| **NEW Professional Optometric Residency Standards Mandatory on July 1, 2017** |  
* (revised 2019) *A copy of the new standards in sequential order may be found on the ACOE web site at: https://www.aoa.org/documents/ACOE/Residency_Standards_Adopted_by_ACOE_effective_07_2017_updated_08_2019.docx |
<table>
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<td><strong>Core Competencies</strong></td>
<td>An ACOE accredited school or college of optometry that has educational responsibility for a residency that is sponsored by a non-ACOE accredited health care entity. Faculty appointment, curriculum development, and program assessment are examples of educational responsibilities of the affiliated school or college of optometry.</td>
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<td><strong>Curriculum</strong></td>
<td>The fundamental components common to all residency programs and expected achievements for all residents. The components result in the attainment of advanced proficiency in areas of clinical knowledge and patient care specific to the mission of the residency.</td>
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<td>That individual at the affiliated school or college of optometry who is administratively responsible (regardless of title) for the overall quality of the residency program(s) of that institution.</td>
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* Effective July 1, 2009 Adopted by the ACOE at its Winter Meeting, February 8-10, 2008; Revised October 2009, October 2010, February 2012 |
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<td>Patient Centered Care</td>
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<th>The minimum infection prevention measures that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where healthcare is delivered. These evidence-based practices are designed to both protect healthcare personnel and prevent the spread of infections among patients. Standard Precautions include: 1) hand hygiene, 2) use of personal protective equipment (e.g., gloves, gowns, facemasks), depending on the anticipated exposure, 3) respiratory hygiene and cough etiquette, 4) safe injection practices, and 5) safe handling of potentially contaminated equipment or surfaces in the patient environment.</th>
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| **NEW Terminal Degree** | The highest academic or professional degree in a given field of study. |

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<td><strong>Examples of Evidence:</strong></td>
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<td><em>NEW</em></td>
<td>INTENT: The resident should spend a significant percentage of time engaged in patient care activities that prepare the resident to practice independently with advanced competency.</td>
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1.2 Specific goals must define the accomplishments necessary to achieve the mission.

*Examples of evidence:*
- Program goals

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*Examples of evidence:*
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1.3 One or more assessable objectives for each goal must specify how that goal is to be met.

*Examples of evidence:*
- Program objective(s) for each goal

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*Examples of evidence:*
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1.4 The residency must annually review the fulfillment of its objectives to determine the degree to which it has attained its mission and goals.

*Examples of evidence:*
- Description of review process
- Outcome measures used to assess fulfillment of objectives
- Copy of most recent annual review (except for programs seeking initial accreditation)

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*Examples of evidence:*
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| 1.5.1   | The resident must evaluate the residency at least semi-annually.  
**Examples of evidence:**  
- Completed program evaluations |
| 1.5.2   | The resident must evaluate the coordinator at least semi-annually.  
**Examples of evidence:**  
- Completed evaluations of coordinator |
| 1.5.3   | At least semi-annually, the resident must evaluate the faculty with whom the resident interacts at least weekly.  
**Examples of evidence:**  
- Completed faculty evaluations |
| 1.5.4   | The resident must receive at least two interim and one final performance evaluations.  
**Examples of evidence:**  
- Completed resident evaluations |
| 1.6     | The residency must modify its program if indicated by the annual review or its analysis of the evaluations.  
**Examples of evidence:**  
- Analysis of program, faculty and resident evaluations |

**NEW**  
INTENT: The intent is to provide the program with periodic feedback regarding the resident's perception of program quality.  
**Examples of evidence:**  
- Completed program evaluations

INTENT: The resident must evaluate those faculty members considered to provide mentoring and oversight as related to accomplishment of the mission, goals, and objectives of the residency.  
**Examples of evidence:**  
- Completed faculty evaluations

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**Examples of evidence:**  
- Analysis of program, faculty and resident evaluations
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<th>1.7</th>
<th>The residency must achieve at least a 70% completion rate within the previous seven year period, or the ACOE will initiate an appropriate review of the residency.</th>
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<td>Examples of evidence:</td>
</tr>
<tr>
<td></td>
<td>- Analysis of completion rate</td>
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**NEW**

INTENT: While the Council recognizes that residents may occasionally leave the program for personal reasons, the intent of this standard is to ensure the appropriate quality of the program and selection of qualified residents.

**Examples of evidence:**
- Analysis of completion rate

<table>
<thead>
<tr>
<th>1.8</th>
<th>Within the previous seven year period, 70% of those who have completed the residency must have worked in a clinical, education, research or administrative setting within one year of completion of the residency, or the ACOE will initiate an appropriate review of the residency.</th>
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<td>Examples of evidence:</td>
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<td>- Tabulation of career placement rates in related fields of residents within one year of completion</td>
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<td>- Listing of known reasons for non-placement of any residents who did not work within one year of program completion (i.e., personal choice, unable to find work in desired area, health issues, etc.)</td>
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<th>1.8</th>
<th>Within the last eight years, 70% of those who have completed the residency must have worked in a clinical, education, research or administrative setting within two years of completion of the residency, or the ACOE will initiate an appropriate review of the residency.</th>
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**NEW**

INTENT: The program must demonstrate that it appropriately prepares the resident to successfully enter into a career utilizing the skills attained from the residency.

**Examples of evidence:**
- Tabulation of career placement rates in related fields of residents within two years of completion
- Listing of known reasons for non-placement of any residents who did not work within two years of program completion (i.e., personal choice, unable to find work in desired area, health issues, etc.)

**Standard II: Curriculum**

2.1 The residency must have a written curriculum that identifies and describes the specific activities for the fulfillment of the clinical, educational, research and administrative experiences of the residency.
<table>
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| didactic and scholarly elements of the mission, goals, and objectives of the program. | Examples of evidence:  
- Written curriculum description  
- Typical weekly schedule of the resident  
- List of clinical activities  
- List of didactic activities  
- List of scholarly activities |
| 2.1.1 The term of the residency must be equivalent to a minimum of 12 months of full-time training. | 2.1.1 The term of the residency must be equivalent to a minimum of 12 months of full-time training. |
| 2.2. The resident’s involvement in patient care must fulfill the residency’s mission, goals and objectives and lead to an advanced level of competence. | 2.2. The resident’s involvement in patient care must fulfill the residency’s mission, goals and objectives and develop an advanced level of clinical competence. |
| 2.2.1 The residency must maintain a record of the resident’s patient encounters that includes diagnoses, and the level of the resident’s involvement (direct, precepting or observational.) | 2.2.1 The residency must maintain an accurate record of the resident’s patient encounters that includes diagnoses, and whether each patient encounter was direct, precepting or observational. |
| Examples of evidence:  
- A record of the resident’s patient encounters that includes diagnoses, and the level of the resident’s involvement (direct, precepting, or observational)  
- Summary or analysis of ICD or CPT codes | Examples of evidence:  
- A record of the resident’s patient encounters that includes diagnoses, and the level of the resident’s involvement (direct, precepting, or observational)  
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| 2.3 The residency must follow a written supervision policy that affords the resident progressively increasing responsibility based upon demonstrated clinical competence. | 2.3 The residency must follow a written supervision policy that affords the resident progressively increasing responsibility based upon demonstrated clinical competence. |
| Examples of evidence:  
- Written supervision policy  
- Records of assessment of resident for determining levels of supervision | *NEW* INTENT: The intent of the supervision policy is to ensure appropriate educational oversight of the resident throughout the program’s duration. The policy serves as a guide to the faculty to assess the resident’s level of attainment of advanced clinical |
### 2.4 The residency must specify in the curriculum the specific knowledge, skills and behaviors needed to attain core competencies and must require the resident to attain core competencies specific to the program’s mission. At a minimum, the resident must attain the core competencies specified in standards 2.4.1 through 2.4.6 below.

**Examples of evidence:**
- Curriculum

2.4.1 The resident must be able to diagnose and manage conditions that include complex, subtle or infrequently seen visual disorders and clinical presentations by using advanced diagnostic and treatment modalities when indicated.

**Examples of evidence:**
- Record of resident’s patient encounters
- Summary or analysis of ICD or CPT codes

2.4.2 The resident must be able to provide patient-centered care for those with complex conditions through patient education, communication, and shared decision making with the patient.

**Examples of evidence:**
- Evaluations of the resident

2.4 The curriculum must specify the knowledge, skills and behaviors required for the resident to attain the advanced competencies indicated in the program’s mission, goals and objectives. At a minimum, the resident must attain the core competencies specified in standards 2.4.1 through 2.4.6 below.

*NEW*

**INTENT:** The intent of Standard 2.4 is to ensure the residency provides clinical, didactic and scholarly activities that will develop advanced clinical competence, effective communication skills, and lifelong learning skills.

**Examples of evidence:**
- Written curriculum made available to the resident

2.4.1 The resident must be able to diagnose and manage complex, subtle or infrequently seen visual disorders and clinical presentations by using standard of care diagnostic and treatment modalities.

**Examples of evidence:**
- Record of resident’s patient encounters
- Summary or analysis of ICD and/or CPT codes to discern the complexity of patient care provided by the resident
- Patient records
2.4.3 The resident must function effectively within interprofessional environments, must demonstrate understanding of the role of other professionals and must be able to communicate and collaborate with other professionals to assure that appropriate resources are utilized for well coordinated patient care.

Examples of evidence:
- Evaluations of resident
- Interdisciplinary rotations
- Consult and referral requests
- Consult and referral responses
- Record of multidisciplinary activities
- Evaluation and treatment reports to other professionals

2.4.4 The resident must be able to continuously improve patient care through self-assessment and quality assurance.

Examples of evidence:
- Quality assurance activities involving residents
- Evaluations of resident

2.4.5 The resident must master, apply, and advance the resident’s knowledge by analyzing the best current scientific information and integrating this knowledge into patient care through evidence-based clinical decision making.

Examples of evidence:
- Journal club schedule
- Reading list
- Evaluations of resident

2.4.2 The resident must provide patient-centered care for those with complex conditions through culturally competent patient education, communication, and shared decision making with the patient.

Examples of evidence:
- Evaluations of the resident
- Patient records
- Surveys completed by patients

2.4.3 The resident must demonstrate an understanding of the role of interprofessional healthcare and must communicate and collaborate with other professionals to assure that appropriate resources are utilized for well coordinated patient care.

Examples of evidence:
- Evaluations of resident
- Interdisciplinary rotations
- Consult and referral requests
- Consult and referral responses
- Record of multidisciplinary activities
- Record of interprofessional education activities
- Evaluation and treatment reports to other professionals

2.4.4 The resident must be able to improve patient care through self-assessment and documented quality assurance activities.

Examples of evidence:
- Quality assurance activities involving residents
- Evaluations of resident
- Feedback from review of resident’s charts
- Chart reviews
| 2.4.6 | The resident must promote and disseminate knowledge through scholarly activities, such as lectures, presentations, publications, posters, or research.  

**Examples of evidence:**  
- Record of scholarly activities undertaken by individual resident(s) |
| 2.4.5 | *REVISED:* The resident must research and analyze current scientific information and integrate this knowledge into patient care through evidence-based clinical decision making.  

**Examples of evidence:**  
- Journal club schedule  
- Reading list  
- Evaluations of resident |
| 2.5 | The curriculum must include didactic activities, such as attending lectures, case conferences, continuing education courses, and/or grand rounds.  

**Examples of evidence:**  
- Record of didactic activities undertaken by individual resident(s) |
| 3.1 | A school or college of optometry accredited by the Accreditation Council on Optometric Education must be the program sponsor or the affiliate (by written agreement) to provide educational direction to the residency.  

**Examples of evidence:**  
- Written agreement between sponsor and affiliate (if applicable) |
3.2 The organizational structures and administration of the affiliate and the sponsor must enable professional autonomy in the delivery of optometric services and resident education commensurate with the evolving scope of optometric practice and in accordance with the mission, goals, and objectives of the residency.

**Examples of evidence:**
- Clinical privileging documents
- Clinical practice protocols of sponsor
- The affiliate’s organizational chart as it relates to the resident (if applicable)
- The sponsor’s organizational chart as it relates to the residency

3.3 The school or college of optometry must have a director of residency programs who provides effective educational and administrative guidance to the program, who is qualified to provide this guidance, and who is allocated adequate time to perform this duty.

**Examples of evidence:**
- Curriculum vitae of the director of residency programs
- Weekly schedule of the director of residency programs
- Records of communication between sponsor and affiliate such as emails, meeting agenda or minutes

3.2 The administration of the affiliate and the sponsor must enable professional autonomy in the delivery of optometric services and resident education commensurate with the evolving scope of optometric practice and in accordance with the mission, goals, and objectives of the residency.

**Examples of evidence:**
- Clinical privileging documents
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3.3 The school or college of optometry must have a director of residency programs who provides effective educational and administrative guidance to the program, who is qualified to provide this guidance, and who is allocated adequate time to perform this duty.

**NEW:**
3.3.1 The director of residency programs must have at a minimum the following qualifications: O. D. degree from an accredited school or college of optometry or its foreign equivalent and experience in residency education.

**INTENT:** The intent of this standard is to ensure that the director of residency programs has thorough administrative and educational knowledge to provide guidance and oversight to the residency.

**Examples of evidence:**
- Curriculum vitae of the director of residency programs
The residency must have a coordinator who is responsible for program administration and whose time dedicated to the residency is adequate to perform this duty.

### Examples of evidence:
- Curriculum vitae of the program coordinator
- Weekly schedule of the program coordinator

3.4.1 The coordinator must be available to the resident for administrative issues.

3.4.2 The coordinator must hold a faculty appointment at the affiliated school or college of optometry.

### Examples of evidence:
- Documentation of faculty appointment

3.4.3 The coordinator/supervisor must hold a doctoral degree in a clinical discipline, and either have completed an accredited residency plus one year of clinical experience or have obtained a minimum of five years of clinical experience.

**INTENT:** The intent of this standard is to ensure that the coordinator/supervisor has clinical, scholarly and educational experience to administer appropriate residency education.

### Examples of evidence:
- Curriculum vitae for program coordinator/supervisor

*NEW: Moved from former 4.1.2*

3.4 The residency must have a coordinator/supervisor who is responsible for program administration and whose dedicated time is adequate to perform this duty.

### Examples of evidence:
- Curriculum vitae of the program coordinator/supervisor
- Weekly schedule of the program coordinator/supervisor

3.4.1 The coordinator/supervisor must be available to the resident for administrative issues.

3.4.2 The coordinator/supervisor must hold a faculty appointment at the affiliated school or college of optometry.

### Examples of evidence:
- Documentation of faculty appointment
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| **Examples of evidence:**  
  - Records of clinical quality assurance process | *NEW:*  
  **INTENT:** The intent of this standard is to ensure appropriate quality of care provided by both the resident and residency faculty. |
| **Examples of evidence:**  
  - Internal/external ongoing peer review  
  - Chart review | *NEW:*  
  - Certificate of malpractice insurance  
  - Statement of coverage through the Federal Tort Claims Act  
  - MOU or other evidence specifying resident liability coverage for any external rotations *revised*  
  *revised* |
| 3.6 The residency must establish and adhere to its requirements for program completion. | 3.6 The residency must establish and adhere to its requirements for program completion. |
| **Examples of evidence:**  
  - Listing of program completion requirements  
  - Program completion statistics  
  - Annual review | **Examples of evidence:**  
  - Listing of program completion requirements  
  - Program completion statistics  
  - Annual review |
| 3.7 The residency must provide the resident’s professional liability protection at all educational sites. | 3.7 The residency must provide the resident’s professional liability protection at all educational sites. |
| **Examples of evidence:**  
  - Certificate of insurance  
  - Federal Tort Claims Act for U.S. Government-sponsored programs, with accompanying MOU’s for external rotations | **Examples of evidence:**  
  - Certificate of malpractice insurance  
  - Statement of coverage through the Federal Tort Claims Act  
  - MOU or other evidence specifying resident liability coverage for any external rotations *revised*  
  *revised* |

**Standard IV: Faculty**

<table>
<thead>
<tr>
<th>4.1 The coordinator and other faculty of the residency must have the qualifications to educate and train the resident in accordance with the mission, goals, and objectives of the residency.</th>
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</table>
| 4.1.1 The coordinator and other faculty of the residency must hold a doctoral level degree in a clinical discipline or | **Revised:**  
  4.1.1 Each faculty member of the residency must hold a |
| 4.1.2 | The coordinator must either have completed an accredited residency plus one year of clinical experience or have obtained a minimum of five years of clinical experience. **Examples of evidence:**  
- Curriculum vitae for program coordinator  
- Curriculum vitae or abbreviated biographical sketch for each faculty member with whom the resident interacts at least weekly |

| 4.2 | The coordinator and other faculty must have the professional autonomy and the authority to provide clinical care to train the resident in accordance with the mission, goals, and objectives of the residency. **Examples of evidence:**  
- Clinical care authorization (e.g., clinical privileges document) |

| 4.3 | The coordinator and other faculty must have sufficient time to educate and train the resident. **Examples of evidence:**  
- Each faculty’s weekly schedule as is applicable to the residency program |

| Standard V: Residents | 5.1 The program must publish its selection procedure including admission eligibility criteria which must be provided to applicants | 5.1 The residency must publish its selection procedure including admission eligibility criteria which must be provided to applicants when requested. |
when requested.

5.1.1 Admissions eligibility criteria must include the requirement that prior to matriculation applicants must have attained the Doctor of Optometry (O.D.) degree from a school or college of optometry accredited by the Accreditation Council on Optometric Education.

5.1.2 Non-discrimination policies must be followed in selecting residents.

5.1.3 The residency’s publications, advertising and resident recruitment materials and activities must present an accurate representation of the program.

*NEW*

INTENT: All programmatic materials should be in agreement with other publicly available documents, whether available electronically or in print.

**Examples of evidence:**
- Selection procedure
- Admissions eligibility criteria
- Application
- Recruitment advertisements/brochures

5.2 The residency must publish its policies regarding the following:

5.2.1 Duration of the resident’s training program,
5.2.2 Expected weekly hours of resident’s attendance including on-call duties (if any),
5.2.3 Resident’s compensation, which cannot be contingent upon productivity of the resident,
5.2.4 Resident’s health, professional and leave benefits,
5.2.5 Resident’s professional liability protection for both internal and external clinical settings,
5.2.6 Requirements for residency completion and awarding of certificate.

**Examples of evidence:**
- Selection procedure
- Admissions eligibility criteria
- Application
- Recruitment advertisements/brochures

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5.2.6 Requirements for residency completion and awarding of certificate.

**Examples of evidence:**
<table>
<thead>
<tr>
<th>5.3 The resident’s orientation to the program must include written information on:</th>
<th>5.4 The residency must maintain records of receiving, adjudicating and resolving resident complaints.</th>
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<td>5.3.1 Clinical practice protocols,</td>
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<td>5.3.2 Infection control,</td>
<td></td>
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<tr>
<td>5.3.3 Supervision policy,</td>
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<td>5.3.4 Facility safety policies,</td>
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<td>5.3.5 Counseling, remediation, and dismissal of the resident,</td>
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<td>5.3.6 Receiving, adjudicating, and resolving resident complaints or grievances,</td>
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<td>5.3.7 Due process provided to the resident on adverse decisions,</td>
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<td>5.3.8 The program’s academic calendar, including the program’s start date, end date and significant deadlines for program requirements,</td>
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<td>5.3.9 Criteria used to assess resident performance.</td>
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</tbody>
</table>

**Examples of evidence:**
- Orientation plan
- Documents and/or policies addressing the above provided to resident

*REVISED*

5.3 The resident’s orientation must include written information on:

*NEW*

**INTENT:** The intent of this standard is to ensure that the resident receives and has available for future reference the print or electronic orientation materials.

5.3.1 Clinical practice protocols consistent with ophthalmic professional standards,
5.3.2 Supervision policy,
5.3.3 Standard precautions for infection control,

*NEW*

**INTENT:** The intent of this standard is that the resident understands standard precautions to prevent the transmission of infection.

5.3.4 Facility safety policies,
5.3.5 Privacy and confidentiality policies,
5.3.6 Counseling, remediation, and dismissal of the resident,
5.3.7 Receiving, adjudicating, and resolving resident complaints or grievances,
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**Examples of evidence:**
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- Documents and/or policies addressing the above provided to resident
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