VHA EYE CARE

1. REASON FOR ISSUE. This Veterans Health Administration (VHA) Handbook is issued to facilitate the provision of optimal eye care in the Department of Veterans Affairs (VA) health care system.

2. SUMMARY OF MAJOR CHANGES. This VHA Handbook is consistent with all current VHA standards and policies and is intended for use by administrators and clinicians in the field. The major changes in this revised VHA Handbook are the addition of:

a. Appendix C: Includes the guidance provided to clinicians regarding prevention of visual impairment from age-related macular degeneration, diabetic retinopathy, and glaucoma. It also emphasizes referral criteria and the importance of ongoing and focused practice evaluations by each eye care discipline and joint collaboration of care reviews by eye care and primary care to ensure patient safety.

b. Appendix D: A sample of a Care Collaboration Agreement between Optometry and Ophthalmology is included.

c. Appendix E: A sample of a Care Collaboration Agreement between Optometry, Ophthalmology, and Primary Care is included.

d. Appendix F: A sample of a Low Vision Rehabilitation Care Collaborative Agreement between Ophthalmology and Optometry.

3. RELATED DIRECTIVE. VHA Directive 1121 (to be published).

4. RESPONSIBLE OFFICE. The Office of Patient Care Services (11) is responsible for the contents of this Handbook. Questions may be addressed to 410-779-1576.

5. RESCISSIONS. VHA Handbook 1121.01, dated September 17, 2008, is rescinded.

6. RECERTIFICATION. This VHA Handbook is scheduled for recertification on or before the last working day of March 2016.

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Under Secretary for Health

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VHA EYE CARE

1. PURPOSE

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

2. BACKGROUND

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

b. The provision of eye care within VA must adhere to the guidelines established by the VHA Office of Specialty Care Services. While each VA health care facility is unique as part of a national system of care, they are to provide predictably consistent high quality eye care.

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

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

d. VHA eye care services can be divided into two subgroups: those which can be provided by specific individuals and those services required of the VISN.

3. DEFINITIONS

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

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

c. **Continuum of Care for Visually Impaired Veterans.** The Visual Impairment Advisory Board has established the following levels in a continuum of care:

(1) **Basic Low Vision Services**. Basic Low Vision Services include prescription of optical low vision devices and a minimum level of visual skills and device training. Basic low vision services are to be available at every VHA eye clinic.

(2) **Intermediate Low Vision Services.** Intermediate Low Vision Services include a moderate breadth and complexity of low vision services, including more complex optical devices, more intricate visual skills training and basic training in activities of daily living.

(3) **Advanced Low Vision Services.** Advanced Low Vision Services include a full spectrum of optical devices and in-depth visual skills training is to be provided, along with basic training in activities of daily living and in orientation and mobility.

(4) **Outpatient Blind Rehabilitation Services.** Outpatient Blind Rehabilitation Services include a full spectrum of optical devices and in-depth visual skills training is to be provided, along with a moderate breadth and depth of training in activities of daily living and in orientation and mobility. Adjustment counseling and service agreements with audiology are provided.

(5) **Inpatient Blind Rehabilitation Services**. Inpatient Blind Rehabilitation Services include the most in-depth and complex care for severely disabled visually impaired Veterans. Inpatient Blind Rehabilitation Centers (BRCs) provide a full spectrum of care in low vision and blindness rehabilitation including activities of daily living and communication, orientation and mobility training, manual skills training, computer-assisted training, as well as a full spectrum of optical low vision devices and visual skills training.

d. **Accreditation Council on Optometric Education (ACOE).** The ACOE is the accrediting agency for optometric educational programs, formerly referred to as the Council on Optometric Education (see: http://www.aoa.org/x5153.xml).

e. **Ophthalmology Residency Review Council (RRC).** The RCC is the accrediting agency for ophthalmology residency training programs. The RRC is a council of the Accreditation Council for Graduate Medical Education (ACGME) (see: http://www.acgme.org/acWebsite/navPages/nav_240.asp)

f. **Relative Value Unit (RVU).** A RVU is a numeric weight assigned to a medical encounter or procedure that provides information on its relative resource use.

g. **Site Director (VA Residency Site Director).** The site Director (VA Residency Site Director) is the individual responsible for implementing the training program curriculum at a particular site.

(1) The Residency Site Director is responsible for:

(a) Developing the local educational program based on the educational plan of the residency or training program director, specifically ensuring that core curricular objectives are met.

(b) Site logistics, ensuring at a minimum that trainees are oriented to site, policies, and

practices, that the details of rotations, schedules, and objectives are communicated to the trainees, and that evaluations of trainees, preceptors, supervisors, and the training site are performed.

(c) Assessing and improving (if necessary) trainee supervision.

(2) The Residency Site Director, generally of the same discipline as that of the trainees, needs to be assisted in the Residency Site Director duties by a clerical or administrative assistant.

4. MISSION

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

5. CORE VALUES

a. The core values of VHA Eye Care are:

(1) Commitment;

(2) Excellence;

(3) People;

(4) Communication; and

(5) Stewardship.

b. In particular, VHA Eye Care strives to:

(1) Provide needed, high-quality eye care in a timely manner to all eligible Veterans.

(2) Ensure the highest possible level of patient satisfaction with VHA Eye Care.

(3) Ensure that all eligible Veterans receive high-quality patient education related to eye care.

(4) Support professional education and research which furthers VHA Eye Care.

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

6. PLANNING ASSUMPTIONS

VHA Eye Care planning assumptions are that:

a. The demand for VHA eye care resources, like many other clinical resources, often exceed the supply;

b. Patient satisfaction must be improved;

c. Eye care quality must be continually improved;

d. The delivery of eye care is most effective when provided by various eye care professionals working cooperatively as part of an eye care team;

e. All persons who participate in the delivery of VHA Eye Care are valued partners in the process;

f. Professional education and research are essential to the delivery of quality eye care; and

g. The demand for eye care will continue to increase.

7. GOALS

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

Specific VHA Eye Care goals are to:

a. Deliver the highest quality eye care to the greatest number of eligible Veterans in a timely, compassionate, and cost-effective manner.

b. Meet Advanced Clinic Access and System Redesign VHA performance measures (see App. B).

c. Provide patient education and eye care counseling to patients and their families or significant others, and continuing medical education to staff, as well as other health care providers and trainees, where appropriate.

d. Establish academically affiliated teaching programs to educate and train students, residents, and fellows.

e. Participate in educating and training eye care professionals.

f. Support eye and vision research in areas including management, quality improvement, education, rehabilitation, health services, and biomedical sciences.

g. Evaluate and improve new technologies for the delivery of eye care.

h. Contribute to a supportive setting for the integration of patient care, education, and research and development.

i. Provide support for the Department of Defense (DOD) in times of military necessity or national emergency.

8. RESPONSIBILITIES OF VHA CENTRAL OFFICE (EYE CARE CONSULTANTS)

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

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

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

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

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

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

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

b. Among the functions of the VHA Eye Care Performance Consultant Team are:

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

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

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

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

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

(6) Facilitating the creation of a VHA eye care related database;

(7) Serving as an advocate for Veteran patients in need of eye care;

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

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

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

9. RESPONSIBILITIES OF THE VISN DIRECTOR

NOTE: *The VISN Director is encouraged to ensure that all of the services described in following subparagraphs 9a through 9d are available to every eligible Veteran.*

Each VISN Director is responsible for:

a. **Health Care**

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

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

(a) Prosthetic eyes;

(b) Special contact lenses;

(c) Optical, non-optical, and electronic low-vision devices; and

(d) Eyeglasses.

(3) Ensuring a VISN-wide plan for care for the provision of rehabilitation for visually impaired Veterans;

(4) Availability of diagnostic services, such as:

(a) Laboratory;

(b) Radiology;

(c) Photography, including fluorescein angiography;

(d) Electro-diagnostics (Visually-evoked potential (VEP), Visually-evoked Response (VER), etc.);

(e) Diagnostic ultrasound; and

(f) Visual fields.

(5) Availability of consultative services.

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

(a) Collection and management of data,

(b) Equipment and service support,

(c) Medical and surgical management of ocular and periocular conditions and disease,

(d) Availability of pre-surgical services,

(e) Screening examinations for 'at risk' patients,

(f) Compensation and Pension (C&P) examinations, and

(g) Anesthesiology coverage including monitoring.

b. **Education.** Education entails:

(1) Patient education;

(2) Trainee supervision (appropriate and available);

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

(4) Continuing education resources;

(5) Resources to support full accreditation;

(6) Resources to support education;

(7) An in-service training plan; and

(8) Support for professional education endeavors.

c. **Research.** Research needs to support:

(1) Eye care research efforts, and

(2) Development of a policy delineating importance of research goals in eye care

d. **Other.** Other VISN responsibilities include:

(1) Outcomes-based quality improvement plan.

(2) Assessment of patient satisfaction.

(3) Collection and assessment of demographic data to include:

(a) International Classification of Diseases Clinical Modification – 9th edition. (ICD-9-CM) or most recent ICD-CM edition;

(b) Current Procedural Terminology (CPT);

(c) Productivity and work load data; and

(d) Information management strategies and performance.

10. RESPONSIBILITIES OF THE FACILITY DIRECTOR

a. The Facility Director, or designee, is responsible for ensuring:

(1) Quality eye care to Veterans.

(2) Integration of eye care services that is promoted by an organizational structure where ophthalmology and optometry, as well as other eye care providers, are represented as partners in the delivery of eye care. ***NOTE:*** *The exact organizational structure is determined locally.*

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

applied throughout VHA."

(4) The respective Section or Service Chiefs of Optometry and Ophthalmology ensure that the Care Collaboration Agreements between Primary Care and Eye Care (Optometry and Ophthalmology) and between Optometry and Ophthalmology are established.

(5) Reporting assignments reflect facility staff and patient care needs. ***NOTE:*** *This needs to be determined at the facility level. Most commonly the Chief Optometrist reports as a Section Chief to the Chief of Primary Care, Chief of Surgery, or Chief of Medicine, or for larger programs, as a Service Chief to the Chief Medical Officer, Associate Chief of Staff (ACOS) for Ambulatory Care, or Chief of Staff.*

b. At the facility level, it is expected, in most instances, that:

(1) A full-time clinical staff optometrist has 2,100 to 3,000 patient visits per year for provision of primary optometric eye and vision care services within a range of 1,200 to 1,700 unique patients annually dependent upon complexity of care provided, as well as availability of adequate space, equipment and support staff. These productivity recommendations exclude those patients requiring extensive low-vision and vision rehabilitation services. ***NOTE:*** *It would be expected that productivity could improve with the addition of more exam-treatment (E-T) rooms, support staff, and equipment.*

(2) 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 perform 150 to 300 surgical procedures, including laser procedures, per year.

(a) The VHA Advisory Group on Physician Productivity and Staffing used a RVU based methodology to evaluate VA ophthalmologist productivity. ***NOTE:*** *A full report is available at: http://vssc.med.va.gov/products.asp?PgmArea=18*
This is an internal VA Web site not available to the public.

(b) Based on the results of that study it would be expected that the overall practice level productivity for ophthalmology should be in the range of 6,000–6,900 RVUs per clinical Full-time Equivalent (FTE) employee annually. Productivity levels in excess of 6,900 need to be considered a best practice if accompanied by high quality. This productivity expectation includes supervised Resident workload. ***NOTE:*** *This number would change depending upon the available clinic support personnel, available operating room time, availability of anesthesiology, if eyeglasses are dispensed in the clinic, and the number of part-time and fee-basis ophthalmologists.*

11. PARTICIPATION IN SPECIAL VHA PROGRAMS

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

develop optometrists and ophthalmologists with advanced competency skills.

b. **Low-Vision Care Clinics and VICTORS Programs.** Basic, Intermediate, and Advanced Low-Vision Clinics, including VICTORS Programs, provide team-based low-vision rehabilitation services to significantly visually-impaired Veterans from a large service area covering numerous VA facilities, as in a VISN.

c. **Blind Rehabilitation Service (BRS).** VHA BRS provides inpatient and outpatient blind and vision rehabilitation programs, adjustment to blindness counseling, patient and family education, and assistive technology. The BRS continuum of care includes intermediate and advanced low vision clinics, outpatient blind rehabilitation clinics with lodger/hoptel capability, and in-depth inpatient blind rehabilitation center-based programs. For severely disabled visually impaired Veterans, BRS Blind Rehabilitation Outpatient Specialists provide in-home and in-community care, and BRS Visual Impairment Service 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.

d. **Polytrauma System of Care.** The Polytrauma System of Care provides acute 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 facilities for ongoing care. ***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.* To care for polytrauma patients with eye and vision related problems in concert with the Office of Physical Medicine and Rehabilitation, ophthalmology, optometry, low-vision, and vision rehabilitation services need to be available at Polytrauma Rehabilitation Centers and Polytrauma Network Sites, as well as availability of these services for Polytrauma Support Teams at local VA facilities.

e. **DOD-VA Vision Center of Excellence.** With the passage of Public Law 110-181, Section 1623, within the National Defense Authorization Act, there are VA and DOD requirements to improve the identification and care of Servicemembers who have sustained significant eye injuries, as well as vision problems resulting from TBI and ensure seamless transition of care from DOD to VA. The joint development of the DOD-VA Vision Center of Excellence in the prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries houses the bidirectional Eye Injury Registry, and better coordinates care and research activities with a network of eye and vision care specialists within VHA. These specialists are familiar with the unique visual problems associated with eye injury and TBI. From VHA, the core Vision Center of Excellence staff is composed of an optometrist, ophthalmologist, blind rehabilitation specialist, and administrative support. This VA-DOD partnership improves the coordination and standardization of TBI vision screening, diagnosis, rehabilitative management, and research on prevention of visual dysfunction related to TBI. In addition, it ensures seamless transition of care from DOD military treatment facilities to VHA medical facilities.

f. **Teleretinal Imaging Screening Program.** The Teleretinal Imaging Screening Program enables VHA to continue to improve the External Peer Review Program (EPRP) clinical indicator for evaluation of 'at risk' patients for diabetic retinopathy. Diabetes affects about 20 percent of the VHA Veteran population.

(1) Blindness and visual impairment are major complications that can be avoided with regular eye examinations by an Eye Care Provider, an optometrist or ophthalmologist. Through teleconsulting, digital retinal imaging, with interpretation by an appropriately trained and clinically-privileged optometrist or ophthalmologist, indicating that the patient passed the screening, needs to be rescreened, or needs a comprehensive eye examination is sufficient to satisfy the clinical reminder for eye care required for screening patients with diabetes mellitus.

(2) There is an ongoing quality assurance program to continually improve the quality of the services provided by the Teleretinal Imaging Screening Program. ***NOTE:*** *Teleretinal imaging screening does not replace a comprehensive eye examination by an optometrist or ophthalmologist.*

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

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

i. **Mobile Clinics.** Veterans located a significant distance from the nearest VHA medical facility may receive screening and primary care services from specially-outfitted mobile vans. Optometrists or ophthalmologists need to provide screening and primary eye and vision care within these mobile clinics, as needed.

j. **Hearing Aid Spectacles.** Optometrists and ophthalmologists need to work cooperatively with audiologists in the fitting of spectacle mounted hearing aids for eligible Veterans.

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

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

12. SPACE AND EQUIPMENT

Specific information relating to the space and equipment necessary to ensure quality eye care is included in Appendix B. ***NOTE:*** *See Space Planning Criteria for VA Facilities: Veterans Health Administration: Eye Clinic at http://www.cfm.va.gov/til/space/SPChapter233.pdf that details the 2008 revision of VA Handbook 7610.3 (Chapter 233).*

13. EDUCATION AND TRAINING OF OPTOMETRY TRAINEES

Education of trainees in medicine and associated health care disciplines, as optometry, is an important component of VHA's patient care mission.

a. **Definition of Trainees**

(1) **Doctor of Optometry (O.D.) Candidates.** Candidates for the O.D. Degree refers to optometry 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 O.D. Degree.

(2) Residents and Fellows

(a) Definition. This category includes trainees who have obtained the O.D. Degree. Residents are post-graduate year (PGY) 1 trainees in a primary eye or vision care residency. Fellows are PGY2 and PGY3 trainees with a specialty or research focus.

(b) Recruitment. Residency and fellowship positions are advertised in accordance with local VA facility guidelines. The national Optometric Residency Matching Services (ORMS), Inc., will be used for selection and matching of candidates to residency programs. Once matched, the local VA facility Human Resources Management appoints the optometry resident(s) or fellow(s) according to VA Handbook 5005/12, Part II, Chapter 3, and VA Handbook 5005/8, Part II, Appendix G5.

b. **Establishing Affiliations Between VA Facilities and Optometry Schools**

(1) Before starting a program of clinical education, an affiliation agreement must exist between the local VA field facility and the closest ACOE-accredited school or college of optometry. 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 O.D. Candidates. VA affiliation agreement templates must be used as detailed in current VHA policy (see the Office of Academic Affiliations (OAA) Web site at http://vaww.va.gov/oaa/policies.asp). ***NOTE:*** *This is an internal VA web site not available to the public.*

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

(3) Once an affiliation is established with an ACOE-accredited school or college of optometry, only optometry students in their third and final professional (fourth) years, PG1, PGY2, and PGY3 trainees will have direct patient care responsibilities. Individuals in earlier professional years can assume supportive roles.

(4) To better coordinate the provision of primary optometric eye and vision care services within a VISN, an appropriate representative from each affiliated school or college of optometry needs to be appointed to the local VA facility and VISN Affiliation Partnership Council, Deans' Committee, Management Assistance Council, or comparable Education Council as described in VHA Handbook 1400.3 or subsequent policies listed on the OAA Web site at http://vaww.va.gov/oaa/policies.asp. ***NOTE:*** *This is an internal VA Web site not available to the public.*

c. **Supervision of Trainees in Optometric Education Programs**

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

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

d. **Credentialing and Privileging Requirements in Optometric Education Programs.** As members of the medical staff, attending optometrists must be credentialed and privileged by the facility (see VHA Handbook 1100.19) and in conjunction with VA Handbook 5005/12, Part II, Chapter 3, to provide the care which they 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 (see VHA Handbook 1100.19) and in conjunction with VA Handbook 5005/12, Part II, Chapter 3, and may supervise optometry students and residents.

e. **Medicare Billing Requirements for Optometric Education Programs**

(1) There are differences between the requirements for educational supervision of residents and the documentation necessary in order to bill for services provided by attending optometrists and residents (see VHA Handbook 1400.1 and subsequent policies listed on the OAA website at http://vaww.va.gov/oaa/policies.asp). ***NOTE:*** *This is an internal VA Web site not available to the public.*

(2) 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. The Department of Health and Human Services (HHS) CMS has approved a Current Procedural Terminology (CPT) modifier identified as "GR" and is defined by CMS as: **GR-** *"This service was provided in whole or in part by a resident at a Department of Veterans Affairs Medical Center or Clinic, supervised in accordance with VA policy."* The GR modifier needs to be attached to the CPT code to bill third-party payers for resident services using the supervising optometrist's name and credentials.

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

f. **Reporting Relationships for Optometric Education Programs**

(1) 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.

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

g. **Evaluation of Optometry Residents**

(1) 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 evaluations.

(2) 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 ACOE-affiliated school, or college of optometry, program director.

(3) 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.

(4) All written evaluations of residents and staff practitioners must be conducted in

accordance with VHA Handbook 1400.1, and must be kept on file in a location consistent with local facility policy.

h. **Scheduling and Productivity Considerations for Optometric Education Programs**

(1) The educational goals and objectives of any optometric education program are to be compatible with those of the VA facility; however at least 1/2 day per week needs to be dedicated solely for educational activities and ideally patients should not be scheduled. VA staff optometrists need to allow, or arrange, for emergency coverage during this 1/2 day "down" time.

(2) VA staff optometrists must ensure that overall productivity meets program goals as defined by the Director, Optometry Service, VHA Central Office.

i. **Staffing Needs for Optometric Education Programs**

(1) **Staffing Ratio.** Programs with trainees assigned should have at least 1.0 FTE staff optometrist(s). There should be frequent interaction with the VA staff optometrist serving as the education program coordinator or director and the Associate Chief of Staff (ACOS) for Education or equivalent VA official. Programs with less than 1.0 FTE optometric professional staff may not be able to provide the proper level of clinical supervision, nor can they properly educate optometric trainees in an integrated program which must meet specific curricular goals and objectives. The desired goal for preceptor (staff optometrist) to trainee ratio needs to be 1:3 for O.D. professional degree students, 1:4 for PGY1 trainees, and 1:5 for PGY2 and beyond optometric trainees.

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

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

j. **Trainee Requirements and Funding Support**

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

(a) Be appointed according to VA Handbook 5005/12, Part II, Chapter 3, and in conjunction with M-8, Part II;

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

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

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

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

(a) Be appointed according to VA Handbook 5005/12, Part II, Chapter 3 and Appendix G5.

(b) Be citizens of the United States.

(c) Be graduates with the O.D. degree resulting from a course of education in optometry. The degree must have been obtained 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.

(d) 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.

(3) **Fellowship Trainees.** Optometric fellows must:

(a) Be appointed according to VA Handbook 5005/12, Part II, Chapter 3 and Appendix G5;

(b) Be citizens of the United States;

(c) Have successfully completed an ACOE accredited optometric residency program; and

(d) 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.*

(4) **Funding.** Allocation of funding for residency and fellowship positions is determined by the Office of Academic Affiliations in collaboration with the Director of VA Central Office Optometry Service.

(5) **Salary.** Salary rates for optometry residents and fellows are determined by the Office of Academic Affiliations.

(6) **Insurance.** Optometry residents and fellows are eligible for VA group health and life insurance benefits (see current VHA policy listed on the OAA Web site at: http://vaww.va.gov/oaa/policies.asp). ***NOTE:*** *This is an internal VA Web site not available to the public*.)

k. **Space and Equipment Needs for Patient Care in Optometric Education Programs**

(1) Administrative and clinical space and equipment need to be available as delineated in Space Planning Criteria for VA Facilities: Veterans Health Administration: Eye Clinic at: http://www.cfm.va.gov/til/space/SPChapter233.pdf that details the 2008 revision of VA Handbook 7610.3 (233).

(2) At least one fully equipped E-T room for each trainee is recommended, in addition to the space required of the attending optometrist(s) as detailed in the 2008 Space Planning Criteria for VA Facilities: VHA: Eye Clinic (see subpar. 13k(1) and App. B).

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

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

14. ACCREDITATION OF OPTOMETRIC EDUCATION PROGRAMS

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

b. All optometric education coming to VA must be accredited by the appropriate accrediting body. ACOE is the accrediting body for the schools and colleges of optometry and for their residency programs (see http://www.aoa.org/x5153.xml). 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 O.D. candidates, accreditation of the school or college of optometry by the ACOE includes all clinical training programs provided to optometry students prior to graduation. The ACOE, through the affiliated school or college of optometry, monitors quality and grants accreditation to the school or college of optometry.

(2) For programs involved in the education of PGY1 trainees, the ACOE must be consulted by the VA facility in order for specific programs to receive accreditation status. The VA staff optometrist residency program 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. ***NOTE:*** *The quality of the program is the strongest determinant in the accreditation process.*

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

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

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

(c) Accreditation with Conditions. Programs which are unable to merit accreditation status, but have sufficient redeeming qualities and characteristics with reasonable likelihood that accreditation status may ultimately be granted, may receive accreditation with conditions. ***NOTE:*** *The conditions are reevaluated at some future time as recommended by the ACOE, typically within an 18 month period. If the conditions have been fully corrected, accreditation status may be achieved.* An autonomous reporting relationship as exemplified in subparagraph 10a(5) for the Optometry educational program is a requirement for ACOE accreditation.

(d) Payment of Accreditation Fees. The annual accreditation fees billed by the ACOE is the responsibility of each VA 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.

15. EDUCATION AND TRAINING OF OPHTHALMOLOGY TRAINEES

Education of trainees in medicine and associated health care disciplines, as ophthalmology, is an important component of VHA's patient care mission.

a. **Definitions**

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

(2) **Ophthalmology Fellows.** Ophthalmology fellows are post-residency positions where 1 to 3 years is spent in acquiring additional training in either comprehensive or sub-specialty

Ophthalmology. There are no Ophthalmic sub-specialties which are ACGME-accredited, rather each fellowship is designed by the sponsor and often reviewed by a sub-specialty professional organization.

b. **Recruitment**

(1) Residents are recruited by the Academic Affiliate and matched through the Ophthalmology Matching Program. The selection of residents is generally the responsibility of the Academic Affiliate according to the affiliation agreement. Once matched, the local VA facility Human Resources Management appoints the ophthalmology resident(s) according to VA Handbook 5005/12, Part II, Chapter 3.

(2) Fellows are recruited by the fellowship sponsor. Once selected, the local VA facility Human Resources Management appoints the ophthalmology fellow(s) according to VA Handbook 5005/12, Part II, Chapter 3. ***NOTE:*** *OAA residency training funds cannot be used to support these positions as it is limited to funding ACGME-accredited programs.*

c. **Educational Affiliation Agreements**

(1) An educational affiliation agreement must be signed by the VA facility and the corresponding medical school affiliate and/or sponsoring institution of the training program. VA affiliation agreement templates must be used as detailed in current VHA policy or subsequent policies listed on the OAA websites at: http://vaww.va.gov/oaa/policies.asp. *This is an internal VA web site not available to the public.*

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

(3) In addition, there must be a program letter of agreement (PLA) between the program sponsor and the VA participating site. The PLA must be renewed at least every 5 years and contain all of the information listed in the Ophthalmology Program Requirements by the ACGME RRC, including the identification of faculty who will assume educational, supervisory, and evaluative responsibility for the ophthalmology residents (see http://www.acgme.org/acWebsite/RRC_240/240_prIndex.asp). ***NOTE****: The PLA must be drafted jointly by the Program Director and the VA Residency Site Director.*

d. **Supervision**

(1) 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.

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

(3) Surgical supervision is required for all residents. All residents need to be directly supervised by an attending Ophthalmologist. Ophthalmologists must be directly involved in the supervision of all surgical cases, including entering an appropriate pre-operative note or addendum to the resident's note and determining the level of resident participation directed by experience level and demonstrated capability. Exceptions to direct supervision are rare and are based on the best care for the patient (e.g., an emergency case being started while the attending is traveling to the facility).

(4) Attending Ophthalmologists must be credentialed and privileged by the facility, as delineated in VHA Handbook 1100.19, to provide the care which they are supervising.

(5) All supervision must meet the stated criteria for supervision of all physicians' training, including documentation and demonstration of direct supervision as described in VHA Handbook 1400.1.

e. **Levels of Responsibility**

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

(2) The determination of a resident's ability to accept responsibility for performing procedures or activities without a staff practitioner present must be based on documented evidence of the resident's clinical experience, judgment, knowledge and technical skills. ***NOTE:*** *Such evidence may be obtained from the affiliated university, evaluations by staff practitioners or program coordinator, and/or other clinical practice information.*

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

f. **Evaluation of Ophthalmology Residents**

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

(2) 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 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.

(3) 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.

(4) All written evaluations of residents and staff practitioners must be kept on file in a location in accordance with local facility policy and conducted in accordance with VHA Handbook 1400.1.

g. **Staffing**

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

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

h. **Space and Equipment Needs for Patient Care in Ophthalmology Education Programs**

(1) Administrative and clinical space and equipment need to be available as delineated in Space Planning Criteria for VA Facilities: Veterans Health Administration: Eye Clinic at http://www.cfm.va.gov/til/space/SPChapter233.pdf that details the 2008 revision of VA Handbook 7610.3 (233).

(2) At least one fully-equipped E-T room for each trainee is recommended in addition to the space required of the attending ophthalmologist(s) as detailed in the 2008 Space Planning Criteria for VA Facilities: VHA: Eye Clinic (see subpar. 13k(1) and App. B).

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

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

16. ACCREDITATION OF OPHTHALMOLOGY RESIDENT TRAINING

a. ACGME is responsible for accreditation of the Ophthalmology residency training programs. Residency programs affiliated with VA must be accredited by ACGME (see http://www.acgme.org/acWebsite/navPages/nav_240.asp).

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

c. VHA expects the Academic Affiliate or sponsoring institution to obtain appropriate accreditation through the ACGME.

d. VHA must provide data to support the application for continued accreditation of the program to the Academic Affiliate or sponsoring institution.

e. VHA must participate, as requested by the sponsoring institution, in the Ophthalmology RRC review process.

17. RESEARCH AND DEVELOPMENT

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

b. A VA-funded intramural research program supports VHA research with its commitment to enhancing patient outcomes.

c. The VHA Merit Review Program is the principal mechanism for sustained biomedical and behavioral research funding of VHA scientists. Eye care providers within VHA may request Clinical Science Research and Development, Health Services Research and Development, Rehabilitation Research and Development, and Biomedical Research funding. Applicants for merit review funding must be at least 5/8 time employees (VHA Handbook 1200.15).

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

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

(2) The Clinical Science Research and Development Program supports clinical research aimed at prevention, diagnosis, and treatment of diseases and disabilities.

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

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

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

18. INFORMATION MANAGEMENT

Quality health care depends on VHA health care providers' ability to timely collect and access the protected health information of VHA patients, while ensuring the integrity and confidentiality of that information. In order to accomplish this goal, information technology (IT) necessary for patient care, education, research, and administrative activities needs to be available as clinically appropriate and must comply with VA IT requirements, regulations and policies. Examples of information technology include: medical facility 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.

19. QUALITY IMPROVEMENT (QI)

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

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

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

(2) All patients with diabetes mellitus need to have funduscopic examinations as determined by the VA-DOD Diabetes Mellitus Clinical Practice Guidelines (see web site at: http://www.healthquality.va.gov/), or more frequently, as indicated by the degree or stage of diabetic retinopathy.

(3) Individuals with significant risk factors for development of glaucoma need to have dilated eye examinations as determined by the National Eye Institute of the NIH, National Eye Health Education Program recommendations:

(a) African Americans over the age of 40;

(b) People with a family history of glaucoma; and

(c) Everyone over the age of 60, especially Mexican Americans (view Web site at: http://www.nei.nih.gov/nehep/glaucoma.asp).

(4) Management of these ocular conditions need to adhere to the Optometric Clinical Practice Guidelines of the American Optometric Association (see http://www.aoa.org/x4813.xml) and the Preferred Practice Patterns of the American Academy of Ophthalmology (see http://one.aao.org/CE/PracticeGuidelines/PPP.aspx).

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

c. **Ophthalmic Surgery Patient Safety and Quality Assessment.**

(1) Each facility ensures that patients obtaining ophthalmic surgery have care that adheres to the appropriate VA policies. In particular, local facility policies and practices need to be in place that address ensuring correct surgery and invasive procedures and the prevention of retained surgical items. Among other things, these policies require that surgical sites be marked by a physician or other privileged provider in cooperation with the patient, and that a "time-out" is performed before starting an operation or invasive procedure. Most of these policies are not limited to the operating room, and also apply in other settings where invasive procedures are performed. These and other applicable policies are available at the VA National Center for Patient Safety website at: http://vaww.ncps.med.va.gov/. ***NOTE:*** *This is an internal VA Web site not available to the public.*

(2) VHA Ophthalmology is committed to developing an assessment of quality using a risk adjusted National Surgical Quality Improvement Program (NSQIP) methodology intrinsic to major ophthalmic surgical interventions. The expertise for creating the outcome criteria is determined by selected eye care providers performing the interventions. Initially, arrangements must be made for development of an ophthalmic data base which collects information on ophthalmic surgical complications and potential risk adjustment variables.

d. **Quality Management and Peer Review.** Eye care provided to VA patients by VA providers is subject to Quality Management and Peer according to current VHA policy.

20. PROCEDURES FOR STAFF DEVELOPMENT

a. **Qualification Standards.** Nationwide qualification standards are in effect for all optometry personnel actions in accordance with the VA Optometrist Qualification Standard; VA Handbook 5005, Part II, Appendix G5 and VA Handbook 5017, Part V. The VA Physician Qualification Standard for ophthalmology personnel actions are covered in VA Handbook 5005, Part II, Appendix G2 and VA Handbook 5017, Part V.

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

c. **Clinical Privileges.** As licensed independent practitioners (LIPs), optometrists and

ophthalmologists must be credentialed and privileged according to VHA Handbook 1100.19.

d. **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, as well as promotion and special advancement requests (VA Handbook 5005/8, Part II, Appendix H4 and VA Handbook 5005/8, Part III, Appendix M), based upon published qualification standards. This board, in which the majority of members are optometrists, functions in accordance with established VA policy.

e. **Reporting Relationships.** Reporting assignments for optometrists and ophthalmologists vary depending upon facility staff and patient care needs. This needs to be determined at the facility level. ***NOTE:*** *Facilities with questions about optometry and ophthalmology reporting relationships are encouraged to contact the Eye Care Performance Consultant Team, the VHA Director of Optometry Service and the Program Director for Ophthalmology.*

f. **Special Advancements.** Clearly defined criteria for Special Advancement for Performance and Special Advancement for Achievement, detailed in VA Handbook 5017/6, Part V, are used for all optometry personnel actions that must be submitted to the Optometry Professional Standards Board according to VA Handbook 5017/4, Part V, Appendix B and VA Handbook 5017/4, Part V, Appendix D.

g. **Recruitment and Relocation Bonuses.** Local VA facilities have the ability to authorize recruitment and relocation bonuses (see VA Handbook 5007, Pt. VI, Ch.3) for optometrists and ophthalmologists.

h. **Retention Allowances.** Optometrists and ophthalmologists are eligible for retention allowances (see VA Handbook 5007, Pt. VI, Ch.3) that may be authorized by the local VA facility within established VA policy.

i. **Education Debt Reduction Program.** To assist VHA in meeting its need for qualified health care staff in certain occupations for which recruitment or retention is difficult, optometrists and ophthalmologists are eligible to participate in the Education Debt Reduction Program as detailed in VHA Directive 1021 and VHA Handbook 1021.1 or subsequent VA policy.

j. **Professional Staff Development**

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

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

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

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

(3) **Administration.** To promote development of future administrative leaders, VA facilities are encouraged to include eye care providers in administrative activities at the local facility or higher level.

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

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

21. ELIGIBILITY

a. Eligibility for Eye Care Services and Prosthetic Devices

(1) Veterans meeting the eligibility requirements to receive health care are eligible for eye care services. Eligibility rules are the same for both inpatient hospital care and outpatient medical services. Within the Title 38 Veterans' Benefits law (see 38 United States Code (U.S.C.) §1701) and accompanying regulations (38 Code of Federal Regulations (CFR) §17.30 Definitions and 38 CFR §17.38 Medical benefits package), all enrolled Veterans are eligible for "medical services" that include 'surgical services' and 'optometric services,' as well as "preventive health (care) services" that include 'routine vision testing and eye care services;' however, not every Veteran is eligible for prosthetic devices, such as eyeglasses. ***NOTE:*** *Veterans must not be denied access to eye and vision care services because they do not meet the eligibility criteria for eyeglasses.*

(2) Any Veteran who meets the current beneficiaries' eligibility criteria, guidelines set forth in 38 CFR §17.149, and VA policy may receive eye-related appliances, devices, and prostheses

(see the Prosthetics and Sensory Aids Service website at: http://vaww.pclo.med.va.gov). *This is an internal VA Web site not available to the public.*

b. **Appointment Policy and Access Mechanisms**

(1) **Appointment Policy.** The appointment policy for eye care provider patients is locally determined and dependent upon the nature of the eye care provider program involved. Typically, Chiefs of Optometry Services, Sections, or Departments, or Chiefs of Ophthalmology determine for their respective disciplines, an appropriate schedule according to local personnel policies.

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

22. REFERENCES

a. Accreditation Council for Graduate Medical Education (ACGME), Ophthalmology Residency Review Council (http://www.acgme.org/acWebsite/navPages/nav_240.asp).

b. Accreditation Council for Graduate Medical Education (ACGME), Program Requirements for Graduate Medical Education in Ophthalmology http://www.acgme.org/acWebsite/RRC_240/240_prIndex.asp.

c. Accreditation Council on Optometric Education (http://www.aoa.org/x5153.xml).

d. Title 38 CFR Section 17.149, Section 17.30, and Section 17.38.

e. Eye Care – Draft National Referral Guide (http://vaww.collage.research.med.va.gov/collage/nsa/nsa_display_draft.asp. *This is an internal VA web site not available to the public.*

f. National Eye Institute of the National Institutes of Health, National Eye Health Education Program Glaucoma Recommendations (http://www.nei.nih.gov/nehep/glaucoma.asp).

g. Optometric Clinical Practice Guidelines, American Optometric Association (http://www.aoa.org/x4813.xml).

h. Preferred Practice Patterns, American Academy of Ophthalmology http://one.aao.org/CE/PracticeGuidelines/PPP.aspx).

i. Title 38 U.S.C. 1701 and 5705.

j. VA-DOD Diabetes Mellitus Clinical Practice Guidelines (http://www.healthquality.va.gov/).

k. VA Directive 5005/12, Part II, Chapter 3.

l. VA Handbook 5017/6, Part V.

m. VA Handbook 5005, Part II, Appendix G5.

n. VA Handbook 5005, Part II, Appendix G2.

o. VA Handbook 5005/8, Part II, Appendix H4.

p. VA Handbook 5017/4, Part V, Appendix B.

q. VA Handbook 5017/4, Part V, Appendix D.

r. VA Handbook 5005/8, Part III, Appendix M.

s. VA Handbook 5007, Part VI, Chapter 2.

t. VA Handbook 5007, Part VI, Chapter 3.

u. VA Handbook 7610.3 (Chapter 233) (see http://www.cfm.va.gov/til/space/SPChapter233.pdf).

v. VA National Center for Patient Safety (see http://www.patientsafety.gov/).

w. VHA Directive 1021.

x. VHA Directive 1201.

y. VHA Directive 1203.

z. VHA Directive 1204.

aa. VHA Handbook 1400.3, http://vaww.va.gov/oaa/policies.asp. *This is an internal VA Web site not available to the public.*

bb. VHA Handbook 1100.19.

cc. VHA Handbook 1021.1.

dd. VHA Handbook 1200.15.

ee. VHA Handbook 1173.12.

ff. VHA Handbook 1400.1.

EYE CARE PROFESSIONS

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

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

b. **Optometrist.** Doctors of Optometry are independent primary health care providers who examine, diagnose, treat, and manage diseases and disorders of the visual system, the eye and associated structures, as well as diagnose related systemic conditions. An optometrist typically completes 4 years of baccalaureate training and 4 years of optometry training. Residency training is 1 year beyond attainment of the optometry degree, and fellowship training is for 1 to 2 years beyond the completion of residency training.

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

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

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

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

d. **Eye Technicians.** Eye technicians carry out duties assigned to them by the supervising Eye Care Providers, optometrists, or ophthalmologists with whom they work.

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

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

g. **Registered Nurse (RN).** RNs may be assigned eye clinic duties in accordance with medical facility policies.

SPACE AND EQUIPMENT

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

1. New Eye Clinics or Alterations. Facilities may refer to the 2008 revision of VA Handbook 7610.3 (Chapter 233), Space Planning Criteria for VA Facilities: Veterans Health Administration: Eye Clinic for recommendations and suggestions on constructing new eye care clinics or for making alterations to existing clinics that may be viewed at http://www.cfm.va.gov/til/space/SPChapter233.pdf.

2. Equipment. The equipment guide list of VA Handbook 7610.3 (Chapter 233) can serve as a guide or benchmark as the facility determines eye care equipment requirements.

3. Space Determinations and Equipment Needs

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

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

(1) Exam-treatment (E-T) rooms (2.5 E-T rooms for each 1.0 Full-time Equivalent (FTE) employee optometrist or ophthalmologist) with refractive and eye health instrumentation, (minimum 130 net square feet (NSF) 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 digitized fundus and slit-lamp camera units;

(5) Pre-testing room with use by technician for preliminary testing; and

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

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

(1) Reception area;

(2) Waiting area;

(3) 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; and

(9) Wheelchair storage area or alcove.

d. **Ultrasound or Optical Coherence Tomography 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. The optical coherence tomography room is used for conducting ocular imaging studies.

e. **Eye 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:

(1) Tarsorrhaphy;

(2) Excisions (chalazia, pterygia, external lid lesions);

(3) Insertion, removal, and repair of sutures; and

(4) Blepharoplasty, and simple entropion or ectropion repair.

f. Clean Utility or Supply Room.

g. Soiled Utility Room.

h. **Laser Room.** The Argon, Diode, Selective Laser Trabeculoplasty (SLT), Neodymium: Yttrium Aluminum Garnet (Nd:YAG), and Carbon Dioxide (CO_2) 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 in treatment of numerous ocular problems; i.e., diabetic retinopathy, glaucoma, retinal tear, etc.*

i. **Low-Vision Poly-Trauma Training Room.** This room is used to provide vision rehabilitation care. Patient education and eye care counseling sessions are conducted so that patients can learn how to use prescribed low-vision aids in order to perform everyday skills, activities of daily living, and to improve their overall functional independence.

j. **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.

4. Space and Equipment Criteria for Eye Care Providers Assigned to Blind Rehabilitation Centers (BRCs) and Clinics. Refer to Space Planning Criteria for VA Facilities: VHA: Eye Clinic at http://www.cfm.va.gov/til/space/SPChapter233.pdf that details the 2008 revision of VA Handbook 7610.3 (Chapter 233) and the accompanying Equipment Guide List for recommended appropriate equipment placement and equipment expansion information. The room floor plan notated in the Equipment Guide List designates the instrumentation suggested to equip various levels of eye clinics.

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

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

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

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

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

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

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

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

6. Productivity Standards

a. Advanced Clinic Access and System Redesign

(1) To reduce waits, delays or missed opportunities, and continually improve Veterans' access to optometry and ophthalmology eye care services, the ten key changes detailed in the Advanced Clinic Access principles needs to be implemented in every VHA Eye Clinic.

(2) The Eye Care – Draft National Referral Guide was developed to assist with Eye Clinic referrals and may be viewed at http://vaww.collage.research.med.va.gov/collage/nsa/nsa_display_draft.asp. *This is an internal VA Web site not available to the public.*

b. Optometry

(1) VHA optometrists provide comprehensive, full-scope primary optometric eye and vision care services; their productivity varies based on local factors, which include the: number of exam rooms and additional space available, equipment, support staff, mission of the facility, complexity of the patients, and administrative responsibilities of the optometrists.

(a) It would be expected, in most instances, for a full-time clinical staff optometrist with adequate space, equipment and support personnel to have 2,100 to 3,000 patient visits a year within a range of 1,200 to 1,700 unique patients annually.

(b) These productivity recommendations exclude those patients requiring extensive low-vision and vision rehabilitation services. It would be expected that productivity could improve with the addition of more E-T rooms, support staff, and equipment.

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

c. Ophthalmology

(1) VHA ophthalmologists provide eye examinations and surgical services. Productivity is based on local factors which include: the number of exam rooms and additional space available, equipment, support staff, mission of the facility, complexity of the patients and administrative responsibilities of the ophthalmologists. It would be expected, in most instances, for a full-time clinical staff ophthalmologist with adequate support personnel to:

(a) Have 1,800 to 4,000 patient visits a year (1,300 to 1,800 unique patients), and

(b) Perform 150 to 300 surgical procedures, including laser procedures, a year.

(2) The VHA Advisory Group on Physician Productivity and Staffing used a Relative value

Unit (RVU) based methodology to evaluate VA ophthalmologist productivity. ***NOTE:*** *A full report is available at: http://vssc.med.va.gov/products.asp?PgmArea=18*
This is an internal VA Web site not available to the public. Based on the results of that study it would be expected that the overall practice level productivity for ophthalmology should be in the range of 6,000–6,900 RVUs per clinical FTE annually.

(a) Productivity levels in excess of 6,900 RVUs may be considered a best practice if accompanied by high quality.

(b) This productivity expectation includes supervised Resident workload. This number changes depending upon the available clinic support personnel, available operating room time, availability of anesthesiology, if eyeglasses are dispensed in the clinic, and the number of part-time and fee-basis ophthalmologists.

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

VISUAL IMPAIRMENT PREVENTION FOR VETERAN PATIENTS

Age-related macular degeneration, diabetic retinopathy, and glaucoma are major causes of visual impairment and blindness. Prevention and treatment of visual impairment and blindness involves optical, medical, surgical, and rehabilitative eye care. The provision of these services crosses the professions of Primary Care, Optometry, and Ophthalmology. In many cases visual impairment and blindness can be prevented or reduced by timely diagnosis and timely medical and surgical treatment when indicated. Despite the best efforts of eye care providers to prevent and reduce vision impairment and blindness some patients will become visually impaired or blind necessitating the need for low vision and blind rehabilitation care.

1. Care Collaboration Agreements From Primary Care to Optometry And Ophthalmology. A Care Collaboration Agreement for referral from Primary Care to Eye Care (Optometry and Ophthalmology) to screen and examine patients is to be established and followed; it is to include the following:

a. For diabetic retinopathy, there needs to be an annual consult or referral for diabetic retinal exam or biennial retinal exam, if a prior exam revealed no retinopathy.

b. For other eye diseases, there needs to be a consult or referral for patients with visual symptoms or for ongoing care of eye disease(age-related macular degeneration, cataract, glaucoma, etc.), as appropriate. Patients need to be encouraged to bring copies of non-VA ophthalmic exams with them in order to facilitate appropriate VA eye care.

2. Care Collaboration Agreements between Ophthalmology and Optometry. There needs to be a Care Collaboration Agreement between Ophthalmology and Optometry covering patients with age-related macular degeneration, diabetic retinopathy, and glaucoma to facilitate appropriate and timely referral of patients for delivery of seamless eye care services consistent with the current, nationally-accepted standards of both eye care professions (Optometry and Ophthalmology). ***NOTE:*** *The Care Collaboration Agreements 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.* These Care Collaboration Agreements are to include:

a. **Age-Related Macular Degeneration (ARMD).** Ophthalmology consult or referral is recommended for, but not limited to ARMD patients with active (clinically significant) choroidal neovascularization or new onset of metamorphopsia requiring ophthalmological intervention (laser, surgery, injection). Both Optometry and Ophthalmology need to recommend or prescribe vitamin supplementation for ARMD patients found to have "High Risk" physical findings, as recommended by AREDS criteria.

b. **Diabetic Retinopathy.** Ophthalmology consult or referral for evaluation and treatment is recommended for but not limited to new Diabetic patients that have one of the following findings (see App. D), or established patients with clinically significant progression of disease requiring ophthalmological intervention (laser, surgery, injection) or one of the following findings, as:

Clinically Significant Macular Edema (CSME); Severe Non-Proliferative Diabetic Retinopathy (NPDR), unless care plan reviewed with Ophthalmology previously; and Proliferative Diabetic Retinopathy (NVD) or Vitreous Hemorrhage.

c. **Glaucoma.** For glaucoma, there is to be a consult or referral to Ophthalmology for patients at high risk for disease progression (documented clinically-significant non-compliance and/or instability on medical therapy). There needs to be consideration of surgical options. For acute angle closure glaucoma, there needs to be a consult or referral to Ophthalmology for patients prior to or after medical therapy stabilization, as appropriate, for consideration of surgical options. For active neovascular glaucoma, there needs to be a consult or referral to Ophthalmology for those patients who have not already had ophthalmological intervention (laser, surgery, injection). When the options for intervention are deemed complete, the patient needs to be referred back to optometry.

d. 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.

3. <u>Focused and Periodic Ongoing Professional Practice Evaluations by Each Discipline</u>

a. There needs to be an initial and periodic clinical review (at least every 6 months; Optometry reviews Optometry, and Ophthalmology reviews Ophthalmology) of patients diagnosed with age-related macular degeneration, diabetic retinopathy, and glaucoma based on current, nationally-accepted standards. These focused and ongoing professional practice reviews, are to be used by the respective Section or Service Chiefs of Optometry and Ophthalmology and the Executive Committee of the Medical Staff for initial privileging and re-privileging decisions.

b. The initial focused and periodic Ongoing Professional Practice Evaluation disease specific evidence-based review is to include:

(1) For age-related macular degeneration, there is evidence of patient education on the risks and benefits of Age-Related Eye Disease Study (AREDS) recommendations for preventing disease progression based upon the severity and type of macular degeneration, as indicated.

(2) For diabetic retinopathy, there is evidence of retinopathy severity and patient education regarding the prevention of disease progression, as indicated.

NOTE: *If the Veteran qualifies for screening through the National Teleretinal Imaging Screening Program, there is a National Teleretinal Imaging Quality Assurance Program that reviews ongoing eye care provider (optometrist or ophthalmologist) competence.*

(3) For glaucoma, there is 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.

c. Facilities with a single eye care provider (optometrist or ophthalmologist) are to make arrangements with the respective optometry or ophthalmology Veterans Integrated Service Network (VISN) lead or a Department of Veterans Affairs (VA) medical facility with optometry or ophthalmology eye care providers to conduct the review, as appropriate.

4. Joint Collaboration of Care Review. There is to be a periodic, at least quarterly, Collaboration of Care review of patients diagnosed with age-related macular degeneration, diabetic retinopathy, and glaucoma. ***NOTE:*** *This Joint Collaboration of Care review is a Quality Improvement activity, and its confidentiality is covered by Title 38 United States Code (U.S.C.) 5705.*

a. This review is to be done jointly by Optometry and Ophthalmology to:

(1) Discuss the timely and seamless provision of care according to the Care Collaboration Agreement between Optometry and Ophthalmology.

(2) Review the care of the selected patient charts in the context of improving patient care. This two-way discussion needs to occur in the collaborative spirit of informing, educating, and contributing to the eye care provided to the patient based upon the complementary strengths that Ophthalmology and Optometry bring to the table. Through this non-punitive process, patient care should improve and all involved can benefit from the discussion.

(a) Medical-Surgical Collaboration Review. This review (at least quarterly and done jointly by ophthalmology and optometry) consists of up to six randomly-selected patients diagnosed with age-related macular degeneration, diabetic retinopathy, and glaucoma from patients seen predominately by both ophthalmology and optometry. The criteria for this review needs to be based on the Care Collaboration Agreements for referral from optometry to ophthalmology and needs to cover the referral for care process.

(b) Facilities with a single eye care provider. 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.

5. Joint Meetings Between Ophthalmology and Optometry. There is to be a periodic (at least quarterly) joint meeting between Ophthalmology and Optometry, as applicable, to review and improve systems of care. These meetings should occur at the facility and if possible, at the VISN level. Unless a separate time is more convenient, time is to be provided, as needed, to discuss other clinical processes that are mutually beneficial for patient care, at the time of the quarterly Joint Collaboration of Care Review.

6. **Education of Primary Care Providers.** The Chief of Staff. or designee, is responsible for the education of Primary Care Providers regarding ARMD, diabetic retinopathy and glaucoma at each facility based on guidance provided by National Directors of Optometry and Ophthalmology.

SAMPLE OF A CARE COLLABORATION AGREEMENT BETWEEN OPTOMETRY AND OPHTHALMOLOGY

The following is a sample Care Collaboration Agreement between **Optometry and Ophthalmology** to facilitate appropriate and timely referral and/or consultation of patients for delivery of seamless eye care services consistent with the current, nationally-accepted standards of both eye care professions (Optometry and Ophthalmology). ***NOTE:*** *This Care Collaboration 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 the ability of patients to have access to care provided by optometry or ophthalmology within their granted clinical privileges.*

1. PURPOSE. These Care Collaboration Agreements are intended to:

a. Meet the goals specified in the Visual Impairment Prevention for Veteran Patients (see App. C).

b. Facilitate appropriate and timely referral of patients from Optometry to Ophthalmology for care of selected age-related macular degeneration, diabetic retinopathy, and glaucoma conditions with discharge back from Ophthalmology to Optometry for continuing care, as appropriate. Those referrals may not always require face-to-face examination, electronic consult or documented personal discussion may be sufficient to review care provided.

c. Ensure that optimal eye care is provided to all Veterans through a collaborative approach to diagnosis, treatment, and management of eye care by both Optometry and Ophthalmology.

2. CARE COLLABORATION FROM OPTOMETRY TO OPHTHALMOLOGY AND OPHTHALMOLOGY TO OPTOMETRY

a. **Prior to Consult Request.** A note documented by Optometry is to be available for Ophthalmology to view in the Computerized Patient Record System (CPRS).

b. **Results of Consult Request.** Ophthalmology is to complete the consult through a CPRS progress note.

c. **Referral Back to Original Referring Section or Service.** For patients consulted between optometry and ophthalmology for eye care, the patient may be sent back to the referring provider for continuing care, when it is appropriate to do so.

3. AGE-RELATED MACULAR DEGENERATION (ARMD)

a. **ARMD.** Ophthalmology consult or referral is recommended for, but not limited to ARMD patients with active (clinically significant) choroidal neovascularization or new onset of metamorphopsia requiring ophthalmological intervention (laser, surgery, injection).

b. **AREDS Vitamins.** Both Optometry and Ophthalmology need to recommend or prescribe vitamin supplementation for ARMD patients found to have "High Risk" physical findings, as recommended by AREDS criteria. The definition of high-risk, non-exudative ARMD 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 ARMD (vision loss secondary to ARMD).

(5) Exudative (Wet) ARMD in at least one eye.

4. DIABETIC RETINOPATHY. Ophthalmology consult or referral for evaluation and treatment is recommended for but not limited to new Diabetic patients that have one of the following findings (see subpar.4a), or established patients with clinically significant progression of disease requiring ophthalmological intervention (laser, surgery, injection) or one of the following findings, as: Clinically Significant Macular Edema (CSME); Severe Non-Proliferative Diabetic Retinopathy (NPDR), unless care plan reviewed with Ophthalmology previously; and Proliferative Diabetic Retinopathy (NVD) or Vitreous Hemorrhage.

a. **Definition of CSME.** It can be any one of the following, by Early Treatment Diabetic Retinopathy Study (ETDRS) Criteria:

(1) Retinal edema or thickening within 500 microns of Foveal Avascular Zone (FAZ)

(2) Hard Exudates within 500 microns of Fovea with associated Retinal edema

(3) Retinal edema measuring more than (>)1 disc diameter (DD) within 1DD of Fovea

b. **Definition of Severe NPDR.** It can be any one of the following, by ETDRS Criteria:

(1) Severe (>) 20 intraretinal Hemorrhages in four quadrants.

(2) Venous beading in two quadrants.

(3) Intraretinal Microvascular Anomaly (IRMA) in one quadrant.

5. GLAUCOMA. For glaucoma, there is to be a consult or referral to Ophthalmology for patients at high risk for disease progression (documented clinically-significant non-compliance and/or instability on medical therapy). There needs to be consideration of surgical options, as:

a. For acute angle closure glaucoma, there needs to be a consult or referral to

Ophthalmology for patients prior to or after medical therapy stabilization, as appropriate, for consideration of surgical options.

b. For active neovascular glaucoma, there needs to be a consult or referral to Ophthalmology for those patients who have not already had ophthalmological intervention (laser, surgery, injection). When the options for intervention are deemed complete, the patient needs to be referred back to optometry.

6. 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 needs to be contacted, or the patient needs to be fee-based out to a local ophthalmologist, as needed.

7. ONGOING PROFESSIONAL PRACTICE EVALUATIONS BY EACH DISCIPLINE

a. There is to be periodic (at least every 6 months) clinical reviews (Optometry reviews Optometry and Ophthalmology reviews Ophthalmology) of patients diagnosed with ARMD, diabetic retinopathy, and glaucoma based on current, nationally-accepted standards, which are incorporated into the ongoing review of each practitioner's professional practice and used by the respective Section or Service Chiefs of Optometry and Ophthalmology and the Executive Committee of the Medical Staff for initial privileging and re-privileging decisions.

b. The periodic Ongoing Professional Practice Evaluation disease specific evidence-based review needs to include:

(1) For ARMD, there should be evidence of patient education on the risks/benefits of Age-Related Eye Disease Study (AREDS) recommendations for preventing disease progression based upon the severity and type of macular degeneration, as indicated.

(2) For diabetic retinopathy, there needs to be 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 National Teleretinal Imaging Quality Assurance Program that reviews ongoing eye care provider (optometrist or ophthalmologist) competence.*

(3) For glaucoma, there needs to be evidence of annual optic nerve head evaluation, intraocular pressure measurement, and visual fields examination.

c. Six randomly selected charts of patients seen by Ophthalmology with ARMD, diabetic retinopathy, and glaucoma are reviewed by the Ophthalmology section and six randomly selected charts of patients seen by Optometry are reviewed by Optometry. ***NOTE:*** *Facilities with a single eye care provider (optometrist or ophthalmologist) should make arrangements with the respective optometry or ophthalmology VISN leads or a VA medical facility with optometry or ophthalmology eye care providers to conduct the review, as appropriate.*

8. JOINT COLLABORATION OF CARE REVIEW

a. Quarterly Collaboration of Care reviews are to be done jointly by Ophthalmology and Optometry of patients diagnosed with ARMD, diabetic retinopathy, and glaucoma. The reviews should be done to discuss the timely and seamless provision of care according to the Care Collaboration Agreement between Optometry and Ophthalmology.

b. The purpose of this joint Collaboration of Care review is to review the care of the selected patient charts in the context of improving patient care. This two-way discussion should occur in the collaborative spirit of informing, educating, and contributing to the eye care provided to the patient based upon the complementary strengths that Ophthalmology and Optometry bring to the table. Through this non-punitive process patient care is improved and all involved can benefit from the discussion. This Collaboration of Care review is a Quality Improvement activity, and its confidentiality is covered by Title 38 United States Code (U.S.C.) 5705. As needed, time needs to be provided at the Collaboration of Care Reviews to discuss and improve systems of care.

c. **Medical-Surgical Collaboration Review.** There should be periodic (at least quarterly) reviews done jointly by ophthalmology and optometry of up to six randomly-selected patients diagnosed with ARMD, diabetic retinopathy, and glaucoma. The criteria for VA medical facility review should be based upon the Care Collaboration Agreements for referral from Optometry to Ophthalmology. The review needs to cover the referral for care process.

9. EDUCATION OF PRIMARY CARE PROVIDERS. The Chief of Staff. or designee, is responsible for the education of Primary Care Providers regarding ARMD, diabetic retinopathy and glaucoma at each facility based on guidance provided by National Directors of Optometry and Ophthalmology.

Chief, Optometry Section or Service_____ Date_____

Chief, Ophthalmology Section or Service_____ Date_____

Chief of Staff _____ Date_____

SAMPLE OF A
CARE COLLABORATION AGREEMENT
BETWEEN OPTOMETRY AND OPHTHALMOLOGY AND PRIMARY CARE

The following is a sample Care Collaboration Agreement between Optometry and Ophthalmology (the Eye Care Specialists) and Primary Care Medicine (the Requesting Provider) which is intended to provide a framework for the consultation of patients for eye care.

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.

(2) Sudden shade in vision or flashes or floaters.

(3) Sudden onset of diplopia.

(4) Painful red eye in a contact lens wearer.

(5) Red eye with significant visual symptoms or significant pain.

***NOTE**: Patients with Diabetes may meet criteria for the Teleretinal Imaging Screening Program (see subpar. 11f) and not require referral to the eye clinic for examination. Consults to both should not be placed.*

b. **Other Conditions.** Other conditions that warrant Eye Care Specialist (Optometrist or Ophthalmologist) consultation include, but are not limited to:

(1) Cataracts;

(2) Systemic disease with ocular manifestations;

(3) Age-related macular degeneration;

(4) Uncorrected refractive error;

(5) Presumed visual impairment;

(6) Systemic medications with ocular toxicity;

(7) Lid disorders;

(8) Eye motility disorders; or

(9) 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 1st Trimester
With Retinopathy	Every 1 year**
No Retinopathy	Every 2 years** *

*Patients may meet criteria to be screened in Teleretinal Imaging Screening Program as opposed to an eye examination (see subparagraph 11f for information about the Teleretinal Imaging Screening Program, and subparagraph 19a(2) ocular funduscopic examination recommendations for diabetic patients from the VA-DOD Diabetes Clinical Practice Guidelines that may be viewed at: http://www.healthquality.va.gov/).
**More frequently if indicated by Provider.

2. ORDERING CONSULTS

a. Primary Care Providers and other potential Requesting Providers must utilize the electronic consultation package in the Computerized Patient Record System (CPRS) 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.; and

(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 on-call eye care specialists after hours.

(3) In-Patient 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 Clinic) or on-call Eye Care Specialist (Optometrist or Ophthalmologist) 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. These are purely guidelines.*

The most important criteria for eye examinations remain symptoms and risks, for without these, there is no hard evidence for timelines for comprehensive eye examinations.

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

* These are recommendations and are not to be considered mandatory
**More frequently if indicated by Provider

c. **Patients with Higher Risk Factors for Glaucoma**

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

These are recommendations and are not to be considered mandatory.

3. DEFINITIONS

a. **Optometrist.** An Optometrist provides primary eye care, which includes but is not limited to diagnosis, treatment, and management of Diabetic Retinopathy, Glaucoma, Macular Degeneration, and other eye diseases. They provide refractions for eyeglasses prescriptions, provide eyeglasses for those that are eligible, contact lenses when medically necessary, and low-vision rehabilitation services.

b. **Ophthalmologist.** An Ophthalmologist provides care for patients with high-risk medical issues and complex conditions. The Ophthalmologist is available for diagnosis, treatment, and management of medical and surgical eye diseases. These treatments include, but are not limited to: Cataract surgery, Diabetic Retinopathy laser therapy, Glaucoma treatment, and Macular Degeneration injections or laser therapy.

c. **Subspecialty Ophthalmology (Cornea, Glaucoma, Oculoplastics, and Retina).** Subspecialty Ophthalmology (Cornea, Glaucoma, Oculoplastics, and Retina) is available at different sites within the Veterans Integrated Services Network (VISN) and patients may be referred to one of these sites, or on occasion to other VA facilities outside the VISN, or to the private sector, when warranted.

4. 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.

5. COMMUNICATION OF QUESTIONS. The CPRS consult package allows for the ongoing addition of comments that automatically flags back to the Requesting Provider and Eye Care Specialist Provider. While this is a convenient and effective means for communicating questions regarding consults, 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. To this end, Requesting Providers and Eye Care Specialist Providers are expected to have accurate and up-to-date contact information readily available to facilitate access by potential consultants.

6. CONSULT COMPLETION

a. Specialist Eye Care Providers (or their proxies) are expected to generate a CPRS consult notation that is linked to the original consult which then automatically views an alert back to the Requesting Provider.

b. Requesting Providers need to be open to receiving additional communication by flagged CPRS addendum, e-mail, phone or pager, as appropriate and available. Requesting Providers need to flag note addenda or consult tracking addenda back to the Eye Care Specialist Provider with follow-up questions on the initial recommendations.

c. Critical or urgent data needs to be relayed by phone, paging the Requesting Provider or the Medical Officer of the Day (MOD), if the clinical situation dictates. It is critically appropriate that Requesting Provider contact information is made available on the consult.

7. CO-MANAGED (DUAL CARE) CARE PATIENTS. VA Primary Care or Requesting Providers, and Eye Care Specialist Providers are frequently asked to act as parallel providers to both General and Specialist physicians in the community as part of the VHA's National Dual

Care policy. Patients are responsible to keep VA appointments and bring all outside records with them to the VA appointments to become part of the VA record.

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

b. At times Primary Care or Requesting Providers need to determine that a patient previously co-managed has failed co-management at which time, by policy, patients must agree to accept all 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. The patient is expected to follow-up with the VA Eye Care Specialist depending on the clinical need.

8. RESTRICTIONS ON CONSULTATIONS

a. All patients, including urgent care consults, must be vested with a 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. However, these patients need to be encouraged to be vested with primary care within VA.

b. Some Eye Care services are not available within VA, such as refractive laser therapy, 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.

9. INTERFACILITY OR INTRA-VISN CARE. When a Specialist determines that care for a unique non-emergent problem must occur outside the ___(provide facility name)___ VA, 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.

10. FEE BASIS

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

11. 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 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

SAMPLE OF A LOW VISION REHABILITATION CARE COLLABORATION AGREEMENT BETWEEN OPTOMETRY AND OPHTHALMOLOGY

The following is a sample of a Low Vision Rehabilitation Care Collaboration Agreement between **Optometry and Ophthalmology** to facilitate appropriate and timely referral and/or consultation of patients for delivery of seamless eye care services consistent with the current, nationally-accepted standards of both eye care professions (Optometry and Ophthalmology). ***NOTE:*** *This Care Collaboration 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 the ability of patients to have access to care provided by optometry or ophthalmology within their granted clinical privileges.*

1. PURPOSE. These Low Vision Rehabilitation Care Collaboration Agreements are intended to:

a. Meet the goals specified in the Visual Impairment Prevention for Veteran Patients (see App. C).

b. Facilitate appropriate and timely referral of patients between Ophthalmology and Optometry for Low Vision Rehabilitation Care of appropriate patients with age-related macular degeneration (ARMD), diabetic retinopathy, and glaucoma conditions with discharge back from Optometry to Ophthalmology for continuing care, as appropriate.

c. Ensure that optimal eye care is provided to all Veterans through a collaborative approach to diagnosis, treatment, and management of eye care by both Optometry and Ophthalmology.

2. CARE COLLABORATION FROM OPHTHALMOLOGY TO OPTOMETRY AND OPTOMETRY TO OPHTHALMOLOGY

a. **Prior to Consult Request.** A note documented by Optometry or Ophthalmology is to be available for Ophthalmology or Optometry to view in the Computerized Patient Record System (CPRS).

b. **Results of Consult Request.** Ophthalmology or Optometry is to complete the consult through a CPRS progress note.

c. **Referral Back to Original Referring Section or Service.** For patients consulted between ophthalmology and optometry for low-vision care, the patient may be sent back to the referring provider for continuing care, when it is appropriate to do so, if, or when, the consulted provider cannot provide additional care beyond that of the referring provider.

3. LOW-VISION REHABILITATION CARE. For low-vision rehabilitation care, a patient consult or referral is required to Optometry at sites where Ophthalmology is not able to provide this care. VA eye patients seen by either the Optometry Section or Service or the

Ophthalmology Section who meet requirements of "low vision" or "legal blindness" need to be appropriately referred for low-vision care. In those 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 needs to follow the guidelines established for the BRS continuum of care. Legally-blind patients, as well as those with excess disability, are to be referred to, and registered with, a Visual Impairment Services Team (VIST) Coordinator for more extensive blindness rehabilitation (see VHA Handbook 1174.03). Patients who are legally blind but retain vision can benefit greatly from a low-vision evaluation and the prescription of low-vision devices while waiting to be seen at a VA BRS inpatient or outpatient blind rehabilitation program.

a. **Definition of Low Vision.** Low vision has:

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

(2) Significant 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.

b. **Definition of Legal Blindness.** Legal Blindness has:

(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.

4. URGENT CONSULT REQUESTS. When a consult request for Low Vision Rehabilitation Care is urgent, Ophthalmology or Optometry are to contact the appropriate low-vision rehabilitation optometrist or ophthalmologist directly to verbally discuss the patient findings and coordinate the plan of action for the patient. If a low-vision rehabilitation optometrist is unavailable to provide this care, the patient needs to be fee-based to a local low-vision rehabilitation optometrist or ophthalmologist, as appropriate.

5. ONGOING PROFESSIONAL PRACTICE EVALUATIONS BY EACH DISCIPLINE

a. There must be periodic (at least every 6 months) clinical reviews (Optometry reviews Optometry, and Ophthalmology reviews Ophthalmology) of patients with low vision and/or legal blindness who are diagnosed with ARMD, diabetic retinopathy, or glaucoma based on current, nationally-accepted standards, which are incorporated into the ongoing review of each practitioner's professional practice and used by the respective Section or Service Chiefs of Optometry and Ophthalmology and the Executive Committee of the Medical Staff for initial privileging and re-privileging decisions.

b. The periodic Ongoing Professional Practice Evaluation disease-specific evidence-based review needs to include:

(1) For ARMD patients, there needs to be evidence of referral for Low Vision Rehabilitation Care, as indicated for those Veterans with Low Vision and/or Legal Blindness.

(2) For diabetic retinopathy patients, there needs to be evidence of referral for Low Vision Rehabilitation Care, as indicated for those Veterans with Low Vision and/or Legal Blindness.

(3) For glaucoma patients, there needs to be evidence of referral for Low Vision Rehabilitation Care, as indicated for those Veterans with Low Vision and/or Legal Blindness.

c. Six randomly-selected charts of patients with low vision and/or legal blindness with ARMD, diabetic retinopathy, or glaucoma seen by the Ophthalmology section are reviewed by the Ophthalmology section and six randomly-selected charts of patients with low vision and/or legal blindness seen by Optometry are reviewed by Optometry. ***NOTE:*** *Facilities with a single eye care provider (optometrist or ophthalmologist) need to make arrangements with the respective optometry or ophthalmology Veterans Integrated Service Network (VISN) leads or a VA medical facility with optometry or ophthalmology eye care providers to conduct the review, as appropriate.*

6. JOINT COLLABORATION OF CARE REVIEW

a. Quarterly Collaboration of Care reviews are to be done jointly by Ophthalmology and Optometry for low vision and/or legal blindness patients diagnosed with ARMD, diabetic retinopathy, and glaucoma. The reviews need to be done in order to discuss the timely and seamless provision of care according to the Low Vision Rehabilitation Care Collaboration Agreement between Optometry and Ophthalmology.

b. The purpose of this joint Collaboration of Care Review is to review the care of the selected patient charts in the context of improving patient care. This two-way discussion needs to occur in the collaborative spirit of informing, educating, and contributing to the eye care provided to the patient, based upon the complementary strengths that Ophthalmology and Optometry bring to the table. Through this non-punitive process patient care is improved and all involved can benefit from the discussion. This Collaboration of Care Review is a Quality Improvement activity, and its confidentiality is covered by Title 38 United States Code (U.S.C.) 5705. As needed, time needs to be provided at the Collaboration of Care Reviews to discuss and improve systems of care.

c. **Rehabilitation-Low Vision Review.** Up to four randomly selected charts (two from patients predominantly seen by Optometry and two from patients predominantly seen by Ophthalmology) of patients with low vision, and one of the preceding three diagnoses need to be reviewed for appropriate referral for low-vision rehabilitation care according to the Care Collaboration Agreement. This review is to be done jointly by optometry and ophthalmology and is to cover the referral of care process. ***NOTE:*** *To accomplish the Rehabilitation and Low Vision Review, Optometrists and Ophthalmologists can use VHA Decision Support Service (DSS) Identifiers 220, 407, 408, 437, 438, and 439 (as appropriate) with International Classification of Diseases Clinical Modification–9th edition (ICD-9-CM) codes 362.0 (diabetic retinopathy),*

362.5 (degeneration of macula and posterior pole), and 365 (glaucoma). To identify low-vision patients in Ophthalmology and Optometry clinics (407 and 408 respectively), the 369 (blindness and low vision) and 368.4 (visual fields defects) ICD-9 codes may also be used in combination with 362.0, 362.5, and 365. An alternative method to identify possible low-vision and legally-blind patients in Ophthalmology clinics would be to review patients scheduled in a Retina Clinic utilizing the previously mentioned ICD-9 codes. In addition, Ophthalmologists and Optometrists are encouraged to work with their local DSS and Business Office representatives to develop and implement 439 DSS 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.

7. EDUCATION OF PRIMARY CARE PROVIDERS. Chief of Staff, or designee, is responsible for education of primary care providers regarding patients with low vision and/or legal blindness from ARMD, diabetic retinopathy, and glaucoma at each facility based on guidance provided by National Directors of Optometry and Ophthalmology.

Chief, Optometry Section or Service_____ Date_____

Chief, Ophthalmology Section or Service_____ Date_____

Chief of Staff _____ Date_____