

VHA EYE AND VISION CARE

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive states policy for the delivery of eye and vision care services by Department of Veterans Affairs (VA) medical facilities emphasizing the use of interdisciplinary care.

2. SUMMARY OF MAJOR CHANGES:

a. Amendment dated August 18, 2020 incorporates and rescinds VHA Directive 1132, Performance of Therapeutic Laser Eye Procedures in Veterans Health Administration Facilities, dated May 27, 2020, including:

(1) Adding the definition of Therapeutic Laser Eye Procedure.

(2) Updating responsibilities under the VA medical facility Director related to laser eye procedures.

(3) Updating Appendix G, Credentialing and Privileging, with requirements for ophthalmologists related to laser eye procedures.

b. Amendment dated June 19, 2020 corrects two ratios in Appendix F, Staffing and Productivity.

c. Major changes from prior policy include:

(1) Update of Eligibility language in paragraph 6.

(2) Update of Quality Improvement to include Patient Safety in Appendix D.

(3) Removal of Information Management.

(4) Removal of Research and Development.

(5) Transition of Appendix A, Eye Care Professions, into the body of the directive.

(6) Transition of Appendix C, Visual Impairment Prevention for Veteran Patients, into the body of the directive.

(7) Incorporation of Appendix B, Care Coordination Agreement between Optometry and Ophthalmology Sample Template and Appendix C, Care Coordination Agreement between Optometry and Ophthalmology and Primary Care or Emergency Department Sample Template.

3. RELATED ISSUES: None.

4. RESPONSIBLE OFFICE: The Office of Specialty Care Services (10P11) is responsible for the contents of this directive. Questions may be referred to Specialty Care Services at 202-461-7163.

5. RESCISSIONS: VHA Handbook 1121.01, VHA Eye Care, dated March 10, 2011 and VHA Directive 1132, Performance of Therapeutic Laser Eye Procedures in Veterans Health Administration Facilities, dated May 27, 2020 are rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of October 2024. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

**BY DIRECTION OF THE OFFICE OF THE
UNDER SECRETARY FOR HEALTH:**

/s/ Lucille B. Beck, Ph.D.
Deputy Under Secretary for Health
for Policy and Planning

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

DISTRIBUTION: Emailed to the VHA Publications Distribution List on October 3, 2019.

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VHA EYE AND VISION CARE

1. PURPOSE

This Veterans Health Administration (VHA) directive is issued to facilitate the provision of eye and vision care throughout the Department of Veterans Affairs (VA) health care system. **AUTHORITY:** Title 38 United States Code (U.S.C.) 7301(b).

2. BACKGROUND

a. Increasing enrollment, especially of Vietnam era Veterans, is resulting in an increased incidence of age-related eye and vision conditions. Age-related macular degeneration (AMD), diabetic retinopathy, and glaucoma are major causes of visual impairment and blindness. In younger Veterans, trauma (both military and non-military) is a frequent cause of eye/vision problems. Accordingly, Veterans need cost-effective, readily accessible, and comprehensive eye and vision care services.

b. Prevention and treatment of visual impairment and blindness involves optical, medical, surgical, and rehabilitative eye care. The provision of these services involves coordination of the professions of primary care, optometry, and ophthalmology.

c. The goals of VHA eye and vision care are:

(1) Provide high-quality and timely care to all eligible Veterans.

(2) Provide patient education to Veterans and caregivers.

(3) Support academically affiliated ophthalmology and optometry teaching programs to educate and train students, residents, and fellows.

(4) Promote and support professional education and continuing medical education for staff, health care providers, and trainees.

(5) Provide expertise to VA and Federal funding agencies on research issues important to Veteran eye health, access, utilization, and quality of care.

(6) Evaluate and champion new technologies to improve access, the cost of eye care, and visual health and surgical outcomes.

(7) Support other Federal agencies and the community in times of military necessity or national emergency.

(8) Monitor access, utilization, quality, and cost of eye care delivered to Veterans within VHA and in the community for ongoing quality improvement.

3. DEFINITIONS

a. **Accreditation Council on Optometric Education.** The Accreditation Council on Optometric Education (ACOE) is the accrediting agency for optometric educational programs.

b. **Low Vision and Blind Rehabilitation Continuum of Care.** The continuum of care for visually-impaired Veterans refers to vision and blind rehabilitation services ranging across multiple levels of care that may be provided at VA medical facilities, in the patient's home, and/or community. Patients are referred to the type program that best matches their functional needs.

c. **Eye and Vision Care.** Eye and vision care comprise a spectrum of needs including primary, specialty, and surgical eye and vision care services.

d. **Eye Care Provider.** An eye care provider is a credentialed and privileged optometrist or ophthalmologist.

e. **Eye Care Health Technicians.**

(1) **Ophthalmology Health Technician.** An ophthalmology health technician is a person who provides primary clinical support to ophthalmology clinics by performing eye and vision care-related clinical tasks. Ophthalmology technicians possess knowledge and skills that are certified by The Joint Commission on Allied Health Personnel in Ophthalmology (JCAHPO). **NOTE:** Refer to VA Handbook 5005/98, *Staffing—Health Technician (Ophthalmology)*, dated February 7, 2018, for qualifications.

(2) **Optometry Health Technician.** An optometry health technician is a person who provides primary clinical support to optometry clinics by performing eye and vision care-related clinical tasks. Optometry technicians possess knowledge and skills that are certified by the American Optometric Association (AOA) Commission on Paraoptometric Certification, or equivalent accredited certification.

f. **Legal Blindness.** For purposes of this directive, legal blindness is defined as:

(1) Best corrected central visual acuity of 20/200 or worse in the better-seeing eye;
or

(2) The widest diameter of the visual field subtends an angle of 20 degrees or less, in the better-seeing eye.

g. **Low Vision.** For purposes of this directive, low vision is defined as:

(1) Best corrected central visual acuity of 20/70 to 20/160 or worse in the better seeing-eye;

(2) Significant central or peripheral visual field loss; or

(3) A combination of visual acuity, visual field loss, contrast sensitivity loss, loss of stereopsis, or eye motility impairment that impacts patient safety or impairs or restricts one or more activities of daily living.

h. **Ocularist.** An ocularist provides the assessment, fitting, and maintenance of ocular prostheses (artificial eyes).

i. **Ophthalmologist.** An ophthalmologist is a Medical Doctor (MD) or Doctor of Osteopathy (DO) who is licensed to independently provide primary, specialty, surgical, and laser eye care services. An ophthalmologist is medically trained and qualified to diagnose and treat all eye and visual system problems, deliver total eye care, and diagnose general diseases of the body. These treatments include, but are not limited to: cataract surgery, diabetic retinopathy laser therapy, glaucoma treatment, and macular degeneration injections. After baccalaureate education, ophthalmologists complete 4 years of medical school, 1 year of internship, 3 years of an ophthalmology residency including the management of complex ocular conditions and surgery, and often 1 to 2 years of additional fellowship training in a specific specialty.

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

k. **Ophthalmology Trainees.**

(1) **Ophthalmology Residency.** Ophthalmology residents must complete a general postgraduate year (PGY) approved by the ACGME and a minimum of 3 years of postgraduate training in an ACGME-accredited ophthalmology training program to become eligible for certification by the American Board of Ophthalmology. All current VHA ophthalmology residencies participate in the Ophthalmology Matching Program and are affiliated with a sponsoring academic center.

(2) **Ophthalmology Fellowship.** Ophthalmology fellowships are post-residency positions to obtain additional training in an area of sub-specialty ophthalmology, including retinal surgery, glaucoma, corneal surgery, plastic surgery and neuro-ophthalmology.

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

m. **Optometrist.** An optometrist is a Doctor of Optometry (OD) who is licensed to independently provide primary and specialty eye and vision care services. An optometrist is medically trained to examine, diagnose, treat, and manage diseases and disorders of the visual system, the eye and associated structures, and diagnose related systemic conditions. This includes, but is not limited to: diagnosis, treatment, and management of diabetic retinopathy, glaucoma, macular degeneration, and other eye diseases; provision of refractions for eyeglass prescriptions, eyeglasses, medically necessary contact lenses, as well as low-vision and brain injury vision rehabilitation services. Optometrists receive 4 years of Doctoral-level education and training after their baccalaureate education. Residency training is 1 year beyond attainment of the optometry degree, and fellowship training is for 1 to 2 years beyond the completion of residency training.

n. **Optometry Trainees.**

(1) **Doctor of Optometry Candidates.** Optometry candidates are students in an ACOE-accredited school or college of optometry in either their first, second, third, or fourth professional year of training prior to being awarded the OD degree.

(2) **Residents and Fellows.** Residents and fellows are trainees who have obtained the OD degree. Residents are PGY1 trainees in a primary eye or specialty vision care residency. Fellows are PGY2 and PGY3 trainees with a specialty or research focus.

o. **Therapeutic Laser Eye Procedure.** Therapeutic laser eye procedures are surgical procedures which use medical grade lasers that produce focused energy with different types and wavelengths of light to treat a variety of eye conditions. Refractive laser surgery (LASIK, PRK) is not performed in VA medical facilities as these are elective procedures not covered by Centers for Medicare and Medicaid Services (CMS) or third-party payors. The laser beam can be used to treat diseased retina from diabetic eye disease and sickle cell disease, create openings within the iris to treat glaucoma, remove cloudy membranes after cataract surgery, treat retinal holes or tears, create incisions within the cornea to treat astigmatism or to make cataract surgery wounds, or to modify the refractive status of the eye.

p. **VA Residency Site Director.** The VA Residency Site Director implements the training program curriculum at a VA medical facility and is generally of the same discipline as that of the trainees.

q. **VHA National Eye Care Program.** The VHA National Eye Care Program is the combination of the national divisions of optometry and ophthalmology and is jointly led by the national directors of optometry and ophthalmology within Specialty Care Services (SCS). It supports the delivery of eye and vision care services throughout VHA.

r. **Vision Correction Surgery (Refractive Surgery).** Vision corrective surgery (refractive surgery) is any surgical procedure to correct disorders of refraction, including farsightedness, nearsightedness, astigmatism, and presbyopia. Laser refractive surgery and corneal crosslinking are not covered procedures within VHA, except for Veterans with service-connected keratoconus.

4. POLICY

It is VHA policy that under the VHA National Eye Care Program all eligible Veterans receive the most appropriate continuum of primary, secondary, and tertiary eye and vision care services delivered by ophthalmologists and optometrists, supported by opticians and technicians, each practicing consistent with their education, training, and privileging and working together in a collaborative and coordinated manner.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Service Networks (VISNs).

(2) Providing assistance to VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to assure compliance with this directive, relevant standards and applicable regulations.

c. **Deputy Under Secretary for Health for Policy and Services.** The Deputy Under Secretary for Health for Policy and Services is responsible for supporting the implementation and oversight of this directive across VHA.

d. **Chief Officer, Specialty Care Services.** The Chief Officer, SCS is responsible for:

(1) Administrative oversight of the VHA National Eye Care Program, including the component programs related to ophthalmology and optometry.

(2) Appointing the VHA National Program Director for Ophthalmology and the VHA National Program Director for Optometry.

e. **National Program Directors, VHA National Eye Care Program.** There are two National Program Directors for Eye and Vision Care:

(1) **VHA National Program Director for Ophthalmology.** The VHA National Program Director for Ophthalmology is a full-time VA ophthalmologist, appointed by and reporting to the Chief Officer, SCS, who is responsible for overseeing the National VA Ophthalmology Program and is jointly responsible with the VHA National Program Director of Optometry for overseeing the VHA National Eye and Vision Care Program.

(2) **VHA National Program Director for Optometry.** The VHA National Program Director for Optometry is a full-time VA optometrist, appointed by and reporting to the Chief Officer, SCS, who is responsible for overseeing the National VA Optometry Program and is jointly responsible with the VHA National Program Director of Ophthalmology for overseeing the VHA National Eye and Vision Care Program.

f. **Eye Care Field Advisory Committees.**

(1) **Ophthalmology and Optometry Field Advisory Committees.** Each program director will be supported by a separate Field Advisory Committee (FAC) appointed by the Chief Officer SCS at the nomination of the respective program directors of optometry and ophthalmology. Each FAC will be comprised of voting, as well as non-voting members as needed for project-related sub-committees. FAC members are appointed for 3-year, staggered terms with the possibility of one re-appointment.

(2) **Eye Care Joint Field Advisory Committee.** The National Program Directors for Ophthalmology and Optometry will jointly convene and co-chair an Eye Care Joint Field Advisory Committee comprised of 6 voting members (3 from optometry and 3 from ophthalmology FACs) that will meet as needed (at least annually) to consider eye care programmatic issues. The Eye Care Joint FAC recommendations will be reported to the Chief Officer SCS by the National Program Directors for Ophthalmology and Optometry.

g. **Veterans Integrated Services Network Director.** The VISN Director is responsible for:

(1) Ensuring that all eligible Veterans have access to eye care, vision care, and visual rehabilitation services.

(2) Designating a VISN ophthalmology consultant and a VISN optometry consultant in concert with the respective VHA National Program Director of Ophthalmology and the VHA National Program Director for Optometry.

(3) Consulting with the VHA National Program Director for Optometry and VHA National Program Director for Ophthalmology regarding changes in eye and vision care services at VISN medical facilities.

h. **VA Medical Facility Director.** The VA medical facility Director is responsible for ensuring that:

(1) All eligible Veterans are provided:

(a) Eye and vision care services that include comprehensive eye examinations, preventative eye care, necessary periodic specialty eye and vision care, surgical eye care, rehabilitation care, and associated patient education, as defined by clinical practice guidelines published by the American Optometric Association (AOA) and the American Academy of Ophthalmology (AAO).

(b) Prosthetic devices as needed, including spectacles, special contact lenses, ocular prostheses, low-vision devices, and associated rehabilitation services.

(2) The eye clinic is designed to be a safe environment for patients and staff as described in VA Handbook 7610.3, Chapter 233, Eye Clinic, dated May 31, 2017, and in the Prototype for Standardized Design and Construction of Community-Based Outpatient Clinics at <https://www.cfm.va.gov/til/prototypes.asp>.

(3) Necessary space and resources (equipment, supplies, support services) are provided to eye clinics to optimize access.

(4) Operating room space, time, resources, and internal processes are available to provide high-quality surgical care to Veterans.

(5) An organizational structure is in place that supports the delivery of eye and vision care services by optometrists and ophthalmologists consistent with their education,

training, and privileging and allows for the professional autonomy appropriate to independently licensed medical staff providers and which is necessary for the education of trainees and to meet student and residency accreditation requirements for training.

(6) Care coordination agreements are in place between primary care and eye care (optometry and ophthalmology) and between optometry and ophthalmology. **NOTE:** *Refer to Appendices B and C for more information.*

(7) Required diagnostic services are available including:

- (a) Laboratory;
- (b) Radiology;
- (c) Pathology;
- (d) Fundus photography;
- (e) Ophthalmic ultrasound;
- (f) Pachymetry;
- (g) Optical coherence tomography (OCT); and
- (h) Visual fields (perimetry).

(8) Recommended services are available including:

- (a) Fluorescein angiography;
- (b) Fundus Auto-Fluorescence (FAF) imaging; and
- (c) Electro-diagnostics testing.

(9) Information technology resources are available including: Veterans Health Information Systems and Technology Architecture (VistA) applications; computer systems; equipment to scan, send, and copy paper medical records; and biomedical information technology such as computer-assisted ophthalmic biomedical devices and equipment, including direct linkage of image transfer from devices into the electronic health record (EHR) where available.

(10) Surgical services appropriate to the Veteran are available either within the VA medical facility, academic partner, or community care. **NOTE:** *Refer to VHA Directive 1220, Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in Any Clinical Setting, dated May 13, 2019.*

(11) Ensuring that privileges to perform laser eye procedures are granted to ophthalmologists who have completed the requirements as described in this directive.

Most VHA ophthalmology sections should provide one or more types of laser eye surgeries.

(12) Academic affiliations for optometry and ophthalmology are established and supported in accordance with VHA Directive 1400.09(1), Education of Physicians and Dentists, dated September 9, 2016, and VHA Handbook 1400.08, Education of Associated Health Professions, dated February 26, 2016, including appointing a representative from each affiliated school or college of optometry and medicine to the local VA or VISN affiliation partnership council or equivalent educational council.

(13) Support for continuing professional and staff education is provided in the form of meeting space and time for rounds, lectures and other interprofessional learning activities and meetings.

(14) Appropriate support for eye and vision care research.

i. **VA Residency Site Directors for Optometry and for Ophthalmology.** The VA Residency Site Director for Optometry and the VA Resident Site Director for Ophthalmology are responsible for the following for their respective training programs:

(1) Developing a local educational program based on national standards and the educational plan of the residency or training program director, and which ensure that core curricular objectives are met.

(2) Implementing the training program curriculum for their discipline at a VA medical facility.

(3) Site logistics and ensuring that trainees are oriented to VA medical facility policies and practices; details of rotations, schedules; objectives are communicated to trainees; and evaluations of trainees, preceptors, supervisors, and training facilities are performed.

(4) Maintaining appropriate trainee supervision. Refer to Appendices H and I for education and training guidelines.

(5) Ensuring ophthalmology residents complete mandatory training as described in VHA Directive 1039(2), Ensuring Correct Surgery and Invasive Procedures, dated November 28, 2018, before beginning a surgical rotation.

6. ELIGIBILITY

All Veterans enrolled in the VA health care system are eligible for eye and vision care services through VHA, regardless of service connection status. However, not all Veterans are eligible for prosthetic devices, such as eyeglasses. If a VA medical facility cannot directly provide the appropriate eye care services to an eligible Veteran or the Veteran meets eligibility for community care, the Veteran may elect to receive services through the community care program. **NOTE:** Refer to VHA Notice 2019-12, Veterans

Community Care Program, dated June 6, 2019, and Public Law 115-182 VA Mission Act of 2018, dated January 3, 2018.

7. PREVENTION OF VISUAL IMPAIRMENT AND BLINDNESS

a. AMD, diabetic retinopathy and glaucoma are leading causes of blindness identified by the National Eye Institute of the National Institutes of Health (NIH). In many cases, visual impairment and blindness can be prevented or reduced by early diagnosis and medical and surgical treatment.

b. The AOA Clinical Practice Guidelines (<https://www.aoa.org/optometrists/tools-and-resources/clinical-care-publications/clinical-practice-guidelines>) and the AAO Preferred Practice Patterns (<https://www.aoa.org/about-preferred-practice-patterns>) provide current guidance for the management of diabetic retinopathy, glaucoma, and AMD.

8. CARE COORDINATION

Care coordination agreements must be established between primary care and eye care (optometry and ophthalmology) and between optometry and ophthalmology at each VA medical facility. **NOTE:** Refer to Appendices B and C for care coordination sample templates.

a. **Care Coordination Agreement between Primary Care and Optometry and Ophthalmology.** There are many eye conditions that necessitate referral by primary care providers to eye care providers. A care coordination agreement for referral from primary care to eye care (optometry and ophthalmology) to screen, evaluate, and manage patients should include:

(1) An annual consultation or referral to eye care for Veterans with diabetes (applies mainly to new patients not already under Eye Care Service diabetic recall). Referral should be expedited if there is new vision loss or symptoms. If serial examinations have not revealed any diabetic retinopathy, the time interval can be extended by the eye care provider to 2 years.

(2) Consults or referrals for Veterans with visual symptoms, eye injuries, surveillance for known eye diseases (glaucoma, AMD, cataract) or monitoring for ocular toxicity in chronic use of certain medications (such as hydroxychloroquine (Plaquenil)), as indicated.

b. **Care Coordination Agreement between Ophthalmology and Optometry.** A care coordination agreement must exist between optometry and ophthalmology to facilitate Veteran-centric care between these services. Typical care coordination agreements between ophthalmology and optometry involve referral of patients with AMD, diabetic retinopathy, glaucoma, and low vision or legal blindness and are based on current, nationally-accepted standards of both eye care professions. The care coordination agreement should not affect or alter the clinical privileges that have been granted to optometrists or ophthalmologists or restrict the ability of patients to have

access to care provided by optometry or ophthalmology within their granted clinical privileges. The care coordination agreement should address:

- (1) AMD;
- (2) Diabetic Retinopathy;
- (3) Glaucoma; and

(4) Low Vision Rehabilitation Care. **NOTE:** Refer to VHA Handbook 1174.05, *Outpatient Blind and Vision Rehabilitation Clinic Procedures*, dated July 1, 2011, and VHA Handbook 1174.03, *Visual Impairment Services Team Program Procedures*, dated November 5, 2009.

(5) For patients consulted between optometry and ophthalmology for eye disease, the patient may be discharged back to the referring provider for continuing care, when appropriate.

c. Clinical Care Review (Ongoing Professional Practice Evaluation or Focused Professional Practice Evaluation) for Ophthalmology and Optometry.

(1) A routine review of clinical care of patients diagnosed with AMD, diabetic retinopathy, glaucoma, and low vision or legal blindness should be conducted by the VA medical facility optometry and ophthalmology services (optometry reviews optometry and ophthalmology reviews ophthalmology) to evaluate timeliness of referral and patient outcomes. These disease-specific review processes should be incorporated as part of the Ongoing Professional Practice Evaluation (OPPE) program or Focused Professional Practice Evaluation (FPPE) in the case of new hires or problem-oriented prospective reviews at each VA medical facility. These disease-specific, evidence-based reviews shall be based on current, nationally-accepted standards of care (e.g., American Academy of Ophthalmology Preferred Practice Patterns at <https://www.aao.org/about-preferred-practice-patterns> and the American Optometric Association Clinical Practice Guidelines at <http://www.aoa.org/optometrists/tools-and-resources/clinical-care-publications/clinical-practice-guidelines>).

(2) These disease-specific reviews are to be used by the respective service chiefs of optometry and ophthalmology and the medical staff executive committee for initial privileging and re-privileging decisions.

(3) VA medical facilities with a single eye care provider (optometrist or ophthalmologist) should make arrangements with the respective optometry or ophthalmology VISN lead or a VA medical facility with optometry or ophthalmology eye care providers to conduct the review, as appropriate.

d. Review of Coordination of Care by Ophthalmology and Optometry.

(1) A semi-annual review of the adequacy and timeliness of care coordination will be performed by a joint meeting of optometry and ophthalmology for a minimum of six

patients diagnosed with AMD, diabetic retinopathy, glaucoma, low vision and/or legal blindness that are managed by both services. This non-punitive and confidential review is conducted within the context of quality assurance (38 U.S.C. 5705) and is intended to improve both care coordination between the eye care services and patient outcomes. This meeting can also review systems of care.

(2) VA medical facilities with a single eye care provider (optometrist or ophthalmologist) should make arrangements with the respective optometry or ophthalmology VISN leads or VA medical facility with optometry or ophthalmology eye care providers to conduct the review, as appropriate.

9. TRAINING

See Appendices H and I for training information.

10. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created in this directive shall be managed per the National Archives and Records Administration (NARA) approved records schedules found in VA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Manager or Records Liaison.

11. REFERENCES

- a. Pub. L. 115-82.
- b. Title 38 Code of Federal Regulations (CFR) Sections 17.30 and 17.38.
- c. 38 CFR 17.149.
- d. 38 U.S.C. 5705.
- e. VA Handbook 5005, Staffing, Part II, Chapter 3, Title 38 Appointments, dated November 22, 2017.
- f. VA Handbook 5005/58, Staffing, Part III, Appendix M, How to Process a Promotion for Optometrist, dated June 14, 2012.
- g. VA Handbook 5005/92, Staffing, Part II, Chapter 3, Section C, Professional Standards Board, dated November 22, 2017.
- h. VA Handbook 5007/46, Pay Administration, Part VI, Chapter 2, Recruitment and Relocation Incentives, dated April 22, 2013.
- i. VA Handbook 5007/46, Pay Administration, Part VI, Chapter 3, Retention Incentives Other than For Closure or Relocation of Employing Office, Facility, or Organization, dated April 22, 2013.

- j. VA Handbook 5017/15, Employee Recognition and Awards, Part V, Title 38 Special Advancements and Cash Awards, dated June 3, 2019.
- k. VA Handbook 7610.3, VHA Space Planning Criteria: Chapter 233, Eye Clinic, dated May 31, 2017.
- l. VHA Directive 1021, Education Debt Reduction Program, dated May 21, 2012.
- m. VHA Directive 1034, Prescribing and Providing Eyeglasses, Contact Lenses, and Hearing Aids, dated October 24, 2019.
- n. VHA Directive 1039(2), Ensuring Correct Surgery and Invasive Procedures In and Out of the Operating Room, dated November 28, 2018.
- o. VHA Directive 1103, Prevention of Retained Surgical Items, dated March 5, 2016.
- p. VHA Directive 1116(2), Sterile Processing Services, dated March 23, 2016.
- q. VHA Directive 1131(3), Management of Infectious Diseases and Infection Prevention and Controls Program, dated November 7, 2017.
- r. VHA Directive 1182, Vocational Rehabilitation: Chapter 31 Benefits Timely Access to Health Care Services, dated April 2, 2015.
- s. VHA Directive 1190, Peer Review for Quality Management, dated November 21, 2018.
- t. VHA Directive 1220(1), Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in Any Clinical Setting, dated May 13, 2019.
- u. VHA Directive 1231(1), Outpatient Clinic Practice Management, dated October 19, 2019.
- v. VHA Directive 1400, Office of Academic Affiliations, dated November 9, 2018.
- w. VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019.
- x. VHA Directive 1400.09(1), Education of Physicians and Dentists, dated September 6, 2016.
- y. VHA Directive 1401, Billing for Services Provided by Supervising Practitioners and Physician Residents, dated July 29, 2016.
- z. VHA Directive 1601, Non-VA Medical Care Program, dated January 23, 2013.
- aa. VHA Directive 2009-038, VHA National Dual Care Policy, dated August 25, 2009.

bb. VHA Directive 2011-040, Referral to Inpatient Blind Rehabilitation Centers and Calculation of the Waiting Time Prior to Admission, dated December 7, 2011.

cc. VHA Directive 2012-030, Credentialing of Health Care Professionals, dated October 11, 2012.

dd. VHA Directive 6300, Records Management, dated October 22, 2018.

ee. VHA Notice 2019-12, Veterans Community Care Program, dated June 6, 2019.

ff. VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012.

gg. VHA Handbook 1173.05, Aids for the Blind and Visually Impaired, dated October 27, 2008.

hh. VHA Handbook 1173.1, Eligibility, dated November 2, 2000.

ii. VHA Handbook 1173.12, Prescription Optics and Low-Vision Devices, dated May 31, 2005.

jj. VHA Handbook 1174.03, Visual Impairment Services Team Procedures, dated November 5, 2009.

kk. VHA Handbook 1174.05, Outpatient Blind and Vision Rehabilitation Clinic Procedures, dated July 1, 2011.

ll. VHA Handbook 1400.03, Veterans Health Administration Educational Relationships, dated February 16, 2016.

mm. VHA Handbook 1400.04, Supervision of Associated Health Trainees, dated March 19, 2015.

nn. VHA Handbook 1400.08, Education of Associated Health Professions, dated February 26, 2016.

oo. VHA Handbook 1601A.04, Benefits Overview, dated February 16, 2016.

pp. VA/DoD Clinical Practice Guidelines: Management of Diabetes Mellitus in Primary Care (<https://www.healthquality.va.gov/guidelines/CD/diabetes/>).

qq. VA National Center for Patient Safety (<http://vaww.ncps.med.va.gov/index.html>).
NOTE: *This is an internal VA Web site not available to the public.*

rr. VA Office of Academic Affiliations (<https://www.va.gov/OAA/index.asp>).

ss. VA Office of Construction and Facilities Management. Prototype for Standardized Design and Construction of Community-Based Outpatient Clinics (CBOCs) (<https://www.cfm.va.gov/til/spclRqmts.asp>).

tt. VA Office of Research and Development (<https://www.research.va.gov>).

uu. VHA Office of Productivity, Efficiency and Staffing (OPES) Eye Care Provider RVU Productivity Recommendations (<http://opes.vssc.med.va.gov/Pages/Default.aspx>. **NOTE:** *This is an internal VA Web site that is not available to the public.*)

vv. Accreditation Council for Graduate Medical Education (ACGME), Ophthalmology Residency Review Committee (<http://www.acgme.org/Specialties/Overview/pfcatid/13/Ophthalmology>).

ww. Accreditation Council for Graduate Medical Education (ACGME), Program Requirements for Graduate Medical Education in Ophthalmology (http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/240_ophthalmology_2017-07-01_TCC.pdf. **NOTE:** *This linked document is outside of VA control and may or may not be conformant with Section 508 of the Americans with Disabilities Act.*)

xx. Accreditation Council on Optometric Education (<http://www.aoa.org/optometrists/for-educators/accreditation-council-on-optometric-education>).

yy. American Academy of Ophthalmology Preferred Practice Patterns (<http://one.aao.org/guidelines-browse?filter=preferredpracticepatternsguideline>).

zz. American Optometric Association Optometric Clinical Practice Guidelines, (<http://www.aoa.org/optometrists/tools-and-resources/clinical-care-publications/clinical-practice-guidelines>).

aaa. American Optometric Association Commission on Paraoptometric Certification (<https://www.aoa.org/paraoptometrics/certification?sso=y>).

bbb. Guideline for Disinfection and Sterilization in Healthcare Facilities, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services (http://www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf. **NOTE:** *This linked document is outside of VA control and may or may not be conformant with Section 508 of the Americans with Disabilities Act.*)

ccc. Joint Commission on Allied Health Personnel in Ophthalmology (JCAHPO) (<http://www.jcahpo.org/>).

ddd. National Eye Institute of NIH (<https://nei.nih.gov/>).

eee. National Eye Institute of the National Institutes of Health, National Eye Health Education Program Glaucoma Recommendations (<http://www.nei.nih.gov/nehep/programs/glaucoma/detection>).

SPACE AND EQUIPMENT

1. PLANNING

Facilities should refer to the latest version of VA Handbook 7610.3, VHA Space Planning Criteria: Chapter 233, Eye Clinic: Ophthalmology and Optometry Services, dated May 31, 2017, and the Prototype for Standardized Design and Construction of Community-Based Outpatient Clinics for guidelines regarding design and construction of new eye care clinics, alteration of existing clinics, and eye care equipment requirements that may be accessed at <https://www.cfm.va.gov/til/space.asp> and <https://www.cfm.va.gov/til/prototypes.asp>. The VHA National Eye Care Program is also available for consultation. Co-location of ophthalmology and optometry or co-location of optometry and primary care is recommended.

2. KEY SPACES

a. **Administrative.** An office needs to be provided for a full-time chief optometrist and/or a full-time chief ophthalmologist. Staff clinicians may have individual or shared offices. Offices for secretaries, technical support, and students may be provided as space permits.

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

(1) Exam-treatment (E-T) rooms (2.5 E-T rooms for each 1.0 full-time equivalent employee optometrist or ophthalmologist) with refractive and eye health instrumentation (minimum 130 net square feet for each E-T room) that can accommodate wheelchair patients.

(2) Low-vision examination, training, or storage room.

(3) Visual fields room with non-automated and automated instruments.

(4) Photography room with fundus and slit-lamp camera units that produce digital images.

(5) Pre-testing room for use by technician for preliminary testing.

(6) Eyeglass fitting, display, and dispensing room (if in concept of operations).

c. **Educational Program Space.**

(1) At least one fully-equipped E-T room for each trainee is recommended in addition to the space required of the attending ophthalmologist(s) and/or optometrist(s).

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

(3) State-of-the-art equipment is recommended for education programs.

d. **Tomography/Imaging Room(s)**. Other imaging devices may include optical coherence tomography (OCT), corneal topography, specular microscope, wavefront analyzer, or tear osmolarity, depending on the level of services provided. More than one room may be required to conduct ocular diagnostic imaging studies.

e. **Photography Room.**

f. **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.

g. **Procedure Room.** This room is for any treatment that requires surgical intervention that is deemed an in-office procedure. This room must contain standard emergency equipment. Procedures commonly performed in this room are: tarsorrhaphy; excisions (chalazia, pterygia, external lid lesions); intraocular injections; insertion, removal, and repair of sutures; blepharoplasty; and simple entropion or ectropion repair.

h. **Clean Utility or Supply Room.**

i. **Soiled Utility Room.**

j. **Laser Room.** The Argon, Diode, Selective Laser Trabeculoplasty (SLT), 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 accompanying instrumentation may need either special power or cooling requirements. ***NOTE: Lasers are used by ophthalmology in treatment of numerous ocular problems; e.g., diabetic retinopathy, glaucoma, retinal tear.***

k. **Low-Vision/Polytrauma Training Room.** This room is used to provide vision rehabilitation care such as patient education and eye care counseling sessions; in which patients learn how to use prescribed low-vision aids in order to perform everyday skills, activities of daily living, and improve overall functional independence.

l. **Electrodiagnosis Room.** The electrodiagnosis room accommodates visual-digitized equipment for conducting electro-oculographic, electroretinographic, and visual-evoked cortical-potential testing of retina, optic nerve, and visual pathway functioning with analysis.

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

(1) Reception area.

(2) Waiting area.

(3) Public toilet (wheelchair accessible, may be unisex).

- (4) Consultation and viewing room.
- (5) Patient education and contact lens dispensing room.
- (6) Equipment and supplies storage area or alcove.
- (7) Medication preparation room.
- (8) Staff toilet.
- (9) Wheelchair storage area or alcove.

CARE COORDINATION AGREEMENT BETWEEN OPTOMETRY AND OPHTHALMOLOGY SAMPLE TEMPLATE

The following is a care coordination agreement sample template between optometry and ophthalmology to facilitate appropriate and timely referral and/or consultation of patients consistent with current, nationally-accepted standards of both optometry and ophthalmology. This agreement should improve the coordination of patient care between these professions and should not affect or alter the clinical privileges that have been granted to providers or restrict patient access to optometry or ophthalmology.

1. PURPOSE

This care coordination agreement is intended to:

- a. Coordinate efforts between providers to deliver Veteran-centric care.
- b. Facilitate appropriate and timely referral of patients from optometry to ophthalmology for care of age-related macular degeneration (AMD), diabetic retinopathy, and glaucoma, and to facilitate discharge back from ophthalmology to optometry for continuing care, as appropriate. These referrals may not require a face-to-face examination; an electronic consult or personal discussion documented within the electronic health care record may be sufficient.
- c. Ensure that optimal eye and vision care is provided to eligible Veterans through a collaborative approach to diagnosis, treatment, and management of eye and vision care by both optometry and ophthalmology.
- d. Provide appropriate and timely referral of patients for low vision rehabilitation care.
- e. Veterans should be educated about their disease progress and the range of appropriate treatment options.

2. CONSULT REQUEST AND REFERRAL

- a. **Prior to Consult Request.** A note documented by optometry or ophthalmology is to be available for ophthalmology or optometry to view in the electronic health record (EHR).
- b. **Results of Consult Request.** Optometry or ophthalmology is to complete the consult through the EHR.
- c. **Referral Back to Original Referring Section or Service.** For patients consulted between optometry and ophthalmology for eye care, the patient should be sent back to the referring provider for continuing care when it is appropriate to do so.

3. AGE-RELATED MACULAR DEGENERATION

a. An ophthalmology consult or referral is warranted for but not limited to: age-related macular degeneration (AMD) patients with active (clinically significant) choroidal neovascularization, new onset of macular edema threatening vision, or new onset of metamorphopsia or AMD-related decreased vision for consideration of ophthalmological intervention (laser, surgery, injection).

b. **Age-Related Eye Disease Study Vitamins.** Both optometry and ophthalmology should prescribe vitamin supplementation for AMD patients found to have “high risk” physical findings, as recommended by Age-Related Eye Disease Study (AREDS-2) criteria. The definition of high-risk, non-exudative AMD can be any one of the following:

(1) Extensive intermediate size drusen.

(2) One or more large soft drusen (approximately 120 microns (um), approximate size of retinal artery at the optic nerve head).

(3) Non-central geographic atrophy in at least one eye.

(4) Category 3/4 AMD (vision loss secondary to AMD).

(5) Exudative (wet) AMD in at least one eye.

4. DIABETIC RETINOPATHY

a. An ophthalmology consult or referral for evaluation and treatment is warranted for but not limited to: clinically significant macular edema, severe non-proliferative retinopathy, proliferative retinopathy, neovascularization, diabetic-related vitreous hemorrhage, or clinically significant progression of diabetic ocular disease for consideration of ophthalmological intervention (laser, surgery, injection) or monitoring.

b. **Definition of Clinically Significant Macular Edema.** It can be any one of the following, by Early Treatment Diabetic Retinopathy Study criteria:

(1) Retinal edema or thickening within 500 microns of foveal avascular zone.

(2) Hard exudates within 500 microns of fovea with associated retinal edema.

(3) Retinal edema measuring more than greater than 1 disc diameter within 1 disc diameter of fovea.

c. **Definition of Severe Non-Proliferative Diabetic Retinopathy.** It can be any one of the following by Early Treatment Diabetic Retinopathy Study (ETDRS) criteria:

(1) Severe (greater than) 20 intraretinal hemorrhages in four quadrants.

(2) Venous beading in two quadrants.

(3) Intraretinal microvascular anomaly in one quadrant.

5. GLAUCOMA

a. An ophthalmology consult or referral for evaluation and treatment is warranted for but not limited to: angle closure glaucoma (prior to, or after, medical stabilization of intraocular pressure, as appropriate), active neovascular glaucoma, clinically-significant glaucoma progression (e.g., retinal nerve fiber layer or visual field loss or instability) despite appropriate medical treatment, documented clinically-significant non-compliance or instability on medical therapy, or when considering initiation of a fourth glaucoma medication for consideration of ophthalmological intervention (laser, surgery, injection), or monitoring. Patients should be made aware of laser trabeculoplasty as an alternative treatment option.

b. Expedited consults are warranted for:

- (1) Acute angle closure glaucoma.
- (2) Active neovascular glaucoma.

6. LOW-VISION REHABILITATION CARE

a. Patients seen by either optometry or ophthalmology who meet the requirements of “low vision” or “legal blindness” need to be referred for low-vision care. A consult is required to optometry at VA medical facilities where ophthalmology is not able to provide this care. In cases where a patient can be referred to a low vision clinic that falls within the oversight of Blind Rehabilitation Service (BRS), the referral process should follow the guidelines established for the BRS continuum of care. Legally-blind patients and those with excess disability are to be referred to, and registered with, a visual impairment services team (VIST) coordinator for extensive blindness rehabilitation services. Patients who are legally blind, but retain vision, can benefit from a low-vision evaluation and prescription of low vision devices while waiting to be seen at a VA BRS program. **NOTE:** Refer to VHA Handbook 1174.05, *Outpatient Blind and Vision Rehabilitation Clinic Procedures*, dated July 1, 2011, and VHA Handbook 1174.03, *Visual Impairment Services Team Program Procedures*, dated November 5, 2009.

b. **Definition of Low Vision.** Low vision is defined as:

(1) Best corrected central visual acuity of 20/70 to 20/160, or worse in the better seeing eye;

(2) Significant central and/or peripheral visual field loss; or

(3) A combination of visual acuity, visual field loss, contrast sensitivity loss, loss of stereopsis, or eye motility impairment that impacts patient safety or impairs or restricts one or more activities of daily living.

c. **Definition of Legal Blindness.** Legal blindness is defined as:

(1) Best corrected central visual acuity of 20/200, or worse in the better seeing eye;
or

(2) The widest diameter of the visual field subtends an angle of 20 degrees, or less, in the better seeing eye.

7. URGENT CONSULT REQUESTS

When a consult request to ophthalmology is urgent, optometry is to contact ophthalmology directly to verbally discuss the patient findings and coordinate the plan of action for the patient. If an ophthalmologist is unavailable, the on-call ophthalmologist or resident should be contacted or the patient should be referred to a community ophthalmologist, as needed.

8. CLINICAL CARE REVIEW (ONGOING PROFESSIONAL PRACTICE EVALUATION AND FOCUSED PROFESSIONAL PRACTICE EVALUATION) FOR OPHTHALMOLOGY AND OPTOMETRY

a. There is to be periodic (at least every 6 months) clinical review (optometry reviews optometry and ophthalmology reviews ophthalmology) of patients who are diagnosed with AMD, diabetic retinopathy, glaucoma, and low vision and/or legal blindness based on current, nationally-accepted standards. These focused and ongoing professional practice evaluation (FPPE AND OPPE) reviews are to be incorporated into the ongoing review of each practitioner's professional practice and used by the respective service chiefs of optometry and ophthalmology and the medical staff executive committee for initial privileging and re-privileging decisions. This disease specific evidence-based review needs to include:

(1) For AMD, evidence of patient education on the risks/benefits of AREDS recommendations for preventing disease progression based upon the severity and type of macular degeneration, as indicated.

(2) For diabetic retinopathy, evidence of retinopathy severity and patient education about prevention of disease progression, as indicated. **NOTE:** *If the Veteran qualifies for screening through the national Teleretinal Imaging Screening Program, there is a quality assurance program that reviews ongoing eye care provider (optometrist or ophthalmologist) competence.*

(3) For glaucoma, evidence of annual optic nerve head evaluation, intraocular pressure measurement, and visual fields examination or documentation that visual field testing was not possible or results were unobtainable, as well as documentation concerning disease stability or progression.

(4) For low vision and/or legal blindness, evidence of referral for low vision rehabilitation care, as indicated.

b. Six selected charts of patients seen by ophthalmology are reviewed by ophthalmology and six selected charts of patients seen by optometry are reviewed by optometry.

c. VA medical facilities with a single eye care provider (optometrist or ophthalmologist) are to make arrangements with the respective optometry or ophthalmology VISN lead or a VA medical facility with optometry or ophthalmology eye care providers to conduct the review, as appropriate.

9. COORDINATION OF CARE REVIEW BY OPHTHALMOLOGY AND OPTOMETRY

a. A semi-annual review of the adequacy and timeliness of care coordination will be performed by a joint meeting of optometry and ophthalmology for a minimum of six patients diagnosed with AMD, diabetic retinopathy, glaucoma, low vision and/or legal blindness that are managed by both services. This non-punitive and confidential review is conducted within the context of quality assurance (Title 38 United States Code (U.S.C.) 5705) and is intended to enhance care coordination between the eye care services as well as improve systems of care and patient outcomes.

b. A minimum of six randomly selected charts (three from patients predominantly seen by optometry and three from patients predominantly seen by ophthalmology) of patients with low vision and/or legal blindness, AMD, diabetic retinopathy, or glaucoma need to be reviewed for referral appropriateness according to the care coordination agreement. **NOTE:** *Optometrists and ophthalmologists can use VHA identifiers 220, 407, 408, 437, 438, and 439 (as appropriate) with International Classification of Diseases Clinical Modification– 10th edition (ICD-10-CM) codes E10, E11, E13 (diabetic retinopathy), H35 (degeneration of macula and posterior pole), and H40 (glaucoma). To identify low-vision patients in ophthalmology and optometry clinics (407 and 408 respectively), the H54.8 and H54.2 (blindness and low vision) and H53 (visual field defects) ICD-10 codes may be used in combination with E10, E11, E13, H53, and H40. An alternative method to identify low-vision and legally-blind patients in ophthalmology clinics is to review patients scheduled in a retina clinic utilizing previously mentioned ICD-10 codes. Ophthalmologists and optometrists should work with the local business office to develop and implement 439 identifier, low-vision care within every VHA eye clinic (optometry and ophthalmology), as indicated where 220, 437, 438, and VA blind rehabilitation center services are not available.*

Concurrence:

Chief, Optometry Section or Service _____ Date _____

Chief, Ophthalmology Section or Service _____ Date _____

Chief of Staff _____ Date _____

**CARE COORDINATION AGREEMENT BETWEEN OPTOMETRY AND
OPHTHALMOLOGY AND PRIMARY CARE OR THE EMERGENCY DEPARTMENT
SAMPLE TEMPLATE**

The following is a care coordination agreement between optometry and ophthalmology (the eye care specialists) and primary care (the requesting provider) or the emergency department (the requesting provider) sample template. It is intended to provide a framework for the consultation of patients for eye and vision care services.

1. PURPOSE

a. **Urgent and Emergent Referral.** Urgent and emergent referrals are to be made for, but are not limited to, the following conditions:

- (1) Sudden loss of vision (including transient loss).
- (2) Sudden shade in vision, or new onset of flashes or floaters.
- (3) Sudden onset of diplopia (double vision).
- (4) Sudden eye lid droop (ptosis). If associated with facial weakness refer to neurology.
- (5) Painful red eye in a contact lens wearer.
- (6) Red eye with significant visual symptoms or significant pain.
- (7) Trauma to the eye or periorbital area sufficient to cause pain or visual symptoms.

b. **Other Conditions.** Other conditions that warrant eye care specialist consultation include, but are not limited to:

- (1) Cataracts.
- (2) Systemic disease with ocular manifestations.
- (3) Age-related macular degeneration (AMD).
- (4) Uncorrected refractive error.
- (5) Presumed visual impairment.
- (6) Systemic medications with ocular toxicity.
- (7) Lid disorders.
- (8) Eye motility disorders.
- (9) Vision examination for a drivers' license.

(10) Glaucoma.

c. Recommendations for Patients with Diabetes.

Condition	Initial Exam
Type 1	5 years after diagnosis
Type 2	At diagnosis
Prior to Pregnancy (Type 1 or 2)	Prior to conception and early in 1 st Trimester
With Retinopathy	Every 1 year
No Retinopathy	Every 2 years

NOTE: Type 1 or Type 2 diabetes patients may meet criteria to be screened in the Teleretinal Imaging Screening Program as opposed to an eye examination (see section 16 paragraph f for information about the Teleretinal Imaging Screening Program and section 7 paragraph 3 for ocular fundusoscopic examination recommendations for diabetic patients in the Department of Veterans Affairs (VA)-Department of Defense (DoD) Diabetes Clinical Practice Guidelines that may be viewed at: <http://www.healthquality.va.gov/>). Consults to both should not be placed. Initial exams for patients with or without retinopathy can be performed more frequently if indicated by the provider.

2. ORDERING CONSULTS

a. **Consult Requests.** Primary care providers and other requesting providers must utilize the electronic consultation package in the electronic health record (EHR) for initiating any request for consultation.

(1) The request must state:

(a) A presumptive diagnosis or clear question or problem to be addressed.

(b) Pertinent information including onset of symptoms, visual impact, etc.

(c) A time frame for the urgency of completion of the consult.

(2) For urgent consults, the primary care provider must contact the eye clinic during working hours and the on-call eye care specialist after hours.

(3) Inpatient consultation needs to be of an urgent nature with rare exception. All routine or screening exams must be scheduled accordingly. Contact the eye clinic (optometry or ophthalmology) or on-call eye care specialist after hours.

NOTE: There are guidelines for the performance of comprehensive eye examinations on adults based on the American Academy of Ophthalmology’s Preferred Practice Patterns and the American Optometric Association’s Clinical Practice Guidelines. The most important criteria remain symptoms and risks.

b. **Recommendations for Patients with No Risk Factors.** These are recommendations and are not to be considered mandatory.

Age (years)	Frequency of Evaluation
Over 65 years	Every 1-2 years*
55-65 years	Every 1-3 years*
40-54 years	Every 2-4 years*
Under 40 years	Every 2-10 years

*More frequently if indicated by provider.

c. **Patients with Higher Risk Factors for Glaucoma.** These are recommendations and not considered to be mandatory.

Intraocular Pressure	More than (>) 21 millimeters of Mercury (mmHg)
Family History	Positive family history of glaucoma
Race	African American or Hispanic or Latino
Ocular Trauma	Positive history of ocular trauma

3. CONTACTS FOR EYE CLINICS

- a. **Ophthalmology Clinic.** Facility contact information must be provided.
- b. **Chief of Ophthalmology.** Facility contact information must be provided.
- c. **On-call (For After Hours).** Facility contact information must be provided.
- d. **Optometry Clinic.** Facility contact information must be provided.
- e. **Chief of Optometry.** Facility contact information must be provided.
- f. **On-call (For After Hours).** Facility contact information must be provided.

4. COMMUNICATION OF QUESTIONS

The EHR consult package allows for the ongoing addition of comments that automatically flags back to the requesting provider and eye care specialist provider. It is expected that more complex situations and potential problems with consults are addressed with a good faith attempt at verbal contact with the requesting provider. Requesting providers and eye care specialists are expected to have accurate and up-to-date contact information readily available to facilitate access by potential consultants.

5. CO-MANAGED (DUAL CARE) CARE PATIENTS

a. VA primary care or requesting providers and eye care specialists are frequently asked to act as parallel providers to general and specialist physicians in the community as part of the Veteran’s Health Administration (VHA) National Dual Care policy. Providers should instruct patients that patients are responsible for keeping VA

appointments and bringing all outside records with them to the VA appointments to become part of the VA record. **NOTE:** Refer to VHA Directive 2009-038, VHA National Dual Care Policy, dated August 25, 2009, for more information.

b. Co-management is not safe for some ocular conditions that require frequent visits, multiple medications, and/or treatments.

c. Primary care or requesting providers will have instances when a patient previously co-managed by dual care has failed co-management. In this event, it is recommended that patients receive their care through VA for safety and continuity reasons. VA eye care specialists are expected to acknowledge and accept referrals that may appear, on the surface, to duplicate an external care authority to review and assist with stabilization or clarification of the eye care specialty plan of care. Providers should advise the patient to follow-up with the VA eye care specialist depending on the clinical need.

6. RESTRICTIONS ON CONSULTATIONS

a. Consult requests are not needed from a primary care provider for direct scheduling of routine vision testing and eye care services appointments for Veterans if local policy and eye clinic capacity permits.

b. All patients, including those with urgent care consults, should be encouraged to be vested with a VA primary care provider, except in situations when the patient is service-connected for eye conditions and chooses not to receive primary care at a VA facility.

c. Some eye care services are not available within VA, such as refractive laser surgery, cosmetic procedures, contact lenses, unless determined to be medically necessary by a VA eye care provider, etc. These consults are denied and the reason for denial given to the Veteran.

7. INTERFACILITY OR INTRA-VETERANS INTEGRATED SERVICE NETWORK CARE

When a specialist determines that care for a unique non-emergent problem must occur outside [provide facility name], they are expected to forward the referral, rather than cancelling or otherwise deferring it back to the requesting provider to attempt to triage the patient care need.

8. COMMUNITY CARE CONTRACTING

[This section needs to be filled out according to local protocol or left out per local facility preference.]

9. OUTSIDE RECORDS OR A TRANSFER OF CARE

Patients frequently present to establish care at VA solely to achieve specialty care for a new or chronic medical problem, either in transfer from or parallel to another health

care system. While requesting providers must establish the patient and do any appropriate pre-work for eye care specialty review, they must also attempt to acquire any and all necessary outside records to facilitate consultative care. When the patient has been evaluated by the eye care specialist, if there are presumed to be additional records or imaging studies needed to assist in the patient's care, it is expected that the eye care specialist clearly indicates to the patient exactly what is still needed and how to get those records directly to the relevant specialist for review.

Concurrence:

_____ Date _____

Chief, Primary Care

_____ Date _____

Chief, Optometry Section or Service

_____ Date _____

Chief, Ophthalmology Section or Service

_____ Date _____

Chief of Staff

PATIENT SAFETY AND QUALITY IMPROVEMENT

1. QUALITY IMPROVEMENT PROGRAM

The Quality Improvement program at each Department of Veterans Affairs (VA) medical facility should include evaluation and improvement of eye and vision care services. Quality indicators will be based on clinical practice guidelines published by national optometric and ophthalmic organizations and other appropriate bodies, such as The Joint Commission, the National Eye Institute of National Institutes of Health, and the American National Standards Institute, Inc.

2. PEER REVIEW

Eye and vision care services provided to Veterans by VA eye care providers are subject to quality management and peer review according to Veterans Health Administration (VHA) Directive 1190, Peer Review for Quality Management, dated November 21, 2018.

3. OPHTHALMIC SURGERY PATIENT SAFETY

VA medical facilities must ensure that Veterans obtaining ophthalmic surgery have care that adheres to VHA Directive 1039(2), Ensuring Correct Surgery and Invasive Procedures In and Out of the Operating Room, dated November 28, 2018. This includes requiring that patient identification is verified, surgical laterality and site are identified and marked by a physician or other privileged provider, informed consent is obtained, a "time-out" is performed, and that all implantable devices are confirmed as described in VHA Directive 1039(2) before starting any operation or invasive procedure. Ophthalmic surgery includes injections, and laser and incisional procedures performed either in the clinic or in the operating room. Surgical safety also includes prevention of retained surgical items and providers should adhere to VHA Directive 1103, Prevention of Retained Surgical Items, dated March 5, 2016. Surgical privileges are granted and updated by the facility credentialing committee.

INFECTION CONTROL AND PREVENTION

1. INFECTION CONTROL AND PREVENTION

VHA eye clinics (optometry and ophthalmology) must comply with VHA Directive 1131(3), Management of Infectious Diseases and Infection Prevention and Controls Program, dated November 7, 2017.

2. REUSABLE MEDICAL EQUIPMENT

VA eye care providers must adhere to VHA Directive 1116(2), Sterile Processing Services (SPS), dated March 23, 2016, for use and reprocessing of reusable medical equipment (RME) in VHA eye clinics when performing ophthalmic surgical or non-surgical procedures. The use of disposable devices for performance of select ophthalmic procedures (tonometry, gonioscopy, etc.) is encouraged where there is limited SPS support, such as at Community-Based Outpatient Clinics (CBOCs) or other remote VA medical facilities.

STAFFING AND PRODUCTIVITY

a. The VA Office of Productivity, Efficiency, and Staffing (OPES) provides relative value unit (RVU) productivity recommendations for optometry and ophthalmology. Acceptable annual net RVU productivity ranges (adjusted for labor mapping) for optometry and for ophthalmology should fall between the 25th and 75th percentile compared to other VA medical facilities with similar Medical Center Group (MCG) complexity. The optometry and ophthalmology RVU productivity recommendations may be viewed on the VHA OPES website at:

<http://opes.vssc.med.va.gov/Pages/Default.aspx>. **NOTE:** *This is an internal VA web site that is not available to the public.*

b. A full-time clinical staff optometrist with adequate support personnel has 1,700 to 3,000 patient visits per year (1,200 to 1,700 unique patients) for provision of primary optometric eye and vision care services. The number of visits is dependent upon complexity of care provided and the availability of adequate space, equipment, and clinical and administrative support staff. These patient and RVU productivity expectations include supervised student and resident workload and exclude patients requiring extensive contact lenses, low-vision, and vision rehabilitation services. If the ratio of health technicians to optometrists is less than 1:1, then these RVU productivity expectations may be greatly reduced.

c. A full-time clinical staff ophthalmologist with adequate support personnel has 1,800 to 4,000 patient visits per year (1,300 to 1,800 unique patients) and performs 150 to 300 surgical procedures per year, including laser and injection surgery, eye cultures, biopsies, and oculoplastic procedures. The productivity expectations for ophthalmologists vary by subspecialty and training and are dependent on surgical support resources, availability of clinic support personnel and clinic space, operating room time, anesthesiology, whether eyeglasses are dispensed in the clinic, and the number of part-time and community care ophthalmologists. These productivity expectations include supervised student and resident workload. If the ratio of health technicians to ophthalmologists is less than 2:1, these productivity expectations may not be applicable.

CREDENTIALING AND PRIVILEGING

1. OPHTHALMOLOGISTS

a. All ophthalmologists requesting privileges must be board-certified/board eligible in ophthalmology. Ophthalmology physicians that do not meet these criteria may be allowed to work in the eye clinic if they have appropriate credentials, knowledge, experience, and are approved by the Chief of Ophthalmology. The applicant must possess and maintain a full, active, current, and unrestricted license to practice in any United States State or Territory to be eligible for appointment, except as provided in VHA Directive 2012-030, Credentialing of Health Care Professionals, dated October 11, 2012. **NOTE:** *Resident physicians cannot be credentialed and privileged as independent licensed practitioners.*

b. Therapeutic laser eye procedures in VHA are currently performed by only ophthalmologists and ophthalmology residents. To independently perform laser eye procedures, ophthalmologists must have completed an accredited ophthalmology residency approved by the Accreditation Council for Graduate Medical Education or the American Medical or Osteopathic Association, have appropriate training and experience in therapeutic laser procedures in accordance with the credentialing and privileging procedures at the VA medical facility, and be board-eligible or board certified by the American Board of Ophthalmology. Physicians who perform laser surgery must maintain currency in laser safety training provided within VA Talent Management System (TMS Laser Safety Training item #3870739) for initial granting of and maintenance of laser privileges. **NOTE:** *For more information on Laser Safety Training, see www.tms.va.gov/SecureAuth35/. This is an internal VA Web site that is not available to the public.*

c. Ophthalmology residents are trained to perform laser eye surgery under supervision of an attending ophthalmologist who is credentialed and has current laser privileges at the VA medical facility.

2. OPTOMETRISTS

As members of the medical staff, all optometrists must be credentialed and privileged by the VA medical facility for the care which they provide and are supervising. Credentialed and privileged optometrists are responsible for the care of all patients examined by optometric trainees. Optometric fellows, who have successfully completed residency training, must be credentialed and privileged and may supervise optometry students and residents. Credentialing and privileging must adhere to VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012, and VA Handbook 5005/57, Part II, Chapter 3, Section B, Credentialing and Licensure, dated June 14, 2012.

EDUCATION AND TRAINING OF OPTOMETRY TRAINEES (RESIDENTS, FELLOWS, STUDENTS)

1. RECRUITMENT

Residency and fellowship positions are advertised in accordance with Department of Veterans Affairs (VA) medical facility guidelines. The national optometry residency match (ORMatch), within the National Matching Services, Inc., is used for selection and matching of candidates to residency programs. Once matched, VA medical facility Human Resources appoints the optometry resident(s) or fellow(s) according to VA Title 38 appointment procedures. **NOTE:** Refer to VA Handbook 5005/92, Part II, Chapter 3, Title 38 Appointments, dated November 22, 2017, and VA Handbook 5005, Staffing, Part II, Chapter 3, Appendix G5, Optometrist Qualification Standard, dated April 15, 2002.

2. ESTABLISHING AFFILIATIONS BETWEEN VA MEDICAL FACILITIES AND OPTOMETRY SCHOOLS

a. An affiliation agreement must exist between the local VA medical facility and the closest Accreditation Council on Optometric Education (ACOE)-accredited school or college of optometry before starting a program of clinical education. If the nearest optometry school does not desire an affiliation, another ACOE-accredited school or college of optometry may be chosen. On occasion, multiple affiliations with accredited schools and colleges of optometry may be possible for the education of Doctor of Optometry (OD) candidates. Affiliation agreements must be consistent with Veterans Health Administration (VHA) Handbook 1400.08, Education of Associated Health Professions, dated February 26, 2016.

b. VA staff optometrists serving as supervising or attending optometrists must be eligible for appointment to the optometry faculty of the affiliated school or college prior to consideration of any affiliation agreement.

c. Once an affiliation is established with an ACOE-accredited school or college, only optometry students in their third and final professional (fourth) years and postgraduate year (PGY)1, PGY2, and PGY3 trainees should have direct patient care responsibilities. Individuals in earlier professional years can assume supportive roles.

d. A representative from each affiliated school or college of optometry must be appointed to the local VA medical facility and Veterans Integrated Service Network (VISN) Affiliation Partnership Council, Deans' Committee, Management Assistance Council, or comparable Education Council as described in VHA Handbook 1400.03, Veterans Health Administration Educational Relationships, dated February 16, 2016.

3. SUPERVISION OF RESIDENTS AND STUDENT 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 that residents are adequately supervised at all times, and that supervision is documented as described in VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019. As part of the training program, residents need to be given progressive responsibility.

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

4. BILLING REQUIREMENTS FOR OPTOMETRIC EDUCATION PROGRAMS

a. There are differences between the requirements for educational supervision of residents and the documentation necessary to bill for services provided by attending optometrists and residents. **NOTE:** Refer to VHA Directive 1401, *Billing for Services Provided by Supervising Practitioners and Physician Residents*, dated July 29, 2016 for more information.

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. CMS guidelines must be met regarding billing third-party payers for services performed by optometry residents within a properly supervised environment. The billing must be made through the supervising optometrist's name and credentials.

5. REPORTING RELATIONSHIPS FOR OPTOMETRIC EDUCATION PROGRAMS

a. Residents and fellows report to the respective VA staff optometrist residency or fellowship program coordinator or director of the program in which they are enrolled.

b. Candidates in any professional year prior to being awarded the OD degree report to the VA staff optometrist externship or internship program coordinator or director of the program in which they are enrolled.

6. EVALUATION OF OPTOMETRY 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. The resident must receive at least two interim and one final performance evaluation.

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 VA staff optometrist residency program coordinator or director must promptly provide written notification of the resident's unacceptable performance or conduct to the program director of the ACOE-affiliated school or college of optometry.

c. At least semi-annually, 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 conducted in accordance with VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019 and kept on file consistent with VA medical facility policy and VHA Directive 6300, Records Management, dated October 22, 2018.

7. SCHEDULING AND PRODUCTIVITY CONSIDERATIONS FOR OPTOMETRIC EDUCATION PROGRAMS

a. The educational goals and objectives of any optometric education program must be compatible with those of the VA medical facility; however at least a half day per week must be dedicated solely for educational activities, ideally without the scheduling of patients. VA staff optometrists need to allow or arrange for emergency coverage during this time.

b. VA staff optometrists must ensure that overall productivity meets program goals as defined by the VHA National Program Director for Optometry.

8. STAFFING NEEDS FOR OPTOMETRIC EDUCATION PROGRAMS

a. Staffing Ratio.

Programs with trainees assigned should have at least 1.0 full-time equivalent (FTE) staff optometrist(s). There should be frequent interaction, usually monthly with the VA staff optometrist serving as the education program coordinator or director and the Associate Chief of Staff (ACOS) for education, designated education officer, 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 or properly educate optometric trainees in an integrated program that meets specific curricular goals and objectives. The preceptor (staff optometrist) to trainee ratio needs to be 1:3 for OD professional degree students, 1:4 for PGY1 trainees, and 1:5 for PGY2 and beyond optometric trainees.

b. Support Staff.

The VA Residency Site Director should be assisted by an administrative assistant. Optometric clinical education programs should have adequate support staff in order to properly manage administrative complexities, including reports, evaluations, syllabuses, scheduling, and other correspondence.

c. **Intergovernmental Personnel Act Agreement.**

Additional staffing can be obtained through an Intergovernmental Personnel Act (IPA) agreement between the VA medical facility and a State or local government agency, an institution of higher learning, an Indian Tribal government, or any other eligible organization to meet VA education and training program needs.

9. TRAINEE REQUIREMENTS AND FUNDING SUPPORT

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

(1) Be appointed according to VA Handbook 5005, Staffing, Part II, Chapter 3, dated December 17, 2015.

(2) Be enrolled in an ACOE-accredited program.

(3) Come from school(s) or college(s) of optometry with an affiliation agreement with the VA medical facility.

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

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

(1) Be appointed according to VA Handbook 5005, Part II, Chapter 3 and Appendix G5.

(2) Be citizens of the United States.

(3) Be graduates with the OD degree resulting from a course of education in optometry from an ACOE-accredited school or college of optometry or an optometry school (including foreign schools) accepted by the licensing body of a State, territory, or Commonwealth of the United States, or in the District of Columbia as qualifying for full and unrestricted licensure.

(4) Obtain licensure in a State, territory, or Commonwealth of the United States, or in the District of Columbia before completion of the first year of VA residency. ***NOTE: The license does not have to be from the State where the residency program is located.***

c. **Fellowship Trainees.** Optometric fellows must:

(1) Be appointed according to VA Handbook 5005, Part II, Chapter 3 and Appendix G5.

(2) Be citizens of the United States.

(3) Have successfully completed an ACOE-accredited optometric residency program.

(4) Possess a full and unrestricted license to practice optometry in a State, territory, or Commonwealth of the United States, or in the District of Columbia before the beginning of the fellowship. **NOTE:** *The license does not have to be from the State where the fellowship program is located.*

d. **Funding.** Allocation of funding for residency and fellowship positions is determined by the Office of Academic Affiliations (OAA) in collaboration with the VHA National Program Director for Optometry.

e. **Salary.** Salary rates for optometry residents and fellows are determined by the OAA.

f. **Insurance.** Optometry residents and fellows are eligible for VA group health and life insurance benefits.

10. SPACE AND EQUIPMENT NEEDS FOR PATIENT CARE IN OPTOMETRIC EDUCATION PROGRAMS

See Appendix A.

11. ACCREDITATION OF OPTOMETRIC EDUCATION PROGRAMS

a. All optometric education provided at VA must be accredited by the appropriate accrediting body. ACOE is the accrediting body for the schools and colleges of optometry and for their residency programs. The ACOE requires optometry residency programs to be affiliated with an ACOE-accredited school or college of optometry. VHA follows the requirements of accrediting and certifying bodies for each associated health discipline and maintains accreditation by The Joint Commission and other health care accreditation bodies, unless these requirements conflict with Federal law or policy.

(1) For programs with only OD candidates, accreditation of the school or college of optometry by the ACOE includes all clinical training programs provided to optometry students prior to graduation.

(2) For specific programs involved in the education of PGY1 trainees, the ACOE must be consulted by the VA medical facility in order to be accredited. The VA staff optometrist residency program coordinator or 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.

(3) New programs must be recommended by the VHA National Program Director for Optometry and approved by OAA before starting a residency program.

b. **Seeking and Maintaining Accreditation.** Through a site visit, the ACOE evaluates programs based on self-studies submitted by the VA staff optometrist residency program coordinator or director in concert with the affiliated school or college of optometry. The ACOE reviews 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 eight years before the next scheduled site visitation of the program. **NOTE:** *If the ACOE denies the accreditation request, OAA will not fund the program.*

c. **Accreditation with Conditions.** Programs which do not meet accreditation standards, but have sufficient redeeming qualities and characteristics to show a reasonable likelihood that accreditation will ultimately be granted, may receive accreditation with conditions.

d. **Payment of Accreditation Fees.** The payment of annual accreditation fees billed by the ACOE is the responsibility of each VA medical facility. Programs which have had their accreditation status canceled due to nonpayment of accreditation fees are ineligible to receive future optometric residency funding by the OAA until their accreditation status is restored.

EDUCATION AND TRAINING OF OPHTHALMOLOGY TRAINEES (RESIDENTS, FELLOWS, STUDENTS)

1. RECRUITMENT

a. Ophthalmology residents (postgraduate year (PGY)2-4) are physicians with a current United States medical license who have completed a PGY1 internship accredited by either the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada. Residents are enrolled in a 3-year postgraduate training program with an ophthalmology academic affiliate (sponsoring institution) under the supervision of a credentialed ophthalmologist for medical and surgical treatment of basic, intermediate, advanced and urgent eye care problems.

b. Ophthalmology fellows (PGY5-6) are American Board of Ophthalmology board-certified or board-eligible ophthalmologists pursuing additional training in a specific ophthalmology discipline, such as retina, glaucoma, cornea, neuro-ophthalmology, oculoplastic surgery, pediatric or strabismus surgery, ocular pathology or ocular immunology.

c. Residents are recruited by the academic affiliate and must be matched through the nationwide ophthalmology matching program. The selection of residents is the responsibility of the academic affiliate according to its affiliation agreement with the Veterans Health Administration (VHA). Once matched, the local Department of Veterans Affairs (VA) medical facility Human Resources office appoints the ophthalmology resident(s) according to VA procedures for Title 38 appointments. **NOTE:** Refer to VA Handbook 5005, Part II, Chapter 3, dated December 17, 2015.

d. Fellows are recruited by the fellowship sponsor. Once selected, the local VA medical facility human resources director or designee appoints the ophthalmology fellow(s) according to VA procedures for Title 38 appointments. **NOTE:** Refer to VA Handbook 5005, Part II, Chapter 3, and VA Handbook 5005, Part II, Chapter 3, Appendix G2). OAA residency training funds cannot be used to support these positions as they are limited to funding ACGME-accredited programs.

2. EDUCATIONAL AFFILIATION AGREEMENTS

a. An educational affiliation agreement must be signed by the VA medical facility Director and the corresponding medical school affiliate and/or sponsoring institution of the training program. VA affiliation agreement templates must be used (<https://www.va.gov/oa/agreements.asp>).

b. In addition, there must be a program letter of agreement (PLA) between the program sponsor and the VA medical facility. The PLA must be renewed at least every 5 years and contain all the information listed in the ophthalmology program requirements by the ACGME and the Residency Review Committee, including the identification of faculty who will assume educational, supervisory, and evaluative

responsibility for the ophthalmology residents. **NOTE:** *The PLA must be drafted jointly by the residency program director and the VA residency site director.*

3. SUPERVISION

a. The attending physician faculty must have current certification in ophthalmology by the American Board of Ophthalmology, or possess qualifications acceptable to the review committee. 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. An attending ophthalmologist must be physically present in outpatient clinics or procedural suites in which residents are involved in the care of VA patients.

b. Each resident must be supervised, depending on the individual resident's abilities and level of training (i.e., PGY 2, 3, or 4).

c. Direct supervision by an attending ophthalmologist is required for all residents performing surgery. Ophthalmologists must be directly involved in the supervision of all surgical cases, including entering an appropriate pre-operative note or addendum to the resident's note; signing the operative report; and determining the level of resident participation based on experience level and demonstrated capability. Exceptions to direct supervision are rare and are based on the best care for the patient (such as an emergency case being started while the attending is traveling to the VA medical facility).

d. Attending ophthalmologists must be credentialed and privileged by the VA medical facility in accordance with VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012, 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 Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019.

4. LEVELS OF RESPONSIBILITY

a. Progressive responsibility may be given to residents as part of their training program. **NOTE:** *Refer to VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019.*

b. The Chief of Ophthalmology determination of a resident's ability to accept responsibility for performing procedures or activities without a staff practitioner present must be based on the resident's clinical experience, judgment, knowledge and technical skills in agreement with the residency program director. Such evidence may be obtained from the affiliated university, evaluations by staff practitioners or program coordinator, and other clinical practice information.

c. Documentation of levels of responsibility must be filed in the resident's record or folder that is commonly maintained in the office of the residency program director at the academic affiliate.

5. EVALUATION OF OPHTHALMOLOGY RESIDENTS

a. Supervisor ophthalmologists evaluate residents based on each resident's 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 by their supervisor to be detrimental to the care of a patient, action must be taken immediately to ensure the safety of the patient. The VA residency site director must promptly provide written notification of the resident's unacceptable performance or conduct to the affiliate program director or the department or division chairperson.

c. Each resident is given the opportunity to complete a confidential written evaluation of staff practitioners and the quality of the resident's training annually. 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, VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019, and VHA Directive 6300, Records Management, dated October 22, 2018.

6. STAFFING NEEDS FOR OPHTHALMOLOGY EDUCATION PROGRAMS

Ophthalmology staffing must be sufficient to maintain appropriate ophthalmology resident training and supervision. Either VA full-time equivalent (FTE) or part-time equivalent, contractors, or volunteer(s) with faculty appointments from the academic affiliate may be recruited to obtain appropriate staff to provide training and resident supervision.

7. SPACE AND EQUIPMENT NEEDS FOR PATIENT CARE IN OPHTHALMOLOGY EDUCATION PROGRAMS

See Appendix A.

8. ACCREDITATION OF OPHTHALMOLOGY RESIDENT TRAINING

a. ACGME is responsible for accreditation of ophthalmology residency training programs. Residency programs affiliated with VA must be accredited by ACGME.

b. The program accreditation is the responsibility of the academic institution.

c. VHA expects the academic affiliate or sponsoring institution to obtain appropriate accreditation through the ACGME.

d. The Facility Office of the Associate Chief of Staff (ACOS) for Education or similar office must provide data the residency program requires to support the application for continued accreditation of the program to the academic affiliate or sponsoring institution.

e. VHA must participate, as requested by the sponsoring institution, in the ophthalmology Residency Review Process (RRC) process.

STAFF DEVELOPMENT

1. QUALIFICATION STANDARDS

Nationwide qualification standards are in effect for all optometry personnel actions in accordance with the Department of Veterans Affairs (VA) Optometrist Qualification Standard. **NOTE:** Please see VA Handbook 5005, Part II, Appendix G5, Optometrist Qualification Standard, dated April 15, 2002. The VA Physician Qualification Standard for ophthalmology personnel actions is in VA Handbook 5005, Part II, Appendix G2, Physician Qualification Standard, dated December 17, 2015.

2. OPTOMETRY PROFESSIONAL STANDARDS BOARD

A centralized professional standards board for optometry in VHA Central Office must determine the initial grade and step for new appointees and promotion and special advancement requests based upon published qualification standards. This board, in which the majority of members are optometrists, functions in accordance with VA policy. **NOTE:** Please see VA Handbook 5005/8, Part II, Appendix H4, Procedures for Appointing Optometrists, dated June 22, 2004; VA Handbook 5005/58, Part III, Appendix M, How to Process a Promotion for Optometrist, dated June 14, 2012; and VA Handbook 5005/92, Part II, Chapter 3, Section C, Professional Standards Boards, dated November 22, 2017.

3. SPECIAL ADVANCEMENTS

Clearly defined criteria for special advancement for performance and special advancement for achievement are used for all optometry personnel actions; which must be submitted to the Optometry Professional Standards Board according to VA policy. **NOTE:** Please see VA Handbook 5017/15, Employee Recognition and Awards, Part V, Title 38 Special Advancements and Cash Awards, dated June 3, 2019.

4. RECRUITMENT AND RELOCATION INCENTIVES

VA medical facilities have the ability to authorize recruitment and relocation incentives for optometrists and ophthalmologists. **NOTE:** Please see VA Handbook 5007/46, Part VI, Chapter 2, Recruitment and Relocation Incentives, dated April 22, 2013.

5. RETENTION INCENTIVES

Optometrists and ophthalmologists are eligible for retention incentives and may be authorized by the local VA medical facility within established VA policy. **NOTE:** Please see VA Handbook 5007/46, Part VI, Chapter 3, Retention Incentives Other Than for Closure or Relocation of Employing Office, Facility or Organization, dated April 22, 2013.

6. EDUCATION DEBT REDUCTION PROGRAM

Optometrists and ophthalmologists are eligible to participate in the Education Debt Reduction Program as detailed in VHA Directive 1021, Education Debt Reduction Program, dated May 31, 2012, and VHA Handbook 1021.01, Education Debt Reduction Program Procedures, dated May 31, 2012.

7. CLINICAL SKILLS AND SCHOLARLY PURSUITS

Eye care providers are encouraged to participate in clinical skills enhancement activities and scholarly pursuits. Each VA medical facility is to facilitate and accommodate the temporal and general resource needs for eye care providers to advance professionally. Appropriate activities 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 or responsibilities, and national eye care provider program responsibilities.

8. CONTINUING EDUCATION

Eye care providers are required to obtain Continuing Medical Education (CME) for license renewal and re-privileging. Local VA medical facilities typically fund and grant authorized absence on an annual basis. Funding consisting of tuition, travel, and per diem is to be provided to ophthalmologists, to the extent allowed by 34 U.S.C. 7411, which authorizes reimbursement of a maximum of \$1,000 per year to any full-time board-certified physician appointed under 38 U.S.C. 7401(1). Authorized absence may be granted, inclusive of travel time, to attend CME meetings. **NOTE:** Refer to VA Handbook 5015/1, paragraph 9, dated June 25, 2010, and VHA Directive 1049 Reimbursement of Continuing Professional Education Expenses for Full-time Board-Certified Physicians and Dentists, dated August 28, 2018.

9. ADMINISTRATION

To promote development of future administrative leaders, VA medical facilities should include eye care providers in administrative activities at the local facility or higher level.

PARTICIPATION IN SPECIAL VHA PROGRAMS

1. EYE CARE CLINICAL PROGRAMS OF EXCELLENCE

Eye care clinical programs of excellence provide clinical training, education, and research opportunities to develop optometrists and ophthalmologists with advanced competency skills. Department of Veterans Affairs (VA) medical facilities that effectively integrate the spectrum of eye care practitioners and ancillary personnel to provide comprehensive primary, secondary, and tertiary eye and vision care, may apply for designation as an eye care clinical program of excellence.

2. VISUAL IMPAIRMENT CENTER TO OPTIMIZE REMAINING SIGHT PROGRAM

The VA Optometric Service Visual Impairment Center to Optimize Remaining Sight (VICTORS) program provides team-based low-vision rehabilitation services to significantly visually-impaired Veterans from a large service area covering numerous VA facilities, as in a Veterans Integrated Service Network (VISN).

3. BLIND REHABILITATION SERVICE

Blind Rehabilitation Service (BRS) provides inpatient and outpatient blind and vision rehabilitation programs, adjustment to blindness counseling, patient and family education, and assistive technology. BRS continuum of care includes intermediate and advanced low vision clinics, outpatient blind rehabilitation clinics with lodger/hotel capability, and in-depth inpatient blind rehabilitation center-based programs. For severely disabled visually impaired Veterans, BRS specialists provide in-home and in-community care and BRS visual impairment services team (VIST) coordinators provide case management to maximize adjustment. A staff optometrist or ophthalmologist provides clinical low-vision care and functions as an interdisciplinary team member within the BRS inpatient and outpatient clinical programs.

4. POLYTRAUMA SYSTEM OF CARE

The polytrauma system of care provides comprehensive medical and rehabilitation care for complex and severe polytrauma injuries and manages Veterans with severe and lasting injuries that return to their VISN area and local VA medical facilities for ongoing care. Ophthalmology, optometry, low-vision, and vision rehabilitation services in collaboration with physical medicine and rehabilitation services should be available at polytrauma rehabilitation centers, network sites, and within polytrauma support teams at local VA medical facilities to care for polytrauma patients with eye and vision related problems. **NOTE:** *Polytrauma is defined as injury to several body areas or organ systems that occur at the same time and where one or more is life threatening. Due to severity and complexity of injuries, polytrauma may result in physical, cognitive, psychological, or psychosocial impairments and functional disabilities. Traumatic brain injury (TBI) frequently occurs in polytrauma in combination with other disabling conditions such as amputation, auditory and visual impairments, spinal cord injury, post-traumatic stress disorder, and other medical problems.*

5. DEPARTMENT OF DEFENSE-VA VISION CENTER OF EXCELLENCE

Section 1623 of Public Law 110-181, the National Defense Authorization Act for Fiscal Year 2008, requires that the Department of Defense (DoD) establish a center of excellence to address the prevention, diagnosis, mitigation, treatment, and rehabilitation of eye injuries and vision dysfunction in service members and Veterans; and that the DoD collaborate to the maximum extent possible with the VA in pursuit of this mission. The Veterans Health Administration (VHA) core Vision Center of Excellence staff is composed of optometry, ophthalmology, blind rehabilitation, and support personnel.

6. OCULAR TELEHEALTH

a. **Teleretinal Imaging Screening Program.** The Teleretinal Imaging Screening Program provides screening for diabetic eye disease through teleconsulting. An appropriately trained and clinically-privileged optometrist or ophthalmologist interprets digital retinal imaging to determine whether the patient passed the screening, needs to be rescreened, or needs a comprehensive eye examination. This is sufficient to satisfy the clinical reminder for eye care required for screening patients with diabetes mellitus; however, teleretinal image screening does not replace a comprehensive eye examination by an optometrist or ophthalmologist. The quality of services provided by the Teleretinal Imaging Screening Program is measured through an on-going quality assurance program for imagers and readers.

b. **Technology-based Eye Care Service.** The Technology-based Eye Care Service (TECS) program provides eye screening for Veterans in rural and underserved communities. This includes diabetic teleretinal image screening, as well as additional visual screening tests. This is sufficient to satisfy screening for select eye disease conditions; however the TECS program screening does not replace a comprehensive eye exam performed by an optometrist or ophthalmologist.

7. ENVIRONMENTAL PROGRAMS

The VA medical facility environmental program is responsible for the safety needs of employees. Optometrists or ophthalmologists provide appropriate eye and vision care services, such as procurement of safety glasses and task analyses of workplace visual demands.

8. VOCATIONAL REHABILITATION PROGRAMS

Veterans enrolled in a vocational rehabilitation program are eligible to receive eye and vision care services and related prosthetic devices. **NOTE:** Refer to VHA Directive 1182, *Vocational Rehabilitation: Chapter 31: Benefits Timely Access to Health Care Services*, dated April 2, 2015.

9. MOBILE CLINICS

Specially-outfitted mobile vans may provide screening and primary care services to Veterans located at a significant distance from the nearest VA medical facility.

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

10. HEARING AID SPECTACLES

Optometrists and ophthalmologists work cooperatively with audiologists in the fitting of spectacle mounted hearing aids for eligible Veterans.

11. HOMELESS CARE

Optometrists and ophthalmologists provide appropriate eye and vision care services to meet the needs of Veterans utilizing VHA "Stand Down" or other similar programs for homeless Veterans.