Residency Manual

Residency in Ocular Disease

Department of Veterans Affairs, VA Southern Nevada Healthcare System
Las Vegas, Nevada

and

Southern California College of Optometry at Mashall B. Ketchum University
Fullerton, California

Revised 2020

Orientation Checklist

Prior to start of residency:

You will be emailed instructions on how to complete the required residency paperwork by the Associate Chief of Staff for Education.

You must return all paperwork to the Associate Chief of Staff for Education by the indicated due date.

Orientation Checklist continued

Prior to start of residency (If available)

_____ SCCO Residency Contract submitted to SCCO

_____ Pre-Employment physical through the VA

_____ Copies of Diploma and Optometry Licenses submitted to Dr. Fujimoto

_____ National Provider Identifier (NPI) number submitted to Dr. Fujimoto

During the first 2 weeks of residency

_____ Attend VA New Employee Orientation Program

_____ Participate in VASNHS Eye Clinic Orientation Program

_____ Participate in SCCO Orientation via telephone conference call

_____ Issuance of VA Identification Badge (PIV Badge)

_____ Issuance of keys to clinic outer door and Omnicell Medication Room

_____ Overview on CPRS Eye Clinic Note templates

_____ Orientation on how to enter a progress note

_____ Orientation on how to review the patient's medical record (i.e. viewing past visits, vital signs, radiology results, laboratory results, remote data)

_____ Orientation on how to respond to consults from another service

_____ Orientation on entering Orders

- _____ Entering medication orders
- _____ Entering lab and radiology orders
- _____ Requesting consultations

Introduction

The staff of the VA Southern Nevada Healthcare System (VASNHS) Eye Clinic would like to welcome you to our program. This manual is intended to be an introduction to the program and a guideline for the policies, procedures, and protocols of the clinic. Residents are responsible for knowing and complying with the contents of this manual. Please familiarize yourself with the material contained within and ask for clarification on any points which you do not understand.

General Information about the VASNHS Eye Clinic

The VA Southern Nevada Healthcare System (formerly the VA Outpatient Clinic and VA Ambulatory Care Center) has had a long-standing academic affiliation with the Southern California College of Optometry (SCCO) dating back to 1982. Due to sustained population growth in southern Nevada and the increasing demand for veteran healthcare, the affiliation between the VASNHS and SCCO has expanded from one intern per rotation (six interns a year) in 1982 to five interns per rotation (twenty interns a year) at present. A secondary affiliation with the Illinois College of Optometry commenced in 2005 with two interns per rotation (eight interns a year); this gives a grand total of twenty-eight optometric interns who rotate through the VASNHS per year.

In addition to the intern program, the VASNHS started a one year residency in Ocular Disease affiliated with SCCO in June 2004 under accreditation pending status from the American Council on Optometric Education (ACOE). In April 2005, The VASNHS received a seven year accreditation status from the ACOE. The VASNHS had one resident for both the 2004-05 academic year and the 2005-06 academic year. In the 2006-07 academic year the VASNHS residency program was temporarily increased to two residents because of difficulty with recruitment of residents at other facilities. A petition for a permanent second residency position was made in 2006, and approved in January 2007. The VASNHS continued with two residents for the academic years 2007-10. In the 2010-11 academic year the VASNHS residency program was temporarily increased to three residents because of difficulty with recruitment of a fellowship program at another facility. After petitioning for a third permanent residency position in October 2010, the VASNHS received approval for it in January 2011. The VASNHS continued with three residents for the academic year 2012-13. After petitioning for a fourth permanent residency position in November 2012, the VASNHS received approval for it for the academic year 2013 and beyond.

At present, the VASNHS Eye Clinic clinical staff is comprised of eleven full-time optometrists, one of whom is residency trained in low vision rehabilitation, and four optometric residents. The low vision rehabilitation trained optometrist was hired to staff the VASNHS Intermediate Low Vision Clinic, which began operations in February 2009.

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General Information

I. Mission Statement, Goals and Objectives

A. Mission Statement:

The mission of this program is to provide optimal eye care in an advanced clinical and educational setting. The resident will be working as part of an interdisciplinary team and their ability to diagnose and manage ocular disease and the ophthalmic manifestation of systemic disease will be enhanced. Additionally, educational activities will be performed to promote optometric knowledge and research.

1. Goal 1:
   To strengthen the resident's optometric skills and train the resident in advanced competencies in ocular disease and secondary eye care.

   Objectives:
   a. The resident will participate in numerous direct patient encounters in primary and secondary eye care, participate in grand rounds conducted by a vitreoretinal specialist, and serve as a preceptor to interns as they examine patients.
   b. The resident will be trained in advanced competencies.
   c. The resident will observe ophthalmic surgical procedures.

2. Goal 2:
   To expand the resident's knowledge base with emphasis on the diagnosis and management of ocular disease, ophthalmic manifestations of systemic disease, and ophthalmic side effects of systemic medications.

   Objectives:
   a. The resident will complete a thorough and accurate record of examination.
   b. The resident will directly examine patients with conditions such as advanced glaucoma, macular degeneration, cerebral vascular accident, corneal ulcers, corneal abrasions, diabetic eye disease, as well as other manifestations of ocular disease.
   c. The resident will review a variety of ophthalmic and healthcare literature.

3. Goal 3:
   To have the resident participate in outpatient care in an interdisciplinary healthcare environment. In addition, to give the resident experience in treating patients with complex systemic diseases and inter-related ophthalmic and systemic conditions.

   Objectives:
   a. The resident will be part of an interdisciplinary team.
   b. The resident will utilize clinical and support services in an appropriate manner..

4. Goal 4:

Develop the resident's contribution to optometric education through serving as a preceptor to fourth year optometric interns.

Objectives:
a. The resident will be guided in the process of lecture presentation.
b. The resident will gain experience to become a clinical instructor.
c. The resident will be guided in the process of manuscript publication.

II. Activities of the Resident

A. To meet the objective of providing direct patient care activities the resident is to:

1. Provide direct primary and secondary optometric care to outpatients at the VASNHS Eye Clinic.
2. Complete a minimum of 1100 direct patient encounters during the residency year.

B. To meet the objective of being trained in advanced techniques the resident is to:

1. Participate at least quarterly in the clinical workshops on scleral indentation, four-mirror gonioscopy, venipuncture, fundus photography, dilation and irrigation of the lacrimal drainage system, and pressure patching.
2. Teach the advanced techniques learned in the first quarter of clinical workshops to the interns participating in the following intern workshops during the residency year.

C. To meet the objective of observation of ophthalmic surgery the resident is to:

1. Observe surgical procedures performed by a general ophthalmologist or view them on video.

D. To meet the objective of completing a thorough and accurate record of examination the resident is to:

1. Utilize a template in CPRS to enter patient examination records.
2. Review assessments and plans for each patient with an attending optometrist and have each chart reviewed and cosigned by and attending optometrist.

E. To meet the objective of diagnosing and managing a variety of interesting cases, the resident is to directly examine a minimum of 1100 patients.

F. To meet the objective of reviewing a variety of ophthalmic and healthcare literature the resident is to:

1. The residents participate in a monthly clinical case conference, which is a presentation of a case that the resident has seen in the previous month. As a part of the clinical case discussion, the resident must research and provide references for his/her discussion.
2. Review journal articles that the attending optometrist suggests and/or provides to the resident.

3. Research literature on various topics as discussed or experienced in the course of patient care.

G. To meet the objective of being a part of an interdisciplinary team the resident is to:

1. Review consultation requests from other clinics and primary care providers for eye care services.
2. Make appropriate referrals to other clinics and primary care providers for patients who require additional services.

H. To meet the objective of utilizing clinical support services the resident is to:

1. Order appropriate lab work to aid in the diagnosis and management of patients.
2. Order appropriate radiology examinations to aid in the diagnosis and management of patients.

I. To meet the objective of completing administrative activities and being subject to quality assurance measures, the resident is to:

1. Fill out the Patient Encounter and Diagnosis Logs, Resident Referral Log, Resident Activity Log, and Resident Reading Log and hand in copies of them to the Academic Affiliate on a quarterly basis.
2. Complete the quarterly Residency Faculty Evaluation, quarterly Residency Program Evaluation, and End-of-the-Year Program Evaluation and hand in copies of them to the Academic Affiliate.
3. Complete a thorough record of Examination into the CPRS system, which is subject to chart review by the Quality Management Section of the VASNHS.
4. Have each entry made by the resident into the patient's medical record reviewed by an attending optometrist and cosigned by said optometrist.

J. To meet the objective of participating in didactic activities the resident is to:

1. Complete the VASNHS Optometric Clinical Conference program.
    a. Clinical conferences are scheduled on the first Friday afternoon of every month starting in August and ending in June. A total of ten conferences will be presented.
2. Complete the VASNHS Residents Case Conference program.
    a. Each resident will present an interesting case from the preceding month to the fellow residents, staff, and optometric interns of the VASNHS Eye Clinic. The Resident Case Conference is scheduled for the first Friday afternoon of every month starting in August and ending in June. A total of ten Resident Case Conferences will be held.
3. Attend the American Academy of Optometry Annual Meeting (strongly encouraged, not required).
4. Attend Council on Optometric Practitioner Education (COPE) approved continuing education programs provided by local ophthalmologists (encouraged, not required).

K. To meet the objective of lecture presentation, the resident is to:

1. Complete a lecture to the fellow residents, staff, and optometric interns of the VASNHS Eye Clinic. The recommended topic is the subject of the residency thesis paper. Other topics may be considered with approval of the Program Coordinator.
2. Complete case presentations to the fellow residents, staff, and optometric interns of the VASNHS Eye Clinic at the Residents Case Conference program.

L. To meet the objective of gaining experience as a clinical instructor the resident is to:

1. Act as a preceptor to optometric interns during the last month of the academic year while under the supervision of an attending optometrist.
2. Instruct interns in the clinical workshops during the last three quarters of the residency.

M. To meet the objective of manuscript publication the resident is to:
1. Prepare a manuscript of publishable quality by the end of the residency with the aid of the attending optometrists. A manuscript committee made up of at least two attending optometrists will provide assistance with topic selection and design of concept, literature search, and drafting or revision. Each manuscript committee member must give final approval prior to submission of the manuscript. All committee members will be granted authorship and the resident will retain primary authorship of the manuscript.
2. Base the manuscript on a case report, case series, or research project approved by the Program Coordinator.

III. Structure of the VA Southern Nevada Healthcare System

The current operational of the locations of the VASNHS are noted below.

-VA Medical Center
-Education Learning Center
-Energy Plant
-Healthcare for Homeless Veterans
-Mike O'Callaghan Federal Hospital
-Northeast Primary Care Clinic
-Northwest Primary Care Clinic
-Pahrump Clinic
-Southeast Primary Care Clinic
-Southwest Primary Care Clinic
-Veterans Recovery Center
-Warehouse

A. Optometry Staff at the VA Southern Nevada Healthcare System

1. Geoffrey F. Chiara, O.D.
2. Theresa Chong, O.D.
3. Lane Fujimoto, O.D.
4. Samantha Kamo, O.D.
5. Brian S. Kawasaki, O.D., M.B.A.
6. Mark Marquez, O.D.
7. Michelle E. Matson, O.D.

8. David J. Mietzner, O.D., M.S.
9. Jennifer L. Monarrez, O.D.
10. Nina T. Tran, O.D.
11. Paul A. Vejabul, O.D.

B. Additional Eye Clinic Staff and Intermediate Low Vision Staff at the VA Southern Nevada Healthcare System include one Visually Impaired Services Team coordinator, one Low Vision Therapist, one Blind Rehabilitation Outpatient Specialist, four Medical Support Assistants, one Administrative Officer, one Program Support Assistant, and four Health Technicians.

IV. Program Curriculum

The resident will be involved in the direct eye care of at least 1100 patients at the Eye Clinic of the VA Southern Nevada Healthcare System. Approximately 75% of the resident's time will be spent in direct patient care; other activities include providing clinical preceptorship of a fourth year optometry interns (approximately 5% of the resident's time), administrative duties in quality management (approximately 5% of the resident's time), didactic (approximately 7.5% of the resident's time), and scholarly activities (approximately 7.5% of the resident's time). The resident will perform full comprehensive primary and secondary eye examinations, consult with various health care practitioners and ophthalmologists in co-management of systemic conditions and ocular manifestations, prescribe oral and topical therapeutic medications, perform fluorescein angiography, and order laboratory and radiology studies as indicated for diagnosis and management. In the final two quarters of the residency, the resident will be exposed to clinical instruction by mentoring interns under the direct supervision of a staff optometrist.

Clinical activities narrative:
The residents will provide comprehensive optometric eye care to an elderly, predominantly male veteran population many of whom have diabetes, hypertension, and hyperlipidemia. This patient population has a high percentage of glaucoma, macular degeneration, and diabetic eye disease. The resident will learn to examine and manage patients who have these and other conditions by utilizing testing such as threshold visual fields, spectral domain optical coherence tomography scans, fluorescein angiography, electrodiagnostics, fundus photography, corneal topography, and b-scan ultrasonography among others. The resident will also see patients who have urgent ocular symptoms and conditions referred from the emergency department. Patients who have experienced loss of vision, eye pain, visual disturbances, diplopia, and trauma are some of the conditions encountered from the emergency department. Examining these walk-in patients gives the residents an opportunity to practice their clinical skills by challenging them to order the appropriate testing, analyze test results, come up with differential diagnoses, choose a working diagnosis, and manage the patient by providing treatment, referrals, and follow up appointments.

Didactic activities narrative:
The program has developed a robust clinical conference series that runs on the first Friday afternoon of each month. The residents will attend each of the monthly clinical conferences where a lecture is presented on an ophthalmic eye care topic. The lectures are presented by the faculty members and visiting lecturers. The visiting lecturers are either residency trained optometrists, ophthalmologists, and subspecialist ophthalmologists.
In addition to being required to attend the clinical conference lecture, each resident is required to present a clinical case to the faculty, student interns, and fellow residents. The

clinical case that each resident presents is on a case that they themself examined. The resident presents their case, provides differential diagnoses, and provides a discussion on the condition that each of the fellow residents listens to. The resident also incorporates a recent journal article into the references for their case presentation and in this manner reads current literature throught the year. Another opportunity for the resident to receive journal articles is through the daily case discussions that each of them has with their attending faculty member. The faculty member will give the resident relevant journal articles to review based on the patient conditions examined.
The program encourages residents to attend the American Academy of Optometry Annual Meeting by providing authorized absence to them so that annual leave does not have to be used. The program also encourages residents to attend COPE approved continuing education that is provided at no charge by local ophthalmologists and local sub-specialist ophthalmologists.

Scholarly activities narrative:
The program enhances scholarly activities by requiring that the resident turn in a manuscript of publishable quality as criteria for completion of the residency. The resident is assisted with the production of the manuscript by one or two of the faculty members. The faculty members assist the resident with topic selection, case management, references for the topic, and editing of the final paper.
The residents also gain experience with lecturing to an audience by providing a monthly clinical case. In producing the clinical case presentation, the resident learns about topic selection, researching the topic, assembling the needed multimedia, time management of a presentation, and speaking in front of an audience. The residents are also encouraged to participate in presentations at schools and colleges of optometry such as the Arizona College of Optometry Residents Day. The residents' participation in the small scale monthly clinical conference culminates into a lecture presented to a few hundred optometrists and optometry students.

Tour of Duty

I. Duration of Residency Program

The residency will be one year in length commencing on July 01 continuous through June 30.

II. Clinic Hours.

A. The VA Southern Nevada Healthcare System Eye Clinic operates on Monday from 7:30 am to 4:00 pm, on Tuesday through Friday from 7:30 am to 6:00 pm, and on Saturday from 8:30 am to 5:00 pm.

B. There are two main weekly work schedules that the resident will be expected to work during the residency year. The resident's work schedule may in some instances vary from these two schedules. The work schedule of the resident will correspond to the attending doctor he or she is working with. The resident is required to remain until all patient care activities are concluded, which may extend beyond the listed hours. The resident does not have on-call duties.

1. Monday through Friday from 7:30 AM to 4:00 PM when working with Dr. Geoffrey Chiara, Dr. Theresa Chong, Dr. Lane Fujimoto, Dr. Brian Kawasaki, Dr. Mark Marquez, Dr. David Mietzner, Dr. Jennifer Monarrez, or Dr. Paul Vejabul.
2. Tuesday through Friday from 9:30 AM to 6:00 PM and Saturday from 8:30 AM to 5:00 PM when working with Dr. Samantha Kamo, Dr. Michelle Matson, or Dr. Nina Tran.

Weekly schedules for each attending doctor (note that the weekly schedules are subject to change without notice):

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
DR. CHIARA	**AM** NONE **PM** REGULAR	**AM-** MEETINGS **PM -** TRAINING	**AM-**REGULAR **PM-**MEETINGS	**AM**- MEETINGS **PM**- REGULAR	**AM**-NONE **PM**- !! ☼♣	OFF
DR. FUJIMOTO	EXAM CLINIC(2)	REGULAR CLINIC	REGULAR CLINIC	**AM**- POST OP **PM**- EXAM CLINIC(2)	**AM-** □ **PM**- !! ►	OFF
DR. VEJABUL	REGULAR CLINIC	**AM**-REGULAR **PM**-*POST OP*	**AM**-REGULAR **PM**-EXAM CLINIC(2)	Teleretinal	Teleretinal **AM-** ☻ 1st wk **PM**- !! ☼	OFF

DR. KAWASAKI	EXAM CLINIC(1)	*DIABETIC RETINAL SCREENING*	**AM**-REGULAR **PM**-POST OP	REGULAR CLINIC	REGULAR CLINIC **Exception: AM:** ☻ 3RD WK **PM**- ‼ ☼ ◊	OFF
DR. MATSON (EXTENDED HOURS)	OFF	EXAM CLINIC(2)	**AM**- POST OP **PM**- REGULAR	REGULAR CLINIC	REGULAR CLINIC **Exception: PM**- ‼ ☼ ◊	EXAM CLINIC(3)
DR. CHONG	REGULAR CLINIC	EXAM CLINIC(1)	LOW VISION	**AM**-REGULAR **PM**-POST OP **Exception: 2-4PM** TBI COMMITTEE-2ND	LOW VISION **Exception: AM-** Θ (1st) **PM**- ‼	OFF
DR. MONARREZ	**AM –**EXAM CLINIC (3) **PM** - REGULAR	**AM**- POST OP **PM**- REGULAR	REGULAR CLINIC **Exceptions: ϕ**	EXAM CLINIC(1)	EXAM CLINIC(1) **Exception: PM**- ‼ ►	OFF
DR. TRAN (EXTENDED HOURS)	OFF	REGULAR CLINIC	**AM-** Regular Clinic **PM-** DRS	**AM**- POST OP **PM**- REGULAR	EXAM CLINIC(2) **Exception: PM**- ‼ ☼	**AM**- EXAM CLNIC(2) **PM**- Teleretinal
DR. MIETZNER	NEW/WI/CV & SRX post TELERETINAL	NEW/WI/CV & SRX post TELERETINAL	NEW/WI/CV & SRX post TELERETINAL	NEW/WI/CV & SRX post TELERETINAL	**AM-**NEW/WI & SRX post TELERETINAL **Exception:** ☻2nd & 4th ALL **PM**- ‼ ☼	OFF
DR. MARQUEZ	DIABETIC RETINAL SCREENING	**AM -**POST OP **PM –** REGULAR	EXAM CLINIC (3)	REGULAR CLINIC	EXAM CLINIC (3) **Exceptions:** ‼ ☼	OFF
DR. KAMO (EXTENDED HOURS)	OFF	**AM** –REGULAR **PM** – POST OP	EXAM CLINIC (1)	**AM –** DRS **PM –** EXAM CLINIC(3)	DIABETIC RETINAL SCREENING **Exceptions:** ‼	REGULAR CLINIC

KEYS FOR REGULAR SCHEDULED CLINICS OR MEETINGS:
ϕ – Research & Development 1st&3rd 12p-2p
‼-PM 1st Fri/Res Conf & Staff Mtg
☼-PM 3rd Fri/Intern Proficiencies
☻-Retina/1st&3rd AM-2nd&4th ALL
Θ-AM 1st Fri/Fluorescein Ang
►-PM 3RD Fri/Electro DX Clinic
♣-PM 1st Fri/Admin Staff Mtg
◊- PM 4th Fri/Intern Case Report
□-AM 3rd Fri/ Fluorescein Ang

III. Holidays, annual leave (vacation leave), and sick leave.

A. The following days are federal holidays with paid time off for the resident(s):

1. Independence Day (July)
2. Labor Day (September)
3. Columbus Day (October)
4. Veterans Day (November)
5. Thanksgiving Day (November)
6. Christmas Day (December)
7. New Year's Day (January)
8. Martin Luther King, Jr. Day (January)
9. Presidents' Day (February)
10. Memorial Day (May)

B. Residents accrue 4 hours of annual leave and 4 hours of sick leave time per 2 week pay period.

1. Requests for annual leave must be submitted prior to the time of leave.
2. Annual leave may not be advanced. You may only use annual leave that you have accrued.
3. Due to patient scheduling considerations, requests for annual leave must be submitted at least 90 days prior to the date(s) requested.
4. Annual leave will not be granted during the last 2 weeks of residency, with the exception of an emergency.
5. The VA will reimburse residents after the residency year is completed for any unused annual leave.
6. Sick leave is not to be used for "moonlighting" purposes.
7. The program coordinator must be contacted as soon as possible to report sick leave use.
8. An electronic request in VATAS for annual leave or sick leave must be submitted in the computer system.

IV. Schedule for the resident(s).

A. The resident will usually work one of the two following schedules, which will coincide with the attending doctor to whom he or she is assigned.

1. Monday through Friday from 7:30 AM to 4:00 PM.

2. Tuesday through Friday from 9:30 AM to 6:00 PM, and Saturday from 8:30 AM to 5:00 PM.

Afternoon Discussions may be held during the last half hour of the day. The resident will present interesting cases from the day's encounters to the attending doctor. From this case presentation, an impromptu discussion may take place regarding the diagnosis, management and treatment of the patient; or the resident may be assigned a topic to review and present at a later day; or the resident may be given a relevant article to read.

B. Clinical conferences and resident case conferences.

1. A total of ten clinical conferences will be held on the first Friday afternoon of each month starting in August and ending the following June. Clinical conferences are presented by the residency faculty and guest lecturers on various pertinent topics which include, but are not limited to glaucoma, ocular inflammation, ocular vascular disease, ultrasonography, and macular degeneration.

2. A total of ten resident case conferences will be held on the first Friday afternoon of each month starting in August and ending the following June. Resident cases are presented by the residents on patients who were seen in the previous month. The residents incorporate a recent journal article as a reference for their case. The cases are presented to their fellow residents, optometric interns, and residency faculty.

C. Quality management activities are conducted daily between the resident and faculty member working with the resident. Faculty members review all of the residents' charts.

V. Clinical Research and Scholarly Activity

A. The resident is required to complete a thesis paper of publishable quality in a peer-reviewed journal. Early topic selection is highly encouraged. Due dates for topic selection, abstract, and rough draft are published in the Southern California College of Optometry Residency Manual.

B. Attendance at the American Academy of Optometry annual meeting (recommended, but not required).

C. The resident is to read articles provided by attending doctors.

D. The resident is to research literature on various topics that arise during afternoon discussions, and as assigned by attending doctors.

VI. Optometric Didactic Activity and Clinical Education

A. The resident is to complete the clinical conferences program and residents' case conferences.

B. Attendance at COPE approved continuing education courses during the residency year (recommended, but not required).

C. The resident is to gain proficiency in advanced procedures, including, but not limited to scleral indentation, fluorescein angiography, dilation and irrigation, venipuncture, fundus photography, and four mirror gonioscopy through a minimum of quarterly attendance at a clinical workshop.

Program Policies

I. Compensation and Benefits (Does not apply to WOC Residents)

A. The annual residency stipend is determined by VHA Headquarters. There are no stipulations regarding productivity.

B. Optional healthcare insurance coverage is offered to the resident; biweekly premiums will be deducted if the resident elects to enroll in such insurance. Information on healthcare insurance will be provided by the Human Resources Management Service during orientation.

C. Each resident accrues 4 hours of annual leave and 4 hours of sick leave per two week pay period.

D. Authorized absence may be granted for attendance at a professional continuing education conference such as the American Academy of Optometry or American Optometric Association annual meetings at the discretion of the Chief of Optometry Section. No travel or tuition stipend is granted.

E. A resident who has taken a leave of absence for personal or medical reasons must be remediated for an amount of time equivalent to the duration of the absence.

F. Residents are paid every two weeks via Direct Deposit. Pay is deposited by the end of Friday for the previous two week pay period.

II. Professional Liability

A. Optometry residents are provided with liability coverage for activities within the scope of the Optometric Residency Training Program under provisions of the Federal Tort Claims Act. Liability coverage is limited to VA-related patient care only.

B. The resident must seek liability/malpractice insurance, at his or her own expense, for any external clinical settings in which the resident participates.

III. Requirements for residency completion and awarding of certificate.

A. Patient care and curriculum criteria must be met.

B. Reporting requirements, to include, but not necessarily limited to, Patient Encounter and Diagnosis Log, Faculty Evaluation, Resident Referral Log, Resident Activity Log, Resident Reading Log, and Final Evaluation of Residency Program must be met.

C. Final version of the resident thesis paper must be approved.

D. All multimedia and/or library materials on loan to the resident must be returned.

E. Each resident must obtain a license to practice optometry 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.

IV. Counseling, remediation, and dismissal of the resident.

A. Counseling

During the residency year, a resident may seek counseling for various personal or professional matters that may affect the performance in carrying out patient care or other residency activities from the Residency Coordinator, other Faculty Mentors, or the Assistant Dean of Residencies if he/she sees fit. A resident may elect to seek counsel that is provided at the residency program site (if available) or an outside, independent provider. If the matter at hand is directly linked to the duties as a resident, the Residency Coordinator and/or Assistant Dean of Residencies should counsel the resident as soon as the issue arises and continue assisting the resident on a planned weekly program (or some other amenable schedule) until resolution is met. MBKU does provide personal counseling services if the resident wishes to utilize this resource. The Director of University Student Counseling Services coordinates resources for students and residents to support issues related to social-emotional well-being. The Director is available for personal counseling for all registered students and residents at MBKU. The Director is on campus on a part-time flexible schedule throughout the week and arrangements can be made for a phone consult. The Director is a licensed clinical psychologist who specializes in student and resident support with considerable experience dealing with test/performance anxiety, school – life balance, stress, relationships, family dynamics and depression. Additionally, MBKU has contracted with AETNA for a Student Assistance Program (SAP). The service is available 24/7 by either phone or online at no cost to our students. There are self-help tools and resources on the website.

Some of the issues covered by the resources and information include:

Academic stress and pressure
Personal relationships
Life coaching
Substance abuse and other addictions
Finances like credit card debt
Depression, grief and general mental health
Body image and eating disorders
Child care services
Divorce, custody, probation and other legal matters

All conversations are confidential and staffed by qualified professionals, including psychologists, family therapists and substance abuse counselors. No reporting of any kind will be sent to the University.

This information on the SAP is accessible on the Portal or at with the Residency Department at MBKU.

B. Remediation

Depending on the matter that needs to be remediated, the resident, the Residency Coordinator, and the Assistant Dean of Residencies should work in concert to develop a remedial program that is tailored to the specific deficiency(ies). At the same time, the remediation must satisfy the residency program's goals and learning objectives and those terms stated in the contract. A reasonable remedial program will be designed to advocate the successful completion by the resident of the residency program. The remediation program should not exceed beyond 12 month equivalency of the residency program year unless the resident request more time.

C. Dismissal

A resident may be dismissed prior to the expiration of any contractual term for adequate cause. Adequate cause is defined as one or more the following: misconduct, unprofessional conduct, sexual harassment, incompetence, failure or refusal to perform the moral or reasonable duties of the position; dishonesty; conviction of a felony or conviction of any misdemeanor involving moral turpitude, financial exigency, programs of discontinuance, or medical reasons. Adequate cause for dismissal should be related directly and substantially to the fitness and effectiveness of the resident to carry out the duties of a resident as written in the terms of the contract.

V. Grievance Procedures:

A. Receiving a Resident Complaint

A resident with assignment-related problems or concerns related to the residency program is encouraged to openly discuss such matters and seek assistance with the Residency Coordinator and/or the Assistant Dean of Residencies as soon as possible. The resident may lodge an informal or formal complaint of another resident, an intern, faculty preceptor, ancillary employee, or patient. An informal or formal complaint can also be filed against the resident by the parties listed above. The Residency Coordinator is to document the encounter and the content of the discussion. The Assistant Dean of Residencies should also be contacted in a timely manner. Residents with a grievance are to seek assistance from the Program Coordinator.

B. Resolving the Resident Complaint

If the resident is still unable to satisfactorily resolve the matter after the encounter, a meeting with the Assistant Dean of Residencies should be arranged to discuss the matter further. The Assistant Dean of Residencies will investigate the resident's concerns and provide a response as soon as reasonably possible. Should the resident seek to pursue the matter further, a request can be made to meet with the President of the University. Any decision reached by the President of the University or designated representative will be considered final and binding on all parties. Every effort will be made to provide the resident an opportunity to raise questions or concerns in confidence and without fear of reprisal or recrimination. The University will make every effort to investigate and settle a resident's grievance in a fair and equitable manner.

C. Adjudicating Resident Complaint

If a resident decides to seek legal advice after final judgment has been rendered by the President of the University, he/she may elect to request for counsel on his/her own accord and at his/her own expense. The University (President, Dean of Optometry, Assistant Dean of Residencies and their representatives) are open to engaging in open dialogue to adequately and promptly settle any unresolved issues.

D. Due Process

Residents with assignment-related problems or concerns are encouraged to seek assistance from the Residency Program Coordinator at their site. If the resident is still unable to satisfactorily resolve these issues after this discussion, a meeting with the Assistant Dean of Residencies should be arranged to discuss the questions or

problems further. The Assistant Dean of Residencies will investigate the resident's concerns and provide a response as soon as reasonably possible. Should the resident seek to pursue the matter further, a request can then be made to meet with the President. Any decision reached by the President or designated representative will be considered final and binding on all parties.

Every effort will be made to provide the resident an opportunity to raise questions or concerns in confidence and without fear of reprisal or recrimination. The University will make every effort to investigate and settle a resident's grievance in a fair and equitable manner.

It is the policy of Marshall B. Ketchum University that every resident shall have the right of due process.

Both the grievant(s) and the student(s) subject to the grievance have the right to confidentially discuss the matter at hand with the Residency Coordinator and/or the Assistant Dean of Residencies.

Due process for grievances:

1. For purposes of this policy, a grievance is a complaint arising from an alleged arbitrary,capricious, or malicious act directed against a current resident by another current resident, student extern, faculty member, administrator, or other employee at the program site.

1.1 It is the responsibility of the Assistant Dean of Residencies to determine if a formal hearing before a panel is warranted to resolve the grievance.

1.2 For the purposes of this policy, a fair hearing means that the grievant(s) can present his/her case without fear of reprisal, and that the subject to the grievance has the right to know the evidence presented against him/her.

2. The resident registering a grievance should first discuss the complaint informally with the Residency Coordinator and/or the Assistant Dean of Residencies. If the complaint concerns a specific incident, it should be reported and discussed within five working days of the incident.

2.1 The Residency Coordinator and/or the Assistant Dean of Residencies may either resolve the complaint informally or recommend that the grievant initiate the grievance procedure in accordance with paragraph 3 of this policy.

2.2 If the complaint involves the Residency Coordinator then the resident may seek informal resolution from the Assistant Dean of Residencies.

3. If the Assistant Dean of Residencies finds grounds for the complaint, but cannot resolve itinformally, then the grievant has the right to initiate formal grievance proceedings. If the matter concerns a specific incident, the formal procedure must be initiated by the resident within ten (10) working days of the incident or within ten (10) working days of being notified by the Assistant Dean of Residencies that the matter cannot be resolved informally. The grievant initiates the formal procedure by submitting to the Assistant Dean of Residencies a signed and dated written request for a hearing of the grievance together with any supporting documentation and the names of any appropriate witnesses.

4. Upon receipt of the grievant's formal request, the Assistant Dean of Residencies will investigate the matter with all concerned parties. The Assistant Dean of Residencies will also ask the subject to the grievance for the names of any appropriate witnesses. After meeting with both parties and their respective witnesses and reviewing all of the evidence, the Assistant Dean of Residencies will either resolve the issue or determine if a panel hearing is warranted. The grievant(s) and any student(s) subject to the grievance are expected to exhibit professional respect and courtesies to the others, refrain from making any false statements, false accusations, or exhibiting

inappropriate or unprofessional conduct during the grievance process.
5. The Assistant Dean of Residencies will appoint an appropriate panel for the hearing. The hearing panel will be composed of up to five (5) representatives from both members from the program site and from MBKU.
6. The Assistant Dean of Residencies will appoint a chairperson to oversee the hearing. The chairperson will be charged with keeping the minutes of the hearing or assign the task to another panel member. No other recordings will be allowed during the hearing. To preserveconfidentiality, all parties must be approved by the Assistant Dean of Residencies in order toattend.
6.1 The chairperson will moderate the questions of the panel members, keep the hearing on topic, enforce time limitations to presenters if necessary, and make every effort to bring relevant facts to light.
6.2 The grievant(s) and any subject to the grievance have the right to be in attendance throughout the hearing and to present supporting evidence and/or witnesses. If the chairperson were to determine that due to the nature of the grievance it is counterproductive to have both parties in the room at the same time, the chair can arrange that the panel will hear each party's testimony separately.
6.3 The Assistant Dean of Residencies may preserve the confidentiality of any information or names of parties who register complaints. However, the subject to the grievance may be presented with the full evidence that is presented to the hearing panel.
6.4 The panel chairperson may recess the hearing, specifying a time certain to reconvene, when such recess is necessary for the obtaining of additional information or otherwise for the satisfactory conclusion of the hearing.
6.5 The grievant(s) and the subject to the grievance, with prior approval by the Assistant Dean of Residencies, may have legal representation present during the hearing for advisory purposes only. Legal representatives will not be allowed to direct questions or statements toward the panel or any other parties in attendance, make arguments, nor introduce any evidence during the hearing. Legal representatives must direct all communications to the University's legal counsel.
6.6 Upon completion of all questioning and presentations, the hearing panel will meet in closed session and make its recommendations based upon the evidence at hand. The recommendations of the panel will be communicated in writing to the Assistant Dean of Residencies by the panel chairperson.
6.7 The results of the hearing, and any further recourse available to the resident(s), will becommunicated in writing to the grievant(s) and those subject to the grievance by the Assistant Dean of Residencies within a reasonable time following the hearing.
7. If the results of the hearing are conclusive, and the recommendations of the hearing panel are inaccordance with current policy, then the panel's recommendations will stand and the partiesinvolved will have no further recourse except as provided under APPEALS, below. If the results arenot conclusive, or if the recommendations of the hearing panel are not consistent with policy, the Assistant Dean of Residencies will refer the matter to the President of the University for final resolution.
8. The results of all hearings are automatically subject to administrative review. The President of the University may accept, modify, or refer for further reconsideration the recommendations of the hearing panel, as appropriate to the best interests of all concerned.

Appeals
9. A current or former resident with sufficient grounds may appeal an action by the University and may be granted a hearing in accordance with this policy. Appealable

actions include those resulting from a hearing panel convened under this policy.
9.1. For purposes of this policy, evidence of any of the following constitutes grounds for an appeal:
9.1.1. The action against the student was arbitrary, capricious, or malicious.
9.1.2. The action was not provided for in published policies of the University, or the University's policies were otherwise not properly applied.
9.1.3. There is additional relevant information which was not considered in the original action.
9.1.4. The resident's rights as defined by this policy, were abridged.
9.2 The resdient's dissatisfaction with the University's decision, by itself, does not constitute grounds for an appeal.
9.3 The appeal must be directed in writing to the Assistant Dean of Residencies, stating the grounds for the appeal as described in paragraph 9.1. above. It must be submitted within ten (10) instruction days of the action taken by the University.
9.3.1. The Assistant Dean of Residencies will determine whether there are sufficient grounds for the appeal. If so, the Assistant Dean of Residencies will appoint an appropriate panel to hear the appeal. The panel will not include any of the previous hearing panel in the same case for that student.
9.3.2. The hearing will be conducted in accordance with paragraphs 6.1-6.7, above.
10. The results of all appeal hearings are automatically subject to administrative review. The President of the University may accept, modify, or refer for reconsideration the recommendations of the hearing panel, as appropriate to the best interests of all concerned.

Department Policies

I. Pertinent Medical Center Memoranda (MCM), Standard Operating Procedures (SOP) and VHA Handbook guidelines index for review by each resident. The bold items below are printed in Appendix I for ease of access. The resident is responsible for understanding and complying with all Medical Center Memoranda, which are available on the VA Southern Nevada Healthcare System intranet found at the following website: https://dvagov.sharepoint.com/sites/LASMcmSop/MCMs/default.aspx.

A. MCM 05-02 Drug-Free Workplace Program

B. MCM 138-01 Fire and Life Safety Prevention Management Program

C. MCM 07B-14 Violence in the Workplace Prevention

D. MCM PRV-03 Facsimile (Fax) Policy

E. MCM 136-03 Patient Scheduling

F. MCM 05-28 Dress Code/Staff Image Policy

G. MCM 05-29 Tobacco Use Policy

H. MCM 138-07 Green Environmental Management System (GEMS)

I. MCM 05-17 Employee Conduct

J. MCM 11-15 Informed Consent

K. MCM 136-22 Health Records

L. MCM 138-28 Hazard Communication Program

M. MCM IC-04 Bloodborne Pathogens Exposure Control Plan (ECP)

N. MCM 05-24 Time and Attendance for Full and Part-Time Physicians, Dentists, Optometrists, and Podiatrists

O. MCM IC-01 Infection Prevention and Control Plan

P. MCM IC-03 Testing for Human Immunodeficiency Virus (HIV)

Q. MCM PS-02 Patient Safety Program

R. MCM IC-09 Hand Hygiene

S. MCM 123-01 Laser Safety Program

T. MCM 123-02 Issuance of Optical Aids

U. MCM 119-11 Proper Dispostion of Medication

V. MCM ACOSE-03 Monitoring Resident Supervision

W. MCM ACOSE-02 Supervision of Postgraduate Residents

X. MCM 11-10 Credentialing and Privileging

Y. MCM 11-22 Employee Fitness Center

Z. MCM 11-28 Cardiopulmonary Resuscitation Certification Programs

AA. VHA Directive 1605 Privacy Policy

BB. VHA Handbook 1400.01 Resident Supervision

CC. MCM IT-16-02 Internet/Intranet Policy

II. Patient Process through the Eye Clinic

A. Check in at reception desk.

1. Patients must present VA identification card at the reception desk.

2. Patients arriving early or on time will be checked in by a clerk and placed in a queue to be seen at their appointed time.

3. Patients arriving less than 15 minutes after their appointed time will be checked in and seen in as timely a manner as possible.

4. Per Medical Center Memoranda 136-03 Patient Scheduling, patients who are not available for a scheduled appointment or do not call to cancel an appointment on the same day the appointment occurs may be considered a “no show”. The clerk is to ask the Attending Staff if the patient may be absorbed into the schedule or if rebooking is necessary. Please see MCM 136-03 Patient Scheduling for further details.

B. Clerk prepares a chart with the following items and places them in a chart rack:

1. Blank progress note.

2. Most recent previous eye examination if the patient is an existing patient.

3. Next appointment scheduling sheet.

C. The resident is to call the patient from the waiting room to the examination room and conduct the examination.

D. A patient who is receiving a primary care eye exam or glasses prescription eye exam and is eligible under MCM 123-02 Issuance of Optical Aids will be receiving glasses at VA expense. A patient who is ineligible to receive glasses through the VA will be provided

with a copy of his or her prescription with the words not to be filled at VA expense printed across the top.

E. The resident is to enter the examination results into the Computerized Patient Record System in accordance with MCM 136-22 Health Records.

F. The resident is required to consult with Attending Staff regarding all laboratory testing orders, radiology imaging orders, consultation requests for other clinics, topical or oral therapeutic medication changes, and fluorescein angiography.

G. The resident is required to consult with Attending Staff prior to patient departure from the clinic for relatively complex cases or cases in which the resident is unsure of the diagnosis and/or management.

H. The resident is to consult with Attending Staff on all new patients to the Eye Clinic

I. The resident is to consult with the Attending Staff to schedule the appropriate time frame for the next patient visit. If further follow up in the Eye Clinic is not needed, the patient is discharged back to his or her primary care provider.

III. Patient Care Protocols

A. Primary Care Eye Examination

1. Notes are to be entered in a subjective complaint, objective findings, assessment and plan format.

2. Residents are required to review the patient's medical and optometric records and be familiar with the following:

a. Patient's medical history

b. Systemic medications being taken

c. Ophthalmic history

d. Ophthalmic medications being taken

e. Patient's problem list, labs, vital signs, medication list, radiology reports and other pertinent clinics' notes

f. Patient's drug allergies and adverse drug reaction history

g. If the patient is an established patient, the previous visit's plan and the patient's chief complaint are to be used to determine what procedures are to be preformed

3. The examination sequence may include, but is not limited to the following:

a. Patient history

b. Entering visual acuity with pinhole testing if reduced.

c. Entrance or preliminary testing to include, but not limited to

   i. Gross observation of patient

   ii. Pupil testing

   iii. Versions

   iv. Cover test

   v. Confrontation visual field testing

d. Refractive analysis may include, but is not limited to

   i. Measurement of the patient's habitual optical correction

   ii. Objective measurement of patient's refractive status (e.g. autorefraction data or retinoscopy)

   iii. Subjective measurement of patient's refractive status and measurement of the patient's monocular best, corrected visual acuity.

   iv. Trial frame demonstration of patient's proposed glasses prescription

e. Ocular health assessment

   i. The anterior segment may be evaluated with a biomicroscopy (slit lamp) examination, which is to include, but is not limited to an assessment of the following:

      -Lids, lashes, and adnexa

      -Cornea

      -Conjunctiva

      -Anterior Chamber

      -Angles

      -Iris

      -Lens

      -Anterior Vitreous

   ii. Intraocular pressure reading using contact applanation tonometry

   iii. The posterior segment may be evaluated with binocular indirect ophthalmoscopy,

direct ophthalmoscopy, and fundus lens (contact and non-contact) examination, which is to include, but is not limited to an assessment of the following:

-Cup to disc ratio

-Neural rim tissue of the optic nerve

-Macula
-Posterior pole

-Peripheral retina

-Retinal vasculature

-Vitreous

*Note: All primary care eye examinations are performed with a dilation of the pupils. With extremely rare exceptions, dilation is not performed (e.g. patient has an iris fixed intraocular lens implant or has documented allergy to dilating agents). If a patient is found to have narrow angles with gonioscopy, dilation may be deferred until prophylactic peripheral iridotomy is completed.

4. The resident is required to complete an assessment and plan in the Computerized Patient Record System to the highest level of his or her understanding and to consult with the Attending Staff regarding each case. The assessment should include, but is not limited to the following:

   i. Addressing of the patient's chief complaint

   ii. Justification for best corrected visual acuity below 20/20

   iii. Justification for change in best corrected visual acuity from what was previously documented

5. Medication reconciliation must be performed for each patient.

6. The resident must electronically sign each note after the entry into CPRS is completed.

B. Follow-up visit eye examination

1. Notes are to be entered in a subjective complaint, objective findings, assessment and plan format.

2. The resident is to review the previous visit's assessment and plan to determine what needs to be done for the patient. The resident should also take into account the patient's chief complaint and any significant findings to determine the course of the examination.

3. Minimum procedures for an intraocular pressure check follow up visit:

-Chief complaint

-History to include inquiring about adverse reactions to glaucoma medications, compliance and time of instillation of last drop

-Visual acuity with pinhole testing if necessary

-Pupil testing

-Slit lamp examination

-Intraocular pressure reading

-Pachymetry if indicated

-Heidelberg Spectralis testing if indicated

-Gonioscopy if indicated

-Inquire regarding the need for renewal of Rx for glaucoma medication.

-Demonstration or review of drop instillation technique if indicated.

-Assess how intraocular pressure compares to target value

-Review chart to determine if intraocular pressure control is adequate and what needs to be performed at the next visit.

4. Minimum procedures for a glasses prescription check

-Chief complaint and history

-Visual acuity with pinhole testing if necessary

-Lensometry on habitual glasses

-Pupil testing

-Autorefraction or retinoscopy if indicated

-Subjective refraction and measurement of patient's best, corrected monocular visual acuity

-Trial frame demonstration of patient's proposed glasses prescription

-Slit lamp examination

-Intraocular pressure reading

5. Minimum procedures for other follow up visits

-Review of previous examination notes

-Chief complaint and history

-Visual acuity with pinhole testing if necessary

-Pupil testing

-Slit lamp examination

-Intraocular pressure reading if possible.

C. Glaucoma examination protocol

1. The resident is expected to follow the standard of care in the community for glaucoma suspects and patients. The resident is to review the Clinical Practice Guidelines from the American Optometric Association regarding the care of glaucoma suspects and patients.

2. Items to be considered at every visit for a glaucoma suspect or patient:

   i. Fundus photographs

      -Baseline optic nerve head photographs should be taken

      -If it has been two or more years since the last fundus photos were taken or if a change in cupping, peripapillary atrophy, or NFL is suspected, additional photos should be considered

   ii. Gonioscopy

      -Baseline gonioscopy should be performed

      -If it has been two or more years since the last gonioscopy was performed or if a change which would indicate a repetition of gonioscopy occurs, it should be considered

   iii. Threshold visual field testing

      -Baseline threshold visual field should be performed

      -If it has been one year or more since the last threshold visual field was performed, another test should be considered.

      -Threshold visual field testing should be run two or more times per year if indicated by the patient's level of glaucoma

      -With rare exception, visual field testing is performed through dilated pupils

   iv. Pachymetry testing

v. Nerve fiber layer analysis

vi. Target intraocular pressure may depend on, but is not limited to the following considerations:

-Type of glaucoma

-Stage of the disease (early, intermediate, advanced)

-Pretreatment intraocular pressure

-Stability or progression of the disease

vii. Adverse reactions to ophthalmic medications

viii. Changes in the patient's medical history

ix. Diurnal variation in intraocular pressure

x. If medical therapy is insufficient, refer patient for surgical intervention after consultation with the Attending Staff

3. The resident must consult with the Attending Staff regarding any change to a patient's glaucoma therapy medication regimen

D. Visual field protocols

1. With rare exception (e.g. iris-fixed IOL), threshold visual field and kinetic visual fields are performed through dilated pupils

2. Patients presenting for primary eye care examinations are to have at minimum a confrontation visual field performed

3. Items to be considered to determine if threshold visual field or kinetic visual field testing is to be performed

a. Patient history of glaucoma

b. Patient risk of glaucoma

c. Examination findings necessitating visual field testing (e.g. abnormal intraocular pressure readings, optic atrophy, nerve fiber layer defect, cupping of the optic nerve neural rim tissue)

d. Patient complaint of loss of peripheral vision

e. Patient history of head/brain trauma

f. Patient history of cerebrovascular accident

g. Patient history of retinitis pigmentosa

h. Patient history of taking medications toxic to vision function

E. Macular degeneration examination protocol

1. The resident is expected to follow the standard of care in the community for macular degeneration patients. The resident is to review the Clinical Practice Guidelines from the American Optometric Association regarding the care of macular degeneration patients.

2. Items to be considered at every visit for a macular degeneration patient:

i. Best, corrected visual acuity

ii. Amsler grid testing

-Test should be performed in office

-Inquire about compliance with daily monitoring

-Remind patient that immediate contact with the Eye Clinic is necessary if changes are noted on the amsler grid

iii. Optical Coherence Tomography scan of the macula

iv. Fluorescein angiography if CNVM is suspected

v. Smoking cessation counseling

vi. AREDS formulation recommendation

F. Other patient protocols

1. The resident is expected to follow the standard of care in the community for the particular condition being managed. The resident is expected to review the Clinical Practice Guidelines from the American Optometric Association regarding patient care protocols.

IV. Medication control

A. The medication supply in the Eye Clinic is for diagnostic or therapeutic use in-office only.

1. Medications may not be dispensed to patients

2. Medications may only be dispensed to patients from the pharmacy

B. The date on which a medication is opened in the Eye Clinic must be written on the bottle

C. Outdated, returned, contaminated, or deteriorated drugs must be disposed of according to MCM 119-11 Proper Destruction of Medication.

D. Notify the Program Coordinator or Attending Staff when items from the medication supply are running low

V. Infection control

A. The resident is expected to review MCM IC-01 Infection Prevention and Control Plan

B. The resident is expected to review and implement MCM IC-09 Hand Hygiene

C. All surfaces on the biomicroscope that come into contact with patients is to be cleaned with isopropyl alcohol

D. A new, disposable tonometer tip is to be used on each patient

E. Latex gloves and surgical masks are available

VI. Resident supervision

A. Attending Staff or supervising practitioners are responsible for the care provided to each patient, and they must be familiar with each patient for whom they are responsible. Fulfillment of that responsibility requires personal involvement with each patient and each resident who is participating in the care of that patient.

B. Within the scope of the training program, each resident must fall under the supervision of Attending Staff or supervising practitioners.

C. This Residency Program is designed to encourage and permit each resident to assume increasing levels of responsibility commensurate with his or her progress in experience, skill, knowledge, and judgment

1. The resident will participate in a system of graduated increasing level of responsibility

a. The determination of a resident's ability to provide patient care without an Attending Staff or supervising practitioner present is based on documented evaluation of the resident's clinical experience, judgment, knowledge, and technical skill.

i. The resident will be allowed to perform primary care examination of the eye and adnexa with diagnostic pharmaceutical agents without direct supervision of the Attending Staff. The documentation for allowing this is the requirement that the resident graduate from an ACOE accredited school of optometry, the successful passing of the National Board of Examiners in Optometry Parts I, II, and III, and the obtaining of a license to practice optometry in one of the fifty states of the United States of America or the District of Columbia.

ii. The resident will be permitted to perform diagnostic procedures such as scleral depression, fundus photography, dilation and irrigation of the lacrimal system, and fluorescein angiography after he or she has demonstrated proficiency during the Clinical Workshops program. The

documentation allowing for this will be the entry of completion of the Clinical Workshops program in the resident's activity log.

iii. The resident will be allowed to act in a teaching capacity beginning in the Clinical Workshops program under the supervision of Attending Staff. The resident must successfully complete a session of the Clinical Workshops as a student prior to assuming a role as an instructor. The documentation allowing for this will be the entry of completion of a session of the Clinical Workshops program in the resident's activity log.

iv. The resident will be allowed to act in a teaching capacity as a Staffing Doctor to optometric interns during the final month of the residency program. The resident will work under the supervision of an Attending Staff and all requirements for resident supervision will be followed. The documentation allowing for this will be the completion of 10 months of residency training, receiving of no less than a rating of 2 on each section of the previous three quarters of residency evaluations by Attending Staff or the successful remediation of any section on which the resident received less than a rating of 2.

D. The resident is required to consult with Attending Staff regarding all laboratory testing orders, radiology imaging orders, consultation requests for other clinics, topical or oral therapeutic medication changes, and fluorescein angiography.

E. The resident is required to consult with Attending Staff prior to patient departure from the clinic for relatively complex cases or cases in which the resident is unsure of the diagnosis and/or management.

F. Documentation of all patient encounters must identify the Attending Staff or supervising practioner and indicate the level of involvement.

1. Acceptable supervision documentation

a. Attending Staff or supervising practitioner progress note or other entry into the medical record.

b. Addendum to the resident progress note by the Attending Staff or supervising practitioner

c. Co-signature of the progress note or other medical record entry by the Attending Staff or supervising practitioner. Note that the Attending Staff's co-signature signifies that the Attending Staff has reviewed the resident's note and absent an addendum to the contrary, concurs with the content of the resident's note or entry. Use of CPRS function "Additional Signer" is not acceptable for documenting supervision.

d. Resident documentation of Attending Staff or supervising practitioner supervision. [Includes involvement of the Attending Staff or supervising practitioner (e.g. "I have seen and discussed the patient with my supervising practioner, Dr. 'X' and Dr. 'X' agrees with my assessment and plan", at a minimum, the responsible Attending Staff or supervising practitioner should be identified (e.g. "The attending of record for this patient encounter is Dr. 'X'")]

G. The following guidelines must be followed for the Eye Clinic as an outpatient clinic

1. The Attending Staff or supervising practitioner for the resident must be physically present in the clinic area during clinic hours

2. The Attending Staff or supervising practitioner must be physically present in the clinic. Every patient who is new to the facility must be seen by or discussed with an attending. An independent note, addendum to the resident's note, or resident note description of attending involvement is required for documentation. Co-signature by attending alone is not sufficient documentation.

H. The resident is to read and familiarize himself or herself with VHA Handbook 1400.01 Resident Supervision

VII. Patient records

A. All patient records are considered confidential.

B. Any and all paper work must be placed in an approved secure box for proper disposal. Trash cans or other non-approved receptacles should not be used

C. All patient records are to be entered into the Computerized Patient Record System as per MCM 136-22 Health Records.

D. Visual fields, Color vision test results, Heidelberg Spectralis nerve fiber analysis, and any other testing that cannot be entered manually into the Computerized Patient Record System will be submitted for scanning into the patient record under VISTA imaging

VIII. Dress code-MCM 05-28. Residents are to follow these guidelines.

A. Clinic attire appropriate for physicians is required on all patient care days. This includes Grand Rounds, Clinical Conference, and Clinical Workshops

-Males are required to wear dress shirts, ties, and long pants

-T-shirts, jeans, shorts, caps and ripped clothing are unacceptable for clinic

-If wearing a skirt, the hem length must extend below the knee

-bare feet, open toed shoes, sandals, and athletic shoes are prohibited

-Jewelry, cosmetics, perfume, and other adornments must be professional and conservative

-clinic jackets or lab coats are to be worn at all times during patient care activities

B. Identification badges are to be worn at all times in the Eye Clinic

IX. Telephone and internet use

A. Personal use of telephones and internet is restricted. If necessary, be brief and do so during “off-patient” hours

B. Telephone

1. Telephone directories are listed on the VA Southern Nevada Healthcare System Intranet

2. Local service or toll free numbers are reached by dialing 9 first

3. Long distance numbers are reached by dialing 9 first, then a 1 followed by the area code and number.

C. Internet

1. Users are responsible for adhering to all VA Southern Nevada Healthcare System policies and applicable laws and regulations related to external networks.

2. Internet use is a privilege not a right

3. The following applies to all internet users:

-Internet users must not use the Internet for personal use when they are expected to be performing official duties

-Internet users must not download games from or play games on the Internet or participate in non-VA related chat rooms

-Internet users must not access inappropriate sites (e.g. those displaying pornographic material, those inappropriate in a business environment)

-Internet users must not transmit personal data or government owned data across the Internet

-Internet users must obey all copyright laws

-Internet users must not be harassing, libelous, or disruptive to others or send threatening, racially harassing, or sexually harassing messages while using VA-provided Internet resources

-Internet users must not attempt to exceed access privileges or use VA-provided access or systems as a staging ground or platform to gain unauthorized access to other systems whether federal or private

-Internet users must not make any personal use of the Internet that could cause congestion, delay or disruption of service to any government system or equipment (e.g. continuous data streams, video, sound, or other large file attachments that can degrade the performance of the network), or for any activities that are illegal, inappropriate, or offensive to fellow employees and the public

-Internet users must not participate in unlawful or malicious activities or use objectionable language while using the Internet

-Internet users must not knowingly introduce computer viruses, worms, Trojan horses or other types of malicious computer software to government computers

4. The resident is expected to review and familiarize himself or herself with MCM IT-02 Internet/Intranet Policy

X. Housekeeping

A. Keep all exam rooms neat and clean

B. Cover all instruments with the appropriate covers at the end of the day

D. No food or drinks are allowed in the exam room or any other patient care area

XI. Patient Safety Program

A. The residents are expected to appropriately report adverse patient events, patient safety concerns, and close calls via the patient safety even reporting system.

B. The residents are expected to participate in patient safety programs and initiatives to promote a culture of safety throughout the facility.

C. The resident is expected to familiarize himself/herself with MCM PS-02 Patient Safety Program.

XII. Patient Privacy

A. The resident is expected to access the minimum necessary data for which they are authorized in accordance with all laws and regulations in the performance of their official VA duties.

B. The resident must exercise appropriate precautions and safeguards when discussing Veterans' individually-identifiable information in public areas to prevent an unauthorized disclosure.

C. The resident must protect an individual's rights to privacy and ensuring proper use and disclosure of information. All workforce members will be held accountable for compliance with these policies, procedures, and applicable laws.

D. Appropriately safeguarding printed and electronic individually identifiable information.

E. Reporting complaints and/or violations of privacy policies or procedures to the facility Privacy Officer immediately upon discovery.

F. Obtaining appropriate approval in accordance with Public Affairs policy to speak to the news media. Employees are not authorized to disclose any individually-identifiable information on a patient or Veteran during an interview without the prior signed, written authorization of the patient or Veteran. When an employee is asked to be interviewed by a third party, such as the news media, VA Form 10-3203a, Informed Consent and

Authorization for Third Parties to Produce or Record Statements, Photographs, Digital Images, or Video or Audio Recordings must be completed.

G. Consulting the facility Privacy Officer for guidance in privacy situations not addressed in this document.

Eye Examinations

I. Supplies and Equipment

A. Examination room equipment

-Computer workstation

-Examination chair and stand

-Chart projector

-Near point reading card

-Feinbloom chart

-Slitlamp biomicroscope

-Digital slitlamp photography/observation system

-Goldmann applanation tonometer

-Lensometer

-Phoropter

-Auxiliary cylinder lenses for phoropter

-Binocular indirect ophthalmoscope

-Direct ophthalmoscope

-Streak retinoscope

-Condensing lenses (20D and 90D)

-Gonioscopic lenses (3 mirror and 4 mirror)

-Occluder with pinhole

-Amsler grid

-Trial lenses and frame

-Loose prisms

B. Other available equipment for examinations

-Farnsworth D-15 color vision test

-Ishihara color vision test

-Hand held Jackson cross cylinder

-Epilation forceps

-Punctal dilator and irrigator

-Hertel exophthalmometer

-Alger brush

-Foreign body spud

-Scleral depressor

C. Ancillary equipment

-Humphrey Field Analyzer

-A/B scan ultrasonography unit

-Ultrasound biomicroscope

-Pachymetry/A-scan unit

-Electrodiagnostic testing unit

-Heidelberg Spectralis OCT analyzer

-Autorefractor/Autokeratometer/Topographer unit

-Topcon Imagenet system for fundus photography and fluorescein angiography

-Automated blood pressure/pulse rate/temperature unit

-Digital camera for external photography

-Hand held electrolysis unit

II. Optometry Clinics

A. General optometry clinics

1. Each Attending Staff has general optometry clinics listed as days in which direct patient care is rendered.

2. See the weekly attending schedule under Tour of Duty for schedule details

3. See Patient Care Protocols under Department Policies for details

B. Diabetic Retinal Screening (DRS) clinic

1. Some Attending Staff have Diabetic Retinal Screening clinic

2. See the weekly attending schedule under Tour of Duty for schedule details

3. Protocol

   a. Examinations for eyeglasses are not performed in DRS clinic

   b. Patient history is to include, but is not limited to:

      -How long patient has been diagnosed with DM

      -Status of insulin use

      -Last blood glucose reading taken by the patient

      -Last HbA1c reading

   c. Entrance testing is to include, but is not limited to:

      -Pupil testing

      -Versions

      -Confrontation visual field

   d. Applanation tonometry is to be performed

   e. Ocular health assessment is to include, but is not limited to:
      i. Anterior segment evaluation with a biomicroscopy (slit lamp) with, at minimum, an assessment of the following:

         -Lids, lashes, and adnexa

         -Cornea

         -Conjunctiva

         -Anterior Chamber

         -Angles

         -Iris

         -Lens

         -Anterior vitreous

      ii. Dilated posterior segment evaluation which may include binocular indirect

ophthalmoscopy, direct ophthalmoscopy, and fundus lens examination with, at minimum, an assessment of the following:

-Cup to disc ratio

-Neural rim tissue of the optic nerve

-Macula

-Posterior pole

-Peripheral retina

-Retinal vasculature

-Vitreous

Note: Dilation is not to be done on patients with iris fixed intraocular lens implant.

iii. Significant negative findings are to include, but not limited to:

-No neovascularization of the iris (NVI)

-No neovascularization of the disc (NVD)

-No neovascularization elsewhere (NVE)

-No clinically significant macular edema (CSME)

C. Low vision clinic

1. Dr. Chong has low vision clinic two days per week.

2. Low vision clinic meets all day on Wednesday and Friday (except the first Friday).

3. Protocol

a. Patients are referred to the low vision clinic from general clinic

b. The patient should have received an examination in general clinic with refraction and diagnosis of cause of low vision

c. Patient history is to include, but is not limited to:

-Cause of low vision

-Length of time that the patient has had low vision

-Treatment for cause of low vision received by the patient (e.g. Avastin, Lucentis, visudyne, macugen, laser)

-Previous training in low vision or vision rehabilitation received by the patient

-Patient's goals from low vision training (e.g. reading, spotting signs, writing checks, watching TV, etc.)

-Assessment of patient's needs for non-optical low vision aids (e.g. check writing guides, talking watch, needle threader, filters, etc.)

d. Entrance testing is to include, but is not limited to:

-Pupil testing

-Versions

-Confrontation visual fields

e. Applanation tonometry is to be performed

f. Determination of patient's refractive status if needed

-Retinoscopy

-Autorefraction

-Trial frame refraction

g. Determine patient's response to magnification

h. Record all low vision aids that were demonstrated to the patient and acuity though the aid if applicable

i. Order appropriate aids through CPRS for the patient.

D. Fluorescein Angiography Clinic

1. Fluorescein Angiography Clinic occurs on the first and third Friday mornings of each month.

2. Protocol

a. Patients are referred to the Fluorescein Angiography Clinic from general clinic or diabetic clinic.

b. The patient should have received an examination in general clinic or diabetic clinic, and been screened for contraindications to fluorescein angiography.

c. The patient checks in at the front desk

d. The optometric residents or optometric interns call the patient into the examination room, re-screen the patient for contraindications to fluorescein

angiography, and if none are found proceed with preparing the patient. Visual acuity is to be taken, entrance testing is to be performed, slitlamp examination is to be performed, Goldmann applanation tonometry is to be taken, and dilating drops are to be instilled.

e. The optometric resident then explains the risks and benefits of fluorescein angiography to the patient and obtains informed consent from the patient documented with IMED Consent in CPRS.

f. The optometric residents obtain fundus photographs on the patient. The optometric residents administer fluorescein dye intravenously to the patient under the direct supervision of an Attending Staff or supervising practioner. The optometric residents take fluorescein angiography photographs of the patient.

h. The optometric residents review the fluorescein angiography with an Attending Staff or supervising practioner and the patient is either referred for further care or a follow up appointment is made for monitoring.

E. Eye Exam Clinic

1. Each Attending Staff has Eye Exam Clinic scheduled during the week

2. See the weekly attending schedule under Tour of Duty for schedule details

3. The Eye Exam Clinic was created to meet the director's performance standard for examining patients in a timely manner

4. See protocol for Primary Care Eye Examination under Patient Care Protocols

III. Clinical Practice Guidelines

A. The resident is expected to follow the standard of care in the community for all patient encounters. The resident is to review the Patient Care Protocols under the Department Policies section of the Resident's Manual as well as the Clinical Practice Guidelines from the American Optometric Association regarding examination protocols.

B. Monitoring for ocular toxicity

1. The resident is expected to be familiar with all the medications a patient is taking and to be familiar with all the anticipated ophthalmic side effects

2. In particular, the resident must monitor patients on the following:

a. Anti-tubercular medicines

b. Anti-malarial medicines

c. Phenothiazines

d. Long-term corticosteroid therapy

3. In general, most patients require the following testing:

    a. Threshold visual field (consider macular threshold visual field)

    b. Monocular D-15 color vision test

    c. Amsler grid test

    d. Optical coherence tomography

    e. Multifocal ERG (equipment will be available in June 2012)

4. Significant negative findings should be documented in the patient's record

5. Consider fundus photographs when appropriate

C. Glaucoma patient progress monitors and management protocol

1. In general, glaucoma patients are to be examined every 3-6 months. Patients with more complex cases may be examined more frequently

2. Intraocular pressure is to be measured on every visit

3. Baseline testing should include, but is not limited to, the following:

    a. Pachymetry

    b. Gonioscopy

    c. Heidelberg Spectralis testing

    d. Threshold visual field testing

    e. Fundus photography

5. Repeat of baseline tests should be done at the appropriate intervals as determined by the standard of care in the community

6. The resident must review the patient's history, intraocular pressure findings, threshold visual fields, and fundus photography prior to examining the patient so that trends may be seen

7. The resident is to make a determination as to whether the patient's glaucoma is adequately controlled or if modification in therapy is required

8. The Attending Staff must be consulted prior to change in medication, addition of medication, or deletion of medication is implemented

9. The Attending Staff must be consulted prior to referral of patient for surgical intervention for glaucoma

IV. Eyeglasses

A. Eligibility is determined by VHA Handbook 1173.12 Prescription Optics and Low-Vision Devices

1. The following categories of veterans are eligible for glasses:

a. Those with any compensable service-connected disability

b. Those who are former prisoners of war (POW)

c. Those who were awarded a Purple Heart

d. Those in receipt of benefits under Title 38 United States Code (U.S.C.) 1151

e. Those in receipt of an increased pension based on being permanently housebound and in need of regular aid and attendance

f. Those with vision or hearing impairment resulting from diseases or the existence of another medical condition for which the veteran is receiving care or services from VHA, or which resulted from treatment of that medical condition, e.g., stroke, polytrauma, traumatic brain injury, diabetes, multiple sclerosis, vascular disease, geriatric chronic illnesses, toxicity from drugs, ocular photosensitivity from drugs, cataract surgery, and/or other surgeries performed on the eye, ear, or brain resulting in vision or hearing impairment.

g. Those with significant functional or cognitive impairment evidenced by deficiencies in the ability to perform activities of daily living.

h. Those who have vision and/or hearing impairment severe enough that it interferes with their ability to participate actively in their own medical treatment and to reduce the impact of dual sensory impairment (combined hearing and vision loss). ***NOTE:*** *The term "severe" is to be interpreted as a vision and/or hearing loss that interferes with or restricts access to, involvement in, or active participation in health care services (e.g., communication or reading medication labels). The term is not to be interpreted to mean that a severe hearing or vision loss must exist to be eligible for hearing aids or eyeglasses.*

2. Glasses may also be provided for patients upon approval of the Chief of Optometry on a per-patient basis provided a medical need exists and justification is given for the prescription (e.g. monocular patients, insulin-dependent diabetics)

B. Orders for glasses are to be written up on the provided order form

C. A second pair of corrective eyeglasses will not be issued to any beneficiary unless there are compelling medical circumstances requiring a second pair

D. Beneficiaries are allowed one pair of bifocal or trifocal glasses or two pairs of single vision glasses, one for reading and one for distance, in cases where bifocal lenses are contraindicated

E. Replacement of corrective eyeglasses necessitated by fair wear and tear, loss or breakage due to circumstances beyond the control of the veteran, or due to required change of prescription, may be made at any time

1. When replacement eyeglasses are prescribed because of a change in refractive error, the change must require a change of at least the following:

a. Sphere change of at least + or – 0.25 diopter

b. Cylinder change of at least + or -0.50 diopter

c. Axis change of at least the following:

-five degrees for 0.25 to 0.75 diopter of cylinder power

-three degrees for 1.00 to 2.00 diopters of cylinder power

-two degrees for 2.25 or more diopters of cylinder power

2. Replacement eyeglasses can be prescribe at any time due to required refractive change of prescription to improve one line of visual acuity

3. If one or both lenses are broken and there is any indication that the veteran's vision has changed, or if it has been more than 1 year since the veteran's eyes were last examined, the veteran is to be referred to an optometrist or ophthalmologist before replacement eyeglasses are ordered.

F. Medical justification is needed for tinted lenses (e.g. post-operative cataract patients, aphakic patients, patients with ocular photosensitivity due to medications, etc.). Tinted lenses will not be provided solely for comfort.

G. Orders are written up on forms that are provided

H. The Health Technicians (opticians) do all orders, adjustments, and repairs of glasses

I. Glasses are mailed to the patient at their home address

V. Coding

A. Diagnostic codes (ICD-10)

1. Code all relevant diagnoses for the patient on the encounter form in the Computerized Patient Record System.

2. Choose the most pertinent diagnosis as the primary diagnosis.

B. Procedure codes (CPT)

1. Residents are advised to not use the evaluation and management codes (99XXX codes)

2. Optometry/Ophthalmology specific codes should be used instead

    a. Comprehensive eye examination codes are 92004 for new patients and 92014 for established patients

    b. Intermediate eye examination codes are 92002 for new patients and 92012 for established patients

3. Other procedure coding will be discussed at the resident orientation to the Eye Clinic

VI. Patient recall

A. The Eye Clinic operates as a specialty clinic and as such there is no recall for a routine comprehensive eye examination

B. Patients in need of a routine comprehensive eye examination may call to direct schedule an appointment.

C. Patients in need of non-routine eye care must have a Return To Clinic Order for the procedure (i.e. IOP check, cataract post op follow up, threshold visual field testing, Heidelberg Spectralis testing, dilated fundus examination, glasses prescription check, etc.) placed in CPRS prior to the patient being booked an appointment.

Electronic Records

I. Background:

A. Decentralized Hospital Computer Program (DHCP) information system

-An automated patient information system utilized in Department of Veterans Affairs medical centers beginning in 1985

B. Veterans Health Information Systems and Technology Architecture (VISTA)

-An enhancement over DHCP information system

-Includes the Computerized Patient Record System, which was implemented in 1997

-CPRS provides a single interface for health care providers to review, update, and add to a patient's medical record.

-CPRS allows a health care provider to place orders for medications, radiology testing, special procedures, consultations, lab testing, etc.

II. Review of electronic records

A. The resident is to review the patient's active problem list, active medication list, known allergies and adverse reactions list, previous eye examination records, pertinent lab tests, pertinent radiology tests and pertinent VISTA Imaging information prior to examining each patient

III. Entry of electronic progress notes

A. All notes are to be entered in a subjective complaint, objective findings, assessment and plan format into CPRS

B. Standardized optometric templates are available for use by the resident. The process of using the templates will be demonstrated to the resident during orientation

IV. Ordering medications

A. The resident is allowed to prescribe therapeutic agents necessary to treat the patient's ocular condition within the scope of the Attending Staff's privileges.

B. The resident is required to consult with the Attending Staff regarding all changes, additions, and/or deletions to a patient's medication profile

C. Medication prescriptions are to be entered electronically via CPRS

1. The procedure for ordering medications will be demonstrated to the resident during orientation and at the first opportunity during patient care activities

D. The VASNHS has a limited formulary from which medications may be prescribed. The formulary is located in the CPRS system

E. Non-formulary drug requests are made in rare cases when all formulary items have proved to be ineffective or contraindicated for the patient

1. There must be adequate documentation that the existing formulary medications have been unsuccessful or contraindicated in both the electronic record and the non-formulary drug request

2. The procedure for placing a non-formulary drug request will be demonstrated to the resident at the first opportunity that arises during patient care activities

V. Ordering radiological testing

A. The resident is allowed to order radiology testing when indicated by a patient's ocular condition

B. The resident is required to consult with the Attending Staff prior to placement of a request for radiological testing

C. Consultations for radiological testing are to be entered electronically via CPRS

1. The procedure for entering a consultation for radiological testing will be demonstrated to the resident at the first opportunity during patient care activities

D. The tests that are available for ordering are as follows:

1. X-ray

2. Computerized Tomography (CT) Scan

3. Magnetic Resonance Imaging (MRI)

4. Magnetic Resonance Angiography (MRA)

5. Carotid Doppler ultrasonography

6. Computerized Tomography Angiography (CTA) Scan

7. Magnetic Resonance Venography (MRV)

E. Once test is complete, results are sent back to the ordering clinician and will appear in the Notifications window of CPRS and in the imaging section of the Reports tab

VI. Ordering laboratory testing

A. The resident is allowed to order laboratory testing when indicated by a patient's ocular condition

B. The resident is required to consult with Attending Staff prior to the placement of a request for laboratory testing

C. Requests for laboratory testing are to be entered electronically via CPRS

1. The procedure for entering a request for laboratory testing will be demonstrated to the resident at the first opportunity during patient care activities

D. Laboratory testing ordered by optometrists includes, but is not limited to the following:

1. CBC with differential
2. Chem 7
3. HbA1c
4. ESR
5. C reactive protein
6. RPR first then FTA-ABS if needed
7. ACE
8. Rheumatoid factor
9. ANA
10. Lyme serologic testing
11. HLA-B27 typing
12. Creatinine
13. Blood urea nitrogen

E. Once a test is complete, results are sent back to the ordering clinician and will appear in the Notifications window of CPRS and under the Labs tab

VII. Vista Imaging

A. Vista Imaging is a medical imaging system that integrates clinical images and scanned documents into a patient's electronic medical record

1. The resident is to submit threshold visual field results and Heidelberg Spectralis testing results for scanning into VISTA Imaging
2. The resident is to submit digital photograph prints and fluorescein angiography prints for scanning into VISTA Imaging as necessary.

B. Vista Imaging may not be used to scan in paper records of eye examinations performed by the resident. Eye examinations performed by the resident must be entered into CPRS manually

C. Paper records produced by non-VA physicians may not be scanned into the Vista Imaging system

Resources

I. VA Medical Library

The VA Medical Library is located in the VA Medical Center. In the Eye Clinic, *Ophthalmology, American Journal of Ophthalmology, Survey of Ophthalmology,*and the *Journal of the American Optometric Association* are among the many titles available through the virtual library. Residents may also submit requests for medline articles from the VA Medical Library as needed.

II. Southern California College of Optometry (SCCO) Library

The library at SCCO is available with full access and extended checkout periods for materials for residents. The librarians are also able to perform a literature search on a given subject of study. Additionally, the SCCO Library sponsors a journal review program in which residents are allowed to select an article from a journal on a regular basis (according to the circulation frequency of the requested journal) for review. The article is sent to the resident through email.

III. Computer and Internet Resources

A. Micromedex is a subscribed online reference for drug information that is available for residents.

B. E-med Library on the VA intranet provides links to search engines such as Pubmed and OVID. Online, full text articles are available from various journals.

Administrative Responsibilities

I. Quality Management

A. All patient notes are to be entered into the Computerized Patient Record System by the resident.

B. All fundus photographs are to be entered into the Imagenet digital camera system. The photograph is to include patient identifiers, condition, and date.

C. All patient visual field results, Heidelberg OCT scanning results, and B-scan results are to be submitted for scanning into the VISTA imaging system.

D. The resident is to keep a log of his or her patient encounters on the patient log prescribed by SCCO.

E. Chart review of all of the resident's charts by the Attending Staff will take place on a daily basis. The Program Coordinator will be made aware of any deficiencies and so that immediate corrective action may be undertaken.

Appendix I

I. MCM IC-01 Infection Prevention and Control Program

Infection Prevention and Control Program

1. PURPOSE: The Infection Prevention and Control Program (IPCP) aims to identify and reduce the risks of acquiring and transmitting infections among patients, employees, volunteers, students, residents, vendors, consultants and visitors. The program covers a broad range of processes and activities in both inpatient and outpatient populations that are coordinated and carried out by the organization. This program also connects with external organizations that support community and environmental health. Infection prevention and control is an integral part of all services provided by the VA Southern Nevada Healthcare System (VASNHS).

2. POLICY: The IPCP is established within the VASNHS to comply with the national standards set by the Centers for Disease Control and Prevention (CDC), Association for Professionals in Infection Control and Epidemiology (APIC), Occupational Safety and Health Administration (OSHA), The Joint Commission (TJC), the Veterans Health Administration (VHA), and other nationally and professionally recognized health organizations whose expertise are followed in the provision of quality healthcare to patients, personnel, and visitors utilizing evidence-based and best practices and processes.

3. ACTION:

a. Definitions:

(1) Focused surveillance – surveillance that focuses on particular care units, related to medical devices, invasive procedures, and organisms of epidemiological significance.

(2) MDRO – multi-drug resistant organisms are organisms that are resistant to one or more antimicrobials in three different classes. Examples are methicillin-resistant *Staphylococcus aureus* (MRSA), vancomycin-resistant *Enterococcus* (VRE), carbapenem-resistant *Enterobacteriaceae* (CRE), and extended spectrum beta lactamase (ESBL) producers.

(3) Surveillance – the ongoing, systematic collection, analysis, interpretation, and dissemination of data.

b. Procedure:

(1) IPCP goals:

(a) Evaluate and improve infection prevention and control practices using evidence-based and best practices and processes throughout the continuum of care;

(b) Monitor and report targeted surveillance activities within the hospital, behavioral health and home care settings;

(c) Promote compliance with standards and guidelines from regulatory agencies and nationally recognized recommending bodies to consistently assess the facility's infection control outcome and process measures as compared to National Healthcare Safety Network (NHSN) and Veterans Administration (VA) national benchmarks.

(2) IPCP scope:

(a) Antibiotic stewardship collaboration and support;

(b) Blood borne pathogen exposures oversight;

(c) *C. diff* prevention strategies;

(d) Communicable disease surveillance reporting;

(e) Construction and water safety;

(f) Device-associated infection surveillance;

(g) Hand hygiene;

(h) Health-care associated infections;

(i) Highly infectious diseases/bioterrorism;

(j) Isolation precautions and appropriate use of personal protective equipment (PPE);

(k) Multi-drug resistant organisms (MDROs); and

(l) Surgical site infections (SSIs).

(3) IPCP activities:

(a) Collaboration with various services to form multi-disciplinary committees and workgroups;

(b) Construction site rounds and Infection Control Risk Assessment (ICRA);

(c) Environment of Care (EOC) rounds;

(d) Hand hygiene and Personal Protective Equipment (PPE) process outcomes;

(e) Influenza vaccination campaign, tuberculosis (TB) screening, Powered Air Purifying Respirator (PAPR) and N-95 fit testing promotion and support;

(f) Outbreak investigations (Attachment A);

(g) Promotion and support of the use of insertion and maintenance "bundles" or checklists for the prevention of central line-associated blood stream infections (CLABSI), catheter-associated urinary tract infections (CAUTI), and ventilator-associated events (VAE) (Refer to MCM-111-11 Mechanical Ventilation Policy), following evidence-based guidelines and best practices;

(h) Risk assessments, plans, program policy development and review and annual evaluation of programs within the hospital, behavioral health, and home care settings;

(i) Surveillance and data reporting to Infection Control Committee, Medical Executive Council and Quality, Safety, and Value Council. Surveillance findings are also communicated to the Southern Nevada Health District, Inpatient Evaluation Center (IPEC), and VISN 21, as required. May also provide information to other facility committees.

(j) Education such as in-services/trainings/presentations to staff, patients and visitors;

(k) Targeted surveillance of device associated infections, surgical site infections and epidemiologically significant MDROs;

(l) Walk-throughs, simulations, observations and tracers.

4. RESPONSIBILITES:

a. The Director has the overall responsibility for the implementation of the IPCP program.

b. The Associate Director is responsible for supporting the efforts of all administrative services for the implementation of this memorandum.

c. The Chief of Staff is responsible for providing support to all clinical services for the implementation of this memorandum.

d. The Associate Director for Patient Care Services/Nurse Executive has the responsibility of providing support to all patient care services for implementing this memorandum.

e. The Infection Prevention and Control Committee (IPCC) is responsible for the continuous monitoring, reporting, and evaluation of the IPCP.

f. IPCC Chairperson is a physician with knowledge of epidemiology and infectious diseases. The chairperson is responsible for direction and advice to the IPC staff and IPCC. The facility gives authority during an outbreak or epidemic situation to the Chairperson of the IPCC to implement strategies for the prevention and control of disease directed towards patients/residents, visitors, employees, and others identified by local needs.

g. The Infection Prevention and Control Manager is responsible for the direct oversight of the program and IPC staff.

h. The Infection Prevention and Control Coordinators assist the manager with the implementation of the IPCP.

i. Service Chiefs are responsible for implementing this memorandum.

j. Employees, volunteers, students, residents, vendors and consultants are responsible to be knowledgeable and abide by this policy.

k. Laboratory personnel are responsible for notifying Infection Control staff of significant laboratory culture reports through VISTA in a timely manner. The microbiologist provides the antibiogram for the facility, at minimum annually.

5. REFERENCES:

Association for Practitioners in Infection Control and Epidemiology Text of Infection Control and Epidemiology, 4th Edition; 2014

CDC Tuberculosis Prevention Guideline for Healthcare Facilities 2005 MMWR Vol 54

Hospital Infections Sixth Edition, Bennett and Brachman

OSHA Blood-borne Pathogen Standard, 29 CFR 1910.1030, revised 2001

The Joint Commission Accreditation Manual, January 2017 edition

VASNHS MCM-111-11 Mechanical Ventilation Policy, January 2015

VHA Directive 1131 – Management of Infectious Diseases and Infection Prevention and Control Programs, November 7, 2017

VHA Clinical Programs, Medical Service, M-2, Part IV, chapter 6

6. RESCISSION: MCM IC-17-01, Infection Prevention and Control Program, dated April 2017

7. RECERTIFICATION: May 2021

8. FOLLOW-UP RESPONSIBILITY: Infection Prevention and Control Manager

Concur/Do Not Concur

Jennifer A. Strawn, DNP, RN, NE-BC
Associate Director, PCS/NE

Concur/Do Not Concur

Tracy L. Skala, M.S. EdL, VHA-CM
Associate Director

Concur/ Do Not Concur
Approved/Disapproved

Ramu Komanduri, MD
Chief of Staff

Concur/Do Not Concur

John L. Stelsel
Assistant Director

Peggy W. Kearns, MS, FACHE
Medical Center Director

Attachment A: Components of an Outbreak Investigation

j. Employees, volunteers, students, residents, vendors and consultants are responsible to be knowledgeable and abide by this policy.

k. Laboratory personnel are responsible for notifying Infection Control staff of significant laboratory culture reports through VISTA in a timely manner. The microbiologist provides the antibiogram for the facility, at minimum annually.

5. REFERENCES:

Association for Practitioners in Infection Control and Epidemiology Text of Infection Control and Epidemiology, 4th Edition; 2014

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Concur/~~Do Not Concur~~

Tracy L. Skala, M.S. EdL, VHA-CM
Associate Director

Concur/~~Do Not Concur~~

Ramu Komanduri, MD
Chief of Staff

Concur/~~Do Not Concur~~

John L. Stelsel
Assistant Director

~~Approved~~/~~Disapproved~~

Peggy W. Kearns, MS, FACHE
Medical Center Director

Attachment A: Components of an Outbreak Investigation

ATTACHMENT A

Components of Initial Outbreak Investigation:

1. Confirming presence of an outbreak
2. Alerting key partners about the investigation
3. Performing a literature review
4. Establishing an initial case definition
5. Developing a methodology for case finding
6. Preparing an initial line list and epidemic curve
7. Observing and reviewing potentially implicated patient care activities
8. Considering whether environmental sampling should be performed
9. Implementing initial control measures

Steps to the Follow-up Investigation:

1. Refining the case definition
2. Continuing case finding and surveillance
3. Regularly reviewing control measures
4. Considering whether an analytical study should be performed

Patient Safety Program

1. PURPOSE: To establish policy and procedures for VA Southern Nevada Healthcare System (VASNHS) Patient Safety Program (PSP). To support efforts to establish a high reliability safety organization where the safety culture remains continuous and drives improvement.

2. POLICY:

a. VASNHS maintains an integrated, patient-centered, evidence-based PSP that supports and promotes the organization's mission, vision, and values. The PSP elements are consistent with the goals of Veterans Healthcare Administration (VHA), Veterans Affairs National Center for Patient Safety (NCPS), and Veterans Integrated Services Network (VISN), and reflects strategies that contribute to the development, implementation, maintenance, and improvement of patient safety processes. The PSP accomplishes this through the identification and analysis of risks that cause, contribute to, or have the potential to cause or contribute to preventable patient injury or impairment, and the implementation of efficient safety-focused processes and preventive measures. The PSP focuses on effective medical/healthcare error reduction through an integrated and coordinated approach, implements a systematic system-wide program designed to minimize physical injury, accidents, and undue psychological stress for patients during patient care appointments, clinic visits, and hospital stays and continues to promote regular reporting of close calls and unsafe conditions to help identify and address potential patient safety issues.

b. VASNHS leadership assumes a role in establishing a culture of safety that minimizes hazardous risks and patient harm by focusing on processes of care. VASNHS leaders are responsible for fostering an environment through personal example, emphasizing patient safety as an organizational priority, educating clinical and non-clinical staff about commitment to the reduction of medical/healthcare errors, supporting proactive reduction in medical/healthcare errors, and integrating patient safety priorities into the new design and redesign of all relevant organizational processes, functions, and services. VASNHS leadership set priorities and assign resources based on event reporting trends, Root Cause Analysis (RCA) outcomes and Healthcare Failure Mode and Effects Analysis (HFMEA), which is a systemic approach to identify and prevent product and process problems before they occur. Prospective risk assessment, such as HFMEA, aim to identify steps in a process to reasonably ensure safe and clinically desirable outcomes. The organization supports and promotes a Just Culture of Safety that encourages reporting, and analyzing risks, errors, and near misses.

3. ACTION:

a. Definitions:

(1) Adverse Event: Untoward incidents, therapeutic misadventures, iatrogenic injuries, or other undesirable occurrences directly associated with medical/healthcare or services provided within the jurisdiction of a medical center, outpatient clinic, or other VHA facility.

(2) Aggregated Review: A method (i.e., process) of analyzing a group of similar incidents or event types to determine common causes, thereby facilitating coordinated actions to prevent recurrences. Issues and incidents reviewed via Aggregated Reviews are those that do not require individual RCAs. The determination of common causes, using Aggregated Reviews, provides the opportunity to correct minor issues before they lead to serious adverse events. Aggregated Reviews are required in three categories of incidents: falls, medication events, and missing patients.

(3) Close Call: Any event or process variation that could have resulted in an adverse event, however did not, either by chance or through timely intervention. Such events have also been referred to as *near miss* incidents.

(4) Patient Safety: An environment that ensures patients the freedom from accidental or inadvertent injury during health care processes.

(5) Patient Safety Electronic Event Reporting System: Web based process for reporting adverse patient events and/or close calls.

(6) Proactive Risk Assessment: A method of evaluating a product or process to identify system vulnerabilities and associated corrective actions before an adverse event occurs. Proactive Risk Assessment models include Healthcare Failure Mode and Effects Analysis (HFMEA).

(7) Root Cause Analysis (RCA): Comprehensive, systematic, and multidisciplinary process for investigating causes and/or contributing factors associated with adverse events.

(8) Sentinel Event: A sentinel event is a Patient Safety Event that reaches a patient and results in any of the following: death, permanent harm, or severe temporary harm and intervention required to sustain life. Such events are

called "sentinel" because they signal the need for immediate investigation and response.

b. Procedures:

(1) VASNHS Patient Safety Staff:

(a) Identify program priorities and implement patient safety initiatives based on analysis of patient safety event reports, internal data, standards from external regulatory and accrediting bodies, and findings from ongoing risk assessments.

(b) Conduct surveys to assess the facility’s culture of patient safety and examine the patient safety program effectiveness to include the willingness of staff to report patient safety errors.

(2) VASNHS Leadership:

(a) Provides oversight for patient safety improvement initiatives through the designation of a multidisciplinary Patient Safety Committee (PSC), which is chaired by the Patient Safety Service.

(b) Sets patient safety priorities for the facility through outcomes from RCAs, HFMEAs and other high risk, high volume, low volume, problem prone activities.

(3) Patient Safety Committee (PSC): Develops and/or evaluates patient safety policies and procedures, implements a facility patient safety plan, designs tools to assess and monitor patient safety processes, and sets prioritization of patient safety activities.

(4) VASNHS Managers/Supervisors:

(a) Foster leadership/management styles that promote staff participation in patient safety initiatives to include proactive risk analysis and participation in RCAs.

(b) Demonstrate value and respect for staff contributions to patient safety and support open communication about patient safety practices/processes and error disclosure.

(c) Incorporates accountability and responsibility for patient safety into staffs' competencies.

(5) VASNHS Clinicians and Organizational Leaders: Ensure that disclosures are a routine part of the response to adverse events and that disclosing to a patient and their family regarding adverse events is accomplished with skill, tact, and within the legal limits that support patient privacy (VHA Handbook 1050.01: Informing Patients about Adverse Events).

(6) VASNHS Staff are Required to:

(a) Appropriately report adverse patient events, patient safety concerns, and close calls via the patient safety event reporting system.

(b) Actively participate in Patient Safety programs and initiatives to promote a Culture of Safety throughout the facility.

(7) VASNHS Reporting Structure:

(a) Patient Safety Committee reports to the Quality, Safety and Value Committee.

(b) The Patient Safety Service organizationally falls under the Medical Center Director.

4. RESPONSIBILITIES:

a. Medical Center Director has overall responsibility for the Patient Safety Program and appoints a Patient Safety Committee responsible for monitoring and reporting program compliance and providing recommendations for program changes.

b. Chief of Staff and Associate Director Patient Care Services/Nurse Executive are responsible to ensure patient safety procedures are implemented and overall staff compliance under their span of control.

c. Service Chiefs, Managers, and Supervisors ensure their employees are knowledgeable about and comply with patient safety policy, procedures, and reporting guidelines.

d. Patient Safety Manager is responsible for:

(1) Patient Safety Service administration and patient safety staff supervision; system-wide patient safety awareness.

(2) Patient Safety Committee leadership and oversight.

(3) Direction of RCAs and HFMEAs, and initiation of reports to internal and external entities.

(4) Dissemination of up-to-date patient safety data throughout the organization with routine, periodic, and required annual reports to leadership.

(5) Provision of data regarding Event Reporting, National Patient Safety Goals (NPSG), RCA/HFMEA action items/outcomes and lessons learned, Sentinel Event Alerts, Alerts and Recalls, and other applicable data to staff via applicable committees and staff meetings.

(6) Development of organization-wide initiatives and processes that promote compliance with NPSGs and other patient safety related standards.

(7) VASNHS point of contact for Patient Safety Alerts and Patient Safety Advisories published by NCPS, VHA, The Joint Commission (TJC) and VHA Central Office (VHACO).

(8) Collaboration with clinicians and organizational leaders to ensure that disclosure is a routine response to adverse events within specified legal restrictions.

e. Patient Safety Staff are responsible for:

(1) Development of relevant, evidence-based patient safety initiatives and processes.

(2) Active leadership/participation on the Patient Safety Committee and other committees and workgroups that impact patient safety.

(3) Promotion of a Culture of Safety and safety awareness; insurance that patient safety program elements are integrated into organizational processes through applicable patient safety policies, education programs, fairs and focused campaigns.

(4) Dissemination of up-to-date patient safety data throughout the organization via multiple forums/avenues that include monthly staff meetings, electronic messaging, reports, and websites.

(5) Implementation and evaluation of patient safety indicators and processes, monitoring compliance with NPSG and other patient safety related standards, development of improvement strategies, and systematically reports of strategies and outcomes.

(6) Education of staff, patients, and family about patient safety programs, policies, initiatives, patient safety goals, best practices, and reporting mechanisms.

(7) Response to Patient Safety Alerts and Advisories published by NCPS, TJC, VHA, and VHACO.

(8) Use of the patient safety event reporting system for reviewing, analyzing, and acting on adverse events, close calls, patient safety incidents, patient safety concerns, and aggregate findings to identify underlying causes and implement changes to reduce the likelihood of recurrence to include: the use of the VHA prioritization method; the Safety Assessment Code (SAC) to assist in determining whether to initiate a review; the collection and analysis of data to evaluate care processes for opportunities to reduce risks; initialization of corrective actions with a focus on processes and systems to reduce risks; and, the documentation and reporting of findings, interventions, and outcomes.

(9) Conduct a minimum of four individual RCAs and three required (e.g., falls, medication errors, missing persons) aggregated reviews per year, and completion of required data entry using the Web-SPOT software application. Complete one HFMEA annually per NCPS and TJC guidelines.

(10) Participation in surveys by TJC, Commission on Accreditation of Rehabilitation Facilities (CARF), Office of Inspector General Continuous Assessment Program (OIG-CAP) and other internal/external inspection and review teams; prioritizes patient safety initiatives based on findings.

(11) Collaboration with leadership, management, and other healthcare professionals to ensure flow of information and congruent action plans to achieve targeted goals and objectives.

f. Employees are responsible for:

(1) Complying with patient safety policies and procedures.

(2) Participating in orientation and education programs that promote safe patient care environments.

(3) Reducing variation in patient care and devising strategies to avoid reliance on memory through use of protocols, checklists, and standardization of work processes.

(4) Methodically evaluating and reporting safety vulnerabilities of current patient care technologies and care delivery systems.

(5) Appropriately reporting via patient safety event reporting system, patient incidents, patient safety concerns, and adverse events to include close calls.

5. REFERENCES:

The Joint Commission Comprehensive Accreditation Manual for Hospitals, Current edition

The Joint Commission Sentinel Event Policy and Procedure: http://www.jointcommission.org/Sentinel_Event_Policy and Procedures/

VHA National Patient Safety Improvement Handbook 1050.01, March 4, 2011

6. RESCISSION: MCM-PS-13-02, Patient Safety Program, dated August 2016

7. RECERTIFICATION: October 2022

8. FOLLOW-UP RESPONSIBILITY: Patient Safety Manager

Approved/Disapproved

William J. Caron, PT, MHA, FACHE
Medical Center Director/CEO
VA Southern Nevada Healthcare System

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HAND HYGIENE

1. PURPOSE: To provide guidance for establishing the basic requirement for hand hygiene at VA Southern Nevada Healthcare System (VASNHS).

2. POLICY: All employees must follow the Veterans Health Administration (VHA), Centers for Disease Control and Prevention (CDC), and the National Center for Patient Safety (NCPS) guidelines for hand hygiene. According to the CDC, hand hygiene substantially reduces potential pathogens on the hand and considered a primary measure for reducing the risk of transmitting infectious organisms to and from patients and health care employees.

3. ACTION:

a. Definitions:

(1) Hand Hygiene: Centers for Disease Control and Prevention (CDC) defines hand hygiene as a general term that applies to routine hand washing, antiseptic hand wash, antiseptic hand rub, or surgical hand antisepsis.

(2) Alcohol-based Hand Rub: An alcohol-containing agent used on the hands to reduce the number of bacterial skin flora to prevent transmission of pathogens among individuals in contact with each other within healthcare facilities. Alcohol-based Hand Rub usually contains Alcohol-based Hand Rub usually contains 60%-95% ethanol or isopropanol.

(3) Antimicrobial Soap: A cleaner containing an antiseptic agent.

(4) Clostridium Difficile (C. diff): Patients prescribed antibiotics for an infection may have the good germs destroyed leaving the patient in a vulnerable state to pick up a healthcare-associated infection (HAI) from C. difficile bacteria from contaminated surfaces or spread from healthcare employees' hands.

b. Procedure:

(1) All healthcare workers in direct patient contact areas (e.g., inpatient rooms, outpatient clinics) and direct patient contact in other settings (e.g., radiology technicians, phlebotomists) are required to:

(a) Use an alcohol-based hand rub or antimicrobial soap and water to decontaminate their hands routinely before and after having direct contact with a patient.

(b) HANDS Not Visibly Soiled: An alcohol-based hand rub is used to decontaminate hands; manufacturers' instructions must be followed for an alcohol hand rub. Directions:

1) Apply to dry hands using a sufficient amount to keep all areas wet throughout the preparation procedure.

2) A sufficient amount of the product should be dispensed on the palm of one hand.

3) Rub both hands together touching all surfaces of both hands and wrists, under the nails, and jewelry until it has evaporated.

4) A paper towel should not be used to wipe off the excess alcohol rub. Let the hands air dry.

(c) Hands Are Visibly Dirty or Contaminated (e.g., proteinaceous material, blood, excretions, mucous membranes, non-intact skin, wound dressings): Hands require washing with soap and water. If there is visible debris on the hands then antimicrobial soap and water must be used. In addition, when caring for a patient with Clostridium difficile, you must use soap and water because alcohol products are not effective against C. difficile. Directions:

1) Wet hands thoroughly with water.

2) Dispense one pump or more of soap onto palm of hands.

3) Wash hands including the wrists using friction with special attention to areas between fingers, under nails, and jewelry.

4) Hand washing should be for a minimum of 15 seconds, making sure that all surfaces of both hands and wrists have been washed.

5) Rinse hands under running water.

6) Dry hands with a paper towel.

7) Use a clean paper towel to turn off the faucet and to open the door to the patient's room.

(2) All clinical staff is required to wash hands with soap and water whenever hands are visibly soiled/contaminated or alcohol based hand sanitizer if there is no visible debris.

(a) After contact with a potential source of microorganism (e.g., bodily fluids, excretions, mucous membranes, non-intact skin, wound dressing).

(b) Before and after each patient contact

(c) Before and after glove use

(d) Before and after aseptic procedures

(e) Before and after handling medications

(f) Before and after meals with soap and water

(g) After use of the toilet with soap and water

(h) After smoking

(i) Before and after handling patient care items

(j) After coughing or sneezing

(k) When hands are visibly soiled

(l) After handling dirty linen

(m) After handling trash/garbage

(n) After handling bedpans, urinals, catheters

(o) Before preparing food

(p) After changing diapers

(q) After handling specimens

(r) After handling inanimate objects that are likely to be contaminated

(s) If moving from a contaminated body site to another body site during care of the same patient.

(t) Before inserting or handling any invasive device for patient care, whether or not gloves are used.

(3) Use antimicrobial soap and water after exposure to potential spore-forming pathogens (e.g., Clostridium difficile).

(4) Wearing of Gloves:

(a) Wear gloves when in contact with blood or other potentially infectious materials, mucous membranes, and non-intact skin is anticipated.

(b) Gloves must be removed after caring for a patient.

(c) If gloves become visibly soiled, or if performing patient care on a contaminated site, remove or change gloves before moving to another body part/site on the same patient, a device, or the environment.

(d) The same pair of gloves is not to be worn for the care of more than one patient; gloves are not to be washed, they are to be disposed of appropriately.

(e) Complete appropriate hand hygiene after the activity is completed.

(5) Artificial Fingernails (e.g., acrylic, sculptured, silk wraps, overlays, tips, shellac, gel, or nail extenders) and nail jewelry must not be worn by healthcare personnel whose duties involve direct patient care, whether non-supervisory or supervisory, and whether it is regular contact or occasional contact, because the nails harbor larger numbers of organisms and implicated in outbreaks of infection.

(6) Nail Polish: If worn, should not be chipped. Nails must be no longer than 1/4 inch beyond the end of the nail bed (Reference MCM-IC-08 Artificial Fingernails).

(7) Provided Supplies:

(a) An alcohol-based hand rub at the point of patient care (e.g., at the entrance to each patient room, bedside, clinics, emergency rooms, Post-Anesthesia Care Units (PACUs).

Note: Alcohol-based hand rubs may present an abuse risk in certain patient care areas, such as inpatient psychiatric or mental health residential rehabilitation treatment

programs. Local clinicians and facility leaders need to use discretion in their use of alcohol-based products in these areas.

(b) Antimicrobial soap is available in all patient care areas where soap is provided (e.g., at all sinks with a soap dispenser).

(c) Appropriate Labeling: VASNHS facilities that supply antimicrobial and non-antimicrobial soap clearly and unambiguously label the dispensers to ensure that all users know which dispenser is providing antimicrobial soap and which dispenser is providing non-antimicrobial soap.

(d) Pocket-sized containers of alcohol-based rub must be available to all health care workers.

Note: This does not imply a requirement for all health care workers to carry pocket-sized alcohol hand rubs.

(e) Appropriate hand lotions or creams to minimize irritant contact dermatitis must be readily available.

Note: Products designed for health care applications that do not reduce the effectiveness of other hand hygiene products, such as antimicrobial compounds (e.g., CHG compliant). Hand lotions or creams must be compatible with gloves used in the facility.

1) Soap is not added to partially empty dispensers. Soap is dispensed from disposable bladders or other containers that prevent old and new soap from mixing.

2) Care is taken in installing and storing alcohol-based hand rubs consistent with fire safety requirements.

3) Alcohol-based hand rub dispensers must not be located over or adjacent to ignition sources including electrical receptacles and switches.

a) Corridors must have at least 6 feet of clear width with hand rub dispensers spaced at least 4 feet apart.

b) Alcohol-based hand rub dispensers may not be installed in carpeted corridors unless the corridor is sprinkler protected.

c) Dispensers may not project more than 6 inches into corridor egress width.

Note: Consideration will be given to installing dispensers at a height that ensures that they can be used by staff, patients and visitors who are in wheelchairs.

d) Supplies of alcohol-based hand rub products must be stored in cabinets or areas approved for flammable materials consistent with applicable regulations and standards.

(8) Improving hand hygiene is an institutional priority and administrative and financial support is provided, as appropriate.

(a) Financial support includes providing adequate supplies of alcohol hand rubs, antimicrobial soaps, gloves (i.e., regular and sterile), and lotion.

(b) Input needs to be solicited from employees regarding the feel, fragrance, and skin tolerance of products, (e.g., soap, alcohol hand rub, hand lotions, gloves) and this information needs to be used to inform local and national purchasing decision makers.

(9) Information or educational materials on hand hygiene provisions are provided to all health care workers. VHA *Infection Don't Pass it On* campaign, led by VHA Office of Public Health and Environmental Hazards and VHA National Center for Patient Safety provides relevant materials on its website at: http://www.publichealth.va.gov/InfectionDontPassItOn/ and http://vaww.ncps.med.va.gov/Guidelines/Hand_Hygiene/index.html.

(a) Monitoring health care workers' adherence to required hand hygiene is conducted, and the health care workers are provided information regarding their performance.

(b) Environmental Management Service refers to guidance on hand hygiene and related practices in the Environmental Services Standard Operation Procedural Guide.

4. RESPONSIBILITIES:

a. Medical Center Director has the overall responsibility for the implementation of this memorandum.

b. Associate Director has the responsibility of supporting the efforts of all administrative services in implementing this plan.

c. Chief of Staff has the responsibility of providing support to all clinical services in implementing this memorandum.

d. Supervisors and managers are responsible for ensuring that all of their employees comply with this memorandum; ensure the assignment of staff to monitor and report compliance with proper hand hygiene on a monthly basis to report to the Infection Prevention and Control Coordinator.

e. Infection Prevention and Control staff and Infection Control Committee are responsible for updates and revisions to this memorandum.

f. All employees are required to comply with this memorandum.

5. REFERENCES:

CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007:
http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html

C. difficile Infection: http://www.mayoclinic.org/diseases-conditions/c-difficile/basics/definition/con-20029664

Centers for Disease Control and Prevention web site with Guideline for Hand Hygiene in Health-Care Settings and related materials: Available at:
http://www.cdc.gov/handhygiene/.
Department of Veterans Affairs.VHA Directive 2011-007 Required Hand Hygiene Practices. Washington DC. February 16, 2011.

Employee Health and Highly Susceptible Populations:
http://www.fda.gov/Food/FoodSafety/RetailFoodProtection/IndustryandRegulatoryAssistanceandTrainingResources/ucm184170.htm#susc

FDA Retail Food Protection: Employee Health and Personal Hygiene Handbook:http://www.fda.gov/Food/FoodSafety/RetailFoodProtection/IndustryandRegulatoryAssistanceandTrainingResources/ucm113827.htm

Joint Commission 2012 National Patient Safety Goals. Available at:
http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/

6. RESCISSION: Medical Center Memorandum IC-10-09: Hand Hygiene, dated September 2012

7. **RECERTIFICATION:** June 2019

8. **FOLLOW-UP RESPONSIBILITY:** Chief, Quality, Safety, and Value Service

Concur/Do Not Concur

Jennifer A. Strawn, MSN, RN, NE-BC
ADPCS/Nurse Executive

Concur/Do Not Concur

John L. Stelsel
Assistant Director

Concur/ Do Not Concur

Ramu Komanduri, M.D.
Chief of Staff

Concur/Do Not Concur

William J. Caron, FACHE
Associate Director

Approved/Disapproved

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IV. VHA Directive 1605 Patient Privacy

Department of Veterans Affairs Veterans Health Administration Washington, DC 20420

VHA Directive 1605 Transmittal Sheet September 1, 2017

VHA PRIVACY PROGRAM

1.REASON FOR ISSUE:

This Veterans Health Administration (VHA) directiveestablishes a Veterans Health Administration (VHA)-wide program for the protection of the privacy of Veterans, their dependents, and beneficiaries in accordance with Federal privacy statutes and regulations. This directive also establishes privacy policies to comply with the Department of Veterans Affairs (VA) Directive 6502.

2.SUMMARY OF MAJOR CHANGES:

This VHA directive includes the followingchanges:

a.Revision and update of policy regarding privacy.

b.Inclusion of a Definitions section.

c.Change of the Office of Informatics and Analytics to Office of Informatics andInformation Governance.

d.Addition of responsibilities for Deputy Under Secretary for Health for Operationsand Management and VHA Personnel.

3.RELATED ISSUES:

VHA Directive 1605.01, VHA Handbook 1605.02, and VHAHandbook 1605.03.

4.RESPONSIBLE OFFICE:

The VHA Office of Informatics and InformationGovernance, Information Access and Privacy Office (10P2C1) is responsible for the contents of this directive. Questions may be referred to the VHA Privacy Officer at 704-245-2492.

5.RESCISSION:

VHA Directive 1605, dated April 11, 2012, is rescinded.

6.RECERTIFICATION:

This VHA directive is scheduled for recertification on or beforethe last day of September 2022. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

Poonam Alaigh, M.D.

Acting Under Secretary for Health

DISTRIBUTION: Emailed to the VHA Publications Distribution List on September 11, 2017.

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VHA PRIVACY PROGRAM

VHA PRIVACY PROGRAM

1.PURPOSE

This Veterans Health Administration (VHA) directive establishes the responsibilityrequirements and procedures for compliance with all applicable Federal privacy and confidentiality statutes and regulations. AUTHORITY: Freedom of Information Act (FOIA), Title 5 United States Code (U.S.C.) 552, implemented by Title 38 Code of Federal Regulations (CFR), Sections 1.550-1.562; 38 U.S.C. 7332; 38 U.S.C. 5701, implemented by 38 CFR Section 1.500-1.527; 38 U.S.C. 5705; and Public Law 104-191, implemented by 45 CFR Parts 160 and 164 (HIPAA).

2.BACKGROUND

The VHA Privacy Program establishes and implements privacy policies andpractices that comply with the requirements of all applicable Federal privacy statutes, regulations, and policies. The main components of the program are: privacy policies, privacy training, use and disclosure of information, individuals' privacy rights, privacy complaints and incidents, notice of privacy practices and privacy compliance monitoring. The focus of the policies and procedures involve individually-identifiable information that is collected, created, transmitted, accessed, used,

disclosed, processed, stored, or disposed of by or for VHA. All Individually-identifiable information, on Veterans maintained by VHA, is considered protected health information. Additionally, this includes all records maintained in any medium, including hard copy and electronic format, and in information systems administrated by, or otherwise under the authority or control of, the Department of Veterans Affairs (VA).

3.DEFINITIONS

a.Business Associate. A business associate is an entity, including an individual,company, or organization that performs or assists in the performance of a function or activity on behalf of VHA that involves the creation, receiving, maintenance or transmission of protected health information (PHI), or that provides to or for VHA certain services as specified in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule that involve the disclosure of PHI by VHA. Subcontractors of business associates are also considered business associates.

b.Compliance. The term compliance is defined as actual and meaningfuladherence to the requirements of any law, regulation, or standard applicable to the activity or practice in question.

c.Disclosure. For the purpose of this directive, the term disclosure refers to therelease, transfer, provision of access to, or divulging in any other manner information outside VHA. Once information is disclosed VHA may retain ownership of the data such as to a Business Associate, contract or other written agreement. There are some cases in which VHA may relinquish ownership of the information. The exception to this definition is when the term is used in the phrase “accounting of disclosures.”

d.Individually-Identifiable Information. Individually-identifiable information is anyinformation pertaining to an individual that is retrieved by the individual’s name or other unique identifier, as well as individually identifiable health information regardless of how it is retrieved. Individually-identifiable information is a subset of sensitive personal information or personally identifiable information and is protected by the Privacy Act (5 U.S.C. 552a (e)(10)).

e.Personally Identifiable Information. Personally identifiable information is anyinformation that can be used to distinguish or trace an individual's identity, such as their name, social security number, biometric records, etc. alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother’s maiden name, etc. Information does not have to be retrieved by any specific individual or unique identifier (i.e., covered by the Privacy Act) to be personally identifiable information. NOTE: The term “Personally Identifiable Information” is synonymous and interchangeable with “Sensitive Personal Information”.

f.Personnel. For the purpose of this directive, the term personnel includes thoseofficers and employees of VHA; consultants and attending clinicians; without compensation (WOC)

employees; Intergovernmental Personal Act (IPA) employees; contractors; others employed on a fee basis; medical students and other trainees; and volunteer workers rendering uncompensated services, excluding patient volunteers, providing a service at the direction of VA staff. NOTE: Compensated Work Therapy (CWT) workers are not VHA personnel; they are patients receiving active treatment or therapy.

g.Sensitive Personal Information. Sensitive Personal Information (SPI), withrespect to an individual, means any information about the individual maintained by VA, including the following:

(1) Education, financial transactions, medical history, and criminal or employment history; and

(2) Information that can be used to distinguish or trace the individual's identity, including name, social security number, date and place of birth, mother's maiden name, or biometric records.

NOTE: SPI is a subset of VA Sensitive Information/Data.

h.Use. Use is the viewing, sharing, employment, application, utilization,examination, or analysis of information within VHA.

4.POLICY

It is VHA policy that the VHA Privacy Program be implemented by means of the VHAPrivacy Office and monitored for compliance with all applicable Federal privacy and confidentiality statutes and regulations.

September 1, 2017 VHA DIRECTIVE 1605

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5.RESPONSIBILITIES

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

b.The Assistant Deputy Under Secretary for Health, Office of Informatics andInformation Governance . The Assistant Deputy Under Secretary for Health, Office of Informatics and Information Governance is responsible for:

(1) Ensuring that VHA-wide privacy policies and procedures are implemented through the VHA Privacy Program and

(2) Ensuring the VHA Privacy Program mission and vision are accomplished by supporting resources, funding, and staffing.

c.Deputy Under Secretary for Health for Operations and Management. TheDeputy Under Secretary for Health for Operations and Management is responsible for:

(1) Ensuring that VISNs and VHA health care facilities implement VHA -wide privacy policies and procedures issued by the VHA Information Access and Privacy (IAP) Office;

(2) Ensuring that the VISNs cooperate with and respond to requests from VHA IAP timely; and

(3) Ensuring VISN and VHA health care facility compliance with mandated VHA-wide privacy policies, including organizational alignment of Privacy Officers.

d.VHA Privacy Officer. The VHA Privacy Officer is responsible for:

(1) Performing all privacy duties and responsibilities as designated by the VA Privacy Service and VHA Assistant Deputy Under Secretary for Health, Office of Informatics and Information Governance;

(2) Developing and implementing a VHA Privacy Program;

(3) Developing, issuing, reviewing, and coordinating privacy policy for VHA in conjunction with policy efforts by VA;

(4) Coordinating requirements and monitoring VHA compliance with all Federal privacy laws, regulations, and guidance;

(5) Establishing requirements for the responsibilities of Veterans Integrated Service Network (VISN) and facility-level Privacy Officers and program office Privacy Liaisons and providing implementation guidance, as needed;

(6) Issuing direction to VISN and facility-level Privacy Officers and program office Privacy Liaisons regarding all aspects of implementing the VHA Privacy Program;

(7) Providing VHA-specific privacy training tools and compliance with the annual training requirement;

(8) Examining new or pending legislation, in conjunction with the VA Office of General Counsel (OGC), to determine the actual or potential impact of such legislation on privacy policy and practice at VHA;

(9) Establishing VHA policy on the reporting, tracking, resolution, and auditing of VHA privacy complaints and incidents;

(10) Ensuring Privacy Officers are aware of the process for recording all actual or suspected breaches of privacy observed or reported at the national level in the tracking system designated by the VA Data Breach Resolution Service (e.g., Privacy and Security Event Tracking System (PSETS));

(11) Ensuring VHA resolves all privacy breaches in a timely fashion and in accordance with applicable law;

(12) Coordinating investigation of and response to privacy complaints received from the Department of Health and Human Services, Office for Civil Rights (HHS OCR), Office of Medical Inspector (OMI) and Office of Special Counsel (OSC);

(13) Maintaining a Notice of Privacy Practices for the VHA health care programs;

(14) Providing expert guidance to VHA field staff in regard to the Privacy Act, title 38 U.S.C. 5701, 5705, and 7332, HIPAA Privacy Rule, Health Information Technology for Economic and Clinical Health Act (HITECH) and other applicable Federal privacy laws;

(15) Creating and supporting a compliance monitoring function within VHA that includes conducting independent performance audits of VHA health care facility's compliance with the VHA Privacy Program;

(16) Ensuring Business Associates are periodically monitored to confirm their compliance with the terms of their Business Associate Agreement (BAA) with VHA; and

(17) Reporting compliance-monitoring findings to VHA leadership at a minimum annually.

e.VISN Directors and Chief Program Officers. VISN Directors and ChiefProgram Officers are responsible for:

(1) Ensuring compliance within their respective facilities and programs with all internal and external requirements including Federal statutes and regulations, VA regulations and policies, and VHA policies relating to privacy;

(2) Ensuring policies and procedures consistent with policies contained in this directive are established within their respective programs and distributed to all personnel;

(3) Ensuring that all personnel within their respective facilities complete privacy training in accordance with VHA privacy policy before they are granted access to any individually-identifiable information and that personnel receive the privacy training annually;

(4) Implementing the requirements of the VHA Privacy Program as it applies to their respective facilities and programs;

(5) Designating an individual with privacy experience which may include certification such as Certified Information Privacy Professional (CIPP) to serve as the VISN Privacy Officer or Program Office Privacy Liaison to provide guidance and oversight to ensure compliance with privacy regulations for their respective programs; and

(6) Ensuring that all personnel within their respective facilities and programs are timely and thorough in completing all monitoring and remediation activities as requested by VHA IAP.

f.Program Office Privacy Liaisons. The Program Office Privacy Liaison isresponsible for:

(1) Developing program office privacy practices consistent with the VHA Privacy Program;

(2) Conduct privacy assessments of all program office programs or activities on a schedule set forth by the VHA Privacy Compliance Assurance (PCA) Office to ensure compliance with program office privacy policies;

(3) Providing guidance to the program office on all privacy-related matters such as the Privacy Act, FOIA, HIPAA Privacy Rule, and title 38 confidentiality statutes, and seeking guidance and advice from VHA IAP to resolve any questions or concerns about privacy-related issues;

(4) Ensuring that the program office responds to requests from the VHA IAP by the required deadline;

(5) Ensuring that all complaints, incidents and actual or suspected breaches of privacy are recorded (by the Privacy Liaison or other responsible party, as appropriate to the circumstances) within one hour in the tracking system (e.g., PSETS) designated by the VA Data Breach Resolution Service and these complaints, incidents and actual or suspected breaches of privacy must also be investigated and resolved in coordination with VHA IAP;

(6) Coordinating with VHA IAP on any Memorandums of Understanding/Agreement (MOU/MOA) or Data Use Agreements (DUA) when sharing personally identifiable information with an outside entity;

(7) Assisting with issues resulting from the review of presentation material by the VHA Privacy Office to ensure compliance as required by VA or VHA policy; and

(8) Tracking privacy training annually and reporting the compliance to IAP upon request.

g.VISN Privacy Officer. The VISN Privacy Officer is responsible for:

(1) Developing VISN privacy policies consistent with the VHA Privacy Program;

(2) Conducting privacy assessments of all VISN-level programs on a schedule set forth by VHA IAP to ensure compliance with VISN privacy policies and monitoring that the facility Privacy Officers are conducting their Facility Self-Assessment (FSA) quarterly at the facility-level as required by VHA IAP;

(3) Providing expert privacy guidance to each VISN facility and VISN staff on all privacy related matters such as the Privacy Act, FOIA, HIPAA Privacy Rule, and title 38 confidentiality statutes,

and seeking guidance and advice from the VHA Privacy Office to resolve any questions or concerns about privacy-related issues;

(4) Ensuring that the VISN office and all facilities within the VISN respond to requests from VHA IAP by the required deadline;

(5) Ensuring that all complaints, incidents and actual or suspected breaches of privacy are reported (by the VISN Privacy Officer or other responsible party, as appropriate to the circumstances) within one hour to the tracking service designated by the VA Privacy Service and these complaints, incidents and actual or suspected breaches of privacy must be investigated and resolved;

(6) Monitoring facility Privacy Officers within their respective VISN to ensure they are completing Privacy Threshold Analysis (PTA), Privacy Impact Assessments (PIA), contract reviews and Business Associate Agreements (BAA) for facility-level systems and agreements, and reporting any deficiencies to the appropriate Medical Center Director;

(7) Conducting privacy-related reviews, such as contract security reviews for VISN-level contracts, and VISN privacy presentation or publication reviews as required by VA or VHA policy;

(8) Ensuring a BAA is in place for VISN-level contracts or other agreements (e.g., MOU/ISA) involving the disclosure of personally identifiable information (PII) to the contractor or other outside entity; and

(9) Partnering with new Privacy Officers within their VISN to ensure that they have the necessary resources and training to build a privacy program.

h.VA Medical Center Director. The VA Medical Center Director is responsible for:

(1) Designating an individual with privacy experience which may include Certified Information Privacy Professional (CIPP) or other related experience, to serve as the Privacy Officer;

(2) Ensuring compliance within the facility with all Federal laws, regulations, VA regulation and policies, and VHA policies relating to privacy;

(3) Ensuring facility policies and procedures consistent with policies contained in this directive are established and distributed to all employees;

(4) Ensuring that all personnel within the facility obtain privacy training before they are granted access to any individually-identifiable information, and that personnel receive the follow-up privacy training periodically;

(5) Ensuring that all personnel within the facility obtain annual privacy training in accordance with applicable requirements and VHA privacy policy;

(6) Implementing the requirements of the VHA Privacy Program as it applies to VHA facilities;

(7) Ensuring that all complaints, incidents and actual or suspected breaches of privacy are recorded (by the Privacy Officer or other responsible party, as appropriate to the circumstances) within one hour in the tracking system designated by the VA Data Breach Resolution Service (e.g., PSETS);

(8) Ensuring the facility Privacy Officer completes PTAs, PIAs, contract reviews and BAAs for facility-level systems and agreements;

(9) Ensuring that the facility Privacy Officer is conducting the FSA quarterly as required by VHA IAP; and

(10) Making their facility, documentation and personnel available for assessment by VHA Privacy Compliance Assurance and ensuring that personnel within the facility are timely and thorough in completing remediation activities as requested by VHA IAP.

i.Facility Privacy Officer. The facility Privacy Officer is responsible for:

(1) Reporting directly to the facility Director or Associate Director for responsibilities as the designated facility Privacy Officer(s) and for activities of the facility Privacy Program;

(2) Performing duties as needed to ensure a robust, effective and compliant facility privacy program, including training, monitoring, analysis, or other specific responsibilities outlined in VA or VHA privacy policies;

(3) Using the facility privacy policy template to develop facility privacy policies consistent with the VHA Privacy Program;

(4) Reviewing or auditing all programs at the facility and outlying Community Based Outpatient Clinics quarterly to ensure compliance with national and facility privacy policies;

(5) Completing and submitting the FSA quarterly as required by VHA IAP;

(6) Providing all documentation and other materials for assessment by VHA Privacy Compliance Assurance timely and completing remediation activities as requested by the VHA IAP;

(7) Providing expert guidance to the facility on all privacy-related matters, such as the Privacy Act, FOIA, HIPAA Privacy Rule, and title 38 confidentiality statutes, and seeking guidance and advice from their VISN privacy officer or privacy liaison to resolve any questions or concerns about privacy-related issues;

(8) Ensuring that the facility responds to requests from the VHA IAP by the required deadline;

(9) Ensuring that all complaints, incidents and actual or suspected breaches of privacy of Individually-identifiable information are reported within 1 hour to the tracking service designated by the VA Data Breach Resolution Service (e.g. PSETS) and these complaints, incidents and actual or suspected breaches of privacy are investigated and resolved;

(10) Conducting privacy-related reviews, such as contract security reviews, PTAs, PIAs, BAAs, facility walk through assessments, privacy presentation or publication reviews and research protocol privacy reviews, as required by VA or VHA policy;

(11) Reviewing any MOU/MOA or DUA when sharing or disclosing facility-level personally identifiable information with an outside entity; and

(12) Ensuring that the facility complies with all corresponding privacy directives associated with this policy.

j.VHA Personnel. All VHA personnel are responsible for:

(1) Complying with all Federal laws and regulations, VA regulations and policies, national VHA policies and local (VISN, program office and/or facility) policies relating to privacy;

(2) Completing all applicable VA- and VHA-required privacy training at the time of employment, annually thereafter, and as directed when changes are made to update the required training;

(3) Reporting all actual or suspected breaches of privacy in a timely and complete manner to the appropriate privacy official, according to established policy;

(4) Seeking guidance and advice from their local Privacy Officer or Privacy Liaison to resolve any questions or concerns about privacy-related issues;

(5) Ensuring privacy authority exists, which may require consultation with an appropriate privacy official, prior to sharing or disclosing PII outside VA; and

(6) Using, disclosing, or requesting the minimum amount of individually-identifiable information necessary to perform their specific job function. The minimum necessary standard does not apply to treatment purposes.

6.REFERENCES

a.38 U.S.C. 5701.

b.38 U.S.C. 5705.

c.38 U.S.C. 7332.

d.HIPAA, 45 CFR, Parts 160 and 164.

e.FOIA, 5 U.S.C. 552.

f.Privacy Act, 5 U.S.C. 552a.

g.VA Directive 6502, VA Enterprise Privacy Program.

h.VHA Directive 1605.01, Privacy and Release of Information.

i.VHA Handbook 1605.02, Minimum Necessary Standard for Protected HealthInformation.

j.VHA Handbook 1605.03, Privacy Compliance Assurance Program and PrivacyCompliance Monitoring.

V. VHA Handbook 1400.01 Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents

Department of Veterans Affairs Veterans Health Administration Washington, DC 20420

SUPERVISION OF PHYSICIAN, DENTAL, OPTOMETRY, CHIROPRACTIC, AND PODIATRY RESIDENTS

1.REASON FOR ISSUE: This Veterans Health Administration (VHA) directiveprovides the procedural requirements to ensure proper supervision of residents inclinical care and its documentation thereof. This is fundamental for the provision ofexcellent patient care and education and training for future health care professionals.

2.SUMMARY OF MAJOR CHANGES: This directive includes the following majorchanges:

a.Adds requirements pertaining to resident supervision standards in tele-medicineand tele-Intensive Care Unit (ICU) situations (see paragraph 8.c.(11)).

b.Adds additional language clarifying requirements for the levels of surgicalsupervision during procedures (see paragraph 8.c.(5)).

c.Clarifies language related to routine, bedside procedures (see paragraph 8.c.(6)).

d.Clarifies requirements for discharge documentation (see paragraph 8.c.(1)(c)).

3.RELATED ISSUES: VHA Directive 1400.09(1), Education of Physicians andDentists, dated September 9, 2016; VHA Directive 1052, Appropriate and Effective Useof Mandatory and Required Training, dated June 29, 2018;; VHA Handbook 1400.03,VHA Educational Relationships, dated February 16, 2016; VHA Handbook 1400.04,Supervision of Associated Health Trainees, dated March 19, 2015; VHA Handbook1400.05, Disbursement Agreement Procedures for Physician and Dentist Residents,dated August 14, 2015; VHA Handbook 1400.07, Education of Advanced Fellows, datedFebruary 26, 2016; VHA Handbook 1400.08, Education of Associated HealthProfessions, dated February 26, 2016; VHA Handbook 1400.10, Health CareResources Contracting: Educational Costs of Physician and Dentist Resident TrainingPursuant to Title 38 United States Code 8153, dated November 16, 2012; VHAHandbook 1400.11, Extended Educational Leave, dated April 1, 2016; and VHAHandbook 1907.01, Health Information Management and Health Records, dated March19, 2015.

4.RESPONSIBLE OFFICE: The Chief Academic Affiliations Officer (10X1) isresponsible for the content of this directive. Questions may be directed to 202-461-9490.

5.RESCISSIONS: VHA Handbook 1400.01, Resident Supervision, datedDecember 19, 2012, is rescinded.

6.RECERTIFICATION: This VHA directive is scheduled for recertification on or before

the last working day of November 2024. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

BY THE DIRECTOR OF THE OFFICE OF THE UNDER SECRETARY FOR HEALTH:

/s/ Carolyn Clancy, MD Deputy Under Secretary for Health for Discovery, Education, and Affiliate Networks

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

DISTRIBUTION: Emailed to the VHA Publications Distribution List on November 8, 2019.

November 7, 2019 VHA DIRECTIVE 1400.01

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CONTENTS SUPERVISION OF PHYSICIAN, DENTAL, OPTOMETRY, CHIROPRACTIC, AND PODIATRY RESIDENTS

SUPERVISION OF PHYSICIAN, DENTAL, OPTOMETRY, CHIROPRACTIC, AND PODIATRY RESIDENTS

1. PURPOSE

This Veterans Health Administration (VHA) directive states policy for the supervision of physician, dentist, optometrist, chiropractic, and podiatry residents and focuses on resident supervision from the educational perspective. NOTE: See VHA Directive 1401, Billing for Services Provided by Supervising Practitioners and Physician Residents, dated July 29, 2016, for guidance on billing related to services provided by supervising practitioners and residents. AUTHORITY: Title 38 United States Code (U.S.C.) 7301(b).

2. BACKGROUND

a. A clear delineation of clinical responsibilities ensures that practitioners provide high-quality patient care, whether they are trainees or full-time staff. As resident trainees acquire the knowledge and judgment that accrues with experience, they are allowed the privilege of increased authority for patient care. To ensure safe patient care and effective teaching to allow this professional advancement, supervising clinicians must supervise resident activity.

b. VHA follows the institutional requirements of the Accreditation Council for Graduate Medical Education (ACGME) and other accrediting and certifying bodies. ACGME states that the Program Director and faculty are responsible for providing residents with direct experience in progressive responsibility for patient management. The process of progressive responsibility through competency-based education inclusive of entrustable professional activities (EPAs) is the underlying educational principle for all graduate medical and health professional education, regardless of specialty or discipline. Supervising clinician educators involved in this process must understand the implications of this principle and its impact on the patient and the resident. NOTE: Accreditation bodies for the disciplines of dentistry, podiatry, chiropractic, and optometry have similar requirements.

c. VHA must comply with the requirements and accreditation standards of health care accrediting bodies, such as The Joint Commission, Commission on Accreditation of Rehabilitation Facilities and others as appropriate. Health care professionals with appropriate credentials and privileges provide care for Veterans and supervise residents in that care.

d. The quality of patient care, patient safety, and the success of the educational experience are inexorably linked and mutually enhancing. Incumbent on the clinician educator is the appropriate level, intensity, and quality of supervision of residents as they acquire the skills to practice independently.

3. DEFINITIONS

a. Additional Signer (or Identified Signer as this is referred to in Computerized Patient Record System). The additional signer (or Identified Signer as this is referred to in Computerized Patient Record System (CPRS)) is a communication tool used to alert a clinician about information pertaining to the patient. This functionality is designed to allow clinicians to call attention to specific documents and for the recipient to acknowledge receipt of the information. Being identified as an additional signer does not constitute a co-signature and cannot be used for resident supervision purposes. NOTE: For additional information, see VHA Handbook 1907.01, Health Information Management and Health Records, dated March 19, 2015.

b. Chief Resident. The chief resident is an individual who is considered senior in the training program and who may be a licensed independent practitioner (LIP). Chief residents are designated by the Program Director and may assume advanced administrative responsibilities necessary for the operation of the residency program. Chief residents fall into one of two categories:

(1) Chief Resident – In Training. In-training chief residents are currently enrolled in an accredited residency program, but have not completed the full academic program leading to board eligibility. These chief residents are not independent and cannot be privileged to work in the discipline for which they are being trained. This model is common in surgery programs. NOTE: In-training chief residents may function as LIPs outside of their training programs if licensed, credentialed and privileged and meet staff appointment qualifications.

(2) Chief Resident – Post Training. Post-training chief residents have completed an accredited residency program and engage in an additional year of training and responsibility. These chief residents have completed training for board eligibility or are board-certified and are able to be privileged in the discipline of their completed specialty training program. These chief residents are frequently licensed independent practitioners. This model is common in internal medicine programs.

c. Co-Signer. A co-signer is the supervising practitioner. A co-signer may also be a service chief, or designee, as defined by the organization's by-laws or policies. A co-signer may edit and authenticate a document if the author has not already signed the document. NOTE: See VHA Handbook 1907.01 for additional information.

d. Designated Education Officer. The Designated Education Officer (DEO) is the single designated Department of Veterans Affairs (VA) employee who oversees all clinical training at each VA medical facility that either sponsors or participates in accredited training programs. The DEO (whose preferred organizational title is ACOS/E) is a designated education leader with expertise in graduate medical education (GME) and health professions education. The DEO describes a functional assignment and not an organizational title.

e. Designated Institutional Official. The Designated Institutional Official (DIO) is an individual employed by the entity sponsoring the residency program who has the institutional authority for the oversight and administration of training in discipline-specific programs. Accreditation Council for Graduate Medical Education (ACGME) requires that each institution sponsoring ACGME-accredited programs have an individual appointed as the DIO. A VA medical facility that sponsors ACGME-accredited programs independently must have a DIO, although the responsibilities and functions overlap with those described for the DEO.

f. Documentation. For purposes of this directive, documentation is the written or electronic health record evidence of the interaction between a supervising practitioner and a resident concerning a patient encounter and the care provided.

g. Entrustable Professional Activity. An EPA is a unit of professional practice, defined as a task or responsibility to be entrusted to a trainee for unsupervised execution once the trainee has attained sufficient specific competence. EPAs are independently executable, observable, and measurable in their process and outcome, and suitable for entrustment decisions.

h. Graduate Medical Education. Graduate medical education (GME) is the process by which clinical and didactic experiences are provided to residents enabling them to acquire those skills, knowledge, attitudes, and professional competencies, which are important in the care of patients. The purpose of GME is to provide an organized and integrated educational program of guidance and supervision of the resident, to facilitate the resident’s professional and personal development, and to provide safe and appropriate care for patients.

i. Milestone. Milestones are stages in the development of specific competencies during a trainee’s training. Milestones may be linked to EPAs in determining the degree of supervision for particular activities.

j. Network Academic Affiliations Officer. The Network Academic Affiliations Officer is the designated education leader at the Veterans Integrated Service Network (VISN) level with expertise in health professions education, who coordinates regional education activities. The assignment may be collateral, part-time or full-time, depending on the size and complexity of the VISN education programs.

k. Night Float and Over Cap Residents.

(1) Night float. In some programs, residents are assigned to cover evening or night admissions for an entire shift. Such residents may be called night floats. Night float may be an assigned rotation with the number of consecutive nights on duty not to exceed accreditation standards.

(2) Over Cap residents. An over cap resident (or similar designation) is on-call (generally from home) to come to the VA medical facility to admit patients when the number of admissions exceeds the limits (or caps) set by the accrediting body.

l. Observation Patient. An observation patient is a patient who presents with an unstable medical, surgical, or mental health condition, and laboratory, radiologic, or other testing is necessary in order to assess the patient's need for hospitalization versus discharge. Alternatively, a patient for whom the treatment plan is not established; however, based on the patient's condition, completion of a treatment plan is anticipated within a period not to exceed 48 hours.

m. Program. For purposes of this policy, a program is a structured, accredited educational experience in graduate medical, dental, podiatry, chiropractic, or optometry education designed to conform to the program requirements of a particular specialty or subspecialty, the satisfactory completion of which may result in eligibility for board certification.

n. Residency/Fellowship Program Director. The Program Director is the person designated with authority and accountability for the operation of the accredited residency or fellowship program.

o. Resident. A resident is an individual who is engaged in an accredited graduate training program for physicians, dentists, optometrists, chiropractors, or podiatrists, and who participates in patient care under the direction of supervising practitioners. Although a trainee may be considered a resident within a training program, that person may also have completed training requirements for board eligibility in another specialty. If so, that resident may be considered an independent licensed practitioner only in accordance with paragraph 11.b., in the specialty for which he or she has met the board eligibility requirements. Within a training program, a resident is never considered a Licensed Independent Practitioner. NOTE: For the purpose of this directive, the term resident includes individuals in their first year of training, who are sometimes referred to as interns, and individuals in approved subspecialty graduate medical education programs, who are also referred to as fellows.

(1) Post-Graduate Year-1 Resident. Post-Graduate Year (PGY)-1 residents are in their first PGY of training. NOTE: Sometimes referred to as interns.

(2) Intermediate Resident. Intermediate resident refers to a second post-graduate year (PGY-2) or higher resident through the next to final year of core training.

(3) Senior Resident. Senior resident refers to residents in their final accredited year of core residency training.

(4) Fellow. Fellow refers to a physician, dentist, optometrist. chiropractor, or podiatrist in a program of accredited graduate education who has completed the requirements for eligibility for first board certification in the specialty. The term subspecialty residents is also applied to such physicians. Other uses of the term fellow require modifiers for precision and clarity, e.g., research fellow. NOTE: The terms fellow and resident in this directive do NOT refer to VA Advanced Fellows or fellows in non-accredited programs.

p. Signer. A signer is the author of the document. Once a document is signed, it cannot be edited. Additional documentation can be added to the original document by addenda. NOTE: See VHA Handbook 1907.01 for additional information.

q. Supervising Practitioner. Supervising practitioner (sometimes referred to as attending or faculty) refers to licensed independent physicians, dentists, optometrists, chiropractors, and podiatrists, regardless of the type of VA appointment, who have been credentialed and privileged at a VA medical facility and by the associated training program, in accordance with applicable requirements. In some training settings and according to the requirements of the accrediting body, other health care professionals with documented qualifications and appropriate academic appointments (i.e., nurse practitioners, psychologists, audiologists), may function as supervising practitioners for selected training experiences. NOTE: A supervising practitioner must be approved by the program of the residency program in order to supervise residents.

NOTE: ACGME defines supervising faculty as “any individuals who have received a formal assignment to teach resident physicians.” Per accreditation requirements, the Program Director at the sponsoring entity approves the assignment to teach and supervise residents. Assignment of supervising practitioners must be coordinated with the Program Director, the VA Site Director, the applicable VA Service Chief, and the affiliated Department Chair as appropriate. The specific VA staff approved to supervise residents should be delineated in the Program Letter of Agreement.

r. Supervision. For purposes of this directive, supervision is an intervention provided by a supervising practitioner (attending) that occurs as residents provide patient care through direct or indirect contacts with patients. The relationship of the supervising practitioner to the resident is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the resident while monitoring the quality of professional services delivered. Supervision is exercised through direct involvement with the patient and resident, observation of care provided by the resident, oversight of patient care, directing the learning of the resident, and role modeling communication and professional skills. NOTE: This definition is adapted from Bernard, J. M., & Goodyear, R. K., Fundamentals of Clinical Supervision (2nd ed.). Needham Heights, MA: Allyn & Bacon 1998. Supervision occurs in the context of the provision of patient care and implies responsibility for patient care. In contrast, didactic teaching, mentoring, and evaluation, even when based on consideration of patient cases or other clinical material (e.g., non-current imaging or case files), are not considered to involve supervision for the purpose of

this directive. Level of supervision refers to the type of involvement of the supervising practitioner with the resident during the patient encounter, procedure, or episode of care.

(1) Direct Supervision. Direct supervision means the supervising practitioner is physically present with the resident and the patient. In direct supervision, the supervising practitioner is a party to the patient encounter between the patient and a resident even if the “encounter” with the patient is non-face-to-face. The resident and supervising practitioner must be co-located if the patient is remote (see paragraph 8.c.(11) on telemedicine). NOTE: Text messaging, voice messaging, emails, or written

letters, are not considered supervision. Direct supervision can be further characterized by the level of attending involvement according to whether the supervising practitioner:

(a) Provides care with the resident observing or assisting.

(b) Participates in care which is provided by the resident.

(c) Observes while the resident provides care.

(2) Indirect Supervision. Indirect supervision is supervision exercised by a supervising practitioner who is not physically present with the resident and the patient during the patient encounter, procedure, or episode of care. In all such instances, the supervising practitioner is either located in the same site of patient care or is on-call by means of telephonic, video-conferencing, or other electronic modalities for consultation. In such instances, the supervising practitioner must be available in a manner that ensures patient safety to participate in patient care or direct supervision, as needed. The supervising practitioner may be:

(a) At the same site of patient care (i.e., clinic, inpatient unit, imaging, laboratory, surgical, or procedural suite) in which the resident is engaged in patient care.

(b) In another location within the VA medical facility or its clinical campus, generally referred to as in-house or on-site.

(c) Not present in the VA medical facility or its clinical campus, generally referred to as off-site.

(3) Oversight. For purposes of this directive, oversight refers to information-gathering activities on the part of the supervising practitioner, such as review of procedures, documentation of encounters, imaging, laboratory, and consultation with other practitioners or clinical personnel. Oversight is intended to gather information either before or after resident-delivered care, in order to assess the patient’s clinical progress, or to evaluate the performance and professional development of the resident as pertaining to the care the patient received or to provide information that is likely to inform and guide the resident’s patient encounter.

NOTE: The definitions of levels and intensity of supervision are from ACGME's Common Program Requirements (see https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements). NOTE: This linked document is outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973.

s. Unstable Condition. Unstable condition is defined as a variance from generally accepted normal laboratory values, and clinical signs and symptoms are present that are above or below those of normal range (for the patient) and are such that further monitoring and evaluation is needed; or changes in the patient's status or condition are anticipated and immediate medical intervention may be required.

t. VA Advanced Fellow. VA Advanced Fellow refers to a VA-based clinical trainee who has enrolled in a VA Advanced Fellowship Program for additional training, primarily in research. Advanced fellowships are non-accredited training programs that are funded directly from the Office of Academic Affiliations in a separate allocation process from accredited residency positions. VA Advanced Fellows are physicians in VA Advanced Fellowships who have completed an ACGME-accredited core residency (medicine, surgery, psychiatry, etc.) and may also have completed an accredited sub-specialty fellowship. They are board-eligible or board-certified, and consequently, are licensed independent practitioners. Dentists in VA Advanced Fellowships have completed a Commission on Dental Accreditation (CODA)-accredited residency and are licensed independent practitioners. Similar requirements apply to any optometrist, podiatrist or chiropractor VA Advanced Fellows. All VA Advanced Fellows must be credentialed and privileged in the discipline(s) of their completed programs. VA Advanced Fellows may function as supervising practitioners for other trainees.

u. VA Program Site Director. In accordance with accrediting and certifying body requirements, appropriately credentialed local VA clinicians are appointed as VA residency training program site directors for each residency training program. In affiliated programs, these designations must be made with the concurrence of the program director of the residency program.

4. POLICY

It is VHA policy that VA-appointed physician, dental, optometry, chiropractic, and podiatry trainees must serve under the supervision of a VHA licensed independent practitioner who is locally credentialed and appropriately privileged. Further, it is VHA policy that residents must be enrolled in accredited or Office of Academic Affiliations-approved training programs, and are not considered licensed independent practitioners regardless of licensure status while performing activities in the training program. Trainees assume graduated and incremental responsibilities (EPAs) for the clinical care of Veterans under supervision.

5. RESPONSIBILITIES

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

b. Deputy Under Secretary for Health for Operations and Management. The Deputy Under Secretary for Health for Operations and Management is responsible for:

(1) Communicating the contents of this directive to each of the VISN.

(2) Ensuring that each VISN Director has sufficient resources to fulfill the terms of this directive in all VA medical facilities within that VISN.

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

c. Deputy Under Secretary for Health for Discovery, Education and Affiliate Networks. The Deputy Under Secretary for Health for Discovery, Education and Affiliated Networks is responsible for:

(1) Overseeing and advancing the health professions education mission for VA.

(2) Enhancing knowledge of VA's education mission through communication with internal and external stakeholders.

(3) Ensuring that the Office of Academic Affiliations (OAA) has sufficient resources to carry out the statutory mission and the responsibilities in this directive.

(4) Providing senior executive leadership guidance to OAA.

d. Chief Academic Affiliations Officer. The Chief Academic Affiliations Officer is responsible for:

(1) Defining national policies pertinent to residents in VA medical facilities, and overseeing implementation of the OAA policies through multiple oversight mechanisms.

(2) Completing an annual review of resident supervision through the Annual Report of Resident Training Programs (ARRTP) (RCN 10-0906).

(3) Sharing results from the annual review with appropriate VHA leadership to ensure that VA continuously improves its ability to provide safe and effective patient care; ensuring applicable feedback is provided to VISNs and their respective facilities.

(4) Presenting pertinent decision-making information to VHA's leadership.

(5) Allocating specific resources for residents' stipends and benefits.

e. Veterans Integrated Service Network Director. The VISN Director is responsible for:

(1) Addressing residency program needs and obligations in VISN planning and decision-making, and making necessary resources available to the respective affiliated VA medical facilities to ensure resident supervision is provided as outlined in this directive.

(2) Appointing a Network Academic Affiliations Officer for coordination of regional education activities.

(3) Ensuring that each affiliated VA medical facility has a monitoring process in place as detailed in paragraphs below.

(4) Reviewing the annual reports of all affiliated facilities in the VISN to identify opportunities for improvement or areas that need further review.

(5) Submitting the VISN reviews to the Chief Academic Affiliations Officer through the ARRTP (RCN 10-0906) process.

f. VISN Academic Affiliations Officer. The VISN Academic Affiliations Officer is responsible for assisting the VISN Director by:

(1) Completing an annual VISN-level ARRTP assessment of VA medical facility residency training and resident supervision activities and identifying opportunities for improvement or areas that need further review after a review of each VA medical facility's ARRTP (RCN 10-0906).

(2) Presenting educational needs and obligations to the VISN Director for consideration in VISN planning and decision-making.

(3) Assisting VA medical facilities in implementing policies relating to health professions training.

(4) Ensuring that all VA medical facilities comply with the contents of this directive and have a robust local monitoring program.

g. VA Medical Facility Director. The VA medical facility Director is responsible for:

(1) Appointing and assigning the duties of the Designated Education Officer (DEO) to the appropriate local education leader and ensuring that appropriate staff is available for monitoring resident supervision at the VA medical facility-level.

(2) Appointing and assigning the duties of the Designated Institutional Officer (DIO) for the facility if the VA facility has sponsorship residency programs.

(3) Ensuring through the Chief of Staff, and/or the Associate Chief of Staff for Education, that a local monitoring process exists for resident supervision.

(4) Reporting to the VISN Director or designee the status of resident training programs in that VA medical facility. This reporting must take place through the ARRTP (RCN 10-0906) process.

(5) Confirming that the VA medical facility adheres to current accreditation requirements as set forth by the ACGME, CODA, the Executive Committee of the Council on Postdoctoral Training (ECCOPT), the Council on Podiatric Medical Education (CPME), the American Osteopathic Association (AOA), the Council on Chiropractic Education and Accreditation Council on Optometric Education (ACOE) for all matters pertaining to the resident training program, including the level of supervision provided.

(6) Confirming that the requirements of the various certifying bodies, such as the pertinent member boards of the American Board of Medical Specialties (ABMS), Bureau of Osteopathic Specialists (BOS), American Board of Podiatric Surgery (ABPS), CODA, American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM),

and ACOE are incorporated into VA training programs and fulfilled through local medical facility guidelines and procedures to ensure that each successful program graduate is eligible to sit for the certifying examination in the graduate's specialty.

h. VA Medical Facility Chief of Staff. The VA medical facility COS or designee is responsible for:

(1) Assessing the quality of residency training programs at the VA medical facility, and the quality of care provided by supervising practitioners and residents.

(2) Ensuring the presence of a work environment that is consistent with quality patient care and the educational needs of residents that meet all applicable program requirements. NOTE: An ACOS/E (DEO) may assist the CoS in fulfilling these requirements.

i. Associate Chief of Staff for Education or the Designated Education Officer. The ACOS/E or the DEO is responsible for ensuring that:

(1) The contents of this directive are followed.

(2) Graduated levels of responsibility are established in each specialty or subspecialty and the information regarding these levels is accessible to ward and clinic staff.

(3) The VA medical facility completes the ARRTP including monitoring resident supervision on a quarterly basis.

(4) The VA medical facility establishes a process for identifying and remediating areas with insufficient resident supervision.

(5) Assists the Chief of Staff (COS) in assessing the quality of residency training programs and the quality of care provided by supervising practitioners and residents. All VA medical facilities with more than a single residency program must have one designated responsible individual for these functions.

j. Residency/Fellowship Program Director. The Residency/Fellowship Program Director (who may be based at the VA or the affiliate institution) is responsible for:

(1) Providing residents with direct experience in progressive responsibility for patient management.

(2) Monitoring the quality of the overall education and training program in a given discipline (i.e., medicine, dentistry, optometry, chiropractic, or podiatry).

(3) Ensuring that the program is in compliance with the policies of the respective accrediting or certifying bodies.

(4) Defining the levels of responsibilities for each year of training by preparing a description of the types of clinical activities residents may perform. Each training program must be constructed to encourage and permit residents to assume increasing levels of responsibility relative to their individual progress in experience, skill, knowledge, and judgment. Annually, at the time of promotion or more frequently as appropriate, this document, along with a list of residents assigned to each year or level of training, is provided to the relevant VA Site Director, Service Chief, COS, and DEO.

(5) Giving residents permission to engage in any clinical activity outside the scope of their current training program.

k. VA Program Site Director. The VA Site Director is responsible for:

(1) Ensuring that supervising practitioners are appropriately fulfilling their responsibilities to provide supervision to residents and that ongoing evaluation of supervisors, residents, and the VA site are conducted.

(2) Ensuring that residents function within their assigned graduated level of responsibility.

(3) Structuring and monitoring training programs, in collaboration with the Program Director, consistent with the requirements of the accrediting and certifying bodies identified in paragraph 5.g.(5) and the affiliated participating entity.

(4) Arranging and ensuring that all residents participate in an orientation to VA policies, procedures, and the role of residents within the VA health care system.

(5) Ensuring that residents are provided the opportunity to give feedback regarding their supervising practitioners, the training program, and the VA site. NOTE: VA medical facilities are encouraged to include resident representation on appropriate VA medical facility committees.

(6) Ensuring that for services that provide 24 hours a day, 7 days per week (24/7) resident coverage, call schedules are provided to the VA medical facility administration. Call schedules must delineate both resident and attending coverage for acute and extended care wards, intensive care units, and consultative services.

(7) Ensuring provision of a duty hour schedule that is consistent with proper patient care, the educational needs of residents, and all applicable program requirements.

l. Designated Institutional Official. The Designated Institutional Official (DIO) (who is usually not based at VA) is responsible for:

(1) The oversight and administration of training in discipline-specific programs.

(2) The oversight and administration of the sponsoring institution's ACGME accredited programs.

(3) Ensuring compliance with ACGME institutional requirements.

m. Supervising Practitioner. The supervising practitioner is responsible for:

(1) Being personally involved in the care of their patients in all clinical settings. Whenever a resident is involved in the care of a patient, the supervising practitioner must continue to maintain a personal involvement in the care of the patient.

(2) Providing the appropriate level and intensity of supervision based on the patient's condition, including the complexity and acuity of such condition, and the experience and capability of the trainee being supervised. All patient care services must be rendered under the supervision of the responsible practitioner or must be personally furnished by the supervising practitioner. Supervising practitioners can provide care and supervision only for those activities and in settings for which they have clinical privileges, and for residents in programs for which they have clearly documented relationships. The supervising practitioner's name must be identifiable in the record of each patient being treated.

(a) For example, while a rheumatologist could supervise a podiatry resident on a rheumatology clinic elective or on an inpatient internal medicine rotation, a rheumatologist could not be the supervising practitioner for a podiatry resident in podiatry clinic or in the operating room (OR).

(b) Likewise, an oral surgery resident rotating on an internal medicine service could not provide oral surgery services when under the supervision of a general internist.

(c) Also, a hospitalist, emergency department (ED) physician, or anesthesiologist may directly supervise a PGY-1 surgery resident for non-surgical patient management when there are appropriately documented relationships in place.

(3) Delegating responsibility for the care of the patient and the supervision of the residents involved to an alternate supervising practitioner, if necessary. Ensuring that the residents involved in the care of the patient are informed of such delegation and can readily access a supervising practitioner at all times.

(4) Ensuring patient safety and high-quality care while maximizing the educational experience of the resident in the clinical setting. In the ambulatory setting, it is expected that an appropriately privileged supervising practitioner will be physically present and available for supervision during clinic hours.

(5) Ensuring that all trainee supervision is properly documented in the health record by the supervising practitioner or reflected within the trainee progress note. The health record must reflect the involvement of the supervising practitioner. (For detailed information, see paragraph 8.)

(6) Authorizing the performance of non-routine, non-bedside procedures and being physically present in the procedural area for such procedures.

(7) Obtaining access to the electronic health record to properly supervise trainees.

6. RESIDENT FUNCTIONS GENERALLY

a. Chief Resident - In Training. In-training chief residents, while senior, are still considered residents and must be supervised by a supervising practitioner. Graduated levels of responsibility, however, may allow a wider scope of practice.

b. Chief Resident - Post Training. Post-training chief residents may function either as a trainee, as a staff physician and supervising practitioner, or as a hybrid trainee and supervising practitioner, depending on the type of personnel appointment, salary level and source, and privileges according to the following three options. NOTE: The requirements for billing are outside the scope of this resident supervision handbook. Refer to VHA Directive 1401 on guidance for services provided by supervising practitioners and physician residents.

(1) Option 1. Chief Resident as Trainee. Post-training chief residents may be paid as trainees at a trainee salary scale and have resident appointments. They neither need to go through the credentialing process nor have a full license to practice. These chief residents are bound by the requirements of this directive and resident supervision standards.

(2) Option 2. Chief Resident as Staff Physician and Supervising Practitioner. Post-training chief residents may be paid and appointed as staff physicians if they meet VA qualifications. They must

go through the credentialing process, have full medical licensure, and be granted clinical privileges by VA to function independently within their specialty. These chief residents are authorized to:

(a) Co-sign other resident and student notes.

(b) Supervise other trainees; and in general.

(c) Function as independent practitioners.

NOTE: Supervision of residents is contingent upon assignment as a supervising practitioner or faculty by the Program Director.

(3) Option 3. Chief Resident as Hybrid Trainee and Supervising Practitioner. Post-training chief residents may be paid as trainees, but also be credentialed and privileged for independent practice. Intermittently, they may be allowed or required to function as supervising practitioners in either an inpatient or outpatient setting.

(a) In order to function as licensed independent practitioners, they must:

1. Go through the credentialing process.

2. Have full medical licensure.

3. Be granted privileges by VA to function independently within their specialty.

(b) Provided they have been assigned to serve as a supervising practitioner or faculty by the Program Director, these chief residents are authorized to:

1. Co-sign other resident and student notes.

2. Supervise other trainees.

3. Function as independent practitioners within the specialty for which they have independent privileges.

c. Resident. Within the scope of the accredited training program, all residents must function under the supervision of supervising practitioners at all times. Residents must:

(1) Be aware of their limitations and not attempt to provide clinical services or perform procedures for which they have not achieved the appropriate level of experience or capability.

(2) Know the graduated level of responsibility described for their level of training and not practice beyond that level or outside their scope of practice.

(3) Be responsible for communicating significant patient data to the supervising practitioner. Circumstances warranting immediate resident communication with the supervising practitioner include, but are not limited to: significant changes in patient status (e.g., acute decline in physiologic condition); end of life decisions; use of restraints; and “near misses” or adverse events that may occasion a patient safety incident report. Such communication must be documented in the record. Residents must introduce themselves to patients or to the patient’s surrogate, in the event that the patient is unable to communicate with the resident, and explain their role in providing supervised patient care to the patient. NOTE: In some cases, residents, including chief residents, have completed one residency program and required training for board eligibility or board-certification while enrolled in an additional residency training program. These individuals (i.e., fellows or post-training chief residents) may be credentialed and privileged for independent practice only in the discipline in which they have attained board certification or have completed the training for board eligibility.

7. GRADUATED LEVELS OF RESPONSIBILITY

a. As part of their training programs, residents earn progressive levels of responsibility (attainment of milestones/EPAs) for the care of the patient. The determination of a resident's ability to provide care to patients without a supervising practitioner present (EPA), or to act in a teaching capacity, is based on documented evaluation of the resident's clinical experience, judgment, knowledge, and technical skill. Ultimately, it is the decision of the supervising practitioner as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. In general, residents may order laboratory studies, radiology studies, pharmaceuticals, and therapeutic procedures as part of their assigned levels of

responsibility. In addition, residents are allowed to certify and re-certify certain treatment plans (e.g., physical therapy, speech therapy) as part of their assigned levels of responsibility. These activities are considered part of the normal course of patient care and require no additional documentation on the part of the supervising practitioner over and above standard setting-specific documentation requirements. See VHA Directive 1400.09(1), Education of Physicians and Dentists, dated September 9, 2016, regarding medical and dental student participation in care and documentation. The overriding consideration in determining assigned levels of responsibility must be the safe and effective care of the patient. In order to write prescriptions for patients, residents must have a National Provider Identifier (NPI). NOTE: See VHA Directive 1066, Requirement for NPI and Taxonomy Codes, dated November 7, 2013. b. VA staff such as nursing, respiratory therapy, and supervising attendings, must have 24/7 access to a listing or description of graduated levels of responsibility. Provision of these lists or access to online resources that allow determination of what each resident may perform is the responsibility of the Program Director (see paragraph 5.j.(4)).

c. Annually, at the time of promotion or more frequently as appropriate, this documentation of the graduated levels of responsibility, along with a list of residents assigned to each year or level of training, is provided to the relevant VA Program Site Director, Service Chief, COS, and DEO.

8. DOCUMENTATION OF SUPERVISION OF RESIDENTS

a. Supervising Practitioner Involvement. The health record must clearly demonstrate the involvement of the supervising practitioner in each type of resident-patient encounter as described below. NOTE: Documentation requirements are outlined in paragraph 8.c.

b. Supervision Documentation. Documentation of supervision must be entered into the patient health record by the supervising practitioner or reflected within the resident progress note or other appropriate entries in the health record (e.g., procedure reports, consultations, discharge summaries). Diagnostic study results must be reviewed and such review documented by a supervising practitioner.

(1) Types of allowable documentation include, depending on the clinical situation, (see below):

(a) Progress note or other entry into the health record by the supervising practitioner.

(b) Addendum to the resident admission or progress note by the supervising practitioner.

(c) Co-signature of the progress note or other health record entry by the supervising practitioner. NOTE: The supervising practitioner's co-signature signifies that the supervising practitioner has reviewed the resident note, and absent an addendum to the contrary, concurs with the content of the resident note or entry.

(d) Resident progress note or other medical record entry documenting the name of the supervising practitioner with whom the case was discussed, a summary of the discussion, and a statement of the supervising practitioner's oversight responsibility with respect to the assessment, diagnosis and the plan for evaluation and treatment. Statements such as the following are acceptable to demonstrate the supervising practitioner's level of supervision or oversight responsibility:

1. "I have seen and discussed the patient with my supervising practitioner, Dr. 'X' and Dr. 'X' agrees with my assessment and plan."

2. "I have discussed the patient with my supervising practitioner, Dr. 'X' and Dr. 'X' agrees with my assessment and plan."

3. "The supervising practitioner of record for this patient care encounter is Dr. 'X'."

(2) The type of allowable documentation varies according to the clinical setting and kind of patient encounter. In all cases, the responsible supervising practitioner must be clearly identifiable in the documentation of the patient encounter or report of reviews of patient material (e.g., pathology or imaging reports). An independent note or addendum by the supervising practitioner is required for inpatient admissions, pre-operative assessment, and extended care admissions. NOTE: The frequency of documentation of involvement of the supervising practitioner depends upon the setting and the patient's condition. The timeframe for signing or co-signing the progress notes, consultations, and reports is delineated in local medical staff bylaws, or accreditation requirements.

c. Supervision and Documentation Across Patient Settings.

(1) Inpatient Care.

(a) Inpatient Admission. For patients admitted to an inpatient service of the VA, the supervising practitioner must physically meet, examine, and evaluate the patient within the timeframe specified in the VA medical facility bylaws, not to exceed the end of the next calendar day after admission, including weekends and holidays. Documentation of the supervising practitioner's personal involvement, findings and recommendations regarding the treatment plan must be in the form of an independent progress note or an addendum to the resident note. This may take the form of "I have personally assessed the patient, reviewed the medical record and diagnostic studies, and agree with the resident's assessment and plan." This documentation must be entered within the timeframe specified in the VA medical facility bylaws, not to exceed the end of the next calendar day following admission. If the specific requirements of the pre-operative notes are included, the admission note (or addendum) may serve as the pre-operative note. PGY-1 residents must have on-site supervision at all times by either a supervising practitioner or a more advanced resident, with the supervising practitioner being available on-call (on-site or off-site).

(b) Night Float and Over Cap Admissions. For patients admitted to an inpatient service of the VA medical facility during evenings or nights, a night float or over cap resident may provide care before the care of the patient is transferred to an inpatient

ward team. In these cases, the supervising practitioner of the inpatient ward team receiving the patient must physically meet and examine the patient within the timeframe specified in the VA medical facility bylaws, not to exceed the end of the next calendar day after admission by the night float to the inpatient service, irrespective of the time the ward team assumes responsibility for the patient. In addition, appropriate handoff procedures and the designation of a supervising practitioner for night float admissions must follow VA medical facility guidelines. On-site supervision of the night float or over cap resident must be in place, if that resident is a PGY-1 resident. NOTE: Documentation requirements are the same as in preceding paragraph 8.c.(1)(a).
(c) Discharge from Inpatient Status. The supervising practitioner, in consultation with the resident, ensures that the discharge of the patient from an inpatient service of the VA medical facility is

appropriate and based on the specific circumstances of the patient's diagnoses and therapeutic regimen; discharge instructions and orders may include physical activity, medications, diet, functional status, and follow-up plans, including coordination with the patient's primary care team. Evidence of this supervisory involvement must be documented by the supervising practitioner's co-signature on the discharge note (last progress note of the patient's stay), of the discharge instruction note, resident documentation of the supervisor's agreement with discharge, or an addendum or independent discharge note, in a timeframe that ensures patient safety. Any of these methods will suffice to ensure supervisor agreement with the discharge plan. The discharge summary must also be co-signed by the supervising practitioner. All timeliness standards should be defined in medical staff bylaws.

(d) Transfer from One Inpatient Service to Another, or Transfer to a Different Level of Care (Inter-service or Inter-ward Transfer). The supervising practitioner, in consultation with the resident, ensures that the transfer of the patient from one inpatient service to another or transfer to a different level of care is appropriate and based on the specific circumstances of the patient's diagnoses and condition and this assessment is documented in the health record using any of the four types of documentation referenced in paragraph 8.b. When a patient requires a different level of care within the same ward or unit, the supervising practitioner must be involved in the decision to change the level of care and documentation of the appraisal must be entered into the health record using any of the four types of documentation referenced in paragraph 8.b.(1)(a)-(d). The supervising practitioner from the receiving service must treat the patient as a new admission and must write an independent note or an addendum to the resident's transfer acceptance note. NOTE: This provision covers transfers into and out of intensive care units or transfers to extended care. However, if the same supervising practitioner is responsible for the patient across different levels of care, transfer documentation is not required.

(e) Inpatient Consultations. A consultant supervising practitioner on a specialty service is responsible for clinical consultations for their specialty service. When residents are involved in consultation services as consultants, the consultant supervising practitioner is responsible for the supervision of these residents. NOTE: Any of the four types of documentation referenced in paragraph 8.b.(1)(a)-(d) is acceptable.

(f) Intensive Care Units, including Medical, Cardiac, and Surgical Intensive Care Units. For patients admitted to, or transferred into, an Intensive Care Unit (ICU) of the VA medical facility, the supervising practitioner must meet, personally evaluate the patient, review the history, perform a physical examination, review diagnostic data, as soon as practicable, but no later than 24 hours after admission or transfer, including weekends and holidays. An admission note or addendum to the resident's admission note indicating the personal involvement and independent assessment (see 8(c)(1)(a)) is required in the timeframe specified in the VA medical facility bylaws, not to exceed the end of the next calendar day after admission. Due to the unstable nature of patients in ICUs, based on the patient's condition, an appropriate level of involvement,

including independent personal assessments, by the supervising practitioner, with documentation of such involvement, is required. PGY-1 residents must have on-site supervision at all times by either a supervising practitioner or a more advanced resident, with the supervising practitioner being available on-call. Supervising practitioner involvement is expected on a daily or more frequent basis and must be documented using any of the four types of documentation referenced in paragraph 8.b.(1)(a)-(d).

(g) Observation Patients. The level of supervision expected for observation patients depends upon the unit where the patient is being held (e.g., ICU, inpatient ward, or emergency department (ED)). If the patient is released before the supervising practitioner sees the patient, the resident must: contact the on-call attending by phone prior to the patient's discharge; discuss the patient's condition, treatment, and follow-up plans; and have the concurrence of that supervising practitioner regarding the plan to release the patient. A summary of the discussion between the resident and the supervising practitioner must be documented in the resident's note as a minimum form of documentation of supervision if the patient was not seen by the attending prior to release. If the supervising practitioner is able to evaluate the patient in person, an independent note or addendum to the resident's note is required. NOTE: Supervising practitioner's co-signature of the resident's note is not sufficient documentation of resident supervision.

(2) Outpatient Clinic.

(a) Physical Presence. The supervising practitioner must be physically present in the clinic area during clinic hours whenever residents are engaged in patient care.

(b) New Outpatient Encounters. New patients to a VA medical facility (including Vet Centers) require a higher level of supervising practitioner documentation than established outpatients. Each new patient needs to be seen by or discussed with the supervising practitioner. Documentation of supervising practitioner involvement must be entered in the patient health record per paragraph 8.b.(1)(a)-(d). NOTE: Supervising practitioner's co-signature of the resident's note is not sufficient documentation of resident supervision.

(c) Outpatient Consultations. A supervising practitioner is responsible for the decision to initiate clinical consultations from an outpatient clinic to a consultation service. When residents are involved in delivering consultation services, the consulting

supervising practitioner is responsible for supervision of these residents. The consulting attending must be contacted by the resident on the consultation service while the patient is still in the clinic. NOTE: Any of the four types of documentation referenced in paragraph 8.b.(1)(a)-(d) is acceptable. (d) Continuing Care in the Outpatient Setting. The supervising practitioner must be identifiable for each resident's patient care encounter. Return patients must be seen by, or discussed with, the supervising practitioner at such a frequency as to ensure that the course of treatment is effective and appropriate.

(e) Discharge from Outpatient Clinic. The supervising practitioner, in consultation with the resident, ensures that the discharge of the patient from the clinic is appropriate.

(3) Extended Care or Community Living Centers.

(a) New Extended Care Admissions. Each new patient admitted to an extended care or Community Living Center (CLC) facility must be seen by the responsible supervising practitioner within 72 hours of admission.

(b) Continuing Care in the Extended Care or CLC Setting. The identity of the supervising practitioner must be communicated to the resident for each resident's patient care encounter. Extended care patients must be seen by, or discussed with, the supervising practitioner at such a frequency as to ensure that the course of treatment is effective and appropriate. Any of the four types of documentation referenced in paragraph 8.b.(1)(a)-(d) is acceptable.

(4) Emergency Department.

(a) Physical Presence. The supervising practitioner for the ED must be physically present in the ED whenever residents are engaged in patient care.

(b) ED Visits. Each patient to the ED must be seen by or discussed with the supervising practitioner.

(c) Discharge from the ED. The supervising ED practitioner, in consultation with the ED resident, ensures that the discharge of the patient from the ED is appropriate.

(d) ED Consultations. A consulting supervising practitioner is responsible for clinical consultations requested for their specialty service. When residents are involved in consultation services, the consulting service supervising practitioner is responsible for supervision of these residents. Residents from a consulting service must contact their supervising practitioners while the patient is still in the ED in order to discuss the case and to develop a recommended plan of management. The ED practitioner is responsible for the disposition of the patient. NOTE: The ED practitioner is not the supervisor of the consulting resident, but is the responsible practitioner for the patient.

(5) Operating Room Procedures. Supervising practitioners must provide appropriate supervision for the patient's evaluation, including management decisions

involving the patient's medical condition, and procedures performed on the patient. The level of supervision is a function of the level of responsibility assigned to the individual resident involved, demonstrated competence, and the complexity of the patient's condition and procedure. PGY-1 residents providing care in the OR must be directly supervised at all times, except if the OR is used for convenience or space reasons, but the procedures are actually routine bedside or clinic

procedures. In that case, supervision more appropriately follows routine or clinic procedure guidelines, where on-site supervision is allowed after demonstration and documentation of competence is attained. NOTE: If independent performance of a routine bedside or clinic procedure is authorized in clinic or inpatient locations, it is also authorized in the OR.

(a) Pre-procedure Note. For all elective or scheduled surgical procedures, a supervising practitioner must evaluate the patient and write a pre-procedural note or an addendum to the resident's pre-procedure note describing the findings, diagnosis, plan for treatment, and choice of specific procedure to be completed. The pre-procedure supervising practitioner note requirement applies to procedures performed in the OR or procedure rooms. It does not apply to routine bedside procedures and clinic procedures such as skin biopsy, central and peripheral lines, lumbar punctures, centeses, incision and drainage, etc. This pre-procedural evaluation and note may be done up to 30 days in advance of the surgical procedure. All applicable health care accrediting body standards concerning documentation must be met. A pre-procedure note may serve as the admission note if it is written within the timeframe specified in the VA medical facility bylaws, not to exceed the end of the next calendar day after admission by the supervising practitioner with responsibility for continuing care of the inpatient, and if the note meets criteria for both admission and pre-operative notes. NOTE: Use of appropriate note titles in the electronic medical record is encouraged. Other services involved in the patient's operative care (e.g., Anesthesiology) must write their own pre-procedure notes (such as for the administration of anesthesia) as required by the pertinent health care accrediting body but such documentation does not replace the pre-operative documentation required by the surgery supervising practitioner.

(b) Informed Consent. Informed consent must be obtained as detailed in VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009.

(c) Time Out. Every procedure must have the attending present for the time out in accordance with the VHA Directive 1039, Ensuring Correct Surgery and Invasive Procedures In and Out of the Operating Room, dated November 28, 2018.

(d) Veterans Health Information and Technology Architecture (VistA) Surgical Package. Staff involvement in procedures as defined in the VistA Surgical Package must be documented in the computerized surgical log (a part of the VistA Surgical Package) and reported to VA Central Office by the Surgical Quarterly Report consistent with the following scale:

1. Level A: Attending Performing the Operation. The staff practitioner performs the case, and may or may not be assisted by a resident.

2. Level B: Attending in OR, Scrubbed. The supervising practitioner is physically present in the operative or procedural room and directly involved in the procedure. The resident performs major portions of the procedure.

3. Level C: Attending in OR, Not Scrubbed. The supervising practitioner is physically present in the operative or procedural room. The resident performs the procedure under the observation and direction of the supervising practitioner. The supervising practitioner may not be engaged in a simultaneous procedure in or outside the OR.

4. Level D: Attending in OR Suite, Immediately Available. The supervising practitioner is physically present in the operative or procedural suite and able to provide direct supervision or consultation without delay as needed and may not be involved in a simultaneous procedure.

5. Level E: Emergency Care. Immediate (i.e., without delay) care is necessary to preserve life or prevent serious impairment. The supervising practitioner has been contacted and informed of the necessity of the care. NOTE: Emergency surgery may be performed at levels A through D, depending upon the level of supervising practitioner involvement. Level E is appropriate only if a resident is performing the emergency surgery without a supervising practitioner present.

6. Level F: Non-OR Procedure. Routine bedside and clinic procedures done electively in the OR for patient safety or due to unavailability of non-OR space (as example, a cystoscopy that would have normally been performed in the clinic gets performed in the OR due to lack of equipment). The supervising practitioner is identified in the documentation by the resident.

(6) Non-Operating Room Procedures.

(a) Routine Bedside and Clinic Procedures. Routine bedside and clinic procedures include activities such as: skin biopsies, therapeutic bronchoscopy in an ICU setting, central and peripheral lines, lumbar punctures, centeses, and incision and drainage (list is not inclusive of all possible routine bedside procedures). The degree of supervision these procedures takes is dependent on the complexity and inherent risk of the procedure, the experience of the resident, and demonstrated competency via graduated levels of responsibility.

(b) Non-routine, Non-bedside Procedures. Non-routine, non-bedside procedures (e.g., endoscopy, cardiac catheterization, invasive radiology) are procedures that require a high level of expertise in their performance and interpretation. Although gaining experience in doing such procedures is an integral part of the education of the resident, such procedures may be done only by residents with the required knowledge, skill, and judgment and under an appropriate level of supervision by a supervising practitioner. The degree of supervision for these procedures is dependent on the complexity and inherent risk of the procedure, the experience of the resident, and demonstrated competency via graduated levels of responsibility. Supervising

practitioners are responsible for authorizing the performance of such procedures and must be physically present in the procedural area.

NOTE: Documentation standards must follow the setting-specific guidelines (see paragraph 8.c.) Documentation of the degree (level and intensity) of supervising practitioner involvement is encouraged. Any of the four types of documentation referenced in paragraph 8.b.(1)(a)-(d) are acceptable.

(7) Chemotherapeutics. The supervising practitioner must provide oversight over treatment planning (i.e., choice of modality and regimen), dosage or dosimetry determinations, and writing of chemotherapy. Neither the supervising practitioner nor the resident needs to be present during the administration of chemotherapy, since therapy delivery is a function of associated health personnel. Any of the four types of documentation referenced in paragraph 8.b.(1)(a)-(d) is acceptable.

(8) Radiation Therapy. For radiation therapy, irradiation may be off-site and neither the responsible radiation oncology attending nor resident presence is necessary during treatment delivery. An attending note or an addendum to, or co-signature of, the resident's note or consultation documenting the treatment plan is acceptable.

(9) Restricted Medications. Some medications require specific training or licensure.

(a) Attending only. Some medications (e.g., clozapine) require the attending physician write the orders. Local Pharmacy and Therapeutics committees will determine these guidelines.

(b) Special licensure or DEA registration (e.g., buprenorphine). Some medications require specialized training, licensure, or DEA registration. While residents may be able to write these orders, they must have completed the required competency and state licensure/DEA registration.

(10) Home Visits. Home visits generally occur as a part of VA's Home-Based Primary Care (HBPC) Program. Residents who participate in home visits must have received orientation and training related to handling of emergency situations and related HBPC policies and procedures, as provided by supervisors in HBPC. PGY-1 residents may participate in home visits only when accompanied by a supervising practitioner. Although the supervising practitioner need not accompany second post-graduate year or higher (PGY-2+) residents on the home visit (assuming an acceptable, documented level of graduated responsibility), the supervising practitioner must be readily available at an agreed-upon, identifiable phone number for the duration of the time the resident is making home visits. Following home visits, the supervising practitioner must discuss each case with the resident. NOTE: Any of the four forms of documentation referenced in paragraph 8.b.(1)(a)-(d) may be used to record this interaction.

(11) Telemedicine and Telehealth.

(a) Real-time Videoconferencing.

1. In situations where the supervising practitioner and resident are physically present at a VA medical facility delivering telehealth care to a remote patient, resident-provided care is acceptable in all circumstances where VA clinical standards permit the staff practitioner to deliver care remotely. The supervising practitioner must be in the general vicinity and available to the resident for direct supervision without delay, as if the patient were being seen in a clinic. At the current time, VA does not endorse or permit supervision configurations where the supervising practitioner and resident are not co-located. Documentation requirements must follow the setting for which the telehealth is being utilized – e.g., outpatient consultations should follow supervisory documentation guidance for outpatient visits.

2. Real-time videoconferencing must not be used to substitute for appropriate educational supervision, e.g., in situations where the resident is with the patient in a remote setting (e.g., at a Community-Based Outpatient Clinic (CBOC)) and the supervising practitioner is at a parent VA medical facility with videoconferencing connectivity. Resident-provided care in remote settings requires the onsite supervision by a supervising practitioner. However, consultation with specialists via remote connections may be handled as any outpatient consultation would be conducted.

(b) Store and Forward Telehealth. In store and forward telehealth, the resident and supervising practitioner would not see the patient, except through examination of images or specimens (e.g., teleradiology films, teleretinal scans, or telepathology specimens). The resident reviews the material with or without the supervising practitioner present, and the supervising practitioner reviews the same material. The interpretations and reports on all images and pathology specimens must be verified by the supervising practitioner. The supervisor, at the minimum, must co-sign validated resident reports.

(c) Home Telehealth. In home telehealth, the supervising practitioner and resident are delivering home care to a patient by videophone or in-home messaging devices. Such an arrangement is acceptable in all circumstances in which VA standards permit the supervising practitioner to deliver care remotely. Residents who are assigned responsibility for home telehealth patients must consult with the supervising practitioner regarding any changes in a patient’s status or proposed changes in the treatment plan. Supervising practitioners are expected to exercise general oversight of the home telehealth care provided by residents. In these instances, the supervising practitioner does not have to be in the same location as the resident. The resident may document the home visit in the record; the supervisor must co-sign any home notes.

(d) Cross-Facility Health Care. Residents and supervising practitioners are often involved in delivering health care to distant locations such as CBOCs or more rural VA medical facilities through telehealth methodologies. CBOCs that are administratively aligned to a VA health care system would necessarily honor all appropriate privileges and trainee appointments from their main VA health care system. However, when delivering care at another VA medical facility or non-aligned CBOC via technology or otherwise, mechanisms through agreements between VA medical facilities must be created that ensure the following:

1. Supervising practitioners must have privileges to provide care in the “receiving” facility. This may be provided through “proxy privileges” or other reciprocal arrangements.

2. Trainees must have an appropriate appointment status in the “receiving” facility such as a Without Compensation appointment. Appointment paperwork may be copied and sent to the receiving facility to enable this appointment action. NOTE: Duplicate onboarding need not be conducted.

3. The trainee’s educational program must permit the trainee to function in this capacity via program director approval.

(e) Tele-ICU Coverage. In ICU settings, resident supervision will be provided by an assigned, local supervising practitioner. See paragraph 8.c.(1) regarding inpatient and ICU supervision. In VA teaching facilities where tele-ICU coverage is provided from a remote monitoring site and includes monitoring of patients in one or more ICUs, residents who provide concomitant, in-house, local ICU coverage will continue to have their assigned, local supervising practitioner who is ultimately responsible for the management of patients assigned to the resident and may not be supervised by the tele-ICU practitioner. Tele-ICU physicians who are remotely monitoring patients in the ICU may act as consultants in the same manner as any consultant assisting with ICU patient care. The tele-ICU practitioner may provide guidance and recommendations to the resident. The resident is expected to discuss significant changes in patient status and proposed changes in treatment plans with the responsible supervising attending.

9. EMERGENCY SITUATIONS

An emergency situation is where immediate (i.e., without delay) care is necessary to preserve the life of or to prevent serious harm to the health of a patient. In such situations, any resident, assisted by medical facility personnel (consistent with the informed consent provisions of VHA Handbook 1004.01) is permitted to do everything medically consistent with the resident’s training to save the life of a patient or to save a patient from serious harm. The appropriate supervising practitioner must be contacted and apprised of the situation as soon as possible. The resident must document the nature of that discussion in the patient's record.

10. ACCREDITATION REQUIREMENTS

a. The procedures within this directive are applicable to supervision of physician, dental, optometric, chiropractic, and podiatric residents involved in patient care services including, but not limited to: Inpatient care, outpatient care, community and long-term care, emergency care, home health care, and the performance and interpretation of diagnostic and therapeutic procedures. Telehealth and telemedicine describe communication modalities that are allowed in the conduct of VA patient care and may be used in certain circumscribed circumstances with appropriate supervision as outlined in this document.

b. Each VA medical facility must adhere to current accreditation requirements as set forth by the ACGME, Commission on Dental Accreditation (CODA), the Executive Committee of the Council on Postdoctoral Training (ECCOPT), the Council on Podiatric Medical Education (CPME), the American Osteopathic Association (AOA), the Council on Chiropractic Education, and Accreditation Council on Optometric Education (ACOE) for all matters pertaining to the resident training program, including the level of supervision provided.

c. Requirements of the various certifying bodies, such as the pertinent member boards of the American Board of Medical Specialties (ABMS), Bureau of Osteopathic Specialists (BOS), American Board of Podiatric Surgery (ABPS), Commission on Dental Accreditation (CODA), American Board of Podiatric Medicine (ABPM), American Board of Chiropractic Specialties (ABCS), and Accreditation Council on Optometric Education (ACOE) must be incorporated into VA training programs and fulfilled through local VA medical facility procedures to ensure that each successful program graduate is eligible to sit for the certifying examination in the graduate's specialty.

11. SUPERVISION OF PHYSICIAN RESIDENTS PROVIDING EMERGENCY CARE COVERAGE

a. Emergency Department Physician. Physicians providing independent Emergency Department (ED) coverage must be credentialed, privileged, and fully licensed. Residents who have not completed core training requirements for board-certification are still subject to the same supervisory requirements specified in this directive. However, in a critical staffing emergency, permission to use a third post-graduate year (PGY-3) and above, non-board-eligible resident for sole, unsupervised coverage may be requested from the VISN Director. When such an emergency exists, the VISN Director may approve the use of a PGY-3 and above, non-board-eligible resident on a short-term, time-limited basis, when truly exceptional circumstances exist and only for the duration of the emergency staffing issue. In these rare instances, the resident must be appropriately credentialed and privileged and be an approved provider of Advanced Cardiac Life Support (ACLS) (see VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012).

b. Supervision of Residents who have Completed Requirements for Board Eligibility (i.e., Subspecialty Fellows or Chief Residents).

(1) Physician residents who are board-certified or who have completed the training requirements for board eligibility may be privileged as independent practitioners for purposes of ED coverage. Privileges sought and granted may only be those delineated within the general category for which the resident is board-certified or has completed training. NOTE: Physician residents who are credentialed and privileged to work as attendings in the ED will maintain the person class of 'resident'. See VHA Directive 1095, Provider Person Class/Taxonomy File, dated July 18, 2018.

(2) Subspecialty residents, fellows, or chief residents who are appointed to work independently in the ED, outside the scope of their training program (i.e., in areas for

which they are fully qualified by virtue of having completed core residency training in either internal medicine, emergency medicine, psychiatry, or general surgery), must be fully licensed, credentialed, and privileged for the duties they are expected to perform. In this capacity, they are not working under the auspices of a training program and must meet the requirements for staff appointment and are subject to the provisions contained in VHA Handbook 1100.19. (3) The residents in subsections (1) and (2) of this paragraph must have the permission of their Program Director to engage in any clinical activity outside the scope of their current program. Specialty or subspecialty privileges which are solely within the scope of the resident's current training program may not be granted.

(4) In all instances, the resident must receive feedback on his or her interpretation of store-and-forward telehealth data for learning purposes.

12. EVALUATION OF RESIDENTS, SUPERVISORS, AND TRAINING SITES

a. Evaluations of Residents.

(1) Each resident must be evaluated according to accrediting and certifying body requirements on patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. Evaluations occur as indicated by the accrediting or certifying body; program directors determine the manner and timeframe of these evaluations.

(2) When a resident's performance or conduct is judged to be detrimental to patient care, evaluation of the resident, in mutual consultation with the faculty, must be completed. Residents may be dismissed from VA assignment in accordance with VA Handbook 5021, Employee/Management Relations, Part VI, Paragraph 18, Separation of Medical and Dental Residents, dated February 19, 2016, and appointed under 38 U.S.C. 7406, which includes a requirement to notify the Program Director of the affiliated participating institution of a proposed dismissal of a resident in an integrated program.

b. Evaluation of Supervising Practitioner and Training Site. Each resident rotating through a VA medical facility must be given the opportunity to complete confidential written evaluations of supervising practitioners and VA. Evaluations must be conducted in accordance with the standards of the appropriate accrediting or certifying bodies. Evaluations need to conform to program-specific requirements. Academic evaluations are the confidential property of the residency program and Program Director, who may be located at a non-VA site.

c. Storage and Use of Evaluations. Secure storage of evaluations of residents, supervisors, and training sites is the responsibility of the Program Director. The evaluations are aggregated and analyzed in compliance with accrediting and certifying body standards. The evaluations must be

communicated to the responsible VHA Service Chief or VA Site Director in a manner and timetable agreeable to both.

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13. MONITORING PROCEDURES

a. Goals and Objectives.

(1) The goal of monitoring resident supervision is to ensure that Veteran care in which residents are involved is performed in a safe and effective manner and to foster a system-wide environment of quality improvement and collaboration among VHA managers, supervising practitioners, and residents. The monitoring process involves the review of existing information, the production of a series of evaluative reports, the accompanying process of public review of key findings, and discussion of policy implications. NOTE: This process helps identify key resident supervision issues that now influence the quality of care and suggests effective ways for addressing them.

(2) The foundation for resident supervision ultimately resides in the integrity and good judgment of professionals (supervising practitioners and residents) working collaboratively in well-designed health care delivery systems. Accordingly, monitoring of resident supervision is a shared responsibility of national, VISN, and local VA medical facility leaders.

(3) The key objectives of the resident supervision monitoring process are to continuously improve and enhance:

(a) Quality and safety of patient care involving residents.

(b) VHA’s educational environment and culture of learning.

(c) Documentation of resident supervision.

(d) Systems of care involving residents.

(4) Monitoring of resident supervision is a health record review process and a quality management activity. Documents and data arising from this monitoring are confidential and protected under 38 U.S.C. 5705 and its revised implementing regulations.

b. VA Medical Facility Monitoring and Use of Results. Resident training occurs in the context of different disciplines and in a variety of structured clinical settings. The VA medical facility Director is responsible for ensuring that a local monitoring process exists for resident supervision. The monitoring process must occur at the institutional level and must include the following:

(1) A local standard operating procedure (SOP) for “Monitoring of Resident Supervision.” This SOP must define the procedures that are to be followed for the monitoring of resident supervision and assignment of facility-level responsibility for monitoring, (i.e., services may not monitor the

adequacy of supervision of their own attending staff members). The SOP must include procedures for monitoring all activities involving the following elements:

(a) Inpatient care involving residents;

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(b) Outpatient care involving residents;

(c) Procedural care (including OR care) involving residents;

(d) Emergency care involving residents; and

(e) Consultative care involving residents.

NOTE: These five elements may be monitored using sampling techniques. Facilities are encouraged to monitor surgical care performed at levels E and F (as coded in the VistA surgical package) for appropriateness.

(2) Reviewing patient safety, risk management, and quality improvement data (protected by 38 U.S.C. 5705 and its revised implementing regulations and current VA policy), to include:

(a) Results of health record reviews and other locally-derived quality management data concerning patient care involving residents;

(b) Incident reports and tort claims involving residents;

(c) Risk events including adverse events and “near misses” involving residents;

(d) Patient complaints involving residents;

(e) Review of externally-derived quality management data such as External Peer Review Program (EPRP) data; and

(f) Review of reports by accrediting and certifying bodies.

(3) Reviewing of residents’ comments related to their VA experience, if available.

(4) Identifying opportunities for improvement in resident supervision and creation of action plans.

(5) Completing the ARRTP (RCN 10-0906).

(6) Engaging the DEO in the review of all risk events involving residents in order to determine the adequacy of resident supervision in these events.

(7) The use of medical staff peer review processes is inappropriate for residents in medical, dental, optometry, or podiatry programs as they are not licensed independent, privileged

practitioners. The DEO must be furnished a list of all cases reviewed that involve residents in order to provide input on the adequacy of the attending's supervision of the resident.

(8) Sharing all results of monitors with clinical leadership at the facility on a regular basis.

NOTE: The local monitoring process will be most successful if it is a collaborative activity among the medical staff, education leadership, and quality management.

c. VISN-Level Oversight and Procedures. VISN oversight of monitoring processes for resident supervision is designed to meet VISN and VHA strategic goals, identify VISN trends, practices and areas for improvement, and support formulation of appropriate action plans.

d. VHA Central Office Oversight. National monitoring processes for resident supervision are designed to meet VHA strategic goals and identify national trends, practices, and areas for improvement. National monitoring processes include the following:

(1) The Office of Academic Affiliations (OAA), in collaboration with the Office of Quality and Performance, may develop measures of appropriate and timely resident supervision using methodologically sound sampling and reporting procedures.

(2) External Peer Review Program and other nationally-contracted abstractors may be used to complete health record reviews using methodologically sound sampling procedures.

(3) National Surgical Quality Improvement Project (NSQIP) data are reviewed quarterly and evaluated annually by the VHA Surgery Office.

(4) ARRTP (RCN 10-0906) is reviewed and evaluated annually by Office of Academic Affiliations.

(5) VHA Trainee Satisfaction Survey (TSS) and other qualitative and quantitative reviews of resident's experiences and perceptions are reviewed and evaluated annually.

(6) Special reviews including site visits are conducted as needed.

(7) Applicable feedback is provided to VISNs and their respective facilities.

14. ANNUAL REPORT ON RESIDENCY TRAINING PROGRAMS (RCN 10-0906)

The Annual Report on Residency Training Programs (ARRTP) (RCN 10-0906) is a Web-based survey of residency education that is updated annually by each VA medical facility with residents and by each VISN. The information is requested from each affiliated VA medical facility for all resident training programs covered in this directive (i.e., medical (allopathic and osteopathic), dental, optometric, and podiatric programs). The ARRTP may include reviewing patient safety, risk management, and quality improvement data (protected by 38 U.S.C. 5705 and its revised implementing regulations and current VA policy) and information about the residency programs.

Protected material cannot be disclosed to anyone without authorization as provided for by 38 U.S.C. 5705 and 38 CFR 17.500 et seq. Summary results may be shared with VHA leadership and other groups as appropriate.

15. TRAINING

There are no formal training requirements associated with this directive.

16. RECORDS MANAGEMENT

All records regardless of format (paper, electronic, electronic systems, created in this directive must be managed according to the National Archives and Records Administration (NARA) requirements and the NARA-approved rules found in VHA Records Control Schedule (RCS) 10-1. Questions regarding any aspect of records management may be referred to the facility Records Manager or Records Liaison.

17. REFERENCES

a. 38 U.S.C. 5705.

b. 38 U.S.C. 7301(b).

c. 38 U.S.C. 7406.

d. 38 CFR 17.500.

e. VA Handbook 5021, Employee/Management Relations, Part VI, Paragraph 18, Separation of Medical and Dental Residents appointed under 38 U.S.C. 7406, dated February 19, 2016.

f. VHA Directive 1039(1), Ensuring Correct Surgery and Invasive Procedures In and Out of the Operating Room, dated November 28, 2018.

g. VHA Directive 1052, Appropriate and Effective Use of VHA Employee Mandatory and Required Training, June 29, 2018

h. VHA Directive 1066, Requirement for National Provider Identifier (NPI) and Taxonomy Codes, dated November 7, 2013.

i. VHA Directive 1095, Provider Person Class/Taxonomy File, dated July 18, 2018.

j. VHA Directive 1400, Office of Academic Affiliations, dated November 9, 2018.

k. VHA Directive 1400.09(1), Education of Physicians and Dentists, dated September 9, 2016.

l. VHA Directive 1401, Billing for Services Provided by Supervising Practitioners and Physician Residents, dated July 29, 2016.

m. VHA Handbook 1004.01(2), Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009.

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

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

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

q. VHA Handbook 1400.05, Disbursement Agreement Procedures for Physician and Dentist Residents, dated August 14, 2015.

r. VHA Handbook 1400.07, Education of Advanced Fellows, dated February 26, 2016.

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

t. VHA Handbook 1400.10, Health Care Resources Contracting: Educational Cost of Physician and Dentist Resident Training Pursuant to Title 38 United States Code 8153, dated November 16, 2012.

u. VHA Handbook 1400.11, Extended Educational Leave, dated April 1, 2016.

v. VHA Handbook 1907.01, Health Information Management and Health Records, dated March 19, 2015.

w. Accreditation Council of Graduate Medical Education's Common Program Requirements. https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements. NOTE: This linked document is outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973.

x. Bernard, J. M. and R. K. Goodyear. Fundamentals of Clinical Supervision. 2nd ed. Needham Heights, MA: Allyn & Bacon, 1998.

y. Kashner, T. Michael et al. "Measuring Progressive Independence with the Resident Supervision Index: Empirical Approach." Journal of Graduate Medical Education, 2010.