orders of the Fire and Police Departments when they arrive.

6. Notify firefighters on the scene if you suspect someone may be trapped inside the building.

**Fire Evacuation Procedure – IECC**

1. Upon discovering a fire, explosion or smoke in the building, activate the fire alarm system.
   a. IECC - A fire alarm pull box is located on the first floor in each of the two main entryways to the building.

2. After sounding the alarm, dial 9-911 and give the following information:
   a. That you are reporting a fire.
   b. Location of the fire, including building name, address, floor, and room number.

3. If possible, notify the School of Optometry’s administrative office.

4. When a fire alarm sounds, complete evacuation is required. Never assume that an alarm is a false alarm.

Walk, do not run, to the nearest stairway exit and proceed to ground level. Close doors and windows as you leave, but do not lock them. In the event of a power outage, wall socket-mounted flashlights are located in the hallways periodically throughout the IECC. DO NOT USE ELEVATORS DURING A FIRE EMERGENCY. If the alarm stops, continue the evacuation and warn others who may attempt to enter the building after the alarm stops.

Once you have exited the building move away from it, leaving walks and drives open for arriving firefighters. Proceed to the designated assembly point in the parking lot or North Street area.

5. Follow the orders of the Fire and Police Departments when they arrive.

6. Notify firefighters on the scene if you suspect someone may be trapped inside the building.

All staff and faculty must keep their keys on them during clinic work hours in order to enter secured areas for search and evacuation procedures in the event of a fire. Certain faculty and staff members are designated as searchers. Searchers are responsible for ensuring that specific areas within IECC are evacuated. This arrangement is critical, especially if a fire alarm is not fully audible. Searchers should be sure to check for people in rest rooms or behind other closed doors. Be direct with patients as they evacuate.

After evacuation to the designated assembly point, each searcher will take a roll call (by room number or intern/staff/faculty name) of interns and staff in their respective search areas to make sure all are accounted for. The searchers will verify with the interns that they have evacuated their patients and any accompanying family members. Senior staff/faculty will verify roll call information from the searchers. If possible to do so without jeopardizing personal safety, front desk personnel should take patient sign-in sheets with them when they evacuate to ensure that all patients are accounted for.

**Emergency Disaster Plan - Earthquake**

During a major earthquake, you may experience a shaking that starts out gently and quickly becomes violent, possibly knocking you off your feet. Or you may be jarred first by a violent jolt - as though your building was hit by a truck. A second or two later you’ll feel the shaking and, as in the first example, may find it very difficult (if not impossible) to move from one room to another.

**During the Quake**
If you are indoors, stay there. Get under a desk or table or stand in a doorway or corner. Stay clear of windows, bookcases, mirrors and fireplaces. If possible, extinguish any open flames or sources of ignition immediately.

If in a multi-story building, stay there. Stay away from windows and outside walls. Get under a desk or table. Do not use elevators!

If in a crowded public place, do not rush for the doors. Move away from shelves containing objects that could fall.

If you are outside, get into an open area away from trees, buildings, walls and power lines.

If driving, pull over to the side of the road and stop. Avoid overpasses and power lines. Stay inside the vehicle until the earthquake is over. If the earthquake was severe, do not attempt to cross damaged bridges, overpasses, or sections of road.

After the Quake
Check for injuries. Apply first aid. Do not move seriously injured individuals unless they are in immediate danger. Help people who are trapped by furniture or other items that do not require heavy tools to move. Rescue and emergency medical crews may not be readily available.

Do not use the telephone unless there is a serious injury, fire or gas leak.

If you suspect or know that someone is trapped in the building, dial 911. Post a message at the front of the building noting the time, date, number of victims and their last known location in the building.

Attempt to block off damaged areas to keep people away from the hazard until additional help can arrive. Do not touch downed power lines or damaged building equipment.

Clean up spilled medicines, bleaches, gasoline or other chemicals.

If you have to evacuate, post a message in clear view stating your name (and the names of all other evacuees) and move to the designated assembly point. If you have a pager, radio, or cellular phone, take them with you along with batteries and chargers, if available. Make sure to leave pertinent phone numbers on your evacuation message. Turn on a battery powered radio for damage reports and information.

Do not use vehicles unless there is an emergency. Keep the streets clear for emergency vehicles.

Be prepared for aftershocks. Aftershocks are usually smaller than the main quake, but may be large enough to do additional damage to structures weakened during the main shock.

Patient Care Policies and Protocols

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The information in this section serves to compliment and supplement the Clinical Practice Guidelines established by the American Optometric Association (AOA). These guidelines are available at each Eye Care Center for reference by optometry interns and faculty.

**Patient Rights**

The traditional doctor-patient relationship takes on a new dimension when care is rendered within an organized structure - legal precedent has established that the institution itself bears a responsibility to the patient. Patient rights are therefore presented with the expectation that their observance will contribute to more effective patient care and greater satisfaction for the patient, the Eye Care Center, and any other individuals involved.

**Individual Patient Rights**

- A patient has the right to respectful care by competent personnel.
- A patient has the right, upon request, to be given the name of his/her physician, the names of all other physicians directly participating in his/her care, and the names and functions of other health care personnel who have had direct contact with the patient.
- A patient has the right to privacy with respect to his/her medical care program. Case discussion, consultation, examination, and treatment are considered confidential and should be conducted discreetly. Additionally all records pertaining to his/her medical care are strictly confidential except as otherwise provided by law or third-party contractual arrangements.
- Upon request, the Clinic shall provide the patient or patient designee access to all information contained in his/her medical records, unless access is specifically restricted by the physician for medical reasons.
- A patient has the right to know what Clinic rules and regulations apply to his/her conduct as a patient.
- The patient has the right to expect emergency procedures to be implemented without unnecessary delay.
- The patient has the right to quality care and high professional standards that are continually maintained and reviewed.
- The patient has the right to full information in layman’s terms concerning his/her diagnosis, treatment, and prognosis, including information about alternative treatments and possible complications. When it is not medically advisable to give such information to the patient, the information shall be given on his/her behalf to the patient’s next of kin or other appropriate person.
- Except for emergencies, the physician must obtain informed consent prior to the start of any procedure or treatment.
• A patient or, in the event the patient is unable to give informed consent, a legally responsible party, has the right to be advised when a physician is considering the patient as a part of a medical care program or donor program, and the patient, or legally responsible party, must give informed consent prior to actual participation in such a program. A patient or legally responsible party may, at any time, refuse to continue in any such program to which he or she has previously given informed consent.

• To the extent permitted by law, a patient has the right to refuse any medication, treatment, or procedure offered by the Clinic, and the physician shall inform the patient of the medical consequences of the patient’s refusal of any medication, treatment or procedure.

A patient has the right to assistance in obtaining consultation with another physician at the patient’s request and own expense.

• A patient has the right to medical services without discrimination based upon race, color, religion, gender, sexual preference, national origin, or source of payment.

• The patient who does not speak English should have access to, where possible, to an interpreter.

• The patient has the right to expect management techniques to be implemented within the Clinic that consider the efficient use of patient time and avoid patient discomfort.

• The patient has the right to examine and receive a detailed explanation of his/her bill.

• The patient has the right to information and counseling on available financial resources for his/her health care.

• A patient cannot be denied the right of access to an individual or agency that is authorized to act on his/her behalf to assert or protect the rights set out in this section.

Professional Decorum/Patient Interaction

Under faculty supervision, every student is responsible for providing thorough care at the highest level of competency which the student can offer. It is expected that the intern’s clinical experience improve not only their technical skills, but also their professional appearance, their poise, and their professional manner.

An optometry intern must therefore be mindful of the following when interacting with patients:

1. Ask for assistance when you need it.

2. Let the faculty consultant know that you are with a patient and waiting for him/her unless they are in an examination room.

3. Relay any pertinent patient-related information such as patient anxieties, significant patient inquiries, and physical problems that will affect instrument use to your consultant.

4. Always knock before entering a room.

5. Introduce your patient to your faculty consultant, who shall be addressed as “Doctor ________.”

6. If you are interrupted to observe other patients, place your patient in an upright position, remove all instrumentation, and turn on room lights if necessary. In some instances, patients should not be left alone. Excuse yourself, examine the other patient as quickly as possible, making sure that you see the findings of interest. Return to your patient.

7. Be mindful of what you discuss in front of the patient. This applies to examination results, fees, courses of treatment, etc. Do not quote exam fees to the patient or tell the patient that there is no charge for the examination. Similarly, discussing a patient’s condition in front of an individual not directly connected with that patient’s care is a violation of the patient’s rights, as well as clinic policy.

8. Failure to respond to a patient’s needs promptly or with a sense a disinterest or lack of concern will be evaluated negatively in judging the student’s performance.
9. Immediately contact your faculty consultant or another clinic staff member if any other unusual or unexpected patient-related incident develops.

10. Insure that spectacle and contact lens orders are placed promptly, even if the record is not yet completed.

11. Do not use patient contact time to complete non-essential record-keeping. You can complete your documentation at the end of the day.

12. Use a personal calendar to keep track of your returning patients.

13. Behavior, language, or comments which embarrass the clinic, add to its operational problems and erode patient confidence in the School of Optometry will not be tolerated.

14. Personal phone calls must be kept to a minimum. All cell phones are to be turned off and their use prohibited while on the clinic floor.

15. Keep all personal items (i.e., purses, backpacks) in your assigned locker or within a secure area at the clinic away from patients.

Miscellaneous Educational and Patient Care Concerns
1. Patients are assigned by the faculty and staff based upon intern availability, continuity, patient type, etc.

2. Regular educational seminars are held and suggestions for topics are welcomed.

3. Feel free to use any available reference materials and to pursue less familiar clinical techniques (e.g., rigid gas permeable contact lens fitting) when time allows.

4. Follow-up intervals that you and the faculty consultant have agreed upon are not to be changed by front desk personnel without conferring with the faculty consultant.

5. Avoiding consultation, conducting undesignated or unsupervised tests, or altering treatments/therapy is considered practicing optometry without a license.

Release of Eyeglass and Contact Lens Prescriptions
By a combination of federal and state law, all optometrists (and ophthalmologists) in the state of Indiana are required to provide our patients with a written copy of their eyeglass and/or contact lens prescriptions.

1. House Resolution 3140 of the United States Congress (H.R. 3140), in addition to Indiana Code 16-29-1-1 requires all optometrists and ophthalmologists to provide a contact lens prescription (CLRx) to their patients at the completion of a contact lens fitting. The prescription is usually valid for no more than one year unless there exists a medical condition that necessitates more frequent evaluation. The number of boxes of lenses prescribed or the number of refills allowed should be consistent with one year’s worth of lenses. Please give the patient a copy of their contact lens prescription and place a copy in their chart.

2. Additionally, the Federal Trade Commission (FTC) requires that a spectacle Rx must be provided to the patient at the completion of the examination. Again, please give the patient a copy of their spectacle Rx and place a copy in their chart.

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By a combination of federal and state law, all optometrists (and ophthalmologists) in the state of Indiana are required to provide our patients with a written copy of their eyeglass and/or contact lens prescriptions.

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Primary Care Exam Protocol

This section is meant to provide a brief outline of the integral parts of an eye examination. It is not intended to be a comprehensive guide to ocular examinations. It also does not take precedence over any of the course syllabi that may detail differing viewpoints.

Overall Goals

1. To define the school-wide clinical guidelines for comprehensive adult eye and vision examinations performed by third-year and fourth year interns at the IUSO Eye Care Centers under the supervision of a consulting OD.

2. To indicate the appropriate standard of care for an eye and vision care examination that is in the best interest of the patient.

3. To describe what is expected of interns when performing an eye and vision care examination.

4. To assure intern competency in the performance of the tests included in an eye and vision care examination.

5. To consider the needs of the patient as an utmost concern.

Goals of the Comprehensive Adult Eye and Vision Examination

1. Evaluate the functional status of the eyes and visual system.

2. Assess ocular health and related systemic health conditions.

3. Establish a diagnosis and formulate a treatment plan.

4. Counsel and educate the patient regarding visual, ocular, and related systemic health conditions.

Premises

1. This protocol is intended for patients 18 years of age and older (i.e., adults).

2. It applies to new patients and to patients who have not been examined for a period of two years or longer.

3. For patients who are not suitable candidates for the protocol in its entirety — for example, a monocular patient, a patient with an acute red eye, or a handicapped patient — the protocol may be modified as directed by the faculty consultant.

Third-year interns should consult their faculty consultant prior to using any diagnostic or therapeutic pharmaceutical agents. At the consultant’s discretion, this requirement may be relaxed for fourth-year interns. These agents should not be used on any pregnant patient without patient consent and prior agreement of the faculty consultant.

4. Examine Room Opening/Set-up

1. Remove equipment covers and place them in the cabinet under the exam room sink.

2. Check to see that all equipment in your room is in working order. It is your responsibility to alert the Clinic Director of any needed equipment repairs.

3. Check to see if all supplies are present in your exam room and check expiration dates. Replace supplies as needed.
4. Clean the tonometer, chin and head rests, cover paddles, etc., before each patient (see Disinfection Procedures in Chapter 2).

5. Store personal equipment in the exam rooms at your own risk. Instead, keep personal items in a locker.

6. Clear the sink area of all supplies at the end of the day to facilitate cleaning.

**Introductory Patient Procedures**

1. Greet your patient by introducing yourself.

2. Check to see how the patient wishes to be addressed by checking the completed Patient Information Form.

3. Escort the patient to your examination room, asking them to bring all their belongings.

4. Do not make any assumptions about relationships between your patient and any individuals that accompany them.

5. Wash your hands before and after touching each patient, especially when examining “red eye” patients (see Disinfection Procedures in Chapter 2).

**Basic Examination Protocol**

1. **History**
   a. Presenting problem/chief complaint
      
      Determine the frequency and duration of the chief complaint.
   b. Visual/ocular/general health history - inquire about the last physical exam (LPE vs. LME).
   c. Medications (usage and allergies).
   d. Past Family and Social History.
   e. Vocational vision needs.

2. **Preliminary Testing and Externals**
   a. General observation.
   b. Distance and near aided visual acuities
      
      If entering visual acuity is less than 20/20, distance pinhole acuity should be performed. Additionally, if entering visual acuity is poor, the cover test, measurement of stereopsis, and color vision testing should be deferred until after the completion of the objective and subjective refraction, at which time these tests should be performed with a trial frame with appropriate trial lenses in place. Unaided visual acuities should be taken when appropriate.
   c. Versions/ductions.
   d. Near point of convergence.
   e. Pupil testing.
   f. Cover test.
   g. Color testing when indicated.
   h. Stereopsis when indicated.
   i. Amsler grid
      
      Some faculty consultants recommend routine Amsler grid testing for patients 55 years of age or older.

3. **Refraction**
a. Keratometry.
b. Objective and subjective refraction, including prism dissociated binocular balance.
c. Trial frame results.

4. Ocular Motility, Binocular Vision, and Accommodation
a. Phorias
b. Near testing
   i. Consider dynamic retinoscopy for patients age 16 and younger, or for computer users with complaints.
   ii. On young adults perform phorias, amplitudes, PRA, NRA, BCC, and compensating ductions as indicated.
   iii. On presbyopes perform PRA, NRA, and BCC. On absolute presbyopes, limit your testing to trial-framing of the proposed addition.
   iv. This protocol may be streamlined for extremely young patients with approval of your consultant.
c. Supplemental Testing (when appropriate)
   i. Vergence amplitude/facility.
   ii. Accommodative amplitude/facility.
   iii. Suppression testing.
   iv. Fixation disparity/associated phoria.

5. Slit lamp examination
   Perform full evaluation (parallelepiped) plus angle grading before tonometry.

6. Faculty Consultation
   Present your case to your faculty consultant. You and your consultant will discuss additional testing, if needed.

7. Slit lamp examination (continued)
   Include tear break-up time and corneal staining with fluorescein alone (no anesthetic) if the patient complains of dry eye, foreign body sensation, tearing, etc.

8. Goldmann applanation tonometry

9. Systemic Health Screening Tests
   Blood pressure measurement on patients age 21 years or older, and other systemic health screening tests as indicated.

10. Dilate
   Unless otherwise indicated, one percent (1%) tropicamide and 2.5 percent (2.5%) phenylephrine are routinely used for pupillary dilation.

11. Screening visual field

12. Frame Selection
Escort your patient to the Eye Wear Center for frame selection when appropriate. It is important to stay with (and assist) your patient personally if the dispensary staff are unavailable.

13. **Posterior Ocular Segment Evaluation**

Perform slit lamp evaluation of the crystalline lens and vitreous followed by brief re-examination of the cornea, which often reveals subtle, frequently overlooked findings. Next, perform fundus biomicroscopy. Direct ophthalmoscopy should be performed when indicated.

14. **Supplemental Testing**

Additional testing procedures may be added by the intern with approval of the faculty consultant.

15. **Assessment and Diagnosis**

a. Evaluate all clinical data to establish a tentative diagnosis treatment plan.

b. Discuss your tentative diagnosis and treatment plan with faculty consultant.

c. Faculty consultant will evaluate the ocular health after which both of you will discuss the case disposition.

d. Do not discuss your management plan with the patient until it has been agreed upon by your faculty consultant

16. **Patient Education**

a. Review examination findings and conclusions.

b. Explain available treatment options, including risks and benefits.

c. Discuss the recommend course of treatment, reasons for its selection, and prognosis.

d. Discuss the need for follow-up care/compliance with prescribed treatment.

e. Recommend re-examination, as appropriate.

*This Comprehensive Adult Eye and Vision Examination Protocol was adopted January 1, 1995, by the Indiana University School of Optometry Eye Care Centers. Revised November 2002.*

**Examination Conclusion**

3. Complete the *Service Summary* and have it initialed by your consultant.

4. Escort the patient to the Payment Desk for dismissal and to make any needed follow-up appointments. Make sure to take the patient’s record and *Service Summary* with you.

5. Give the white copy of the spectacle Rx to the patient after all fees are paid; the yellow copy should be placed within the patient’s record.

6. If materials are ordered, write the patient’s name on the Order Sheet at the Payment Desk.

**Record Completion**

1. Make sure that all tests and procedures are thoroughly documented within the patient record.

2. Assessments and Plans should comply with Problem-Oriented Medical Records guidelines. For each documented Assessment there should be a corresponding Plan.

3. All patient education should be recorded in the patient record.

4. The record must include intern and consultant signatures.

5. A copy of any written information given to the patient must be made for the record, using the photocopier near the Payment Desk.

6. Be sure to document follow-up appointments on the examination form and in the Chart Summary Form.

7. Obtain all information necessary to complete the on-line patient log.
8. Place completed records in the “To Be Filed” or “To Be Ordered” box or return to consultant if not signed and completed.

Follow-Up/Established Patient Examination Protocol
1. Review the patient record for past history, test results, assessments, plans and procedures.
2. Review interval history with the patient, especially as it relates to the problem being followed. Review medications and allergies, specifically inquiring about compliance with medications prescribed at previous Eye Care Center visits.
3. Discuss appropriate testing procedures with your faculty, remembering to assess any changes in visual acuity.

Auxiliary Clinic
The primary purpose for auxiliary clinic duty is maintenance of efficient, quality patient care. Student interns are responsible for frame selections, dispensary business tasks, and support in patient care areas. Interns should have their equipment available in order to fill in for other interns in emergency or overflow situations.

Optical Dispensary Protocols
Ordering Ophthalmic Materials
1. Never leave a patient unassisted in the dispensary. If the dispensary staff (supervising tech, tech students) is busy, then you must assist your patient. Leaving a patient alone can result in a poor frame choice, a big mess in the frame room, and a lot of wasted time.
2. Ask the patient if their insurance plan offer eyeglass benefits. If it does, or they are unsure, dispensary staff should be consulted to determine what benefits the patient is entitled to, if any.
3. Consider such factors as the patient’s Rx, facial shape, preference, etc. when assisting with frame selection.
4. Complete the lab pricing as directed by dispensary staff. The total cost, including all extra charges for tints, prism, and other add-ons must be figured at the time of frame selection.
5. Have dispensary staff check all frame selections and sign the order form before the patient goes to the Payments Desk.
6. The patient must make a minimum of a fifty percent (50%) deposit for all materials ordered at the Payments Desk. If the patient has eyeglass benefits through their insurance plans, uncovered fees must be paid before the order is placed.
7. Place the completed patient record in the box in the Payments Desk area.

Dispensing of Ophthalmic Materials
1. Circle the correct code corresponding to the services provided. For example, if you dispense a complete pair of glasses with new lenses and frame, circle Dispensing, Complete Rx.
2. Choose the correct case for the frame being dispensed.
3. Have a member of the dispensary staff check dispensing.
4. Escort the patient to the Payments Desk to pay the remainder of their balance. Only in situations approved by the Clinic Director or the Clinic Administrator may a patient leave the clinic with their new glasses without paying the full balance due.
5. If lenses are being replaced under warranty, the old lenses must be returned to the dispensary when the time new lenses are dispensed.
Ophthalmic Lens Liability

The interns, technicians, and faculty must check the occupational and/or sports needs of each patient to determine if other considerations warrant increased safety protection.

Every patient must be informed that polycarbonate and plastic lenses are preferred for break-resistance over glass, with the former being the most break-resistant material available. If the patient chooses glass lenses, or if the patient absolutely refuses to follow recommendations on lens material, this must be documented in the patient’s record. In the case of glass lenses it must be documented that they were informed that glass is the least impact-resistant spectacle lens material available. Never tell a patient that any lens is “break-proof”.

Polycarbonate lenses are indicated in the following circumstances:

1. Children.
2. Monocular patients, even if there is no refractive error.
3. Safety glasses.
4. Athletes.
5. Occupational needs: e.g., law enforcement officer.

In the State of Indiana, the prescribing optometrist is required to verify safety glasses when the prescription is filled elsewhere. Our prescription form includes the following statement:

“Safety glasses prescribed using this Rx must be returned for verification or the prescription is null and void.”

This statement should also be added to outside safety Rx forms to which we have added spectacle information. During verification of these glasses, it is imperative that the lens material and center thickness be checked.

Safety Prescriptions

If the patient is an Indiana University employee:

1. They must bring a departmental authorization form with an account number and supervisor signature.
2. You must check the box marked “IU Safety” on the order form.
3. The safety frames we use are made by On-Guard and are marked Z.87.
4. Polycarbonate lenses are recommended for all safety prescriptions; glass is not allowed.
5. Safety lenses will have a 3.0 mm center thickness, so it will be heavier than dress lenses.

If the patient is NOT an Indiana University employee:

1. Print “NOT I.U. Safety” in the space marked special instructions.
2. All other steps are the same as above.
Course Syllabus for Summer Intensive
Primary Care Clinic
V-680

Course Instructor: Kimberly D Kohne, OD, FAAO
Clinical Assistant Professor
Chief of Primary Care Clinic
AECC Rm 118
855-1929
kkohne@indiana.edu

Introduction

This syllabus is for use in conjunction with The Student Orientation Manual--AECC/CECC, henceforth referred to as “the Manual,” which is located on-line. Please study both carefully. The syllabus outlines policies regarding grading, requirements for normal progress, non-passing grade (what constitutes failure), proficiencies, remediation, and conduct expectations. It will also include an approximate timetable with important dates to remember.

General Considerations and Requirements

A. The intern must avail him/herself to have a certain number of patient encounters per course before being eligible to continue. The expected average patient encounters for the summer intensive clinic course, V680, is 35*. The expected average patient encounters for the fall and spring clinic courses, V786-789, is 20*. Patient encounters include comprehensive exams, acute problem focused exams, and any follow-up visits. In order to maintain continuity of care for the patient, the original intern will perform the dilation whenever a patient must reschedule the completion of examination, as well as return for a red eye follow-up visit.
*Patient numbers may vary. Allowances are made if patient volume drops below expected*

B. Non-clinical activity (e.g., reading novels, playing computer games) is strictly prohibited on the clinic floor. If you are without patients, you must occupy your time with reading optometric/medical texts, help in the dispensary, if possible you can observe another intern, practice diagnostic skills, update your on-line patient log, or consult the faculty for ideas as to how to manage your free time meaningfully.

Attendance

A. You must have a written medical excuse for missing clinic in case of illness, or otherwise show proof of your inability to attend clinic (e.g., contagious nature of the illness). Other unforeseen events (e.g., inclement weather) must be similarly documented.

B. There is NO swapping of clinic assignments during the summer

C. See the Manual for details.
The 10% rule will apply. Whether excused or unexcused, if you miss over 10% of your assigned time in clinic, you must repeat/complete the course. See the Manual (Section 1.2) for details.

D. As soon as you know that you will not be able to attend clinic, contact the front desk at the clinic to which you are assigned, your consultant, and Brian Page in the Student Administration Office and cc Dr. Kohne, in that order. We need to know ASAP in order to ensure patients are rescheduled if necessary. You will be required to make up any missed time in clinic and need to email and/or call Dr. Kohne to make arrangements.

Grading

The Grading method is adopted from Dr. Meetz’s and Dr. Tonekaboni’s criteria, which have been discussed in Diagnostics III.

A. Please refer to Course Grade Determination, Section 1.1.1. Of the Manual. This section best describes the grading policy for all clinic courses. Clinical performance is judged by adhering to the guidelines outlined in the Manual. However, remember that, while every attempt is made to retain uniformity, there will be variations depending on the patient, the level of difficulty, and the consultant to whom you may be assigned. Also, note that the OUTCOME of the case will determine the Final Grade for the specific case, regardless of the performance in each category (see below). In addition, the final grade for the course is not a tally of each individual patient encounter. Comprehensive exams will be weighted against shorter patient encounters. Remember, The Clinical Skills Assessment Form is intended to provide the intern with the necessary feedback in order to improve clinical skills on a daily basis. OUTCOME is defined as: How a patient’s needs were explored, addressed, and satisfied. Therefore, the concept of partial credit cannot consistently exist in clinic.

B. Chair time is of utmost importance for V680. Routine examinations, including dilation and frame selection MUST be completed within an approximate two-hour time limit. If the time is exceeded, the patient must be made fully aware as to the reasons (e.g. extra testing, emergency situations), which might delay the consultant, etc.

Exceptions

As you consider the following criteria for grading, please keep in mind that certain situations will cause your final DAILY grade to be affected negatively or positively beyond the sum of the categories listed on the grade slip.

Examples

1. Intern has performed satisfactorily (Level 3) in all categories. Intern goes beyond the call of duty to deliver the glasses in non-ambulatory cases. The intern will receive an (A) for the patient (consultant prerogative).

2. The intern has performed satisfactorily (Level 3) in all categories, but forgets to patch one eye during HVF testing, thereby inordinately increasing total chair time, and affecting other patients who might be waiting for the instrument. The intern may receive an (F) for the patient (consultant prerogative).

3. If the Rx is highly unusable and unreasonable for patient use, the intern may be considered to have failed that exam.

4. Abnormalities/anomalies of the posterior pole, as well as most conditions affecting the anterior segment must be described accurately as to shape, size, level of pigmentation, etc. If this is not achieved, the exam may be failed.
5. Intern does not present the case to the consultant efficiently and omits pertinent patient history of findings (e.g. pupil abnormalities, diabetes). The intern may receive an (F) for the patient.

6. Any comprehensive eye exam in which the patient arrives wearing contact lenses, must have the consultant evaluate the lenses prior to removal. Failure to do so may result in an (F) for the patient regardless of how well the rest of the exam was performed.

7. Documentation Counts! It is of the utmost importance that all documentation in the chart be done and done properly. Failure to complete the documentation can result in a failure for that case. Examples of this would be: not signing the chart, forgetting to write the final RX down, or not putting name and birth date on both sides of the exam form.

What Constitutes Failure of V680?
1. Violating patient confidentiality, forging consultant signatures, and unethical and fraudulent conduct.
2. Receiving an “F” constitutes immediate failure of the course. The intern must repeat the course after having gone through remediation (see Manual).
3. Patient endangerment as deemed by the clinical faculty. The endangerment can be direct (e.g., corneal abrasion caused by inadequate applanation tonometry), or indirect (e.g., missing an obvious corneal finding that might lead to visual impairment; e.g., misreading the applanation tonometry resulting in erroneously low pressures and misdiagnosis of glaucoma). (The above are examples of the many possible situations)
4. Absenteeism. Unexcused absence is grounds for failure of the course
5. Unprofessional Behavior—toward patients, staff, other interns or consultants

What Constitutes a First Dismissal?
1. Violating patient confidentiality, forging consultant signatures, and unethical and fraudulent conduct.
2. Patient endangerment as deemed by the clinical faculty. Depending on severity and nature of the endangerment, the intern may be terminated from the program.
3. Receiving a second non-passing grade at any point in the sequence (V 680 – V 789).

Note: In case of a first dismissal, the intern has the option of petitioning for reinstatement. The Academic Review Committee will consider the petition. An interview may be arranged to hear the student’s reasons for the infraction/below-expected performance. The Committee then considers the case and either grants or denies readmission.

Academic Misconduct

Academic integrity is fundamental to the intellectual life of the university and to the education of each student. The following acts of academic dishonesty are prohibited: cheating, fabrication, plagiarism, interference, and facilitating academic dishonesty. Proven academic misconduct is grounds for dismissal.

Professional Misconduct

Maintaining standards of professional conduct is essential to the integrity of the profession. Professional misconduct is strictly prohibited. This includes dishonest
conduct (including, but not limited to, false accusation of misconduct; forgery; alteration or misuse of any university document, record, or identification; and giving to a university official any information known to be false) and use or possession of alcoholic beverages or illegal drugs on university property or during a university activity.

In addition, fraud and patient endangerment and abandonment will be grounds for dismissal. Standards for patient care procedures and for professional behavior in a clinical setting are detailed in the most recent Indiana University School of Optometry Eye Care Centers Student Orientation Manual.

Professionalism must be maintained on the clinic floor at all times. Speaking to a faculty member or staff member disrespectfully will be considered unprofessional and the student could be failed for that days’ worth of patients. Also, as stated in the Clinic Manual, cell phones should not be used while on the clinic floor except for emergency situations. This includes case conference. If a student is seen using a cell phone in excess a verbal warning may be given to the student. If the student does not comply they will receive a failure for that days’ worth of patients.

Additional rules and regulations of the university are available in the Code of Student Rights, Responsibilities, and Conduct published by Indiana University. It is each student’s responsibility to be aware of these regulations. Violation of the Code of Student Rights, Responsibilities, and Conduct may result in dismissal.

**How to make up a failed course**

In case of failure (see above), the intern must enroll in the remedial course (V780). After the course has been completed successfully, s/he is allowed to continue normal clinical rotation. **Note:** Patient numbers and time spent in clinic are BOTH criteria for a successful second attempt. Therefore, an intern who does not pass a rotation must realize s/he will be behind a minimum of 3 weeks during the summer and 8 weeks during the academic year.

**Specific Requirements for (V 680)**

**Summer 2012**

Summer clinic is **Introduction to Clinic**. There are generally five rotations, each three weeks in length. There will be Wednesday evening and Saturday morning clinic. You might be assigned to one or both for 1, 2, or all 3 weeks, depending on the scheduling needs.

**EVALUATION FOR A ROUTINE CASE**

Please refer to the Daily Intern skills Assessment Sheet

**EVALUATION FOR A ROUTINE CASE**

**Clinical Skills:** (including history, refraction, BV, Ocular Health, and efficiency/completedness)
Level 3: able to completely and effectively perform clinical skills without consultant prompting
Level 2: Some skills are left undone and intern struggles with some of the skills-consultant had to contribute to clinical skills
Level 1: Skipped or forgot key clinical skills and/or consulting doctor did most of the skills
Failure: Inability to do clinical skills and/or consultant does most or all of the examination or has to take over the examination

Problem Solving/Critical Thinking: (A&P, Case Presentation, Case Conference)

Level 3: Intern offers insight, shows initiative in patient care and can handle and answer consultant questioning effectively
Level 2: With prompting intern can come up with differential diagnosis for CC, other possible clinic skills that could be done and RTC times
Level 1: Inability to discuss case reasonably, unable to develop A&P without consultant, unsure of proper f/u time for patient care
Failure: Unable to answer questions even with prompting from consultant, improper addressing of CC in A&P, no initiative or responsibility in patient care

Communication/Professionalism:

Level 3: Able to answer questions from both patient and consultant, treated patient, consultant, staff and fellow interns with respect and kindness
Level 2: Able to answer some questions from patient and deferred others to the consultant, tolerance of patient and borderline respect to patient, faculty and/or staff
Level 1: Most questions from patient or consultant left unanswered, ignoring requests from patient, faculty and/or staff, unapproachable, poor attitude
Failure: Inability or refusal to answer questions, rude to and/or abandoned patient, unprofessional to faculty and/or staff, blatantly disrespectful.

On-line Patient Log

For each clinic course, all patient interactions need to be entered in the on-line patient log. We use Meditrek as our system for entering patient encounters. You will receive an email from Meditrek with a website and a password. The password you need to enter the site will be emailed to you through your school account. The log for each clinic course MUST be finished by the Monday after your last day in that course. As outlined in the Manual Section 1.1.1, an INCOMPLETE will be given for each course that does not satisfy this requirement. If you have any questions or problems with the patient logs please contact Dr. Elli Kollbaum and if you cannot get through to Dr. Kollbaum you can contact me, Dr. Kohne.

Auxiliary Clinic

The auxiliary requirement is divided into 3 rotations, summer, spring, and fall. Once an intern completes a rotation, the requirement is met for the school year. The purpose of auxiliary clinic is to provide reinforcement in the optical dispensary (e.g., an intern calls
in sick, clinic overbooked and walk-in patient arrives, or clinic is running behind schedule). In order to address these situations, students should have their equipment accessible (in their locker or car) while in auxiliary clinic. The goals are to increase the overall learning experience for auxiliary interns, increase the appreciation and value of dispensary obligations, and increase the dispensary’s productivity. In addition, this requirement gives the intern the opportunity to learn the day-to-day dispensary operations, the opportunity to apply Ophthalmic Optics, and to learn the business aspects of a dispensary. You will be required to sign in and out for each session. See your assigned dispensary supervisor for the location of the binder. Working in another area of the building is not an automatically excused absence from auxiliary clinic.

At the end of auxiliary clinic, a performance evaluation is given to the intern. The evaluation will be on an outstanding/adequate/poor level and will affect the final grade accordingly. The details of each category are listed below and posted in each dispensary (AECC/CECC) or you may discuss them with the auxiliary supervisor.

<table>
<thead>
<tr>
<th>Outstanding</th>
<th>Adequate</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>•This category is reserved for the student(s) that perform over and above the required level of expectation</td>
<td>•This category is reserved for the student(s) that perform at all levels of expectation</td>
<td>•This category is reserved for the student(s) whose performance is unacceptable, disappointing to the auxiliary supervisor, and well below the level of expectation</td>
</tr>
<tr>
<td>•The student exhibits excellence in patient care and education of eyewear needs and options such as add-ons, specialty lenses and second pair of spectacles</td>
<td>•The student exhibits the ability to care for patients and make the necessary recommendations of eyewear and specialty lens options</td>
<td>•The student exhibits the poor patient care and the lack of knowledge for patient education of eyewear needs and options</td>
</tr>
<tr>
<td>•The student exhibits excellence in communication, cooperation, and attitude toward responsibilities of auxiliary clinic</td>
<td>•The student exhibits a positive attitude toward responsibilities of auxiliary clinic, communicates and cooperates well with auxiliary staff</td>
<td>•The student exhibits a poor and disrespectful attitude towards auxiliary responsibilities and staff</td>
</tr>
<tr>
<td>•The student exhibits excellence in commitment to auxiliary without any unexcused absences in dispensary</td>
<td>•The student has no more than 2 absences from clinic excused or unexcused</td>
<td>•The student has more than 3 absences from clinic with only 2 allowed as excused*</td>
</tr>
<tr>
<td></td>
<td>•Clean and neat appearance</td>
<td>•Sloppy appearance</td>
</tr>
</tbody>
</table>

*At the discretion of the clinic course instructor
V680 Standards Summer 2012

- History: Be able to establish a chief complaint and a reasonable understanding of present illness
- Entrance Tests: Competency level and understanding of entrance tests
- Ret/Refraction: Be able to write a wearable RX
- Slit Lamp: Be able to locate and describe unusual anterior segment findings, not necessarily layer of abnormality or the diagnosing of the disorder
- Posterior Exam: Locate and describe unusual posterior segment findings
- Exam Time: No more than 2 hours
Combined Course Syllabi for Primary Care Clinic

(V- 786, 787)
Fall 2012

Course Instructor: Kimberly D Kohne, OD
Clinical Assistant Professor
Chief of Primary Care Services
AECC Rm 118
855-1929
kkohne@indiana.edu

This syllabus is for use in conjunction with The Student Orientation Manual—AECC/CECC, henceforth referred to as “the Manual,” is located on the School of Optometry home page under Internal Business. Please study it carefully. The syllabus outlines policies regarding grading, requirements for normal progress, non-passing grade (what constitutes failure), proficiencies, remediation, and conduct expectations. It will also include an approximate timetable with important dates to remember.

General Considerations and Requirements

A. The intern must avail him/herself to have a certain number of patient encounters per course before being eligible to continue. The expected average patient encounters for the summer intensive clinic course, V680, is 35*. The expected average patient encounters for the fall and spring clinic courses, V786-789, is 20*. Patient encounters include comprehensive exams, acute problem focused exams, and any follow-up visits. In order to maintain continuity of care for the patient, the original intern will perform the dilation whenever a patient must reschedule the completion of examination, as well as return for a red eye follow-up visit.

*These numbers have been arrived at by taking into account a sample number of encounters during each course and extrapolating an average number during approximately 2-7 previous years (depending on the course). Patient numbers may vary. Allowances are made if patient volume drops below expected

B. Non-clinical activity (e.g., reading novels, playing computer games) is strictly prohibited on the clinic floor. If you are without patients, you must occupy your time with reading optometric/medical texts, help in the dispensary, if possible you can observe another intern with the permission of your consultant, practice diagnostic skills, update your on-line patient log, or consult the faculty for ideas as to how to manage your free time meaningfully.

Attendance
A. You must have a written medical excuse for missing clinic in case of illness, or otherwise show proof of your inability to attend clinic (e.g., contagious nature of the illness). Other unforeseen events (e.g., inclement weather) must be similarly documented. See the Manual for details.

**The 10% rule will apply.** Whether excused or unexcused, if you miss over 10% of your assigned time in clinic, you must repeat/complete the course. See the Manual (Section 1.2) for details.

B. As soon as you know that you will not be able to attend clinic, contact the front desk at the clinic to which you are assigned, your consultant, and Dr. Kohne in that order. You will also need to email your class and try to find someone to cover you that day. We need to know ASAP in order to ensure patients are rescheduled if necessary. **You will be required to make up any missed time in clinic.**

C. You are required to be on the clinic floor 15 minutes before the start of the first patient. If you are tardy several times in a row it will affect your clinic grade.

D. **Swapping!!!!!** You will only be allowed to swap out of clinic time one time per 8 week session or two times a semester. The amount of patient contact time is limited during the school year. To maximize the amount of patients seen it is imperative that you are on the floor at your assigned times. Only in extreme circumstances will there be an exception to this rule, such as death and extreme illness. An excuse form from a doctor will be required for an absence. If more than the allotted amount of clinic time is used, your clinic grade will be decreased by at least half a letter grade and possibly more. The final grade will be determined by the instructor of record and your main clinical consultant during that 8 week session.

**Grading**

The grading criteria were determined by the Primary Care Clinical Faculty and is discussed and reviewed at the end of every year.

A. Please refer to **Course Grade Determination, Section 1.1.1.** Of the Manual. This section best describes the grading policy for all clinic courses. Clinical performance is judged by adhering to the guidelines outlined in the Manual. However, remember that, while every attempt is made to retain uniformity, there will be variations depending on the patient, the level of difficulty, and the consultant to whom you may be assigned. Also, note that the OUTCOME of the case will determine the Final Grade for the specific case, regardless of the performance in each category (see below). In addition, the final grade for the course is not a tally of each individual patient encounter. Comprehensive exams will be weighted against shorter patient encounters. Remember, **The Clinical Skills Assessment Form** is intended to provide the intern with the necessary feedback in order to improve clinical skills on a daily basis. **OUTCOME** is defined as: How a patient’s needs were explored, addressed, and satisfied. Therefore, **the concept of partial credit cannot exist in clinic.**
B. Course Assignments will be a part of the final grade for the clinic course
to which they are assigned. Failure to complete the assignments will result in
an incomplete for the course. Course assignments include case presentations,
auxiliary, and school screenings.

C. Chair time is of utmost importance for V786 & V787. Routine
examinations, including dilation and frame selection MUST be completed within
an approximate two-hour time limit for V786 and 1 hour and 45 minutes for
V787. If the time is exceeded, the patient must be made fully aware as to the
reasons (e.g. extra testing, emergency situations), which might delay the
consultant, etc.

D. Documentation Counts! It is of the utmost importance that all
documentation in the chart be done and done properly. Failure to complete the
documentation can result in a failure for that case. Examples of this would be:
not signing the chart, forgetting to write the final RX down, or not putting name
and birth date on both sides of the exam form.

E. Pure Clinic Grade! To progress on to the next section of Clinic you must
pass each 8 week session with the grade of C or better. This grade will be
calculated alone (clinic only) before your dispensary and school screening
grades are added in. After it is determine you passed the clinic session with a C
or better, your dispensary and school screenings will be added in to your final
grade.

F. Participation in Case Conferences (see below) can also affect the grade (see
below).

Exceptions

As you consider the following criteria for grading, please keep in mind that
certain situations will cause your final DAILY grade to be affected negatively or
positively beyond the sum of the categories listed on the grade slip.
Examples:
1. Intern has performed satisfactorily (Level 3) in all categories.
   Intern goes beyond the call of duty to deliver the glasses in non-ambulatory
cases. The intern will receive an (A) for the patient (consultant prerogative).
2. The intern has performed satisfactorily (Level 3) in all categories, but
   forgets to patch one eye during HVF testing, thereby inordinately increasing total
   chair time, and affecting other patients who might be waiting for the instrument.
The intern may receive an (F) for the patient (consultant prerogative).
3. If the Rx is highly unusable and unreasonable for patient use, the intern
   may be considered to have failed that exam.
4. Abnormalities/anomalies of the posterior pole, as well as most conditions
   affecting the anterior segment must be described accurately as to shape, size,
   level of pigmentation, etc. If this is not achieved, the exam may be failed.
5. Intern does not present the case to the consultant efficiently and omits pertinent patient history of findings (e.g. pupil abnormalities, diabetes). The intern may receive an (F) for the patient.

6. Any comprehensive eye exam in which the patient arrives wearing contact lenses, must have the consultant evaluate the lenses prior to removal. Failure to do so may result in an (F) for the patient regardless of how well the rest of the exam was performed.

What Constitutes Failure of V786 or V787?

1. Violating patient confidentiality, forging consultant signatures, and unethical and fraudulent conduct.

2. Receiving a “C” constitutes failure of the course. The intern must repeat the course after having gone through remediation (see Manual).

3. Patient endangerment as deemed by the clinical faculty. The endangerment can be direct (e.g., corneal abrasion caused by inadequate applanation tonometry), or indirect (e.g., missing an obvious corneal finding that might lead to visual impairment; e.g., misreading the applanation tonometry resulting in erroneously low pressures and misdiagnosis of glaucoma). (The above are examples of the many possible situations)

4. Absenteeism. Unexcused absence is grounds for failure of the course.

How to make up a failed course

In case of failure (see above), the intern must enroll in the remedial course (V780). After the course has been completed successfully, s/he is allowed to continue normal clinical rotation.

Note: Patient numbers and time spent in clinic are BOTH criteria for a successful second attempt. Therefore, an intern who does not pass a rotation must realize s/he will be behind a minimum of 8 weeks during the academic year.

Remediation

If an intern receives a C- grade in any third- or fourth-year clinic course, the student must accept remediation and must enroll in either V 780 Clinical Skills Enhancement–3rd Year or V 880 Clinical Skills Enhancement–4th Year.

A student who fails to complete V 780 or V 880 with a grade of C– or better will be ineligible to continue.

If an intern is unable to continue with a clinical rotation for academic or clinical performance reasons, the grade of F will be assigned.

Policies and procedures are explained in detail in the most recent Indiana University School of Optometry Eye Care Centers Student Orientation Manual.

Ineligible to Continue
A student is ineligible to continue when one or more of the following conditions hold:

1. the student earns lower than a 1.00 GPA for any semester, regardless of cumulative GPA;
2. the student earns both (a) lower than a 2.30 GPA in a semester and a recommendation by the Academic Review Committee;
3. the student has failed the clinical competency examination two times and a recommendation by the Academic Review Committee;
4. the student fails a clinical course after remediation; clinical courses are V 680, V 786, V 787, V 788, V 789, V 885, V 887, V 888;
5. the student has failed to complete the professional curriculum in six years;

These conditions indicate unsatisfactory progress and could result in automatic dismissal.

**Academic Misconduct**

Academic integrity is fundamental to the intellectual life of the university and to the education of each student. The following acts of academic dishonesty are prohibited: cheating, fabrication, plagiarism, interference, and facilitating academic dishonesty. Proven academic misconduct is grounds for dismissal.

**Professional Misconduct**

Maintaining standards of professional conduct is essential to the integrity of the profession. Professional misconduct is strictly prohibited. This includes dishonest conduct (including, but not limited to, false accusation of misconduct; forgery; alteration or misuse of any university document, record, or identification; and giving to a university official any information known to be false) and use or possession of alcoholic beverages or illegal drugs on university property or during a university activity.

In addition, fraud and patient endangerment and abandonment will be grounds for dismissal. Standards for patient care procedures and for professional behavior in a clinical setting are detailed in the most recent *Indiana University School of Optometry Eye Care Centers Student Orientation Manual*.

Professionalism must be maintained on the clinic floor at all times. Speaking to a faculty member or staff member disrespectfully will be considered unprofessional and the student could be failed for that days’ worth of patients. Also, as stated in the Clinic Manual, cell phones should not be used while on the clinic floor except for emergency situations. This includes case conference. If a student is seen using a cell phone in excess a verbal warning may be given to the student. If the student does not comply they will receive a failure for that days’ worth of patients.

Additional rules and regulations of the university are available in the Code of Student Rights, Responsibilities, and Conduct published by Indiana University. It
is each student's responsibility to be aware of these regulations. Violation of the Code of Student Rights, Responsibilities, and Conduct may result in dismissal.

**Important Requirements for V786-787**

**A. On-line Patient Log**
For each course, all patient interactions need to be entered in the on-line patient log. The link to the patient log system is found at the "Students" section of the IU Opt Website ([http://www.opt.indiana.edu/students/students.htm](http://www.opt.indiana.edu/students/students.htm)). The log for each course (eight week session during the semester) needs to be finished by the Monday after your last day in that course. As outlined in the Manual Section 1.1.1, an **INCOMPLETE** will be given for each course that does not satisfy this requirement. Meditrek will email you your log in and password information. If you have not received this email you need to contact Brian Page ([bcpage@indiana.edu](mailto:bcpage@indiana.edu)) for assistance. If you have questions about the system in general, ask Dr. Kim Kohne or Cassie Moore or email Elli Kollbaum ([ekollbaum@indiana.edu](mailto:ekollbaum@indiana.edu)).

**B. School Screenings**
Intern participation and attendance is required and mandatory. School vision screenings will be included as a part of the grade for **V787**. Dr. Don Lyon, director of the school screening program, will give further details on the grading system.

**C. Auxiliary Clinic**
The auxiliary requirement is divided into 3 rotations, summer, fall, and spring. Once an intern completes a rotation, the requirement is met for the school year. The purpose of auxiliary clinic is to provide reinforcement in the optical dispensary (e.g., an intern calls in sick, clinic overbooked and walk-in patient arrives, or clinic is running behind schedule). In order to address these situations, students must have their equipment accessible (in their locker or car) while in auxiliary clinic. The goals are to increase the overall learning experience for auxiliary interns, increase the appreciation and value of dispensary obligations, and increase the dispensary’s productivity. In addition, this requirement gives the intern the opportunity to learn the day-to-day dispensary operations, the opportunity to apply Ophthalmic Optics, and to learn the business aspects of a dispensary. You will be required to sign in and out for each session (See full-time staff for location of binder). Working in another area of the building is not an automatically excused absence from auxiliary clinic. **At the end of auxiliary clinic, a performance evaluation is given to the intern. The evaluation will be on an outstanding/adequate/poor level and will affect the final grade accordingly.** The details of each category are posted in each dispensary (AECC/CECC). You may discuss them with the auxiliary supervisor and/or Dr. Kohne.

**D. Third year proficiency**
You will need to demonstrate good diagnostic and case management skills as well as perform a series of more advanced procedures under the direct supervision of a
consultant before you will be able to enter your fourth year external/clinical rotations. These procedures are: Goldmann tonometry, fundus lens utilization (90D or equivalent and BIO), gonioscopy, and medication Rx writing. **All procedures MUST be performed on actual clinic patients, unless otherwise authorized by Dr. Kohne.** You may perform multiple procedures on the same patient. It will be up to YOU to ask a consultant to observe you when you are ready. A Proficiency form will be provided for you and a list of those who have completed the procedures will be compiled and kept in my office. I will need to see the completed Proficiency form (initialed and dated by your consultants) before I add your name to the list.

The following timetable is strictly adhered to:

- **Goldmann tonometry** must be completed during the first 8 weeks of the fall semester (V786);
- **90D/Equiv.** must be completed during the second 8 weeks of the fall (V787);
- **Gonioscopy and Rx writing** must be completed during the first 8 weeks of the spring (V788),
- **BIO** must be completed before finals week during (V789).

**Note:** If you feel prepared, you may complete any or more of these procedures **EARLIER** than the deadline. **If you are unable to complete the requirement in a timely manner, your 8 week grade will be decreased by half a letter grade.** In the event of illness or other unforeseen complications and you can provide a reasonable explanation/documentation for failure to complete the skill prior to the end of the 8 week session, other arrangements will be made with Dr. Kohne. In order to avoid a grade reduction arrangements must be made and approved by Dr. Kohne prior to the end of the 8 wk course.

**Case Conference:** A the end of each clinic day or at an assigned time agreed upon by the interns and the consultant, each group will meet to review all the cases of the day(s). This time is used to ask and answer questions, review differential diagnoses, and most importantly, learn from colleagues' cases of the day. Case Conferences may be as long as an hour or more, particularly early on (V680), and might become more streamlined as interns become comfortable with more routine cases. During each case conference, either the intern or the consultant will present the cases (less time will be spent on the routine cases, as mentioned) and questions will be asked and answered from the group. If for academic reasons (an exam or class) there is no time for a meeting, the Case Conference may be postponed to the following clinic day or another assigned time. Depending on the case or the consultant, review assignments maybe given and the intern(s) might be expected to present, orally or via e-mail, the results of their research on the pertinent topic. This may impact the grade given at the end of the term. Please note that Case Conference time is part of the clinic experience and should be treated as such.

**Specific Skill Requirements by Course**

**Fall Semester (V 786-V 787)**
Any given intern will be scheduled in clinic for either two half-days every week, or alternating one half-day and two half-days every other week. The majority of interns will then have the OPPOSITE schedule in the spring semester. Unless otherwise specified, the grade expectations will be based on a routine case and identical for V786 and V787.

Please refer to the Clinic Grading Slips

EVALUATION FOR A ROUTINE CASE

Clinical Skills: (including history, refraction, BV, Ocular Health, and efficiency/completeness)

Level 3: able to completely and effectively perform clinical skills without consultant prompting
Level 2: Some skills are left undone and intern struggles with some of the skills-consultant had to contribute to clinical skills
Level 1: Skipped or forgot key clinical skills and/or consulting doctor did most of the skills
Failure: Inability to do clinical skills and/or consultant does most or all of the examination or has to take over the examination

Problem Solving/Critical Thinking: (A&P, Case Presentation, Case Conference)

Level 3: Intern offers insight, shows initiative in patient care and can handle and answer consultant questioning effectively
Level 2: With prompting intern can come up with differential diagnosis for CC, other possible clinic skills that could be done and RTC times
Level 1: Inability to discuss case reasonably, unable to develop A&P without consultant, unsure of proper f/u time for patient care
Failure: Unable to answer questions even with prompting from consultant, improper addressing of CC in A&P, no initiative or responsibility in patient care

Communication/Professionalism:

Level 3: Able to answer questions from both patient and consultant, treated patient, consultant and staff with respect and kindness
Level 2: Able to answer some questions from patient and deferred others to the consultant, tolerance of patient and borderline respect to patient, faculty and/or staff
Level 1: Most questions from patient or consultant left unanswered, ignoring requests from patient, faculty and/or staff, unapproachable, poor attitude
Failure: Inability or refusal to answer questions, rude to patient, faculty and/or staff, blatantly disrespectful
The following are the Standards for V786 and 787. These criteria are what are considered a “B” level. These standards were determined by the Primary Care Clinical faculty and will be reviewed every year.

V786 Standards

1. Perform a routine examination in 2 hours or less
2. Establish a reason for visit/chief complaint (RFB/CC) as well as an appropriate history for the RFV/CC. Establish an appropriate history for all other issues that the patient presents with.
3. Know the indications and contra-indications of entrance tests, selectively performing them as indicated by the type of examination and/or patient presentation, and be able to interpret their results
4. Accurately and effectively determine a wearable eyeglass prescription at distance and near
5. With respect to the anterior segment, be able to visualize and describe (using descriptors such as size, shape, color, elevation, and location, including depth/layer of an item in the cornea or lens) normal and abnormal findings, and start to associate names with those findings. As you have already had the Anterior Segment Disease course, you should be fairly conversant with anterior segment findings.
6. With respect to the posterior segment (both the posterior pole and periphery), be able to visualize and describe (using descriptors such as size, shape, color, elevation, location) normal and abnormal findings, and start to associate names with those findings.

V787 Standards

1. Perform a routine examination in 1 hour and 45 minutes or less
2. Establish a reason for visit/chief complaint (RFV/CC) as well as an appropriate history for the RFV/CC. Establish an appropriate history for all other issues that the patient presents with.
3. Know the indications and contra-indications of entrance tests, selectively performing them as indicated by the type of examination and/or patient presentation, and be able to interpret their results
4. Accurately and effectively determine a wearable eyeglass prescription at distance and near
5. With respect to the anterior segment, be able to visualize, describe and name normal and abnormal findings (using descriptors such as size, shape, color, elevation, and location, including depth/layer of an item in the cornea or lens). As you have already had the Anterior Segment Disease course, you should be conversant with anterior segment findings. With respect to the posterior segment (both the posterior pole and periphery), be able to visualize and describe (using descriptors such as size, shape, color, elevation, location) normal and abnormal findings, and start to associate names with those findings.
This syllabus is for use in conjunction with The Clinic Policy Protocol Manual--AECC/CECC, henceforth referred to as “the Manual,” which will be provided to you during the summer clinical rotation. Please study both carefully. The syllabus outlines policies regarding grading, requirements for normal progress, non-passing grade (what constitutes failure), proficiencies, remediation, and conduct expectations. It will also include an approximate timetable with important dates to remember.

General Considerations and Requirements

A. The intern must avail him/herself to have a certain number of patient encounters per course before being eligible to continue. The expected average patient encounters for the summer intensive clinic course, V680, is 35*. The expected average patient encounters for the fall and spring clinic courses, V786-789, is 20*. Patient encounters include comprehensive exams, acute problem focused exams, and any follow-up visits. In order to maintain continuity of care for the patient, the original intern will perform the dilation whenever a patient must reschedule the completion of examination, as well as return for a red eye follow-up visit.

*These numbers have been arrived at by taking into account a sample number of encounters during each course and extrapolating an average number during approximately 2-7 previous years (depending on the course).

Patient numbers may vary. Allowances are made if patient volume drops below expected

B. Non-clinical activity (e.g., reading novels, playing computer games) is strictly prohibited on the clinic floor. If you are without patients, you must occupy your time with reading optometric/medical texts, help in the dispensary, if possible you can observe another intern, practice diagnostic skills, update your on-line patient log, or consult the faculty for ideas as to how to manage your free time meaningfully.

Attendance

A. You must have a written medical excuse for missing clinic in case of illness, or otherwise show proof of your inability to attend clinic (e.g., contagious nature of the illness). Other
unforeseen events (e.g., inclement weather) must be similarly documented. See the Manual for details.

The 10% rule will apply. Whether excused or unexcused, if you miss over 10% of your assigned time in clinic, you must repeat/complete the course. See the Manual (Section 1.2) for details.

B. As soon as you know that you will not be able to attend clinic, contact the front desk at the clinic to which you are assigned, your consultant, and Dr. Kohne in that order. We need to know ASAP in order to ensure patients are rescheduled if necessary. As soon as you know you are not going to be on the clinic floor you should find a substitution. You will be required to make up any missed time in clinic.

C. You are required to be on the clinic floor 15 minutes before the start of the first patient. If you are tardy several times in a row it will affect your clinic grade.

D. Swapping!!!! You will only be allowed to swap out of clinic time one time per 8 week session or two times a semester. The amount of patient contact time is limited during the school year. To maximize the amount of patient contact time it is imperative that you are on the floor at your assigned times. Only in extreme circumstances will there be an exception to this rule, such as death and extreme illness. An excuse form from a doctor will be required for an absence. If more than the allotted amount of clinic time is used, your clinic grade will be decreased by at least half a letter grade and possibly more. The final grade will be determined by the instructor of record and your main clinical consultant during that 8 week session.

Grading

The grading criteria were determined by the Primary Care Clinical Faculty and is discussed and reviewed at the end of every year.

A. Please refer to Course Grade Determination, Section 1.1.1. Of the Manual. This section best describes the grading policy for all clinic courses. Clinical performance is judged by adhering to the guidelines outlined in the Manual. However, remember that, while every attempt is made to retain uniformity, there will be variations depending on the patient, the level of difficulty, and the consultant to whom you may be assigned. Also, note that the OUTCOME of the case will determine the Final Grade for the specific case, regardless of the performance in each category (see below). In addition, the final grade for the course is not a tally of each individual patient encounter. Comprehensive exams will be weighed against shorter patient encounters. Remember, The Clinical Skills Assessment Form is intended to provide the intern with the necessary feedback in order to improve clinical skills on a daily basis. OUTCOME is defined as: How a patient's needs were explored, addressed, and satisfied. Therefore, the concept of partial credit cannot exist in clinic.

B. Course Assignments will be a part of the final grade for the clinic course to which they are assigned. Failure to complete the assignments will result in an incomplete for the course. Course assignments include case presentations, auxiliary, and school screenings.

C. Chair time is of utmost importance for V788 & V789. Routine examinations, including dilation and frame selection MUST be completed within an approximate one hour and 30 minutes. If the time is exceeded, the patient must be made fully aware as to the reasons (e.g. extra testing, emergency situations), which might delay the consultant, etc.

D. Participation in Case Conferences (see below) can also affect the grade (see below).

E. Pure Clinic Grade! To progress on to the next section of Clinic you must pass each 8 week session with the grade of C or better. This grade will be calculated alone (clinic only) before your dispensary and school screening grades are added in. After it is determine you passed the clinic
session with a C or better, your dispensary and school screenings will be added in to your final grade.

F. Documentation Counts! It is of the utmost importance that all documentation in the chart be done and done properly. Failure to complete the documentation can result in a failure for that case. Examples of this would be: not signing the chart, forgetting to write the final RX down, or not putting name and birth date on both sides of the exam form.

Exceptions

As you consider the following criteria for grading, please keep in mind that certain situations will cause your final DAILY grade to be affected negatively or positively beyond the sum of the categories listed on the grade slip.

Examples:

1. Intern has performed satisfactorily (Level 3) in all categories. Intern goes beyond the call of duty to deliver the glasses in non-ambulatory cases. The intern will receive an (A) for the patient (consultant prerogative).

2. The intern has performed satisfactorily (Level 3) in all categories, but forgets to patch one eye during HVF testing, thereby inordinately increasing total chair time, and affecting other patients who might be waiting for the instrument. The intern may receive an (F) for the patient (consultant prerogative).

3. If the Rx is highly unusable and unreasonable for patient use, the intern may be considered to have failed that exam.

4. Abnormalities/anomalies of the posterior pole, as well as most conditions affecting the anterior segment must be described accurately as to shape, size, level of pigmentation, etc. If this is not achieved, the exam may be failed.

5. Intern does not present the case to the consultant efficiently and omits pertinent patient history of findings (e.g. pupil abnormalities, diabetes). The intern may receive an (F) for the patient.

6. Any comprehensive eye exam in which the patient arrives wearing contact lenses, must have the consultant evaluate the lenses prior to removal. Failure to do so may result in an (F) for the patient regardless of how well the rest of the exam was performed.

What Constitutes Failure of V788 or V789?

1. Violating patient confidentiality, forging consultant signatures, and unethical and fraudulent conduct.

2. Receiving an “F” constitutes immediate failure of the course. The intern must repeat the course after having gone through remediation (see Manual).

3. Patient endangerment as deemed by the clinical faculty. The endangerment can be direct (e.g., corneal abrasion caused by inadequate applanation tonometry), or indirect (e.g., missing an obvious corneal finding that might lead to visual impairment; e.g., misreading the applanation tonometry resulting in erroneously low pressures and misdiagnosis of glaucoma). (The above are examples of the many possible situations)

4. Absenteeism. Unexcused absence is grounds for failure of the course.

How to make up a failed course

In case of failure (see above), the intern must enroll in the remedial course (V780). After the course has been completed successfully, s/he is allowed to continue normal clinical rotation.

Note: Patient numbers and time spent in clinic are BOTH criteria for a successful second attempt. Therefore, an intern who does not pass a rotation must realize s/he will be behind a minimum of 8 weeks during the academic year.

Remediation
If an intern receives a C- grade in any third- or fourth-year clinic course, the student must accept remediation and must enroll in either V 780 Clinical Skills Enhancement–3rd Year or V 880 Clinical Skills Enhancement–4th Year.

A student who fails to complete V 780 or V 880 with a grade of C– or better will be ineligible to continue.

If an intern is unable to continue with a clinical rotation for academic or clinical performance reasons, the grade of F will be assigned.

Policies and procedures are explained in detail in the most recent *Indiana University School of Optometry Eye Care Centers Student Orientation Manual*.

**Ineligible to Continue**

A student is ineligible to continue when one or more of the following conditions hold:

1. the student earns lower than a 1.00 GPA for any semester, regardless of cumulative GPA;
2. the student earns both (a) lower than a 2.30 GPA in a semester and a recommendation by the Academic Review Committee;
3. the student has failed the clinical competency examination two times and a recommendation by the Academic Review Committee;
4. the student fails a clinical course after remediation; clinical courses are V 680, V 786, V 787, V 788, V 789, V 885, V 887, V 888;
5. the student has failed to complete the professional curriculum in six years;

These conditions indicate unsatisfactory progress and could result in automatic dismissal.

**Academic Misconduct**

Academic integrity is fundamental to the intellectual life of the university and to the education of each student. The following acts of academic dishonesty are prohibited: cheating, fabrication, plagiarism, interference, and facilitating academic dishonesty. Proven academic misconduct is grounds for dismissal.

**Professional Misconduct**

Maintaining standards of professional conduct is essential to the integrity of the profession. Professional misconduct is strictly prohibited. This includes dishonest conduct (including, but not limited to, false accusation of misconduct; forgery; alteration or misuse of any university document, record, or identification; and giving to a university official any information known to be false) and use or possession of alcoholic beverages or illegal drugs on university property or during a university activity.
In addition, fraud and patient endangerment and abandonment will be grounds for dismissal. Standards for patient care procedures and for professional behavior in a clinical setting are detailed in the most recent *Indiana University School of Optometry Eye Care Centers Student Orientation Manual*.

Professionalism must be maintained on the clinic floor at all times. Speaking to a faculty member or staff member disrespectfully will be considered unprofessional and the student could be failed for that day’s worth of patients. Also, as stated in the Clinic Manual, cell phones should not be used while on the clinic floor except for emergency situations. This includes case conference. If a student is seen using a cell phone in excess a verbal warning may be given to the student. If the student does not comply they will receive a failure for that day’s worth of patients.

Additional rules and regulations of the university are available in the Code of Student Rights, Responsibilities, and Conduct published by Indiana University. It is each student’s responsibility to be aware of these regulations. Violation of the Code of Student Rights, Responsibilities, and Conduct may result in dismissal.

**Important Requirements for V788-789**

**A. On-line Patient Log**

For each course, all patient interactions need to be entered in the on-line patient log. The link to the patient log system (now called Meditreck) is found at the "Current Students" section of the IU Opt Website ([http://www.opt.indiana.edu/students/students.htm](http://www.opt.indiana.edu/students/students.htm)). The log for each course (eight week session during the semester) needs to be finished by the Monday after your last day in that course. As outlined in the Manual Section 1.1.1, an INCOMPLETE will be given for each course that does not satisfy this requirement. You will be required to log in with your username and a password. A password and username will be provided for you by the Meditrek system. If you have any questions about your password, please contact Brian Page (bcpage@indiana.edu) in the Student Administration office. If you have questions about the system in general, ask Chris Coffey or Dr. Elli Kollbaum.

**B. Auxiliary Clinic**

The auxiliary requirement is divided into 3 rotations, summer, spring, and fall. Once an intern completes a rotation, the requirement is met for the school year. The purpose of auxiliary clinic is to provide reinforcement in the optical dispensary (e.g., an intern calls in sick, clinic overbooked and walk-in patient arrives, or clinic is running behind schedule). In order to address these situations, students must have their equipment accessible (in their locker or car) while in auxiliary clinic. The goals are to increase the overall learning experience for auxiliary interns, increase the appreciation and value of dispensary obligations, and increase the dispensary’s productivity. In addition, this requirement gives the intern the opportunity to learn the day-to-day dispensary operations, the opportunity to apply Ophthalmic Optics, and to learn the business aspects of a dispensary. You will be required to sign in and out for each session (See full-time staff for location of binder). Working in another area of the building is not an automatically excused absence from auxiliary clinic. At the end of auxiliary clinic, a performance evaluation is given to the intern. The evaluation will be on an outstanding/adequate/poor level and will affect the final V789 clinic course grade accordingly. The details of each category are posted in the syllabus of V680 and each dispensary (AECC/CECC). You may discuss them with the auxiliary supervisor and/or Dr. Kohne.
C. Third year proficiency
You will need to demonstrate good diagnostic and case management skills as well as perform a series of more advanced procedures under the direct supervision of a consultant before you will be able to enter your fourth year external/clinical rotations. These procedures are: Goldmann tonometry, fundus lens utilization (90D or equivalent and BIO), gonioscopy, medication Rx writing, and BIO. **All procedures MUST be performed on actual clinic patients, unless otherwise authorized by Dr. Kohne.** You may perform multiple procedures on the same patient. It will be up to YOU to ask a consultant to observe you when you are ready. A Proficiency form will be provided for you and a list of those who have completed the procedures will be compiled and kept in my office. I will need to see the completed Proficiency form (initialed and dated by your consultants) before I add your name to the list. Failure to complete these tasks in the 8 week period will result in a deduction of half a letter grade from your final grade. EX: Gonioscopy and RX writing are due during the first 8 weeks of V788; failure to turn in the pink sheet by the required time will result in a deduction of your final grade by half a letter grade.

The following timetable is strictly adhered to:

- **Goldmann tonometry** must be completed during the first 8 weeks of the fall semester (V786);
- **90D/Equiv.** must be completed during the second 8 weeks of the fall (V787);
- **Gonioscopy and Rx writing** must be completed during the first 8 weeks of the spring (V788),
- **BIO** must be completed before finals week during (V789).

**Note:** If you feel prepared, you may complete any or more of these procedures **EARLIER** than the deadline. If you are unable to complete the requirement in a timely manner, will result in a deduction of half a letter grade from your final clinic grade. In the event of illness or other unforeseen complications and you can provide a reasonable explanation/documentation for failure to complete the skill prior to the end of the 8 week session, other arrangements will be made with Dr. Kohne. In order to avoid a grade deduction, arrangements must be made and approved by Dr. Kohne prior to the end of the 8 wk course.

***An incomplete for V789 will prevent the intern from going to his/her external rotation until it can be satisfactorily removed.***

**Case Conference:** A the end of each clinic day or at an assigned time agreed upon by the interns and the consultant, each group will meet to review all the cases of the day(s). This time is used to ask and answer questions, review differential diagnoses, and most importantly, learn from colleagues’ cases of the day. Case Conferences may be as long as an hour or more, particularly early on (V680), and might become more streamlined as interns become comfortable with more routine cases. During each case conference, either the intern or the consultant will present the cases (less time will be spent on the routine cases, as mentioned) and questions will be asked and answered from the group. If for academic reasons (an exam or class) there is no time for a meeting, the Case Conference may be postponed to the following clinic day or another assigned time. Depending on the case or the consultant, review assignments maybe given and the intern(s) might be expected to present, orally or via e-mail, the results of their research on the pertinent topic. This may impact the grade given at the end of the term. Please note that Case Conference time is part of the clinic experience and should be treated as such.

**Specific Skill Requirements by Course**

**Spring Semester (V 788-V 789)**

**Note:** If the exam form is incomplete without explanation/documentation or the record is illegible and errors are not properly corrected you will receive an **F** for that patient experience. **Failure will result if the consultant has to intervene and/or excessively coach the intern throughout the exam.**

Please refer to the Clinic Grading Slips
Unless otherwise specified, the expectations will be the identical for V 788 and V 789.

EVALUATION FOR A ROUTINE CASE

Clinical Skills: (including history, refraction, BV, Ocular Health, and efficiency/completeness)

Level 3: able to completely and effectively perform clinical skills without consultant prompting
Level 2: Some skills are left undone and intern struggles with some of the skills-consultant had to contribute to clinical skills
Level 1: Skipped or forgot key clinical skills and/or consulting doctor did most of the skills
Failure: Inability to do clinical skills and/or consultant does most or all of the examination or has to take over the examination

Problem Solving/Critical Thinking: (A&P, Case Presentation, Case Conference)

Level 3: Intern offers insight, shows initiative in patient care and can handle and answer consultant questioning effectively
Level 2: With prompting intern can come up with differential diagnosis for CC, other possible clinic skills that could be done and RTC times
Level 1: Inability to discuss case reasonably, unable to develop A&P without consultant, unsure of proper f/u time for patient care
Failure: Unable to answer questions even with prompting from consultant, improper addressing of CC in A&P, no initiative or responsibility in patient care

Communication/Professionalism:

Level 3: Able to answer questions from both patient and consultant, treated patient, consultant and staff with respect and kindness
Level 2: Able to answer some questions from patient and deferred others to the consultant, tolerance of patient and borderline respect to patient, faculty and/or staff
Level 1: Most questions from patient or consultant left unanswered, ignoring requests from patient, faculty and/or staff, unapproachable, poor attitude
Failure: Inability or refusal to answer questions, rude to patient, faculty and/or staff, blatantly disrespectful

The following are the Standards for V788 and V789. These criteria are what are considered a “B” level. These standards were determined by the Primary Care Clinical faculty and will be reviewed every year.

V788 Standards

1. Perform a routine examination in 1 hour and 30 minutes or less
2. Establish a reason for visit/chief complaint (RFV/CC) as well as an appropriate history for the RFV/CC. Establish an appropriate history for all other issues that the patient presents with.
3. Know the indications and contra-indications of entrance tests, selectively performing them as indicated by the type of examination and/or patient presentation, and be able to interpret their results
4. Accurately and effectively determine a wearable eyeglass prescription at distance and near
5. With respect to the anterior segment, be able to visualize, describe and name normal and abnormal findings (using descriptors such as size, shape, color, elevation, and location, including depth/layer of an item in
the cornea or lens). As you have already had the Anterior Segment Disease course, you should be conversant with anterior segment findings.

6. With respect to the posterior segment (both the posterior pole and periphery), be able to visualize, describe and name normal and abnormal findings (using descriptors such as size, shape, color, elevation, location).

V789 Standards

1. Perform a routine examination in LESS than 1 hour and 30 minutes
2. Establish a reason for visit/chief complaint (RFV/CC) as well as an appropriate history for the RFV/CC. Establish an appropriate history for all other issues that the patient presents with.
3. Know the indications and contra-indications of entrance tests, selectively performing them as indicated by the type of examination and/or patient presentation, and be able to interpret their results.
4. Accurately and effectively determine a wearable eyeglass prescription at distance and near.
5. With respect to the anterior segment, be able to visualize, describe and name normal and abnormal findings (using descriptors such as size, shape, color, elevation, and location, including depth/layer of an item in the cornea or lens). As you have already had the Anterior Segment Disease course, you should be conversant with anterior segment findings.
6. With respect to the posterior segment (both the posterior pole and periphery), be able to visualize, describe and name normal and abnormal findings (using descriptors such as size, shape, color, elevation, location).
7. Be largely independent regarding management and treatment of most PC patients.
Introduction
The contact lens research clinic is a specialty clinic where care is provided for patients requiring contact lenses for visual correction. The clinic serves as a referral center for the Atwater Eye Care Center and the IU Student Health Center, as well as for local practitioners. Fourth and third year optometry students are assigned to this facility for specialized training in contact lens practice.

This facility is the site of clinical research carried out by faculty members of the Cornea and Contact Lens Service. FDA and individual research projects are also pursued.

Philosophy
The Cornea and Contact Lens Service is a teaching institution designed to give the student intern the opportunity to gain clinical proficiency in contact lens practice while maintaining a level of excellence in the care delivered to the patients of this facility. The patients of the contact lens service are the responsibility of the faculty consultants. Students work with the consultants to provide this care. Absolutely no patient contacts are to be made by the student interns by phone or otherwise, unless specifically instructed by the faculty consultant involved in the case. The main goal of the exam is to treat the patient’s chief complaint while providing excellent care.

Objectives for Optometry Interns
1. Student Interns are expected to gain a working knowledge of the various types of contact lenses available in the clinic, and the fitting characteristics of each.
2. Student Interns are expected to gain a working knowledge of the care systems available in the clinic for both rigid and soft contact lenses.
3. Student Interns are to have an understanding in rigid contact lens inspection and verification, and modification.
4. Student Interns are required to gain proficiency in soft contact lens inspection and verification.
5. Student Interns are required to gain clinical proficiency in hard and soft contact lens insertion, removal, fitting, and responsible follow up care. This entails an understanding of lens centration, movement, and fluorescein patterns.
6. Student Interns are expected to gain proficiency in general and contact lens problem solving, including parameter determination and lens ordering.
7. Student Interns are expected to gain proficiency in the S.O.A.P. problem oriented record system.
8. Student Interns are expected to gain proficiency in general office procedures.
Responsibilities of Optometry Interns

1. You must be set up, and be ready to see patients 15 minutes before your assigned clinic time. (i.e. by 7:45 am for morning clinic, 12:45 pm for afternoon clinic, and 4:45 pm for evening clinic.) You cannot leave your equipment in a room more than one session before your scheduled clinic time. **If you will be late or are sick, call CL Desk at 855-2902. DO NOT leave a message!! You must speak w/a staff member.**

2. In the event that you end up without a patient to see, you can help with another Intern’s patient, be available to take a walk in, fit comp lenses on one another, practice contact lens verification and modification, check you exam room and make sure it is clean and well stocked, read journals, or practice for boards.

3. **Remember to check all patients out on the schedule in the lab area with your initials.**

4. Check the bulletin board and your intern box every day for notices, messages, articles, and charts that need to be completed.

5. **KEEP YOUR EXAMINATION LANES CLEAN.** All exam rooms have been cleaned and stocked. It is your responsibility to keep it them that way. (See the Contact Lens Inventory list of supplies included at the end of this section.) All surfaces in the room, including the slit lamp table and sink, should be kept clean. All rooms should have mirrors for contact lens insertion and removal and these should be kept free of fingerprints and smudges. All solution bottles should be kept capped while not in use. Used alcohol wipes, tissues and paper towels should not be left on the floor but picked up. **The cleanliness of the examination room is the student’s responsibility and may determine whether a patient elects to have their eyes examined at our clinics.**

6. Charts are to be completely filled out and signed by intern and doctor. **Summary Sheets are to be updated with every visit.** If a paper chart is not completed, place it in the doctor’s box that needs to complete it unless there is a contact lens order. If so, the chart needs to go to the “To Be Ordered” bin.

7. Patients returning for follow-up visits are to be scheduled at the contact lens desk unless staff is gone for day. Make sure to give the patient an appointment card. If ordering trials, make appointments at least one week out giving ample time for trials to come in. Your consultant will indicate if a specialty lens may take more time.

8. Make sure Service Summary Sheet is filled out completely before you go to the payments desk! This includes Doctor’s initials, your 3-digit Compulink ID, charges, and diagnostic codes. (You will be sent back if this is not done!) If ordering contacts lenses, please make sure to circle contact lens you are ordering as well as entering the number of boxes being ordered. **Do not expect the payments desk to look up diagnostic codes for you. This is your responsibility.**
9. Walk the patient to the payments desk for checkout and stay there until payments desk staff says they do not need you there anymore. **If you are ordering contact lenses, tell payments desk staff. Every patient must stop at the payments desk, even if it is a no charge visit.**

10. Always wash hands before and after every patient (preferably in front of the patient).

11. Check equipment often to make sure it is working order. Interns should report any problems promptly to Kim in supply room.

12. Make sure all contact lens order forms are filled out completely. Orders must be paid in full before contact lenses are ordered including RGPs, Annual Replacements, and custom made lenses. After order is paid, put completed order form in chart and place in Kristy’s bin.

13. If you have questions, please ask.

14. Once completed with the chart, place chart in Kristy's bin.

15. Please clean and cover all equipment, and turn off equipment and lights before you leave.

16. Dress code: As stated in the Clinic Manual. Appropriate shoes include heels that do not make excessive noise on the tiled hallways.

**Consultation**

1. For the first two weeks you are in the clinic, a consultant needs to see all contact lenses on the patient before you can remove the lenses. **All GP and specialty lenses (hybrid, custom, etc.) need to be evaluated by a consultant before removal for the entire rotation (12 weeks.)**

2. 4\textsuperscript{th} year interns will be able to proceed through dilation without the need for consultation. However, all near testing needs to be completed (especially if there are near complaints) before dilation. **When in doubt, consult with your preceptor. 3\textsuperscript{rd} year interns will still need to consult before dilation.**

3. When possible, consult with the same preceptor who has seen the patient in the past (by looking in the chart.) Try to schedule the patient for follow-up care with yourself (most important) and same preceptor if possible.

4. Most specialty lens consultations will be done with the CL resident if possible.

5. If the patient is wearing monovision, monocular acuities at distance and near must be taken and recorded. VAs of all patients should be recorded on the “Objective” tab of Compulink.
<table>
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<th>Third Year Track</th>
<th>Fourth Year Track</th>
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| Patients seen in the Cornea and Contact Lens Service are to be considered Problem Based exams. Not every Primary Care exam element will be performed during the examination. For example, accommodative testing, vergences and phorias are rarely needed unless there are near complaints. Stereo and Color are done once on new patients unless there are problems; Amsler Grid only as needed. Keratoconics and patients needing scleral lenses are to be seen by fourth year interns. **Essential Exam Elements for Full Exam with Contact Lens Fit/Evaluation:** | Solve Chief Complaint
Perform Problem Based Examination: Essential Exam Elements for Full Exam
with Contact Lens Fit/Evaluation

**Chief Complaint/History**
VA: record type of correction
Pinhole if entering VAs are ˂ 20/25
Hab. Spec Rx
Keratometry if fitting GP lenses
CT Dist and Near (needs to be in Chart once)

**Retinoscopy/Subjective/Final Rx** (Do not overminus, cut existing minus, change cyl axis) Use Age Add to calculate ADD-do not evaluate ADD behind phoropter)
Visual Field: FDT, not CONF
Pupils (always Full Exam or DFE F/U)
SLE- Contact Lens Fit/Eval here

**Tonometry** (must consult before Goldmann with CL fit or Red Eye visit)
Must consult before dilation/NaFL
Internal (may defer DFE to CL F/U) but need to evaluate with 90D for Full Exam

**NOTE:** Proficiency Testing for Goldmann tonometry, 90D, Gonioscopy, BiO will be reserved for Primary Care Clinic. |
1. Explain the contact lens fitting and care policy of our clinic. Contact lens fitting is an involved process. The final fitting may not be achieved and its effects evaluated until three months after the patient first starts to wear lenses. Therefore we prefer to provide a total contact lens care package to our patients. This includes the fitting, dispensing, and follow up care up to the time a successful fit is achieved. During this time the lens fitting and the ocular response to the lens and care products are evaluated. Modifications and reorders due to fitting problems are not charged to the patient for the first three months. Interns should be familiar with the exchange policy and warranty for lenses, so that they can keep this in mind when seeing the patient. Be sure that patients are aware that missed follow up appointments can result in paying the cost for refitting lenses. Adjustments are made if necessary.

2. Ensure that a complete eye exam was performed within the last twelve months. Make arrangements to obtain records if the exam was not here. Contacts cannot be ordered until a copy of this exam is in the chart. No contact lenses that are not examined on the eye will be ordered.

3. While fitting a new patient try both soft and rigid contact lenses, especially if attempting a spherical fit. Soft lenses should be tried first.

4. Check out the appropriate lenses from the supply room. Limit of three lenses out at one time. When returning lenses to supply room, let staff know they were tried on a patient. Staff will need to disinfect lenses before putting lenses back on shelves.

5. Clean and place the lenses on the patient’s eye yourself. Don’t let the patient insert them yet at this stage.

6. Allow the lenses a few minutes to equilibrate in the eye before checking for movement, alignment and visual acuity. Scleral lenses take much more time to settle on the eye and NaFl should be added to the bowl before insertion, consult with your preceptor when fitting scleral lenses.

7. Check the fee schedule and consult with faculty or Kristy before presenting the various fee options to the patient.

8. Do not leave empty vials of dispensed lenses or flat packs of GPs in the chart. Give them to the supply room to be stored for exchanges. This applies to most specialty lens orders.

9. Be sure to review the wearing and follow up schedules with the patient.

10. All first time wearers are to be given patients instruction forms on the day lenses are dispensed. Review these instructions completely with the patient.

11. Instruct all patients to bring their glasses to all follow up visits.

12. Instruct patients on the importance of follow up visits.

13. Try to schedule follow up appointment before the patient leaves with the same Intern and Doctor. If ordering trials, please schedule follow up one week (in some cases more) out to give ample time for trials to come in.
14. Disinfecting solutions: Educate the patient on the importance of disinfecting solutions, and that the different contact lens solutions are “not all the same.” Please do not give patient more than one sample of contact lens disinfection solution at a time, and not every year unless you are prescribing a new solution. Also, do not give a patient a handful of artificial tears to “try out.” Make an educated decision and give the patient one brand.

**Contact Lens Room Inventory**

At the beginning and end of each day, all exam rooms are to be left neat and orderly with adequate and necessary supplies.

**Supplies include:**

| Tyler’s Quarterly (most recent copy) | Alcare Hand Foam |
| Proparacaine .5% | Cotton Tip Applicators |
| 1% Tropicamide | Alcohol Pads |
| Phenylepherine 2.5% | Contact Lens Cases (~12 cases) |
| Fluorets Strips | Optifree Puremoist |
| Florox | Boston Simplus or Optifree GP |
| Tissues | Mirror for CL I&R |
| Saline | |

Yellow Wratten filter is to be left in the room.

All solutions in the room should be capped when not in use.

Equipment covers to be placed in cabinet under the sink when not in use.

Equipment must be properly covered each night and turned off.
Pediatrics/Binocular Vision Services

INTERN CLINICAL MANUAL
Atwater Eye Care Center
Indianapolis Eye Care Center

May 2013-April 2014
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General Information
Indiana University School of Optometry
Pediatrics/Binocular Vision Service

The Pediatrics/Binocular Vision Service of the Indiana University School of Optometry offers a wide range of specialized eye and vision care. This includes the comprehensive optometric care of children, including infants, evaluation and management of amblyopia, the evaluation and nonsurgical management of strabismus, the management of nonstrabismic problems with binocular vision, and the vision-related learning skills assessment of children and adults having learning problems.

Pediatrics/Binocular Vision Services Staff
Dr. Don Lyon, Chief of Service  Dr. Paula Jarrard, Educational Consultant
Dr. Rowan Candy  Dr. Tawna Roberts
Dr. David Goss  Dr. Vivian Wong
Dr. Doug Horner  Dr. Adrianna Hempelmann, Resident 2012-2013
Dr. Mark Obenchain, Resident 2013-2014

Clinical Services

1. Pediatric Care

Children have special needs that require special care. The Pediatric Service offers complete optometric care to children from birth to 12 years of age. Evaluation and management of refractive errors, binocular vision problems (like lazy or crossed eyes, eye teamwork problems, and poor eye coordination), and ocular health problems, as well as screening for visual perceptual deficits, are included in our pediatric services. The latest methods of examining children are used, and the results of our evaluations are explained in full to parents/guardians.

2. Binocular Vision Evaluation and Management

Problems with accommodation and binocular vision often lead to symptoms such as headaches or eyestrain, or can cause more serious problems such as suppression or amblyopia. These problems can be found in individuals of all ages. The Binocular Vision Service provides complete evaluation of accommodative and binocular vision function, and offers a wide variety of treatment and management options. Glasses may be the solution for some of these problems, but are not always the best option. Other treatment methods such as patching an eye, use of prism lenses, or vision therapy may be more effective in managing certain eye and vision difficulties. In some cases, a referral may be needed for opinions regarding the possibility of eye surgery.

3. Visual Information Processing / Learning Skills Assessment and Management

The learning process requires efficient and effective interaction of all of the body's senses. Many children and adult students suffer from vision-related learning problems. Although optometrists are not educators or psychologists, they can provide care related to vision conditions that may interfere with reading and learning. Our Educational Consultant performs thorough evaluations of learning-related vision skills using a comprehensive battery of standardized tests. A visual processing skills therapy program can also be developed for individuals who demonstrate significant difficulties during testing. In addition, the service recognizes the importance of proper communication between parents, schools, psychologists, therapists, and other health care providers in the care of students with learning problems. We believe that these students benefit tremendously from this multidisciplinary team approach to education and learning.
Intern Expectations and Responsibilities

The Pediatrics/Binocular Vision Services of the IU School of Optometry is equipped and staffed to provide care to patients of all ages with functional abnormalities of the binocular vision system and with suspected vision-related learning problems. Such anomalies include problems with convergence or divergence, accommodative deficiencies, strabismus and related problems, and visual processing difficulties. These patients are generally examined on a referral basis. Comprehensive optometric examinations are available for children 12 years old and younger. Fourth-year optometry interns are the primary providers of care, and clinical faculty with professional expertise and interest in pediatrics and binocular vision serve as consultants.

It is imperative that the intern be thoroughly familiar with each of the following procedures and diagnoses. Consultants will expect interns to be proficient in all of these areas. If an intern is not familiar with or does not understand a particular concept, an effort should be made to review class notes or other reference materials, ask classmates, or talk to consultants to resolve the problem.

Specific patient care expectations:

1. The intern is expected to be able to administer the diagnostic test procedures found in Table 1. These procedures were covered in V755 (Basic Vision Therapy), V781 (Pediatric Optometry), and V782 (Visual Information Processing), and are essential for the proper diagnosis of anomalies of accommodation and binocular vision, and for the optometric care of the pediatric patient. Analysis of examination data and creation of Assessments and Plans should follow the material taught in V758.

2. The intern will know the indications for the diagnostic tests discussed above, and will understand and be able to diagnose the conditions listed in Table 2.

3. The intern will understand and be able to perform the vision therapy procedures listed in Table 3.

4. The intern will know when to make an appropriate referral for a Visual Information Processing assessment. In addition, the intern will be familiar with assessment instruments discussed in V782, and listed in Table 4 and will be responsible for knowing how to appropriately administer a visual information processing assessment.

5. The intern will be able to develop a sequential treatment plan for the diagnoses listed in Table 2, as well as know the approximate treatment duration and prognosis. Typical management options include spectacle correction, added lenses, prism, vision therapy, and referral. There are several readily available sources of information to help the intern in formulating an appropriate treatment plan. These sources are listed in Table 5.
1. Pediatrics/Binocular Vision Diagnostic Procedures

1. accommodative amplitude using Donder’s push-up technique
2. accommodative facility using flipper lenses or Hart Charts
3. dynamic retinoscopy using the Nott or MEM technique
4. DEM and NYSOA K-D saccade tests
5. prism neutralized cover test
6. forced vergence cover test
7. von Graefe phorometry
8. Maddox rod test
9. Hirschberg and Bruckner tests
10. objective and subjective angles using Synoptophore
11. Worth 4-dot
12. binocular refraction using vectograph slide
13. LogMAR visual acuity testing
14. visuosity
15. afterimage transfer fixation testing
16. Hering-Bielschowsky afterimage testing of correspondence
17. Parks 3-step procedure
18. Sheedy disparometry (fixation disparity)
19. Wesson card disparometry (fixation disparity)
20. Mallett unit and vectograph slide (associated phoria)
21. Saladin Card
22. modified Thorington Cards
23. von Graefe vergence range measurements
24. prism bar vergence range measurements
25. vergence facility using flipper lenses
26. BIM/BOP facility
27. NPC, NRA, PRA, BCC
28. preferential looking visual acuity using Teller/Cardiff cards
29. tonometry using Kowa hand-held tonometer and tonopen
2. Accommodative and BV Diagnoses

1. **Non-strabismus anomalies**
   a) basic lateral heterophoria
   b) anomalies of convergence
      1. insufficiency
      2. excess
   c) anomalies of divergence
      1. insufficiency
      2. excess
   d) symptomatic vergence range and facility deficiencies
   e) vertical heterophoria
   f) anomalies of accommodation
      1. insufficiency
      2. infacility
      3. spasm
      4. fatigue
   g) pseudo-convergence insufficiency
   h) anomalies of ocular motility
   i) symptomatic anisometropia/aniseikonia

2. **Strabismus and related anomalies**
   a) intermittent strabismus
   b) constant strabismus
   c) amblyopia
   d) suppression
   e) eccentric fixation
   f) anomalous correspondence
   g) sensory fusion anomalies
   h) anomalies of accommodation
   i) anomalies of ocular motility
3. Vision Therapy Procedures

1. Computer Orthoptics/HTS
   accommodative facility, vergence ranges and facility, eye movements, suppression, amblyopia, visual
   perception skills
2. Hart Charts and accommodative screen for accommodative facility
3. Synoptophore
4. vis-a-vis and pola-mirror techniques
5. TV trainer
6. bar reader
7. Sherman’s playing cards
8. MITy Mazes
9. R/G Litetracs
10. Brock String
11. hand-held mirror
12. cheiroscope
13. mirror stereoscope
14. Michigan tracking activities
15. fixed tranaglyphs
16. variable tranaglyphs
17. vectograms
18. aperture rule trainer
19. opaque and transparent free-space fusion (Lifesaver) cards
20. occlusion techniques and schedules for amblyopia
21. BIM/BOP procedures
4. Visual Information Processing Assessment Instruments

1. Developmental Test of Visual Perception (DTVP-2)
2. Test of Visual Perceptual Skills (TVPS)
3. Developmental Test of Visual-Motor Integration (VMI)
4. Developmental Eye Movements Test (DEM)
5. Matching Familiar Figures Test (MFFT)
6. Woodcock-Johnson Psycho-Educational Assessment Battery (WJ-R)

Other test instruments may be used depending upon the nature of the case.
5. Available Clinic Information Resources

1. Class notes from V755, V781m, V782 and V758
2. Texts
   a. Goss (V652)
   b. Griffin (V755)
   c. Scheiman and Wick (V755)
   d. Rosenbloom and Morgan (V781)
   e. Scheiman and Rouse (V782)
3. Computer and on-line resources
4. V755, V781, and V782 slide shows on TEACHING volume
5. World Wide Web information
6. Various instrument and equipment manuals
7. This manual
Administrative Rules of Engagement

Bloomington Clinic

1. Interns are required to remain available on assigned clinic days until at least 11:30 (Saturday), 4:30 p.m. (Tuesday, Wednesday, Thursday), or 7:30 p.m. (Wednesday).
2. Interns must be set up in their exam rooms and ready to go at least 15 minutes before the beginning of the daily case conference.
3. White coats (clean) are required during clinic hours.
4. Please review your patient charts before your patients arrive. This is especially vital for vision therapy and visual information processing patients.
5. Please remain on the clinic floor and available if you are not with a patient.
6. Always return borrowed equipment and supplies in a timely manner.
7. Service Summary must be completed in full, run through the billing desk. Return all patient charts to the consultant’s mailbox before you leave for the day.
8. Please make sure that the doctor is linked to the EHR chart by looking on the com tab. The doctor should be listed if they are linked. If there is not a doctor linked please inform the consultant so they can sign onto the chart.
9. Cover all equipment in your exam room, turn off all lights, lower the exam chair, and clean up the room when leaving for the day so that it is ready to be used by the next intern.

Indianapolis Clinic

1. Look at appointment sheets either the day before or that morning to see if you have been assigned to any patients. If you have a patient make sure you are available when that patient comes in.
2. White coats (clean) are required during clinic hours.
3. Always return borrowed equipment and supplies before you leave for the day.
4. Have all charts completed and ready for the consultant’s signature before leaving for the day.
5. Service Summaries must be completed in full and run through the billing desk. This needs to be done before you leave for the day.
6. Please make sure that the doctor is linked to the EHR chart by looking on the com tab. The doctor should be listed if they are linked. If there is not a doctor linked please inform the consultant so they can sign onto the chart.
7. Cover all equipment in your exam room, turn off all lights, lower the exam chair, and clean up the room when leaving for the day so that it is ready to be used by the next intern.
Binocular Vision Service (for all clinic sites)

1. Interns are responsible for the care of their patients from the initial evaluation, through all vision therapy and evaluation visits, until dismissal from care. If an intern cannot be available for a patient visit, proper arrangements must be made for a substitution. **Continuity of care is critical in this service.**

2. If vision therapy is indicated, complete a Fee Agreement with your consultant to give your patient an idea of how much it will cost, what’s involved, and how long it will take.

3. When discussing BV evaluations or therapy with patients who have IU POS insurance, we MUST have a POS referral from the patient’s PCP before starting therapy. Ask what the GP’s name is and where they are located to make things easier. Do NOT tell the patient insurance will cover everything.

4. Any referral, be it from a teacher or another OD or MD, needs a letter this is your responsibility to write this letter and it should be done in a timely manner (i.e. less than a week). If POS authorizes visits for VT, a letter should be sent to the PCP detailing the therapy and how the patient is responding.

Pediatric Service (for all clinic sites)

1. Work quickly and efficiently with your young patients. Their attention span is short. Remember, you are “on the clock”.

2. Always ask permission from parents or guardians to dilate children.

3. Parents are to fill out the confidential patient survey the first time they come in. This document should be updated at least every three years. This gives us a good picture of how the child has developed, and is very important when the child has a VIP workup. On subsequent visits the intern must review the history and expand any problems on the exam form.

4. Any referral, be it from a teacher, or another OD or MD, needs a letter. This is your responsibility, and it should be done in a timely manner (i.e. less than a week).

5. Inform Mom and/or Dad that they may accompany their child in the examination. If there are more children then parents/guardians then inform the parents/guardians where each child is and encourage them to go visit each room during the examination. If the parent does not want to stay in the room for the entire exam it is imperative that they come back to discuss the chief complaint, history and get permission to instill drops for dilation. **DO NOT** discuss anything about the patient in the waiting room or the hallway, this is in direct violation of HIPPA standards. If the parent would like to leave the room during the exam please have them back in the room before your consultant comes in for the final review and checkout so they may discuss the results in the room.

6. Please don’t keep younger patients waiting. Children become EXTREMELY restless, and besides rearranging our waiting area, they may choose to make your examination that much more challenging.

7. Talk directly to your patients as much as possible. It is easy to talk only to parents, and unintentionally ignore your young patient.

8. Avoid asking permission from your patient for testing procedures. Although it is tempting to say “can I put these drops in your eyes now?,” don’t. The answer will inevitably be “NO.”

9. You will often be relying very heavily on objective testing procedures. Retinoscopy and prism neutralized cover testing are particularly important, and you should be confident and practiced in these skills. Your consultant will be more then happy to check your findings.

Infant Clinic (for all clinic sites)

The goal of this clinical experience is to provide resources that enable interns to feel comfortable seeing infant patients when they are out in practice. Historically we have found that interns get more out of the experience if they start by watching these examinations, for the following reasons:
• Many interns have not spent much time with young children, and have asked for ‘helpful hints’ about interacting with infants of different ages. Watching an exam has been the most efficient way to convey these hints.

• Infants do not have the patience to sit through 2 exams (the intern and then the check-out by the faculty member). Unless the intern is particularly comfortable working with infants, it is usually a more productive (and therefore educational!) experience to have the faculty member help with/do the exam to keep the time to a minimum.

We therefore intend that no intern should be seeing a child under 3 without help from faculty throughout the exam. However, if you have already had experience with testing infants and would like to attempt these exams by yourself, please let us know and we will aim to move you along your path to independence!!

This clinic is an opportunity for you to learn more about (and ask questions about)
Components of an infant exam: Binocularity, Acuity, Refraction, Ocular Health
Acuity tests: Teller Cards, Cardiff Cards, Lea Symbols.
How much refraction to prescribe at which age?
Expectations for behavior and cooperation from infants of different ages.
When to refer an infant patient.
How to treat strabismus and amblyopia in infancy.
The VIP clinic typically serves school-age patients referred for learning difficulties. These children may have processing problems or oculomotor dysfunction despite a normal binocular vision exam. If the child exhibits accommodative or convergence deficits in pre-assessment work-up, these must be corrected with vision therapy before the VIP assessment is performed.

The majority of patients seen in the VIP clinic have learning disabilities, but may not yet have been formally diagnosed by psycho-educational testing. Various tests administered in the VIP assessment attempt to sort out specifically whether visual processing or oculomotor deficits exist on top of possible language processing, writing disability, or working memory factors. Therapy may be recommended for documented evidence of visual-cognitive skill deficits or inefficient eye movements.

Diagnostic codes for the VIP assessment are typically 315.2 (Learning difficulties, other) or 379.57 (saccadic dysfunction).

Based on assessment findings, appropriate referrals are initiated if applicable. You may recommend that the parent seek psychoeducational testing through the child’s school, which is free; psycho-educational testing by a private licensed psychologist; dyslexia “screening” if it is provided in your community; or referral to the child’s pediatrician for medical or behavioral concerns.

During your rotation in peds, each intern will be required to write one assessment and plan for one VIP assessment and one therapy plan for a VIP therapy patient.
Referrals

**VIP Screener:** Should be completed by patients ages 5-9 with parent c/o learning difficulty (reading, handwriting, letter or word reversals, homework takes very long time to complete, “doesn’t work up to potential”) Score and evaluate whether VIP assessment may be helpful.

**Parent-Teacher Questionnaire:** Distribute two copies to parents who are scheduling for a VIP assessment. Both parent and teacher may complete these forms that may be mailed (address on other side of form) or brought to the appointment. This information may be very helpful with interpretation of data.

**Scheduling Appointment:** Schedule with the clinic coordinator for a 90 minute time block.

Ocular Testing Prior to and After VIP Assessment

*Tests to perform prior to a VIP for new patients to the clinic, if a former patient discuss with Mrs. Jarrard and a clinical faculty member*

- Record on Visual Efficiency Examination form,
  - Visual acuities (Distance and Near)
  - Cover Test (Distance and Near)
  - NPA
  - Accommodative Lag
  - Accommodative facility (if needed)
  - NPC (one time and after 5 attempts)
  - Associated phoria (Saladin)*
  - Vergences (if needed)
  - Maples NSUCO Oculomotor Test (pursuits and saccades). See attached instructions and scoring criteria.
  - DEM results also need to be recorded on this form

*It is difficult to assess for hyperphoria in pediatric patients. The child may not understand directional concepts. You may need to simplify your vocabulary or have the patient show you with his hand movements what he is seeing. Also observe for any head tilt with near acuity testing. Thorton or Maddox rod testing may also be necessary.

**After assessment:**

- NPA
- NPC (one time and after five attempts)
- Measurement for vertical phoria

Check with Dr. Lyon after your initial work-up before proceeding with the VIP assessment. The presence of any uncorrected acuity or binocular findings will invalidate VIP assessment results.
VIP ASSESSMENT

Evaluation Grid

See attached. This guide is generally followed. However, other tests may be substituted or added depending on age, problem, or observations. You will be responsible for administering and scoring the first 3 tests below. Instructions for administration follow. Tests that require timing will be indicated in BOLD print. Scoring instructions are found in the test manuals located in the VIP room or office.

1. **DTVP (Developmental Test of Visual Perception):**

   There are 2 versions of this test. Use DTVP-2nd edition for ages 4 through 10-11. Use DTVP-A (Adolescent and Adult) for ages 11 and up. This battery of 8 subtests (6 for the A version) alternates visual-motor and motor-reduced visual perceptual subtests. You can record scores for all non-motor tests directly on Record Form, but score all VMI tests after the assessment. Because most of our patients are below 11 years of age, instructions in this manual are given for the 2nd edition.

   You will need:
   - DTVP-2 Profile/Examiner Record Form (to record all responses and scoring) (See attached)
   - DTVP-2 Response Booklet (for patient to perform all VMI subtests)
   - DTVP-2 Picture Book (contains all motor-reduced subtests for patient to choose correct response)

   **Subtest 1.** Eye-Hand Coordination. Patient uses Response Booklet. Patient asked to draw line only within gray “road” and instructed NOT to pick up pencil while drawing lines.

   **Subtest 2.** Position in Space. Use Picture Book. Record responses on Record Form. Note ceiling 3/5 incorrect.

   **Subtest 3.** Copying. Patient uses Response Booklet. Instruct patient to copy each design. Stop subtest with obvious difficulty (frustration level) or obvious no score for design.

   **Subtest 4.** Figure-Ground. Use Picture Book. Record responses on Record Form. Note ceiling.

   **Subtest 5.** Spatial Relations. Patient uses Response Booklet. Instruct patient to copy each dot to dot figure, making sure to touch dots with connecting lines.

   **Subtest 6.** Visual Closure. Use Picture Book. Record responses on Record Form. Note ceiling.

   **Subtest 7.** Visual-Motor Speed. Instruct patient to repeat pattern by drawing 2 lines in large circles and X in small squares as patient performs examples. Allow 1:00 only to complete as many targets as he can.


2. **MFFT (Matching Familiar Figures Test):**
This test is used to determine VIP learning style and strategy, impulsive/reflective and efficient/inefficient. This test is timed to the first response only.

You will need:
- Test book with pictures
- Scoresheet (See attached)

You will record the exact time taken in seconds for the first response only (latency) and all responses. If the patient gives the wrong response, say “There is a better answer.” The patient is to guess until he gives the correct answer. Record all responses. (Each error will count.).

Scoring: Use the formulae on both front and back pages and mark both I and E calculations on the graph to determine performance.

3. DEM (Developmental Eye Movements):

This test contains a pre-test, two vertical subtests, and one horizontal subtest.

You will need:
- Test Booklet
- Scoresheet (See attached)

Administer pre-test to ascertain if patient can read numbers accurately.
Administer both vertical tests (numbers read in columns), timing each test and noting any errors. If patient self-corrects, don’t count as error. Total both times.
Administer horizontal test (numbers read in horizontal rows without use of fingers to mark place). Encourage patient to complete this subtest, but if he becomes too frustrated, do not complete. This may happen with younger patients. When scoring the test while the patient is reciting the numbers, just circle errors or line if omitted. You can determine later the type of error.

Scoring: Refer to Examiner’s Manual.

Other Tests: Dr. Jarrard or Dr. Lyon will administer and score these tests.

Woodcock-Johnson III: This psycho-educational battery is used for particular subtests to determine visual processing and reading achievement measures. Most tests are timed.

Visagraph: Goggles are fit and vertical midlines are adjusted to line up with midline of pupils. The Visagraph may not work with some glasses, such as those that have anti-reflective coating or prism. The patient is asked to read a paragraph (determined to be below his reading level) and instructed that he will be asked 10 yes/no questions about the reading afterwards. The Visagraph recording is valid only with comprehension 70% or above. If the patient is too young to read, but can accurately recite numbers, there is an option to perform a numbers test. This is not standardized like the reading test, but can give some useful information. See Visagraph manual for interpretation. Remember that any head or body movement may generate artifactual findings. Placing your hands gently on the patient’s head may prevent this.
**WOLD:** This near copy test is used to look at visual-motor integration skills of handwriting with observation of pencil grasp, accuracy of copying, letter and word spacing, writing on the baseline, and letter formation. The time it takes to complete the exercise is recorded to calculate handwriting speed.

**Handwriting sample:** The patient will write numbers and letters dictated in random order by the therapist. This is to test motor automaticity and to document reversals. The patient is asked to write his name and produce a sentence if able. The therapist may write a sentence for the patient to copy.

**Learning Efficiency Test-II (LET-II):** This test is a quick and reliable measure of the immediate, short-term, and long-term recall of visual and auditory memory.

**VIP Charts:**

Mrs. Jarrard keeps separate VIP charts with original assessment data and therapy progress notes. Exam forms, VIP assessment reports, and any written correspondence are kept in the main patient chart.

**VIP Report:**

Mrs. Jarrard writes this report. The evaluation grid is a quick scan of scores. The Summary/Recommendations section at the end of the report is most useful for a quick scan.

**VIP Vision Therapy Plan:**

See attached. Information from the summary is used to plan patient-centered goals and treatment. Therapy is typically recommended for 8-12 weekly 60-minute sessions with reassessment at the 8th week to determine if the patient would benefit from more therapy. Home therapy with commitment from the parent 10 minutes per day 4-5 times per week is CRITICAL to the success of the patient.

VIP therapy services differ from VT in the peds clinic with an emphasis on incorporating functional activities to enhance transfer of skills to school tasks of reading and writing. Therapeutic activities are tailored individually at every session depending on the patient’s performance.

A combination of in-office activities, workbook resources, and computer orthoptics programs may be used. The activities must be varied to keep the child’s interest and to prevent eye fatigue during the session (Remember he may have homework to do after therapy). Key is providing therapy using the “just right” approach – challenging, but not so difficult the child cannot succeed, but not easy enough that skills will not progress.

**Resources available in the VIP clinic are listed below:**

1. **Workbook resources:**

Ann Arbor Publishers (Academic Therapy Publications), Michigan Tracking series (Letter Tracking, Word Tracking, Sentence Tracking)
Mazes, word search, and various visual perceptual activities available free on line incorporating a special interest of the patient.

2. **Computer orthoptics programs:**

Computer programs offer several advantages for you and your patients. Recording of results allows easy documentation. A variety of options allow grading of activities so that the program can be individualized.

**VTS** (Vision Training System, 2005): This program is also heavily used for VT. Saccadic and visual memory programs are used to provide saccadic warm-up activities. Use of arrows as visual stimuli may be more useful than letters unless goals incorporate a keyboarding component.

**CPT** (Computerized Perceptual Training, 2007, HTS, Inc.): These modules provide a means to work on several visual-cognitive components during one activity. Audible feedback is a useful feature of these program.

Module I: **Visual scan.** Begin with an array of 10 large numbers, then upper case (UC) letters, then lower case (LC) letters in an array of 50 on either the black or white background. You can then vary size of stimulus, number of targets, background color, etc. as the patient progresses.

Module II: **Visual search.** Start with 3 large stimuli (numbers, then UC, then LC) for the patient to identify and click targets with the mouse. This module can also be used for visual and auditory memory practice.

We are in the process of adding more modules to this program.

**PTS II** (Computerized Perceptual Therapy, 2007, HTS, Inc.): This home-based program is sometimes prescribed if the parent desires extra support for practice of visual perceptual skills. The therapist is able to monitor progress and send notes to tailor therapy through a designated internet address.

**AceReader.** This program is used for a variety of saccadic activities incorporating reading. It also offers a self-paced comprehension test to determine baseline reading speed and a forced-speed mode to increase reading rate while maintaining comprehension. Sometimes this program is recommended for parents for purchase at [www.acereader.com](http://www.acereader.com) after therapy is completed so that the patient can continue to practice skills. A free demo is available on this web site for the parents to trial. Cost is reasonable at $50.
3. Other:

Toys, games, and hands-on activities are important components to sustain the patient’s attention for 60 minute sessions. Available options include:

- Matching patterns with Geoboard, peg board, and tangrams
- Wayne Fixator or AcuVision 1000
- Near copy and handwriting practice using adaptive paper
- Where’s Waldo? series, word search, and other visual perceptual activities available in children’s magazines or free on internet sites.
- Tracing and cutting activities
- Lacing, stringing beads following a pattern
- Marsden ball, throwing/kicking and catching a ball

VIP Rehabilitation for Patients with Acquired Brain Injury:

This clinic provides comprehensive vision rehabilitation for patients in collaboration with the IU Low Vision Clinic and IU Speech and Hearing Services. These patients often exhibit field cuts that impact functional activities. Various communication deficits must be considered during evaluation and treatment of these patients. Improved reading fluency and scanning in preparation for driving are typical goals.

Assessment is tailored to evaluate memory, attention, and processing speed factors relating to visual-cognitive skills:

1. Oculomotor function: DEM, Maples, Visagraph
2. Spatial neglect: Trailmaking Test B, star cancellation and line crossing subtests (Behavioral Inattention Test)
3. Reduced motor and visual-motor integration visual perception: DTVP-A
4. Visual memory: LET-II
5. Reading skill level: WJ-III, Reading Comprehension Battery for Aphasia (RCBA)
6. General memory: Ross Information Processing Assessment-2nd ed. (RIPA-2)
7. Handwriting: Functional handwriting sample

Vision therapy will include many of the techniques used for pediatric patients with the addition of instrumental daily activities (money skills, functional writing, map reading, reading labels and recipes) and simulated reading exercises with errorless learning. Auditory feedback is an important component of this therapy.
The Maples Oculomotor Test
(reprinted with permission from W.C. Maples, 4-16-09)

Most subjective testing uses an observation style technique. It is easy to see variations in scoring from one clinician to another. Many discrepancies are due to the optometrist’s experience level and familiarity with the appropriate testing modalities. Maples and Ficklin introduced the Northeastern State University College of Optometry’s Oculomotor Norms (NSUCO pursuit and saccadic battery) in 1992. They introduced this testing model to standardize subjective observation tests of saccades and pursuits.

The Maples’ testing battery incorporates three areas of graded performance:

**Ability** Can attentions be kept under control for five round trips for saccades and two clockwise and then two counterclockwise rotations for pursuits.

**Accuracy** Can fixations be maintained accurately and consistently with no noticeable correction for saccades or no noticeable re-fixations for pursuits.

**Movement** Can saccades and pursuits be accomplished without moving the head or body.

These protocols are rate from one to five, with five being optimal. It has been noted by Maples that girls show better scores in the earlier years than boys. By age nine the boys seem to “catch up” developmentally. Therefore before age nine the scoring criterion is different for boys than it is for girls.

The test sequence starts with the patient standing on both feet, shoulder length apart, and without the aide of any outside support. The two fixation targets are spaced 20 cm apart and approximately 40 cm, or the appropriate Harmon distance away. The patient is instructed to fixate on one target at a time and is asked to wait to change fixation to the other target until instructed to do so.

**Standard Set of Instructions**

1. **Posture:**
   Standing with feet shoulder width apart, directly in front of examiner

2. **Head:**
   NO instructions given to the patient to move or not to move the head

3. **Target:**
   Two fixation targets are used, two for saccades and one for pursuits

4. **Movement of the Target:**
   A. Directional:
   a. Saccades are done in the horizontal meridian only
   b. Pursuits are done rotationally, both clockwise and counterclockwise

   B. Extent:
   a. Saccades extent should be approximately 10 cm on each side of the patient’s midline (20 cm total)
   b. Pursuits paths should be approximately 20 cm in diameter. The upper and lower extent of the circular path should coincide with the patient’s midline.
5. **Test Distance** (from the patient):
   No more than 40cm and no less than the Harmon distance, i.e. the distance from the patient’s middle knuckle to the elbow

6. **Ocular Conditions:**
   Binocular conditions only

7. **Age of patient:**
   Five (5) years to adult

8. **Instructions:**
   A. Saccades:
   “*When I say* <yellow> look at the <yellow> bead. *When I say* <green> look at the <green> bead. Remember do not look until I tell you to.”

   B. Pursuits
   “*Watch the bead as it goes around. Try to see yourself in the bead. Do not take your eyes off the bead.*”

**References:**


## METHOD OF SCORING

<table>
<thead>
<tr>
<th></th>
<th>Score</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SACCades</strong></td>
<td>Ability</td>
<td>&lt;2 round trips</td>
<td>Completes 2 round trips</td>
<td>Completes 3 round trips</td>
<td>Completes 4 round trips</td>
<td>Completes 5 round trips</td>
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<tr>
<td></td>
<td>Accuracy</td>
<td>Large over/under shooting</td>
<td>Moderate over/under 1+ times</td>
<td>Constant slight over/under &gt;50%</td>
<td>Intermittent slight over/under &lt;50%</td>
<td>No over/under shooting noted</td>
</tr>
<tr>
<td></td>
<td>Movement</td>
<td>Large head (body) movement at any time</td>
<td>Moderate head (body) movement at any time</td>
<td>Slight head (body) movement &gt;50%</td>
<td>Slight head (body) movement &lt;50%</td>
<td>No head (body) movement noted</td>
</tr>
<tr>
<td><strong>Pursuits</strong></td>
<td>Ability</td>
<td>Cannot complete ½ rotation CW/CCW</td>
<td>Completes ½ rotation CW/CCW</td>
<td>Completes 1 rotation in either direction</td>
<td>Completes 2 rotations but not both ways</td>
<td>Completes 2 rotations both CW and CCW</td>
</tr>
<tr>
<td></td>
<td>Accuracy</td>
<td>No attempt to follow &gt;10 re-fixations</td>
<td>Re-fixates 5-10 times</td>
<td>Re-fixates 3-4 times</td>
<td>Re-fixates &lt;2 times</td>
<td>No re-fixations</td>
</tr>
<tr>
<td></td>
<td>Movement</td>
<td>Large head (body) movement at any time</td>
<td>Moderate head (body) movement at any time</td>
<td>Slight head (body) movement &gt;50%</td>
<td>Slight head (body) movement &lt;50%</td>
<td>No head (body) movement noted</td>
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## SACCADE TEST MINIMAL ACCEPTABLE SCORES BY AGE & GENDER

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<th>Age</th>
<th>Ability</th>
<th>Accuracy</th>
<th>Head Movement</th>
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<tr>
<td>14 or &gt;</td>
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<td>3</td>
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## PURSUIT TEST MINIMAL ACCEPTABLE SCORES BY AGE & GENDER

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<th>Ability</th>
<th>Accuracy</th>
<th>Head Movement</th>
<th>Body Movement</th>
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<td>14 or &gt;</td>
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The comprehensive optometric evaluation of the pediatric patient can be a very challenging and frustrating experience for optometry interns. The Pediatric Service of the IU School of Optometry provides care to patients from birth to age 12. These guidelines are designed to help the optometry intern formulate an appropriate examination strategy when dealing with young patients.

These recommendations are based upon the American Optometric Association’s Optometric Clinical Practice Guideline entitled *Pediatric Eye and Vision Examination*. Pediatric patients have been divided into the following subcategories:

1. Infants and toddlers (birth to age 3)
2. Preschool children (ages 3 to 5)
3. School-age children (ages 5 to 12)
4. Non-strabismic evaluation
5. Strabismic evaluation

The guidelines are intended to assist the optometry intern in examining children. They are NOT meant as strict protocols to be followed for every patient. The intern, with the assistance of the faculty consultant, must develop an appropriate examination sequence for each individual patient.
Infants and Toddlers
(Birth to age 3)

1. Patient history

   Parents are expected to complete the Confidential Patient Survey pediatric history form used by the Pediatric Service. Particular attention should be given to the following areas:
   a. nature of presenting problem and chief complaint
   b. visual and ocular history
   c. pre-, peri-, and postnatal health history
   d. family eye and medical histories
   e. developmental history of patient

2. Visual acuity (at least one of the following)
   a. forced-choice preferential looking (Teller cards)
   b. fix and follow, fixation preference tests
   c. optokinetic nystagmus response

3. Binocular status (Cover Test is the minimum)
   a. Hirschberg test
   b. Bruckner test
   c. cover test
   d. NPC

4. Refractive error
   a. nearpoint (Mohindra) retinoscopy
   b. dry retinoscopy
   b. cycloplegic retinoscopy

5. Ocular health
   a. anterior segment (gross external, hand-held slit lamp)
   b. pupillary reflexes
   c. ocular media and posterior pole (DFE with BIO)
   d. tonometry when indicated
Preschool Children
(Ages 3 to 5)

1. Patient history

   Parents are expected to complete the Confidential Patient Survey pediatric history form used by the Pediatric Service. Particular attention should be given to the following areas:

   a. nature of presenting problem and chief complaint
   b. visual and ocular history
   c. pre-, peri-, and postnatal health history
   d. family eye and medical histories
   e. developmental history of patient

2. Visual acuity (at least one of the following)

   a. HOTV chart
   b. Lea symbols
   c. Cardiff Cards
   d. Allen figures (only if nothing else works)

3. Binocular status and accommodation

   a. cover test
   b. stereopsis
   c. dynamic retinoscopy (MEM or Nott)
   e. NPC
   f. versions
   g. additional accommodative test(s) as needed

4. Refractive error

   a. manifest (dry) retinoscopy
   b. cycloplegic retinoscopy
   c. keratometry
   d. photorefractive screening

5. Ocular health

   a. anterior segment (gross external, hand-held slit lamp)
   b. pupillary reflexes
   c. color vision testing
   d. confrontation visual fields
   e. ocular media and posterior pole (DFE with BIO)
   f. tonometry when indicated
School-Aged Children  
(Ages 5≤13)  

1. Patient history  

Parents are expected to complete the Confidential Patient Survey pediatric history form used by the Pediatric Service. Particular attention should be given to the following areas:  

a. nature of presenting problem and chief complaint  
b. visual and ocular history  
c. pre-, peri-, and postnatal health history  
d. family eye and medical histories  
e. developmental history of patient  
f. school performance history  

2. Visual acuity (at least one of the following)  

a. Snellen acuity  
b. Lea Symbols  

3. Binocular status and accommodation  

a. cover test  
b. stereopsis  
c. dynamic retinoscopy (MEM or Nott)  
e. NPC  
f. fusional vergences  
g. versions  
h. additional accommodative test(s) as needed  

4. Refractive error  

a. manifest (dry) retinoscopy  
b. subjective refraction  
c. cycloplegic retinoscopy  

5. Ocular health  

a. anterior segment (gross external, hand-held slit lamp)  
b. pupillary reflexes  
c. color vision testing  
d. confrontation visual fields  
e. tonometry  
f. ocular media and posterior pole (DFE with BIO)
Highlights of a Non-Strabismic Binocular Vision Evaluation

This evaluation will be completed after an initial pediatric/primary care exam, unless another doctor refers the patient and we have the results of that exam.

**History:** Be as thorough as possible, expanding when necessary from the patient survey form and/or prior exams.

In incidences where the complaint is diplopia or headache, make sure that all of following questions are asked:

1. Time of onset?  
2. Time of day?  
3. Frequency?  
4. Association?  
5. Duration?  
6. Location?  
7. Is it worse at distance or near?  
8. Does it disappear when one eye is closed?

**VA’s:** Record which test you used and if you isolated to a line or to a certain letter.

**Cover Test:** Always try to neutralize with prism. On young children you may have to use your thumb as an occluder.

**Maddox:** After cover test re-check for a vertical component. Neutralize if necessary. Testing for a vertical deviation is especially important in cases of headaches and losing place while reading.

**Worth 4-dot:** Start at a distance of approximately 10’ and walk towards the patient, instructing them to inform you if there is an change in number or location of the dots. Note distances where changes occur.

**NPC:** In addition to recording break and recovery distances, note subjective observations about how easily this task was performed.

**Phorias:** Use modified Thorington cards, distance and near if high cover test findings to confirm.

**Fixation Disp:** Use modified Thorington card.

**Assoc. Phoria:** Use a Saladin Card.

**Ret:** Check refractive status of patient, to make sure it corresponds with any earlier findings.

**Dynamic Retinoscopy:** Perform MEM or Nott retinoscopy on all children up to age 18.

**Cycloplegic Refraction:** Perform if not completed within two months of evaluation.
Highlights of a Strabismic Binocular Vision Evaluation

This evaluation will be completed after an initial pediatric/primary care exam, unless another doctor refers the patient and we have the results of that exam.

**History:** Be as thorough as possible, expanding when necessary from the patient survey form and/or prior exams.

In incidences where the complaint is diplopia or headache, make sure that all of following questions are asked:

1. Time of onset?  
2. Time of day?  
3. Frequency?  
4. Association?  
5. Duration?  
6. Location?  
7. Is it worse at distance or near?  
8. Does it disappear when one eye is closed?

**VA’s:** Record which test you used and if you isolated to a line or to a certain letter.

**Cover Test:** Always try to neutralize with prism. On young children you may have to use your thumb as an occluder. Do the cover test in all nine directions of gaze to check for comitancy.

**Maddox:** After cover test re-check for a vertical component. Neutralize if necessary.

**Worth 4-dot:** Start at a distance of approximately 25 cm and walk away from the patient, instructing them to inform you if there is any change in number or location of the dots in both light and dark conditions.

**Retinoscopy:** Do a dry retinoscopy and a wet retinoscopy.

**Dynamic Ret:** Perform MEM or Nott retinoscopy on all children up to age 18.

**Lancaster:** To test the right field (muscles of the right eye) the patient wears the glasses so Red is over Right. The intern will hold the Blue “flashlight” while the patient has the Red one. Switch the lights to test the Left eye.

If the patient has an Eso deviation you would expect their target to be to the left of the examiners target. The patient will project the light in the direction of deviation.

**Park’s:** The key is to know the direction of muscle action for each set of muscles. Use either cover test or red lens test to check for an increase in the hyper-deviation during this procedure.

**Fixation:** Use visuoscopy, remember fixation is a monocular phenomenon.

**Correspondence:** Use Bagolini Lenses, Hering-Bielschowsky test or Synoptophore to test for correspondence. This is a binocular phenomenon.

**Synoptophore:** Use this to test for sensory fusion and quality of fusion. Use first, second and third degree targets to fully assess sensory fusion.
Highlights of an Evaluation of Suspected Amblyopia

This evaluation will usually be completed after an initial pediatric/primary care exam, unless another doctor refers the patient and we have the results of that exam. Of course the diagnosis of amblyopia may be suspected or made during a routine examination.

**History:** Be as thorough as possible, expanding when necessary from the patient survey form and/or prior exams.

In incidences where the complaint is diplopia or headache, make sure that all of following questions are asked:

1. Time of onset?  5. Duration?
2. Time of day?  6. Location?
3. Frequency?  7. Is it worse at distance or near?
4. Association?  8. Does it disappear when one eye is closed?

**VA’s:** Record which test you used and if you isolated to a line or to a certain letter. Ideally you want to perform both full chart and single surround isolated visual acuity.

**Cover Test:** Always try to neutralize with prism. On young children you may have to use your thumb as an occluder. Look closely for vertical component.

**Worth 4-dot:** Start at a distance of approximately 25 cm and walk away from the patient to end of the room, instructing them to inform you if there is any change in number or location of the dots. Perform this both in light and dark conditions. Note distances where changes occur.

**Color Vision:** Be sure to check color vision monocularly.

**NPC:** In addition to recording break and recovery distances, note subjective observations about how easily this task was performed.

**Accomm:** Complete a full accommodative evaluation.

**Fixation:** Use visuoscopy, remember fixation is a monocular phenomenon.

**Visual Field:** Minimally needed is a confrontational visual field.

**Ret:** Check refractive status of patient, to make sure it corresponds with any earlier findings.

**Dynamic Retinoscopy:** Perform MEM or Nott retinoscopy on all children up to age 18.

**Cycloplegic Refraction:** Perform if not completed within two months of evaluation.

**DFE:** *Always perform a dilated fundus examination before diagnosing amblyopia.*
Handbook of Vision Therapy

INDIANA UNIVERSITY
SCHOOL OF OPTOMETRY

Indiana University School of Optometry
Binocular Vision Service
May 2010
ACCOMMODATIVE INSUFFICIENCY

Patients with accommodative insufficiency will often complain of eye fatigue and blurred vision while reading. Testing reveals that the accommodative amplitude is reduced (the only accommodative condition in which this occurs). Flipper facility will be reduced due to inability to clear the minus. Dynamic retinoscopy will show a lag. These patients respond well to plus at near and may show an increase in stereo with reading glasses.

<table>
<thead>
<tr>
<th>Home Therapy</th>
<th>In-Office Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monocular Push-ups using PD sticks. 20-25 repetitions twice a day.</td>
<td>Hart Charts, monocular initially then binocular. Using different charts is recommended.</td>
</tr>
<tr>
<td>Hart Charts monocular initially then binocular. Using different charts is recommended. 5-10 minute sessions twice a day.</td>
<td>Transparent Films: Have patient focus on an image at near then look through the film to a distant target.</td>
</tr>
<tr>
<td>Lens Rock: Starting with low (+1.00) and increasing to +2.50. They can trade up flippers if they are kept in good working order. Monocular initially binocular in later therapy.</td>
<td>Minus Lens in Phoropter: Have patient focus through minus lenses starting at plano and increasing, at distance and near to read lines of letters.</td>
</tr>
<tr>
<td>HTS: It has an accommodation program in which the patient can use. You may also use the saccades or pursuits program with flipper lenses.</td>
<td>Computer Therapy. Accommodation therapy. Start with a low, +1.00 and increasing to a +2.50 to improve accommodation.</td>
</tr>
<tr>
<td>Brock String: Start with jumping from bead to bead. Then work on fine control of accomm. by having patient walk the “X” up and down the string 5-10 minute sessions twice a day</td>
<td>Tranaglyphs: Therapy fusional vergence. Begin with BO using large targets then proceeding to smaller targets. Train BI to improve relaxation using larger targets then smaller ones.</td>
</tr>
<tr>
<td>Life Saver Cards: Train patient to move up and down the card while holding it at various distances. Start at 40cm. This may be combined with flippers. 10 minutes twice a day.</td>
<td>Lens Rock starting with low powers and working up to higher powers. In late therapy incorporate BIM/BOP as well.</td>
</tr>
<tr>
<td></td>
<td>Aperture Rule: Therapy fusional vergence. Begin with BO then BI in for relaxation.</td>
</tr>
</tbody>
</table>
ACCOMMODATIVE INFACILITY

Patients with accommodative infacility are unable to change fixation quickly and/or accurately. Reading causes the ciliary muscles to “cramp” resulting in blurred distance vision for a few seconds to minutes. These patients often complain of eyestrain, headaches, fatigue, and blurred distance vision after reading or computer use. Tests of accommodative amplitude are normal while the NRA and PRA may be reduced. Flipper facility is reduced both monocularly and binocularly due to inability to change focus (difficulty with both plus and minus sides) and dynamic retinoscopy is usually normal.

Example VT program would include the following:

<table>
<thead>
<tr>
<th>Home Therapy</th>
<th>In-Office Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance Rock: With PD stick. Have patient</td>
<td>Distance Rock: With Hart charts. Have patient focus on near chart then focus on</td>
</tr>
<tr>
<td>focus on the near target and then at a distant</td>
<td>the distant chart. Monocular initially then binocular.</td>
</tr>
<tr>
<td>target. Start monocular then move to binocular.</td>
<td>20-25 repetitions twice a day.</td>
</tr>
<tr>
<td>20-25 repetitions twice a day.</td>
<td></td>
</tr>
<tr>
<td>Distance Rock: With Hart charts. Have patient</td>
<td>Loose Lens Rock: Instruct the patient to fixate on a target. Then introduce a</td>
</tr>
<tr>
<td>focus on near chart then focus on the distant</td>
<td>loose lens to change the accommodative demand. Plus or minus for near, minus for</td>
</tr>
<tr>
<td>chart. Monocular initially then binocular.</td>
<td>distance.</td>
</tr>
<tr>
<td>5-10 sessions twice a day.</td>
<td>Computer Therapy. Accommodation therapy. Start with a low, +1.00 and increasing</td>
</tr>
<tr>
<td></td>
<td>to a +2.50 to improve accommodation.</td>
</tr>
<tr>
<td>Lens Rock: Start with a low power (+1.00) increase</td>
<td>5-10 minute sessions twice a day.</td>
</tr>
<tr>
<td>to a +2.50. Initially start monocular and later</td>
<td></td>
</tr>
<tr>
<td>go to binocular. 5-10 minute sessions twice a day.</td>
<td></td>
</tr>
<tr>
<td>Brock String: Start with jumping from bead to</td>
<td>Tranaglyphs: Therapy fusional vergence. Begin with BO using large targets then</td>
</tr>
<tr>
<td>bead. Then work on fine control of accomm. by</td>
<td>proceeding to smaller targets. Train BI to improve relaxation using larger targets</td>
</tr>
<tr>
<td>having patient walk the “X” up and down the</td>
<td>then smaller ones.</td>
</tr>
<tr>
<td>string 5-10 minute sessions twice a day.</td>
<td></td>
</tr>
<tr>
<td>BIM/BOP: Late stage therapy. Instruction same as</td>
<td>Aperture Rule: Therapy fusional vergence. Begin with BO then BI in for relaxation.</td>
</tr>
<tr>
<td>with flipper lenses. Start low and work to a</td>
<td></td>
</tr>
<tr>
<td>higher level of prisms and powers.</td>
<td></td>
</tr>
</tbody>
</table>
ACCOMMODATIVE EXCESS or SPASM

Patients with accommodative excess will present with distance blur complaints after near work, which may last a few minutes. They may or may not have headaches or eyestrain. They are often low myopes, and may not have a clear 20/20. Amplitude of accommodation will be normal. Dynamic retinoscopy will show a lead. The NRA will be normal or low and the PRA will vary because they may “eat” minus.

Example VT program would include:

<table>
<thead>
<tr>
<th>Home Therapy</th>
<th>In-Office Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Distance Rock: With PD stick</strong> Have patient focus on the near target and then at a distant target. Start monocular then move to binocular. 20-25 repetitions twice a day.</td>
<td><strong>Distance Rock: With Hart charts</strong> Have patient focus on near chart then focus on the distant chart. Monocular initially then binocular.</td>
</tr>
<tr>
<td><strong>Distance Rock: With Hart charts.</strong> Have patient focus on near chart then focus on the distant chart. Monocular initially then binocular. 5-10 sessions twice a day.</td>
<td><strong>Loose Lens Rock:</strong> Instruct the patient to fixate on a target. Then introduce a loose lens to change the accommodative demand. Plus or minus for near, minus for distance.</td>
</tr>
<tr>
<td><strong>Lens Rock:</strong> Start with a low power (+1.00) increase to a +2.50. Initially start monocular as well and later go to binocular. 5-10 minute sessions twice a day.</td>
<td><strong>Computer Therapy.</strong> Start with a low, +1.00 and increasing to a +2.50 to improve accommodation.</td>
</tr>
<tr>
<td><strong>HTS program:</strong> Has accommodation program you can use. May also use the pursuits and saccades program with a flipper as a later stage therapy exercise.</td>
<td><strong>Tranaglyphs:</strong> Therapy fusional vergence. Begin with BO using large targets then proceeding to smaller targets. Train BI to improve relaxation using larger targets then smaller ones.</td>
</tr>
<tr>
<td><strong>Brock String:</strong> Start with jumping from bead to bead. Then work on fine control of accomm. by having patient walk the “X” up and down the string 5-10 minute sessions twice a day.</td>
<td><strong>Aperture Rule:</strong> Therapy fusional vergence. Begin with BO then BI in for relaxation.</td>
</tr>
<tr>
<td><strong>BIM/BOP:</strong> Late stage therapy. Instruction same as with flipper lenses. Start low and work to a higher level of prisms and powers.</td>
<td></td>
</tr>
</tbody>
</table>
BASIC EXOPHORIA

Patients with exophoria may present with complaints of eyestrain, fatigue, blurred vision and horizontal diplopia. Significant phoria at both distance and near, with inadequate vergence ranges, is characteristic as well as a normal AC/A ratio.

Differential Diagnoses: Convergence Insufficiency
                       Divergence Excess

Example VT program could include the following:

<table>
<thead>
<tr>
<th>Home Therapy</th>
<th>In-Office Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Push-up: Using the doggie stick perform this task binocularly. 20-25 repetitions twice a day.</td>
<td>Brock String: Starting from a distance of better fusion and working toward the area of weaker fusion/diplopia. Initially jump the “X” between beads. Later walk the “X” along the string, this will take finer control.</td>
</tr>
<tr>
<td>Brock String: Starting from a distance of better fusion and working toward area of weaker fusion/diplopia. 5-10 minute sessions twice a day.</td>
<td>Tranaglyphs: Train both BI &amp; BO but working predominately on the BO ranges.</td>
</tr>
<tr>
<td>Tranaglyphs: Train both BI &amp; BO but working predominately on the BO ranges. 10-15 sessions twice a day.</td>
<td>Computer Orthoptics: Train BO ranges mainly but also do BI for relaxation.</td>
</tr>
<tr>
<td>Life Saver Cards: 5-10 minute sessions twice a day.</td>
<td>Vectograms: Use the same way as tranaglyphs.</td>
</tr>
<tr>
<td>Prism Flippers: 5-10 minute sessions twice a day.</td>
<td>Aperture Rule Trainer: You will use both cards, (single and double slot), but will predominantly work with the single slot.</td>
</tr>
<tr>
<td>Aperture Rule Trainer: You will use both cards, (single and double slot), but will predominantly work with the single slot. 5-10 minute sessions twice a day.</td>
<td>Synoptophore: Start with first degree targets then as patient feels comfortable go to second and third degree. Train mainly the BO ranges. Use the BI for relaxation.</td>
</tr>
</tbody>
</table>
**BASIC ESOPHORIA**

Patients with esophoria may present with complaints of headaches, eyestrain, blurred vision and horizontal diplopia. These complaints are chronic and long standing. Significant phoria at both distance and near, with inadequate vergence ranges, is characteristic as well as a normal AC/A ratio.

Differential Diagnoses:
- Neurological disorders (sudden onset)
- Convergence Excess
- Divergence Insufficiency

Example VT program could include:

<table>
<thead>
<tr>
<th>Home Therapy</th>
<th>In-Office Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brock String:</strong> Starting from a distance of</td>
<td>Brock String: Starting from a distance of</td>
</tr>
<tr>
<td>better fusion and working toward area of</td>
<td>better fusion and working toward area of</td>
</tr>
<tr>
<td>weaker fusion/diplopia. Initially jump the “X”</td>
<td>weaker fusion/diplopia. Initially jump the “X”</td>
</tr>
<tr>
<td>between beads. Later walk the “X” along the</td>
<td>between beads. Later walk the “X” along the</td>
</tr>
<tr>
<td>string, this will take finer control. 5-10 minute</td>
<td>string, this will take finer control.</td>
</tr>
<tr>
<td>sessions twice a day.</td>
<td></td>
</tr>
<tr>
<td><strong>Tranaglyphs:</strong> Train both BI &amp; BO but working</td>
<td>Tranaglyphs: Train both BI &amp; BO but working</td>
</tr>
<tr>
<td>predominately on the BI ranges. 10-15 sessions</td>
<td>predominately on the BI ranges.</td>
</tr>
<tr>
<td>twice a day.</td>
<td></td>
</tr>
<tr>
<td><strong>Life Saver Cards:</strong> 5-10 minute sessions twice</td>
<td>Computer Orthoptics: Train BI ranges mainly but also</td>
</tr>
<tr>
<td>a day.</td>
<td>do BO for relaxation.</td>
</tr>
<tr>
<td><strong>Prism Flippers:</strong> 5-10 minute sessions twice a</td>
<td>Vectograms: Use the same way as tranaglyphs.</td>
</tr>
<tr>
<td>day.</td>
<td></td>
</tr>
<tr>
<td><strong>Aperture Rule Trainer:</strong> You will use both</td>
<td>Aperture Rule Trainer: You will use both cards, single</td>
</tr>
<tr>
<td>cards, single and double slot, but will</td>
<td>and double slot, but will</td>
</tr>
<tr>
<td>predominately work with the double slot. 5-10</td>
<td>predominately work with the double slot</td>
</tr>
<tr>
<td>minute sessions twice a day.</td>
<td></td>
</tr>
<tr>
<td><strong>Synoptophore:</strong> Start with first degree targets</td>
<td>Synoptophore: Start with first degree targets then</td>
</tr>
<tr>
<td>then as patient feels comfortable go to second</td>
<td>as patient feels comfortable go to second and third</td>
</tr>
<tr>
<td>and third degree. Train mainly the BI ranges.</td>
<td>degree. Train mainly the BI ranges. Use the BO for</td>
</tr>
<tr>
<td>Use the BO for relaxation.</td>
<td>relaxation.</td>
</tr>
</tbody>
</table>
CONVERGENCE INSUFFICIENCY

Patients with CI complain of problems associated with reading, eyestrain, fatigue, words jumping around, headaches, diplopia. Symptoms are relieved by cessation of reading. Increased exophoria at near, with receded NPC and reduced vergence ranges are characteristic, as well as a low AC/A. If you think your patient has CI but does not have any positive complaints, ask about avoidance to reading or other near tasks. This condition can lead people to not want to read. In this instance VT is strongly recommended. The VT program is similar to the exophoria except that the emphasis is placed at near, since that is where the patient is symptomatic.

Differential Diagnoses: Pseudoconvergence Insufficiency (accommodative prob.)
Basic Exophoria
Divergence Excess
Multiple Sclerosis, Myasthenia Gravis
Convergence Paralysis

Example VT program could include the following:

<table>
<thead>
<tr>
<th><strong>Home Therapy</strong></th>
<th><strong>In-Office Therapy</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brock String:</strong> Starting from a distance of better fusion and working toward area of weaker fusion/diplopia. 5-10 minute sessions twice a day.</td>
<td><strong>Brock String:</strong> Starting from a distance of better fusion and working toward area of weaker fusion/diplopia.</td>
</tr>
<tr>
<td><strong>Tranaglyphs:</strong> Train in both directions but stress the BO ranges. Record the highest number for break and recovery on data sheet and bring it to VT. 10-15 minute session twice a day.</td>
<td><strong>Synoptophore:</strong> Start with a first degree target and work up to a third degree. Work mainly the BO ranges but do the BI for relaxation purposes.</td>
</tr>
<tr>
<td><strong>Vectograms:</strong> Use the same as tranaglyphs.</td>
<td><strong>Tranaglyphs:</strong> Train in both directions but stress the BO ranges.</td>
</tr>
<tr>
<td><strong>HTS:</strong> Can use Base In and Out vergences and jump vergences. 10-15 minute sessions twice a day.</td>
<td><strong>Computer Orthoptics:</strong> Do vergence therapy. Can also do saccades with prism flippers at a later stage.</td>
</tr>
<tr>
<td><strong>Prism Flippers:</strong> Can be used while reading, working on activity books, computer. 5-10 minute sessions twice a day.</td>
<td><strong>Aperture Rule:</strong> Stress the single slit for BO therapy but do the double slit for relaxation as well.</td>
</tr>
<tr>
<td><strong>Life Saver Cards:</strong> Start at the bottom of the card and work up to the top with rotation 5-10 minute sessions twice a day.</td>
<td><strong>Prism Flippers:</strong> Can do with any near activity.</td>
</tr>
</tbody>
</table>
CONVERGENCE EXCESS

Patients with convergence excess complain of eyestrain and headaches after reading for a short amount of time. After reading for a longer time they can experience blurred vision, diplopia and difficulty concentrating. Some patients might be asymptomatic due to avoidance of reading or covering one eye while reading. Patients will show an increased esophoria at near, a high AC/A ratio, decreased negative fusional ranges and a high lag. If a patient shows these signs but is asymptomatic inquire about avoidance of reading or other near tasks.

Differential Diagnoses: Basic Esophoria
Divergence Insufficiency Accommodative Disorders
Spasm of accom secondary to iritis, flu, drug side effects, etc.

A plus add for near work should be considered.

Example VT program could include the following:

<table>
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<tr>
<th>Home Therapy</th>
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<tbody>
<tr>
<td>Brock String: Starting from a distance of better fusion and working toward area of weaker fusion/diplopia. 5-10 minute sessions twice a day.</td>
<td>Brock String: Starting from a distance of better fusion and working toward area of weaker fusion/diplopia.</td>
</tr>
<tr>
<td>Tranaglyphs: Train in both directions but stress the BI ranges. Record the highest number for break and recovery on data sheet and bring it to VT. 10-15 minute session twice a day.</td>
<td>Vectograms: Train in both directions but stress the BI ranges.</td>
</tr>
<tr>
<td>HTS: Can use Base In and Out vergences and jump vergences. 10-15 minute sessions twice a day.</td>
<td>Computer Orthoptics: Do vergence therapy. Can also do saccades with prism flippers at a later stage.</td>
</tr>
<tr>
<td>Life Saver Cards: Start at the bottom of the card and work up to the top with rotation 5-10 minute sessions twice a day.</td>
<td>Aperture Rule: Stress the double slit for BI therapy but do the single slit for relaxation as well.</td>
</tr>
<tr>
<td>Prism Flippers: Can be used while reading, working on activity books, computer. 5-10 minute sessions twice a day.</td>
<td>Life Saver Cards: Start at the bottom of the card and work up to the top with rotation.</td>
</tr>
</tbody>
</table>
DIVERGENCE INSUFFICIENCY

Patients with divergence insufficiency complain of problems at distance. The most common complaint is intermittent diplopia (not of sudden onset). They can also complain of headaches, ocular fatigue and dizziness. Signs include greater esophoria at a distance, low calculated AC/A ratio with reduced distance BI ranges.

Differential Diagnoses:
- Convergence Excess
- Basic Esophoria
- Sixth Nerve Palsy
- Divergence Paralysis

Example VT program would include the following:

<table>
<thead>
<tr>
<th>Home Therapy</th>
<th>In-Office Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brock String: Starting from a distance of better fusion and working toward area of weaker fusion/diplopia. 5-10 minute sessions twice a day.</td>
<td>Brock String: Starting from a distance of better fusion and working toward area of weaker fusion/diplopia.</td>
</tr>
<tr>
<td>Tranaglyphs: Train in both directions but stress the BI ranges. Record the highest number for break and recovery on data sheet and bring it to VT. 10-15 minute session twice a day.</td>
<td>Synoptophore: Start with a first degree target and work up to a third degree. Work mainly the BI ranges but do the BO for relaxation purposes.</td>
</tr>
<tr>
<td>HTS: Can use Base In and Out vergences and jump vergences. 10-15 minute sessions twice a day. Can be used with prism flipper therapy later in therapy.</td>
<td>Computer Orthoptics: Do vergence therapy. Can also do saccades with prism flippers at a later stage.</td>
</tr>
<tr>
<td>Prism Flippers: Can be used while watching TV or playing on computer. 5-10 minute sessions twice a day.</td>
<td>Vectograms: Train in both directions but stress the BI ranges.</td>
</tr>
<tr>
<td>Life Saver Cards: Start at the bottom of the card and work up to the top with rotation 5-10 minute sessions twice a day.</td>
<td>Life Saver Cards: Start at the bottom of the card and work up to the top with rotation.</td>
</tr>
<tr>
<td>Aperture Rule: Stress the double slit for BI therapy but do the single slit for relaxation as well.</td>
<td>Aperture Rule: Stress the double slit for BI therapy but do the single slit for relaxation as well.</td>
</tr>
</tbody>
</table>
DIVERGENCE EXCESS

Patients with divergence excess often present with an intermittent exotropia, which worsens with inattention, fatigue or illness. Parents may even notice wandering eyes. Usually the only symptoms a patient will have will be squinting and/or excessive photophobia. Diplopia almost never occurs due to suppression and/or anomalous correspondence but may occur with fatigue. Signs of divergence excess include exophoria greater at distance than near. A high AC/A ratio and reduced positive fusional vergences are also characteristic. If the patient has intermittent suppression you may want to start with red/green activities (i.e. anti-suppression activities) at distance. (see Anti-Suppression Techniques)

Differential Diagnoses: Basic Exophoria
Simulated Divergence Excess
Convergence Insufficiency

A plus add for near work should be considered.

Example VT could include:

<table>
<thead>
<tr>
<th>Home Therapy</th>
<th>In-Office Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brock String: Starting from a distance of better fusion and working toward area of weaker fusion/diplopia. 5-10 minute sessions twice a day.</td>
<td>Brock String: Starting from a distance of better fusion and working toward area of weaker fusion/diplopia.</td>
</tr>
<tr>
<td>HTS: Can use Base In and Out vergences and jump vergences. 10-15 minute sessions twice a day. Can be used with prism flipper therapy later in therapy.</td>
<td>Tranaglyphs: Train in both directions but stress the BO ranges. The theory is that if you train at near it translates to better distance ranges.</td>
</tr>
<tr>
<td>Prism Flippers: Can be used while watching TV or playing on computer. 5-10 minute sessions twice a day.</td>
<td>Synoptophore: Start with a first degree target and work up to a third degree. Work mainly the BO ranges but do the BI for relaxation purposes.</td>
</tr>
<tr>
<td>Tranaglyphs: Train in both directions but stress the BO ranges. Record the highest number for break and recovery on data sheet and bring it to VT. 10-15 minute session twice a day.</td>
<td>Aperture Rule: Stress the single slit for BI therapy but do the double slit for relaxation as well.</td>
</tr>
<tr>
<td>Prism Flippers: Can be used while watching TV or playing on computer. 5-10 minute sessions twice a day.</td>
<td>Life Saver Cards: Start at the bottom of the card and work up to the top with rotation.</td>
</tr>
</tbody>
</table>
AMBLYOPIA

Highlights

**Functional Amblyopia:** A reduction of visual acuity (poorer than 20/20) which is not correctable by refractive means, is not attributable to obvious structural or pathological anomalies, and is associated with form deprivation, strabismus, anisometropia, or other amblyogenic refractive errors.

**Potentially Amblyopiogenic Refractive Errors**

<table>
<thead>
<tr>
<th></th>
<th>Isoametropia</th>
<th>Anisometropia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Astigmatism</td>
<td>&gt;2.50D</td>
<td>&gt;1.50D</td>
</tr>
<tr>
<td>Hyperopia</td>
<td>&gt;5.00D</td>
<td>&gt;1.00D</td>
</tr>
<tr>
<td>Myopia</td>
<td>&gt;8.00D</td>
<td>&gt;3.00D</td>
</tr>
</tbody>
</table>

**Prognosis of Recovery of Visual Acuity:**

Dependent upon several factors:

1. Patient compliance (this is probably the most important factor for a good outcome)
2. Specific type of amblyopia
3. Monocular fixation status
4. Age of Onset
5. Initial visual acuity
6. Age of patient when treatment is initiated
7. Type of treatment prescribed

**Prognosis for specific forms of amblyopia:**

1. **Deprivation Amblyopia**
   Improvement to visual acuity of 20/50 or better is good for a patient with a unilateral cataract if treated within first two months of life.

2. **Isoametropic Amblyopia**
   Hyperopic isoametropia: Improvement of visual acuity between 20/50 to 20/30 is excellent. This is independent of the magnitude of the hyperopia, initial visual acuity, or age at initial correction.
   Myopic isoametropia: Improvement of visual acuity is clinically considered to be good. Need to rule out structural or pathological causes of the reduced vision.

3. **Anisometropic Amblyopia**
   Hyperopic anisometropia: Improvement of visual acuity to 20/40 or better is good.
   Myopic anisometropia: Improvement of visual acuity is fair.

4. **Strabismic Amblyopia**
   Improvement of visual acuity is considered to be the same as treating anisometropic amblyopia patients. The younger and more compliant the patient is, the better the chances for improvement of vision. The length of treatment will be considerably longer.
**Testing:**

1. **Visual Acuity**
   It is important to achieve the best corrected acuity. While isolated letters may be used to judge acuity without crowding phenomenon the best clinical way to measure acuity in patients with amblyopia is single surround acuity, either HOTV or Snellen depending on age of patient.

2. **Refraction**
   You need to do both a noncycloplegic and cycloplegic refraction on all children, especially if the child has hyperopia or a strabismus.

3. **Monocular Fixation**
   You may use visuoscopy or afterimage testing to measure this. In the record you need to assess the characteristics of fixation. Is there eccentric fixation present? If there is then you need to assess the location, magnitude and steadiness of the fixation.

4. **Muscle Balance:**
   Ideally you will want to perform a cover test on the patient. If one can not be completed then try Hirschberg or Bruckner. Assess any strabismus or phoria by the magnitude, unilateral vs. alternating, constant vs. intermittent.

5. **Fusional Capabilities**
   Examples of this type of testing are Worth Dot, Random dot Stereo, red lens, Synoptophore.

6. **Accommodation**
   An evaluation of the accommodative system includes getting a measurement of the amplitude, facility, ranges and lag of accommodation.

7. **Motility**
   This is done to assess the quality of fixation, saccades and pursuits.

8. **Ocular Health**
   This needs to be evaluated to rule out disease process as being a cause of the amblyopia. This includes pupil testing and a thorough slit lamp exam with DFE.

**Prescribing Glasses:**

There are many different theories on what you should prescribe when. You will prescribe based on the patient and the information you have received by your examination. The one detail that will be common between all cases is that ANY patient with amblyopia needs polycarbonate lenses in their glasses and educated on the necessity of this. If the patient or parents refuse polycarbonate lenses it needs to be recorded!
**STRABISMUS**

Highlights

If a parent brings their child in with a complaint of an eye turning out but you (the practitioner) don’t see it, the eye probably turns out. If the parent thinks the eye turns in and you (the practitioner) don’t see it, the eyes are probably straight. With any strabismus you need to determine the following:

**Subjective:**

1. Time of onset
2. Time of day
3. Frequency
4. Associations
5. Does it disappear when one eye is occluded
6. Location of images
7. Is it greater at distance or near
8. Duration:

Acquired strabismus with diplopia in teen or an adult should be presumed to be disease-related until proven otherwise

**Objective:**

1. Intermittent or constant?
2. Monocular or alternating?
   - True alternators will switch at midline automatically, making the fixating eye lose fixation during ductions at midline.
3. Objective angle
4. Comitancy
5. Correspondence

**Testing:**

**Objective Angle:**
1. Prism neutralized cover test at distance and near
2. Hirschberg
3. Cover test or red lens in all nine positions of gaze
4. Synoptophore

**Subjective Angle:**
1. Modified Thorington or Von Graefe
2. Worth Dot test using prism to gain fusion
3. Bagolini lenses using prism to put lights in center of “X”
4. Maddox rod: *Vertical only*
5. Synoptophore

If the subjective angle (or the amount of prism needed to align the targets) is not equal to the objective angle (or the amount of prism needed to align the eyes reflexes) the patient has anomalous correspondence

**Other:**
1. Bar vergences, if possible (put prism in front of the non-dominant eye)
2. Ductions (looking for restrictions)
3. Stereopsis/Fusion
4. Park’s Procedure
Spectacle Prescription: Must evaluate the necessity of the following:
1. Distance correction
2. Bifocal
3. Over-minus
4. Prism
5. Binasal occlusion
6. Partial or complete occlusion
7. Polycarbonate lenses (note in record if prescribed or if parent refused)
EXOTROPIA

Step 1: Prescribing glasses

1. Always do a cyclo ret and refraction.
2. In all cases fully correct with balance of accommodation.
3. Correct the full astigmatism.
4. Consider initial prism correction with plans to wean them off the prism with VT.
5. RTC one month for re-check of vision and stereopsis. At this time continue to the next appropriate stage of therapy.

Step 2: Amblyopia

1. Rule out Eccentric Fixation and Anomalous Correspondence: You can do this with visuoscropy, entoptic phenomena, Synoptophore, or after image testing (EF and ARC are rare for exotropes). If eccentric fixation exists, then you need to patch the amblyopic eye initially and have the child use his good eye. The “good” eye should be patched only when the eccentric fixation can be controlled (i.e. in-office vision therapy). This is known as inverse patching. Once the patient has normal fixation you can initiate direct patching procedures.

2. Patching: Begins usually one month after child starts wearing glasses. Patching continues until visual acuity plateaus (shows no improvement at three consecutive visits). With any patching regiment at follow-up visits you need to check the visual acuity of the “good” eye as well to check that it is not being compromised by the therapy.

3. Partial Occlusion: Atropine
   Goal is to fog the “good” eye too worse than the amblyopic eye.

4. Active Therapy: While the patient is patched you can instruct them to do near work (activity books, computer games, cards, reading license plates, etc.). This will force them to “use” the amblyopic eye. Do this twice a day for thirty minutes each session.
**Stage 3: Anti-Suppression Therapy**

If amblyopia is present you will normally want to start it when the visual acuity in the amblyopic eye is 20/80-20/60. Need to start with simple therapy and with large targets. The goal is to work down to smaller and more detailed tasks. Therapy is stopped until there is no more improvement of three consecutive visits. Examples with anti-suppression therapy follows.

<table>
<thead>
<tr>
<th>Home Therapy</th>
<th>In-Office Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monocular in Binocular Field: Use R/G glasses and a red pen in which only the eye covered by the green lens can see (not all red pens are the same). Have the patient do activity books with the pen. Two sessions per day, thirty minutes each session.</td>
<td>Computer Orthoptics: Start with BO therapy. Switch to BI for relation purposes. Use the larger targets first and work towards the smaller more detailed targets.</td>
</tr>
<tr>
<td>R/G TV Trainer: Have patient use this for thirty minutes twice a day each day.</td>
<td>Synoptophore: Work BO ranges mainly but occasionally switch to BI for relaxation.</td>
</tr>
<tr>
<td>Vis-à-vis</td>
<td>R/G Hart Charts</td>
</tr>
<tr>
<td>R/G Bar Reader</td>
<td>Aperture Rule</td>
</tr>
<tr>
<td>HTS computer program</td>
<td>Life Saver Cards</td>
</tr>
</tbody>
</table>

**STEP 4: Vergence Therapy**

Can be started after improvements in anti-suppression are made. Continue therapy until ranges can compensate for the tropia and are stable. Examples of vergence therapy follows.

<table>
<thead>
<tr>
<th>Home Therapy</th>
<th>In-Office Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>HTS computer system: Start with large targets and work towards smaller ones.</td>
<td>Computer Orthoptics: Start with large targets and work towards smaller ones.</td>
</tr>
<tr>
<td>Tranaglyphs: Initially you want the patient to achieve higher ranges, especially BO. After the quantity is achieved stress quality of the images. When you do this initially the ranges will decrease but with practice they should reach the “normal” level.</td>
<td>Vectograms: These will be done the same as tranaglyphs. Initially concerned with the quantity and then later the quality of the images.</td>
</tr>
<tr>
<td>Aperture Rule: Initially start with BO then jump between BO and BI. Finally add prism flippers with this exercise.</td>
<td>Prism Flippers with near Hart Chart. Can also be done at home. Considered late stage therapy.</td>
</tr>
<tr>
<td>Life Saver Cards</td>
<td>Life Saver Cards.</td>
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</table>

Exotropia usually responds well to vision therapy. The usual time to complete this program is four to twelve months. If the angle of deviation is large (20-25) or if it is smaller and the patient lacks motivational or physiological (including fusion potential) characteristics surgery should be considered. If surgery is elected is important that you co-manage the patient. The surgery will help with the cosmetic look of the eye but will not fully correct the binocular status, which requires vision therapy.
ESOTROPIA
NOTE: Esotropes are likely to be younger (congenital) with deeper amblyopia and suppression. They are also more likely to have eccentric fixation and/or anomalous retinal correspondence therefore you need to thoroughly test for these. Push the plus at distance and near (do not go strictly by visual acuity when prescribing) and always cycloplege!

**STEP 1:** Prescribing glasses
1. Always do a cyclo ret and refraction.
2. In all cases fully correct with balance of accommodation.
3. Correct the full astigmatism
4. Consider an add on esotropes if there is a significant difference between the distance and near measurements. The bifocal must bisect the pupil. Use a +3.00 if the patient is under six, and a +2.50 if the child is in school.
5. RTC one month for re-check of vision and stereopsis. At this time continue to the next appropriate stage of therapy.

**Step 2:** Amblyopia

1. Rule out Eccentric Fixation and Anomalous Correspondence: You can do this with visuoscopry, entoptic phenomena, Synoptophore, or after image testing (*EF and ARC are more common for esotropes than for exotropes*). If eccentric fixation exist then you need to patch the amblyopic eye initially and have the child use his good eye. The “good” eye should be patched only when the eccentric fixation can be controlled (i.e. in-office vision therapy). This is known as inverse patching. Once the patient has normal fixation you can initiate direct patching procedures.

2. Patching: Begins usually one month after child starts wearing glasses. Patching continues until visual acuity plateaus (shows no improvement at three consecutive visits). With any patching regiment at follow-up visits you need to check the visual acuity of the “good” eye as well to check that it is not being compromised by the therapy.

3. Partial Occlusion: Atropine

4. **Active Therapy:** While the patient is patched you can instruct them to do near work (activity books, computer games, cards, reading license plates etc.). This will force them to “use” the amblyopic eye. Do this twice a day for thirty minutes each session.

**Stage 3:** Anti-Suppression Therapy

If amblyopia is present you will normally want to start it when the visual acuity in the amblyopic eye is 20/80-20/60. Need to start with simple therapy and with large targets. Also esotropes may have to start at their nose where both eyes are converging and the images are huge. The goal is to work down to smaller and more detailed tasks. Therapy is stopped until there is no more improvement with three consecutive visits. Examples of anti-suppression therapy follow.
**Home Therapy** | **In-Office Therapy**
--- | ---
Monocular in Binocular Field: Use R/G glasses and a red pen in which only the eye covered by the green lens can see (not all red pens are the same). Have the patient do activity books with the pen. Two sessions per day, thirty minutes each session. | Computer Orthoptics: Start with BI therapy. Switch to BO for relaxation purposes. Use the larger targets first and work towards the smaller more detailed targets.

Polarized glasses in the mirror. | R/G Hart Chart

R/G Bar Reader: Have them use this twice a day for thirty minutes at a time. | Synoptophore: Work BI ranges mainly but occasionally switch to BO for relaxation.

R/G TV trainer | Aperture Rule

HTS computer program | Life Saver Cards

**STEP 4: Vergence Therapy**

Can be started after improvements in anti-suppression are made. Continue therapy until ranges can compensate for the tropia and are stable. With esotropia it will be difficult to arrive at this level. Examples of vergence therapy follow.

**Home Therapy** | **In-Office Therapy**
--- | ---
HTS computer system: Start with large targets and work towards smaller ones. | Computer Orthoptics: Start with large targets and work towards smaller ones.

Tranaglyphs: Initially you want the patient to achieve higher ranges, especially BI. After the quantity is achieved stress quality of the images. | Vectograms: These will be done the same as tranaglyphs. Initially concerned with the quantity and then later the quality of the images. Always start with larger targets.

Aperture Rule: Initially start with BI then jump between BI and BO. Finally add prism flippers with this exercise. | Prism Flippers with near Hart Chart. Can also be done at home. Considered late stage therapy.

As a general rule esotropes respond poorer to vision therapy then exotropes. Surgical intervention should be considered when the angle of deviation is 15-20 prism diopters. If surgery is elected then you should co-manage the patient. Surgery will straighten the eye but it usually does not fully correct the fusional problems the patient experiences. The normal time it takes for vision therapy to be completed is six to sixteen months or more.
USE OF THE SYNOPTOPHORE: MEASUREMENT

1. Adjust the Synoptophore for patient’s PD and chin height.

2. Insert a first-degree target (i.e. car/garage, lion/cage). The targets should be associated but not alike.

3. To measure the subjective angle of anomaly (S), lock one arm and position the other arm at about 50pd Exo (on prism scale not degrees).

4. Instruct the patient to hold one handle, the one that is not locked. Have the patient superimpose the targets and record the angle. Do this several times to convince yourself the patient is doing it correctly (they should put the target in the same place each time). Starting with an easy target such as the car and garage then switch to a smaller target (still first degree) is a good approach.

5. The objective angle of anomaly (H) can be found using the flashing technique immediately after measuring angle “S”, tell the patient not to move their head and alternately turn off each eye’s image using the buttons on the front of the Synoptophore.

6. Watch the patient’s eye for movement and adjust the arm until you see neutral, then continue to a reversal just with a prism bar in free space.

Note: If “H” and “S” are not the same, the patient has ARC. See Griffin text for specifics on the differences between “H”, “S” and ARC.
HESS-LANCASTER SCREEN

1. Place patient one meter from screen with middle of the screen at eye level. You may need to have the patient sit on a chair, stand, stand on chair, etc.

2. Place the Red/Blue glasses found in the cardboard box (not the computer glasses!) on the patient with red over the right eye.

3. Put the blue light in the patient’s hand while you hold the red one. The patient’s right eye is fixating while the left eye is being tested and the results should be drawn on the left grid on the Strabismus Evaluation form.

4. Aim the red light at the center mark and instruct the patient to put their blue mark on top of yours. Note the location of the patient’s light by marking it on the grid.

5. Instruct the patient to look for the light as you move using only their eyes, they may not move their head. On younger patients you may need to hold their head while testing. Move the red light to the various positions, noting where the patient puts their light on the grid.

6. Switch lights with the patient, so you hold the blue light and the patient holds the red. The left eye is fixating and the right eye is being tested here. Move the red light to the various positions, noting where the patient puts their light on the grid.

7. Return the glasses to the box.
PARKS THREE STEP

Write down right eye muscle grouping, (always):

Left Hyper in primary gaze, so the right eye is Hypo. Cross out the muscles that are not working For the right eye. Which would be the elevators IO and SR.

Left hyper increases in Left Gaze. Move to the left of the middle line to cross out the IO and SO.

Left hyper increases with Left Head Tilt. Cross out the muscles so that the line angles to the left IO and IR.

The affected muscle is RIO. It is crossed out three times.

Next example write it out.

1. Write down the right eye groupings always:

2. The Right eye is Hyper in primary gaze, therefore the depressors are not working properly. So cross out the SO and IR

3. Right hyper increases in Right gaze. So cross out the SR and IR. (those muscles to the right of the middle)

4. Right Hyper increases with Right Head tilt, So cross out The muscles so the line angles to the right. SO and SR

5. The affected muscle is the LIO since it has not been crossed out at all.
Go through this exercise with each muscle to make sure you understand how to do it properly.
A patient after vision therapy.
INDEX TO HOME VT PROCEDURE INSTRUCTIONS

The following is an alphabetical listing of the vision therapy procedures contained in this manual. These activities are principally used for home therapy, but they are always reviewed in-office before being assigned to the patient.

Once procedures are reviewed with each patient, the patient should be given a copy of the specific instructions for reference. At subsequent follow-up appointments, the patient should demonstrate each procedure to ensure they are being performed properly.

These instructions have been adapted from:

General Home Vision Therapy Procedures

- Patient Introduction to Home Vision Therapy Activities
- Guidelines for Home Assistants to Children in Vision Therapy
- Anaglyphic Television Therapy (“TV Trainer”)
- Aperture Rule: Convergence
- Aperture Rule: Divergence
- Brock String (Three Colored Beads)
- Directional Arrows
- Eccentric Circles
- Hart Charts: Near/Far
- Hart Charts: Prism or Lens Flipper Accommodative Rock
- Hart Charts: Saccadic Therapy
- Hart Charts: Coding
- Lens Rock with Single Vectogram or Tranaglyph
- Life Saver Card
- Peg-Board Rotator
- Push-up Accommodation Therapy
- Push-up Convergence Therapy
- Red/Green Bar Reader Anti-suppression Therapy
- Red/Green Bar Reader with Lens Flippers
- Sherman’s Playing Cards
- Stick (Pointer) in Straw
- Variable Tranaglyph (Red/Green) Vergence Therapy
- Vectogram: Chicago Skyline
- Vectogram: Clown
- Vectogram: Mother Goose
- Vectogram: Quoits (Rope)
- Vectogram: Spirangle
PATIENT INTRODUCTION TO HOME VISION THERAPY ACTIVITIES

Welcome to the world of vision therapy! Your eyes are intimate extensions of your brain, so you will literally be learning how to look at, see, feel, and understand things differently than you have ever before or at least for quite some time!

Your vision therapy program has been carefully customized for you. The bulk of learning that you will experience occurs during your office sessions.

Then why do home therapy? Reinforcement of new learning; elaboration to the home, school, or work environment; speeding up the results of therapy; just to name a few of the benefits.

We all have busy schedules, and we know that it will take some effort at first to incorporate home therapy into your daily activities. For an adult, some of the activities can be taken to work and done during a break. For a child, the activities will be done after school and on weekends.

A few words of caution. Home vision therapy should not be treated as "homework." These activities are interesting, challenging, and fun. They should be presented to a child as an opportunity, not as a chore. The role of a parent working with a child is to make sure that the time is set aside to do the activity. You may observe by following the printed instructions, but do not correct your child independently. Call us at (812)855-9196 if you have any questions.

Home therapy is a bonus. If you miss doing it for whatever reason, don't think that you have to push off your next session, or your progress evaluation because you "didn't practice enough." Consistency with your office visits is the key to successful completion of your vision therapy program.

This manual is designed to organize your home vision therapy activities. It complements your office therapy program. Each activity will be explained and reviewed during the office session before it is assigned to you.

The activities in this manual are the core procedures that all of our therapy patients do. Periodically you will be given additional activities. The material needed to do the activities will be given to you when the activity is assigned. We have included a sheet so that we can track when each activity is assigned and when it is completed.

One question usually arises at home: "If I wear glasses, should I use them for the therapy activities?" The answer is: If you normally wear your glasses all the time, wear them for the activities. If you normally remove your glasses for near work, remove them for therapy activities done at near. If you have a bifocal or progressive lens, view through the lower area of the lens for near, and the upper portion for distance, just like you always do. If the activity involves wearing special red/green glasses or polaroid glasses, they will fit over your glasses.
GUIDELINES FOR HOME ASSISTANTS TO CHILDREN IN VISION THERAPY
Modified from J. Baxter Swartwout, OD
Swartwout JB. Optometric vision therapy manual: procedures and forms.

Note:
"She" and "he" are used interchangeably here, because the world is happily filled with both!

1. The home procedures should not be approached on a right or wrong basis.

2. Don't tell your child how she did on each procedure; let her tell you. In other words, she should be allowed to assess her own performance.

3. Don't emphasize the unaccomplished phase of the performance. Instead stress the part that was accomplished. Being 75% right is more encouraging than being 25% wrong.

4. Don't supply your child with too many answers. The instruction sheets that accompany each procedure will let you be a good observer.

5. Don't make a value judgment about your child's performance. If there is a discrepancy between the instruction sheet and the way your child performed the procedure, make a note of it and review it with the therapist on your next visit to the office, or give us a call.

6. Discuss with her how much progress she has made each time and let her figure out what she must do differently next time if she is to move toward the desired goal.

7. It is not always necessary to work on a given procedure for a specific length of time. If it is obvious that your child is tired, stop short of frustration and have him try it again another time. We encourage your child to come to you and request that you observe them doing the procedure.

8. Be consistent with your philosophy as a parent. Although we try to make vision therapy fun and interesting, there is an element of learning involved, and it is bound to resemble "homework." What is your philosophy about school work? Do you tell the teacher that it is the child's responsibility to get it done? Or do you work together with the teacher to figure out a way that you can be a positive facilitator?

9. Having said that, the visual problem that your child has is his problem, and only he, with all our help, can change it. You should not have to nag to get things done. If there is a problem with home therapy, please let the therapist know.
ANAGLYPHIC TELEVISION THERAPY ("TV Trainer")

**Purpose:** To help you learn to see with both eyes at all times by eliminating the tendency to suppress (tune out or turn off) one eye.

**Material:** One red and one green filter sheet, red/green glasses, tape, television set

**Procedure:**

1. Tape the red and green filters to the television screen, with a small space between them. Put the red initially on the right side.

2. Put the red/green glasses on with the red filter over the right eye and sit approximately 5 feet from the television.

3. If the right (red) side of the screen is blacking out, you are tuning out the right eye; if the left (green) side of the screen is blacking out, you are tuning out the left eye.

4. If either side of the screen appears black, blink your eyes, then concentrate on seeing the whole picture. If this does not help, put your hand over the eye that is seeing the screen so that the other eye can now see what was blacked out.

5. If you are having difficulty, try moving in a little closer or further away. If you can find a distance where it is easiest to see the whole screen, watch at that distance for 5 minutes. Then try to move 2 feet closer; then a few feet farther.

**Guidelines:**

1. Let's say that one color, the red for example, keeps blacking out. Remove the green filter from the television and tape the red filter to the center of the screen. This should make it easier to keep the red from blacking out. If it does, watch for 5 minutes, then try to put the green filter back on. If it does not black out, just leave the red in the middle for the session.

2. If your eye tends to drift inward, your therapist may tell you to begin initially with the red filter on the left side of the television but the red side of the glasses in front of the right eye. This will make it easier to do. Then, you will be asked to reverse the filters, which makes it more difficult.

3. Sometimes we try too hard and one eye tunes out the picture, causing it to "black out." If this happens, relax, take a deep breath, and try to be aware of as much going on around the television set as you can while watching the program.

4. The same procedures can be used when playing computer video games.

**Therapy Time:** 30 minutes or more per day.

It is best to watch at least one 30-minute program daily in this manner. If you have a lot of difficulty keeping parts of the screen from blacking out, make each viewing time shorter but do it more often. Try to watch twice for 15 minutes or three times for 10 minutes, until you are able to keep the whole screen on.
APERTURE RULE: CONVERGENCE

**Purpose:** To help you improve the accuracy and efficiency of your two eyes working as a team, and to coordinate this with the focusing abilities of each eye. This will make prolonged near work such as reading, writing, and computing more comfortable and pleasurable.

**Material:** Aperture Rule instrument (gray) including flip-card (AP cards) booklet, and window (single slot), called the AP slider. A red pointer stick is optional.

**Procedure:**
1. Assemble the Aperture Rule with the AP card booklet placed at "O" on the scale; turn to the picture of the two clocks (AP 1).
2. Move the slider so that it is positioned at "1 and 2" on the scale.
3. Place the tip of your nose against the edge of the rule so that you are looking through the slider window at the card.
4. Blink your right eye shut, and the clock on the left will disappear. You should see one clock with a set of circles underneath it and a black cross above the circles. If you see part of a second clock, move the card a little closer to you until only one clock is seen.
5. Now blink your left eye, and the clock on the right will disappear. You should see one clock with a set of circles underneath it and a black dot below the circles. If you see part of a second clock, move the card a little closer to you until only one clock is seen.
6. Now look at the target with both eyes open and you should see one clock with a set of circles underneath it, with a cross above the circles and a dot below them. The targets should be clear and single. Remember, you must see both the cross and the dot at the same time. The circles should appear three-dimensional. (Which circle is closer to you, the small or the large one?).
7. If you can't get or keep the targets single, place the red pointer stick (or a pencil tip) at the top of the window opening. This will better orient you as to where your eyes should be looking.
8. When you have it, look over the flip card into the distance, then back through the window slider. You should be able to do this several times, obtaining a clear single picture within a few seconds each time you look back to the card.
9. Now flip the card over to the two parrots (AP 2). Keep the slider positioned where it is ("1 and 2"). Repeat steps 1 through 8 above. When you go to the next flip card (Golfer, AP 3) you will have to move the slider to position "3" on the scale. Just remember--always leave the AP cards at position "0" but move the slider to the number on the scale that matches the AP card (slider to 4 on scale for AP 4, and so on).
10. Your goal is to get to card AP 12.

**Guidelines:**
1. When you get good at this, you needn't bother to start with AP 1 each session. If you are up to card AP 8, for example, begin the next session with card AP 4; if your previous best was AP 10, you can begin the session with AP 6.
2. Do not be discouraged if this is a tough procedure; it may take a while before you can attain the goal. Even if you can't get to card AP 12, the speed with which you can get each card single and clear, with depth of the circles, and the flexibility of being able to look away and look back again, is more important than the number you can reach. If you used the pointer at the window as a crutch (step 7), try to do without it as soon as you can.

**Therapy Time:** 10 to 15 minutes each day
**APERTURE RULE: DIVERGENCE**

**Purpose:** To help you improve the accuracy and efficiency of your two eyes working as a team and to coordinate this with the focusing abilities of each eye. This will make prolonged near work such as reading, writing, and computing more comfortable and pleasurable.

**Material:** Aperture Rule instrument (gray) including flip-card (AP cards) booklet, and double window called the AP slider. A red pointer stick is optional.

**Procedure:**
1. Assemble the Aperture Rule with the AP card booklet placed at "O" on the scale; turn to the picture of the two clocks (AP 1).
2. Move the slider so that it is positioned at "1 and 2" on the scale.
3. Place the tip of your nose against the edge of the rule so that you are looking through the slider window at the card.
4. Blink your right eye shut and the clock on the right will disappear. You should see one clock with a set of circles underneath it and a black dot underneath the circles. If you see part of a second clock, move the card a little closer to you until only one clock is seen.
5. Now blink your left eye shut and the clock on the left will disappear. You should see one clock with a set of circles underneath it and a black cross above the circles. If you see part of a second clock, move the card a little closer to you until only one clock is seen.
6. Now look at the target with both eyes open and you should see one clock with one set of circles underneath it with a cross above the circles and a dot below them. The targets should be clear and single. Remember, you must see both the cross and the dot at the same time. The circles should appear three-dimensional. (Which circle is closer to you, the small or the large one?).
7. If you can't get or keep the targets single, place the red pointer stick (or a pencil tip) in the hole of the rule, marked at "A" on the scale. This will better orient you as to where your eyes should be looking, take a deep breath and relax, and look at the red pointer as if it were very far away.
8. When you have it, look across the room into the distance, then back through the window slider. You should be able to do this several times, obtaining a clear single picture within a few seconds each time you look back to the card.
9. Now flip the card over to the two parrots (AP 2). Keep the slider positioned where it is ("1 and 2"). Repeat steps 1 through 8 above. When you go to the next flip card (Golfer, AP 3) you will have to move the slider to position "3" on the scale. Just remember, always leave the AP cards at position "0" but move the slider to the number on the scale that matches the AP card (slider to 4 on scale for AP 4, and so on).
10. Your goal is to get to card AP 7.

**Guidelines:**
1. When you get good at this, you need not bother to start with AP 1 each session. If you are up to card AP 4, for example, begin the next session with card AP 1; but if your previous best was AP 6, you can begin the session with AP 3.
2. Don't be discouraged if this is a tough procedure; it may take a while before you can attain the goal. Even if you can't get to card AP 7, the speed with which you can get each card single and clear, with depth of the circles, and the flexibility of being able to look away and look back again, is more important than the number you can get up to.
3. If you used the pointer beyond the window as a crutch (step 7), try to do without it as soon as you can. Remember, relaxing makes it easier; if you are trying too hard, it will be more difficult!

**Therapy Time:** 10 to 15 minutes each day.
BROCK STRING (Three Colored Beads)

**Purpose:** To learn and improve the accuracy of how and where your two eyes are aiming together.

**Material:** Brock string - a ten to twenty foot string with three colored beads (and red/green glasses, if necessary)

**Procedure:**
1. Tie one end of the Brock string to a doorknob. Place the green bead at the end of the string near the knob, the yellow bead 12 inches from the other end, which is closest to you, and the red bead halfway in between.
2. Loop the close end of the string around your index finger and hold the string between your eyes, midway down your nose. Walk backward from the door until there is no slack in the string.
3. You should see two strings that appear to be coming out from opposite sides of your head. Look down the string at the green bead. The two strings should come together at the green bead, like a V, with two red and two yellow beads along the way. Which beads are closer to each other, the two red or the two yellow?
4. Look at the red bead, and the strings should come together and cross at the red bead like an X. How many yellow beads do you see in front of the red bead? How many green beads do you see behind the red bead?
5. Look at the yellow bead, and the strings should come together and cross at the yellow bead. You should be aware of two red beads and two green beads behind the one yellow bead. Which beads are closer to each other, the two red or the two green?
6. There are two basic ways to change where your eyes are aiming. One is to follow an imaginary "bug on a string" that is slowly crawling from one bead to the next. The other way is to "jump" from one bead to the next. Make sure you see what happens both ways.

**Guidelines:**
1. If one of the strings or beads is missing, you are not using both eyes together at that point. Blinking your eyes, flicking the string, or putting on red/green glasses may be helpful in keeping everything visible.
2. If the strings criss-cross closer to the point where you aim your eyes, take a deep breath, relax, and imagine that you are looking at a point very far away. If the strings cross farther than the bead you are looking at, you are "phasing through." Touch the bead with your finger or use a pointer or stick to touch it, so you can confirm its physical location.
3. If you have more difficulty with the near bead, move the bead a little closer to you. If you have more difficulty with the near bead, move it a little further from you. Then try to move it back to its original position. Your goal is to bring the near bead to a distance of 4 inches from your nose, with the far bead at the doorknob, and the middle bead halfway in between.
4. There is a trick to which eye sees which bead. Let's say the yellow bead is closest to you, the red bead is in the middle, and the green bead is at the doorknob. When you look at the red bead you will see two yellow beads. Close your right eye. Which yellow bead disappeared, the one on the left or the one on the right? Now, look at the red bead and be aware of the two green beads behind it. Close your right eye. Which green bead disappeared, the one on the left or the one on the right? (Answer: in front of the point where you are looking, the left eye sees what is on the right side; beyond the point where you are looking, it crosses over, and the left eye sees what is on the left side).

**Therapy Time:** 5 to 10 minutes each day.
DIRECTIONAL ARROWS

**Purpose:** To develop your concept of left and right in space.

**Material:** Arrow chart, metronome (optional)

**Procedure:**

1. Tape the arrow chart to a wall at eye level and stand approximately 8 feet away.

2. Call out the direction of each arrow in sequence as you move along the line from left to right. When you call out the direction, point your finger in the same direction.

3. If you have trouble remembering which way is left and which way is right, make up a new chart with some lines of only left arrows, and others with only right arrows. Then make some lines with only one or two right arrows, and others with only one or two left arrows. A chalkboard or erasable slate is good for this purpose.

4. If you still have trouble remembering which way is right and which way is left, draw a circle around all the circles that point to the left and a square around all the circles that point to the right.

5. After you get used to going from left to right, point and call out the directions going from right to left. After that, try top to bottom, then bottom to top.

6. **Add rhythm:** Now try calling out and pointing in the matching direction to the beat of a metronome.

7. **Add Visualization:** Now we are going to make things tougher:
   (a) When the arrow points up, say "down" and point down.
   (b) When the arrow points down, say "up" and point up.
   (c) When the arrow points left, say "right" and point right.
   (d) When the arrow points right, say "left" and point left.

8. **Add Visual-Tactile Mismatch:** Now you will call the actual direction out loud but point in the opposite direction.
   (a) When the arrow points up, say "up" and point down.
   (b) When the arrow points down, say "down" and point up.
   (c) When the arrow points left, say "left" and point right.
   (d) When the arrow points right, say "right" and point left.

**Guidelines:**

1. Some patients find the Visual-Motor Series Form "A" in which directional triangles are used easier to begin with.
2. We use a metronome in step 6 to insure automaticity. Until this procedure can be performed in rhythm, it is not solid. Begin with the slowest possible beat, then gradually speed it up.
3. Visualization, step 7, enables you to become flexible with this procedure. It means that you can manipulate directions when necessary.
4. Visual-kinesthetic mismatch, step 8, establishes that instead of needing to use your finger as an aid in "feeling" directions, your vision dominates over touch.

**Therapy Time:** 10 to 15 minutes each session. Directional knowledge involves positive reinforcement. If you are doing well during a session, you may want to continue longer; if you are having difficulty, set the activity aside and come back to it later.
ECCENTRIC CIRCLES

**Purpose:** To coordinate the focusing and localization of your eyes in static (at rest) and dynamic (moving) conditions.

**Material:** Two little eccentric circle cards, small plastic holder (optional), red pointer stick

**Procedure:**
1. Take the two targets and overlap them so that the letter "B" of one target is superimposed on the letter "B" of the other target.
2. If your cards are opaque (black circles on white background), continue with step 3. If your cards are transparent (black circles on clear acetate), place a small piece of white paper behind them so you can't see through.
3. Hold the circles at arm's length and place the tip of your red pointer stick flat and midway between the two circles, directly above the letter "B."
4. Slowly move the red pointer toward you, and be aware of what is happening to the circles in the background. Each of the targets will "wiggle" apart, so that you briefly have four sets of circles instead of two. As you continue to move the pointer toward your eyes, the middle set of circles will slide together to form one new set. Stop! Move the pointer away. Can you still see the middle circle? If so, don't use the pointer for the remaining steps; if not, use it.
5. You now have three sets of circles, two blurry ones off to the side, and one clearer set in the center. If the word "CLEAR" in the center is not clear, move it in or out slowly until you find a point where it is clear.
6. The set of circles in the center is different than the ones off to the side - it has depth to it. Which circle appears closer to you, the small one or the large one?
7. Trombone the circles. Begin by slowly pulling the target closer to you, keeping it clear. When you lose it or when it blurs, move it further away until it is clear. Repeat the procedure of pulling it as close to your eyes and as far from your eyes as you can. Trombone in 5 times and out 5 times.
8. Now we are going to move the targets in a circular arc. Follow the target around clockwise, then counterclockwise, always be aware of the depth of the middle set of circles, and keep the word "CLEAR" clear.
9. Now replace the targets with clear acetate eccentric circles (if you have been using clear ones with a white paper background, remove the background). When you did step 4 above, your eyes felt like they were pulling or crossing inward. This time you will place the red pointer stick on the back side of the target and move the stick further away.
10. You should have the feeling that you are "spacing out" or "phasing through" the target. It is almost like the feeling you get when someone is talking to you but your mind is elsewhere.
11. Repeat steps 5 through 8.

**Guidelines:**
1. Good lighting and space to be able to look through the target is important for step 9. It also helps if the background "projecting" to is a light-colored wall or floor.
2. When you get good at both looking near and looking far, try alternating between the two. It is fun! It is almost like the feeling of doing a push-up with your vision or flinging your eyes forward like a yo-yo then bringing them back again.
3. Children may give up or do it too quickly and stop. Better to do it once or twice while thinking about what you see and feel than five times "lightning quick."

**Therapy Time:** 10 minutes each day.
HART CHARTS: NEAR/FAR

**Purpose:** To develop flexibility in the change of focus when looking near to looking far.

**Material:** One large Hart alphabet chart, one small Hart chart, eye patch, and masking tape

**Procedure:**

1. Tape the large chart to a wall. Be sure that there is good lighting on the chart and that you have a clear path to move backward (ideally, a 20-foot space).
2. Along the baseboard, measure 1 foot intervals and place pieces of masking tape so that you can see them as you step backwards.
3. Place a patch over your left eye. Walk away from the large chart until the letters just start to blur, then take one small step closer to the chart.
4. Hold the small letter chart at your normal reading distance (16 inches from the eyes for adults and 12 inches for children).
5. Read the first line on the small chart all the way across (O, F, N, P...), then look up and read the second line on the large chart (Y, B, A, K...), then read the third line on the small chart (E, T, H, W...), and so on.
6. When you get to the bottom of the chart, take one step back and see if you can still see the wall chart clearly. If so, repeat step 5. If not, record how far you are from the distance chart.
7. Switch the patch to the right eye and repeat steps 4 through 6.

**Guidelines:**

1. If you cannot get as far from the wall chart with one eye as the other eye or if it takes more time to clear either chart with one eye compared with the other, spend more time with the eye that is sluggish.
2. If you do not have trouble keeping your place, try switching from near to far and back again once every three letters until you get to the end of each line.
3. For variety, try reading the chart in different directions. Instead of going from left to right, go from right to left, then try top to bottom and bottom to top. The most difficult is to read the chart on a diagonal.
4. There are different versions of Hart Charts available if the standard one proves too difficult.

**Therapy Time:** full chart each eye daily.
HART CHARTS: ACCOMMODATIVE ROCK

**Purpose:** To improve flexibility, efficiency, and stamina in focusing with each eye or with both eyes.

**Material:** Small Hart Chart (or any reading material of similar size), eye patch, lens flippers

**Procedure:**

1. Place the chart or reading material on a table at a comfortable reading distance (16 inches for adults and 12 inches for children).

2. If doing monocular (one-eyed) therapy, lace the patch over your left eye and hold one lens of the flippers over your right eye. Make sure the lens is close to your eye.

3. How long did it take to get the print clear through the first lens? Did the print get bigger or smaller? Does it feel like you are looking closer or farther? Like you are working harder or relaxing? Continue reading for several rows, make sure to keep it clear.

4. Flip to the other lens of the flippers. Answer the questions in step 3. Keep alternating between the two lenses for one minute. Clear the letters as quickly as possible between flips. Count the number of flips for each minute. Record this number in your log.

5. Switch the patch to your right eye and repeat steps 3 and 4.

**Guidelines:**

1. If there is a difference between the two eyes in clarity, speed, or feeling, spend more time using the eye that is less accurate and less efficient.

2. The size of the print used is important. Newspaper print is 20/50, which is the standard size of the near Hart Chart.

3. If you substitute other print for the near Hart Chart, make sure your therapist knows what size print you have been working with at home.

**Therapy Time:** 3 times (one minute each) for each eye daily.
HART CHARTS: SACCADIC

Purpose: To develop accuracy in the type of eye movements used in the reading process.

Material: Large Hart Chart, eye patch, and masking tape

Procedure:

1. Tape the large chart to a wall. Be sure that there is good lighting on the chart and that you have a clear path to move backward (ideally, a 20-foot space).

2. Along the baseboard, measure 1 foot intervals and place pieces of masking tape so that you can see them as you step backwards.

3. Place a patch over your left eye. Walk away from the large chart until the letters just start to blur, then take one small step closer to the chart.

4. Read aloud the first letter and last letter of each line (O, E, Y, X, etc.) until you reach the bottom.

5. Return to the top line and read aloud the second letter and the next-to-last letter of each line (F, H, B, R, etc.).

6. Return to the top line and read aloud the third letter and the third-from-the-last letter of each line (N, C, A, K, etc.).

7. Return to the top line and read aloud paired opposite letters on a diagonal from upper left to lower right (O, L, B, P, etc.), then from lower left to upper right (H, E, M, R, etc.).

8. Switch the patch to the right eye and repeat steps 4 through 7.

Guidelines:

1. For variety, try reading the chart in different directions. Instead of going from left to right, go from right to left. Then try top to bottom and bottom to top. The most difficult is to read the chart on a diagonal.

2. As you read aloud each letter, try to maintain a steady rhythm.

3. If you have more difficulty when using one eye compared with the other, spend more time using the difficult eye.

4. If you have trouble keeping your place, move closer to the chart. This should make it easier. Then move back again.

5. If you still have difficulty, use a chart with wider spacing, or cut the chart into four equal sections and space them out on the wall.

Therapy Time: 3 times (one minute each) for each eye daily.
HART CHARTS: CODING

**Purpose:** To develop task-oriented scanning ability.

**Material:** Large coded Hart Chart

**Procedure:**

1. Tape the large coded chart to a wall. There is a row of numbers across the top of the chart and a single row of vertical letters marking the left margin of the chart. Make sure there is good lighting on the chart.

2. We are going to look at the chart like a map. Each letter can be designated by a coordinate location.

3. Here are a couple of examples to get you started. Location C5 is the letter "F." Location H3 is the letter "P," and so on. You can also do this by designating the number first. For example, position 9F is the letter "K."

4. Now try the reverse. Pick out a letter anywhere and identify what its designation is. For example, the "Z" on the bottom row is at location J9.

5. Let's try a variation of this just to keep you sharp. If the letter "O," which begins the chart is letter 1, and the letter "L," which ends the chart is letter 100, what is the 66th letter on the chart?

**Guidelines:**

1. Your therapist may instruct you to use an eye patch and do this with one eye at a time.

2. If you are working by yourself, write your answers down and show them to the therapist on your next visit to the office.

3. Did you get the answer to step 5? It is the letter "K." No, it is not the letter "N." That's the 56th letter! Make up some more to challenge yourself.

**Therapy Time:** 3 times (one minute each) for each eye daily.
LENSES ROCK WITH SINGLE VECTOGRAM OR TRANAGLYPH

**Purpose:** To improve focusing without suppression.

**Material:** Polaroid glasses, one vectogram or tranaglyph slide, polaroid or red/green filter glasses, loose lenses or lens flippers

**Procedure:**

1. Put the filter glasses on. If you use prescriptive glasses, place the filter glasses over your glasses.

2. Place the vectogram or tranaglyph in the holder or hold it against a lighted background.

3. Your therapist will tell you whether the vectogram or tranaglyph corresponds to your left eye or your right eye. Hold the lens or flippers up in front of the eye that is viewing the vectogram or tranaglyph. First try to clear the larger letters or pictures in each of the boxes, then try to clear the smaller letters or pictures.

4. Place the lens down and clear the next lens (or flip the flipper) and repeat step 3.

**Guidelines:**

1. A flipper may be used instead of loose lenses if you are working by yourself and need to have an extra hand free.

2. This procedure is only a "stepping stone." It is part of a category of procedures known as "monocular activities in a binocular field." Once you are able to clear the lenses in front of the eye you are working with, you will probably be asked to use both halves of the vectogram or tranaglyph at the same time.

**Therapy Time:** 5-10 minutes daily.
LIFE SAVER CARD

Purpose: To improve your ability to use both eyes together, to balance your central and peripheral vision, and to make fast visual changes while sustaining clarity.

Material: Red/green life saver card, pencil or pointer stick

Procedure:

1. If your card is opaque (red/green circles on white background), continue with step 2. If your card is transparent (red/green circles on clear acetate), place a piece of white paper behind it so you can't look through.

2. Hold the card at arm's length and place the tip of your red pointer stick flat and midway between the two circles.

3. Slowly move the red pointer toward you and be aware of what is happening to the circles in the background. Each of the targets will "wiggle" apart so that you briefly have four circles instead of two. As you continue to move the pointer toward your eyes, the middle circles will slide together to form one new set. Stop! Move the pointer away. Can you still see the middle circle? If so, don't use the pointer for the remaining steps; if not, use it.

4. You now have three sets of circles, two blurry ones off to the side, and one clearer set in the center. If the word "CLEAR" is not clear, move it in or out slowly until you find a point where it is clear.

5. Notice the relative depth of the words in the middle circle on the bottom row. You should notice that the word "LETTERS" is closer to you than the other two words. Try to keep both colors present in the middle circle. If it is green, you are favoring your left eye; if it is red, you are favoring your right eye.

6. Trombone the circles. Begin by slowly pulling the target closer to you, keeping it clear. When you lose it, or when it blurs, move it further away until it is clear. Repeat the procedure of pulling it as close to your eyes and as far from your eyes as you can. Trombone in 5 times and out 5 times.

7. Now we are going to move the target in a circular arc. Follow the target around clockwise, then counterclockwise. Always be aware of the depth clue of the middle circle and keep the words clear.

8. Now look at the second row and get the third circle on in the middle. Depth is present in the word "CLEAR." The letters C,E, and R are on the same plane. Which letter is closer to you, L or A? The letters L and F in the center should overlap. What new letter does this form? Repeat steps 6 and 7.

9. Now look at the third row. In the word "CLEAR," the letters C, L, and A are on the same plane. Which letter is closer to you, R or E? Try to overlap the L and F again. Repeat steps 6 and 7.

10. Now look at the fourth row. The word "CLEAR" should appear further away than the other two words. Try to overlap the L and F again. Repeat steps 6 and 7.

11. When you can accomplish each of the rows, jump from one to the other so that you can make fast changes.

12. If you were using an opaque white card, switch to the clear acetate. If you were using the acetate with white paper behind it, remove the paper. Repeat steps 2 through 11 while looking through (beyond) the target. A good background is the broad area of an office fluorescent light or a smooth lightly painted wall. All of the depth effects of the letters are now reversed!

Guidelines:

1. There are various clues on each row that tell you when you are not using both eyes together with maximum efficiency. If the green color fades, you are tuning out the left eye; if the red color fades you are tuning out the right eye. On the second row, the letter "H" in the word "THESE" is seen only by the left eye and the "S" only by the right eye. On the third row the letter "E" in the word "LETTERS" is seen only by the left eye and the letter "R" is seen only by the right eye. On the fourth row it is "T" and "H" in the word "THESE."
2. When you look ahead of the card, you will feel like you are pulling your eyes inward or crossing them. When you are looking through the target, you should have the feeling that you are "spacing out" or "phasing through" the target. It is almost like the feeling you get when you are someone is talking to you but your mind is elsewhere.

3. Always try to be aware of what is surrounding the card; do not sacrifice periphery for the sake of central detail (do not shut out the rich information around you when you concentrate on the detail in front of you).

4. Anytime you look through the target, you will find it easier if you relax and take a deep breath.

5. When you get good at both looking near and looking far, try alternating between the two. It is fun! Almost like the feeling of doing push-ups with your vision, or flinging your eyes forward like a yo-yo and then bringing them back in again.

6. Children may give up or do it too quickly and stop. Better to do it once or twice thinking about what they see and feel, than five times "lightning quick."

**Therapy Time:** 5-10 minutes each day.
PEG-BOARD ROTATOR

**Purpose:** To develop eye-hand coordination under static conditions with saccadic eye movements or dynamic conditions with pursuit eye movements. Visual sequencing and spatial concepts may be included.

**Material:** Manico Peg Board Trainer, golf tee pegs, eye patch is optional

**Procedure:**

1. Begin with a static task (rotator on speed zero) and the concentric squares disk.
2. Determine the static fill time by recording the time it takes to place all the pegs in the disk.
3. Repeat the task by increasing the speed to 5; repeat again at maximum speed (10).
4. Repeat the task by rotating counterclockwise.

**Guidelines:**

1. To stimulate interest, the disk can be filled with the pegs in a variety of sequences. For example, you can begin with the four corners, working your way toward the center. Place the first peg in the upper right corner, then the upper left, then the lower left, and then the lower right. Now return to the upper right and place another peg next to it and repeat the sequence.
2. To aid localization, begin by hovering over the hole into which you are going to place the peg for one revolution (360 degrees) and then touch down. The act of inserting the peg in the hole only at a specific point will be difficult initially if you are impulsive.
3. You may be asked to do this procedure with a patch over one eye to compare the performance of each eye and then both eyes together.

**Therapy Time:** In-office procedure only.
PUSH-UP ACCOMMODATION THERAPY

Purpose: To learn how to focus your eyes more efficiently.

Material: Push-up stick (“doggie paddle” or similar target with small details), eye patch, ruler

Procedure:

1. Put the eye patch over one eye if doing monocular therapy. Start by patching the left eye. Hold the push-up target at arm’s length in front of you and focus on the smallest letters you can read.

2. Slowly bring the stick closer to your eye while keeping the letters clear.

3. When the letters first start to blur, work as hard as you can to make them clear. If you cannot clear the letters, slowly push the stick away from your eyes until they first become and remain clear. Hold this position for a count of 10. Measure and record this distance.

4. Repeat the procedure three times.

5. Repeat steps 3 and 4 with the right eye patched, if doing monocular therapy.

Guidelines:

1. Work as hard as you can to keep the letters clear and readable.

2. Because your eyes are doing some pretty hard work, you may experience eyestrain or a slight headache. This is normal and should subside with continued therapy. If the discomfort becomes intolerable, stop the therapy and let your eyes rest for a few minutes.

3. You should try to move the stick closer at each therapy session. The procedure should become easier and easier over time.

Therapy Time: 5 to 10 minutes each session daily.
PUSH-UP CONVERGENCE THERAPY

**Purpose:** To learn how to use your binocular (two-eyed) vision more efficiently.

**Material:** Push-up stick (“doggie paddle” or similar target with small details), ruler

**Procedure:**

1. Hold the push-up target at arm’s length in front of your and focus on the smallest letters you can read. Try and keep the letters clear and single at all times.

2. Slowly bring the stick closer to your eye while keeping the letters clear and single.

3. When the letters first start to blur or break into two, work as hard as you can to make them clear and single. If you cannot, slowly push the stick away from your eyes until they first become and remain clear and single. Hold this position for a count of 10. Measure and record this distance.

4. Repeat the procedure three times. Rest for a minute between procedures and look at something across the room to rest your eyes.

**Guidelines:**

1. Work as hard as you can to keep the letters clear, single, and readable.

2. Because your eyes are doing some pretty hard work, you may experience eyestrain or a slight headache. This is normal and should subside with continued therapy. If the discomfort becomes intolerable, stop the therapy and let your eyes rest for a few minutes.

3. You should try to move the stick closer at each therapy session. The procedure should become easier and easier over time.

**Therapy Time:** 5 to 10 minutes each session daily.
RED/GREEN BAR READER ANTI-SUPPRESSION THERAPY

**Purpose:** To help you learn to see with both eyes at all times by eliminating the tendency to suppress (tune out or turn off) one eye.

**Material:** Red/green/clear strips on small or large acetate sheet, red/green glasses, interesting reading material

**Procedure:**

1. Obtain print material with approximately the same size type as newspaper print (magazine, textbook, etc.). You may be given a sheet with letters or numbers on it as a trial.

2. Seat yourself at a table with good lighting overhead.

3. Put on the red/green glasses with the red filter over your right eye. If you wear glasses for reading, put the filters over your glasses.

4. The print under the red filter is seen by the right eye and the print under the green filter is seen by the left eye. If you cannot see the print under one color, try closing the opposite eye briefly to see it or to see it more clearly.

5. Read as usual, while making sure ALL print is visible through ALL colored strips at the same time. If one strip turns black, it means that one eye is being suppressed, and you should cover the other eye briefly to eliminate the suppression.

**Guidelines:**

1. Remember, always keep print visible through all colored strips at all times.

**Therapy Time:** as often as possible while reading or doing other near tasks such as using a computer.
RED/GREEN BAR READER WITH LENS FLIPPERS

**Purpose:** To improve your ability to focus both eyes at the same time.

**Material:** Red/green/clear strips (8 x 10 acetate sheet), red/green glasses, lens flippers (letter sheet optional)

**Procedure:**

1. Obtain print material with approximately the same size type as newspaper print (magazine, textbook, etc.). You may be given a sheet with letters or numbers on it as a trial.

2. Seat yourself at a table with good lighting overhead.

3. Put on the red/green glasses with the red filter over your right eye. If you wear glasses for reading, put the filters over your glasses.

4. The print under the red filter is seen by the right eye and the print under the green filter is seen by the left eye. If you cannot see the print under one color, try closing the opposite eye briefly to see it or to see it more clearly.

5. Hold one side of the lens flipper against your red/green glasses and read one line aloud. When you get to the next line, flip to the opposite side. Flip once per line until you get to the bottom of the page.

**Guidelines:**

1. If you cannot clear one side, let your therapist know. The power of your lens flipper may have to be reduced. Sometimes, though, it just takes a while for "your engine to get started."

**Therapy Time:** 5-10 minutes daily.
SHERMAN'S PLAYING CARDS

**Purpose:** To encourage both eyes to work together at the same time.

**Material:** Sherman's VT Playing Cards (anaglyptic cards); red/green glasses

**Procedure:**

1. Put on the red/green glasses with the red filter over the right eye.
2. The cards with black on red background are only seen by the eye looking through the red filter (right eye).
3. The number cards with red on white background are only seen by the eye looking through the green filter (left eye).
4. The picture cards with red on white background have the letters and suit seen only by the eye looking through the green filter (left eye). The picture itself can be seen by either eye.
5. The goal is keep all the cards clear and visible at all times.

**Guidelines:**

1. Cards games that stimulate interest and require a rapid response, such as Slap Jack or War, are particularly necessary for young children.
2. Younger children can be asked to sort the cards into piles by color, such as red pile and black pile. The black pile will be the cards printed in black on red background, and the red pile will be the cards printed in red on white background.
3. When doing a red/green activity with a young child, do it first without the filters to make sure they understand.
4. Because a young child can learn to "alternate," to use one eye and then the other, but not both at the same time, watch the response closely. If the activity was performed without hesitation without the filters on, but with hesitation with the filters on, the child is probably trying to alternate.

**Therapy Time:** 10 minutes, two times each day. If you are doing well with the activity, feel free to spend more time during each session. However, guard against saturating a child, try to make it a special treat to play cards.
STICK (POINTER) IN STRAW

**Purpose:** To develop accuracy in judging three-dimensional space.

**Material:** Red pointer stick, regular size drinking straw, eye patch

**Procedure:**

1. There are three phases of this procedure that involves placement of the red pointer stick into the opening of the straw. It is helpful to have someone assist you by holding the straw. Stand erect and maintain good balance.

2. Phase one is the "X" axis. Cover one eye and have the assistant hold the straw at a distance of 16 inches from your eyes (12 inches for a child). Use your dominant hand, and begin with the straw held behind your ear, as if you were going to thrust a spear. Slowly bring the pointer down in an arc so that you aim for the hole in the straw. While watching the hole, maintain awareness of the straw as it approaches.

3. Phase two ("Z" axis) is the same as step 2, but the assistant holds the straw with the opening straight ahead, lining up the hole straight ahead.

4. Phase three ("Y" axis) is the same as step 2, but the assistant holds the straw with the opening sideways while you approach it, lining up the hole from the side.

5. Repeat steps 2 through 4 with the other eye, then with both eyes together. Try to equalize performance with both eyes and in all three phases (directions).

6. If you have difficulty, it is helpful to hold the straw yourself (this gives you a "tactile" or touch clue as well).

**Therapy Time:** In-office procedure
VARIABLE TRANAGLYPH (RED/GREEN) VERGENCE THERAPY

**Purpose:**
To learn how to use your binocular (two-eyed) vision more efficiently.

**Material:**
Tranaglyphic trainer (two acetate sheets with red and green pictures), red and green filter glasses, pointer stick (optional)

**Procedure:**

1. Put on the red and green filter glasses. The Red lens should be over the Right eye. Set the two halves of the picture with the scale on the bottom row at 0. View the small diamond shape. The right eye should see the ‘R’, and the left eye should see the ‘L’. Make sure both letters are seen at all times while doing the procedures.

2. In this zero position, you may notice some depth to the picture. Let the depth of the picture grow on you. When you feel the three-dimensional effect of the picture, close one eye, the picture should now look flatter.

3. Slowly pull the two pictures apart so that numbers appear in the scale on the bottom; observe what happens to the appearance. For convergence (eye crossing) the green picture should be on the left of the red picture.
   (a) Does the picture seem to get larger or smaller? It should appear to be smaller and moving towards you if you are converging (crossing) your eyes.
   (b) Make a note of the highest number you can get to before the picture splits into two. After it splits, slowly pull it back together and make a note of when it is one again. Hold this position for a count of 10.

4. Repeat the procedure three times.

5. Repeat steps 3 and 4 but pull the pictures the opposite way so that letters appear in the scale on the bottom.

**Guidelines:**

1. The further apart you pull the pictures, the more dramatic the depth effect should be. If you have difficulty judging the depth, use the pointer stick to localize where the target is.

2. The depth and size effects of different parts of the picture work in different directions. Therefore some may become double before others do.

3. If you have more difficulty judging the depth effects or cannot move the pictures too far before seeing double, spend more time on the side of the scale (numbers or letters) that is more difficult to do.

**Therapy Time:** 10 to 15 minutes daily
VECTOGRAM: QUOITS (Rope)

**Purpose:**
To learn how to use your binocular (two-eyed) vision more efficiently.

**Material:**
Vectogram (two 5 x 7 acetate sheets) of a rope, polaroid glasses, pointer stick (optional)

**Procedure:**
1. Put on the polaroid glasses. Set the two halves of the picture with the scale on the bottom row at @.

2. Let the depth of the picture grow on you. When you feel the three-dimensional effect of the picture, shut one eye, the picture should now look flatter. Make sure the "R" and "L" in the box to the left are both on at the same time, as well as both parts of the cross in the center of the rope.

3. Slowly pull the two pictures apart so that numbers appear in the scale on the bottom; observe what happens to the depth.
   (a) Does the rope look like it is coming closer to you or going farther away? Is it getting bigger or smaller?
   (b) If you stop and sway your body side-to-side, is the rope moving in the same direction as your body or the opposite way?
   (c) Make a note of the highest number you can get to before the picture splits into two. After it splits, slowly pull it back together and make a note of when it is one again.

4. Repeat the procedure three times.

5. Repeat steps 3 and 4 but pull the pictures the opposite way so that letters appear in the scale on the bottom.

**Guidelines:**
1. The further apart you pull the pictures, the more dramatic the depth effect should be. If you have difficulty judging the depth, use the pointer stick to localize where the target is.

2. It may be helpful to place a small round sticker in the center of one of the ropes to use as a reference for "on plane" (flat), and judge whether the rope is coming closer or going further than the sticker.

3. Use of the pointer stick is particularly effective to help localize where the target is. If you keep the pointer under the rope, and you feel or see your pointer coming closer, then you should perceive the target coming closer.

4. Another clue to the correct localization of the target is to keep the pointer stick flat against the rope. Let's say that you slide the pictures apart in the direction that makes the rope appear to come toward you. If you leave the pointer against the picture, the pointer must appear doubled in the background as you look at the float of the rope in the foreground. If you look through the rope to the pointer to make it single, the rope will double in the foreground.

5. If you cannot move the pictures too far before seeing double, spend more time on the side of the scale (numbers or letters) that is more difficult to do.

**Therapy Time:** 10 to 15 minutes each session daily
**VECTOGRAM: SPIRANGLE**

**Purpose:** To learn how to use your binocular (two-eyed) vision more efficiently.

**Material:** Vectogram (two 5 x 7 acetate sheets) of spiraling letters, polaroid glasses, pointer stick (optional)

**Procedure:**
1. Put on the polaroid glasses. Set the two halves of the picture with the scale on the bottom row at @.

2. Let the depth of the picture grow on you. Make sure the "R" and "L" in the circles to the left of the center box are both visible at the same time. Each of the letters is in its own little box. Some of the letters appear even with the box, some appear to be popping out, and some appear to be pushed in. Take a sheet of paper and for each letter, record your response as "even," "out," or "in."

3. You should see a spiral effect. The letter "E" attached to the center screen should be closest to you and the letter "I" should appear farthest away. When you feel the three-dimensional effect of the picture, close one eye, the picture should now look flatter.

4. Slowly pull the two pictures apart so that numbers appear in the scale on the bottom; observe what happens to the depth.
   (a) Does the rope look like it is coming closer to you or going farther away? Is it getting bigger or smaller?
   (b) If you stop and sway your body side-to-side, is the rope moving in the same direction as your body or the opposite way?
   (c) Make a note of the highest number you can get to before the picture splits into two. After it splits, slowly pull it back together and make a note of when it is one again.

5. Repeat the procedure three times.

6. Repeat steps 3 and 4 but pull the pictures the opposite way so that letters appear in the scale on the bottom.

**Guidelines:**
1. The farther apart you pull the pictures, the more dramatic the depth effect should be. If you have difficulty judging the depth, use the pointer stick to localize where the target is.

2. Use of the pointer stick is particularly effective to help localize where the target appears to be as you separate it sideways. If you keep the pointer under the letter, and you feel or see your pointer coming closer, then you should perceive the target coming closer.

3. Another clue to the correct localization of the target is to keep the pointer stick flat against the target. Let's say that you slide the pictures apart in the direction that makes the spiral appear to come toward you. If you leave the pointer against the picture, the pointer must appear doubled in the background as you look at the float of the spiral in the foreground. If you look through the spiral to the pointer to make it single, the spiral will double in the foreground.

4. If you cannot move the pictures too far before seeing double, spend more time on the side of the scale (numbers or letters) that is more difficult to do.

**Therapy Time:** 10 to 15 minutes each session daily
This manual and all items within the manual are property of Dr Shirin E. Hassan.

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Disclaimer

This course is intended to assist students in the mastery of knowledge needed of a Doctor of Optometry. While this course should help you prepare for future licensing exams, nothing in this course including the lectures and discussions, coursework, study guides, manuals, teaching notes or other materials, should be believed or understood to use actual confidential exam items from licensing exams. All materials in this course have been prepared in good faith to comply with the highest ethical standards of the profession.

Previous low vision course exams are not permitted as study materials for this course.
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Low Vision Clinic Meeting Agenda

1. Welcome and Introduction

2. Discuss LV Clinic Manual

3. Tour of Vision Rehabilitation Service area and location of resources

4. Review and Practice LV Clinical Assessment Techniques
   a. ETDRS Distance VA’s (recording in both Log MAR and Snellen notation)
   b. Single letter ETDRS Near Vision (recorded in M notation)
   c. MN Read performance (TPS and CPS in M notation)
   d. MARS Contrast Testing
   e. Trial Frame Refraction
   f. Goldmann Kinetic perimetry
   g. Tangent (Bjerrum) Screen perimetry

5. Review and Test Predicting (i) Distance Magnification; and (ii) Near power / magnification

6. LV Case reviews, time permitting
Low Vision Clinic Rotation Duties and Responsibilities

1. Key Clinic Personnel

   Bloomington:
   a. Dr. Hassan (Monday PM Clinic), Dr. Kollbaum (Friday PM Clinic)
   b. Leah Malone (LV dispenser)

   Indianapolis:
   a. Dr. McConnaha (All day Monday and Thursday)
   b. Chelsea Kratz (LV dispenser)

2. Educational Goals of Vision Rehabilitation Service (VRS) Rotation

   a. Become an effective low vision optometrist by being able to:
      i. Competently evaluate patients with visual impairment.
      ii. Successfully manage visually impaired patients with common goals.

3. Schedule Overview

   Bloomington:
   a. Tuesday and Friday Afternoons
      • 1:00 PM Rounds Discussion
      • 1:15 PM Patient appointments begin

   b. Both clinic sessions have:
      • Three blocks of patients
         1. Two “full” evaluations at start time (assigned 2 hrs)
         2. Three “follow-up” appointments in the third slot (assigned 1 hour each)

   Indianapolis:
   a. All day Monday and Thursday (8.30 am – 5.00 pm)
   b. Both LV clinic days have:
      • Four blocks of patients. Within each block there are:
         1. Two “full” evaluations at start time (assigned 1.5 hrs)
         2. One “follow-up” appointment at the start time (assigned 1 hour)

      • The four blocks on both LV clinic days commence at 8.30am, 10 am, 1 pm and 3 pm.
4. Intern Schedule
   a. Work in pairs for full evaluations, with one student being the “lead clinician” and the other student is an “assistant” when schedule and number of students dictate.
      
      Duties of Lead Clinician: performs all clinical assessments and determines the appropriate management strategies for patient

      Duties of Assistant: observes, records and interacts with patient where appropriate

   b. For the follow-up appointments, will continue to work in pairs however, roles will be reversed (ie. the Assistant from the full evaluation will become the “lead clinician”).

5. Intern Responsibilities/ Expectations
   a. Professionalism at all times when in the clinic.

   b. Utilization of the Clinic Manual and CECC Low Vision folder on the Teaching server as references. Letter templates available on the teaching server. Also use class notes.

   c. Correct chart assembly with all required forms.

   d. Use of proper low vision clinical techniques when performing all vision assessments. This includes:
      - ETDRS Distance VA’s (recorded both in Log MAR and Snellen equivalent);
      - Single letter ETDRS and MN Read performance in M notation for Near vision;
      - MARS Contrast Sensitivity testing in Log CS;
      - Trial Frame Refraction (using the JND and bracketing technique for best sphere and cyl);
      - VF assessment (when appropriate: Amsler grid, Wand Confrontation, Tangent Screen and/or Goldmann Kinetic perimetry).

   e. Select, trial and record appropriate low vision device(s) with correct estimated power or magnification. This includes trialing device(s) on both clinical charts and real-world sample material, recording results and the patient’s response to the device.

   f. Make appropriate clinical decisions regarding the services and/or resources that would benefit the patient.

   g. Document all clinical interactions between interns and patient as well as interaction between doctor and patient.

   h. Draft all letters to referral source and complete all paperwork.
      - Interns are responsible for all letters to incoming referral source and if referring out to other providers. These documents are due at the end of that clinic session, time permitting. If there is insufficient time, letters are due electronically to the supervising clinician prior to your next low vision clinic session.
6. **Exam Review**
   a. Full LV evaluation / consultation will include the following assessments:
      1. Hx must include:
         - POchx including most recent DFE;
         - Social Hx (*i.e.* Px’s living situation identifying who performs household tasks such as cooking, cleaning, paying bills etc.);
         - Review Px intake form (for family & systemic diseases & Px medications & allergies);
         - ADL’s (*i.e.* identify the activities (cooking, reading, driving etc.) that Px has difficulty with); and
         - Px’s Goals to be addressed in appointment.
      2. OD, OS and OU ETDRS Distance VA’s with habitual Rx and any other LV device that Px has brought with them to the appointment.
         Measure Snellen VA’s (using Projector Chart) for patients with driving as a goal (or requiring Certificate of Vision for the BMV).
      3. OD, OS and OU Single letter ETDRS Near VA (in M notation) with and without additional illumination. Determine illumination setting that provides optimal performance for patient.
      4. Verify Glasses (to be performed by Assistant).
      5. OU MARS Contrast Sensitivity with habitual Rx.
      6. OU MN Read performance (TPS and CPS) with Habitual Rx (under illumination condition that yielded best performance for single letter ETDRS N VA).
      7. OD and OS Trial Frame Refraction.
      8. OD, OS and OU Amsler Grid (*only* if a central field loss patient).
      9. OD, OS and OU Tangent Screen (Bjerrum) VF (*only* if scotoma is causing difficulty with EV, reading and/or other functional performance).
     10. OD and OS Wand Confrontation (*only* if Goldmann Bowl perimetry is not to be performed).
     11. OD and OS Goldmann Bowl perimetry (*only* when indicated *e.g.* for issues pertaining to:
         - Driving and/or mobility;
         - StrokePx; or
         - An ocular disease (such as severe glaucoma, RP etc.).
Upon completion of initial assessments, determine, if appropriate, the power and type of LV device(s) you estimate would best address the Px’s goals and determine an appropriate LV rehabilitation management plan. Also determine whether a DFE is required at this appointment.

Then consult with your supervising clinician your device recommendation, LV management rehabilitation plan and if a DFE is required. Supervising Clinician to provide feedback and direction.

12. The remaining time (~1 hr) will be spent on trialing the recommended LV device(s). This includes trialing device(s) on both clinical charts and real-world sample material, recording results and the patient’s response to the device. If no LV device is recommended, skip this step.

13. The supervising clinician, during the second hour, will check your findings, spend “face-time” with the patient reviewing and explaining the recommended LV management plan and answer any patient questions.

b. A Follow-up appointment will either be for dispensing a LV device and/or LV rehabilitation training.

1. If the follow-up is for dispensing, the following should be performed:
   - Assess vision with device(s).
   - Review with patient proper use of device(s) (ie. what activities the device is to be used on and how to use the device, including do they use it with their habitual Rx and which part of the Rx).
   - Review with patient proper care of device(s) (ie. how to clean the lenses, change batteries and change viewing options if applicable etc).

2. If the follow-up is for LV rehabilitation training, the procedures to be performed will be determined during that day’s Rounds in consultation with the supervising clinician.
Clinic Forms

The forms that are to be utilized during your LV Clinic evaluations include:

1. **LV Student Exam Form**
   Use this form to document all findings of your LV clinical assessment for all “Full” Low Vision Evaluations on new and returning patients. Use this form when also performing ocular health assessments on your LV Px’s.

2. **LV Doctor Exam Form**
   This form is used by the supervising clinician when he/she assesses a Px. The form enables the supervising clinician to document all of his/her findings, including the results of any ocular health assessments, as well as information and topic areas that were discussed in person with the Px.

3. **Treatment Notes Form**
   Use this form to document all findings and all items discussed at any “Follow-Up” appointment, including when dispensing a LV device or when administering LV training (such as EV training, or spatial neglect training).

4. **Separate Score Sheets for:**
   - Distance ETDRS VA (OD, OS and OU are all on one sheet);
   - Near Single Letter ETDRS VA Chart;
   - MARS CS;
   - MN Read;
   - Amsler Grid;
   - Goldmann Bowl Perimetry;
   - Trails Making Test – Part B;
   - Mini-Mental State Exam
   - Bell’s Cancellation Test

5. **Vision Rehabilitation Service Prescription Device Order Form**
   Complete this form whenever a LV device has to be ordered. This form along with the Px chart should then be given to the LV dispenser so that the device can be ordered.

   Must complete this form and send it to the Blind Registry of Indiana whenever a Px is unable to read all letters on the 20/50 line (best-corrected in the better eye) and / or their VF in their better eye is reduced to at least 45° – 70° in diameter.

   Therefore if a Px’s best-corrected VA is 20/50\(^{-1}\), or the VF in their better eye is 69.5° in diameter, they must be reported to the Blind Registry of Indiana.
Only complete this form if the Px meets the criteria for reporting AND there is no copy of a previously completed form in the Px’s chart.

Failure to submit this form of eligible Px’s to the Blind Registry of Indiana results in a “Class C” infraction.

7. Diagnostic Testing Interpretation & Plan Form (Cream-colored form)
   Must complete this form whenever a Goldmann VF is performed, retinal imaging (OCT) is performed, photographs (of any structure of the eye) are taken or if corneal topography is performed.

8. Certificate of Vision
   Complete this form only if Px fails the “vision test” at their local BMV branch.

9. Certificate of Vision for Bioptic Drivers
   Complete this form for Px’s applying for a Bioptic Driver’s License for the first time, or if they are undergoing their annual license review or it has been 4 yrs since their Indiana bioptic driver’s license was issued and therefore they need to be issued with a new Indiana bioptic driver’s license.

10. Request for Special / Courtesy Test Affidavit
    Complete this form for Px’s who want to re-sit the BMV behind-the-wheel driving test at the BMV. There is no cost associated with this test.

    The outcome of this assessment is final. Therefore, if the Px fails, their driving license is immediately suspended.

11. Application for Disability Parking Placard or Disability Plate
    Complete Sections 1, 3 and 4b of this form for Px’s who want to have a disability parking permit.

    If a Px is referred by Vocational Rehabilitation for a LV Evaluation, this form will be given to you by the Px for completion.

    Vocational Rehabilitation is the State Agency that assists Visually Impaired people find or retain employment.
Sample #1: Detailing the outcomes of the Px’s LV rehabilitation only

Dear Dr. XXXXX

Re: Mr / Mrs. XXXXX
DOB: XX/XX/XXXX

I had the pleasure of evaluating our mutual patient, XXXXX in the Vision Rehabilitation Clinic on XXXXX, 2013. As you know, Mr. / Mrs. XXXXX is XXXXX visually impaired due to a history of XXXXX. Mr. / Mrs. XXXXX’s goal(s) for the evaluation was/were to improve XXXXX.

Upon examination, Mr. / Mrs. XXXXX’s best corrected distance visual acuities using the Early Treatment Diabetic Retinopathy Study (ETDRS) Chart, were 20/XX OD and 20/XX OS. Near acuities with the Single Letter ETDRS Near card were XXXX M OU at XXX cm (20/XX) with a +XXXX DS Near Add. We found no change in his/her current spectacle correction which was XXXXXX OD and XXXXXX OS with a Near Add of + XXXXX DS.
During Mr. / Mrs. XXXXX’s visit, we trialed various distance / near optical devices to improve his / her vision for distance / near. Based on our evaluation, we made the following recommendations:

1. **+8.00D/3.0X Power Mag+ illuminated stand magnifier**
   With this device, Mr. / Mrs. XXXXX was able to spot read XXXXX M print (20/XX) at XXX cm.

2. **+10.00D/3.5X Power Mag+ hand held magnifier**
   With this device, Mr. / Mrs. XXXXX was able to fluently read XXXXX M print (20/XX) at XXX cm.

Mr / Mrs. XXXXX liked the improvement in his / her vision with these devices and as a result, both these devices have been ordered and will be dispensed on XXXXX.

If you have any questions or concerns regarding this patient please contact me by phone at (812) 855 9405 during business hours or by email at: shhassan@indiana.edu.

Thank you for referring this patient to us.

Sincerely,

Shirin E. Hassan, BAppSc(Optom), PhD, FAAO
Assistant Professor
Low Vision Optometrist
Dear Dr. XXXXX

Re: Mr. / Mrs. XXXXX  
DOB: XX/XX/XXXX

I had the pleasure of evaluating our mutual patient, XXXXX in the Vision Rehabilitation Clinic on XXXXX, 2013. As you know, Mr. / Mrs. XXXXX is XXXXX visually impaired due to a history of XXXXX. Mr. / Mrs. XXXXX’s goal(s) for the evaluation was/were to improve XXXXX.

Upon examination, Mr. / Mrs. XXXXX’s best corrected distance visual acuities using the Early Treatment Diabetic Retinopathy Study (ETDRS) Chart, were 20/XX OD and 20/XX OS. Near acuities with the Single Letter ETDRS Near card were XXX M (20/XX) OU at XX cm with a +XXXX DS Near Add. We found no change in his/her current spectacle correction which was XXXXX OD and XXXXX OS with a Near Add of + XXX DS.

Pupils were equal, round and responsive to light, although an ??? afferent pupil defect was noted in the right eye. An evaluation of the anterior segment revealed XXXXX.

A dilated fundus exam showed flat, distinct optic disc margins with healthy neural rims. CD ratios were recorded as being XXX OD and XXX OS. The maculae and fundus of both eyes appeared XXXXX. Amend accordingly to your findings.
During Mr / Mrs. XXXXX’s visit, we also trialed various near optical devices to improve his / her vision for distance / near. Based on our evaluation, we made the following recommendations:

1. **+8.00D/3.0X Power Mag+ illuminated stand magnifier**
   With this device, Mr. / Mrs. XXXXX was able to spot read XXX M print (20/XX) at XXX cm.

2. **+10.00D/3.5X Power Mag+ hand held magnifier**
   With this device, Mr. / Mrs. XXXXX was able to fluently read XXX M print (20/XX) at XXX cm.

Mr / Mrs. ? XXXXX liked the improvement in her vision with these devices and as a result, both these devices have been ordered and will be dispensed on XXXXX.

Mr / Mrs. XXXXX is scheduled to return to our clinic for a full low vision and ocular health assessment in XXXXX year’s time unless he / she experiences any sudden changes in his / her vision.

If you have any questions or concerns regarding this patient please contact me at (812) 855 9405 during business hours.

Thank you for referring this patient to us.

Sincerely,

Shirin E. Hassan, BAppSc(Optom), PhD, FAAO
Assistant Professor
Low Vision Optometrist
DATE

REFERRING DOCTOR
ADDRESS

Re: XXXX  DOB:XXXXX

Dear Dr. XXXX,

We had the pleasure of evaluating your patient, XXXXX, in the Vision Rehabilitation Service on XXX. As you know, she is visually impaired due to DISEASE CAUSING VISUAL IMPAIRMENT. Her goals for the evaluation were to XXXXX.

Visual acuities, best corrected, were: OD XX; OS XX. These may vary from those obtained in your office as we use special charts and lighting designed for the functional assessment of the visually impaired.

Based on evaluation of XXXX’s goals and vision in conjunction with assessment of appropriate low vision devices, we made the following recommendations:

1. Use of a XXXXX for near work (ACUITY FOUND CONVERTED TO REDUCED SNELEN). Pt educated on using her bifocal portion of her glasses with the bar reader flat on the paper.

OTHER EXAMPLES:
2. Distance magnifier Max TV 2x to use for the opera, television, sporting events, etc.

3. Advised patient on non-optical devices like big button phone and we recommended the Low Vision Support Group as a resource for her.

4. Also, reinforced use of a line guide as she is bothered by her metamorphopsia.
Thank you for referring this very nice patient to us for consultation. We appreciate the opportunity to participate in his vision rehabilitation. If you have any questions, do not hesitate to call.

Sincerely,

Elli J. Kollbaum, O.D.
Chief, Vision Rehabilitation Service
When Letters are to be sent to the VA:

- Use size 14 - 16 font

- Include the following items in the letter:
  - Diagnosis and ICD-9 Codes
  - Level of Visual Impairment using the classification system on the back of the pink fee sheet (i.e. profound, severe, moderate, mild)
  - Whether the Px is legally blind (Y/N)
  - Whether glasses were recommended and if so, what type (i.e. SV D Rx, Flat-top Bifocals etc)
  - List all recommended LV devices including the company/manufacturer, catalog # and cost of device

- Send the letter Attention to: Deanna Austin, VIST Coordinator, and Outpatient Care Coordinator

- The VA will then order all recommended LV devices. The devices will then be shipped to us for dispensing and training

- Orders for “standard glasses” can be done through our Eyewear Center using the VA plan and frames

- A sample VA letter is given on the following page
VA LETTER SAMPLE:

DATE

Roudebush Indianapolis VAMC
1481 West 10\textsuperscript{th} Street
Indianapolis, IN 46202

Attn: Deanna Austin, VIST Coordinator
Outpatient Non VA Care Coordinator

Re: XXXXX
DOB: XXXX

Dear Deanna:

We had the pleasure of evaluating your patient, Mr. XXXX, in the Low Vision Rehabilitation Service on XXXXX, 2013. As you know, he has some vision loss and glare secondary to

Diagnosis: XXXXX

His goals for the evaluation were to be able to read checks and bills more easily and to write checks and notes more effectively.

... /2
Visual acuities, best corrected, were:

Distance
OD: 20/XX
OS: 20/XX

Near, with +XX Add
OD: 20/XX at cm
OS: 20/XX at cm

These acuities are obtained using specialty EDTRS charts and lighting designed for use in the functional evaluation of the visually impaired, and may differ from those obtained using standard Snellen acuity charts. Mr. / Mrs. XXXX also reported central distortion on Amsler Grid testing with both eyes together.

Based on evaluation of XXXXX’s goals and vision, in conjunction with assessment of appropriate low vision devices, we made the following recommendations:

VISUAL DEVICE AND PURPOSE (Customize for your patient with VA & Cost)

1. Illuminated Stand magnifier HaloBright PowerMag 4X/+12D
   This device improved XXXXX’s reading to 20/XX at XX cm.
   Supplier: Shoplowvision.com, Catalog #: XXX Cost:$

2. Daylight tabletop lamp, 1.75X, with mag lens
   This device enabled XXX to write checks and read notes: 20/XX at XX cm
   Supplier: Shoplowvision.com, Catalog #: XXX Cost:$
3. **NOIR U50 54% Yellow Filter** (shoplowvision.com)
   These filters reduce XX’s overall glare, inside and outdoors

   Supplier: Shoplowvision.com,   Catalog #: XXX   Cost:$

   Total Cost of all devices: $ XXXX

(ASSESSMENT OF VISUAL IMPAIRMENT AND LEGAL BLINDNESS)
By our assessment today, he is considered to have XXX level of visual impairment. He is legally blind (CHANGE TO NOT IF THAT IS THE CASE)

Thank you for referring this very nice gentleman to us for consultation. If you have any questions, do not hesitate to call me.

Sincerely,

Elli J. Kollbaum, O.D. - OR- Shirin E. Hassan, BAppSc(Optom), PhD, FAAO
Chief, Vision Rehabilitation Service    Assistant Professor
                                          Low Vision Optometrist
Your clinical performance and Px management skills during your LV clinic rotation will be rated by the Faculty Supervisor on a scale of 1 – 4 in the areas of:

- Professionalism and conduct; and
- Patient care skills and techniques.

The rating scale categories are:

- **4 = Exemplary Clinical Skills**: Accurate, Efficient, Comprehensive, & Independent (top 10% of interns).
- **3 = Above Average Clinical Skills**: Complete, Effective, Consistently Uses Good Judgment.
- **2 = Adequate Clinical Skills**: Overall Good performance with limits to understanding and efficiency.
- **1 = Inadequate Clinical Skills**: Some Incomplete and/or inaccurate data, limited knowledge base, repeated unsatisfactory performance.

The Faculty Supervisor will record their evaluation using the “IUSO Fourth Year Intern Performance Evaluation” recording sheet which is provided on the next page.

You shall receive two evaluations:

- One evaluation is given half-way through your LV clinical rotation.
  
  This evaluation is to provide you with initial feedback regarding your performance and thus highlights areas where you are doing well and areas that require improvement. This evaluation does not count towards your final grade.

- The final evaluation at the conclusion of your rotation. This evaluation is the grade that is applied to your LV clinic rotation.
# The IUSO Fourth Year Intern Performance Evaluation Recording Sheet

<table>
<thead>
<tr>
<th>Score</th>
<th>Criteria</th>
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<tbody>
<tr>
<td><strong>PROFESSIONALISM AND CONDUCT</strong></td>
<td></td>
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<tr>
<td>1</td>
<td>1½</td>
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<td>1½</td>
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</tbody>
</table>

| **PATIENT CARE SKILLS AND TECHNIQUES** | |
| 1 | 1½ | 2 | 2½ | 3 | 3½ | 4 | 1. Performs adequate history & testing relevant to CC or reason for visit |
| 1 | 1½ | 2 | 2½ | 3 | 3½ | 4 | 2. Performs proper procedural skills correctly, accurately, and efficiently |
| 1 | 1½ | 2 | 2½ | 3 | 3½ | 4 | 3. Has critical thinking skills to analyze and assess examination findings |
| 1 | 1½ | 2 | 2½ | 3 | 3½ | 4 | 4. Ability to differentiate normal & abnormal & prioritize problems properly |
| 1 | 1½ | 2 | 2½ | 3 | 3½ | 4 | 5. Ability to formulate diagnostic & therapeutic plan relating to CC & other History |
| 1 | 1½ | 2 | 2½ | 3 | 3½ | 4 | 6. Record keeping with clear and complete assessment and plans |
| 1 | 1½ | 2 | 2½ | 3 | 3½ | 4 | 7. Patient communication |
| 1 | 1½ | 2 | 2½ | 3 | 3½ | 4 | 8. Efficiency, time and patient management |
| 1 | 1½ | 2 | 2½ | 3 | 3½ | 4 | 9. Overall clinical competency |

Assigned Letter Grade: ________________________
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I. INTRODUCTION

The mission of Indiana University School of Optometry (IUSO) is to provide eye care, eye care training and vision research. An integral part of this mission is the acquisition, storage and dissemination of health information on individual patients. IUSO understands and respects the private nature of this information and has developed mechanisms to control access to, secure storage of, and restrict dissemination of patient information. In so doing, IUSO aims to comply with applicable laws and regulations relating to healthcare privacy and security.

Indiana University is a covered entity that has chosen “hybrid status” under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In essence only the health care components of Indiana University are required to comply with HIPAA’s mandates. IUSO is such a health care component and therefore operates as a “Covered Entity” under HIPAA. The goal of the IUSO HIPAA Compliance Plan is to provide guidelines that promote understanding and compliance with applicable laws, rules, and regulations, governing the privacy and security of protected health information, including both state law and HIPAA, and to outline the structure of IUSO’s continuing compliance efforts.

The objectives of this HIPAA Compliance Plan are to:

- Ensure the privacy and security of all protected health information (PHI) regarding patients and research subjects maintained by IUSO.
- Ensure that members of IUSO’s Workforce understand how to appropriately handle and safeguard PHI.
- Ensure that the affairs of IUSO are conducted in accordance with applicable laws and regulations relating to healthcare privacy and security.
- Establish a collaborative process with the IU Office of Research Administration for monitoring HIPAA privacy and security compliance in the conduct of Research.
- Outline the responsibility for continuing efforts to ensure HIPAA compliance within the school and the structure by which IUSO’s policies and procedures relating to HIPAA compliance are approved, implemented and enforced.

The HIPAA Compliance Plan is not intended to set forth all the necessary processes that are needed for compliance, but to compliment IUSO’s and Indiana University’s overarching HIPAA compliance effort.

The IUSO HIPAA Compliance Plan will not address other HIPAA Rules, such as: Transactions and Code Sets, National Provider Identifier, Health Plan Identifier, Claims Attachments and other related rules.

This HIPAA Compliance Plan is approved by the Compliance Committee and the Dean of the Indiana University School of Optometry. This plan is subject to ongoing review and revision by the Compliance Committee as deemed necessary to effectuate compliance.

Adopted: February 22, 2012
II. DEFINITIONS

**Covered Entity** is defined under HIPAA to include health plans, health care clearinghouses, and health care providers who transmit any health information in electronic form in connection with a HIPAA required standard transaction. Health care providers who do not submit HIPAA transactions in standard form become covered entities when other entities such as a billing service or a hospital transmit standard electronic transactions on their behalf. IUSO is a Covered Entity for purposes of HIPAA.

**Disclosure** shall mean the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.¹

**Indiana University School of Optometry (IUSO) Workforce** includes all employees, volunteers, trainees, and other persons whose conduct is under the direct control of IUSO, whether or not they are paid by IUSO.²

**IUSO Compliance Plan** shall mean the compliance plan established and approved by the Office of the Dean and the Indiana University School of Optometry Compliance Committee to address health care fraud and abuse and health care reimbursement issues in accordance with the Department of Health and Human Services Office of Inspector General Model Guidance Documents.

**Limited Data Set** means Protected Health Information that excludes the following identifiers of the Individual, or of relatives, employers or household members of the Individual: names, postal address information (other than town or city, state and zip code), telephone numbers, fax numbers, electronic mail address, social security number, health plan beneficiary number, account number, certificate/license number, vehicle identifiers and serial numbers, including license plate numbers, device identifiers and serial numbers, web universal resource locators (URLs), Internet Protocol (IP) address numbers, biometric identifiers, including finger and voice prints and full face photographic images and any comparable images. A limited data set may contain: dates of birth; dates of death; dates of service; town or city; state; zip code

**Protected Health Information (PHI)** means information about a patient created or received by a healthcare provider, health plan, or healthcare clearinghouse, including demographic information that may identify a patient, that relates to the patient’s past, present or future physical or mental health or condition, related health care services or payment for health care services³

**Treatment** means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

**Use** means the sharing, employment, utilization, examination or analysis of information within the Covered Entity holding the information.⁴

1. 45 CFR § 160.103  
2. 45 CFR § 160.103  
3. 45 CFR § 160.103  
4. 45 CFR § 160.103  

**Adopted: February 22, 2012**
III. PROGRAM OVERSIGHT AND RESPONSIBILITIES

A. Structure

Compliance oversight shall be pursued through the Office of the Dean, with the full authority of that office. The Dean shall appoint a Privacy and Security Officer. The Privacy and Security Officer shall be responsible for implementing HIPAA compliance training programs, provide oversight of the IUSO HIPAA compliance program and report directly to the Dean.

The Compliance Committee appointed by the Dean, as described under the IUSO Compliance Plan, shall be responsible for drafting and recommending overall compliance policies and standards to the Dean for approval and adoption. The Committee shall provide input to the Privacy and Security Officer on HIPAA Compliance Plan initiatives and implementation strategies.

B. IUSO Compliance Committee

The HIPAA Compliance Plan establishes the following core functions of the IUSO Compliance Committee:

1. Establish policies to effect compliance with applicable federal, state and local laws, regulations and ordinances involving health care privacy and security.

2. Develop and implement a means for members of IUSO’s Workforce to address questions and receive appropriate guidance regarding health care privacy and security issues;

3. Perform regular reviews of the IUSO’s compliance efforts to determine whether any assistance is needed to improve the compliance program;

C. Privacy and Security Officer Responsibilities

The Privacy and Security Officer shall be responsible for implementing and managing the School’s HIPAA Compliance Program. The Privacy and Security Officer shall work closely with the faculty and clinic administration of the IUSO to foster and enhance compliance with all applicable healthcare privacy and security laws, regulations and requirements.

The Privacy and Security Officer’s responsibilities shall include the responsibility to:

1. Assist the Compliance Committee in the review, revision and development of appropriate policies to guide all members of IUSO’s Workforce in their HIPAA compliance efforts.

2. Implement the privacy and security compliance efforts of the HIPAA Compliance Program as outlined by the policies appended to this Plan, with the support and assistance of the IU Office of Research Administration and IU Information Policy Office.

3. Monitor all developments and changes in relevant local, state and federal statutes, regulations and ordinances that may affect the HIPAA Compliance Program.

4. Develop and implement ongoing training programs to ensure that members of IUSO’s Workforce are aware of and updated on the required standards for health care privacy and security;

Adopted: February 22, 2012
5. Develop and implement a process to handle complaints, concerns and the reporting of possible non-compliance situations, including providing access to a hotline.

6. Investigate inquiries regarding HIPAA privacy and security issues or other reports of non-compliance, in collaboration with the IU Information Policy Office, University Information Technology Services (UITS), IUSO Human Resources Director, the Supervisor of the affected IUSO department and other Compliance Departments within the IU community where applicable.

7. Utilize monitoring and auditing systems that are reasonably designed to detect unauthorized uses and disclosures and other privacy practices that do not comply with HIPAA.

8. Assist in developing appropriate corrective action plans to address HIPAA privacy non-compliance issues. The Privacy and Security Officer shall advise and recommend as to appropriate action to be taken in response to an issue, but any personnel action affecting employment shall, in accordance with IU policy, be the purview of the Supervisor, after consulting with IUSO HR and/or appropriate IUSO functional unit head.

IV. RESEARCH AND HIPAA COMPLIANCE

The IUSO’s research compliance effort shall be coordinated through a cooperative interaction with the Indiana University Institutional Review Boards (IRBs) and the Office of Research Administration (ORA).

The responsibility of the IRBs and the ORA is to monitor activities and provide guidelines regarding the protection of human subjects involved in all facets of research including the protection of confidential health information used or disclosed for research purposes. In accordance with HIPAA, the IRBs function as the Privacy Board for the IU research community.

The IUSO Privacy and Security Officer shall work with the Office of Research Administration to identify the issues related to HIPAA privacy and security requirements for research conducted at the IUSO. In addition, the Privacy and Security Officer shall assist with the following initiatives as it relates to studies conducted by members of IUSO’s Workforce:

- Provide technical assistance and interpretation of HIPAA privacy requirements for research;
- Develop procedures for the access of patient information maintained by IUSO clinics for purposes of research.
- Provide specific training to members of IUSO’s Workforce who participate in research impacted by HIPAA on any IUSO policies and procedures which govern how they handle and safeguard PHI.

V. IUSO PRIVACY POLICIES

To guide IUSO and its Workforce in maintaining compliance with applicable privacy and security regulations, the Compliance Committee with the assistance of the Privacy and Security Officer shall develop and periodically review policies and procedures to address privacy and security compliance issues. These policies will be appended to this plan after approval and adoption by the Dean and will outline the expectations of IUSO’s Workforce members in using, disclosing and safeguarding PHI which is maintained by IUSO. Each of these policies may be reviewed and revised as needed independent of a review and revision of the entire plan document.

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At minimum IUSO’s policies will address the following areas:

- Uses and disclosures of PHI
  - Routine and Recurring
  - Non-Routine
  - Permitted disclosures to authorities
- Uses and disclosures of PHI for marketing purposes
- Uses and disclosures of PHI for research purposes
- Uses and disclosures of PHI for fundraising purposes
- Minimum Necessary
- Authorizations
- Access by Personal Representatives and Others Involved in a Patient’s Care
- Technical and Physical Safeguards to Protect PHI maintained by IUSO
- Notice of Privacy Practices and Notice Acknowledgment

- Patient Rights
  - Access
  - Amendment
  - Restrictions regarding the Use and Disclosure of PHI
  - Confidential Communications
  - Accounting of Disclosures
  - De-identified Data
  - Limited Data Sets
  - Business Associates
  - Training the Workforce
  - Complaint Handling
  - Non-Retaliation / Waiver of Patient Rights
  - Sanctions
  - Breach Investigation and Notification

VI. EDUCATION AND TRAINING

The HIPAA Privacy Rule mandates that a covered entity train its workforce with respect to the use and disclosure of PHI.

All members of IUSO’s Workforce must receive mandatory general HIPAA awareness training within thirty (30) days of joining the Workforce. In addition, they must receive training on the HIPAA policies and procedures that impact their job functions. Training must be provided to each member of the Workforce whose functions are affected by a material change in the policies and procedures within a reasonable period of time after the material change becomes effective. All members of IUSO’s Workforce will receive a mandatory general HIPAA refresher training every two (2) years.

Students must receive mandatory general HIPAA awareness training at orientation and specific training on HIPAA policies and procedures that impact their clinical functions, prior to beginning their clinical training.

VII. INTERNAL REVIEW AND MONITORING

The Privacy and Security Officer shall review activity at each Clinic and the Central Billing Office annually to evaluate compliance with the general requirements of the HIPAA privacy and security rules.

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Review of the activity of other areas of IUSO outside the Clinics and Central Billing Office to evaluate the area’s compliance with HIPAA shall occur on a periodic basis and/or at the request of the area supervisor, the Dean, the Compliance Committee or as part of a Corrective Action Plan in response to a complaint or identified issue.

If a review identifies issues, the Privacy and Security Officer shall report the issue to the Compliance Committee, Dean, and Associate Dean for Clinical and Patient Care Services as needed. If at the conclusion of any investigation, it appears that there are compliance concerns, a corrective action plan will be formulated in accordance with Section VIII.D. Response and Corrective Action and initiated as quickly as possible.

VIII. REPORTING SYSTEM

A. Reporting Responsibilities

The IUSO maintains an “open door” policy with respect to information of suspected violations of compliance. Members of IUSO’s Workforce are encouraged to report any activity which they believe is in violation of this plan or any legal requirements to one or more of the following persons: their supervisor, the Associate Dean for Clinical and Patient Care Services, the IUSO Privacy and Security Officer, or any member of the Compliance Committee.

It is the responsibility of all members of IUSO’s Workforce, including all faculty, staff and students, to report knowledge of wrongdoing. Any manager or supervisor receiving a report of possible illegal conduct must immediately advise the Privacy and Security Officer.

B. Notification/Hotline

The Privacy and Security Officer will maintain and publicize a telephone line that may be used to report compliance issues or possible violations of HIPAA privacy and security standards and policies. To the extent possible, calls to the “hotline” will remain confidential and anonymous. The “hotline” will be operated in a manner designed to encourage complete disclosure by the caller of information such as a particular description of the activity in question, the department or clinic location in which it has taken place, and the identity of the people who may have knowledge of the relevant facts. A record will be maintained of any reports. Each complaint will be investigated. After a review and investigation, the Privacy and Security Officer will prepare a written report of findings and identify any corrective action that is required. The report shall be provided to the Dean and the Associate Dean for Clinical and Patient Care Services or Associate Dean for Research as applicable. A summary of incidents shall be provided to the Compliance Committee annually.

C. Non-retaliation

The Indiana University School of Optometry prohibits retaliation against any individual who reports actual or suspected violations of the laws, regulations, or policies. All reported violations will be handled with an appropriate level of confidentiality to ensure that the identity of the reporting individual, when known and the identity of the person or persons involved in the suspected violation is only given to those persons with an absolute need to know. In addition, the IUSO does not permit members of its Workforce to force patients to waive their privacy rights under HIPAA.

Adopted: February 22, 2012
D. Response and Corrective Action

Whenever a compliance issue has been identified, the Privacy and Security Officer shall obtain advice and guidance, as needed, from the Office of University Counsel and the University Information Policy Office. There may also be consultation with the Dean, and appropriate clinical or research personnel. The Dean shall make any necessary reports to the Indiana University Board of Trustees.

Corrective action plans shall be designed to ensure not only that the specific issue is addressed, but also that similar problems do not occur in other areas. Corrective action plans may require PHI to be handled in a designated way; that certain training or re-training be conducted; that restrictions be placed on the processes used by particular faculty members or other members of IUSO’s workforce; or that the matter be disclosed to persons or entities outside the IUSO. Sanctions or discipline, in accordance with University rules, may be recommended. If it appears that certain individuals have exhibited a propensity to engage in practices that raise compliance concerns, the corrective action plan should identify actions that will be taken to prevent such individuals from exercising substantial discretion with regard to the privacy and security of PHI.

IX. ENFORCEMENT AND DISCIPLINE

It is each IUSO Workforce member’s responsibility to comply with the law and behave in an honest, ethical manner. This responsibility cannot be delegated or assumed by the University. Violating laws, regulations, University policies, and the policies adopted under this plan or failing to report such violations can result in serious disciplinary action by the University. In addition, violators could be subject to civil or criminal charges by outside regulatory agencies.

Indiana University has a policy of progressive discipline for infractions committed by employees, except where immediate termination of employment is identified as the discipline necessary to correct the situation. Aggravating and mitigating factors will be considered in determining and administering discipline.

To ensure all Workforce members are aware of their obligations and responsibilities:

- All faculty and staff will be required to acknowledge that adherence to the HIPAA Compliance Program outlined in this Plan is a material condition of employment.

- All students will be required to acknowledge that adherence to the HIPAA Compliance Program outlined in this plan is a material condition of their participation in educational and training programs with the IUSO.

X. RESPONSE AND PREVENTION

This HIPAA Compliance Plan is intended to be flexible and readily adaptable to changes in the regulatory requirements and in the health care system as a whole. The Plan will be regularly reviewed to assess whether it is working effectively. The Plan will be revised as experience shows that a certain approach is not effective.

Adopted: February 22, 2012
Scope

This policy applies to all members of IUSO’s workforce who handle protected health information (PHI).

Policy Statement

HIPAA provides all patients with specific rights with regards to their protected health information (PHI). This policy describes each of the rights granted to the patient under HIPAA, how the patient can exercise the right, and IUSO’s response:

1. **The right of a patient to inspect their PHI and to obtain a copy of it.**
   All patients have the right to inspect or obtain a copy of their PHI. Requests for such access must be in writing. A patient’s right to access their PHI is limited to the PHI contained within the “designated record set.”

   *Designated Record Set:* The designated record set is comprised of the medical and billing records about patients maintained by IUSO to make treatment or payment decisions about the patient. It includes any photographs or other images that identify the patient, and includes records from other providers if treatment decisions are based on this information. Billing records will include the charge, payment, and statement history for the patient. The designated record set does not include the following:
   a. psychotherapy notes;
   b. Administrative data containing patient identifiable information including, but not limited to, EHR audit trails, quality assurance reviews, financial remittance advices, and service summary sheets;
   c. PHI that is compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding; and
   d. Data collected for purposes of research which is not used to make treatment decisions about the patient.
Denial of Access: IUSO may deny a patient’s request for access for following reasons:

a. Patient agreed to a temporary denial of access when consenting to participate in research that includes treatment, and the research is not yet complete;
b. A licensed health care professional has determined that access is likely to cause substantial harm to the patient or another person;

Procedures for granting and denying requests for access are outlined in the procedures section.

2. The right of a patient to request an amendment to their PHI.
The patient has the right to request amendment of information collected and maintained about them within their ‘designated record set’ if they believe the information is incomplete or inaccurate. Request for such amendments must be in writing.

Denial of Amendment: IUSO may deny a patient’s request for amendment if it is determined the PHI that is the subject of the request:

a. Was not created by IUSO, unless the patient provides a reasonable basis to believe the creator of the information is not longer available to act on the requested amendment;
b. Is not part of the ‘designated record set’;
c. Would not be available for the individual to access under section 1.
d. Is accurate and complete.

Procedures for granting and denying requests for amendment are outlined in the procedures section.

3. The right to an Accounting of Disclosures made by IUSO.
The patient has the right to receive an accounting of all disclosures of protected health information made by IUSO during the six (6) years prior to the date of the request, except for disclosures for treatment, payment and health care operations, and disclosures based on a patient’s written Authorization to Release Medical Records. Requests for such accounting must be in writing.

Procedures for the maintenance of the accounting of disclosures and processing of such requests are outlined in the procedures section.

4. The right to request restrictions on the uses and disclosures of their PHI made by IUSO.
The patient has the right to request that IUSO restrict certain uses and disclosures of PHI about the patient to carry out treatment, payment or health care operations. Requests for such restrictions must be made in writing.

IUSO is not required to agree to a restriction. If IUSO does agree to the restriction, IUSO may not use or disclose the PHI in violation of such restriction, except the in event such use or disclosure is necessary to provide the patient emergency treatment.

Procedures for granting and denying requests for restriction are outlined in the procedures section.

5. The right to confidential communications.
IUSO shall permit patients to request to receive communications of about their PHI at an alternative location (i.e. at work instead of at home) or via an alternative means (i.e. mail only). Such requests shall be made in writing, and IUSO shall accommodate all such reasonable requests.

Procedures for processing requests for confidential communication are outlined in the procedures section.
**Reason for Policy**

This policy is adopted to ensure IUSO honors all rights granted to its patients under HIPAA.

**Procedures**

1. **The right of a patient to inspect their PHI and to obtain a copy of it.**
   a. *Requests:* If a patient requests access to his/her PHI, the individual receiving the request must obtain a completed Authorization to Release Medical Information prior to granting access *(see Policy on Authorization to Release Medical Information for the requirements for a valid authorization).*
   b. *Denials:* If IUSO denies the patient access to his/her medical record for one of the reasons listed in the policy above, the Privacy Officer shall provide the patient with a written denial explaining the basis for the denial, a statement of the patient’s review rights, and a description of how the patient may file a complaint with IUSO.
   c. *Review:* If the patient requests a review of the denial, a licensed IUSO health care professional who was not directly involved in the decision to deny access will review the case, determine whether or not to deny the access requested based on this policy, and notify the Privacy Officer of the result of the decision. The Privacy Officer shall provide the patient with written notice of the reviewing professional’s determination. If additional assistance is required, University Counsel and University Compliance will be consulted.
   d. *Timing:* All responses to requests for access shall be provided within thirty (30) days of the receipt of the request. If IUSO is unable to take action within this period of time, it may extend the time period for responding by thirty (30) days upon written notice to the patient of the delay.

2. **The right of a patient to request an amendment to their PHI.**
   a. *Requests:* A patient may request an amendment to his or her PHI by completing the Request for Amendment of Protected Health Information form. All requests will be submitted to the Privacy Officer. The request for amendment will be reviewed by the following in order of preference:
      i. the provider who created the record;
      ii. the current treating provider;
      iii. the Chief of Service for the Service in which the patient was last seen
   b. *Granting the request:* If the request for the amendment is granted, IUSO must:
      i. Amend the health information by identifying the records in the designated record set that are affected by the amendment and appending the amendment. All amendment to the health record should indicate the date of the amendment, and under no circumstances should the original record be deleted.
      ii. Notify the patient that the amendment was accepted and ask the patient to identify any relevant persons with which the amendment needs to be shared.
   c. *Denying the request:* If the request for the amendment is denied, IUSO must:
      i. Provide the patient with a written denial explaining the basis for the denial; the patient’s right to submit a written statement disagreeing with the denial and how the individual may file such a statement; a statement that the patient may request that the request for amendment and denial be included with any future disclosures; and a description of how the patient may file a complaint with IUSO.
      ii. Append the patient’s request for an amendment, IUSO’s denial of the request, the patient’s statement of disagreement, if any, and the covered entity’s rebuttal, if any, to the designated record set.
3. The right to an Accounting of Disclosures made by IUSO.
   a. Accounting of Non-routine Disclosures: IUSO will maintain a log of disclosures made without
      the patient’s written authorization. Such disclosures will be logged by the Privacy Officer who
      will be notified of the disclosure in accordance with the Policy on Use and Disclosures of
      Protected Health Information.
      i. The following disclosures do not need to be logged:
         1. Disclosures made to carry out treatment, payment or healthcare operations
         2. Disclosures made to the patient
         3. Disclosures made to persons involved in care
         4. Disclosures that are part of a limited data set
      ii. The information that must be documented for each disclosure is:
         1. the date of the disclosure
         2. the name of the entity or person who received the PHI and, if known, the address and
            contact information
         3. a statement of the purpose of the disclosure or a copy of the written request for the
            disclosure
         4. description of the protected health information disclosed
   b. Accounting of Disclosures for Purposes of Research: If a researcher within IUSO obtains access
      to patient records pursuant to a ‘Waiver of Authorization’ such disclosure must be logged in
      accordance with the procedures laid out in IU Research SOPs. The Researcher will apprise the
      Privacy Officer of the access and provide the information laid out in the IU Research SOPs to
      ensure the disclosure is logged.
   c. Requests for Accounting: All requests for accounting of disclosures must be submitted in writing
      to the Privacy Officer. The Privacy Officer will consider, approve or deny requests.
   d. Documentation: The request for accounting and the written accounting provided shall be
      maintained in the health record.
   e. Timing: All responses to requests for accounting shall be provided within sixty (60) days of the
      receipt of the request. If IUSO is unable to take action within this period of time, it may extend
      the time period for responding by thirty (30) days upon written notice to the patient of the delay.

4. The right to request restrictions on the uses and disclosures of their PHI made by IUSO.
   a. Requests: All patient requests for a restriction on the use or disclosure of their PHI shall be
      submitted in writing to the Privacy Officer. The Privacy Officer will, in consultation with the
      Associate Dean of Clinical Care, consider, approve or deny requests.
   b. Granting the request: If the request for the restriction is granted, the Privacy Officer will notify
      the Clinic Administrator and Clinic Financial Officer of the restriction who will coordinate with
      clinic staff to ensure the restriction is followed. The restriction will be documented in the
      medical record
   c. Denying the request: If the request is denied the patient will be informed in writing.
   d. Terminating the restriction: IUSO may terminate the agreement to the restriction if:
      i. The patient agrees to or requests the termination and the agreement is documented
      ii. The covered entity informs the individual that it is terminating the restriction. In this case the
          termination is only effective with respect to PHI created or received after the patient is
          informed.
   e. Documentation: The request for restriction and any communications related to the request shall
      be maintained in the health record.
f. **Timing:** All responses to requests for amendment shall be provided within sixty (60) days of the receipt of the request. If IUSO is unable to take action within this period of time, it may extend the time period for responding by thirty (30) days upon written notice to the patient of the delay.

5. **The right to confidential communications.**
   a. Absent a special request from the patient, IUSO will contact the patient utilizing address, phone number, and email provided on the patient demographic form.
   b. The patient may designate a preferred method of communication on the patient demographic form, but such designation shall not prevent IUSO from utilizing other methods if they are unable to reach the patient through the preferred method.
   c. If the patient wishes to request that confidential communications only take place to specified locations, the patient must submit such request in writing to the Privacy Officer.
   d. The Privacy Officer will, in consultation with the Associate Dean of Clinical Care, consider, approve or deny requests. IUSO shall accommodate all reasonable requests.
   e. IUSO may retain the right to use alternative means to contact the patient for purposes of payment if the patient cannot be reached at the location specified, provided the patient is informed of this in advance.

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**Definitions**

**Designated Record Set** -- (1) A group of records maintained by or for a health plan or health care provider, that is:
   (i) The medical records and billing records about individuals maintained by or for a covered health care provider;
   (ii) The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
   (iii) Used, in whole or in part, by or for the health plan or health care provider to make decisions about individuals.

   (2) For purposes of this definition, the term **record** means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a health plan or health care provider.

**Protected Health Information** – information, (i) which is created or received by a healthcare provider, health plan, or healthcare clearinghouse; about a patient and (ii) including demographic information that may identify a patient that relates to the patient's past, present or future physical or mental health or condition, related health care services or payment for health care services.

**Workforce** – includes all employees, volunteers, trainees, and other persons whose conduct is under the direct control of IUSO, whether or not they are paid by IUSO

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**Forms**

*Authorization to Release Medical Information*

*Request for Amendment of Health Information*
Privacy and Security—
Accessibility and Security of Patient Information

Scope

This policy applies to all protected health information (PHI) collected and maintained by IUSO in the course of its clinical functions, including all demographic, health and financial information.

Policy Statement

In order to protect patient medical records from loss, improper modification or inappropriate disclosure of information contained within the record, IUSO will take appropriate precautions to prevent unauthorized access to an individual’s personal health information. IUSO will store medical records properly and will strive to protect medical records from unintentional damage.

Access to Clinic Computer Systems:

The clinic’s current patient management system (Compulink) and all legacy systems may only be accessed by approved members of IUSO’s workforce, including patient caregivers, clinic support staff, and members of the central billing office. Access will be controlled and authenticated by an individual userid and password, and each member’s access will be defined as narrowly as possible to allow the members to perform his or her job functions. No access permission requests will be acted on without supervisor authorization.

Storage and Access of Medical Records

All medical records are the property of IUSO. Medical records should not leave the IUSO clinic facilities except in the following circumstances:

a. Original medical records may be removed from the premises if by court order, subpoena, or other statute.

b. The medical records have been identified for transfer to authorized storage facilities.

Paper medical records will be stored in limited access areas, and access will be granted only to authorized members of IUSO’s Workforce.
Protected Health Information in Other Paper Files
Any protected health information contained in paper files which are not part of the patient’s official medical record (i.e. Clinic financial information, audit records, quality assurance records, eyewear center inventory logs, etc.) shall be stored in a manner consistent with the University’s guidelines for handling critical data and the procedures listed below.

Transmission of Protected Health Information
Medical Records and other Protected Health Information will only be transmitted using the following approved methods: U.S. Mail, fax, approved courier, and IU’s secure file upload site (slashtmp). Protected Health Information should not be transmitted via email.

Disposal of Protected Health Information
All Protected Health Information should be securely disposed of as follows:
- Paper files shall be destroyed using a University approved document destruction vendor.
- Hard-drives and other electronic devices which contained PHI should handled in accordance with University guidance for Securely Removing Data

Reason for Policy
This policy is adopted to promote the privacy and security of an individual’s protected health information when it is maintained by IUSO according to the standards outlined by State and Federal Law. IUSO has adopted this policy to ensure that all Protected Health Information (PHI) in IUSO’s control is stored, transmitted and destroyed in a manner which will prevent inadvertent or unauthorized disclosures of PHI.

Procedures

- Patient Management System Access:
  - A userid and passwords is required to access the clinic’s patient management system (Compulink). No Workforce Member should access Compulink under another member’s userid.
  - Passwords will be periodically changed and are encrypted during transmission on the network. Passwords may not be:
    - Shared with any other person.
    - Embedded in computer log-on scripts or other applications
    - Written down in accessible locations, or
    - Stored on an individual user’s computer
  - Computers will be positioned to limit shoulder surfing as much as possible. All eyewear center computers will be locked to workstation desks. All intern laptops will be stored overnight in a locked cabinet.
  - All computers should be locked before being left unattended.
  - Workforce members will logoff Compulink prior to leaving for the day or allowing another workforce member to access the system.

- Access and Storage of Paper Medical Records:
  - Chart Room: The chart room for each clinic will be located in a separate room behind the patient registration desk in an area that is not readily accessible to the general public. The patient registration desk will be manned at all times during clinic hours and access to the chart room will be limited to
    c. IUSO Clinical Faculty and Students who have patient care responsibilities for the patient
d. IUSO support staff with patient care administrative functions
To aid in identifying authorized individuals IUSO faculty, staff and students who work in clinics are issued staff badges and must wear them at all times while in clinic.

- **Faculty Offices:** Faculty members should make every effort not to keep medical records in their offices. If a faculty member does have medical records in their office for completion, the office should be locked if left unattended.

- **Long term Storage:** Medical records will be transferred to long-term storage after three years of inactivity. Medical records in off-site long term storage will be kept in a University approved secure facility. Transfer of medical records to long term storage will be done at the request of the IUSO Clinic Administrator.

**Protected Health Information in Other Paper Files**

- Outside of the medical record, paper copies of protected health information should be maintained in files only if there is a business reason to do so.

- Printed materials containing PHI should not be left unattended at copy machines, printers, or fax machines.

- Paper records should be maintained in locked file cabinets and offices.

- Files should be periodically reviewed to determine if the information is still needed.

- **Clinical support staff should consult with Clinic Administration and obtain approval prior to storing protected health information in files outside the medical record.**

**Transmitting Protected Health Information**

- **U.S. Mail** – Medical records and protected health information may be transmitted via U.S. mail. Efforts should be made to verify the address prior to sending.

- **Fax** – Medical records and protected health information may be transmitted by fax. When faxing PHI the following procedures should be followed:
  - Anyone sending PHI by fax must use a standard cover sheet for the clinic transmitting the information.
  - Anyone sending a fax that contains PHI will double check the accuracy of the destination number in the fax machine’s display before sending the fax.
  - All fax machines which transmit or receive PHI must be located in a limited access area. The fax machines will be set not to retain a copy of the information faxed on its hard-drive.

- ** Courier** – Only couriers which have been approved by IUSO clinic administration may be used to transmit PHI. Clinic Administration will maintain a list of approved courier services.

- **Electronic Transmission** – PHI should not be sent via email. If it is necessary to transmit a file containing PHI electronically, the IU site [https://slashtmp.iu.edu](https://slashtmp.iu.edu) should be used.
  - The Critical version of slashtmp should be used.
  - A password must be set and should be sent to the recipient in a separate email.

**Disposing of Protected Health Information:** Protected Health Information should be securely disposed of when it is no longer needed.

- Paper containing PHI must be disposed of in the locked gray shred bins. It should never be disposed of in the trash or recycling.

- Any computers, hard-drives, or other media devices which contained PHI must be wiped using a University approved method or physically destroyed prior to disposal or resale.
Definitions

Protected Health Information – information, (i) which is created or received by a healthcare provider, health plan, or healthcare clearinghouse; about a patient and (ii) including demographic information that may identify a patient that relates to the patient's past, present or future physical or mental health or condition, related health care services or payment for health care services.

Workforce – includes all employees, volunteers, trainees, and other persons whose conduct is under the direct control of IUSO, whether or not they are paid by IUSO
Indiana University School of Optometry Policy

SUBJECT: Confidentiality Policy

APPROVAL DATE: 

EFFECTIVE DATE: 

REVIEW DATE: 

POLICY NO: 

RATIONALE: The Indiana University School of Optometry (IUSO) is committed to conducting business in compliance with all applicable laws and regulations. The medical record is maintained for the benefit of the patient, faculty, and the clinics. We have a statutory obligation to maintain the confidentiality and the integrity of medical information regarding treatment rendered to patients. Guidelines pertaining to the release of such information are established to protect the patient's right to privacy; to provide information to authorized providers of patient care; for approved research; for insurance, legal matters and other legitimate business purposes. Authorization by the patient or his representative is necessary before such information may be released according to procedures, state and federal regulations. The policy is also intended to protect IUSO proprietary information.

SCOPE: This policy applies to all faculty, staff and agents of IUSO. This policy includes the medical records of all patients. It also includes patient information that any employee sees, hears, or otherwise learns in performing regular daily work, or learns in any manner while on and off duty. Electronic medical record information is also included.

DEFINITIONS: MEDICAL RECORDS are records which include paper medical record documents in the patient's medical record folder, all documents being processed for insertion into the medical record folder, all department/clinic/office patient files, medical records stored in any other medium (i.e. microfilm, optical imaging, laser disc, etc.) and portions of the medical record stored on any computer system.
AUTHORIZED RESEARCHERS include those individuals who are conducting clinical trials under the auspices of the Institutional Review Board or those who have presented a completed "Authorization for Chart Review" request for approval.

POLICY:

I. Confidentiality Requirement
   A. All individuals engaged in the collection, handling, or dissemination of patient medical information shall be specifically informed of their responsibility to protect the confidentiality of the medical record and the penalties for violation of this trust. At the time of employment, all employees shall sign a commitment of confidentiality. Penalties for proven violation of the confidentiality of patient information shall include immediate disciplinary action up to and including termination.
   B. The collection and discussion of patient data, whether by interview, observation, or review of documents, shall be conducted in a setting that provides appropriate privacy and protection of the information from unauthorized individuals. Discussions regarding individual patients should also be conducted in settings that protect confidentiality.
   C. All service organizations which process patient identifiable health information (e.g. medical record photocopy services, transcription vendors, etc.) shall agree in writing to conditions which mandate the security of patient information and specify the method by which the information is handled and transported.

II. Confidential Information
   A. Confidential information includes patient demographic information, information regarding the nature and extent of the patient’s injury, illness or condition, symptoms, diagnosis and treatment, the service to which the patient is hospitalized, and any other information that documents communication between the patient and the practitioner. The patient has the right to expect that the record pertaining to his care will be treated as confidential, and we have the obligation to safeguard these records against unauthorized disclosure. Protected Health Information includes but is not limited to:

   1. Physical, medical, and psychiatric records including paper, photo, video, diagnostic and therapeutic reports, laboratory and pathology samples;
   2. Patient insurance and billing records;
   3. Mainframe and department based computerized patient data and alphanumeric radio pager messages;

   2
4. Visual observation of patients receiving medical care or accessing services; and
5. Verbal information provided by or about a patient.

B. Information related to employees and related to Business information is also considered to be confidential and shall be protected. Employee and Business information includes, but is not limited to, the following:

1. Employee home telephone number and address;
2. Spouse or other relative names;
3. Social Security number or income tax withholding records;
4. Information related to evaluation of performance;
5. Other such information obtained from IUSO records which if disclosed, would constitute an unwarranted invasion of privacy; or
6. Disclosure of Confidential business information that would cause harm to the IUSO.

III. Record Storage
All medical records, including hospital records, clinic records, physician records, and facsimiles of the record, shall be housed in secure areas, and are subject to stated policies of confidentiality of patient health information. Access to areas housing records shall be limited to authorized personnel. Computer-stored information shall be security level protected by issuance of user identification codes and passwords.

IV. Routine Administrative Functions
Direct access to patient medical records for routine business functions shall not be permitted except to treating physicians and employees who: display the proper identification, have a “need to know” to perform their job duties, and have been instructed on policies of confidentiality including penalties arising from violation as specified in #1. Release of the medical record is limited to individuals on a “need to know basis” for the following purposes only:

A. To complete permanent documentation of the course of the patient’s illness and medical treatment;
B. To facilitate communication between physicians and other professionals contributing to the patient’s care;
C. To provide continuity of patient care for subsequent providers of patient care;
D. To provide a basis for review, study, and evaluation of the patient care processes for Peer Review, Quality Management, and Risk Management purposes;
E. To provide clinical data for approved research, study, and education; and
F. For legitimate business purposes such as provision of:
   1. statistical data for administrative decision making and planning;
   2. data to third parties concerned with the patient's treatment including insurance companies, governmental and regulatory agencies, and others as specified by law (e.g. communicable diseases, coroner's cases, burns, cancer registry reporting, etc.);
   3. documentation for billing and insurance claims processing;
   4. appropriate access to medical records and data as required for licensing and accreditation purposes.

V. Restricted Records
Medical records may be restricted at the request of a patient, Risk Management or Legal Counsel, or Director of IUSO. Restricted medical records will be available if needed for patient care purposes or as directed by Legal Counsel, Risk Management or the Dean of IUSO.

VI. Disciplinary Action
Failure to adhere to this policy will result in the appropriate disciplinary and/or legal action, up to and including termination.

Approval Body:

Approval Signature: Name, Title  
Date

Approval Signature: Name, Title  
Date
Privacy and Security—
Authorization to Release Medical Information

FULL POLICY CONTENTS

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ADDITIONAL DETAILS

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Scope

This policy applies to all members of IUSO’s workforce who handle protected health information (PHI).

Policy Statement

Except as provided by University or IUSO policy or otherwise permitted by law, IUSO will only use or disclose Protected Health Information (PHI) pursuant to a valid HIPAA compliant Authorization to Release Medical Information (“Authorization”).

For an Authorization to be considered valid it must meet the following requirements:

- The authorization is writing, is dated, and is signed or otherwise authenticated by the patient or patient’s personal representative;
- The authorization specifies the information to be disclosed;
- The authorizations specifies the person, class of persons or entity authorized to disclose the information;
- The authorization specifies the person or persons to receive the information;
- The authorization describes the purpose of the disclosure. (The statement ‘at the request of the individual’ is a sufficient description when the individual initiates the authorization); and
- The authorization includes an expiration date or expiration event that relates to the individual or purpose of the use or disclosure.

IUSO shall not condition the provision of treatment to any patient on the receipt of a valid HIPAA Authorization, except in the following situations:

- **Research:** IUSO may condition the provision of research-related treatment on the receipt of a valid HIPAA Authorization for the use or disclosure of PHI for such research; and
- **Health Care created for a Third Party’s Information:** IUSO may condition the provision of health care solely for the purpose of creating PHI for disclosure to a third party on the receipt of a valid HIPAA Authorization for disclosure of that PHI to the third party.
Reason for Policy

This policy is adopted to provide direction on what a valid Authorization for Release of Medical Information must contain according to the standards outlined by State and Federal Law, and to outline the procedures for responding to the receipt of such an Authorization.

Procedures

1. Patients or designated individuals requesting copies of their medical records shall complete an Authorization to Release Medical Information form. At minimum the Authorization should provide the following information
   • Patient’s name and date of birth
   • The name of the facility/person to which the PHI is to be released
   • Description of the purpose for which the PHI is to be used/disclosed
   • Description of information to be released. The information released must be limited to that specified by the patient. If the patient would like a copy of their entire medical record they may do so by checking the “Other” box and specifying ‘Complete Record’ or similar language.
   • Authorization must be signed by the patient or patient’s personal representative. If signed by patient’s personal representative, authorization shall include a description of his/her authority to act for the individual to whom the PHI pertains. If the individual is unable to sign and the HIPAA authorization is read to the individual, specify the reason the individual is unable to sign and obtain the signature of the Witness.
   • The date on the authorization must be no more than sixty (60) days old unless the Authorization specifies a different expiration date.

   A copy of the signed HIPAA Authorization shall be provided to the individual upon request.

2. Invalid HIPAA Authorizations: An invalid HIPAA Authorization shall not be used for the use or disclosure of PHI. A HIPAA Authorization is invalid when:
   • The expiration date or event has passed and this is known by IUSO
   • The Authorization does not contain all the elements listed above
   • IUSO has knowledge that the HIPAA Authorization has been revoked
   • IUSO has knowledge that any material information in the HIPAA Authorization is false

3. Verification of Identity: The Authorization and the medical record should be reviewed to assure that the signature and patient date of birth matches the documentation in the medical record.

4. Responding to HIPAA Authorization: Medical records will be copied and forwarded within 30 business days of receipt of a valid HIPAA Authorization. IUSO may charge a reasonable fee for access to patient medical information not to exceed the State statutory limits as follows:
   a. One dollar ($1) per page for the first ten (10) pages.
   b. Fifty cents ($.50) per page for pages eleven (11) through fifty (50).
   c. Twenty-five cents ($.25) per page for pages fifty-one (51) and higher

5. Retention: Copies of all HIPAA Authorizations shall be kept in the patient’s medical record.
6. **Revocation of HIPAA Authorization**: A patient or patient’s personal representative may revoke a HIPAA Authorization at any time in writing except to the extent IUSO has acted in reliance on the HIPAA Authorization. Revocation shall be effective on the date IUSO receives written notice of such revocation.

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**Definitions**

**Protected Health Information** – information, (i) which is created or received by a healthcare provider, health plan, or healthcare clearinghouse; about a patient and (ii) including demographic information that may identify a patient that relates to the patient's past, present or future physical or mental health or condition, related health care services or payment for health care services.

**Workforce** – includes all employees, volunteers, trainees, and other persons whose conduct is under the direct control of IUSO, whether or not they are paid by IUSO

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**Forms**

*Authorization to Release Medical Information*
AUTHORIZATION TO RELEASE
MEDICAL INFORMATION

IMPORTANT PLEASE READ: This form authorizes your health care provider to release health information regarding your care or treatment to the individual or organization you identify as set out below:

I hereby authorize IU School of Optometry to: (check one) Purpose of Request:
[ ] Provide records to: Name and address of person or organization
_________________________________________________________ __________________________________________________________
Name and address of person or organization
Phone Fax
[ ] Obtain records from the entity listed below:

The medical records of:

Patient Name:

Last First Middle/Maiden

Address:

Street City State Zip

Date of Birth: Telephone #:

Records to Be Released From: [ ] Indiana University School of Optometry [ ] Entity Listed Below

Name and address of the provider

Please release the following information: (please check minimum information needed to achieve purpose)

[ ] Eyeglasses Prescription [ ] Contact Lens Information [ ] Copy of Last Exam
[ ] BMV Application [ ] School Report [ ] Insurance Disability Form
[ ] Summary Report/Letter [ ] Other (specify):

I understand this release may include disclosure of information relating to treatment for alcohol/substance abuse, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), sexually transmitted disease (STD), or for psychiatric treatment or counseling, unless I specify otherwise below:

Please do not release any information concerning treatment for the following:

__________________________________________________________________________________

I UNDERSTAND THIS AUTHORIZATION MAY BE REVOKED AT ANY TIME EXCEPT TO THE EXTENT ACTION HAS BEEN TAKEN BASED UPON IT. THIS AUTHORIZATION WILL EXPIRE IN 60 DAYS FROM THE DATE SIGNED UNLESS OTHERWISE SPECIFIED:

Information used or disclosed because of this authorization may be further disclosed by the recipient and therefore no longer protected.

Date: Signature:

Patient

Signature: / Parent/Guardian

If Patient Unable to Sign: Witness

Reason

IUSO may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization except as allowed under the HIPAA regulations.

Release by Date

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REQUEST FOR AMENDMENT OF HEALTH INFORMATION

IMPORTANT PLEASE READ: As a patient of IUSO you are entitled to request IUSO amend your health information if you believe it contains inaccurate or incomplete information about you. If you wish to request an amendment to your health information, you must complete the form and return it to: Privacy Officer, IU School of Optometry, 800 E. Atwater Ave, Bloomington, IN 47405.

I am requesting amendment of the medical records of:

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Last</th>
<th>First</th>
<th>Middle/Maiden</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Birth:</th>
<th>Telephone #:</th>
</tr>
</thead>
</table>

What Needs to be Amended:

1. Please describe the information you wish to amend:

2. Please explain how the information is inaccurate or incomplete (you may attach additional information if necessary):

I understand that the provider may or may not supplement the medical record with an addendum based on my request. In any event, this request for an amendment will be made part of my permanent medical record:

<table>
<thead>
<tr>
<th>Date:</th>
<th>Signature:</th>
</tr>
</thead>
</table>

Signature: ____________________________ / ____________________________

Parent/Guardian Relationship

FOR INTERNAL USE ONLY

<table>
<thead>
<tr>
<th>Date Received:</th>
<th>[ ] Accepted</th>
<th>[ ] Denied</th>
</tr>
</thead>
</table>

If Denied, check reason for denial:

[ ] PHI was not created by this organization
[ ] PHI is not part of patient’s designated record set
[ ] PHI is not available to the patient for inspection under Federal law (e.g. psychotherapy notes)
[ ] PHI is accurate and complete

Signature of Determining Provider:

[ ] Individual was informed of denial in writing (Attach Amendment Denial Letter)

| Signature/Title of Staff Member | Date |

Additional Comments:
INDIANA UNIVERSITY SCHOOL OF OPTOMETRY

CODE OF CONDUCT

The mission of the Indiana University School of Optometry (IUSO) is to protect, advance and promote the vision, eye care and health of people worldwide by preparing individuals for careers in optometry, the ophthalmic industry and vision science, and by advancing knowledge through teaching, research and service. As an educational institution, IUSO subscribes to the highest professional, ethical and moral values. As part of its educational responsibility, a corollary and essential IUSO mission is to ensure that its graduates understand and are prepared to carry out their clinical tasks in compliance with applicable laws, rules, and regulations. By establishing this Code of Conduct, the faculty, staff and students of the IUSO, affirm their ongoing commitment to provide high quality education, patient care to individuals seeking health care services and assure that the school’s research efforts are conducted under high ethical and legal standards.

The IUSO requires faculty, staff and students to act in a manner, consistent with all applicable federal and state laws, governmental regulations and standards, as well as any applicable code(s) of conduct established from time to time by Indiana University. The following is a listing of some of the handbooks currently in place at the University level, applicable to faculty, staff and students:

Faculty: [http://www.indiana.edu/~deanfac/acadhbk/acad_handbk_2006.pdf](http://www.indiana.edu/~deanfac/acadhbk/acad_handbk_2006.pdf)
Staff: [http://www.indiana.edu/~uhrs/policies/index.htm](http://www.indiana.edu/~uhrs/policies/index.htm)
Students: [http://dsa.indiana.edu/Code/index1.html](http://dsa.indiana.edu/Code/index1.html)

**Purpose of Our Code of Conduct**

This Code of Conduct provides guidance to all IUSO faculty, staff and students, beyond the guidance given in the general university documents listed above. This Code is designed to assist those to whom it applies in carrying out daily activities within applicable ethical and legal standards, and forms a component of our overall Compliance Plan. These obligations apply to our relationships with patients, affiliated clinicians, third-party payors, funding agencies, scientific collaborators, subcontractors, independent contractors, vendors, consultants, and one another. This Code is mandatory and must be followed.

**General Policy Statement**

The IUSO is in a position of trust with respect to many external organizations and agencies. Additionally, all IUSO personnel have a responsibility to the government, patients and the public in general to act prudently and ethically when conducting business activities, directly or indirectly, for IUSO. Ethical conduct has been and continues to be the very foundation of IUSO.
Leadership Responsibilities

While all IUSO faculty, staff and students are obligated to follow our Code we expect our leaders to set the example, to be in every respect a model. They must ensure that those within their areas of responsibility have sufficient information to comply with the law, regulation, and policy, as well as the resources to resolve ethical dilemmas. They must help to create a culture within the school that promotes the highest standards of ethical behavior and compliance. This culture must encourage everyone in the organization to voice concerns when they arise.

IUSO Commitments

To our students: IUSO has an ethical responsibility to provide an environment that is supportive for learning. Faculty and staff will help provide clear communications involving student participation in the clinics and classes. They will also provide feedback on progress. IUSO will provide help should it be required, although it is acknowledged that there are limits to that help and the student shares in the responsibility for learning the material and procedures that are taught. IUSO commits to providing constructive feedback not only on learning related to the professional degrees, but also about the requirements for interacting constructively in a clinical or laboratory setting. The students will be provided a learning environment that is characteristic of professional and ethical health care providers.

To our patients: We are committed to providing quality care that is sensitive, compassionate and cost effective.

To our IUSO and Indiana University colleagues: We are committed to an environment that treats all colleagues with fairness, dignity, and respect, and affords them an opportunity to grow, to develop professionally, and to work in a team environment in which all ideas are considered.

To our third-party payors: We are committed to dealing with our third-party payors in a way that demonstrates our commitment to contractual obligations and reflects our concern for quality healthcare and bringing efficiency and cost effectiveness to healthcare. We encourage our private third-party payors to adopt their own set of comparable ethical principles to explicitly recognize their obligations to patients as well as the need for fairness in dealing with providers.

To our regulators: We are committed to an environment in which compliance with rules, regulations, and sound business practices is woven into the IUSO culture. We accept the responsibility to self-govern and monitor adherence to the requirements of law and to our Code of Conduct.

To the communities we serve: We are committed to understanding the particular needs of the communities we serve and providing these communities quality service.
We realize as an academic teaching facility that we have a responsibility to help those in need. We proudly support charitable contributions and events in the communities we serve in an effort to promote good will and further good causes.

**Third-Party Payors**

**Coding and Billing for Services**

We will take care to ensure that all billings to government and private insurance payors reflect accuracy and conform to all pertinent federal and state laws and regulations. We prohibit any employee, faculty or staff member of the IUSO from knowingly presenting or causing to be presented claims for payment or approval, which are false, fictitious, or fraudulent. As part of our documentation effort, we will maintain current and accurate medical records.

IUSO policies require IUSO faculty, staff, and students to conduct IUSO business transactions related to billing for patient services with the highest level of honesty, accuracy and fairness. Each situation needs to be examined under this standard. No unethical practice will be allowed based on the assertion that it is “customary” outside IUSO or that it serves some other worthy goal. Expediency should never compromise integrity.

IUSO students, faculty and staff must be forthright in dealing with any billing inquiries. Requests for information will be answered with complete, factual, and accurate information, in a manner consistent with the policies of the IUSO. IUSO will cooperate with and be courteous to IU and all government inspectors and provide them with the information to which they are entitled during an inquiry.

**Regulatory Compliance**

**A. Compliance with Laws**

We will transact the business of the IUSO in compliance with the laws of the jurisdictions in which it does business. In any instance where IUSO compliance plan policies appear difficult to interpret or apply, or where there may appear to be some conflict with our principles, IUSO faculty and staff should contact the Office of University Counsel or the IU office responsible for compliance matters. Questions about interpretation or application of laws and regulations should be referred to the Office of University Counsel.

**B. Compliance with Contractual and Grant Obligations**

In addition to laws and regulations with respect to billing issues, we consider the obligations of IUSO under its contractual arrangements with the government, suppliers, donors and others a high priority. In any instance where particular contractual or grant requirements are difficult to interpret or apply, the research administrator or the party who signed the grant or contract on behalf of IUSO should be consulted.
C. Compliance with Standards of Integrity and Quality

IUSO recognizes that it must maintain a reputation for integrity, which includes, but is not limited to, compliance with laws and regulations, its contractual and grant obligations and University policies. Any appearance of misconduct or impropriety can be very damaging to IUSO. All IUSO faculty, staff and students must strive at all times to maintain the highest standards of integrity and quality.

Any business activity of the IUSO that is not specifically subject to laws and regulations should be conducted using rules of fairness, honesty, and respect for the rights of others.

IUSO will provide access to education and resources regarding the compliance program at IUSO.

**License and Certification Renewals**

Faculty and staff in positions that require professional licenses, certifications, or other credentials are responsible for maintaining the current status of their credentials and shall comply at all times with Federal and state requirements applicable to their respective disciplines. To ensure compliance, IUSO may require evidence of the individual having a current license or credential status. Adverse action, of any nature or duration, taken by any licensure, certification or credentialing body must be promptly reported to the IUSO Dean or the Dean’s designee.

**General Responsibilities**

A. Individual Responsibility

Ethics and integrity are the responsibility of every student, faculty or staff member of the IUSO. Therefore, every member of IUSO, and any other person acting on behalf of the IUSO, is responsible for ethical conduct consistent with this Code and with IUSO’s policies. IUSO administration and supervisors must assume responsibility for ensuring their conduct and the conduct of those under their supervision complies with this Code. IUSO faculty, staff and students must be especially careful to avoid even the appearance of misconduct or impropriety.

**Reporting of Suspected or Actual Violations**

A. Personal Obligation to Report

IUSO is committed to ethical and legal conduct that is compliant with all relevant laws and regulations and to correcting wrongdoing wherever it may occur in the organization. Every student, faculty and staff member has an individual responsibility for reporting any activity by any IUSO student, faculty and staff member, subcontractor, or vendor that they reasonably believe to violate applicable laws, rules, regulations, or this Code.
Faculty, staff and students are expected to be knowledgeable about and ensure compliance with relevant and applicable laws and regulations related to their activities and position. In addition, violations or suspected violations should be immediately reported to a supervisor or member of management, the IUSO Compliance Officer, the IUSO hotline or any member of the IUSO Compliance Committee as required by the IUSO Compliance Plan.

B. Reporting Anonymously

Suspected or actual violations of laws, statutes, regulations or policies related to billing may be reported anonymously to the IUSO hotline. The hotline number is 812-856-0382.

C. Reporting to Management

Suspected violations of applicable laws, regulations, government contracts or grant requirements or this Code should be reported. This reporting should normally be made initially through standard management channels, beginning with the immediate supervisor. Alternatively, reports may be made to a higher level of management or to the Office of University Counsel, the IUSO Compliance Office or any member of the IUSO Compliance Committee.

D. Confidentiality

Reporting suspected violations is a service to IUSO and the good faith reporting of a suspected violation will be subject to the IU whistleblower policy. To the extent possible, confidentiality of any reported incident will be maintained except to the extent necessary to conduct the investigation and to comply with any applicable laws such as the Open Records Act.

E. Accurate Reporting

Any report of wrongdoing must be based on a good faith belief that wrongdoing has occurred. Reports of wrongdoing that are fabricated or based on information that is known to be false will result in appropriate disciplinary action up to and including immediate termination.

G. Cooperation

IUSO students, faculty and staff are expected to cooperate fully with any investigation of an allegation of wrongdoing or misconduct. During any inquiry or a government inspection, documents must never be concealed, destroyed, or altered. Students, faculty and staff will demonstrate candor and honesty in responding to anyone conducting an inquiry including the government representatives. Students, faculty and staff should not attempt to cause another colleague to fail to provide accurate information or obstruct, mislead, or delay the communication of information or records relating to a possible violation of law.
Conflicts of Interest

All IUSO students, faculty and staff should be sensitive to situations that could raise questions of potential or apparent conflicts between personal interests and the interests of IUSO. As part of the IUSO community, each of us should consider ourselves as persons in positions of trust, and each of us should conduct ourselves accordingly. We must be particularly aware of situations where there exists a conflict between the private interests of a person and the official responsibilities of a person. Such conflicts can involve governmental agencies, investments, private companies, present or prospective employees or members of the communities in which we operate. For additional guidance on conflicts of interest you should review the other applicable policies or procedures (Research: http://www.researchadmin.iu.edu/cs-coi.html Staff: http://www.indiana.edu/~uhrs/policies/uwide/coi.htm).

Confidential Information

The IUSO is entrusted with many kinds of confidential, proprietary and private information. It is imperative that those who have access to this information do not make any unauthorized or impermissible disclosures of the information, either during or after employment.

Gratuities and Kickbacks

A. Governmental Officials

IUSO students, faculty and staff shall not give, offer or promise anything of value to any government official to enhance relations with that official or the government, regardless of whether the official is in a position to influence any government decision with respect to IUSO or its activities.

B. Commercial Insurance Payors and Others

IUSO students, faculty and staff shall not give, offer or promise anything of value to any commercial insurance payor or others for the purpose of obtaining or receiving improper favorable treatment. Nor shall an IUSO student, faculty or staff solicit or accept anything of value from any commercial insurance payor or others for such a purpose.
C. Items of Nominal Value

Whether a gift of nominal value may be given or received by an IUSO student, faculty or staff member may be governed by a variety of laws, rules, regulations and policies. In some instances it may be acceptable to give or receive a gift so long as it is considered of nominal value. However, before accepting or giving an item of nominal value other applicable policies and procedures should be referenced for guidance on the appropriateness of giving or accepting the gift (http://www.indiana.edu/~purchase/policies/p34.html).

Financial Reporting and Billing

All IUSO accounts, financial reports, expense reimbursements, time sheets, and other documents, including those submitted to government agencies, must be accurate, clear and complete. All entries in IUSO books and records, including accounts and individual expense reports, must accurately reflect each transaction.

Research

IUSO follows high ethical standards in any research conducted by its students, faculty and staff. IUSO does not tolerate the misuse of research funds received from governmental or private sources. Individuals involved in research projects are responsible for assuring that all direct research moneys are used for the purpose designated by the grant or contract and that all accounts for research projects properly reflect the expenditures for the particular grant or contract. As in all accounting and financial record keeping, our policy is to submit only true, accurate, and complete financial information related to research grants.

All personnel applying for or performing research of any type are responsible for maintaining high ethical standards in any written or oral communications regarding their research projects as well as following appropriate research guidelines.

Acknowledgment Process

IUSO requires all colleagues to sign an acknowledgment confirming they have received and are responsible to read the Code, and understand it represents mandatory policies of IUSO. New employees, faculty and staff will be required to sign this acknowledgment as a condition of employment.

Adherence to and support of IUSO’s Code of Conduct, and participation in related activities and training, will be considered in decisions regarding hiring, promotion, and compensation for all employees, faculty and staff.

Approved and adopted by faculty, students and staff of IUSO December 8, 2008.
1. Within the organization, information about services, programs, systems, costs, volumes, patients, guarantors, families, physicians, physician groups, other healthcare providers, payors and staff is available. Access to information is available in many formats and media. Some information is necessary and accessible for general public awareness, wellness, safety, and use. In addition, other information is necessary and accessible for mandatory and voluntary reporting to appropriate health and regulatory agencies. This Commitment of Confidentiality applies to the use and disclosure of information considered to be sensitive information.

2. Sensitive information is a broad term referring to business critical information about its services, finances, programs, patients, employees, students, researchers, and its medical staff that should not be obtained by or accessible to the public, is subject to certain regulatory and operational protection, or protected under policy. Sensitive information includes patient protected health information.

3. Patient protected health information, as defined by the HIPAA Privacy Rule, includes patient demographic information, information regarding the nature and extent of a patient’s injury, illness, or condition, symptoms, diagnosis and treatment, the service to which a patient is hospitalized, and any other information that documents communications with the patient and the practitioner.

4. All sensitive information is to be considered confidential. Reasonable precautions are to be taken to protect sensitive information from unintentional or unauthorized inquiry, update, alteration, destruction or removal. It is to be safeguarded by all information customers at all times, both on duty and off duty.

5. Information Customers is defined as employees, physicians, physician office staff, students, volunteers, vendors, consultants, contractors, regulatory agencies, payors, and/or anyone else having a need to access sensitive information or data to perform his or her professional responsibilities.

6. Information customers will only access (read, add, change or delete) or disclose information for which they have a business reason to do so. At no time shall information be accessed or disclosed for a personal, unauthorized, unethical or illegal reason. It is inappropriate to access your own health record, unless there is a business reason to do so.

7. Information access must be requested, approved and implemented through established protocols. Access to information will be granted on an appropriately identified, validated and authorized basis.

8. Indirect access to information is defined as that information an individual may see or hear from sources obtained in the course of doing business or performing his or her professional responsibilities that may not be directly related to those responsibilities, cannot be reasonably prevented, is limited in nature, and occurs as a by-product of an otherwise permitted use or disclosure of information (e.g. overhearing a conversation in a hall, viewing of paper information which is laying out, posted, printed, or being faxed, or even a glimpse at some trash.) It is possible, that in the course of business, indirect access to information may become available. All responsibilities outlined in this statement apply to direct and indirect access to information.
9. When unsure of the confidentiality or security precautions to be taken, it is the responsibility of the information customer to seek and obtain direction regarding release of information and/or information protection safeguards.

10. Information customers shall report suspected confidentiality breaches or other information violations immediately to the Compliance Notification Line (1-877-526-6759).

11. Failure to adhere to this responsibility statement will result in the appropriate disciplinary and/or legal action.

12. I understand my obligation to safeguard confidentiality continues after my termination of employment.

I have read and understand this Commitment of Confidentiality and have received the Confidentiality Policy. I have had an opportunity to have my questions addressed to my satisfaction. I agree to the terms above and have indicated my agreement by signing my name below:

_____________________________  ______________________________
User Name (printed)            User Signature

_____________________________
Employee Number (if employee)

_____________________________
Indiana University School of Optometry
School                        Date
GENERAL PRIVACY PRINCIPLES

As a Covered Entity under HIPAA, IUSO and all of its members (faculty, staff, students) are required to safeguard the security and privacy of an individual’s protected health information (PHI).

WHAT IS PHI?

Protected health information – PHI – is individually identifiable health information that:

- is created or received by a health care provider, health plan, or health care clearinghouse; and
- relates to the past, present or future physical or mental health condition of an individual; or the past, present or future payment for the provision of health care to an individual

PHI includes anything you see or hear that lets you know about the health of a specific patient. It can be in many forms, such as:

WHEN IS PHI DE-IDENTIFIED?

Unless PHI has been de-identified it can only be used or disclosed under certain specific circumstances. It takes a lot to de-identify PHI. There are 18 identifiers that must be removed from the information. If any identifiers remain the information is still subject to HIPAA. If you would like to use information for a purpose other than the ones discussed on the back, you need to talk to the Privacy Officer about de-identifying the information.

TEN HIPAA DOs and DON’Ts

1. If PHI is accessed, transmitted or stored using a mobile device (smartphones, tablets, laptops, portable hard-drives), the device must have all the safeguards in the IU Mobile Device Security Standard in place. Including:
   - Passwords & Autolock
   - Encryption
   - Remote Wiping
   See http://protect.iu.edu/cybersecurity/policies/IT12/12.1 & https://kb.iu.edu/data/bcnh.html for more info

2. DO NOT share your passwords. Passwords should not be written down or stored where someone else may access it.

3. All workstations should be locked if left unattended.

4. Patient information should be discussed in limited access areas only. Such discussions should not take place in open access areas such as hallways, etc.

5. Patient information should never be discussed with your friends and family members.

6. Any paper containing PHI must be disposed in a locked shredding receptacle.

7. Medical records or paper containing PHI should be kept in locked file cabinets or offices.

8. Do not leave specific treatment information on a patient’s answering machine or voicemail.

9. Verify an individual’s identity before providing access to PHI.

10. IF YOU’RE CONCERNED THERE MAY BE A BREACH CONTACT THE PRIVACY OFFICER IMMEDIATELY. 855-3402

TRANSMITTING PHI – If you need to send a file which contains PHI over the internet, there are two options:

- **SECURE EMAIL** – IUSO Faculty and Staff can use secure email to send encrypted emails if they contain PHI. To encrypt the email place the words ‘secure’ ‘confidential’ or ‘secure message’ somewhere in the in the subject line.

- **NEVER SEND OR RECEIVE PHI FROM A PERSONAL EMAIL ADDRESS!**

- **SLASHTMP** -- If you’re a student and don’t have secure email or need to send a file that’s too large for the email system, please use the following IU site which allows you to encrypt the file and set a password.

  https://slashtmp.iu.edu

Select the CRITICAL version. Upload the file and set a password. You can then have the file link sent to the email of the receiving party and send them the password in a separate email.
### COMMON PERMITTED USES AND DISCLOSURES AT IUSO

IUSO members **may not** access, use or disclose PHI for personal purposes. This includes accessing their own or family member's medical or billing records or the records of high-profile patients. All records access must be limited to that needed to perform your duties at IUSO.

<table>
<thead>
<tr>
<th>Purpose/Reason</th>
<th>Requirements</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLINIC BUSINESS OPERATIONS</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Treatment | PHI may be used for the treatment of the patient, including disclosures to other covered entities. Authorization is not required unless the covered entity does not have a relationship with the patient. | • Summary letters to primary care doctors  
• Referrals to other specialists  
• Conversations with other clinicians at IUSO for consult |
| Payment | PHI can be disclosed to a patient's insurance for purposes of obtaining payment | • Claims sent to insurance companies contain diagnosis information  
• Billing staff may access records to ensure accuracy of claims |
| Operations | PHI can be used by the Clinic to conduct its own internal business such as compliance and quality assurance | • Chart Reviews  
• Yearly Budgeting |
| **PATIENT COMMUNICATIONS** | | |
| With Patient | IUSO may disclose information to a patient or patient's personal representative (i.e. legal guardian)  
**Note:** If the patient is requesting a copy of their medical records IUSO asks for a Written Authorization | • Discussing a minor’s care with their parent (note: once a patient is 18 their parent is no longer the patient representative) |
| With family/friends/individuals involved in patient care | The patient must have the opportunity to **agree or object** to the communication  
It is good practice to ask the patient whether they would like to speak privately. | • If a patient asks their spouse to come back to the exam room with them |
| **OTHER COMMON DISCLOSURES** | | |
| Research | IUSO researchers are part of the Covered Entity and are permitted access to PHI for the following:  
• Recruitment for an IRB approved protocol  
• With a Waiver of Authorization from the IRB  
• To prepare a research protocol  
IUSO has specific requirements for such access. If you are on a study your PI should ensure such requirements are met | • Searching electronic health records for purposes of recruitment  
• Reviewing patient records for a study which has been approved by an IRB with a waiver of authorization |
| Judicial or administrative proceedings | Patient information may be disclosed in response to a court order, subpoena or discovery request  
If the request is not accompanied by a Written Authorization it should be forwarded to the Privacy Officer to respond. | • Attorney letter with Written Authorization  
• Discovery Subpoena  
• Court Order |

**UNCOMMON DISCLOSURES:** There are additional situations in which PHI may be used or disclosed, but they are uncommon for IUSO and have specific requirements. If you would like to use or disclose information for a reason that is not listed above, contact the Privacy Officer to determine proper handling.
Privacy and Security—Minimum Necessary Standard

Scope
This policy applies to all members of IUSO’s workforce who handle protected health information (PHI).

Policy Statement
When PHI is used, disclosed or requested, IUSO will take reasonable efforts to limit the PHI that is used, disclosed or requested to the minimum amount necessary to accomplish the purpose of the use, disclosure or request. This policy encompasses PHI in any format (e.g. oral, electronic, written).

All members of IUSO’s workforce should only access PHI in order to perform their job duties, and the type, and amount of PHI that they access should be limited to that which is necessary to perform the job duty at hand.

In general IUSO should not request or disclose an individual’s entire medical record except when the entire medical record is specifically justified as the amount of PHI that is reasonably necessary to accomplish the purpose for which the PHI is requested or disclosure is sought.

Exceptions to Applicability of the Minimum Necessary Rule: The Minimum Necessary Rule does not apply in the following situations:

1. Use and disclosure of PHI to a health care provider for treatment purposes
2. Use and disclosure of PHI pursuant to Individual Authorization; provided, however, that the PHI used or disclosed shall be limited to the type and amount specified in the authorization
3. Disclosure of PHI to the Individual
4. Use and disclosure of PHI for purposes of complying with and enforcing the HIPAA privacy regulations
Reason for Policy

This policy is adopted to promote the privacy and security an individual’s protected health information when it is maintained by IUSO according to the standards outlined by State and Federal Law. IUSO has adopted this policy to ensure that access to, requests for, or use and disclosure of a patient’s or subject’s (the “Individual’s”) Protected Health Information (PHI) is based on a minimum necessary standard as required by HIPAA.

Procedures

1. **Use of PHI: Persons or Classes of Persons in IUSO Workforce Who Need Access to PHI**
   
   IUSO recognizes that a number of persons or groups of persons need access to some level of PHI to carry out their job duties. A list of the classifications of personnel (including students and volunteers) approved to have routine access to PHI in the performance of their duties and the categories of PHI to which the classification is approved to have routine access is maintained by the Privacy Officer and attached to this policy as Exhibit A.

2. **Routine Disclosures of and Requests for PHI**
   
   IUSO recognizes that the need for information varies according to the duties performed by the party obtaining the information. Routine disclosures/requests are those that do not require individual review/analysis of the purpose and amount of information necessary before a disclosure/request may be made. A list of situations in which IUSO routinely discloses PHI is maintained by the Privacy Officer and attached to this policy as Exhibit B.

   For any disclosures that are not listed on Exhibit B, IUSO Workforce members should consult with the Privacy Officer to determine the appropriate types and amounts of PHI to be disclosed.

3. **Non Routine Disclosures and Requests**
   
   All non-routine disclosures will be reviewed by the Privacy Officer in order to determine that the disclosure complies with the minimum necessary standard, in accordance with the criteria contained in this Policy.

4. **Reliance on request for disclosure as minimum necessary**
   
   IUSO will rely on requested disclosure as the minimum necessary when:
   - The information is requested by another covered entity
   - The request comes from a public official if the public official represents that the PHI requested is the minimum necessary for the stated purpose
   - The information is requested by a professional who is an employee of IUSO or a business associate of IUSO for the purpose of providing professional services to IUSO if the person represents that the information requested is the minimum necessary; or
   - The information is requested for research purposes and the person making the request has complied with all of the required documentation and representations for a permitted disclosure for such purposes by obtaining an Institutional Review Board Study number and approval for such access.

Definitions
**Protected Health Information** – information, (i) which is created or received by a healthcare provider, health plan, or healthcare clearinghouse; about a patient and (ii) including demographic information that may identify a patient that relates to the patient's past, present or future physical or mental health or condition, related health care services or payment for health care services.

**Treatment** – the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

**Workforce** – includes all employees, volunteers, trainees, and other persons whose conduct is under the direct control of IUSO, whether or not they are paid by IUSO

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**History**

Supersedes section IV of the IUSO Confidentiality Policy with respect to Protected Health Information.
### Use of Minimum Necessary PHI According to Job Classification

<table>
<thead>
<tr>
<th>Job Classification</th>
<th>Categories of Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faculty, Staff and Students providing <strong>treatment</strong> (including treating optometrists, therapists, technicians, trainees)</td>
<td>Access to the medical record to the extent such information is necessary to enable the member to perform his or her job function in providing treatment to the individual.</td>
</tr>
</tbody>
</table>
| Faculty and Students for purposes of **education** | Access to patient information for purposes of education should be limited to that needed to accomplish the educational purpose. The following information shall be removed prior to using it for education:  
  - Name  
  - Birthdate  
  - Date of Service  
  - Address and phone number  
  - Names of Co-managing/Referring Physicians |
| Faculty, Staff and Students for purposes of **research** | **Feasibility Study/Review Preparatory to Research:** Results of searches done for purposes of assessing the feasibility of a research study shall be limited to the number of individuals who meet the specified criteria, and shall not include patient names, demographic information or specific dates of service  

**Recruitment:** Researchers shall limit their access to a potential research subject’s contact information, the PHI necessary to assess whether the individual meets the criteria for a potential research subject as approved by the IRB  

**Study:** Researchers shall limit their access to the PHI necessary to perform the research study as outlined in the Individual Authorization or IRB’s Waiver of Authorization |
<p>| Eyewear Center Workforce members | Access to PHI in the medical record to the extent such information is necessary to enable the member to perform his or her job function in providing accurate prescription eyewear. This includes analyzing refractive results and visual acuity data. |</p>
<table>
<thead>
<tr>
<th>Role</th>
<th>Access to PHI in the medical record</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Office Service Assistant</td>
<td>Access to PHI in the medical record shall be limited to the extent necessary for the Workforce member to perform his or her authorized job functions (Ex: review of record for completeness, date last seen, notation of communications; review of fee sheets for services performed and diagnoses associated)</td>
</tr>
<tr>
<td>Central Billing Office Staff</td>
<td>Access to PHI in the medical record shall be limited to the extent necessary for the Workforce member to perform his or her authorized job functions. In general the Central Billing Office staff should not review information contained in the medical chart unless it is necessary to do so for billing/account maintenance (Ex: verification of diagnoses to be billed; post-operative coordination documentation)</td>
</tr>
<tr>
<td>Optical Lab Staff</td>
<td>Access is limited to DVI application which contains patient demographic information and eyewear prescription. Staff shall not routinely have access to the PHI in the medical record.</td>
</tr>
<tr>
<td>Compliance/Coding Staff</td>
<td>Access to PHI shall be limited to the extent necessary for the Workforce members to perform his or her authorized job functions. In general the Compliance staff shall have access to the patient medical and billing records for the purposes of performing audits and reviews specified under the School’s Compliance and HIPAA plans.</td>
</tr>
<tr>
<td>IT Administration</td>
<td>Administrative rights to Compulink, IUSO’s patient management system and other electronic databases containing PHI for purposes of maintenance. Such access shall be limited to the extent necessary for the Workforce member to perform his or her authorized job functions.</td>
</tr>
<tr>
<td>Financial</td>
<td>Access to PHI shall be limited to extent necessary for the Workforce members to perform his or her authorized job functions. In general the School’s Financial/Budget Office staff shall only have access to PHI necessary to process reimbursements and refunds including Patient Demographic information and insurance remittances. Access to Compulink is not required.</td>
</tr>
<tr>
<td>Human Resources</td>
<td>Access to PHI in the medical record shall be limited to the extent necessary for the Workforce members to perform his or her authorized job functions. In general the Human Resources staff shall not routinely have access to PHI, except as needed by the Director of Human Resources for the purpose of investigating a personnel issue which involved the use or misuse of PHI. In such cases the Director of Human Resources will coordinate with the Privacy Officer. Access to Compulink is not required</td>
</tr>
</tbody>
</table>

The Clinic IT Manager shall be responsible for maintaining and documenting, access and edit rights to IUSO’s patient management system and Electronic Medical Record which are consistent with routine access categories listed above.

Other members of IUSO’s workforce who do not fall into one of the categories listed above shall not be granted routine access to individual PHI. In the event a specific job duty requires access to be granted to such an individual, the Privacy Officer will be consulted and the reason for and extent of such access will be documented by the individual’s supervisor.
# Examples of Disclosure of PHI Based on Purpose of Disclosure

<table>
<thead>
<tr>
<th>Receiving Person or Entity/Type of Disclosure</th>
<th>Purpose</th>
<th>Amount of PHI to be Disclosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual (i.e. patient/patient representative)</td>
<td>Permitted or Required Disclosures</td>
<td>All PHI requested by the Individual (Minimum Necessary rule is not applicable)</td>
</tr>
<tr>
<td>Health Care Provider (e.g. physicians, hospitals)</td>
<td>Treatment</td>
<td>All PHI requested by the Health Care Provider (Minimum necessary rule is not applicable)</td>
</tr>
<tr>
<td>CMS (Centers for Medicare and Medicaid Services)</td>
<td>Payment</td>
<td>PHI pertinent to the date of service requested</td>
</tr>
<tr>
<td>Third Party Payor</td>
<td>Payment</td>
<td>PHI pertinent to the date of service requested</td>
</tr>
<tr>
<td>Attorneys</td>
<td>Litigation</td>
<td>• PHI within the scope of the patient’s authorization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• PHI within the scope of an Indiana Court order for production of records</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Any questions regarding release of information to attorney should be directed to Privacy Officer</td>
</tr>
<tr>
<td>Collection Agency</td>
<td>Obtain payment on past due accounts</td>
<td>File of patient names, addresses, dates of service, and amount owed</td>
</tr>
<tr>
<td>Researcher</td>
<td>Research</td>
<td>Information specified in Individual’s Authorization, IRB’s Waiver of Authorization, or approved Recruitment checklist</td>
</tr>
</tbody>
</table>
Policy: In order to continue to improve quality patient care and patient satisfaction, it is IUSO’s policy to address all patient concerns in a professional and systematic manner. Every effort will be made by the faculty, students, and staff within the clinic to address and resolve a patient’s concern at the time it is raised. In the event concern cannot be resolved to the patient’s satisfaction, or if the patient voices the desire to file a formal complaint, the concern shall be documented and reviewed by the appropriate member of Clinic Administration or Compliance.

Procedure:

1. In the event the patient or patient representative (hereinafter “patient”) raises a concern, any faculty, student or staff member to whom the concern is voiced shall make every effort to attempt to assist the patient in addressing and resolving the concern. Such efforts should include, as necessary, attempting to address the concern directly if it is within the scope of the member’s duties, placing the patient in contact with the member’s direct supervisor, or placing the patient in contact with the member of the clinic faculty or staff who is responsible for the patient’s area of concern.

2. If the patient’s concern cannot be resolved to the patient’s satisfaction at the time, or if the patient voices a desire to file a complaint, the Patient will be offered the opportunity to fill out the Patient Concern Form. Any IUSO member or other interested party may complete a Patient Concern Form on a patient’s behalf.

3. The IUSO member who received the patient’s complaint should add any additional information which might be relevant including what efforts, if any, were made to address the patient’s concern.

4. The completed Patient Concern Form shall be forwarded, the same day, using the most expedient means available (including hand-delivery, scan and email, fax, etc) to the appropriate member of Clinic Administration or Compliance (“Reviewing Member”) as follows:
   a. For Billing concerns – Revenue Cycle Manager
   b. For Customer Service concerns – Clinic Operations Administrator
   c. For Compliance and Privacy concerns – Compliance and Privacy Officer

5. The Reviewing Member receiving the Patient Concern Form shall be responsible for investigating the concern, within 48 hours of receiving the Form. Such investigation shall include as necessary, speaking with the IUSO members involved, review of the patient’s account information, and contacting the individual who filed the concern for more information.
6. The Reviewing Member shall complete the “Handling” section of the Patient Concern Form indicating the result of the investigation and what action, if any, has been taken to resolve the patient’s concern, and any system or process improvements which are necessary to prevent future issues. If it is determined that no action is needed, the Reviewing Member will provide a brief description of the basis for this determination.

7. The Reviewing Member shall be responsible for following up with the patient regarding the concern. Such follow up shall be done within 3 business days of the filing of the Patient Concern Form, and the date of the follow up shall be noted on the Patient Concern form.

8. The Reviewing Member is responsible for maintaining copies of completed Patient Concern Forms reviewed by their office, including any relevant additional documentation.

9. If review of the Patient Concern Form indicates there may be concerns regarding the quality of the care provided to the patient the Reviewing Member will inform the Chief of Clinical Care of such concerns.

10. If at any time during review of the Patient Concern Form, it is determined that the concern raises potential compliance or privacy concerns, the Reviewing Member will immediately contact the Compliance and Privacy Officer. The Compliance and Privacy Officer will work with the member to determine whether a Compliance Inquiry should be initiated. In this event, the Compliance and Privacy Officer will become responsible for the investigation and proceed according to IUSO’s Compliance Plan.

11. Once a month the Reviewing Members will report to the Operations Committee regarding the Patient Concerns received by their office, including the number of concerns, any trends in concerns, and any actions which may be necessary to address such concerns.

12. In accordance with IUSO’s non-retaliation policy no retaliatory action will be taken against a member of IUSO faculty, students or staff for assisting a patient in filing a Patient Concern Form or filing a form on a patient’s behalf. This policy does not prevent appropriate disciplinary action regarding a member’s own performance or conduct discovered during an investigation, if such action is determined to be necessary.
Dear Patient, Indiana University School of Optometry is committed to providing you with the best experience possible. We encourage you to voice any concerns, grievances, or recommendations you may have either by speaking directly with one of our staff members or filling out this Concern Form. No retaliatory action will ever be taken against you as a result of your voicing such a concern.

In order for us to best address your concern please fill out the information below as completely as possible. If a staff member is unable to directly address your concern at the time of service, the concern will be forwarded on to the appropriate manager who will investigate the concern, take any action necessary and follow up with you in writing or by telephone within three (3) business days. If there is no satisfactory resolution, the concern will be referred to the next level of management up to the Clinic Director.

Person submitting concern: ________________________________________________________________
Patient Name (if different): ___________________________ Patient Date of Birth: ___ / ___ / _____
Address: ________________________________________________________________________________
Telephone: _____________________________ E-mail Address: ___________________________________
Best way to reach you? _______________________ Best time to reach you? ___________________

Details of concern (Please be as specific as possible, include the details of the situation, and the names of any individuals involved, if known). Feel free to attach additional sheets if needed.

Date of Concern: ___________________ Description of situation: __________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Signature ______________________________________ Date: ____________________________

Please turn this form in to a Staff Member or if you wish you can mail it to the following address:

David K. Fields, Clinic Operations Administrator
Indiana University School of Optometry
800 E. Atwater Ave., Bloomington, IN 47405
(812)-855-1959
FOR OFFICE USE ONLY

Date received: __________ Patient Account #: __________ Health Insurance Claim #: __________

Concern received by: ________________________________________________________________

Staff Member Comments: (Please describe the efforts made to address the concern prior to the completion of this form, if any. Include any individuals with whom the patient/representative spoke; the solutions or explanations provided, and the patient’s reaction):

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Category: □ Billing  □ Customer Service □ Compliance/Privacy

Forwarded To: ___________________________________________________________

REVIEW AND HANDLING:

Reviewed on: __________ Reviewed by: ____________________________________________

The situation surrounding patient’s concern has been investigated and it has been determined that:

_____ no action is necessary, for the following reasons: __________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

_____ improvement or correction is warranted, and the following actions were taken (if the reviewer determined that potential issues of noncompliance were indicated, such that a Compliance Inquiry was initiated, provide the Inquiry number and date Inquiry initiated):

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Communication with Person Submitting Concern and Date: ________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Reviewers Signature: __________________________________ Date Closed: ________________
Clinic Visitation Packet
2012-2013
IUSO Compliance Memorandum

From: A. Haag
Date: 7/9/2012

Re: Clinic Visitor Procedures

IUSO allows temporary visitation privileges to its Optometry clinics for purposes of shadowing and observation of patient care. The following procedures should be followed for these individuals:

1) All visitors must have a sponsoring doctor and be approved by the head of the shadow program in advance of their shadow period.

2) Individuals coming into the clinics under this program must be over the age of eighteen (18) and may operate as a shadow for up to three months for ten hours a week. If a longer period of access is needed, additional registration, background checks and education will be required.

3) Prior to beginning the shadow experience the sponsoring doctor or the head of the shadow program should review the enclosed basic HIPAA information and responsibilities with the visitor.

4) The visitor must complete and sign all of the enclosed paperwork, and the paperwork should be returned to the Privacy Officer following the first day of the visit.

5) All shadows must be accompanied by a member IUSO’s Workforce while within the clinics. Shadows will not have patient contact outside of the presence of IUSO faculty or students. Shadows will not participate in patient care in any way. Their role is strictly observational.

6) All patients should be asked by the treating doctor or student if they will consent to being observed by the visitor prior to the visitor entering the room. The consent to observation will be noted in the patient’s medical record.

7) Shadows shall not be given access to patient files or the electronic patient medical record.
IUSO Visitor Log

Name: ____________________________________________________________

Email: ____________________________  Phone #: ______________________

Address: __________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

Dates of Visit: _________________________________

Responsible Faculty Member: ________________________________________

Permission of Shadow Program Director: ______________________________

Activities to be Completed: ___________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
Certification of HIPAA Training

TO BE COMPLETED BY THE VISITOR:

I ___________________________ (Name), hereby certify that I have received instruction concerning the federal and state requirements regarding patient privacy prior to observing patient care. I further certify that I understand that as a shadow within the IUSO Optometry clinic I am subject to all Indiana University policies and regulations regarding patient privacy and that any violations of these policies or regulations may result in the imposition of sanctions including, but not limited to, being dismissed from participation in the Experience.

Date(s) of Instruction: ______________

Observer signature: _________________________________________________

Today’s date: _____________________

TO BE COMPLETED BY THE INSTRUCTOR:

I hereby certify that I provided the observer listed above with instruction concerning the federal and state regulations dealing with patient privacy prior to observing patient care.

_______________________________________________________________
(Instructing Faculty Name – Please print)

_______________________________________________________________
(Instructing Faculty Signature – Please print)

Date: _________________
CONFIDENTIALITY AGREEMENT, ASSUMPTION OF RISK AND RELEASE OF LIABILITY

This Confidentiality Agreement, Assumption of Risk and Release of Liability pertains to a Prospective Optometric Professional Observational Experience sponsored by Indiana University School of Optometry (IUSO) on ___________________ [Date] (hereinafter referred to as the “Experience”)

I, ______________________________________________ [Name], state that I wish to participate in the Experience and that my participation is wholly voluntary. In consideration of the opportunity to participate, I hereby state:

1. I understand that I will be observing the clinical care of patients in the School of Optometry clinics performed by students and/or faculty members of the School of Optometry. I understand there are certain inherent risks in the Experience and related activities and I fully accept those risks. These risks may include but are not limited to, such things as fainting or becoming unconscious while observing a clinical procedure, accidentally injuring myself during a fall or other accidental mishap, and other physical, mental or emotional injury. I also understand that there may be other risks not known or reasonably foreseeable.

2. I understand and agree that Indiana University does not provide insurance to cover medical expenses for injuries that may be sustained by me or for damage to my personal property and that Indiana University strongly recommends that I carry my own health, medical, and property insurance for purposes of potential losses related to this Experience.

3. I release and fully discharge The Trustees of Indiana University, and its employees, officers and agents, from all liability in connection with my participation in the Experience for, or on account of, any injury to or illness of my person or death or for, or on account of, any loss or damage to any personal property or effects owned by me.

4. Confidentiality: I understand Indiana University School of Optometry and its associated clinics are legally required by the Health Insurance Portability and Accountability Act (HIPAA) and state law to protect the privacy and security of health care information of all patients treated at our clinics. I acknowledge that my participation in the Experience may result in my having access to such patient information and Federal law prohibits me from making any disclosure of such patient information.

5. I fully understand that all Indiana University policies and regulations including, for example, policies on patient privacy, etc. are in effect and apply to my behavior for the entire duration of the Experience and that any violations of these policies or regulations may result in the imposition of sanctions against me including but not limited to, being dismissed from participation in the Experience.

I have read the information above and agree to abide by the terms of this Agreement.

__________________________________________________________________________  ______________________________________________________________________
Participant’s Signature  Date

__________________________________________________________________________
Participant’s Name (printed)
Protecting Patient Privacy

Welcome! We hope you enjoy your visit to Indiana University School of Optometry Clinics. Optometry is a very rewarding and challenging profession.

Patients provide us with personal information about their condition, lifestyle, and medical histories so that we can provide appropriate quality care to them. Patients trust us to safeguard their personal information, and may be hesitant to share important information with us if they do not believe we will keep it confidential.

We have a legal duty to maintain the confidentiality of patient information. The Health Insurance Portability and Accountability Act (HIPAA) provides patients with federal privacy protection.

During your visit, you may encounter:

- People you know who are patients here
- Discussions between care providers about patients they are treating.

If you encounter such information, you must keep it confidential. Do not discuss or share it with anyone, including friends or family members.

While it is human nature to want to share specific information about interesting experiences with others, we have a legal obligation to maintain patient privacy.

Please respect the privacy of others and treat patient information the way you would want your own personal information treated.
IUSO Visitor Orientation

Expectations and HIPAA Training
Welcome to IUSO

- We are happy that you chose to visit the I.U. School of Optometry
- There are a few guidelines that we ask you to follow while you are here . . .
Patient Privacy - It’s the Law!

- Protecting the privacy and confidentiality of our patients is both a legal and ethical duty of all health care providers.

- As our visitor it is your responsibility too!
Patient Privacy - It’s the Law!

HIPAA is a federal law enacted to protect the privacy of a patient’s personal and health information by governing how such information can be used or disclosed.

All health care providers and anyone operating as part of the provider must follow HIPAA and there are significant penalties for failing to do so.
HIPAA Violations Can Carry Penalties

Failing to follow HIPAA can have serious consequences.

• **Criminal and Civil Penalties:**
  - Ranging between $10,000 to $1,500,000;
  - (there can be jail terms for willful violations)

• **Fines for violations of State law**

• **IUSO Corrective and Disciplinary Action:**
  - Violations of HIPAA and IUSO’s HIPAA policies **will** result in dismissal from the shadow program
Your Responsibilities

As *visitors your cooperation is required*:

- All written patient information (on computers, forms and charts) including demographic info is private and confidential
- Conversations between clinicians and patients are confidential
- Patient appointments are confidential information
IMPORTANT! - Do’s and Don’ts

• If you see someone you know here at the school as a patient, please keep the fact that you saw them here to yourself.

• Don’t repeat or discuss any patients or treatment that you observe with anyone outside the school
IMPORTANT! - Do’s and Don’ts

• DO NOT access IUSO patient files or computer systems.

• DON’T go into patient rooms or medical records areas unattended.

• DO NOT post or text any details of your shadow experience on the web (Facebook, twitter, tumblr, etc)
We hope you enjoy your visit to IUSO.

Please make sure to complete the following and give them back to your sponsor:

• Visitor Log
• Certification of HIPAA Training
• Confidentiality Agreement & Release
## The Clinical Skills Assessment Form

**Intern Daily Skills Assessment**

<table>
<thead>
<tr>
<th>Intern Name:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>File #:</td>
<td>Pt Initials:</td>
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<tr>
<td>*Level of Difficulty:</td>
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<th>Clinical Skills:</th>
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<th>2</th>
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<td>2</td>
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<tr>
<td>Communication/Professionalism:</td>
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<td>1</td>
<td>2</td>
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**Comments:**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Consultant’s signature(s):

*1-Below Expected Level, 2-At Expected Level, 3-Above Expected Level
†- Grade assessed does NOT reflect final course grade*
Appendix 3

Professional Leave Request Form

Intern: ________________________________________________________________

Desired date of professional leave: ___________ Reason: ________________________________

Submit completed request form to Brian Page in Student Administration.

Leave is granted on a case-by-case basis, and is contingent upon the clinic schedule.

Form must be signed by clinic scheduler and clinic faculty member before submitting to the Director’s office for approval.

| AM Clinic to be missed: | PC BV CL OD LV CC | at AECC | CECC RHC HC |
| PM Clinic to be missed: | PC BV CL OD       | at AECC | CECC RHC HC |
| Evening Clinic:        | PC BV CL          | at AECC |

(Clinic Scheduler Initials & Date) (Chief/faculty Signature & Date) (Intern Signature & Date)

It remains your responsibility to check the web & clinic schedules to ensure that your request has been recorded as you intended. Professional Leave may NOT be used the final week of rotation, the day before the start of vacation, or the first day after vacation. Please use one form per day if more than one request per line will be listed.

For Administrative Use Only: Specialty Clinic: ___________ Web: ___________ Logged: ___________
Appendix 4

**Clinic Swap Form**

Today's Date: ____________

Signature of Clinic Consultant: ____________

Submit **completed** request form to Brian Page in Student Administration.

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<thead>
<tr>
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<th>Session: AM PM EVE</th>
<th>Area: PC BV CL OD</th>
<th>Dispensary</th>
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<td></td>
<td>will cover for ____________</td>
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<table>
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<tr>
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<tr>
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<td>will cover for ____________</td>
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*It remains your responsibility to check the web & clinic schedules to ensure that your request has been recorded as you intended.*

(Signature of First Individual)  (Signature of Second Individual)

For Administrative Use Only:  Web: ____________  PC Faculty: ____________  Paper: ____________  Logged: ____________
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<tr>
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<td>Left Lower Lid (L)</td>
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Exposure to Blood

What Health-Care Workers Need to Know

Department of Health & Human Services
OCCUPATIONAL EXPOSURES TO BLOOD

Introduction

Health-care workers are at risk for occupational exposure to bloodborne pathogens, including hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV). Exposures occur through needlesticks or cuts from other sharp instruments contaminated with an infected patient's blood or through contact of the eye, nose, mouth, or skin with a patient's blood. Important factors that may determine the overall risk for occupational transmission of a bloodborne pathogen include the number of infected individuals in the patient population, the chance of becoming infected after a single blood contact from an infected patient, and the type and number of blood contacts.

Most exposures do not result in infection. Following a specific exposure, the risk of infection may vary with factors such as these:

- The pathogen involved
- The type of exposure
- The amount of blood involved in the exposure
- The amount of virus in the patient's blood at the time of exposure

Your employer should have in place a system for reporting exposures in order to quickly evaluate the risk of infection, inform you about treatments available to help prevent infection, monitor you for side effects of treatments, and to determine if infection occurs. This may involve testing your blood and that of the source patient and offering appropriate postexposure treatment.

How can occupational exposures be prevented?

Many needlesticks and other cuts can be prevented by using safer techniques (e.g., not recappping needles by hand), disposing of used needles in appropriate sharps disposal containers, and using medical devices with safety features designed to prevent injuries. Many exposures to the eyes, nose, mouth, or skin can be prevented by using appropriate barriers (e.g., gloves, eye and face protection, gowns) when contact with blood is expected.
IF AN EXPOSURE OCCURS

What should I do if I am exposed to the blood of a patient?

1. Immediately following an exposure to blood:

   ◆ Wash needlesticks and cuts with soap and water
   ◆ Flush splashes to the nose, mouth, or skin with water
   ◆ Irrigate eyes with clean water, saline, or sterile irrigants

No scientific evidence shows that using antiseptics or squeezing the wound will reduce the risk of transmission of a bloodborne pathogen. Using a caustic agent such as bleach is not recommended.

2. Following any blood exposure you should:

   Report the exposure to the department (e.g., occupational health, infection control) responsible for managing exposures. Prompt reporting is essential because, in some cases, postexposure treatment may be recommended and it should be started as soon as possible.

Discuss the possible risks of acquiring HBV, HCV, and HIV and the need for postexposure treatment with the provider managing your exposure. You should have already received hepatitis B vaccine, which is extremely safe and effective in preventing HBV infection.

RISK OF INFECTION AFTER EXPOSURE

What is the risk of infection after an occupational exposure?

HBV
Health-care workers who have received hepatitis B vaccine and have developed immunity to the virus are at virtually no risk for infection. For an unvaccinated person, the risk from a single needlestick or a cut exposure to HBV-infected blood ranges from 6-30% and depends on the hepatitis B e antigen (HBeAg) status of the source individual. Individuals who are both hepatitis B surface antigen (HBsAg) positive and HBeAg positive have more virus in their blood and are more likely to transmit HBV.

HCV
Based on limited studies, the risk for infection after a needlestick or cut exposure to HCV-infected blood is approximately 1.8%. The risk following a blood splash is unknown, but is believed to be very small; however, HCV infection from such an exposure has been reported.
HIV

- The average risk of HIV infection after a needlestick or cut exposure to HIV-infected blood is 0.3% (i.e., three-tenths of one percent, or about 1 in 300). Stated another way, 99.7% of needlestick/cut exposures do not lead to infection.

- The risk after exposure of the eye, nose, or mouth to HIV-infected blood is estimated to be, on average, 0.1% (1 in 1,000).

- The risk after exposure of the skin to HIV-infected blood is estimated to be less than 0.1%. A small amount of blood on intact skin probably poses no risk at all. There have been no documented cases of HIV transmission due to an exposure involving a small amount of blood on intact skin (a few drops of blood on skin for a short period of time). The risk may be higher if the skin is damaged (for example, by a recent cut) or if the contact involves a large area of skin or is prolonged (for example, being covered in blood for hours).

How many health-care workers have been infected with bloodborne pathogens?

HBV

The annual number of occupational infections has decreased sharply since hepatitis B vaccine became available in 1982 (i.e., there has been a 90% decrease in the number of estimated cases from 1985 to 1996). Nonetheless, approximately 800 health-care workers become infected with HBV each year following an occupational exposure.

HCV

There are no exact estimates on the number of health-care workers occupationally infected with HCV. However, studies have shown that 1% of hospital health-care workers have evidence of HCV infection (about 1.8% of the U.S. population has evidence of infection). The number of these workers who may have been infected through an occupational exposure is unknown.

HIV

As of December 1998, CDC had received reports of 54 documented cases and 134 possible cases of occupationally acquired HIV infection among health-care workers in the United States since reporting began in 1985.
TREATMENT FOR THE EXPOSURE

Is vaccine or treatment available to prevent infections with bloodborne pathogens?

HBV
As mentioned above, hepatitis B vaccine has been available since 1982 to prevent HBV infection. All health-care workers who have a reasonable chance of exposure to blood or body fluids should receive hepatitis B vaccine. Vaccination ideally should occur during the health-care worker’s training period. Workers should be tested 1-2 months after the vaccine series to make sure that vaccination has provided immunity to HBV infection.

Hepatitis B immune globulin (HBIG) is effective in preventing HBV infection after an exposure. The decision to begin treatment is based on several factors, such as:

- Whether the source individual is positive for hepatitis B surface antigen.
- Whether you have been vaccinated.
- Whether the vaccine provided you immunity.

HCV
There is no vaccine against hepatitis C, and no treatment after an exposure that will prevent infection. Immune globulin is not recommended. For these reasons, following recommended infection control practices is imperative.

HIV
There is no vaccine against HIV. However, results from a small number of studies suggest that the use of zidovudine after certain occupational exposures may reduce the chance of HIV transmission.

Postexposure treatment is not recommended for all occupational exposures to HIV because most exposures do not lead to HIV infection and because the drugs used to prevent infection may have serious side effects. Taking these drugs for exposures that pose a lower risk for infection may not be worth the risk of the side effects. You should discuss the risks and side effects with a health-care provider before starting postexposure treatment for HIV.
What about exposures to blood from an individual whose infection status is unknown?

**HBV–HCV–HIV**
If the source individual cannot be identified or tested, decisions regarding follow-up should be based on the exposure risk and whether the source is likely to be a person who is infected with a bloodborne pathogen. Follow-up testing should be available to all workers who are concerned about possible infection through occupational exposure.

What specific drugs are recommended for postexposure treatment?

**HBV**
If you have not been vaccinated, then hepatitis B vaccination is recommended for any exposure regardless of the source person’s hepatitis B status. HBIG and/or hepatitis B vaccine may be recommended depending on your immunity to hepatitis B and the source person’s infection status.

**HCV**
Currently there is no recommended postexposure treatment that will prevent HCV infection.

**HIV**
The Public Health Service recommends a 4-week course of two drugs (zidovudine and lamivudine) for most HIV exposures, or zidovudine and lamivudine plus a protease inhibitor (indinavir or nelfinavir) for exposures that may pose a greater risk for transmitting HIV (such as those involving a larger volume of blood with a larger amount of HIV or a concern about drug-resistant HIV). Differences in side effects associated with the use of these two drugs may influence which drug is selected in a specific situation.

These recommendations are intended to provide guidance to clinicians and may be modified on a case-by-case basis. Determining which drugs and how many drugs to use or when to change a treatment regimen is largely a matter of judgement. Whenever possible, consulting an expert with experience in the use of antiviral drugs is advised, especially if a recommended drug is not available, if the source patient's virus is likely to be resistant to one or more recommended drugs, or if the drugs are poorly tolerated.
How soon after exposure to a bloodborne pathogen should treatment start?

HBV
Postexposure treatment should begin as soon as possible after exposure, preferably within 24 hours, and no later than 7 days.

HIV
Treatment should be started promptly, preferably within hours as opposed to days, after the exposure. Although animal studies suggest that treatment is not effective when started more than 24-36 hours after exposure, it is not known if this time frame is the same for humans. Starting treatment after a longer period (e.g., 1-2 weeks) may be considered for the highest risk exposures; even if HIV infection is not prevented, early treatment of initial HIV infection may lessen the severity of symptoms and delay the onset of AIDS.

Has the FDA approved these drugs to prevent blood-borne pathogen infection following an occupational exposure?

HBV
Yes. Both hepatitis B vaccine and HBIG are approved for this use.

HIV
No. The FDA has approved these drugs for the treatment of existing HIV infection, but not as a treatment to prevent infection. However, physicians may prescribe any approved drug when, in their professional judgment, the use of the drug is warranted.

What is known about the safety and side effects of these drugs?

HBV
Hepatitis B vaccine is very safe. There is no information that the vaccine causes any chronic illnesses. Most illnesses reported after an HBV vaccination are often related to other causes and not the vaccine. However, you should report any unusual reaction after a hepatitis B vaccination to your health-care provider.

HIV
All of the antiviral drugs for HIV have been associated with side effects. The most common side effects include upset stomach (nausea, vomiting, diarrhea), tiredness, or headache. The few serious side effects that have been reported in health-care workers using combination postexposure treatment have included kidney stones, hepatitis, and suppressed blood
cell production. Protease inhibitors (indinavir and nefinavir) may interact with other medicines and cause serious side effects and should not be used in combination with certain other drugs, such as prescription antihistamines. It is important to tell the health-care provider managing your exposure about any medications you are currently taking, if you need to take antiviral drugs for an HIV exposure.

Can pregnant health-care workers take the drugs recommended for postexposure treatment?

HBV
Yes. Women who are pregnant or breast feeding can be vaccinated against HBV infection and/or get HBIG. Pregnant women who are exposed to blood should be vaccinated against HBV infection, because infection during pregnancy can cause severe illness in the mother and a chronic infection in the newborn. The vaccine does not harm the fetus.

HIV
Pregnancy should not rule out the use of postexposure treatment when it is warranted. If you are pregnant you should understand what is known and not known regarding the potential benefits and risks associated with the use of antiviral drugs in order to make an informed decision about treatment.

FOLLOW-UP AFTER AN EXPOSURE

What follow-up should be done after an exposure?

HBV
Because postexposure treatment is highly effective in preventing HBV infection, CDC does not recommend routine follow-up after treatment. However, any symptoms suggesting hepatitis (e.g., yellow eyes or skin, loss of appetite, nausea, vomiting, fever, stomach or joint pain, extreme tiredness) should be reported to your health-care provider.

HCV
You should have an antibody test for hepatitis C virus and a liver enzyme test (alanine aminotransferase activity) as soon as possible after the exposure (baseline) and at 4-6 months after the exposure. Some clinicians may also recommend another test (HCV RNA) to detect HCV infection 4-6 weeks after the exposure. Report any symptoms suggesting hepatitis (mentioned above) to your health-care provider.
HIV
You should be tested for HIV antibody as soon as possible after exposure (baseline) and periodically for at least 6 months after the exposure (e.g., at 6 weeks, 12 weeks, and 6 months).

If you take antiviral drugs for postexposure treatment, you should be checked for drug toxicity by having a complete blood count and kidney and liver function tests just before starting treatment and 2 weeks after starting treatment.

You should report any sudden or severe flu-like illness that occurs during the follow-up period, especially if it involves fever, rash, muscle aches, tiredness, malaise, or swollen glands. Any of these may suggest HIV infection, drug reaction, or other medical conditions.

You should contact the health-care provider managing your exposure if you have any questions or problems during the follow-up period.

What precautions should be taken during the follow-up period?

HBV
If you are exposed to HBV and receive postexposure treatment, it is unlikely that you will become infected and pass the infection on to others. No precautions are recommended.

HCV
Because the risk of becoming infected and passing the infection on to others after an exposure to HCV is low, no precautions are recommended.

HIV
During the follow-up period, especially the first 6-12 weeks when most infected persons are expected to show signs of infection, you should follow recommendations for preventing transmission of HIV. These include not donating blood, semen, or organs and not having sexual intercourse. If you choose to have sexual intercourse, using a condom consistently and correctly may reduce the risk of HIV transmission. In addition, women should consider not breast-feeding infants during the follow-up period to prevent exposing their infants to HIV in breast milk.
OTHER SOURCES OF INFORMATION

HBV and HCV
For additional information about hepatitis B and hepatitis C you can call the hepatitis information line at 1-888-4-HEPCDC (1-888-443-7232) or visit CDC’s hepatitis website at www.cdc.gov/ncidod/diseases/hepatitis/index.htm

Anyone believing they have had a reaction or adverse event should report it to his/her health care provider. The Vaccine Adverse Event Reporting System (1-800-822-7967) receives reports from health-care providers and others about vaccine side effects.

HIV
Information specialists who staff the CDC National AIDS Hotline (1-800-342-2437) can answer questions or provide information on HIV infection and AIDS and the resources available in your area. The HIV/AIDS Treatment Information Service (1-800-448-0440) can also be contacted for information on the clinical treatment of HIV/AIDS. For free copies of printed material on HIV infection and AIDS, please call or write the CDC National Prevention Information Network, P.O. Box 6003, Rockville, MD 20849-6003, telephone 1-800-458-5231, Internet address www.cdcnpin.org

Additional information about occupational exposures to bloodborne pathogens is available on CDC’s Hospital Infections Program’s website at www.cdc.gov/ncidod/hip or on CDC’s National Institute of Occupational Safety and Health’s website at www.cdc.gov/niosh or call 1-800-35 NIOSH (1-800-356-4674).
Appendix 7

TB Facts
For Health Care Workers

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for HIV, STD, and TB Prevention
Division of Tuberculosis Elimination
Atlanta, Georgia 30333
TUBERCULOSIS — YES! IT'S STILL A PROBLEM!

- Eight million new tuberculosis (TB) cases occur each year in the world and 3 million people die of the disease.

- In the United States, after several decades of decline, TB cases increased 20 percent between 1985 and 1992. Reasons for the increase included:
  - The HIV epidemic
  - Immigration of persons from areas with a high prevalence of TB
  - Transmission of TB in high-risk environments, such as correctional facilities, homeless shelters, hospitals, and nursing homes
  - Deterioration of the TB public health care infrastructure

- During the resurgence of TB, outbreaks of multidrug-resistant TB occurred in hospitals and prisons, resulting in high death rates and transmission to health care workers.

- The 21,337 TB cases reported in 1996 represent the fourth consecutive year of decline, suggesting the successful use of new resources in different areas of the U.S. to better detect and treat persons with active TB and latent infection.

- While the decrease in TB cases is encouraging, there are several areas of concern which will require expanded efforts:
  - TB cases continue to increase in many areas.
  - Outbreaks of drug-resistant TB continue in many areas.
  - An estimated 10 to 15 million persons in the U.S. are infected with Mycobacterium tuberculosis. Without intervention, about 10 percent of these persons will develop TB disease at some point in life.
  - Directly observed therapy is not available for many persons with active TB who have difficulty completing a full course of TB treatment.
An increasing proportion of TB cases in the U.S. are among individuals born in areas with a high prevalence of TB, and international collaboration needs to be strengthened to prevent and control TB in these persons.

POPULATIONS AT RISK FOR TUBERCULOSIS

Persons at risk for TB include anyone who has ever had contact with a person with infectious TB. Some persons are considered to be at high risk for TB disease because they belong to groups in which the prevalence of TB infection is higher than it is in the general population. These groups include foreign-born persons from areas with a high prevalence of TB; residents and employees of long-term institutional settings (such as nursing homes and correctional facilities); and medically underserved populations, including the poor, the homeless, high risk racial and ethnic minority groups, and injecting drug users (IDUs). Other persons are at high risk for developing active TB disease if they become infected with Mycobacterium tuberculosis. They include immunocompromised persons (especially those with HIV infection), persons with other medical risk factors (such as diabetes, end-stage renal disease, and being 10 percent or more below ideal body weight), and IDUs.

HIV infection is one of the strongest known risk factors associated with the progression from TB infection to active TB disease. Studies suggest that the risk of developing TB disease is 7% to 10% each year for persons who are infected with both M. tuberculosis and HIV, whereas it is 10% over a lifetime for persons infected only with M. tuberculosis.

MODE OF TRANSMISSION

Mycobacterium tuberculosis is spread by airborne particles, known as droplet nuclei, that can be generated when persons with pulmonary or laryngeal TB sneeze, cough, speak, or sing. Persons who share the same airspace with persons with infectious TB disease are at greatest risk for infection. Infection occurs when a susceptible person inhales droplet nuclei containing tubercle bacilli and these bacilli become established in the alveoli of the lungs and spread throughout the body.
IDENTIFICATION OF PERSONS WITH
TB INFECTION AND DISEASE

Identifying TB Infection

A person exposed to an individual with infectious TB or who has other risk factors for TB as noted above should be given a tuberculin skin test.

The Mantoux tuberculin skin test is the preferred method of skin testing. The Mantoux tuberculin skin test is the intradermal injection of purified protein derivative (PPD) of killed tubercle bacilli, usually on the inner forearm. The site is examined by a trained health care worker 48 to 72 hours after injection for induration (palpable swelling). The diameter of induration is measured and recorded; erythema or bruising is disregarded.

The criteria endorsed by the American Thoracic Society and CDC for a positive tuberculin skin-test result (Table 1) are intended to increase the likelihood that persons at high risk for TB will be candidates for preventive therapy and that persons having tuberculin reactions not caused by M. tuberculosis will not receive unnecessary diagnostic evaluation or treatment.

For each of the risk groups listed in Table 1, reactions below the cutoff point are considered negative. A negative TB skin test result does not absolutely rule out TB infection, especially in persons with TB-like symptoms, HIV infection, or AIDS. Also, because it takes 2 to 10 weeks from the time of exposure for a person to react to tuberculin, the initial skin test result of an infected contact may be falsely negative. Therefore, a repeat skin test 10 weeks post exposure is warranted.

Some persons with both HIV and TB infections may have false negative skin test reactions (anergy). Anergy refers to the inability to react to a skin test antigen even though the person is infected with the organism being tested. Several delayed-type hypersensitivity (DTH) antigens (such as tetanus toxoid, mumps or Candida) administered by the Mantoux technique have been used in an attempt to determine anergy status. Recent CDC recommendations, however, note several factors that limit the usefulness of
anergy skin testing. These include problems with standardization and reproducibility, the low risk for TB associated with a diagnosis of anergy, and the lack of apparent benefit of preventive therapy for groups of anergic HIV-infected persons. Therefore, the use of anergy testing in conjunction with PPD testing is no longer routinely recommended for screening programs for M. tuberculosis infection conducted among persons infected with HIV in the United States.

Persons with latent TB infection should be evaluated for HIV risk behaviors and offered counseling and HIV-antibody testing if such behaviors are present.

Many foreign countries still use BCG as part of their TB control programs, especially for infants. In persons vaccinated with BCG, sensitivity to tuberculin is highly variable, depending upon the strain of BCG used and the group vaccinated. There is no reliable method of distinguishing tuberculin reactions caused by BCG from those caused by natural infections. A reaction to tuberculin in a person with a history of BCG vaccination is more likely to be due to infection with M. tuberculosis if:

- the induration is large
- the person was vaccinated a long time ago
- the person is a recent contact of a person with infectious TB
- there is a family history of TB
- the person comes from an area where TB is common
- chest radiograph findings show evidence of previous TB

In a BCG-vaccinated person who has any of the preceding risk factors, a positive tuberculin reaction probably indicates infection with M. tuberculosis. Such persons should be evaluated for isoniazid preventive therapy after disease has been ruled out.
Table 1
Summary of interpretation of tuberculin skin-test results

• An induration of \( \geq 5 \text{ mm} \) is classified as positive in the following:
  — Persons who have had recent close contact with persons who have active TB;
  — Persons who have human immunodeficiency virus (HIV) infection or risk factors for HIV infection but unknown HIV status (e.g., injecting drug users);
  — Persons who have fibrotic chest radiographs consistent with healed TB.

• An induration of \( \geq 10 \text{ mm} \) is classified as positive in all persons who do not meet any of the above criteria, but who belong to one or more of the following groups having high risk for TB:
  — Injecting-drug users known to be HIV seronegative;
  — Persons who have other medical conditions that have been reported to increase the risk for progressing from latent TB infection to active TB. These medical conditions include diabetes mellitus, conditions requiring prolonged high-dose corticosteroid therapy and other immunosuppressive therapy (including bone marrow and organ transplantation), chronic renal failure, some hematologic disorders (e.g., leukemias and lymphomas), other specific malignancies (e.g., carcinoma of the head or neck), weight loss of \( \geq 10\% \) below ideal body weight, silicosis, gastrectomy, jejunoileal bypass;
  — Residents and employees of high-risk congregate settings: prisons and jails, nursing homes and other long-term facilities for the elderly, health-care facilities (including some residential mental health facilities), and homeless shelters;
  — Foreign-born persons recently arrived (i.e., within the last 5 years) from countries having a high prevalence or incidence of TB;
  — Some medically underserved, low-income populations, including migrant farm workers and homeless persons;
  — High-risk racial or ethnic minority populations, as defined locally;
  — Children <4 years of age or infants, children, and adolescents exposed to adults in high-risk categories.

• An induration of \( \geq 15 \text{ mm} \) is classified as positive in persons who do not meet any of the above criteria.
Identifying TB Disease

If the skin test result is positive or if symptoms suggestive of TB are present (e.g., productive and prolonged cough, fever, chills, loss of appetite, weight loss, fatigue, or night sweats), a chest radiograph should be obtained to help rule out active pulmonary TB. The chest radiograph may also be used to detect the presence of fibrotic lesions suggestive of old, healed TB or silicosis.

Acid-fast bacilli (AFB) smears and cultures should be performed on sputum specimens of all persons who have symptoms of TB or whose chest radiograph suggests TB. A positive AFB smear is an indication for beginning treatment for TB. However, a positive AFB smear may also indicate the presence of nontuberculous mycobacteria. A positive culture for Mycobacterium tuberculosis is the only definitive proof of TB disease.

Health care providers of HIV-infected persons should be aware of atypical patterns of TB disease in these persons. Extrapulmonary TB is more common. Also, pulmonary TB may present in an unusual manner (e.g., in the lymph nodes or in the lower part of the lungs).

All persons with TB infection or TB disease should be offered counseling and HIV-antibody testing, because medical management may be altered in the presence of HIV infection.

Maintain a high index of suspicion for TB in persons with undiagnosed pulmonary disease, especially in persons who are HIV seropositive.
PREVENTION OF TUBERCULOSIS

The main purpose of preventive therapy is to prevent latent infection from progressing to clinically active TB disease. Therefore, persons with positive tuberculin skin test results who do not have clinically active disease should be evaluated for preventive therapy.

Candidates for Preventive Therapy

Preventive therapy is recommended for the following persons with a positive tuberculin test result regardless of age:

- Persons with known or suspected HIV infection, including persons who inject drugs and whose HIV status is unknown (≥5mm)*
- Close contacts of persons with infectious, clinically active TB (≥5mm)*
- Persons who have chest radiograph findings suggestive of previous TB and who have received inadequate or no treatment (≥5mm)
- Persons who inject drugs and who are known to be HIV negative (≥10mm)
- Persons with certain medical conditions that have been reported to increase the risk of TB (see “Summary of interpretation of tuberculin skin-test results” on page 5) (≥10mm)

*In some circumstances, persons in these categories may be given preventive therapy in the absence of a positive tuberculin test result. For example, tuberculin-negative children and adolescents who are close contacts of infectious persons and who may be infected but whose skin test result has not yet converted to positive may be given preventive therapy. If therapy is initiated, a repeat tuberculin skin test should be performed 3 months after contact has been broken with the infectious source. If the reaction is positive, therapy should be continued. If the reaction is negative, therapy may be discontinued if contact with the infectious source case continues to be broken. In addition, persons who are immunosuppressed, especially HIV-infected persons may have a negative tuberculin skin test reaction because they are anergic. All HIV-infected persons who are close contacts of persons who have infectious tuberculosis should be administered a full course of preventive therapy—regardless of tuberculin skin test results or prior courses of chemoprophylaxis—after the diagnosis of active tuberculosis has been excluded.
• Persons whose tuberculin skin test reaction converted from negative to positive within the past 2 years (≥10mm increase if younger than 35 years of age; ≥15mm increase if 35 years of age or older)

Preventive therapy is recommended for the following persons in high-incidence groups who have a positive tuberculin test result (10 or more millimeters induration), are younger than 35 years of age, and do not have additional risk factors:

• Foreign-born persons from high-prevalence areas (e.g., Latin America, Asia, and Africa)
• Medically underserved, low-income populations, including high-risk racial or ethnic groups (e.g., Asians and Pacific Islanders, blacks, Hispanics, and Native Americans)
• Residents of long-term care facilities (e.g., correctional institutions, nursing homes, and mental institutions)
• Children younger than 4 years of age
• Other groups identified locally as having an increased prevalence of TB (e.g., migrant farm workers or homeless persons)

Persons younger than 35 years of age with no known risk factors for TB should be evaluated for preventive therapy if their reaction to the tuberculin test is ≥15mm. This group should be given a lower priority for prevention efforts than the groups already listed. Tuberculin-positive staff of facilities in which a person with clinically active disease would pose a risk to large numbers of susceptible persons should also be considered for preventive therapy.

**Preventive Therapy Regimens**

The usual preventive therapy regimen is isoniazid (INH) (for children—10 mg/kg daily, for adults—5 mg/kg daily up to a maximum of 300 mg daily) for a minimum of 6 continuous months for adults and 6-9 continuous months for children. Twelve months is recommended for persons with HIV infection or other forms of immunosuppression. (Note: Persons with fibrotic infiltrates on a
chest radiograph that are thought to represent old, healed TB and those with silicosis who were formerly considered candidates for preventive therapy should receive 4 months of multidrug chemotherapy.)

To ensure that persons in high-risk groups adhere to therapy, INH can be given twice weekly at a dosage of 15 mg/kg, up to a maximum of 900 mg, using directly observed preventive therapy (DOPT). DOPT refers to the observation by a healthcare provider of patients as they ingest anti-TB medications.

The method of DOPT should be based on a thorough assessment of each patient’s needs, living and employment conditions, and preferences. The patient and provider should agree on a method that ensures the best possible DOPT routine and that maintains the patient’s confidentiality.

Situations in which patients not receiving DOPT miss appointments or demonstrate other nonadherent behavior should be brought to the attention of the appropriate public health officials. These patients should be considered for DOPT.

Persons given preventive therapy should be monitored monthly for drug side effects, especially signs and symptoms of hepatitis.
TREATMENT OF TUBERCULOSIS

Treatment Regimens

TB is usually curable if effective treatment is instituted without delay. Because of the increase in multidrug-resistant TB (MDR-TB), nearly all persons with TB should be started on a four-drug regimen of INH, rifampin (RIF), pyrazinamide (PZA), and ethambutol (EMB) or streptomycin (SM) until the drug susceptibility results are known. A less than four-drug initial regimen should only be considered if there is little possibility of drug resistance (i.e., less than 4% primary resistance to isoniazid in the community and the patient has had no previous treatment with TB drugs, is not from a country with a high prevalence of drug resistance, and has no known exposure to a patient with drug-resistant disease). If the drugs are given daily at the start of therapy and susceptibility results show no drug resistance, EMB or SM can be discontinued and the other drugs continued until PZA has been given for 2 months. INH and RIF should then be continued for another 4 months, including at least 3 months of therapy after the culture has converted to negative. Several options for daily and intermittent therapy have been published. Persons given anti-TB therapy should be monitored monthly for drug side effects.

The recommendations for the duration of TB treatment for HIV-infected persons are generally the same as for persons not infected with HIV. However, in HIV-infected patients, it is critically important to assess the clinical and bacteriologic response to therapy. Treatment should be prolonged if the response is slow or otherwise suboptimal.

Adherence

A major cause of treatment failure and drug-resistant TB is non-adherence to treatment. Treatment failure and drug-resistant TB threaten the health of TB patients. These factors also pose serious public health risks because they can lead to prolonged infectiousness and the transmission of TB within the community.
One way to ensure that patients adhere to therapy is to use directly observed therapy (DOT). DOT means that a health care worker or another designated person watches the patient swallow each dose of TB medication. DOT should be considered for all patients because clinicians are often inaccurate in predicting which patients will adhere to medication on their own.

In many areas, patients are routinely given DOT. DOT has been shown to be cost-effective when intermittent regimens are used. Nearly all the treatment regimens for drug-susceptible TB can be given intermittently if they are directly observed; using intermittent regimens reduces the total number of doses a patient must take, as well as the total number of encounters with the health care provider or outreach worker. Furthermore, DOT can significantly reduce the frequency of acquired drug resistance and relapse.

Other measures commonly used to promote adherence include:

- Developing an individualized treatment plan for each patient
- Working with outreach staff from the same cultural and linguistic background as the patient
- Educating the patient about TB medication dosage and possible adverse reactions
- Using incentives and enablers to remove barriers to adherence (e.g., transportation tokens and food vouchers)
- Facilitating access to health and social services
REPORTING

TB reporting is required by law in every state. All new TB cases and suspect cases should be reported promptly to the health department by the clinician. Cases may also be reported by infection control nurses or by pharmacies when TB drugs are dispensed. In addition, all positive TB smears and cultures should be reported promptly by laboratories. Early reporting is important for the control of TB and it gives clinicians access to the resources of the health department for assistance in case management (e.g., DOT) and contact investigation.

MULTIDRUG-RESISTANT TUBERCULOSIS (MDR-TB)

An extremely serious aspect of the TB problem in the United States is MDR-TB (i.e., TB resistant to at least isoniazid and rifampin). **MDR-TB can usually be prevented by initially treating TB patients with four drugs and by administering TB medications on a directly observed basis.** Persons at high risk for MDR-TB include persons who have been recently exposed to MDR-TB, especially if they are immunocompromised; TB patients who failed to take medications as prescribed; TB patients who were prescribed an ineffective treatment regimen; and persons previously treated for TB.

MDR-TB presents difficult treatment problems. Treatment must be individualized and based on the patient’s medication history and drug susceptibility study results. **Clinicians who are not familiar with the management of patients with MDR-TB disease or with patients infected with multidrug-resistant organisms should seek expert consultation.**

For persons likely to have been infected with M. tuberculosis resistant to both isoniazid and rifampin, observation without preventive therapy is usually recommended because only isoniazid and rifampin have been evaluated for preventive therapy. However, for persons at an especially high risk for TB disease once infected (e.g., persons with HIV infection), preventive therapy with an alternative regimen should be strongly considered.
INFECTION CONTROL MEASURES

The spread of TB in health care settings can be minimized by implementing CDC recommendations for preventing TB transmission in these settings. The early detection, isolation, and treatment of disease in persons with infectious TB are essential to controlling transmission. TB should be suspected in all persons with symptoms consistent with TB (for example, cough, fever, night sweats, chills, fatigue, weight loss or loss of appetite), especially those with confirmed or suspected HIV infection and undiagnosed pulmonary disease. Precautions should be taken to prevent airborne transmission of infection until TB is diagnosed and treated or ruled out.

Effective AFB isolation should be initiated for persons with confirmed or suspected TB to reduce the risk that they will expose others. Precautions should be taken during and immediately after procedures that may induce coughing, such as bronchoscopy, sputum collection, the aerosol induction of sputum, and the administration of aerosolized medication, such as pentamidine.

Antituberculosis drug treatment should be promptly initiated for persons with active disease to render them noninfectious. Persons at high risk for TB infection should be screened and, if infected, evaluated for preventive therapy. Ongoing TB screening should be provided to health care workers who have regular contact with persons with TB or HIV infection.

Remember! The key to preventing TB infection and death and disability from TB disease is to consider the possibility of TB in high-risk groups, make the diagnosis as quickly as possible, and initiate effective, directly observed drug therapy for persons found to have TB. Think TB!

FOR ADDITIONAL INFORMATION, CONTACT YOUR LOCAL HEALTH DEPARTMENT
Selected Bibliography


Centers for Disease Control. Screening for tuberculosis and tuberculosis infection in high-risk populations. MMWR 1995;44(No. RR-11).

Centers for Disease Control. Management of persons exposed to multidrug-resistant tuberculosis. MMWR 1992;41(No. RR-11).


Hand Hygiene Guidelines Fact Sheet

- Improved adherence to hand hygiene (i.e. hand washing or use of alcohol-based hand rubs) has been shown to terminate outbreaks in health care facilities, to reduce transmission of antimicrobial resistant organisms (e.g. methicillin resistant staphylococcus aureus) and reduce overall infection rates.

- CDC is releasing guidelines to improve adherence to hand hygiene in health care settings. In addition to traditional handwashing with soap and water, CDC is recommending the use of alcohol-based hand rubs by health care personnel for patient care because they address some of the obstacles that health care professionals face when taking care of patients.

- Handwashing with soap and water remains a sensible strategy for hand hygiene in non-health care settings and is recommended by CDC and other experts.

- When health care personnel's hands are visibly soiled, they should wash with soap and water.

- The use of gloves does not eliminate the need for hand hygiene. Likewise, the use of hand hygiene does not eliminate the need for gloves. Gloves reduce hand contamination by 70 percent to 80 percent, prevent cross-contamination and protect patients and health care personnel from infection. Hand rubs should be used before and after each patient just as gloves should be changed before and after each patient.

- When using an alcohol-based handrub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry. Note that the volume needed to reduce the number of bacteria on hands varies by product.

- Alcohol-based hand rubs significantly reduce the number of microorganisms on skin, are fast acting and cause less skin irritation.

- Health care personnel should avoid wearing artificial nails and keep natural nails less than one quarter of an inch long if they care for patients at high risk of acquiring infections (e.g. Patients in intensive care units or in transplant units).

- When evaluating hand hygiene products for potential use in health care facilities, administrators or product selection committees should consider the relative efficacy of antiseptic agents against various pathogens and the acceptability of hand hygiene products by personnel. Characteristics of a product that can affect acceptance and therefore usage include its smell, consistency, color and the effect of dryness on hands.

- As part of these recommendations, CDC is asking health care facilities to develop and implement a system for measuring improvements in adherence to these hand hygiene guidelines.
recommendations. Some of the suggested performance indicators include: periodic monitoring of hand hygiene adherence and providing feedback to personnel regarding their performance, monitoring the volume of alcohol-based handrub used/1000 patient days, monitoring adherence to policies dealing with wearing artificial nails and focused assessment of the adequacy of health care personnel hand hygiene when outbreaks of infection occur.

- Allergic contact dermatitis due to alcohol hand rubs is very uncommon. However, with increasing use of such products by health care personnel, it is likely that true allergic reactions to such products will occasionally be encountered.

- Alcohol-based hand rubs take less time to use than traditional hand washing. In an eight-hour shift, an estimated one hour of an ICU nurse’s time will be saved by using an alcohol-based handrub.

- These guidelines should not be construed to legalize product claims that are not allowed by an FDA product approval by FDA’s Over-the-Counter Drug Review. The recommendations are not intended to apply to consumer use of the products discussed.

###

CDC protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.
Appendix 9

Title: Indiana University Safety Eyewear Policy

Applies to: Indiana University
Date Issued: 9/30/99
Date Revised: 3/10/04

This policy supersedes all previous safety eyewear policies issued by IU.

Policy Objective – To comply with applicable OSHA standards and its policy of protecting employee health and safety, Indiana University will:

- Evaluate all jobs and tasks performed by IU employees to identify potential eye injury hazards;
- Determine appropriate and feasible controls, including engineering controls, work practices and safety eyewear;
- Provide safety eyewear to all employees whose jobs pose identified eye injury hazards where engineering and work practice controls are infeasible or insufficient to provide adequate protection;
- Provide safety eyewear with prescription corrective lenses according to the provisions below for employees who normally use prescription corrective lenses at work.

Safety eyewear is defined as:
Any face or eye covering designed to protect the wearer’s eyes from contact with flying objects, hazardous liquids or gases or other materials that may be hazardous to the eye. This eyewear is designed to resist impact and shattering when struck by flying or hazardous materials. Safety eyewear includes spectacles (safety lenses in a safety frame and side shields if needed), goggles and face shields with or without a prescription component.

Safety eyewear will be selected according to:
- The identified eye injury hazard(s)
- Performance of the eyewear vs. applicable ANSI standards
- Availability
- Employee preference among available choices
- Department’s choice to use prescription safety eyewear or alternative safety eyewear that meets the OSHA standard.

Frames issued by the IU School of Optometry will be fitted with side shields, where required by the hazard assessment. The employee’s supervisor in the originating department must indicate this requirement on the Departmental Approval and Selection Form (see attached.)

New safety eyewear will be provided when:
- The employee is initially hired;
- The employee’s current safety eyewear lenses are seriously scratched or lenses or frames are broken or lost in an incident or in routine use at work or at home, unless the campus disallows.
- A routine or specially scheduled eye examination by the IU Optometry Clinic or other qualified provider indicates the need for a change in the wearer’s prescription.
A period of two years elapses without a change in the lens prescription. A current eye exam will be required before any new prescription safety eyewear is issued, even if the prescription does not change. The employee must have had an eye examination by the IU Optometry Clinic or other qualified provider within the last two years to be considered current.

An assessment by the University Office of Environmental, Health, and Safety Management (UOEHSM) indicates that protective eyewear is required (i.e., after a new piece of equipment is put into service.)

The employee’s department chooses to issue prescription eyewear instead of over the eyeglass safety glasses.

Who will provide safety eyewear and examinations?
The affected employee’s department will provide non-prescription safety eyewear based on a hazard assessment and any other required guidance by UOEHSM.

The Optometry Clinic at the IU School of Optometry will provide all prescription safety eyewear. Employees may use either the School of Optometry or other qualified providers for eye examinations; however, the School of Optometry will only issue safety prescription lenses and frames covered by this policy.

Note: Effective January 1, 2004, all employees covered by any IU Healthcare Plan are entitled to one eye exam per year with applicable co-payment. Since plan provisions change from time to time, please check with your provider to determine if the cost of an eye exam is covered by your insurance plan. The affected employee is otherwise responsible for payment of the eye examination fee.

Responsibilities

<table>
<thead>
<tr>
<th>Responsible Party</th>
<th>Responsibility</th>
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<tbody>
<tr>
<td>UOEHSM</td>
<td>• Assess eye injury hazards for all jobs, tasks</td>
</tr>
<tr>
<td></td>
<td>• Assist with selection of non-prescription eyewear</td>
</tr>
<tr>
<td></td>
<td>• Annual review of this policy with participation from affected IU departments and personnel</td>
</tr>
<tr>
<td>Department Managers</td>
<td>• Purchase and provide selected safety eyewear</td>
</tr>
<tr>
<td></td>
<td>• Ensure that safety eyewear is always used where required</td>
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<tr>
<td></td>
<td>• Complete departmental approval form</td>
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<tr>
<td>IU Optometry Clinics</td>
<td>• Provide eye examinations</td>
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<tr>
<td></td>
<td>• Make and issue prescription safety eyewear, with side shields when indicated by the originating department or requested by the employee</td>
</tr>
<tr>
<td>Employee</td>
<td>• Keep scheduled eye exam appointments</td>
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<td></td>
<td>• Select eyewear from available choices</td>
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<tr>
<td></td>
<td>• Pay any required fees for exams and approved options</td>
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</tbody>
</table>
Scheduling a Safety Eyewear Hazard Assessment
If the job being performed is identified as being one that requires safety eyewear, an assessment needs to be conducted by someone from UOEHSM. This can be done by contacting the main office at 856-6311 and asking for the Occupational Safety Manager or a member of the Occupational Safety Group that covers PPE assessments.

IU Prescription Safety Eyewear
Polycarbonate and Trivex lens materials are the most impact-resistant lens materials available. At the present time, Indiana University School of Optometry uses polycarbonate for all safety lenses. Polycarbonate is thinner and lighter in weight than most other materials.

Tinted Lenses for Prescription Sunwear
If sun protection is required, the originating department will provide either:
- Slip-over protective sunwear (ordinarily supplied by department) or
- A second pair of prescription sunwear through the IU School of Optometry
Safety lenses will be supplied to the employee with a tint without an employee co-payment only when required by the prescription or the Certification of Hazard Assessment for PPE Use (available from UOEHSM)

Polarized Lenses*
Polarized lenses are effective in reducing glare and are available only in tinted lenses; a co-payment will apply and is only available if a second pair of safety glasses has been approved for sunwear by both the department and by UOEHSM. If this option is elected it must be paid for by the employee.

Variable Intensity Lenses (Photochromics)*
Photochromic lenses darken when exposed to outdoor light and some other light sources. (Trade names for photochromic lenses include brands such as Transitions and SunSensors.) Use of photochromic lenses must be approved by the department and appear on the Departmental Approval and Selection Form. A “Certification of Hazard Assessment for PPE Use” (available from UOEHSM) which states that the employee works outdoors and may need some sun protection must be indicated on the form. There will be an employee co-payment* on any prescription safety eyewear that is issued with photochromic lenses. The department does not pay for the upgrade from clear to photochromic lenses.

Light or Cosmetic Tinted Lenses*
The tint referred to here is not a sunglass tint, but a tint that would usually be a light cosmetic tint that could safely be used indoors. A light tint (down to approximately 80% transmission) may be elected by the employee and does not require approval. If this option is elected, the employee must pay it for. *
Standard Frames
Basic safety frames such as the On Guard 311 and other equivalent frames will be covered by the IU Safety Eyewear Policy. (Note: Brand/models are subject to change due to manufacturer availability and production.)

Up-Graded Frames*
If an employee desires a premium or a designer-type safety frame, then the employee must make a co-payment* equal to the difference between the retail price for a standard safety frame and the retail price of the upgraded frame that was selected by the employee.

*Any options not required as basic safety eyewear, but acceptable to safety standards will require a co-payment by the employee (i.e., when cosmetic tinted or photochromic lenses are acceptable and do not present a safety hazard.) This amount will equal the difference between the retail price for the standard eyewear and the retail price of the upgraded eyewear selected by the employee.
Instructions for Using the “Departmental Approval and Selection for Prescription Safety Eyewear” Form

All departments and employees covered by the scope of this program must use this form. The IU School of Optometry will not issue eyewear without a completed form on file. The purpose of this form is to:
• Inform employees and departments of the lens and side shield options available to them.
• Provide departmental account information for billing purposes.
• Indicate whether an assessment of personal protective equipment needs has been performed.

Supervisor and UOEHSM Representative use these instructions to complete the form:
1. Read all parts of the form.
2. Print the employees name where indicated.
3. Circle A, B, or C regarding whether the employee is to receive a (A) new pair of safety eyewear OR (B) repair of existing pair of safety eyewear OR C if this is for a 2nd pair of prescription sunwear. (a separate form is required for each pair of glasses).
4. Circle Y or N to indicate whether a Hazardous Assessment has been completed. Note: UOEHSM performs Hazard Assessments to determine the need for personal protective equipment (PPE), including safety eyewear, and to select the most appropriate PPE for the job. Upon completion of the assessment, UOEHSM will generate a “Certification of Hazard Assessment for PPE Selection” and send this to the affected department. An employee being issued safety eyewear under this policy must check with his/her department to determine whether an Assessment is on file. The employee must read the Assessment and follow the guidelines given therein. Assessment forms should contain guidelines on safety eyewear and eyewear side shield selection.
5. Circle Y or N to indicate if side-shields are required and if so, the type of side-shield.
6. Read the “Options Not Covered by the IU Safety Eyewear Plan which must be paid for by the employee” section of the form and note any lens options that are approved by the certification of hazard assessment for PPE use (UOEHSM) from the “Options Not Covered by the IU Safety Eyewear Plan” at the bottom of the form.
7. Enter the departmental billing information (account / sub account number, object / sub object codes) to be used in billing for the safety eyewear.
8. The supervisor must print their name and title, sign the appropriate line, and indicate the date and phone number.
9. If prescription safety eyewear is determined necessary after completion of the Hazard Assessment, a UOEHSM representative must sign the form.

Note: Form will not be valid without signature.
Appendix 10

Indiana University Alcohol and Drug-Free Campus Policy

In compliance with the Drug-Free Workplace Act of 1988, and of the federal Drug-Free Schools and Communities Act Amendments of 1989, the following policy will govern the conduct of all University students and employees (including, but not limited to faculty, appointed and hourly employees, and student-hourly employees) on all campuses and workplaces controlled by Indiana University.

1. The unlawful manufacture, distribution, dispensation, possession or use of a controlled substance (usually referred to as illegal drugs listed under the federal Controlled Substance Act) and alcohol is prohibited on University property or in the course of a University activity.

2. As a condition of employment with Indiana University, University employees are required:
   a. To abide by the prohibition contained in paragraph 1, above; and
   b. To notify the campus Chancellor of any criminal drug statute conviction for a violation occurring on University property no later than five days after such conviction.

3. Any person employed by the University found to be under the influence of alcohol or a controlled substance while on University property, or in the course of a University activity, is subject to disciplinary action described in paragraph 5, below.

4. Any University employee convicted of a criminal alcohol violation or of a violation of the criminal drug statutes occurring on University property is subject to disciplinary in paragraph 5, below.

5. Consistent with local, state, and federal law, and with applicable Indiana University policies and procedures, Indiana University will discipline students and employees who violate this Alcohol and Drug-Free Campus Policy up to and including expulsion, termination of employment, and/or referral for prosecution. Discipline may also include the completion of an appropriate rehabilitation program.

6. Any employee whose use of alcohol or of controlled substances away from the University can reasonably be established to be the cause of poor attendance or performance problems may be counseled to seek rehabilitation from available University or community resources. See the University’s publication “Procedure for Handling Alcohol and Drug Abuse Among Staff Employees” or the local telephone directory for a list of available resources.

7. When notice of a criminal drug statute conviction for a violation occurring on University property is received, the campus Chancellor’s Office will coordinate compliance with the reporting requirements of the Drug-Free Workplace Act of 1988.

8. Each campus Human Resources Office shall maintain and periodically publish for its campus a list of available University and community resources for alcohol or drug abuse assistance or rehabilitation programs. In addition, each campus Human Resources Office shall provide employees with information about the dangers of alcohol or drug abuse in the workplace.

9. Students may obtain information regarding drug or alcohol counseling, treatment, or rehabilitation programs from Indiana University’s Alcohol-Drug Information Center, Student Health Center, Counseling and Psychological Services, or Dean of Students Office.

Criminal Penalties - Alcohol and Drugs

All students and employees are reminded that conviction under state and federal laws that prohibit alcohol-related and drug-related conduct can result in fines, confiscation of automobiles and other property, and imprisonment. In addition, licenses to practice in certain professions may be revoked, and many employment opportunities may be barred.

Health Risks Associated with Alcohol and Controlled Substance (Drugs)

All persons should be aware of the health risks caused by the use of alcohol, and by the illegal use of controlled substances (drugs).

• Consumption of more than two (2) average servings of alcohol in several hours can impair
coordination and reasoning and make driving unsafe.

- Consumption of alcohol by a pregnant woman can damage the unborn child. A pregnant woman should consult her physician about this risk.
- Regular and heavy alcohol consumption can cause serious damage to liver, nervous and circulatory systems, mental disorders and other health problems.
- Drinking large amounts of alcohol in a short time may quickly produce unconsciousness, coma and even, death.

Use of controlled substances (drugs) can result in damage to health and impairment of physical condition, including:

- Impaired short-term memory or comprehension.
- Anxiety, delusions, hallucinations.
- Loss of appetite resulting in general damage to the user’s health over a long term.
- A drug-dependent newborn if the mother is a drug user during pregnancy. Pregnant women who use alcohol, drugs, or who smoke should consult their physicians.
- AIDS, as a result of “needle-sharing” among drug users.
- Death from overdose.

The health risks associated with drugs or excessive use of alcohol are many and are different for different drugs. The excessive use of alcohol and the use of controlled substances not prescribed by a physician are harmful to one’s health.

Indiana University Equal Opportunity/Affirmative Action Policy
Indiana University pledges itself to continue its commitment to the achievement of equal opportunity within the university and throughout American society as a whole. In this regard, Indiana University will recruit, hire, promote, educate, and provide services to persons based upon their individual qualifications. Indiana University prohibits discrimination based on arbitrary consideration of such characteristics as age, color, disability, ethnicity, gender, marital status, national origin, race, religion, sexual orientation, or veteran status.

Indiana University shall take affirmative action, positive and extraordinary, to overcome the discriminatory effects of traditional policies and procedures with regard to the disabled, minorities, women, and Vietnam-era veterans. An Affirmative Action office on each campus (Bloomington: 812-855-7559; Indianapolis: 317-274-2306) monitors the university’s policies and assists individuals who have questions or problems related to discrimination.

Indiana University Policy against Sexual Harassment
Harassment on the basis of sex is a violation of federal and state law. Indiana University does not tolerate sexual harassment of its faculty, staff, or students. Individuals who believe they are victims of sexual harassment, as well as those who believe they have observed sexual harassment, are strongly urged to report such incidents promptly. Indiana University will investigate every sexual harassment complaint in a timely manner and, when there is a finding of sexual harassment, take corrective action to stop the harassment and prevent the misconduct from recurring. The severity of the corrective action, up to and including discharge or expulsion of the offender, will depend on the circumstances of the particular case.

Once a person in a position of authority at Indiana University has knowledge, or should have had knowledge, of conduct constituting sexual harassment, the University could be exposed to liability. Therefore, any administrator, supervisor, manager or faculty member who is aware of sexual harassment and condones it, by action or inaction, is subject to disciplinary action.

Definitions
Following federal guidelines, Indiana University defines sexual harassment as follows:
Unwelcome sexual advances, requests for favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment when:

- Submission to such conduct is made either explicitly or implicitly a term or condition of an individual’s employment or academic advancement;
- Submission to or rejection of such conduct by an individual is used as the basis for employment or academic decisions affecting such individuals; or
- Such conduct has the purpose or effect of unreasonably interfering with an individual’s work or academic performance or creating an intimidating, hostile, or offensive working or learning environment.

Application
This University policy is designed to protect all members of the University community. It applies to relationships among peers, as well as to superior/subordinate relationships. It also applies to all individuals, regardless of their gender or sexual orientation.

Provisions
Faculty, staff, and students have the right to raise the issue of sexual harassment. Further harassment against complainants or retaliation against complainants or others who participate in the investigation of a complaint will not be tolerated. Appropriate and prompt disciplinary or remedial action will be taken against persons found to be engaging in such further harassment.

The University will deal with reports of sexual harassment in a fair and thorough manner, which includes protecting, to the extent possible and to the extent permitted by law, the privacy and reputation interests of the accusing and accused parties.

Education is the best tool for the prevention and elimination of sexual harassment. Each dean, director, department chair, and/or administrative officer is responsible within his/her area of jurisdiction for the implementation of this policy, including its dissemination and explanation.

It is the obligation and shared responsibility of all members of the University community to adhere to this policy.

Enforcement Principles
Enforcement and implementation of this sexual harassment policy will observe the following principles:

- Each campus must have procedures – consistent with notions of due process – for implementing this policy including where complaints are made, who investigates complaints, how complaints are resolved, what procedures are available for appeals, and how records are kept.
- The Campus Affirmative Action Officer (Bloomington: 812-855-7559; Indianapolis: 317-274-2306) shall serve as a resource with regard to interpretation of sexual harassment guidelines.
- Confidentiality of information relating to investigations of complaints of sexual harassment shall be maintained to the extent practical and appropriate under the circumstances and to the extent permitted by law. Individuals charged with implementing this policy shall share information with regard to given incidents of sexual harassment only with those who have a “need to know” in order to implement this policy.
- Investigations must be conducted promptly and thoroughly.
- Whether particular actions constitute sexual harassment will be determined from the facts, on a case-by-case basis. The university will look at the record as a whole, as well as the context in which the alleged misconduct occurred.
- Both the charging party and the respondent will be notified of the outcome of the investigation.
- In the event it is found that sexual harassment has occurred, corrective action, up to and including discharge or expulsion of the offender, will be taken through the appropriate channels of the university. The corrective action will reflect the severity and persistence of the harassment, as well as the
effectiveness of any previous remedial action. In addition, the university will make follow-up inquiries to ensure the harassment has not resumed and the complainant has not suffered

Immunization Policy
No one can see patients in clinic until verification of all immunizations is provided.

You should have received most of the immunizations listed below as a child. Although you were required to present verification of childhood immunizations to the Bursar’s office upon enrolling at Indiana University, the School of Optometry does not have access to this information and therefore duplicate verification of immunization status MUST be provided to the IU School of Optometry, Director of Clinics.

Because of direct patient contact during your time in clinic you are required to provide the IUSO proof of the immunizations listed below prior to entering clinic. This information can be provided by your physician on an immunization card. Keep the original card for your personal medical records, and bring a copy of this card to the office of the Director of Clinics in room 306.

To insure that all students meet the immunization requirements prior to entering clinic, it is mandatory that all students begin their Hepatitis-B vaccination series during their first semester of coursework, and that proof of completion of the series be provided to the IUSO by the completion of their first year of coursework.

Hepatitis-B
Hepatitis-B is a viral infection which causes inflammation of the liver. Although it is usually a mild illness that normally resolves in 3 to 4 months, it can occasionally cause severe illness and may be fatal in rare instances. Hepatitis-B infection is usually transmitted by direct contact with Hepatitis-B virus contaminated blood and blood products.

Because of patient contact, you are at increased risk for acquiring Hepatitis-B. You are therefore required to get the Hepatitis B vaccination series. You must furnish proof that you have started this vaccination series before entering clinic.

The vaccine is effective for preventing infection, and experience acquired since its widespread use indicates that it is safe and well tolerated. The following information relates to this vaccine:

- It consists of a series of three (3) injections over a six (6) month period.
- It is safe with no risk of contacting hepatitis or any other disease as a result of vaccination.
- It is effective in over 95% of people who complete the series.
- Booster shots for those who have completed the series in the past are not currently recommended by the Center for Disease Control (CDC).

Measles/Mumps/Rubella Vaccine (MMR)
You must have received the appropriate vaccination (per university requirements) against measles, mumps, and rubella.

Polio
You must have received the appropriate vaccination against polio.

Smallpox
The Indiana University School of Optometry does not require its students, faculty, or staff to be vaccinated against the smallpox virus.

As the vaccination uses a live form of the smallpox virus, there is a small possibility that a recently vaccinated individual can spread the virus to others. All who voluntarily undergo smallpox vaccination must therefore report their vaccination to the Director of Clinics before they come in contact with patients. The Director of Clinics will determine the appropriate response to recent vaccination based on the most up-to-date information available. A valid response might include, but is not limited to, short-term suspension
of direct patient contact and care.

Further information about the smallpox virus and the risks and benefits of vaccination can be found at the Centers for Disease Control and Prevention website at www.bt.cdc.gov.

Tetanus and Diphtheria
Within the past 10 years you must have received a vaccination against tetanus and diphtheria.

Tuberculosis
You must provide proof to the IUSO that you have had a PPD skin test for tuberculosis within the last three months. If you have a newly positive reaction to the skin test, a chest x-ray is required and the results should be recorded on your immunization card. Your physician should indicate what treatment (if any) you received as a result of a positive chest x-ray. PPD testing is offered each spring at the IUSO, and is required yearly. A completed Signs and Symptoms Questionnaire will be required annually for those who have previously had a positive PPD test.

Immunizations Required by External Rotation Sites
Fourth year students should contact their external rotation sites for their immunization requirements.

Appendix 11
Exposure Control Policies

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Introduction
On December 6, 1991, the Occupational Safety and Health Administration (OSHA) promulgated a final rule entitled “Occupational Exposure to Blood Borne Pathogens”. Indiana Occupational Safety and Health Administration (IOSHA), the governing body for the occupational health and safety in Indiana, adopted the federal standard without change. The purpose of the standard is to eliminate or minimize occupational exposure to the Hepatitis B virus (HBV), the Hepatitis C virus (HCV), the Human Immunodeficiency Virus (HIV), and other blood borne pathogens.

The risk of exposure to blood borne pathogens by optometry clinic personnel is low except as it pertains to the use of sharps (i.e., needles). Situations may arise in which our risk of is increased such as when a patient vomits or experiences a bloody nose, the examiner has breaks or cuts in the skin, or emergency first aid is administered.

Even though optometrists are not generally at high risk, an awareness of high risk situations, the mechanisms of exposure, the availability of personal protective equipment, and what to do if exposure occurs, among other issues, is imperative.

Portions of this manual have been rewritten from the Bloodborne Pathogens Exposure Control Plan – Indiana University – Bloomington Campus (May 1, 2000).

School of Optometry OSHA Compliance Officer
The current IUSO OSHA Compliance Officer is Doug Horner, OD. He can be reached at:

812-855-____

hornerdg@indiana.edu

Exposure Incident Defined
An exposure incident occurs when a person contacts with potentially infectious materials that can cause the transmission of disease. The three (3) recognized modes of workplace transmission of blood borne pathogens that require medical treatment are:

1. Parenteral Exposure
   Piercing, puncturing or cutting the skin with potentially-contaminated sharp items. Examples include needle sticks, human bites, or cuts with broken glass.

2. Exposure to Non-Intact Skin
   Contact of potentially infectious material with existing cuts, rashes, abrasions or other breaks in the skin.

3. Mucous Membrane Exposure
   Splashing or spraying of potentially infectious materials into unprotected eyes, nose or mouth.

What to Do In the Event of an Exposure Incident
Exposure incidents require written reporting and medical attention. The following protocol (much of it taken from the CDC document Exposure to Blood - What Health-Care Workers Need to Know, included in the Appendices) should be followed when an exposure incident occurs:

1. Wash the exposed area immediately and thoroughly.
2. Flush splashes to the nose, mouth, or skin with water.

3. Irrigate eyes with clean water, saline, or sterile irrigants.

4. Remove soaked clothing, wash skin and put on clean, dry clothing.

No scientific evidence shows that using antiseptics or squeezing the wound will reduce the risk of transmission of a bloodborne pathogen. Using a caustic agent such as bleach is not recommended.

5. Report the exposure

Your clinical consultant or work supervisor and the IUSO OSHA compliance officer should be notified immediately. They are responsible for immediately contacting the appropriate university authorities responsible for managing exposures. Prompt reporting is essential because, in some cases, postexposure treatment may be recommended and it should be started as soon as possible.

Federal law HR 5178 (the Needlestick Safety and Prevention Act) requires that all percutaneous injuries from contaminated sharps be recorded and maintained in a log that minimally contains:

a. The type and brand of device involved in the incident,

b. The department or work area where the exposure incident occurred, and

c. An explanation of how the incident occurred.

6. Seek immediate medical counsel

Discuss the possible risks of acquiring HBV, HCV, and HIV and the need for postexposure treatment with the provider (who should be familiar with current CDC guidelines for postexposure prophylaxis for HBV, HCV, and HIV) managing your exposure. You should have already received hepatitis B vaccine, which is extremely safe and effective in preventing HBV infection.

7. Complete an Incident Report. Include the name of the source individual, if known.

8. Maintain recommended follow-up schedules.

Telephone Numbers

All phone calls from IECC and IU Eye at Carmel must be preceded by a “9” to get an outside line.

In the event that you are exposed to an infectious or pathogenic agent, or if you have any questions regarding exposure control, immediately call the following numbers:

- Police, Fire, Emergency Medical Service: 911
- Bloomington - Department of Environmental Health and Safety: 812-855-6311
- Indianapolis - Department of Environmental Health and Safety: 317-274-2005
- IUSO OSHA Compliance Officer: 317-321-1470

Sources of Blood Borne Infections

Certain human-source fluids and materials are likely carriers of infectious viruses if the host is infected. A list of the most likely infectious waste materials follows:

- Amniotic Fluid
• Blood
• Cerebrospinal Fluid
• Pericardial Fluid
• Peritoneal Fluid
• Pleural Fluid
• Semen
• Synovial Fluid
• Unfixed Human Body Tissue (other than intact skin)
• Vaginal Secretion

Other body fluids are believed to possess little risk for carrying and transmitting pathogenic viruses. The following are not included as sources of blood borne pathogens (unless they contain blood):

• Feces
• Nasal Secretions
• Saliva (except in dental treatment)
• Sputum
• Sweat
• Tears
• Urine
• Vomitus

Personal Protective Equipment

Personal Protective Equipment (PPE) includes items worn by an employee to provide a barrier between the worker and contaminated materials. PPE must be supplied by the employer at no cost to the employee. Appropriate sizes and types of equipment must be provided in the location where they are to be used.

Potentially contaminated PPE must be removed before leaving the area where it is used.

Examples of the type of PPE used and some of their characteristics are as follows:

**Gloves**

- Gloves are required when manual contact is initiated with potentially infectious materials such as blood.
- Must be appropriate for the task.
- Must be available in appropriate sizes and in hypo-allergenic (non-latex) versions.
- Gloves are to be considered single use devices, and properly disposed of as hazardous waste after use.

**Eye and Face Protection**

- Eye and face protection is required when danger of splashing or spraying of infectious materials is anticipated.
- Safety glasses are the minimum protection. Face shields and surgical-type masks may be required.
Clothing

- Fluid-resistant clothing must be worn if there is potential for splashing and soak through.
- All clothing (lab coats, scrubs) that is potentially contaminated with blood borne pathogens must be laundered through the University – do not take potentially contaminated clothing home for cleaning.

CPR/Resuscitation Equipment

- CPR/Resuscitation PPE is required for employees whose job includes CPR or emergency treatment.
- One-way masks are required for mouth-to-mouth resuscitation.

Warning Signs and Labels

Biohazardous warning signs and labels are used to notify all persons of the presence of potentially infectious materials. For blood borne pathogens these signs and labels are required to be fluorescent orange or orange-red with words and symbols in a contrasting color.

Biohazardous labels are required for the following situations:

- Biowaste containers
- Refrigerators/freezers used to store blood or other infectious materials
- Containers for storing, transporting, or shipping blood or other infectious materials.
- Contaminated equipment requiring handling for service, repair or shipping.

Work Practice Controls

Work practice controls involve altering the way a task is performed to reduce or eliminate exposure to potentially infectious materials. IUSO has adopted the following work practice controls:

- Recapping of needles is prohibited. Dispose of all needles in an appropriate sharps container.
- Hand washing after contact with potentially infectious materials is required.
- Eating, drinking and like activities in areas where potentially infectious materials are used or stored is prohibited.
- Methods that minimize splashing or spraying of potentially infectious materials must always be used.
- Absorbent coverings for countertops and equipment to contain spills or splashes and to facilitate easier cleanup must be used when potentially infectious materials are present.
- All potential exposure incidents must be reported immediately to the clinic consultant and IUSO OSHA Compliance Officer.

Housekeeping, Decontamination and Spill Cleanup

All work areas where potentially infectious materials are used must be maintained in a clean and sanitary condition.
If a spill of a potentially infectious material or bodily fluid occurs, the Environmental Health and Safety Department should be contacted (Bloomington: 812-855-6311; IECC: 9-573-6060;) to initiate clean up. Under no circumstances should you try to clean up potentially infectious materials or bodily fluids.

Regulated and Other Infectious Waste
Regulated waste is waste that is capable of transmitting disease to those handling it. Examples of regulated waste, according to Indiana State regulation, include the following:

• Liquid or semi-liquid blood or other potentially infectious materials.
• Contaminated items capable of releasing blood or other contaminated materials if compressed.
• Items caked with dried blood or other potentially infectious materials which are capable of releasing these materials during handling.
• Contaminated sharps.
• Human tissues.
• Infectious biological cultures or agents.
• Contaminated animal carcasses, body parts and bedding.

It is also recommended that the following materials be included in the infectious waste stream:

• Potentially contaminated disposable gloves.
• Potentially contaminated surface or equipment protective coverings that are.
• Bandages that have contacted blood or other body fluids.

Containment and Disposal of Infectious Waste
Infectious waste must be divided into two (2) waste streams: sharp and non-sharp items. Non-sharp items, including disposable gloves, gowns and barrier materials, are disposed in an infectious waste bag. Sharps include items that are sharp in their original form or can become sharp on breaking or bending. Sharp items are disposed in puncture-resistant sharp containers, typically constructed of heavy-duty plastics. Sharps include the following:

• Glassware
• Needles
• Pasteur pipets
• Rigid plastic pipettes
• Scalpels
• Syringes

Infectious waste must be treated to eliminate its infectious properties prior to disposal. The primary treatment for infectious waste is autoclaving, a heat treatment for inactivating infectious materials. If there is an autoclave within the department or building, infectious waste can be treated on-site and marked “treated”. Once infectious waste has been properly autoclaved and marked as such, it can be disposed as ordinary trash.

If there is no autoclave available for use within the department or building, contact Environmental Health and Safety for information on treatment and disposal of infectious waste.
NOTE: Although human blood is listed as a regulated infectious waste, it is allowed to be disposed in sink or sewer drains as long as it is done carefully without splashing and is thoroughly washed down the drain with water. The sewage system and treatment plant provide appropriate treatment for this material.

Clinical Disinfection Procedures
Disinfection of Goldmann Tonometer Probes

Goldmann probes are to be left in the exam rooms. It is the intern’s responsibility to ensure that the probe has been properly disinfected prior to each use.

Please read the directions below and follow them exactly to assure proper disinfection of the probes:

1. You must disinfect the probes between patients with an alcohol pad.
2. Let the probes air dry for approximately two minutes.
3. Make certain you rinse the probes carefully after air drying with saline. Do not use tap water.
4. You may use no-lint tissue paper to dry the saline. Do not use paper towels. They will craze the probe surface.

Note: If you are using a probe on the same patient, rinse the probe with saline and dry with no-lint tissue paper.

Trial Contact Lens Disinfection

1. Return all used trial contact lenses to the designated area.
2. Wear sterile or non-sterile examination gloves, then wash your hands to remove glove powder.
3. All trial contact lenses, including hard, gas permeable and soft lenses, are to be disinfected using products effective against the HIV virus as directed by the dispensary technician.
4. All contact lens vials are to be emptied of the used saline, filled with 3% hydrogen peroxide and left for 10 minutes, emptied and rinsed well with saline solution (not water) and refilled with fresh saline before inserting the disinfected lens. Contact lens cases used in-office should be discarded after each use or given to the patient for whose lenses it was utilized.

Surgical Instruments Disinfection (excluding Alger brush)

Following usage the metal anterior segment surgical instruments are to be soaked for 10 minutes in a fresh 3% hydrogen peroxide solution, then run through a cycle in the heat sterilizer.

Clinical Precautions and Procedures

You are not to handle any body fluid spills other than those encountered in the course of a normal optometric examination (e.g., tears). If a body fluid spill occurs (e.g., vomit, blood, etc.), contact your faculty consultant or supervisor immediately. The consultant or supervisor will have the body fluid spill removed by appropriate personnel.

1. Wash your hands with soap and water or use an alcohol-based hand rub immediately before and after performing a procedure that results in patient contact. Perform this step whether or not gloves are worn.
2. Use a sterile cotton-tipped applicator to examine a red eye patient.
3. You are encouraged to wear gloves when working with contact lens patients or when coming into contact with tears. You must do so if you have cuts, scratches or other dermatologic lesions on
your hands. If you are using powdered gloves, wash your hands after putting the gloves on to avoid powder contamination of any surfaces.

4. If your patient appears ill and you believe body fluid spills such as vomiting may occur, suggest to the patient that they reschedule the appointment. Immediately seek out your consultant if you believe a potential body fluid spill could be avoided by rescheduling.

5. If you are ill with a potentially contagious condition such as a cold or the flu, it is recommended that you refrain from patient care (refer to the chapter General Operational Policies and Procedures for the IUSO clinic "Attendance Policy")

6. Disposable surgical masks are available for your use. The use of a mask during patient care is strongly encouraged in cases where you or the patient might harbor a potentially contagious condition.

IECC Laser Safety Policy
The following information pertains to the Diode Laser used by our Ophthalmology Service.

General Summary of Hazards
- The Diode Laser is a Class 4 laser.
- No laser hazard is present if the instrument is turned off.
- Class 4 lasers can damage the eyes via direct or reflected exposure (i.e., walls, mirrors, instruments, etc.).
- A warning sign is needed when the laser is in use in room Green 1.
- Except for the patient and the operator of the laser, personal protective equipment (laser safety glasses) must be worn by all persons in or entering Green 1 while the laser is in use.
- The risk of injury is minimal when laser safety procedures are followed.

Operation of the Diode Laser in Room Green 1
- Only the IECC Staff Ophthalmologist or his/her staff member is allowed to set up the slit-lamp mounted Diode Laser in Green 1.
- The laser is not operational without a key. Only the IECC Staff Ophthalmologist or a member of his/her staff is allowed to turn on the laser with the key.
- The “Danger: Laser, Wear Eye Protection” sign is mounted on the door to room Green 1 whenever the laser is in use.
- The appropriate informed consent is reviewed with the patient and signed.
- The patient is positioned behind the slit lamp/laser and the appropriate laser contact lens is applied.
- The IECC Staff Ophthalmologist will confirm that all those in the room, except the laser operator and the patient, are wearing appropriate laser safety glasses.
- The patient will be advised that the treatment is about to begin.
- The laser is set in the treatment mode and the treatments are delivered.
- After appropriate intervals, the IECC Staff Ophthalmologist will signal the observing interns and/or faculty to rotate, and he will ensure that the door to Green 1 is shut and that the laser safety glasses are being worn.
Tuberculosis Exposure Information
The pamphlet *TB Facts for Health Care Workers* is included as an appendix to this document.

Material Safety Data Sheets (MSDS)
A Material Safety Data Sheet (MSDS) is a document which provides workers and emergency personnel with the proper procedures for handling or responding to exposure to a particular substance. An MSDS summarizes information such as the physical properties of the substance, toxicity, health effects, first aid, reactivity, storage, disposal, protective equipment, and spill/leak procedures. OSHA mandated MSDS's for hazardous materials effective May 26, 1986. MSDS's are meant for:

1. Employees who may be occupationally exposed to a hazardous material at work.
2. Employers who need to know the proper methods for storage and handling hazardous material at work.
3. Emergency responders and medical personnel who need to know how to handle and treat individuals exposed to hazardous materials.

MSDS's are kept on file at each Eye Care Center in the Director’s or Chief of Clinic’s office.