

VHA EYE CARE

- 1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) Handbook is issued to facilitate the provision of optimal eye care in the veterans health care system. It has been developed to support the efforts of local Department of Veterans Affairs (VA) health care facilities to deliver consistent and predictable high quality eye care, and emphasizes the use of interdisciplinary teams in the provision of eye care based on the belief that, by working as a team, VA can provide better eye care for the patient.
- 2. SUMMARY OF MAJOR CHANGES:** This handbook is consistent with all current VA standards and directives and is intended for use by administrators and clinicians in the field.
- 3. RELATED DIRECTIVE:** VHA Directive 1121 (to be published).
- 4. RESPONSIBLE OFFICE:** The Office of Patient Care Services (112) is responsible for the contents of this Handbook.
- 5. RESCISSIONS:** None.
- 6. RECERTIFICATION:** This VHA Handbook is scheduled for recertification on or before the last working day of July 2007.

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Under Secretary for Health

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1. PURPOSE

This Veterans Health Administration (VHA) Handbook was prepared to facilitate the provision of optimal eye care in the veterans health care system. It has been developed to support the efforts of local Department of Veterans Affairs (VA) health care facilities in delivering consistent and predictable high quality eye care, and emphasizes the use of interdisciplinary teams in the provision of eye care based on the belief that, by working as a team, VA can provide better eye care for the patient. **NOTE:** *This Handbook is consistent with all current VA standards and directives and is intended for use by administrators and clinicians in the field.*

2. BACKGROUND

a. The increasing number of older veterans and consequent increased incidence of eye disease underscore the need for cost-effective, readily accessible, comprehensive eye care.

b. The provision of eye care within VA needs to adhere to the primary care guidelines established by the VHA Office of Primary and Ambulatory Care Strategic Health Care Group (SHG). While each VA health care facility is unique as part of a national system of care, they are to provide predictably consistent high quality eye care.

c. Eye care in VHA involves ophthalmologists, optometrists, and other eye care professionals working as partners for the betterment of the patient.

d. When considering changes in the provision of eye care within the Veterans Integrated Service Network (VISN), VISN eye care leaders are encouraged to review the information provided in this handbook and to seek the advice from the VHA Eye Care Performance Consultant Team, composed of the VHA Director of Optometry Service and the Ophthalmology Consultant.

3. DEFINITIONS

a. **Team.** A team is a group of health care providers working cooperatively together. **NOTE:** *'Team', as used in this handbook, should not be construed to imply any particular organization or leadership.*

b. **Eye Care Provider.** An eye care provider is an appropriately credentialed and privileged optometrist or ophthalmologist.

c. **Low-vision and Visual Rehabilitation Services.** Low-vision and Visual Rehabilitation Services include low-vision clinics, Visual Impairment Centers To Optimize Remaining Sight (VICTORS) programs, blind rehabilitation outpatient specialists (BROS) and blind rehabilitation

clinics and centers, all supported by Visual Impairment Services Teams (VISTs) and VIST specialists.

d. **Accreditation Council on Optometric Education (ACOE)**. ACOE is the accrediting agency for optometric educational programs, formerly referred to as the Council on Optometric Education.

e. **Ophthalmology Residency Review Council (RRC)**. RCC is the accrediting agency for ophthalmology residency training programs. The RRC is a council of the Accreditation Council for Graduate Medical Education (ACGME).

4. SCOPE

The mission of the VHA Eye Care program is to optimize the visual functioning of the veterans health care system patients. In doing this, VA strives to be the eye care provider of choice for the veteran.

5. CORE VALUES

a. The core values of VHA Eye Care are the same as the core values for VHA: Trust, Respect, Excellence, Commitment, and Compassion.

b. In particular, VHA Eye Care strives to:

- (1) Provide needed, high quality eye care in a timely manner to all eligible veterans.
- (2) Ensure the highest possible level of patient satisfaction with VHA Eye Care.
- (3) Ensure that all eligible veterans receive high-quality patient education related to eye care.
- (4) Support professional education and research which furthers VHA Eye Care.

c. Eye care services must be optimally organized and delivered. Each network competes in a unique geographic environment, so organization at the network level needs to emphasize high quality care and prudent financial principles to efficiently provide care. Development of an eye care delivery model, which is competitive at the local level, is essential.

6. PLANNING ASSUMPTIONS

VHA Eye Care planning assumptions are as follows:

- a. VHA eye care resources, like other clinical resources, will continue to be limited;
- b. Patient satisfaction must be improved;
- c. Eye care quality must be continually improved;

- d. The delivery of eye care is most effective when provided by various eye care professionals working cooperatively as part of an eye care team;
- e. All persons who participate in the delivery of VHA Eye Care are valued partners in the process;
- f. Professional education and research are essential to the delivery of quality eye care; and
- g. The demand for eye care will continue to increase.

7. GOALS

NOTE: The goals of VHA Eye Care may be used as guidelines for planning. Networks and other units of VHA care are encouraged to develop their eye care objectives utilizing the goals described in order to facilitate local planning for the provision of quality eye care.

Specific VHA Eye Care goals are:

- a. Deliver the highest quality eye care to the greatest number of eligible veterans in a timely, compassionate, and cost-effective manner.
- b. Provide patient education and eye care counseling to patients and their families or significant others, and continuing medical education to staff as well as other health care providers and trainees, where appropriate.
- c. Establish academically affiliated teaching programs to educate and train students, residents, and fellows.
- d. Participate in educating and training eye care professionals.
- e. Support eye and vision research in areas including management, quality improvement, education, rehabilitation, health services, and biomedical sciences.
- f. Evaluate and improve new technologies for the delivery of eye care.
- g. Contribute to a supportive setting for the integration of patient care, education, and research and development.
- h. Provide support for the Department of Defense (DoD) in times of military necessity or national emergency.

8. RESPONSIBILITIES

a. VHA Central Office (Eye Care Consultants)

(1) To facilitate the continuous improvement of VHA eye care, the Office of Patient Care Services has created a joint Eye Care Performance Consultant Team. This consulting team is composed of the VHA Director of Optometry Service and the Ophthalmology Consultant, both of whom report directly to the Chief Consultant, Primary and Ambulatory Care. These two eye care professionals are viewed as equal partners in providing support for VHA eye care. Some of the key concepts on which this partnership is founded are:

(a) VHA eye care is best supported by consultants with equal shared responsibility for the continuous improvement of VHA eye care.

(b) The open and free exchange of data and information between eye care providers is necessary to ensure the continuous improvement of VHA eye care.

(c) The timely exchange of data and information increases the capability of the Eye Care Performance Consultants to provide meaningful support for the continuous improvement of VHA eye care.

(d) The goal of the VHA Eye Care Consultants is to ensure the continued improvement of VHA eye care as a whole.

(e) The VHA Eye Care Consultant Team ensures that the views of the professional groups they represent are known on issues important to VA. It supports communication between VA and professional eye care providers. The goal of this sharing of information is to assure that all opportunities for improvement are fully explored.

(f) To ensure a full and equal partnership, both consultants will report to the same VA official.

(2) Among the functions of the VHA Eye Care Performance Consultant Team are:

(a) Providing reviewing, advising, and consulting services to networks, facilities, and other appropriate VA organizations with eye care issues;

(b) Assisting in the development of VHA eye care guidelines;

(c) Serving as consultants on issues related to eye care professional training;

(d) Serving as consultants on research matters related to VHA eye care;

(e) Providing eye care data and information, as needed;

(f) Facilitating the creation of a VHA eye care related data base;

(g) Serving as an advocate for veteran patients in need of eye care;

(h) Acting as consultants and advisors to the VISNs and VA health care facilities for issues related to supplemental contracting of eye care services or optical appliances for veterans; and

(i) Serving as a liaison between VA and the non-VA professional eye care community.

(3) Ophthalmologists, optometrists, ophthalmic technicians, nurses, opticians, and others may be involved in providing some aspects of care. Consultation with the Eye Care Performance Consultant Team is strongly recommended when there are network or facility questions concerning eye care.

b. **VISN.** VHA eye care services can be divided into two subgroups: those which can be provided by specific individuals and those services required of the network. **NOTE:** *The network is encouraged to ensure that all of the services described in following subparagraphs 8b(1) through 8b(4) are available to every eligible veteran.* The network requirements are:

(1) **Health Care**

(a) Provision of a basic eye examination as defined by clinical guidelines published by the American Optometric Association and the American Academy of Ophthalmology.

(b) Provision of special prosthetic devices, such as:

1. Prosthetic eyes,
2. Special contact lenses,
3. Low-vision devices, and
4. Eyeglasses.

(c) An operating VIST.

(d) Provision of low vision and visual rehabilitation services.

(e) Availability of diagnostic services, such as:

1. Laboratory;
2. Radiology;
3. Photography, including fluorescein angiograms;
4. Medical Media support;

5. Electro-diagnostics (Visually-envoked potential (VEP), Visually-envoked Response (VER), etc.);

6. Diagnostic ultrasound; and

7. Visual fields.

(f) Availability of consultative services.

(g) Availability and use of information and image technology, to include:

1. Collection and management of data,

2. Equipment and service support,

3. Medical and surgical management of ocular and periocular disease,

4. Availability of pre-surgical services,

5. Screening examinations for at risk patients,

6. Compensation and Pension (C&P) examinations, and

7. Anesthesiology coverage including monitoring.

(h) DoD backup plan.

(2) **Education.** Education entails:

(a) Patient education;

(b) Trainee supervision (appropriate and available);

(c) Education of academic affiliate to the role and priorities of VHA eye care;

(d) Continuing education resources;

(e) Resources to support full accreditation;

(f) Resources to support education;

(g) An in-service training plan; and

(h) Support for professional education endeavors.

(3) **Research.** Research needs to support:

- (a) Eye care research efforts, and
- (b) Development of a policy delineating importance of research goals in eye care.
- (4) **Other.** Other VISN responsibilities include:
 - (a) Outcomes-based quality improvement plan.
 - (b) Assessment of patient satisfaction.
 - (c) Collection and assessment of demographic data to include:
 - 1. International Classification of Diseases Clinical Modification – 9th edition. (ICD-9-CM);
 - 2. Current Procedural Terminology (CPT);
 - 3. Productivity and work load data; and
 - 4. Information management strategies and performance.

c. **Local**

(1) Responsibilities which may be conducted by specific providers to ensure the provision of quality eye care to veterans.

(2) Integration of eye care services at the facility level is promoted by an organizational structure where ophthalmology and optometry, as well as other eye care providers (e.g., blind rehabilitation specialists, VIST, etc.), are represented as partners in the delivery of eye care.

NOTE: *The exact organizational structure is determined locally.*

(3) The administrative organization of eye care needs to reflect the clinical provision of eye care in order to optimize the quality and cost-effectiveness of care. **NOTE:** *The Office of Patient Care Services in its recommendations for implementation of the Prescription for Change has reinforced an interdisciplinary organizational model by charging optometry and ophthalmology to “develop interdisciplinary models for the provision of coordinated primary, subspecialty, surgical, and rehabilitative eye care services which can be applied throughout VHA.”*

(4) Reporting assignments vary depending upon facility staff and patient care needs. **NOTE:** *This should be determined at the facility level. Facilities most commonly assign the Chief Optometrist to report as a Section Chief to the Chief of Primary Care, Chief of Surgery, or Chief of Medicine, or for larger programs, as a Service Chief to the Chief Medical Officer, Associate Chief of Staff (ACOS) for Ambulatory Care, or Chief of Staff.*

(5) It would be expected, in most instances, for a full-time staff optometrist with adequate support personnel to have 2100 to 3000 patient visits per year.

(6) It would be expected, in most instances, for a full-time staff ophthalmologist with adequate support personnel to have 1800 to 4000 patient visits per year and perform 150 to 300 surgical procedures, including laser procedures, per year.

9. PARTICIPATION IN SPECIAL VHA PROGRAMS

a. **Eye Care Clinical Programs of Excellence.** VHA medical facilities that can effectively integrate the spectrum of eye care practitioners and ancillary personnel to provide a continuum of comprehensive primary, secondary, and tertiary eye and vision care services, may apply and be considered for designation as an Eye Care Clinical Program of Excellence. These clinical programs of excellence should provide clinical training, education, and research opportunities to develop optometrists and ophthalmologists with advanced competency skills.

b. **VICTORS Programs.** VICTORS Programs provide team-based low-vision rehabilitation services to significantly visually-impaired veterans from a large service area covering numerous VA facilities, as in a VISN. It is recommended for continuity of service that these special programs be developed and directed by the eye care service at a strategically located, adequately staffed, and equipped VA facility within each VISN. The core staff is composed of optometrists, ophthalmologists, social workers, and low vision training specialists while other disciplines, such as audiology and/or psychology, provide needed assistance. *NOTE: When the visual impairment is such that low-vision rehabilitation alone does not meet the goals of the veteran, referral may be made to a Blind Rehabilitation Center (BRC) for further care.*

c. **Blind Rehabilitation Service Programs.** Blind Rehabilitation Centers provide team-based rehabilitation services to legally blind patients through Blind Rehabilitation Service programs. Each program provides care to veterans from a broad service area covering numerous VA facilities. A staff optometrist or ophthalmologist provides and coordinates clinical low-vision care. This care includes initial and ongoing guidance provided to low vision therapists regarding training of patients in the use of devices. The prescription of optical, non-optical, and electronic low-vision devices should be under the authority of the clinically privileged optometrist or ophthalmologist who interacts with the Chief, Blind Rehabilitation Service, who should also coordinate day-to-day activities for provision of low-vision services, while professionally reporting to the Chief Optometrist, or other member of the professional staff as defined by subparagraph 8c(2).

d. **Environmental Programs.** Optometrists or ophthalmologists may provide appropriate eye care services, such as procurement of safety glasses, to meet the safety needs which are the responsibility of the environmental program at VHA medical facilities, as well as provide task analysis of workplace visual demands.

e. **Vocational Rehabilitation Programs.** Focused or full-scope eye and vision care services, as determined by local VA facility policy, may be provided to patients enrolled in a vocational rehabilitation program.

f. **Mobile Clinics.** Veterans located a significant distance from the nearest VHA medical facility may receive screening and primary care services from specially outfitted mobile vans.

Optometrists or ophthalmologists may provide screening and primary eye and vision care within these mobile clinics as needed.

g. **Hearing Aid Spectacles.** Optometrists and ophthalmologists should work cooperatively with audiologists in the fitting of prescription hearing aid spectacles for eligible veterans.

h. **Homeless Veterans' Care.** Optometrists and ophthalmologists may provide appropriate eye and vision care services to meet the needs of veterans utilizing VHA "Stand Down" or other similar programs.

i. **Blindness Prevention.** Due to the high incidence of ocular diseases in the geriatric patient population, VA may initiate broad-based public health programs which attempt to decrease or eliminate blindness from preventable causes as identified by the National Eye Institute of the National Institutes of Health, including glaucoma, diabetic retinopathy, cataracts, and macular degeneration. These four disease entities account for over two-thirds of all legal blindness cases in patients demographically typical of those found in the VA system. Significant visual impairment may adversely impact independent daily living skills, quality of life, as well as socioeconomic and mental status.

10. SPACE AND EQUIPMENT

Specific information relating to the space and equipment necessary to assure quality eye care is included in Appendix B. **NOTE:** See also VA Handbook 7610.3 (Chapter 233).

11. EDUCATION AND TRAINING

a. **Optometry.** Education of trainees in medicine and associated health care disciplines is an important component of VHA's patient care mission.

(1) Definition of Trainees

(a) **Doctor of Optometry (O.D.) Candidates.** Candidates for the O.D. Degree refers to students in an accredited school or college of optometry in either their first, second, third, or fourth professional year of training prior to being awarded the O.D. Degree.

(b) Residents and Fellows

1. **Definition.** This category includes trainees who have obtained the O.D. Degree. Residents are post-graduate year (PGY)1 trainees in a primary eye or vision care residency. Fellows are PGY2 trainees with a specialty or research focus.

2. **Recruitment of Residents and Fellows.** Residency and fellowship positions will be advertised in accordance with local VA facility guidelines. The national Optometric Residency Matching Services (ORMS), Inc., will be used for selection and matching of candidates to residency and fellowship programs.

(2) Establishing Affiliations Between VA Facilities and Optometry Schools

(a) Before starting a program of clinical education, an affiliation agreement must exist between the local VA field facility and the most proximal accredited school or college of optometry. If the nearest optometry school does not desire an affiliation, another accredited school or college of optometry may be chosen. On occasion, multiple affiliations with accredited schools and colleges of optometry may be possible for education of Doctor of Optometry Candidates. VA affiliation agreement templates must be used (http://www.va.gov/oaa/AHE_Partner.asp).

(b) VA staff optometrists, who will serve as supervising or attending optometrists, need to be eligible for appointment to the potential school or college of optometry's faculty prior to consideration of any affiliation agreement.

(c) Once an affiliation is established with an accredited school or college of optometry, only students in their final professional year (fourth), PGY1 and PGY2 trainees will have direct patient care responsibilities. Individuals in earlier professional years can assume supportive roles.

(d) To better coordinate the provision of primary optometric eye and vision care services within a VISN, an appropriate representative from each affiliated school or college of optometry may be typically appointed to the Management Assistance Council and/or VISN Education Council.

(3) Supervision of Trainees in Optometric Education Programs

(a) Supervision of residents refers to the authority and responsibility that VA staff optometrist(s) exercise over the care delivered to patients by optometry residents. Such authority is applied by observation, consultation and direction, and includes the imparting of knowledge, skills, and attitudes by the practitioner to the resident. VHA residency-training programs must ensure adequate supervision is provided for residents at all times and that supervision is documented as described in VHA Handbook 1400.1. Progressive responsibility may be given to residents as part of their training program (http://www.va.gov/oaa/1400_1hk_Oct2001.doc).

(b) Candidates in any professional year prior to being awarded the O.D. degree must be educated and supervised within a specific optometric educational curriculum. The determination of a student's ability to provide care to patients will depend upon documented evaluation of the student's clinical experience, judgment, knowledge and technical skills. The supervision of students is the responsibility of VA staff optometrist(s) with faculty appointments at the affiliated accredited school or college of optometry.

(4) Credentialing and Privileging Requirements in Optometric Education Programs
Attending optometrists must be credentialed and privileged by the facility to provide the care which they are supervising. Credentialed and privileged optometrists are responsible for the care of all patients examined by optometric trainees.

(5) Medicare Billing Requirements For Optometric Education Programs

(a) There are differences between the requirements for educational supervision of residents and the documentation necessary in order to bill for services provided by attending optometrists and residents.

(b) Specific payers, such as the Centers for Medicare and Medicaid Services (CMS) or other third party insurers, apply specific guidelines for documentation of patient care services that are acceptable for purposes of third-party billing.

(c) Optometry residents are not treated as residents under Medicare, and by association, Medicare supplemental insurance carriers. Optometry residents are considered licensed or license-eligible practitioners for the purposes of Medicare reimbursement. For VA reimbursement purposes, an optometry resident needs to be licensed in a state, but not necessarily in the state in which the resident is employed by VA.

(d) An optometry student is never considered to be a resident. Any contribution of an optometry student to the performance of a service or billable procedure (other than the taking of a history in the case of an Emergency and Management Service) must be performed in the physical presence of an optometrist or jointly with an optometry resident.

(6) Reporting Relationships for Optometric Education Programs

(a) Residents and fellows report to the VA staff optometrist residency program director of the program in which they are enrolled.

(b) Candidates in any professional year prior to being awarded the O.D. degree report to the VA staff optometrist externship/internship program director of the program in which they are enrolled.

(7) Scheduling and Productivity Considerations for Optometric Education Programs.

The educational goals and objectives of any optometric education program are to be compatible with those of the VA facility, however at least one-half day per week should be dedicated solely for educational activities and ideally patients should not be scheduled. VA staff optometrists should allow or arrange for emergency coverage during the 1/2 day "down" time. VA staff optometrists must ensure that overall productivity meets program goals as defined by the Director, Optometry Service, VHA Central Office.

(8) Staffing Needs for Optometric Education Programs

(a) Programs with trainees assigned should have at least 1.0 Full-time Equivalent (FTE) staff optometrist(s). There should be frequent interaction with the VA staff optometrist serving as the education program director and the ACOS for Education or equivalent VA official. Programs with less than 1.0 FTE optometric professional staff may not be able to provide the proper level of clinical supervision, nor can they properly educate optometric trainees in an integrated program which must meet specific curricular goals and objectives. The desired goal for

preceptor (staff optometrist) to trainee ratio should be 1:2 for fourth professional year students, 1:3 for PGY1 trainees, and 1:4 for PGY2 and beyond optometric trainees.

(b) Optometric clinical education programs should have adequate support staff in order to properly manage administrative complexities; i.e., reports, evaluations, syllabi, scheduling, and other correspondence.

(c) Intergovernmental Personnel Act (IPA) Agreement. In special circumstances, additional staffing can be obtained through an IPA between the VA facility and a State or local government agency, an institution of higher learning, an Indian Tribal government, or any other eligible organization.

(9) Accreditation of Optometric Education Programs

(a) Facilities offering optometric education must meet accreditation standards related to staffing, space, equipment, etc.

(b) All optometric education coming to VA must be accredited by the appropriate accrediting body. The Accreditation Council on Optometric Education (ACOE) is the accrediting body for the schools and colleges of optometry and for their residency and fellowship programs.

1. For programs with only O.D. candidates, accreditation of the school or college of optometry by the ACOE includes all clinical training programs provided to optometry students prior to graduation. The ACOE, through the affiliated school or college of optometry, monitors quality and grants accreditation to the school or college of optometry.

2. For programs involved in the education of PGY1 and PGY2 trainees, the ACOE must be consulted by the VA facility in order for specific programs to receive accreditation status. The VA staff optometrist residency program director in concert with one or more representatives of the affiliated school or college of optometry, prepares annual reports, self-studies, and other information required to secure and maintain ACOE accreditation of the specific program.

NOTE: The quality of the program is the strongest determinant in the accreditation process.

3. The ACOE must accredit all VA Optometry residency programs. The ACOE requires optometry residency programs to be affiliated with an accredited school or college of optometry. New programs must obtain candidacy pending status from the ACOE prior to seeking approval to establish a residency program through the Office of Academic Affiliations.

a. Obtaining Candidacy Pending Accreditation. After a PGY1 or beyond program has been designed, the proposed VA staff optometrist residency program director, in concert with the affiliated school or college of optometry, may apply for candidacy pending accreditation status. Before making this application, there must be a signed affiliation agreement between the local VA facility and the accredited school or college of optometry. Information, including goals and objectives, clinical and academic curriculum, specific schedules, and a description of faculty, will be detailed in the initial request to the ACOE for candidacy pending accreditation status. After the ACOE evaluates the program self-study proposal, a decision is made whether or not to

grant candidacy pending accreditation status. **NOTE:** *If the ACOE denies the request for candidacy pending accreditation, the Office of Academic Affiliations will not fund the program.*

b. **Seeking and Maintaining Accreditation.** Through a site visitation, the ACOE evaluates programs based on self-studies submitted by the VA staff optometrist residency program director in concert with the affiliated school or college of optometry. The ACOE reviews the adherence of the program to stated accreditation guidelines, goals, objectives, resolution of prior conditions, and overall program quality before granting accreditation status. The ACOE may accredit a residency program for a period not to exceed 7 years before the next scheduled site visitation of the program.

c. **Accreditation with Conditions.** Programs which are unable to merit accreditation status, but have sufficient redeeming qualities and characteristics with reasonable likelihood that accreditation status may ultimately be granted, may receive accreditation with conditions. **NOTE:** *The conditions are reevaluated at some future time as recommended by the ACOE, typically within a 1- to 3-year period. If the conditions have been fully corrected, accreditation status may be achieved.* An autonomous reporting relationship for the Optometry educational program is a requirement for ACOE accreditation.

d. **Payment of Accreditation Fees.** There are annual accreditation fees that are billed by the ACOE. It is the responsibility of each VA facility to pay these fees. Programs which have had their accreditation status canceled due to nonpayment of accreditation fees will be ineligible to receive future optometric residency funding by the Office of Academic Affiliations.

(10) **Trainee Requirements and Funding Support**

(a) **Students, Candidates, and Trainees.** Optometric students or candidates assigned to VA external rotations must:

(1) Be enrolled in an ACOE-accredited program;

(2) Come from school(s) or college(s) of optometry with an affiliation agreement with the VA facility;

(3) Be appointed on a without compensation (WOC) basis.

(b) **Resident Trainees.** Optometric residents must:

1. Be citizens of the United States;

2. Be graduates of an ACOE accredited School or College of Optometry;

3. Have successfully completed Parts I and II of the National Board of Examiners in Optometry (NBEO) examinations.

(c) Stipend rates for optometry residents are determined by the Office of Academic Affiliations.

(d) Allocation of funding for residency positions is determined by the Office of Academic Affiliations in collaboration with the Director of VA Central Office Optometry Service. **NOTE:** *Funding cannot be provided by the local facility should funds not be available from the Office of Academic Affiliations.*

(e) Optometry residents and fellows are eligible for VA group health and life insurance benefits (see VHA Directive 2001-067).

(11) **Space and Equipment Needs for Patient Care in Optometric Education Programs**

(a) Administrative and clinical space and equipment need to be available as delineated in VA Handbook 7610.3 (233).

(b) At least one fully equipped examination and/or treatment room per trainee is recommended in addition to the space required of the attending optometrist(s) as detailed in Appendix B.

(c) There should be space available to conduct seminars, lectures, case conferences and grand rounds.

(d) The equipment guide list of VA Handbook 7610.3 (Chapter 233) can serve as a guide or benchmark as the VA facility determines eye care equipment requirements. State-of-the-art equipment is recommended for Optometric Education Programs.

b. **Ophthalmology**

(1) **Definitions**

(a) Ophthalmology Residents. Ophthalmology residents complete a minimum of 3 years of postgraduate training in ACGME-accredited training programs (PGY2-4) in order to be eligible for certification by the American Board of Ophthalmology.

(b) Ophthalmology Fellows. Ophthalmology fellows are post-residency positions where 1 to 3 years is spent in acquiring additional training in either comprehensive or sub-specialty Ophthalmology. There are no Ophthalmic sub-specialties which are certified, rather each fellowship is designed by the sponsor and often reviewed by a sub-specialty professional organization.

(2) **Recruitment**

(a) Residents are recruited by the Academic Affiliate and matched through the Ophthalmology Matching Program. The selection of residents is generally the responsibility of the Academic Affiliate per the affiliation agreement.

(b) Fellows are recruited by the fellowship sponsor. **NOTE:** *OAA residency training funds cannot be used to support these positions as it is limited to funding ACGME- accredited programs.*

(3) Academic Affiliation Agreements

(a) An academic affiliation agreement must be signed by the VA facility and the corresponding medical school affiliate. VA affiliation agreement templates must be used (<http://www.va.gov/OAA/default.asp>).

(b) The academic affiliation agreement must be reviewed on a regular basis.

(4) Supervision

(a) Supervision refers to the authority and responsibility that staff practitioners exercise over the care delivered to patients by residents. Such authority is applied by observation, consultation and direction, and includes the imparting of knowledge, skills, and attitudes by the practitioner to the resident. VHA residency training programs must ensure adequate supervision is provided for residents at all times.

(b) Each resident must be appropriately supervised, depending on the individual resident's abilities and level of training (i.e., PGY 2, 3, or 4). **NOTE:** *Complex patients require more supervision than routine patients.*

(c) Surgical supervision is required for all residents. All residents need to be directly supervised by an attending Ophthalmologist. Ophthalmologists must be directly involved in the supervision of all surgical cases, the level of resident participation directed by experience level and demonstrated capability. Exceptions to direct supervision are rare and are based on the best care for the patient (e.g., an emergency case being started while the attending is traveling to the facility).

(d) Attending Ophthalmologists must be credentialed and privileged by the facility to provide the care which they are supervising.

(e) All supervision must meet the stated criteria for supervision of all physicians' training, including documentation and demonstration of direct supervision as described in VHA Handbook 1400.1 (<http://www.va.gov/OAA/default.asp>).

(5) Levels of Responsibility

(a) Progressive responsibility may be given to residents as part of their training program (see VHA Handbook 1400.1).

(b) The determination of a resident's ability to accept responsibility for performing procedures or activities without a staff practitioner present must be based on documented evidence of the resident's clinical experience, judgment, knowledge and technical skills.

NOTE: Such evidence may be obtained from the affiliated university, evaluations by staff practitioners or program coordinator, and/or other clinical practice information.

(c) Documentation of levels of responsibility must be filed in the resident's record or folder that is maintained in the office of the residency program director, Chief of Staff, or program coordinator, and will include all applicable information.

(6) Evaluation of Ophthalmology Residents

(a) Residents are evaluated on the basis of clinical judgment, knowledge, technical skills, humanistic qualities, professional attitudes, behavior, and overall ability to manage the care of patients. Evaluation of the resident's performance in ongoing rotations is to be conducted at least quarterly.

(b) If at any time a resident's performance is judged to be detrimental to the care of a patient(s), action must be taken immediately to ensure the safety of the patient(s). The residency program director must promptly provide written notification to the affiliate program director or the department or division chairperson of the resident's unacceptable performance or conduct.

(c) Each resident is given the opportunity to complete a confidential written evaluation of staff practitioners and the quality of the resident's training. Such evaluations are to include the adequacy of clinical supervision by the staff practitioners.

(d) All written evaluations of residents and staff practitioners must be kept on file in a location in accordance with local facility policy.

(7) Accreditation of Ophthalmology Resident Training

(a) ACGME is responsible for accreditation of the Ophthalmology residency training programs. Residency programs affiliated with the VA must be accredited by ACGME.

(b) The program accreditation is the responsibility of the sponsoring institution.

(c) VHA expects the Academic Affiliate to obtain appropriate accreditation through the ACGME.

(d) VHA must provide data to support the application for continued accreditation of the program to the Academic Affiliate.

(d) VHA must participate, as requested by the Academic Affiliate, in the Ophthalmology Residency Review Committee (RRC) review process.

(8) Staffing

(a) Ophthalmology staffing is required at a level to maintain appropriate Ophthalmology resident training and supervision.

(b) Either VA FTE, contract, or volunteer(s) with faculty appointments from the Academic Affiliate may be recruited to obtain appropriate staff to provide training and resident supervision.

12. RESEARCH AND DEVELOPMENT

a. Eye and vision care research and development is an integral part of the VHA eye care program; it supports eye and vision care needs of veterans. Research needs to be encouraged and promoted within each VISN. Staff eye care providers, residents, fellows, and students are encouraged to develop research skills and participate in research studies.

b. A VA-funded intramural research program supports VHA research with its commitment to enhancing patient outcomes. The mission of the VHA Research Service is to support the clinical mission of M-3, Part I. **NOTE:** *Research needs to support the eye and vision care needs of veterans.*

c. The VHA Merit Review Program is the principal mechanism for sustained biomedical and behavioral research funding of VHA scientists. Eye care providers within VHA may request Health Services Research and Development, Rehabilitation Research and Development, and Biomedical Research funding. Applicants for merit review funding must be at least five-eighths time employees (see VHA Handbook 1200.15).

d. Eye care providers seeking VA funding must choose the research program area that most closely matches their interests and follow established application procedures and guidelines.

(1) The Biomedical Research Program supports and enhances patient care by providing resources to acquire new knowledge leading to improvements in the prevention, diagnosis, and treatment of diseases and disabilities (see VHA Directive 1201).

(2) The Health Services Research and Development Program searches for the most cost-effective approaches to delivering quality health services to the Nation's veterans through support of Health Services Research studies (see VHA Directive 1204).

(3) The Rehabilitation Research and Development Program focuses on research, development, and evaluation of existing and emerging technology, devices, techniques, and concepts of rehabilitation (see VHA Directive 1203).

(4) VHA Research Service encourages directed collaborative research programs by using the unique capabilities of the VA system of medical centers and affiliated academic institutions to study appropriate health problems. VHA research contributes to a professional and desirable work environment that favors the recruitment, retention, and professional growth of highly qualified eye care staff. The development of research skills needs to be encouraged to provide a nucleus of providers who are capable of conducting meaningful clinical research.

13. INFORMATION MANAGEMENT

a. **Scope.** Quality health care depends on the collection, storage, analysis, and distribution of information. Microcomputers, medical center Veterans Health Information Systems and Technology Architecture (VistA) computer systems, microcomputer networks, facsimile machines, copiers, and computer assisted ophthalmic equipment must be available to help eye care providers meet patient care, education, and research requirements.

b. **Equipment Requirements**

(1) Ideally, every clinic exam room and office should be equipped with a VistA terminal for patient scheduling, ordering lab work, x-rays, etc., and one VistA terminal in the Chief's office for clinic administration, electronic mail, and access to pertinent electronic bulletin boards. Additionally, at least one microcomputer, laser printer, and photocopier needs to be in each clinic to support clinic generated paperwork, correspondence, data collection, publications, and research. At a minimum, one terminal in the clinic and one in the administrative offices are required.

(2) As clinics increase in size, complexity, and patient care responsibilities, additional information resource management equipment is necessary. For example, those clinics with VICTORS Programs, or those designated as Eye Care Clinical Programs of Excellence will benefit from microcomputer networks, facsimile machines, photocopiers, digital ocular photography and/or angiography, as well as other computer-assisted equipment (lensometer, keratometer, pen-based clinic information computer system, computerized low vision prosthetic devices, etc.)

c. **Software Utilization and Research and Development.** Eye care providers need to directly participate in the utilization of any state-of-the-art software program packages; i.e., patient care programs, Prosthetic and Sensory Aids Service (PSAS) Programs. Additionally, they need to be included on any pertinent software research and development team, projects, programs, surveys, or grants, regarding patient care, education, research, and training.

14. QUALITY IMPROVEMENT (QI)

a. **Scope.** The evaluation and improvement of eye care services enhances the facility's overall QI Program. This includes both Service-specific as well as interdisciplinary monitoring of quality indicators. The eye care providers are responsible for the effective implementation of the eye care QI plan.

b. **Preventative Eye Care Policies for Diabetes and Glaucoma**

(1) The National Eye Institute of the National Institutes of Health (NIH) has identified diabetic retinopathy and glaucoma as the leading causes of preventable blindness.

(2) All patients with diabetes mellitus need to have dilated fundusoscopic examinations as determined by the VHA Diabetes Mellitus Clinical Guidelines (see web site <http://www.oqp.med.va.gov/cpg/cpg.htm>) or more frequently as indicated by the degree or stage of diabetic retinopathy.

(3) Individuals with significant risk factors for development of glaucoma need to have eye examinations as determined by the VA Glaucoma referral guidelines; i.e., family history of glaucoma, history of ocular trauma, African-American heritage, age 50 or greater, and diabetes mellitus (see web site http://www.oqp.med.va.gov/cpg/Glaucoma/GLA_Base.htm).

(4) Management of these ocular conditions need to adhere to the Optometric Clinical Practice Guidelines of the American Optometric Association and the Preferred Practice Patterns of the American Academy of Ophthalmology.

c. **Clinical Indicators.** Clinical indicators need to be based upon well-documented clinical practice guidelines published by national optometric and ophthalmic organizations and other appropriate bodies, such as Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Eye Institute of NIH, as well as the American National Standards Institute (ANSI), Inc., which have documented standards of care applicable to the practice of eye care within VHA. The goal of VHA eye care is to improve patient care.

15. PROCEDURES FOR STAFF DEVELOPMENT

a. **Qualification Standards.** Nationwide qualification standards are in effect for all optometry personnel actions in accordance with Optometrist VA Qualification Standards; Circular 00-77-27, Attachment C; and VHA Supplement to MP-5, Part II, Chapter 2, Appendix 2K. Qualification standards for ophthalmology personnel actions are covered in MP-5, Part II, Chapter 2.

b. **Medical Staff Membership.** To fully integrate the functions of the eye care unit, optometrists and ophthalmologists must be members of the medical staff.

c. **Optometry Professional Standards Board.** A centralized professional standards board for optometry in VHA Central Office determines the initial grade and step for new appointees, as well as promotion and special advancement requests, based upon published qualification standards. This board, in which the majority of members are optometrists, functions in accordance with established VHA policy.

d. **Reporting Relationships.** Reporting assignments vary depending upon facility staff and patient care needs. This needs to be determined at the facility level. Facilities most commonly assign the Chief Optometrist to report as a Section Chief to the Chief of Primary Care, Chief of Surgery, or Chief of Medicine, or for larger programs, as a Service Chief to the Chief Medical Officer, ACOS for Ambulatory Care, or Chief of Staff.

e. **Special Advancements.** Clearly defined criteria for Special Advancement for Performance and Special Advancement for Achievement, detailed in the Optometrist Qualification Standards, are used for all optometry personnel actions.

f. Professional Staff Development

(1) **Clinical Skills and Scholarly Pursuits.** To realize the patient care, research and educational benefits of having a professionally active clinical staff, eye care providers are encouraged to participate in clinical skills enhancement activities and scholarly pursuits. Each VA facility is to facilitate and accommodate the temporal and general resource needs required for eye care providers to advance professionally. Appropriate activities may include: attendance and completion of educational training courses and programs in clinical areas; academic pursuits leading to faculty appointments; professional organization involvement with officer or committee responsibilities; pursuit of special meritorious recognition from recognized professional organizations; research and publication endeavors; training program development and/or responsibilities; and national eye care provider program responsibilities.

(2) **Continuing Education.** Since eye care providers are required to obtain continuing medical education (CME) for license renewal and reprivileging, local VA facilities typically fund and grant authorized absence on an annual basis.

(a) Funding consisting of tuition, travel, and per diem expense support is to be provided as local resources permit.

(b) Authorized absence may be granted, inclusive of travel time, to attend CME meetings.

(3) Written Policies and Procedures

(a) The provision of eye care provider services is guided by written policies and procedures that address various components of patient care. These components include the initial appointment process, the integration of eye care providers into the facility's governing bodies, credentialing and privileging, and reporting relationships. *NOTE: It is recommended that these policies be reviewed at least annually by local management to ensure compliance with all applicable VA regulations and accreditation standards.*

(b) The eye care leadership team is responsible for development of related eye care policies as well as adherence to local medical center policies. Examples include: Safety, Health, and Fire Protection Plan; Infection Control; Fire Emergency Response Plan; Disaster Response Plan; Monitoring Ocular Toxicity from Systemic Medications; Interdisciplinary Quality Assessment and/or Improvement Plan; Safety and Life Safety Management Program; Hazard Communication Program; Patient and Family Health Education; C&P and VIST Eye Examinations; Medication Control; Patient Falls; Ocular Angiography; Excision of Minor Periocular Dermatologic Lesions; etc.

(4) Appointment Policy and Access Mechanisms

(a) Appointment Policy. The appointment policy for eye care provider patients is locally determined and dependent upon the nature of the eye care provider program involved. Typically, Chiefs of Optometry Services, Sections, or Departments, or Chiefs of Ophthalmology

will determine for their respective disciplines, an appropriate schedule according to local personnel policies.

(b) Patient Access Mechanisms. Local policy determines access mechanisms for eye care patients. Any outpatient with an ocular or visual complaint may be referred to eye care providers based on national VHA eligibility requirements for outpatient care. Inpatients with ocular and/or visual symptoms may be referred to eye care providers dependent upon national VHA eligibility requirements for inpatients. Patients may have direct access to eye care where local policy permits.

16. ELIGIBILITY

Veterans meeting the eligibility requirements to receive health care are eligible for eye care. Eligibility rules are the same for both inpatient hospital care and outpatient medical service. Any veteran who meets current eligibility criteria may receive eye-related appliances, devices, and/or prostheses.

EYE CARE PROFESSIONS

1. The professions of Ophthalmology and Optometry submitted the following definitions; therefore, the definitions are representative of the groups' self-perceptions.

a. **Ophthalmologist.** An ophthalmologist is a physician who specializes in the comprehensive care of the eyes and visual system. An ophthalmologist is medically trained and qualified to diagnose and treat all eye and visual system problems. An ophthalmologist can deliver total eye care as well as diagnose general diseases of the body. An ophthalmologist has completed 4 years of college premedical training, 4 or more years of medical school, 1 year of internship, and 3 years or more of specialized medical training and experience in eye care. An additional 1 to 3 years may be spent in sub-specialty training.

b. **Optometrist.** Doctors of Optometry are independent primary health care providers who examine, diagnose, treat, and manage diseases and disorders of the visual system, the eye and associated structures, as well as diagnose related systemic conditions. An optometrist typically completes 4 years of baccalaureate training and 4 years of optometry training. Residency training is 1 year beyond attainment of the optometry degree.

2. Additional professionals who may be involved in eye care are:

a. **Administrative and Clerical Support Staff.** Clerks, secretaries, prosthetics personnel, pharmacists, social workers, and others may be assigned to support eye care services as part of their duties.

b. **Blinded Veterans Services.** Visual Impairment Services Team (VIST) Coordinators, Blind Rehabilitation Specialists, and Blind Rehabilitation Outpatient Specialists (BROSs) are involved in coordinating and providing services and equipment to blinded veterans.

c. **Nurse Practitioner (NP).** Nurse practitioners may be assigned duties in eye care with practice scope and reporting requirements defined by facility policy.

d. **Ocularist.** An ocularist is an expert in the assessment, fitting, and maintenance of ocular prosthesis.

e. **Ophthalmic Technicians.** Ophthalmic technicians carry out duties assigned to them by the eye care providers with whom they work.

f. **Optician.** An optician is an expert in the science, craft, and art of optics as applied to the translation, filling, and adapting of ophthalmic prescriptions, products, and accessories.

g. **Physician Assistant (PA).** PAs may be assigned duties in eye care with practice scope and reporting requirements defined by facility policy.

h. **Registered Nurse (RN).** RNs may be assigned eye clinic duties in accordance with medical center directives and policies.

SPACE AND EQUIPMENT

While each facility knows its own demands and constraints relative to space, equipment, and utilization, the Veterans Health Administration (VHA) Eye Care Performance Consultant Team is available for consultation to assist Department of Veterans Affairs (VA) facilities regarding how best to support an eye care clinic. **NOTE:** *Facilities are encouraged to consult the following references for suggestions and recommendations for the most efficiently functioning eye care clinics.*

1. **New Clinics or Alterations.** Facilities may refer to VA Handbook 7610.3 (Chapter 233), VHA - Patient Care and Clinical Support, Chapter 13, Eye Clinic, for recommendations and suggestions on constructing new eye care clinics or for making alterations to existing clinics.
2. **Equipment.** The equipment guide list of VA Handbook 7610.3 (Chapter 233), can serve as a guide or benchmark as the facility determines eye care equipment requirements.
3. **Space Determinations and Equipment Needs**

a. **Administrative.** An office should be provided for a full-time Chief Optometrist and/or a full-time Chief Ophthalmologist. Staff clinicians can, depending on facility resources, have individual or shared offices. Facility resources determine whether offices are provided to secretarial and/or technical support staff and for students and residents. **NOTE:** *While the former are desirable, their provision is typically governed by facility resources.*

b. **Clinical.** It is recommended that the basic eye clinic consist of the following:

- (1) Examination-treatment rooms with refractive and eye health instrumentation, (minimum 130 square feet per examination and/or treatment room),
- (2) Visual fields room with both non-automated and automated instruments,
- (3) Photography room with fundus and slit-lamp camera, and
- (4) Optical fitting and dispensing room.

c. **Additional Space.** Additional space may be required and may consist of the following functional areas which may be combined or shared:

- (1) Reception area;
- (2) Waiting area;
- (3) Restroom (wheelchair accessible, may be unisex);
- (4) Consultation room;

- (5) Pre-test room;
- (6) Dispensing room;
- (7) Equipment and supplies storage area or alcove;
- (8) Low-vision rehabilitation room;
- (9) Staff restroom; and
- (10) Wheelchair storage area or alcove.

d. **Ultrasound Room.** This room provides complete ultrasound instrumentation with diagnostic A and B modes. It is used for disease diagnosis and management and is essential if cataract surgery is to be performed.

e. **Eye Procedure Room.** This room is for any treatment that requires surgical intervention that is deemed an "in-office procedure." *NOTE: The room is to contain standard emergency equipment.* Procedures commonly performed in this room are:

- (1) Tarsorrhaphy;
- (2) Excisions (chalazia, pterygia, external lid lesions); and
- (3) Insertion, removal, and repair of sutures.

f. **Clean Utility and/or Supply Room.**

g. **Soiled Utility Room.**

h. **Laser Rooms.** The Argon, Neodymium: Yttrium Aluminum Garnet (Nd:YAG), and Carbon Dioxide (CO₂) rooms contain separate laser or combination units consisting of laser cart(s), slit-lamp delivery system(s), contact lenses for laser application, and safety equipment. Lasers and/or accompanying instrumentation may need either special power or cooling requirements. *NOTE: Lasers are used in treatment of numerous ocular problems; i.e., diabetic retinopathy, glaucoma, retinal tear, etc.*

i. **Optic Nerve Analysis Room.** This room may accommodate a special digitized unit with separate anterior and posterior photography component(s). This particular instrumentation is essential for optic nerve head analysis and ocular angiography. It can produce hard copies via a printer system as well as provide an R-232 computer link to clinic systems allowing for instant retrieval of information.

j. **Low-vision Therapy Room.** This room is for low-vision rehabilitation training, storage of low-vision aid sets, and patient education.

4. **Space and Equipment Criteria for Eye Care Providers Assigned to Blind Rehabilitation Centers (BRCs) and Clinics.** Refer to VA Handbook 7610.3 (Chapter 233) and the accompanying Equipment Guide List for recommended appropriate equipment placement and equipment expansion information. The room floor plan notated in the Equipment Guide List designates the instrumentation suggested to equip various levels of eye clinics.

5. **Design Considerations.** The following recommendations are based on established and anticipated standards, which are subject to modification. The selection of the level of service is determined by anticipated health care needs within each facility and Veterans Integrated Service Network (VISN).

a. The examination treatment room does not require windows, but if windows exist, provision for total darkening of the room is recommended.

b. It is preferable to locate the eye clinic in or near the primary care area of the medical facility.

c. The clinic should comply with the Uniform Federal Accessibility Standards (UFAS) Public Law 90- 480, (Title 42 United States Code 4151, et.seq.).

d. In the patients' waiting area, 10 percent of seats need to be reserved for patients in wheelchairs.

e. Patient corridors within the eye clinic need to be 8'0" wide to handle patients on gurneys. All other corridors need to be a minimum of 6'0" wide.

f. Floor and wall finishes of the eye procedure room need to be resistant to repeated use of disinfectants and cleaning procedures. The ceiling needs to be made of impervious material.

g. Examination and/or treatment, diagnostic, and procedure rooms need to have a lavatory with foot controls or long-blade faucet handles for hand washing, soap dispenser, paper towel dispenser, waste receptacle, disposable glove holder, and needle box to meet infection control standards.

6. **Productivity Standards**

a. **Optometry**

(1) VHA optometrists provide comprehensive, full-scope primary eye examinations and productivity varies based on local factors, which include the number of exam rooms and additional space available, equipment, support staff, mission of the facility, complexity of the patients, and administrative responsibilities of the optometrists. It would be expected, in most instances, for a full-time staff optometrist with adequate support personnel to have 2100 to 3000 patient visits per year.

(2) It is expected that productivity may be affected in cases where a significant amount of visual rehabilitation is being provided, nursing home or psychiatric patients are being served, or there is an absence of support staff.

b. Ophthalmology

(1) VHA ophthalmologists provide eye examinations and surgical services. Productivity is based on local factors which include the number of exam rooms and additional space available, equipment, support staff, mission of the facility, complexity of the patients and administrative responsibilities of the ophthalmologists. It would be expected, in most instances, for a full-time staff ophthalmologist with adequate support personnel to have 1800 to 4000 patient visits per year and perform 150 to 300 surgical procedures, including laser procedures, per year.

(2) It is expected that productivity may be affected in cases where many complex tertiary care procedures are performed, where available support staff is inadequate, or where operating room time is restricted. When more surgical procedures are being performed, it is expected that the number of clinic visits would be reduced.

DELINEATION OF CLINICAL PRIVILEGES

Clinical privileges of all Ophthalmologists and Optometrists will be granted in accordance with this Handbook and in compliance with existing policy as detailed in the Veterans Health Administration (VHA) Manual, M-1, Part I, Chapter 26, and VHA Handbook 1100.19 Credentialing and Privileging. In circumstances wherein Optometrists have been privileged to practice beyond the clinical authority permitted by the state license which they possess, there will be a 2-year period from the date of issuance of VHA Handbook 1121 so that they may completely fulfill the requirements to obtain appropriate licensure. VA facilities must provide resources and support to accomplish this goal. **NOTE:** *There will be no reductions, suspensions or revocations of clinical privileges solely due to the scope of licensure issue during this 2-year transition period.*