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# SECTION 1: PROGRAM OVERVIEW

## Mission Statement

To serve our patients and community by educating physicians in an outstanding academic environment that offers the best health services in a respectful and caring environment.

## Program Aims

Train compassionate, lifelong learners with broad knowledge of contemporary ophthalmology and competency in both surgical and non-surgical management.

## Program Overview

This manual describes program structure, residency training at affiliate institutions, and resident performance standards and expectations.

### Program Structure

- 4-year program combining clinical training, academics, and research
- 4 residents per year level

### Faculty and Staff

- Alvernon Clinics: 7 full-time ophthalmologists, 2 full-time optometrists, research faculty, supporting technical staff
- SAVAHCS: 7 physicians, supporting technical staff
- Multiple affiliate/associate faculty

### Training Sites

- Banner University Medical Center – Tucson (BUMCT), Level 1 Trauma Center
- Banner University Medical Center – South (BUMCTS)
- Southern Arizona Veterans Administration Health Care System (SAVAHCS)
- Community practices

All sites offer active inpatient/outpatient services, research, and teaching facilities. These varied environments expose residents to different healthcare systems, cultural diversity, and patient populations.

### Clinical Experience

- Approximately 25,000 patient visits annually at Alvernon clinic
- Approximately 16,000 patient visits annually at SAVAHCS
- Exposure to state-of-the-art diagnostic and therapeutic interventions

### Community Physicians

- Advanced Eye Care Tucson: Patrick Tsai, MD, MHA (glaucoma)
- Arizona Eye Consultants: Khin Kilgore, MD and Jason Levine, MD (glaucoma)
- Catalina Eye Care: Ovette Villavicencio, MD, PhD (cornea); Lynn Polonski, MD (oculoplastics)
- Cornea Associates: Ann McColgin, MD, Mingwu Wang, MD, PhD, and Bohan Xing, MD (cornea and refractive surgery)

- Midwestern University Eye Institute: Robert Fintelmann, MD (refractive surgery)
- Oculoplastics: Kathleen Duerksen, MD
- Oracle Eye Physicians and Surgeons: Michael Henry, MD, Brian Hunter, MD, Jeff Maltzman, MD, and Tatyana Sherman, DO (refractive surgery)
- Retina Associates: April Harris, MD, Cameron Javid, MD, Anthony Joseph, MD, Mark Walsh, MD, and Ryan Wong, MD; Retina Associates (ocular oncology and retina)

## Program Goals & Learning Objectives

See separate document, Goals and Objectives.

## Program Structure (4-Year Overview)

Residents progressively assume greater responsibility for patient care and education throughout their training. Beginning residents work under close supervision and gain autonomy as they demonstrate competency.

Residents are expected to:

- Prepare case presentations.
- Organize journal clubs.
- Teach medical students and rotating residents.
- Participate in wet and dry labs to develop surgical skills and suturing techniques. The wet lab is equipped with a microscope and phacoemulsification unit for hands-on surgical training.

Senior residents supervise and mentor junior residents under faculty guidance. Faculty are available on all rotations for consultation and support.

### ***First Year (PGY-1) Resident***

The PGY-1 is assigned to the SAVAHCS except for 4 weeks of consults.

- Ophthalmology: 13 weeks, including 7 days of shadow call and 1 rounds presentation
- Internal Medicine: 13 weeks
- Emergency Medicine: 8 weeks
- Neurology: 5 weeks
- Otolaryngology (ENT): 5 weeks
- Rheumatology: 4 weeks
- Ophthalmology Consults: 4 weeks at BUMCT/BUMCS/SAVAHCS

### ***Second Year (PGY-2) Resident***

#### **Clinical Skills**

- Complete ocular examinations
- Gonioscopy
- Indirect ophthalmoscopy
- Tonometry
- Biomicroscopy
- Refraction

- Physiologic testing

#### **Clinical Experience**

- Daily evaluation of walk-in and emergency patients
- First exposure to ocular trauma
- Introduction to subspecialty services

#### **Surgical Training**

- Begin assisting in surgery.
- Perform minor surgical procedures.

#### **Rotations**

- Pediatric Ophthalmology and Strabismus: 2 months – Alvernon Clinics (Dr. Sarah Elhomosany, Dr. Jonathan Holmes, Dr. Mireille Jabroun, Dr. Rommel Izaguirre Pereira)
  - Cornea and Refractive Surgery: 1.5 months – Oracle Eye Physicians and Surgeons, Catalina Eye Care (Dr. Ovette Villavicencio). Resident may rotate at Midwestern Eye Institute, Glendale (Dr. Robert Fintelmann) for surgery and post-ops the following morning.
  - Consults: 1 month between November-February, 1 month between March-June – BUMCT/BUMCS/SAVAHCS
  - Cornea: 1 month – Cornea Associates (Dr. Ann McColgin, Dr. Mingwu Wang, Dr. Bohan Xing)
  - Glaucoma: 1 month – Alvernon Clinics (Dr. Todd Altenbernd), Advanced Eye Care (Dr. Patrick Tsai), Arizona Eye Consultants (Dr. Khin Kilgore, Dr. Jason Levine)
  - Oculoplastics/Consults: 1 month between July-December, 1 month January-June – BUMCT (Dr. Lynn Polonski, surgery), Dr. Kathleen Duerksen private practice (as available)
  - Retina: 1 month – Alvernon Clinics (Dr. Igor Kozak), 1 month – VA (Dr. Tanu Thomas)
  - Comprehensive Ophthalmology: 0.5 month – Alvernon Clinics (Dr. Jeremy Wood)
- In addition, all PGY-2 residents have a continuity clinic at SAVAHCS except during their consults rotation.

### ***Third Year (PGY-3) Resident***

#### **Clinical Skills**

- Complete ocular examinations
- Gonioscopy
- Indirect ophthalmoscopy
- Tonometry
- Biomicroscopy
- Refraction
- Physiologic testing

#### **Clinical Experience**

- Daily evaluation of walk-in and emergency patients.
- First exposure to ocular trauma.
- Introduction to subspecialties: contact lenses, cornea and external disease, glaucoma, neuro-ophthalmology, oculoplastics, pediatrics, and retina.

#### **Surgical Training**

- Begin assisting in surgery.

- Perform minor surgical procedures.

#### **Rotations**

- Comprehensive Ophthalmology: 2 months – Alvernon Clinics (Dr. Jeremy Wood)
- Consults: 1 month
- Cornea: 1 month – Cornea Associates (Dr. Ann McColgin, Dr. Mingwu Wang, Dr. Bohan Xing)
- Glaucoma: 1 month – Alvernon Clinics (Dr. Todd Altenbernd), Advanced Eye Care (Dr. Patrick Tsai), Arizona Eye Consultants (Dr. Khin Kilgore, Dr. Jason Levine)
- Ocular Oncology/Retina: 1 month July-December, 1 month January-June – Retina Associates (Dr. Cameron Javid, Dr. Mark Walsh)
- Oculoplastics/Consults: 1 month between July-December, 1 month January-June – BUMCT (Dr. Lynn Polonski, surgery), Dr. Kathleen Duerksen private practice (as available)
- Pediatric Ophthalmology and Strabismus: 1 month – Alvernon Clinics (Dr. Sarah Elhomosany, Dr. Jonathan Holmes, Dr. Mireille Jabroun, Dr. Rommel Izaguirre Pereira)
- Retina: 1 month – Alvernon Clinics (Dr. Igor Kozak), 1 month – VA (Dr. Tanu Thomas)
- Transition: 1 month (June) – 3 residents at SAVAHCS, 1 resident at BUMCT/BUMCS

In addition, all PGY-3 residents have a continuity clinic at SAVAHCS except during their consults rotation.

### ***Fourth Year (PGY-4) Resident***

#### **Clinical Responsibilities**

- Serve as Chief Resident for 3 months.
- Manage clinics at SAVAHCS for 9 months.

#### **Surgical Training**

- Perform surgery under faculty supervision.
- Progress through increasing levels of autonomy based on case complexity, resident experience, and attending preference.
- Manage pre-operative and post-operative care for all procedures.

#### **Chief Resident Duties**

- Schedule clinical and surgical duties.
- Receive 4 hours weekly for administrative responsibilities.
- Supervise junior residents.

#### **Program Completion**

By conclusion of PGY-4, residents must demonstrate knowledge, skills, and behaviors necessary to enter autonomous practice without supervision.

## **Core Competencies**

In accordance with ACGME guidelines, residents are expected to develop competencies in six core areas: professionalism, patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, and systems-based practice.

## ***Professionalism***

Residents must demonstrate a commitment to professionalism and an adherence to ethical principles.

Residents must demonstrate competence in:

- compassion, integrity, and respect for others;
- responsiveness to patient needs that supersedes self-interest;
- cultural humility;
- respect for patient privacy and autonomy;
- accountability to patients, society, and the profession;
- respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation;
- ability to recognize and develop a plan for one's own personal and professional well-being; and,
- appropriately disclosing and addressing conflict or duality of interest.

## ***Patient Care and Procedural Skills***

Residents must be able to provide patient care that is patient- and family-centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health.

Residents must demonstrate competence in patient care, including:

- evaluating and assessing pre-operative ophthalmic and general medical indications for surgery and surgical risks and benefits;
- managing systemic and ocular complications that may be associated with surgery and anesthesia;
- obtaining informed consent; and
- providing acute and long-term post-operative care.

Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.

Residents must demonstrate competence in patient care, including:

- intra-operative skills;
- performing ophthalmic procedures as primary surgeon, including:
  - cataract;
  - cornea;
  - glaucoma;
  - globe trauma;
  - oculoplastics/orbit;
  - retinal/vitreous; and,
  - strabismus.
- laser procedures, such as YAG capsulotomy, laser trabeculoplasty, laser iridotomy, panretinal laser photocoagulation;
- using local and general anesthetics.

## ***Medical Knowledge***

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care.

- Residents must demonstrate competence in their knowledge of the basic and clinical sciences specific to ophthalmology.
- Residents must demonstrate competence in their knowledge of: cataract surgery, contact lenses, cornea and external disease, eyelid abnormalities, glaucoma, neuro-ophthalmology, ocular trauma, optics and general fraction, orbital disease and ophthalmic plastic surgery, pathology, pediatric ophthalmology and strabismus, systemic disease consults, uveitis, visual rehabilitation and refractive surgery, and retinal/vitreous diseases.

## ***Practice-Based Learning and Improvement***

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.

Residents must demonstrate competence in:

- identifying strengths, deficiencies, and limits in one's knowledge and expertise;
- setting learning and improvement goals;
- identifying and performing appropriate learning activities;
- systematically analyzing practice using quality improvement methods, including activities aimed at reducing health care disparities, and implementing changes with the goal of practice improvement;
- incorporating feedback and formative evaluation feedback into daily practice; and,
- locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems.

## ***Interpersonal and Communication Skills***

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

Residents must demonstrate competence in:

- communicating effectively with patients and patients' families, as appropriate, across a broad range of socioeconomic circumstances, cultural backgrounds, and language capabilities, learning to engage interpretive services as required to provide appropriate care to each patient;
- communicating effectively with physicians, other health professionals, and health-related agencies;
- working effectively as a member or leader of a health care team or other professional group;
- educating patients, patients' families, students, other residents, and other health professionals;
- acting in a consultative role to other physicians and health professionals; and,
- maintaining comprehensive, timely, and legible medical records, if applicable.

Residents must learn to communicate with patients and patients' families to partner with them to assess their care goals, including, when appropriate, end-of-life goals.

## ***Systems-Based Practice***

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the structural and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care.

Resident must demonstrate competence in:

- working effectively in various health care delivery settings and systems relevant to their clinical specialty;
- coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty;
- advocating for quality patient care and optimal patient care systems;
- participating in identifying system errors and implementing potential systems solutions;
- incorporating considerations of value, equity, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate;
- understanding health care finances and its impact on individual patients' health decisions; and,
- using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated).

Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals, including, when appropriate, end-of-life goals.

## SECTION 2: HOME CALL

### Call Schedule and Assignments

**Purpose:** Provide timely ophthalmologic emergency and consultative services at BUMCT, BUMCS, and SAVAHCS within individual competence limits.

#### *Call Coverage*

##### **Resident Coverage**

Two residents assigned at all times:

- **Primary (First) Call:** Junior resident
  - Schedule
    - > Approximately one weeknight in eight.
    - > Approximately one weekend in eight.
  - Responsibilities
    - > Receive all consultation requests from BUMCT and BUMCS from 5:00 p.m. to 7:00 a.m.
    - > Receive all weekend and holiday consultations.
    - > Consultations phoned in by housestaff or faculty.
- **Back-up Call:** Senior resident (or PGY-3 during AAO, June starting resident graduation)
  - Responsibilities
    - > Supervise first-call residents.
    - > Examine patients as needed.
    - > Determine need for faculty notification.

Residents must be assigned for call to avoid work hours violations.

##### **Location Requirements**

- Take call from home or any accessible location via pager.
- Must be within 30 minutes of hospitals under normal travel conditions.

##### **Faculty Coverage**

Faculty take call on a rotating basis coordinated by the program coordinator. An on-call faculty schedule is maintained at all times, listing the designated faculty member for BUMCT/BUMCS and SAVAHCS.

#### *Call Response Requirements*

- Residents must respond appropriately to all emergency calls. “Appropriately” usually requires the resident to see the patient. On occasion, the inquiring service may merely be requesting guidance.
- Residents must provide emergency and consultative services in a timely fashion. Residents must provide emergency and consultative services within the limits of individual competence. PGY-2 residents must consult with the PGY-3 or senior (PGY-4) resident on-call for all patient encounters prior to initiating care until adequate experience is obtained.
- Residents **MUST** examine patients if:
  - Any risk of sight or life-threatening injury/illness exists, even if not recognized by calling service.
  - Resident has any doubt.

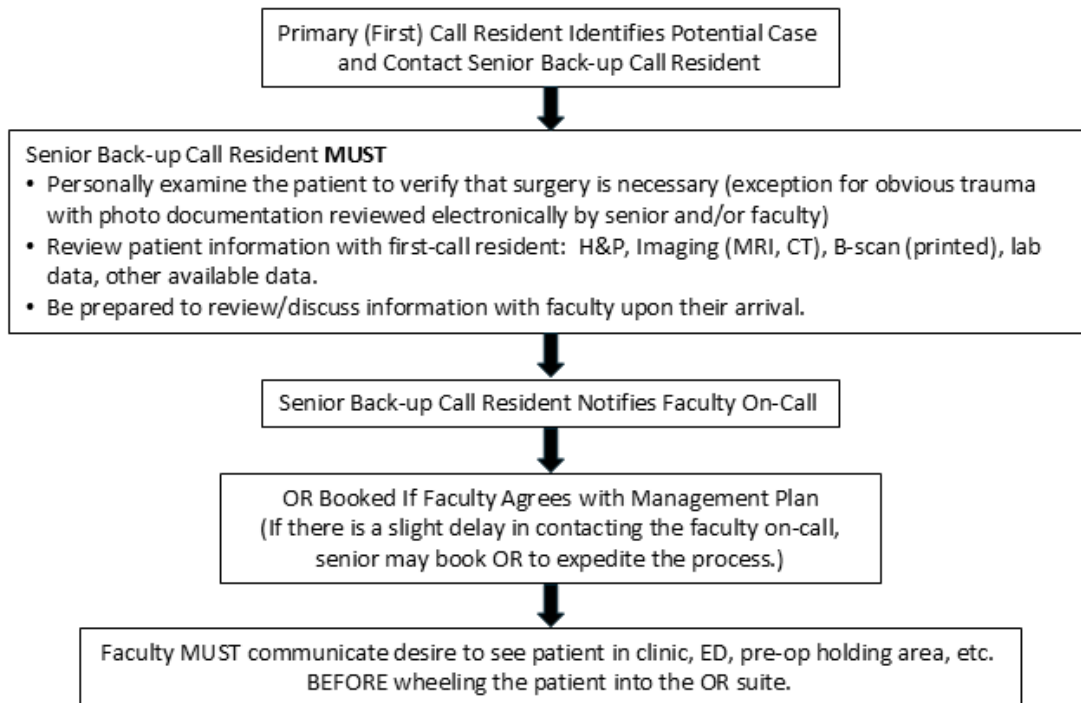
- Requested by the ED physician.

### **Faculty Participation**

- Resident **ALWAYS** involves faculty for major vision or life-threatening situations. A copy of the patient’s medical record must be provided to faculty as soon as practical.
- **No resident may admit or take a patient to surgery without faculty participation.**
- Patients seen by residents without faculty involvement may be scheduled for follow-up at appropriate intervals with a faculty member.

### **Potential Surgical Cases After Regular Hours (5:00 p.m. to 7:00 a.m.)**

#### **Surgical Case Identification and Scheduling Process**



#### **Surgical Roles**

- Senior back-up call resident: primary surgeon or assistant (as determined by attending).
- First-call resident: observe surgery in OR.
- Attending may modify based on circumstances (work hours, case appropriateness, etc.).

#### **First-Call Resident**

- Must remain in-house until case starts to:
  - Observe admitting process.
  - Complete history and physical.
  - Learn pre-operative management.
  - Write orders.
  - Participate in care.
- May return home if considerable delay, with faculty approval.
- Exceptions for duty hour violations: senior resident assumes these duties.

## Continuity of Care

### Residents Going Off-Call

- Remain responsible for patient follow-up unless alternate arrangement made.
- Notify incoming on-call resident of all patients under their care.

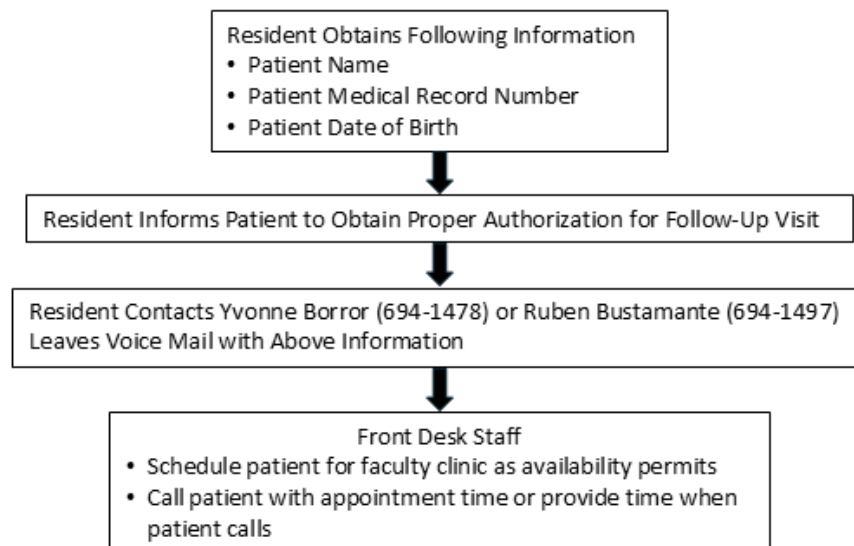
### On-Call Examination Rooms

On-call examination rooms are available in the Emergency Department at Banner University Medical Center South (BUMCS) and Southern Arizona VA Health Care System (SAVAHCS).

- **BUMCS:** One dedicated on-call room is available; patients may be seen in any EM room with the portable slit lamp.
- **SAVAHCS:** Do not transport patients to the SAVAHCS Eye Clinic after hours without a security escort.
- **Alvernon Clinic:** NEVER see patients alone in the Alvernon clinic after hours.
- **SAVAHCS/Alvernon Patient Assignment Protocol:** SAVAHCS patients must not be seen at Alvernon and vice versa without prior authorization.

### Patients Seen Through the BUMCT Emergency Room

#### When Patient Does Not Require On-Call Examination:



## Must Call List

First-call resident **MUST** call senior resident or attending faculty (or both) for the following. **This rule is strictly enforced for PGY-2 and PGY-3 residents.**

## Must Call List by Priority

### CALL ATTENDING IMMEDIATELY

Condition	Priority
Acute angle closure unable to lower IOP <35 or continued significant pain	2, 1
Acute blind painful eye	2, 1
Acute posterior segment inflammation	2, 1
Acute retinal necrosis	2, 1
Blebitis	2, 1
Choroidal mass	2, 1
Exogenous endophthalmitis	2, 1
Ischemic optic neuropathy lab? or sx + for GCA	2, 1
Lens induced glaucoma uncontrolled	2, 1
Optic nerve edema (R/O GCA)	2, 1
Peripheral retina break	2, 1
Presumed endogenous endophthalmitis (call retina on-call)	2, 1
Pupil involving 3rd nerve palsy	2, 1
Retinal detachment – call retina attending on-call	2, 1
Ruptured globe/suspected rupture	2, 1
Uncontrollable NVG (pain & IOP >35)	2, 1
Uncontrollable uveitis (IOP >35)	2, 1
Vitreous heme (if B-scan shows pathology other than vit heme)	2, 1

### CALL SENIOR RESIDENT NOW

Condition	Priority
Acute angle closure, treated IOP <30 and pain much better	2, 3
Chemical exposure high pH with IOP asymmetrically elevated (>5 mmHg) or loss of limbal vasculature >180 degrees or pH >8 for 30 minutes	2
Chemical exposure, red eye, symmetric IOPs, pH >5-<8 on arrival	2
CSR young patient	2, 4, 5
Full thickness lid laceration through margin	2
Hyphema treated IOP >29 or corneal blood staining	2
Laceration to lacrimal system	2
LASIK flap dislocation	2, 3
Leaking surgical incision	2
New loss of vision	2
Orbital hemorrhage with APD or decreased vision or treated IOP >25	2
Partial thickness cornea laceration	2
Recent CRAO	2+
Sudden loss of vision, unknown cause	2
Uncontrollable IOP with pain, treated IOP >35	2

### WITHIN 8 HOURS

**Response Time:** Call attending seeing the patient in clinic or to be staffed next day if inpatient

<b>Condition</b>	<b>Priority</b>
Acute angle closure, treated IOP <30 and pain much better	2, 3
Cavernous sinus or orbital apex syndrome	3
Hyperacute conjunctivitis	3
Infiltrative optic neuropathy	3
LASIK flap dislocation	2, 3
Post-op IOP spike uncontrolled >35	3
Postseptal cellulitis	3
Pupil sparing 3rd nerve palsy	3
Recent CVO, BVO, BRAO	3
Recent onset optic neuritis	3

<b>WITHIN 8-16 HOURS</b>
--------------------------

**Response Time:** To be seen by an attending in clinic or to be staffed if inpatient

<b>Condition</b>	<b>Priority</b>
Acute flare of pars planitis	4
Acute PVD with hemorrhage	4
Acute sarcoidosis	4
Admission	4
Amaurosis fugax	4
Corneal FB central 5 mm	4
Corneal graft rejection	4
CSR >45 years	4
CSR young patient	2, 4, 5
Dacryocystitis	4
HSV keratitis	4
HSV uveitis, corneal edema	4
Hyphema IOP <29, no corneal blood staining	4
HZ uveitis, lid involvement	4
Ischemic optic neuropathy (lab normal, no GCA symptoms)	4
Isolated 4-6th nerve palsy	4
Lacrimal gland mass	4
LASIK subflap infiltrates	4
Leukocoria (child)	4
Lid laceration with no margin or lacrimal system involvement (simple)	4
Loss of vision with presumed CNV	4
Neurotrophic corneal ulcer	4
New onset tropia (child)	4
Orbital blow out fracture with intact globe, symmetric eye pressures ( $\leq 3$ mmHg) and no posterior segment pathology except edema	4
Orbital tumor/mass	4
Probable infectious keratitis	4
Thyroid eye disease with optic nerve involvement	4

Condition	Priority
Traumatic optic neuropathy	4
Unknown new onset tropia or movement disorder	4
VKH, sympathetic ophthalmia	4

<b>ROUTINE/PATIENT CALL</b>
-----------------------------

**Response Time:** Have patient call for appointment as instructed or staffed within 24 hours

Condition	Priority
Corneal foreign body outside central 5 mm	5
CSR young patient	2, 4, 5

### *Must Call List by Condition*

1		<b>Call Attending Immediately</b>
2		<b>Call Senior Resident Now</b>
3		<b>Within 8 Hours</b> (Call attending seeing the patient in clinic or to be staffed next day if inpatient)
4		<b>Within 8-16 Hours</b> (To be seen by an attending in clinic or to be staffed if inpatient)
5		<b>Routine/Patient Call</b> (Have patient call for appointment as instructed or staffed within 24 hours)

### *Trauma/General*

2,1			Acute blind painful eye
2,1			Ruptured globe/suspected rupture
2			Hyphema treated IOP >29 or corneal blood staining
2			Leaking surgical incision
2			Orbital hemorrhage with APD or decreased vision or treated IOP > 25
2			Sudden loss of vision, unknown cause
4			Admission
4			Hyphema IOP <29, no corneal blood staining
4			Traumatic optic neuropathy
4			Orbital blow out Fx with intact globe, symmetric eye pressures (3 mmHg) and no posterior segment pathology except edema

### *Cornea*

2			Chemical exposure, high pH with IOP asymmetrically elevated (>5 mmHg) or loss of limbal vasculature >180 degrees or pH > 8 for 30 minutes
2			Chemical exposure, red eye, symmetric IOPs, pH >5-<8 on arrival
2			Partial thickness cornea laceration
2,3			LASIX flap dislocation
4			Cornea FB central 5 mm
4			Corneal graft rejection
4			HSV keratitis
4			HSV uveitis, corneal edema
4			HZ uveitis, lid involvement

4		LASIX subflap infiltrates
4		Neurotrophic corneal ulcer
4		Probable infectious keratitis
5		Corneal foreign body outside central 5 mm

#### **Lid/Lacrimal System**

2		Full thickness lid laceration through margin
2		Lac to lacrimal system
4		Dacryocystitis
4		Lid lac with no margin or lacrimal system involvement simple
4		Preseptal cellulitis

#### **Orbit**

3		Postseptal cellulitis
4		Lacrimal gland mass
4		Orbital tumor/mass
4		Thyroid eye disease with optic nerve involvement

#### **Pediatric Emergencies**

3		Hyperacute conjunctivitis
4		Leukocoria child
4		New onset tropia child

#### **Glaucoma**

2,1		Acute angle closure unable to lower IOP <35 or continued significant pain
2,1		Blebitis
2,1		Lens induced glaucoma uncontrolled
2,1		Uncontrollable NVG (pain & IOP >35)
2,1		Uncontrollable uveitis (IOP >35)
2		Uncontrollable IOP with pain, treated IOP >35
3		Acute angle closure, treated IOP <30 and pain much better
3		Postop IOP spike uncontrolled >35

#### **Neuro**

2,1		Ischemic optic neuropathy lab? or sx + for GCA
2,1		Optic nerve edema (R/O GCA)
2,1		Pupil involving 3rd
3		Cavernous sinus or orbital apex syndrome
3		Infiltrative optic neuropathy
3		Pupil sparing 3rd nerve palsy
3		Recent onset optic neuritis
4		Amaurosis fugax
4		Ischemic optic neuropathy lab normal, no GCA sx
4		Isolated 4-6th nerve palsy
4		Unknown new onset tropia or movement disorder

#### **Retina**

2,1	Yellow	Red	Acute posterior segment inflammation	
2,1	Yellow	Red	Acute retinal necrosis	
2,1	Yellow	Red	Choroidal mass	
2,1	Yellow	Red	Exogenous endoph	
2,1	Yellow	Red	Presumed Endogenous endophthalmitis (call retina on-call)	
2,1	Yellow	Red	Retinal detachment (call retina attending on-call)	
2,1	Yellow	Red	Vitreous heme (if B-scan shows pathology other than vit heme)	
2	Yellow		New loss of vision	
2+	Yellow		Recent CRAO	
2,4,5	Yellow	Green	Blue	CSR young patient
3	Yellow		Recent CVO, BVO, BRAO	
4	Green		Acute flare of pars planitis	
4	Green		Acute PVD with heme	
4	Green		Acute sarcoidosis	
4	Green		Recent LOV with presumed CNV	
4	Green		VKH, sympathetic oph	
5	Blue		CSR > 45 years	

## SECTION 3: SUPERVISION POLICY AND LINES OF RESPONSIBILITY

### Supervision Policy

Supervision in the Ophthalmology Residency program balances resident education with patient safety and quality care. An attending physician must always be clearly designated as responsible for determining the supervision level and resident responsibilities. Residents receive **graduated responsibility** as they advance through PGY-2, PGY-3, and PGY-4 positions. However, all patient care remains ultimately the responsibility of the supervising attending.

#### *Definition of Supervision*

Supervision is an intervention provided by a supervising practitioner to a resident. This relationship 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 observation, consultation, directing the learning of the resident, and role modeling. **Note:** This definition is adapted from Bernard JM & Goodyear RK, *Fundamentals of Clinical Supervision* (2<sup>nd</sup> ed.), Needham Heights, MA: Allyn & Bacon, 1998

#### *Categories of Supervision*

- (1) **Direct:** Attending is in contact with the patient and participates in care (e.g., attending present in OR).
- (2) **Indirect**
  - a. **Immediately Available:** Attending is physically present (e.g., outpatient clinic).
  - b. **Available:** Attending is immediately available by phone/electronically and can be physically present if needed (e.g., in-house or page for questions).
- (3) **Oversight:** Attending reviews patient care after delivery (e.g., overnight call).
- (4) **General:** Attending is involved through instruction and establishing the system of care within which the resident functions.

#### *Teaching Sites and Supervision*

The Department of Ophthalmology operates at three major teaching sites (BUMCT, BUMCS, and SAVAHCS) plus five community-based affiliated sites staffed by volunteer faculty. While supervision policies vary slightly by site, all require close attending supervision and maintain attending authority over patient care.

### Lines of Responsibility

The lines of responsibility flow according to experience.

- Senior residents are responsible for junior residents' actions.
- Faculty is responsible for residents under their direct supervision.
- The chief of service at each institution is ultimately responsible for all staff and residents at that site.

## Outpatient Clinics

### BUMCT and BUMCS

- PGY-2 and PGY-3 residents rotate monthly; PGY-4 residents rotate assigned quarterly.
- **Supervision:** Direct (1) or indirect with immediate availability (2a).
- **All components of the resident examinations must be duplicated by attending.**
- Attending reviews and attests to all resident EMR entries.

### SAVAHCS

- Residents manage clinics with attending present at all times.
- **Supervision:** 1, direct or 2a, indirect with direct supervision immediately available.
- Supervising attending involvement must be documented as:
  - (1) **Independent attending** note or entry.
  - (2) **Attending addendum** to resident note.
  - (3) **Co-signature** by attending (implies review and agreement). Use of CPRS function “Additional Signer” is **not acceptable** for documenting supervision.
  - (4) **Resident documentation** of attending supervision/involvement (e.g., *“I have seen and discussed the patient with my supervising attending, Dr. ‘X’, and Dr. ‘X’ agrees with my assessment and plan”*), at a minimum, the responsible attending should be identified (e.g., *“The attending of record for this patient encounter is Dr. ‘X’.*)]

### Summary of Supervision Policies

New Patient or New Consult Visit	<ul style="list-style-type: none"> <li>• Attending must be physically present.</li> <li>• Every new patient seen/discussed with attending.</li> </ul>	Independent attending note, addendum to the resident note, or resident note description of attending involvement. Co-signature by attending alone is not sufficient documentation.
Return Visit	<ul style="list-style-type: none"> <li>• Attending physically present.</li> <li>• Patient seen or discussed with attending at frequency to ensure effective and appropriate treatment</li> </ul>	Any type of documentation; attending's name must be documented.
Outpatient Discharge	Attending ensures appropriateness.	Any type of documentation.

## Inpatient Consultations

### BUMCT and BUMCS

- PGY-2 and PGY-3: Three months total on consults rotation. Monthly rotations assure maximum continuity of care.
- **New Patient Consultations:** Resident evaluates patient (2b, indirect supervision); arranges to see patient with on-call attending within one day, if possible (1, direct supervision). Resident completes EMR. Each category of the exam documented and recorded by attending.
- **Inpatient Consultations:** Resident rounds with on-call attending (1, direction supervision) on patients requiring daily follow-up examination. Note entered in patient’s chart by both resident and attending (1, independent attending note; 2, attending addendum; 3, attending co-signature with attestation. Inpatient consults after 5:00 p.m./weekend are seen, if necessary, by the on-call resident with supervision by the on-call attending (1, director; or 2a or 2b, indirect).

- **After-Hours/Weekend Consultations:** Resident determines urgency—bedside or scheduled outpatient clinic visit; direct (1) or indirect (2a/2b) supervision by on-call attending. Secondary on-call resident or attending can assist junior residents in decision-making process.
  - If scheduling can wait until morning, on-call resident will communicate this to consults resident.
  - If a specific outpatient clinic is appropriate for scheduling, attending staffing that clinic should provide approval.
- **Communication Requirements**
  - Service requesting consultation communicates directly with on-call resident (not clerical/technical staff); faculty name required on consult request.
  - Resident requesting consultation with another service communicates directly with a member of the requested service to facilitate the transfer of information and arrange consultation. Resident must update EMR.

### SAVAHCS

- **Regular Hours:** Resident transports patient to eye clinic for senior resident evaluation with attending supervision (1, direct). If transport is not possible, resident evaluates patient at bedside with MOD (medical officer of the day) attending follow-up within 24 hours (2a, indirect with independent note/addendum)
- **ED Referrals (7:30 a.m.-4:00 p.m.):** Refer patient to Optometric Section. If indicated, patient will be referred to Ophthalmology and senior resident in clinic evaluates with attending supervision (1, direct or 2a, indirect).
- **ED Referrals (after 4:00 p.m.):** Senior resident evaluates with attending supervision (1, direct or 2a, indirect).
- **After-Hours ED Consultations:** Primary on-call resident will examine patient in the ED with ED on-duty attending (1, direct or 2a, indirect) and/or back-up on-call senior resident and/or Ophthalmology on-call attending (2a, indirect), if necessary.

### *Inpatient Admissions*

#### **BUMCT and BUMCS**

At times, resident and supervising attending will participate together (1, direct supervision) in evaluating the patient and writing admission orders. At other times, the resident will admit the patient and write orders (2a or 2b, indirect supervision), and the supervising attending must examine and evaluate the patient within 24 hours.

#### **Summary of Supervision Policies**

New Admissions	Attending must see and evaluate the patient within 24 hours.	The attending will review the resident note, attest to the note, and add as necessary.
Continuing Care	Attending available on as-needed basis.	
Consultations	Attending must see and evaluate the patient within 24 hours.	
Discharge	Resident will complete.	

## SAVAHCS

At times, resident and supervising attending will participate together (1, direct supervision) in evaluating the patient and writing admission orders. At other times, the resident will admit the patient and write orders (2a or 2b, indirect supervision), and the supervising attending must examine and evaluate the patient within 24 hours.

### Summary of Supervision Policies

New Admissions	Attending must see and evaluate the patient within 24 hours.	An attending note or addendum documenting findings and recommendations regarding the treatment plan within one calendar day of admission (no exceptions for weekends or holidays).
Continuing Care	Attending must be personally involved in ongoing care.	Any of the four types of documentation, at a frequency consistent with the patient's condition and principles of graduated responsibility.
Consultations	Attending physician must supervise all consults performed by residents.	An independent note, addendum to the resident's note, or resident note description of attending involvement. Co-signature by attending alone is not sufficient documentation.
Discharge	Attending must be personally involved in decisions to discharge patient.	Co-signature of the discharge summary is required.

## Operating Room

**Direct supervision by the attending is required for all surgical procedures—no exceptions.**

### BUMCT and Surgery Centers

- **History & Physical:** May be performed by resident or attending. If resident performs, supervision is direct (1) or indirect (2a or 2b); attending must confirm findings within 24 hours of surgery (day of surgery attending H&P co-signature). H&P valid for 30 days.
- **Surgical Consent:** May be performed by resident or attending in clinic (1, direct). In some cases, attending completes form; resident reviews surgery with patient and obtains patient signature during evaluation in pre-op clinic (2a or 2b, indirect supervision). Surgical consent valid for 30 days.
- **Pre-Operative Note:** Resident obtains; attending signs day of surgery (1, direct supervision or 2a, indirect supervision).
- **Brief Operative Note:** Resident completes; attending signs within 2 hours of surgery (or within 2 hours if operative note entered in Cerner).
- **Operative Note:** Resident completes within 24 hours of surgery (1, direct supervision, or 2a, indirect supervision); attending signs electronically.

## **SAVAHCS**

- All patient notes completed same day—**no exceptions**.
- **History & Physical** (as part of resident pre-op): Valid 30 days. Beyond that requires repeat or verbal phone update with bedside exam.
- **Surgical Consent**: Resident completes within 60 days before surgery; beyond that requires repeat. Exception: notify in OR consult for long-distance patients; consent can be completed at bedside morning of surgery.
- **Pre-Operative Note**: Resident completes before procedure on day of surgery.
- **Brief Operative Note**: Resident completes within 2 hours of procedure.
- **Operative Note**: Resident completes within 24 hours of procedures.

## **Emergency Department**

### **BUMCT and BUMCS ED**

- **Supervision**: Available by supervising attending in ED for all resident at all times (1, direct and 2a, indirect with direct supervision immediately available).
- **Supervision for Procedures**: Certain procedures may require direct supervision (1) by attending ophthalmology on-call. Others may proceed with indirect supervision (2b, with direct supervision immediately available phone/electronically) by ophthalmologist on-call if proper training and “sign-off” have been obtained (see “Supervision of Procedures Other Than OR”).
- **Oversight Supervision** (e.g., supervising attending reviews case following morning): Possible for first call and/or back-up call resident depending upon condition and resident experience.
- **Equipment**: Portable slit lamp available in storage room adjacent to ICU at BUMCT but may be in use or at other locations in the ED; available in fast track area of BUMCS ED (often under desk in South Pod EM resident area). Indirect ophthalmoscopes available: (1) cabinet in BUMCT ED, and (2) underneath desk in resident work area of BUMCS ED.
- **After-Hours Alvernon Clinic Exams**: Minimum two residents or one resident + one faculty member required; residents are **not** allowed see patients alone.

### **SAVAHCS ED**

- Fully equipped eye call room available in ED.
- **After-Hours Clinic Exams**: ED patients will **not** be taken to eye clinic after-hours. Exception: equipment unavailable in ED, e.g., ultrasonography unit; requires security escort to eye clinic and standby during entire exam.
- **Supervision**: ED attending physician always on-premises (1, direct or 2a, indirect). Ophthalmology on-call attending offers direct (1), indirect (2a or 2b), or oversight (3) supervision based on situation and resident experience
- **Inpatient Consultations**: Resident must transport hand-held slit lamp and equipment to bedside.
- **Attending Call**: SAVAHCS attending staff only; call list maintained online.
- **Work Hours**: Resident on-call adheres to work hours policy.

### **Affiliated Preceptor Teaching Sites (Community Rotations)**

- PGY-2 and PGY-3 residents rotate periodically.
- Preceptor has University of Arizona faculty appointment and is supervising attending for clinical examinations, clinic procedures, and surgical procedures.
- **Supervision**: Direct (1) or indirect with immediate availability (2a).
- Applies to clinical exams, clinic procedures, and ASC/OR procedures
- **Resident Role**: Primarily observer or assistant (rarely primary surgeon).

## *Procedures Outside OR (ED/Clinic)*

### **Requires DIRECT Supervision (Attending in Room)**

- Lid or facial lacerations involving lacrimal system.
- Any OR procedure.
- Laser to macula.

**Requires at least ONE DIRECTLY Observed Procedure + Attending Sign-Off Before Indirect Supervision (Attending Available by Phone).** May also be observed by resident who has been signed off for the procedure but attending sign-off required.

- Simple eyelid or facial laceration repair (not involving margin; no significant tissue disruption) (may also be supervised/staffed by ED attending; attending sign-off required)
- Punctal plug insertion and removal
- Punctal cautery
- Tarsorrhaphy
- Ocular suture removal
- Lateral canthotomy and cantholysis (at attending discretion and on case-by-case basis, may be emergently without attending)
- Conjunctival or corneal foreign body removal
- Corneal or conjunctival cultures
- Simple eyelid mass excision
- Lid abscess incision and drainage
- Anterior segment OCT
- Intralesional Kenalog injection
- Anterior chamber paracentesis (at attending discretion and on case-by-case basis, may be emergently without attending)
- Subconjunctival or subtenons injections
- Corneal scraping

**Requires at least TWO DIRECTLY Observed Procedures + Attending Sign-Off Before Indirect Supervision (Attending Available by Phone).** May also be observed by resident who has been signed off for the procedure but attending sign-off required.

- Complex eyelid or facial laceration repair (significant architecture disruption or margin involvement)
- Chalazion removal
- Adhesive corneal perforation repair
- Retrobulbar or peribulbar anesthesia
- Laser suture lysis
- YAG laser capsulotomy
- Laser peripheral iridotomy
- Laser peripheral iridoplasty
- Anterior chamber and vitreous tap/inject

**Requires at least TWO DIRECTLY Observed Procedures + Sign-Off Before Indirect (Attending On-Site)**

- Intraocular injections
- Laser trabeculoplasty
- Vitreous tap and inject

### **Indirect Supervision (Attending Available by Phone) Without Prior Observation**

- Topical and oral medications and diagnostic eye drops
- Skin suture removal
- Bandage or other contact lens insertion
- Ocular prosthesis insertion or removal
- IV fluorescein injection for fluorescein angiography
- Local anesthesia injection (except as listed above)

### *Transition of Care (Hand-Offs)*

#### **Goals**

- Minimize number of transitions in patient care.
- Ensure and monitor effective, structured hand-over processes to facilitate continuity of care and patient safety.
- Ensure resident competence in communication with team members.
- Ensure availability of schedules informing all team members of responsible attending and resident for each patient's care.

#### **Protocol**

Both transferring and receiving teams must communicate **person-to-person** regarding:

- Updates by transferring team in electronic transfer tool records/consult list.
- Lab, radiology, or tests requiring follow-up; conditional plans for results.
- Pertinent recent or upcoming communication between Ophthalmology and other services or patients and patient's family.
- Foreseeable problems and conditional plans.
- Current Ophthalmology inpatient service patients.

**Before Transfer:** Transferring team and receiving team review electronic transfer tool/consult list; note any foreseeable issues to be addressed in upcoming personal communication. Alternatively, both teams may review together to clarify duties and foreseeable issues.

#### **Communication Methods**

- **Unstaffed Consultations:** Verbal + electronic tool.
- **Clinic Patients:** Verbal + EMR note clearing stating required information (or handwritten notes with required information).

#### **Baseline Information**

If **acute changes from baseline status is important, the receiving team MUST:**

- **Best:** Receiving team member sees condition prior to transfer and verbally discusses uncertainties with transferring team member.
- **Acceptable** (when best not possible): Transferring team provides detailed drawing and/or description with discussion with receiving team.

or

- Transferring team provides digital photographs which can be accessed by receiving team in HIPAA-compliant manner and discussion with receiving team.

#### **Requirements for Transfer of Consult/ED Clinic Patient to Outpatient Setting**

- Follow-up clinic address, phone, and directions, if necessary
- Appointment time, date, attending physician name

or

- If clinic hours preclude above, then patient name, MRN, contact number, service/physician to be seen, and follow-up timeframe should be given to Yvonne Borrer (694-1478) or Ruben Bustamante (694-1497) at Alvernon Clinic by next business day.
- Regular Monday clinic available for weekend patient follow-up; call team may provide follow-up list to clinic before 8:00 a.m. Monday.

## SECTION 4: SURGICAL TRAINING AND REQUIREMENTS

### Resident Surgical Experience

#### Surgical Eligibility

Residents may serve as primary surgeons only for cases within their training level and experience. All resident surgery must be approved and staffed by faculty.

- **SAVAHCS:** All resident surgery requires faculty approval and supervision.
- **BUMCT:** Surgical cases from on-call consults or faculty clinics must be approved and staffed by faculty. All cases are evaluated for surgical appropriateness and the resident's ability to serve as primary surgeon. Residents are assigned to assist faculty during surgery on specific days.
- **Cases Assigned to Faculty**
  - Monocular patients
  - Complicated cases as determined by faculty
- **Phacoemulsification Surgery:** Phacoemulsification is an advanced procedure requiring demonstrated proficiency. Before performing phacoemulsification as primary surgeon, residents must:
  - Complete required wet/dry lab experience and maintain surgical logs per total quality improvement guidelines (Section 5, Total Quality Improvement, page 32).
  - Complete required reading and video viewing.

#### Surgery Preparation

- **Pre-Operative History and Physical**
  - Must be completed by a member of the operative team.
  - If completed by an outside physician, it must be reviewed and cosigned by a member of the surgical team.
- **Pre-Operative Review**
  - Resident reviews cases with the attending **at least 48 hours in advance** of surgery .
    - > Check laboratory and diagnostic tests.
    - > Review and update the history and physical, if necessary.
    - > Review informed consent.
    - > Review any unusual lens calculations.
  - **Note:** Each surgical attending has their own policy for pre-operative case review. Consult directly with each attending regarding their preference.
- **Day of Surgery**
  - Resident rechecks laboratory tests, consent form, surgical site, and lens calculations upon arrival to the operating room
  - At SAVAHCS: Resident enters a pre-operative note in CPRS; the attending must review and enter an addendum confirming agreement with the findings.

#### Resident Surgical Patients (SAVAHCS)

- **Pre- and Post-Operative Instructions:** Resident provides patients with pre-operative and post-operative cataract surgery instructions at the time of surgical approval.
- **Pre-operative Laboratory Work:** Resident checks all pre-operative lab data one week before surgery for contraindications. Routine labs include:
  - EKG within 6 months.
  - CBC and electrolytes (including glucose) within 1 month.

- For patients with medical conditions affecting ability to lie flat or remain still, or with severe cardiac or pulmonary disease, contact anesthesia for recommendations on additional work-up or specific instructions.
- **96 Hours Before Surgery**
  - Resident confirms updated H&P, consent, additional pre-operative clearance, attending surgeon clearance.
  - Resident enters note in the surgical OR consult. Example: "Case reviewed and discussed with Dr. X. H&P and consent current. Patient cleared for surgery."
- **Day Before Surgery:** Patients are contacted by PAT for instructions and to answer any questions.

## ACGME Surgical Logs

### Resident Operative Minimum Numbers

Procedure	Minimum Requirement (Surgeon)
Cataract (S)	86
Laser Surgery - YAG Capsulotomy (S)	5
Laser Surgery - Laser Trabeculoplasty (S)	5
Laser Surgery - Laser Iridotomy (S)	4
Laser Surgery - Panretinal Laser Photocoagulation (S)	10
Keratoplasty (S+A)	5
Pterygium/Conjunctival and Other Cornea (S)	3
Keratorefractive Surgery (S+A)	6
Strabismus (S)	10
Glaucoma – Minimally Invasive Glaucoma Surgery (MIGS) (S)	5
Glaucoma – Tube Shunts and Trabeculectomy (S+A)	5
Retinal Vitreous (S+A)	10
Intravitreal Injection (S)	10
Oculoplastic and Orbit (S)	28
Oculoplastic and Orbit - Eyelid Laceration (S)	3
Oculoplastic and Orbit - Chalazia Excision (S)	3
Oculoplastic and Orbital - Ptosis/Blepharoplasty (S)	3
Globe Trauma (S)	4

S = Surgeon Procedures Only

S+A = Surgeon and Assistant Procedures

### Logging Requirements

All procedures, surgeon and first assistant, must be entered in the ACGME Case Logs. This helps to demonstrate progressive, graduated, and broad surgical experience.

### ACGME Definitions

- **Surgeon:** Must be present for all critical portions of the procedure and perform ≥50% of critical portions, as determined by supervising faculty.
- **Assistant:** Must serve as first assistant to faculty or another resident performing the surgery under faculty supervision. Residents may log Assistant if observing through the microscope and actively

engaged (e.g., observing surgeon's technique, patient counseling, stabilization methods). Only one resident per case can claim Assistant credit.

## Case Log Entry Guidelines

### Bilateral Procedures

- **Same Role Both Sides:** CPT code is entered twice under one role (Surgeon or Assistant).
- **Different Roles (one side each):** Two 2 separate case entries are created—one as Surgeon, one as Assistant.

### Multiple Procedures on One Patient

Each procedure is logged separately with its CPT code to ensure accurate credit toward minimums.

Examples:

- Surgeon for combined phaco/trabeculectomy: Log both procedures as Surgeon.
- Surgeon for bilateral medical rectus muscle recession and anterior transposition of right superior oblique: Log 3 procedures as Surgeon.
- Surgeon for 2 horizontal muscles in the same eye: Enter the CPT code (67311) for one horizontal muscle twice as Surgeon.
- Surgeon for strabismus surgery on 2 different muscles in each eye: Record each muscle as a separate procedure as Surgeon.
- Surgeon for bilateral blepharoplasty combined with bilateral ptosis repair: Log 4 procedures as surgeon.
- Surgeon for scleral buckle procedure and Assistant on pars plana vitrectomy: Create 2 cases—one as Surgeon for scleral buckle and one as Assistant for pars plana vitrectomy.

### Two Residents on One Case

Only one resident may claim Surgeon credit per case, except when:

- Each resident performs a different procedure and each meets Surgeon criteria in case with more than one procedure (CPT code).
- Each resident performs one side of a bilateral procedure and each meets Surgeon criteria.

Examples:

- Pars plana vitrectomy combined with phacoemulsification of cataract: Each records procedure performed as Surgeon.
- Excision and repair of eyelid: Each records procedure performed as Surgeon.
- Bilateral blepharoplasty case where one resident performs surgery on one eye and the other residents on the opposite eye: Each records procedure as Surgeon.

### Batch Entry (Multiple Cases in One Entry)

Procedures for these categories only may be entered by the batch (maximum per entry):

- **Cataract:** up to 5 procedures
- **YAG Capsulotomy:** up to 5 procedures
- **Laser Trabeculoplasty:** up to 5 procedures
- **Panretinal Photocoagulation:** up to 5 procedures
- **Intravitreal Injection:** up to 10 procedures

Case information (date, role, attending, site), CPT code, and total number of procedures per day are entered.

**Batch Entry by CPT Code** (most common CPT code(s) highlighted).

<b>Category</b>	<b>CPT Codes</b>
Cataract*	66840, 66850, 66852, 66940, <b>66982, 66984</b> , 66988
Laser Surgery – YAG Capsulotomy	<b>66821</b>
Laser Surgery – Laser Trabeculoplasty	<b>65855</b>
Laser Surgery – Laser Iridotomy	<b>66761</b>
Laser Surgery – Panretinal Laser Photocoagulation	67105, 67145, <b>67228</b>
Intravitreal Injection	0465T, 67015, 67025, 67027, <b>67028</b> , 67110

\*CPT codes 66989 and 66991 are not included and must be individually entered because the case gives credit to the cataract and glaucoma-MIGS minimums.

**Amniotic Membrane Placement (CPT 65778):** Credit toward Pterygium/Conjunctival and Other Cornea minimum only given when using tissue glue. Self-retained membranes do not qualify for this minimum.

**Competence vs. Minimum Numbers**

Minimum numbers do not equal competence. The Program Director, in consultation with the Clinical Competency Committee, determines resident competence. Minimum numbers represent what the Review Committee believes to be an acceptable minimal experience and are not final targets. **Residents should continue logging procedures after achieving minimums.**

## SECTION 5: QUALITY IMPROVEMENT

### Quality Improvement/Patient Safety (QIPS) Conference

QIPS conferences are held on a monthly basis, in a closed session limited to members of the Department of Ophthalmology.

#### Objectives

- Discuss patient care complications openly so all residents can learn from others' experiences.
- Track complications and rates to identify when surgical privileges need adjustment or additional training.
- Monitor individual resident progress in quality improvement.

#### Documentation

Patients discussed during a QIPS conference will be recorded by the faculty member in charge in accordance with the policy of the BUMC Quality Assurance office. QIPS documents are legal documents, and any cases to be discussed must be recorded on a special form and submitted to the faculty coordinator.

### Total Quality Improvement

Residents must participate in a total quality management program to advance their surgical skills. This program has several requirements as enumerated below.

#### *Wet/Dry Lab Experience*

##### Specimen Acquisition

Location	Specimen Type	Contact	Notice Required
Alvernon Wet Lab	Pig or artificial eyes	Program coordinator	7-10 days
SAVAHCS OR	Artificial eyes only	Krista Tosynski (x6106)	as needed

**Note:** SAVAHCS artificial eyes are for SAVAHCS use only; do not transport to Alvernon.

##### Supervision

Wet/dry lab sessions are supervised by:

- Resident only (with or without video when possible)
- Senior resident
- Company representative
- Attending physician (see table on next page)

##### Electronic Logging (Required)

Log all wet/dry lab sessions electronically with:

- Date and total time
- Location
- Type of practice
- Supervisor name

The Program Director reviews resident progress at 6-month evaluations. Incomplete wet/dry requirements may delay progression to human phacoemulsification surgery.

### **Equipment Orientation**

- PGY-2 residents: AMO Signature Unit orientation (mandatory)
- PGY-3 residents: Alcon Infiniti Unit orientation (mandatory)

See table below for details.

### **Extramural Courses (Optional)**

Residents are encouraged to attend sponsor-funded courses:

- Alcon CSE Course (PGY-3)
- Alcon CPE Course (PGY-4)

Maximum 2 residents per course date. Academic time may be allowed.

### **Intramural Phaco Course (Mandatory)**

Annual course sponsored by Johnson & Johnson with Dr. Brian Hunter as primary instructor. Held in the Alvernon conference room. Attendance required for all residents.

### ***Wet/Dry Lab Requirements by PGY Level***

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#### **PGY-2**

- Q1**  Lid/Lacrimal Wet Lab
- Canthotomy
  - Paracentesis
  - Cornea Cultures
  - AC Tap (Altenbernd/Polonski, Alvernon)
- Q2**  Artificial/Pig Eyes x1 each (PGY-4 supervised, Alvernon)
- MISCS Wet Lab
- Q3**  Artificial/Pig Eyes x2 each (PGY-4 supervised, Alvernon)
- Allergan Wet Lab
- Q4**  Artificial Eyes x2 (Attending, ASC)
- SLT Model Eye x1 (Altenbernd, Alvernon)
  - Alcon Phaco & MIGS Wet Lab
  - Wet Lab (J&J/Hunter, Alvernon)
- 

#### **PGY-3**

- Q1**  Artificial/Pig Eyes x2 each (Attending)
- Corneal Suturing (Belin, OR9)
- Q2**  CORE Alcon Course (or Q3)
- MISCS Wet Lab
  - Artificial/Pig Eyes x2 each (Self, video PRN)
- Q3**  Artificial/Pig Eyes x2 each (Self, video PRN)
- Allergan Wet Lab
  - MISCS Wet Lab
- Q4**  Artificial Eyes x4 each (Attending, ASC or OR9)
- Alcon Phaco & MIGS Wet Lab
  - Wet Lab (J&J/Hunter, Alvernon)
-

**PGY-4 (PRN)**

**Q1**  Alcon CPE Course (Fort Worth) (or Q2)

Corneal Suturing (Belin, OR9)

**Q2**  Artificial Eyes x4 (Self, video PRN)

MISCS Wet Lab

**Q3**  Allergan Wet Lab

**Q4**  Alcon Phaco & MIGS Wet Lab

Wet Lab (J&J/Hunter, Alvernon)

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**Key Notes**

- **Minimum Requirements:** All eye counts listed are minimums. The Program Director monitors progress at 6-month evaluations.
- **Important Restriction:** No human phacos until all wet lab requirements are completed.

**Legend**

= Completion checkbox

Q = Quarter

ASC = Ambulatory Surgery Center

MISCS = Micro-incision cataract surgery

OR9 = Operating Room 9

PRN = As needed for remediation

***Education – Videos and Reading for Cataract Surgery***

Residents are required to view surgical videos and read selected book chapters to prepare themselves for cataract surgery. The Program Director will review resident progress at the 6-month evaluations. Incomplete requirements could delay resident progression to human phaco surgery.

## REQUIRED EDUCATION VIDEOS FOR CATARACT SURGERY

(<https://www.eyetube.net> – Cataract)

### Second and Third Year (PGY-2 and PGY-3) Residents\*

#### ***Wound Construction***

1. Scleral Incisions (D.M. Colvard)
2. Testing Clear Corneal Incision Integrity (J.A.H.)
3. Corneal Incisions (D.M. Colvard)
4. Making a Square Incision
5. Video Atlas of Ophthalmic Suturing: Fundamentals and Techniques (EBSCO eBooks from AAO)

#### ***Capsulorhexis***

1. Capsulorhexis (H. Gimbel)

#### ***Hydrodissection and Hydrodelineation (H. Fine)***

#### ***Phacoemulsification***

1. Basic Divide and Conquer (D.M. Colvard)
2. Using Hydrodissection (David Chang)
3. Managing Flow and Vacuum Levels with Today's Phaco Systems (R. Olson)

\*Completion required before advancement to human cataract surgery.

### Third Year (PGY-4) Residents: Cataract

All of the above, PLUS

#### ***Phacoemulsification***

1. Toric IOL's
2. Malyugin Ring and Trypan Blue with Small Pupil
3. Complete IFIS Case with Iris Prolapse (Bob Oshner)
4. Horizontal Chop (David Chang)
5. Vertical Chop (David Chang)
6. A Punctured Posterior Capsule (Howard Fine)
7. Malyugin Ring System for Small Pupils (Boris Malyugin)
8. Stop and Chop Technique (Bonnie Henderson)
9. Basic Techniques in Ophthalmic Surgery, 3<sup>rd</sup> edition, Chapters 1-8 (EBSCO eBooks from AAO)

#### ***Capsulorrhexis***

1. Completing Surgery with Compromised Rhexis (B. Little)

#### ***Irrigation and Aspiration***

1. Management of Intraocular Iris Prolapse (G. Hirshfield)
2. Insertion of 3-Piece IOL After Capsular Tear (R. Hoffman)

### ***Video Journal of Cataract and Refractive Surgery***

Another excellent source for cataract surgery videos is the “Video Journal of Cataract and Refractive Surgery.” Dr. Robert H. Osher is the editor of this video journal and he is a leader in cataract surgery innovations; he enlists some of the best cataract surgeons in the world in making these videos, which cover surgical complications and difficult cases. If residents want to review instructions on how to place a tension ring, deal with a dropped nucleus or sculpt a very dense nucleus, this is an excellent source. The website is as follows: [Video Journal of Cataract, Refractive, and Glaucoma Surgery \(VJCRGS\)](#)

#### **REQUIRED AND RECOMMENDED READING**

##### **Required Reading**

1. *Steinert's Cataract Surgery, 2023* (Available online through Arizona Health Sciences Library, [www.ahsl.arizona.edu](http://www.ahsl.arizona.edu).) [Steinert's Cataract Surgery - ClinicalKey](#)
2. *Phaco Chop and Advanced Phaco Techniques : Strategies for Complicated Cataracts.* David F. Chang. You can read online or download from this site: [ProQuest Ebook Central - Book Details](#) We also have hard copies. If you wish to check one out

##### ***All Residents***

*Cataract Surgery:* For a one-month rotation, the following reading schedule is recommended:

Week 1	Chapters 1-7, 12, 13, 16-18
Week 2	Chapters 8-11, 14
Week 3	Chapters 17-19, 21, 24-26, 29, 30, 34
Week 4	Chapters 38-40, 44-49, 54-55

##### ***Senior Residents Only***

*Phaco Chop:* Operating senior residents should have read the following by deadline dates below

##### **Reading Deadline: July 30**

Chapter 16	Capsulorrhexis: Sizing Objectives and Pearls
Chapter 17	Conquering Capsulorrhexis Complications
Chapter 18	Pearls for Hydrodissection and Hydrodelineation
Chapter 27	Strategies for Managing Posterior Capsular Rupture
Chapter 30	Posterior Capsule Rupture and Vitreous Loss: Advanced Approaches

##### **Reading Deadline: December 31**

Chapter 1	Why Learning Chopping
Chapter 2	Horizontal Chopping: Principles and Pearls
Chapter 3	Vertical Chopping: Principles and Pearls
Chapter 4	Comparing and Integrating Horizontal and Vertical Chopping
Chapter 5	Transitioning to Phaco Chop: Pearls and Pitfalls
Chapter 8	Understanding the Phacodynamics of Chopping
Chapter 9	Optimizing Machine Settings for Chopping Techniques
Chapter 10	Optimizing the Alcon Infiniti for Chopping
Chapters 25-30	Complicated Cataract Surgeries ( <i>Cataract Surgery</i> ; online)

Can be completed over a one-month period. A short, multiple-choice exam will be given. A passing score on the test is required prior to starting cataract surgery at the VA. Other

residents will be tested at the end of their anterior segment and/or cornea rotations based on attending preference.

## Patient Surgery

- **Surgical Assistant Experience:** Residents must serve as surgical assistant on a subspecialty-defined number of procedures before performing primary surgery in that procedure category.
- **Pre-operative Evaluation and Approval**
  - **All primary surgical cases:** Pre-operative evaluation must be approved by faculty.
  - **First three primary surgical cases:** Pre-operative evaluation must be completed with the faculty member who will staff those cases.

## Surgical Logs and Evaluation Tool

### Case Log Documentation

- All residents must:
  - Maintain surgical logs in the ACGME web-based case log program (required by ACGME), .
  - Include diagnosis, procedure, and role (Surgeon, Assistant).
  - Log surgery within 24 hours of the procedure.
  - **Not** enter patient names or chart numbers.
- **Consequence for Non-Compliance:** Residents who fail to have logs updated by 6<sup>th</sup> working day of the month may lose surgical privileges. Privileges are restored upon completion of case entry.
- **Surgical Summaries:** Every 3 months, surgical summaries are printed by the program coordinator and signed by the resident and Program Director. The Program Director will discuss the summaries with the resident at their 6-month review. Final summary is provided to senior residents at program completion.

### Cataract Surgery Competency Assessment

- Resident cataract surgery skills are evaluated using a competency-based tool via Qualtrics survey emailed to attending on the day of surgery. Attendings grade surgery on a scale of 1 to 4.
  - 1 Novice—little or no experience and considerable attending assistance required.
  - 2 Able to perform some steps.
  - 3 Able to Perform most steps but attending presence necessary.
  - 4 Target—procedure could have been performed independently; attending presence a formality.
- Attendings provide descriptive feedback for each surgical session.
- Program Director monitors progression and provides residents with regular survey reports. Stalled or suboptimal progression triggers notification to faculty and assignment of additional wet lab practice.

### Surgical Video Documentation (SAVAHCS)

- **Requirements**
  - Residents must videotape all cataract surgeries as primary surgeon (using Leica Operating Microscope recording equipment).
  - Residents review and discuss at least one video with the attending surgeon per surgical session (i.e., cataract surgical block).
  - Resident uploads one video every three months (four total annually) to Box.
  - **Best Practice:** When possible, residents should have videos reviewed by at least 2 attendings to ensure diverse surgical experience and varied expertise.

### **Cataract Surgery Complication Management (SAVAHCS)**

- **Target Complication Rate:** Less than 5%.
- **Remedial Plan Trigger:** Two complications in any 10 consecutive cataract surgeries.
- **Plan Development:** VA Site Director determines the remedial plan with input from attending surgeons. Plan involves wet/dry lab practice and direct observation by one or more attending cataract surgeons.

## **Continuous Quality Improvement**

### **How Residents Participate**

- Residents may discuss concerns with the Program Director and/or Department Chair individually.
- Residents participate in a quality improvement project tracking surgical complications and outcomes (led by Dr. Altenbernd).
- Residents have regular meetings with the Program Director and Department Chair.
- Residents meet with Program Director and faculty on a semi-annual basis (September, March/April).
- Residents complete a semi-annual electronic survey evaluating the program (December/May).
- The Chief Resident participates in the annual program review (June).
- Informal discussions may occur after rounds to address timely program concerns.

### **Anonymous Feedback**

- Residents may submit concerns anonymously via Qualtrics (link on resident webpage), which will be reviewed by the faculty ombudsman.
- Residents may report concerns to the resident or faculty ombudsmen.
- Residents report concerns to the Chief Resident for presentation at the semi-annual meetings with the Program Director and faculty.

**Note:** Residents with questions about confidential reporting should contact the GME Office at 626-7878.

## SECTION 6: ACADEMICS AND DIDACTIC TRAINING

### Core Components

- Weekly clinical teaching rounds
- Wet labs
- Specialty conferences
- Journal clubs

### Additional Learning Opportunities

- Tucson Ophthalmological Society meetings
- Annual Arizona Ophthalmological Society conference
- Guest speakers at community industry-sponsored events

### Attendance Expectations

Residents are expected to attend all lectures, rounds, wet labs, specialty conferences, and journal clubs. Residents are also expected to attend the Tucson Ophthalmological Society meetings unless a scheduled resident conference takes priority.

## Scheduled Educational Activities (Lectures and Rounds)

### Friday Morning Lectures

Lectures are held Friday mornings, 7:00–11:00 a.m., and at other scheduled times.

### Rounds

Rounds are held Wednesday mornings, 7:00–8:30 a.m., except the first Wednesday of each month.

#### • Presenter Responsibilities

- Contact a relevant subspecialist within the department about the case.
- Ideally, have the faculty member see the patient beforehand.
- Brief the faculty before presentation.
- Aim to involve multiple faculty members in discussion and share management insights.
- Submit presentation title and learning objectives to the program coordinator the Wednesday *before* presentation date.
- Enter presentation title/date and upload presentation in New Innovations > Portfolio. If file is too large, upload a copy of the presentation to Box > Scholarly Activities folder.

#### • Recruitment of Guest Rounds Speakers

- Obtain approval from CME Director approval (Dr. Kozak).
- Provide the speaker's name and contact information to the program coordinator at least **two weeks in advance** for CME documentation and approval.

## Basic Responsibilities

### Self-Directed Education

Each resident is responsible for their own education through:

- Studying patients
- Reading relevant texts

### Patient-Centered Learning

Patients are resident's most valuable teaching resource and must be treated with respect and dignity.

## Required Reading

### BCSC Curriculum (Required)

Residents must complete the Academy of Ophthalmology (AAO) **Basic and Clinical Science Course (BCSC)** in its entirety. The BCSC mirrors the core curriculum of ophthalmology residency training. Residents are required to participate in the BCSC curriculum.

### Daily Reading

Residents should read about specific diagnostic entities encountered in clinic each day.

### BCSC Resources

- Faculty (full-time, part-time, and volunteer) provide clinical expertise to support BCSC didactic training.
- Printed BCSC copies are available for purchase from the AAO at a member discount rate.

## Recommended Textbooks

To assist in the new resident's introduction to ophthalmology, the following specific textbooks/manuals are recommended. These are:

- *Practical Ophthalmology: A Manual for Beginning Residents*
- *Video Atlas of Ophthalmic Suturing: Fundamentals and Techniques*. Read online or download at: [Video Atlas of Ophthalmic Suturing : Fundamentals and Techniques - EBSCO](#)
- *Fundamentals and Principles of Ophthalmology* (Book 2, BCSC)
- *Wills Eye Manual*

*Practical Ophthalmology: A Manual for Beginning Residents* and *Fundamentals and Principles of Ophthalmology* are available from the American Academy of Ophthalmology (AAO) ([www.aao.org](http://www.aao.org)).

The *Wills Eye Manual* can be purchased from [amazon.com](http://amazon.com). You may also be able to request an eBook copy from the Library.

### Arizona Health Sciences Library Online Textbooks

Many ophthalmology textbooks are available online through the Arizona Health Sciences Library website. Residents will need to use their UA netID login and password to access the ebooks.

1. Go to <https://libguides.library.arizona.edu/clinicalkey>
2. Click "Books" (near middle of screen under "Deepen your specialty and medical knowledge").
3. Click "Filter By" on the left sidebar.
4. Click "Specialties" on the left sidebar.
5. Click "+ More Subspecialties" on the left sidebar.
6. Select "Ophthalmology."

There are 51 online textbooks, which include all subspecialties, as well as atlases, video atlases, general ophthalmology references, differential books, therapy references, etc. Some of these books, such as *Ryan's Retina*, *Cornea*, and *Glaucoma* are the go-to sources for general

information on a topic. Of course, by the time a book goes to print some of the information requires updating and the journal articles will help fill in the contemporary gaps for presentation.

**ClinicalKey** also has direct access to a few of the most cited ophthalmology journals, but access to a larger number may be achieved through the PubMed portion of the Arizona Health Sciences Library portal. Residents can also access these books via the EBSCO link below.

Directions below to access this resource additional textbooks through EBSCO.

1. <https://libguides.library.arizona.edu/ebSCOclinical>
2. Sign in using EBSCO username and password (set one up if don't have one).
3. In the search field, enter Ophthalmology and then click on the Search button.
4. On the left side, residents can limit their search to eBooks by clicking the eBook radio button
5. Click "Choose Databases" near the top center of the page and check eBook Medical Collection (EBSCOhost), eBook Collection (EBSCO host) and eBook Comprehensive Academic Collection (EBSCO host).
6. 127 eBooks will then be listed. Residents can add any of these to their personal folder by clicking on the folder icon to the right of the entry. Upon signing in next time, residents can open their folder and access their books without going through the 100 choices.

## SECTION 7: RESEARCH

### Research Opportunities

The Department investigates amblyopia, corneal diseases, glaucoma, retinal diseases, strabismus, and vision development, with emphasis on optics, ocular physiology, and pharmacology. Ongoing clinical studies evaluate new treatment modalities.

#### Research Laboratory

A basic science lab is located on the second floor of the Medical Research Building (near BUMCT).

#### Resident Participation

- Residents are encouraged (not required) to participate in research projects.
- Educational support on research design, hypothesis testing, statistics, and epidemiology.
- Research topics may include results of basic or clinical research.

#### Presentation at National Meetings

Residents encouraged to present research at:

- Association for Research in Vision and Ophthalmology (ARVO)
- American Association for Pediatric Ophthalmology and Strabismus (AAPOS)
- American Society of Cataract and Refractive Surgery (ASCRS)
- American Academy of Ophthalmology (AAO)

#### Department Support

- Faculty mentorship (required to be eligible for travel expense reimbursement). Faculty member must be a co-author.
- Eligible travel expenses are covered (up to \$1,200), plus membership and early registration.
- Residents receive academic time for the presentation day, as well as the day immediately before and after the conference.
- There is no support for case reports or duplicate presentations.
- Poster printing is available.

#### Poster Printing

A printer is available for research posters up to 36" x 56". Residents should submit the file to the program coordinator via email or USB drive when ready to print. Posters exceeding 36" x 56" must be printed elsewhere; printing costs require advance approval.

### Publications

Residents are encouraged to publish their research. Publishing develops skills in scientific writing and critical evaluation of literature.

**Research Publication Fee:** Before submitting an article to a journal that requires a publication fee, residents must obtain approval from the Department Chair. The Department prioritizes submitting to high-quality journals without publication fees to preserve research funding. Fee-based journal submissions are considered case-by-case and require prior Department Chair approval for reimbursement.

## Research and IRB

### **Human Subjects Training (Required)**

Residents must complete the CITI Course in The Protection of Human Research Subjects online at <https://www.research.arizona.edu/compliance-public/human-subjects-protection-program> by August 31 of the first year. Submit the completion certificate to the program coordinator for the file.

### **Conflict of Interest (Required)**

Residents must complete conflict of interest (COI) training and submit a Disclosure of Significant Financial Interests at <https://research.arizona.edu/compliance/office-responsible-outside-interests>. Submit this form even if no conflicts to disclose.

### **IRB Approval (Required)**

- **Human Subjects Research:** IRB approval is required for all research projects involving human subjects.
- **Non-Human Subjects Research:** Residents must submit the "Determining Human Research" form for all research projects not requiring IRB approval. The form is available at <https://research.arizona.edu/compliance/human-subjects-protection-program/HSPP-form/forms-index>

## SECTION 8: EVALUATION AND ASSESSMENT

### Faculty Evaluation of Residents

#### *Faculty 6-Month Evaluation of Residents*

Every 6 months, the faculty complete evaluations in New Innovations, which are compiled into a single report for the Program Director. This evaluation will be reviewed and signed at the 6-month evaluation conference with the Program Director.

#### **Evaluation Meeting**

Residents meet with the Program Director at least twice yearly for a formal evaluation of their overall performance. All evaluations are discussed confidentially, and the resident's strengths, any deficiencies, and plans for improvement will be addressed. A sample evaluation form is available in the Forms (pages 27-33).

#### **Board Process**

If a resident believes an evaluation is inaccurate or unfair, he/she may request a formal meeting with the Program Director, department faculty, and their faculty advisor. If changes are made following the review, the prior evaluation will be destroyed.

#### *Faculty Rotation Evaluations*

Faculty evaluate resident performance at the end of each rotation. Residents must complete the rotation evaluation with faculty during the final days of the rotation and sign it in New Innovations. The program coordinator will print the evaluation and provide it to the Program Director for the resident's 6-month review. Sample rotation evaluation forms are available in Forms (pages 1-33).

### Resident Evaluations

#### *Evaluation of Faculty*

Residents must complete anonymous faculty evaluations via New Innovations ([www.new-innov.com](http://www.new-innov.com)):

- **Full-Time Clinical Faculty** — December and June
- **Research and Affiliate/Associate Faculty** — December and June

#### **Evaluation Criteria (Full-Time Clinical Faculty)**

- Clarity of lectures
- Completeness of curriculum
- Effectiveness of lectures
- Organization of material
- Suggested improvements

Faculty evaluations are confidential and shared only with the Department Chair and Program Director. See sample evaluation form (Forms, pages 40-41).

### ***Peer Evaluations and Self Evaluation***

Residents must complete peer evaluations and a self evaluation every 6 months.

### ***Rotation Evaluations***

Residents must complete an evaluation at the end of each rotation. Most rotations are either one month or 3 months in length.

### ***Evaluation of the Program***

Residents must complete two mandatory, anonymous program evaluations per year:

- Mid-Year Evaluation (November/December) — Forms, pages 42-43
- Annual Evaluation (April/May) — Forms, page 39

Both evaluations are submitted through New Innovations ([www.new-innov.com](http://www.new-innov.com)). Results are compiled into a report for the Program Director and Program Evaluation Committee.

## **Other Evaluations**

### ***Technician Evaluation of Residents***

Technicians complete anonymous evaluations via Qualtrics twice per year (Forms, page 45). The program coordinator compiles results into a single summary report for the Program Director. Results are reviewed during the 6-month evaluation.

### ***Patient Surveys***

Patients may complete surveys via Qualtrics (Forms, page 38). All survey responses are available for review during the 6-month evaluation with the Program Director.

## **Promotion**

### **Promotion Criteria**

Residents advance to positions of higher responsibility based on demonstrated:

- Satisfactory completion of rotations.
- Attendance at educational activities.
- Competence in:
  - Patient care.
  - Medical knowledge.
  - Practice-based learning and improvement.
  - Interpersonal and communication skills.
  - Professionalism.
  - Systems-based practice.

### **Notification**

The program communicates advancement to the resident and GME Office for:

- Annual promotion evaluation,
- Final summative evaluation for graduating residents.

## Probation, Letter of Concern, and Dismissal

Residents with unsatisfactory progress may be placed on probation or given a Letter of Concern only after consultation with the Department Chair, Program Director, Clinical Competency Committee, and faculty.

### Requirements

- Written acknowledgment required.
- Includes specific goals and objectives.
- Remediation Period: Reasonable amount of time up to 6 months; at the Program Director's discretion with consultation with the Clinical Competency Committee.

### Non-Improvement

If deficiencies are not resolved within the remediation period, dismissal may result. Residents may appeal.

### Immediate Action

A resident may be immediately suspended from surgical duties and placed on probation if deemed a patient safety risk.

### Additional Resources

See the program coordinator for UA College of Medicine Resident Physician Probation Procedures, Nonrenewal Procedures, and suspension and Dismissal Procedures.

## Oral and Written Examinations

### *Mock Oral Examination*

PGY-2, PGY-3, and PGY-4 residents must complete a mock oral examination during fall or spring. The exam covers the following topics:

- Anterior segment/optics
- Cornea/uveitis
- Glaucoma
- Neuro-ophthalmology
- Oculoplastics
- Pediatric ophthalmology
- Posterior segment

The Program Director will receive a written summary of each resident's exam performance and will meet individually with each resident to discuss results; usually at the 6-month review.

### *OKAP Examination*

#### Annual Examination

- All residents must participate in the Ophthalmic Knowledge Assessment Program (OKAP) annually, administered by the ABO
- Examination is taken at an authorized examination site.

#### Score Confidentiality

Individual scores are confidential and known only by the Department Chair, Program Director, and the resident.

### Score Review

- Program Director will meet with each resident to discuss OKAP results.
- Results are used to evaluate resident performance and identify programmatic strengths and weaknesses.

### Score Interpretation

OKAP reports provide individual subject scores, overall scores, and "core knowledge" scores as percentiles compared to residents at the same training level

### Required Actions by Score

- **Overall score below 30th percentile**
  - Forbidden from moonlighting.
  - Required to read all subsections scoring below the 30th percentile.
  - Meet with the faculty member responsible for each subsection.
  - Develop a written study plan and reading schedule.
  - Meet with GME learning specialist to create a self-study plan.
- **Overall score at 30th percentile or higher, but individual subsection below 30th percentile**
  - Required to read the subsection scoring below the 30th percentile.
  - Meet with the faculty member responsible for that subsection.
  - Develop a written study plan and reading schedule.

### Recognition

Residents scoring above the 75th percentile in an individual subsection will be recognized by the responsible faculty member and the Department Chair.

## Board Eligibility

### Certification Requirements

To be considered Board eligible, residents must:

- Satisfactorily complete 36 months of residency training (in addition to PGY-1, which includes 3 months of ophthalmology).
- Hold a valid, unrestricted medical license in the United States.
- Receive certification from the Department Chair that the prescribed residency has been satisfactorily completed.

For additional details, visit the ABO website at [www.abop.org](http://www.abop.org).

### Probationary Status Impact

If a resident is placed on formal probationary status:

- The Department Chair will consult with the Program Director and faculty to determine if additional training is required to meet the Board of Ophthalmology's training requirement.
- Time spent on probation typically does **NOT** count toward the Board of Ophthalmology's training requirement.
- Time on probation is **NOT** considered time "in good standing."

### Right to Appeal

Residents have the right to appeal decisions regarding probationary status and Board.

## Clinical Competency Committee

The Clinical Competency Committee (CCC) consists of at least three full-time program faculty from SAVAHCS or Banner. The CCC will:

- Review all resident evaluations at least twice yearly (October/November and March/April).
- Advise the Program Director on resident progress, including promotion, remediation, and dismissal.

## Clinical Logs

Clinical logs track the number of patients seen each week by subspecialty and emergency cases. Enter patient numbers weekly into the Excel file in the Box > Clinical Logs folder. Include:

- Outpatient visits by subspecialty clinic.
- Inpatient visits.
- Emergency visits.

The program coordinator provides quarterly clinical log sheets for signature by resident and program director. Residents receive a final summary at program completion.

## Pre-Rotation Review

At the beginning of each rotation, residents must:

- Review the rotation's goals and objectives with the supervising faculty
- Confirm completion online through New Innovations within the first week of the rotation (see See "Confirming Curriculum" in the Appendices for instructions).

## SECTION 9: WELLNESS AND PROFESSIONAL CONDUCT

### Attendance Policy

#### *Clinic/Surgery*

##### **Clinic Attendance**

- Clinics begin at 8:00 a.m. and 1:00 p.m. at Alvernon Clinics and SAVAHCS.
- Resident must **arrive 5 minutes early** before each clinic start time.
- Residents remain at clinic unless excused by the supervising faculty.

##### **Surgery Attendance**

- Resident must arrive **15 minutes early at BUMCT** and **30 minutes early at SAVAHCS**, dressed appropriately.

##### **Tardiness**

- Arriving late to surgery may result in loss of one or more primary cases at the attending's discretion.

#### *Lectures/Rounds*

##### **Conference Schedule**

- **Rounds:** Wednesday mornings, 7:00–8:30 a.m. (except first Wednesday of each month—QIPS)
- **Lectures:** Friday mornings, 7:00–11:30 a.m., plus other scheduled times

##### **Attendance Requirements**

- Residents must attend **all lectures** except for vacation, sick leave, emergency call/surgery, or post-call duty.
- Residents must arrive **on time**; more than 15 minutes late counts as tardy.
- Educational activities take precedence over clinical work. Residents may not leave teaching activities for patient care unless it is a true emergency that cannot wait or with prior faculty approval. **Exception:** The consults resident must round with the attending before late afternoon. If approved to miss an activity (e.g., for VA surgery), residents must notify the faculty lecturer, Program Director, and program coordinator.
- Lecture attendance is taken by responding to email from program coordinator.
- Rounds attendance is taken via CloudCME.

#### *Emergencies, Sickness and Other Circumstances*

Residents who are absent due to emergency, illness, or other circumstances, must immediately notify:

- Chief Resident
- Program coordinator
- All faculty members scheduled to work with that day.

## Chief Resident Responsibilities

The Chief Resident will ensure coverage for all patient care responsibilities.

## Time Off

### Vacation

#### House Staff Manual Guidelines

- Residents receive four one-week periods (4 weeks) of vacation each academic year.
- Vacation must be approved by Program Director; subject to program's staffing needs.
- Vacation cannot be carried over from one academic year to the next.

#### Program Guidelines

Vacation requests are given to the Chief Resident for review by program coordinator and approval by Program Director.

- **Submission Deadlines**

- **Vacation Blocks:** Residents submit requests to Chief Resident by May 15 for August-December; October 15 for January-June.
- **Vacation Changes:** Residents submit requests to Chief Resident/program coordinator for review/approval.
- **Individual Vacation Days:** Residents submit requests to Chief Resident/program coordinator by April 1. Example: If used 3 days for Thanksgiving, request remaining 2 individual days by April 1.

- **Vacation Blocks**

- Vacation is taken in consecutive 5-day blocks, Monday through Friday. Exceptions for individual days for fellowship or job interviews or accrued holiday compensation.
- No weekend call immediately before or after vacation week.
- Banner holidays do not count as vacation.

- **Priority System**

- Chief > PGY-4 > PGY-3 > PGY-2 > PGY-1
- The Chief Resident resolves conflicts; Program Director has final approval.

- **Number of Residents on Vacation**

One resident per year, except:

- PGY-4 residents may take additional time for fellowship/job interviews. *Note:* Requires VA Section Chief of Ophthalmology approval for >1 senior off when rotating at the VA, as well as Program Director approval.
- Maximum of 2 residents per PGY level may attend extramural courses simultaneously (e.g., Alcon, Bausch & Lomb).

- **Quarterly Distribution**

- Residents are allowed 1 week vacation during each quarter:
  - > July–September
  - > October–December (week including Christmas counts for December)

- > January–March (week including New Year’s Day counts for January)
- > April–June
- **Restrictions**
  - > Resident may not take the last week of one quarter and first week of the next (e.g., last week of September and first week of October).
  - > Residents may not take consecutive weeks during 2-month rotations (pediatric ophthalmology, general ophthalmology).
  - > Residents may not take vacation during holidays already taken in previous years until all residents have had the opportunity.
- **Blackout Periods—No Vacation Allowed**
  - July (all residents)
  - Consults rotation (PGY-2 and PGY-3 resident)
  - AAO meeting week (October 9-12, 2026) for PGY-3 or PGY-2 (seniors attend)
  - Resident interviews (December 11–12, 2026)
  - Week of OKAP Exam (March \_\_, 2027; must take exam in person at assigned location/time)
  - June (PGY-2 and PGY-3 residents)
  - Graduation dinner (June 10, 2027) (all residents)
- **Other Vacation Requirements**
  - **Mock Exam Week** (TBD): May take vacation week of mock oral exam, but must participate in Saturday morning mock orals, as assigned.
  - **Phaco Wet Lab** (TBD, Dr. Hunter) and **Alcon Wet Lab**: May take vacation week of lab, but mandatory participation for wet lab.
  - **USMLE Step 3 Exam**: Must use vacation time.
  - **Senior Residents at End of Year**: May leave one week (5 days) prior to completion of residency on June 30; reserve vacation for June 24–25, and 28–30, 2027.

### ***Sick Leave***

- 5 days of sick leave per year.
- May use hours for self.
- May use for **certain** family members in following circumstances:
  - Medical care or mental/physical illness, injury, or health condition.
  - A public health emergency.
- May use for absences due to domestic violence, sexual violence, abuse, or stalking.
- May not schedule doctor appointments in June. Seniors must schedule any doctor appointments needed for fellowship or personal need in May or sooner.

### ***Holidays***

#### **Banner Designated Holidays (6 per year)**

- Independence Day
- Labor Day
- Thanksgiving
- Christmas
- New Year's Day
- Memorial Day

### Assignment on a Holiday

If given an assignment on a holiday (call, consults), the resident will be granted an alternate day off. These resident must notify the Chief Resident and program coordinator with an alternate date; must be one full day.

### SAVAHCS-Only Holidays

On holidays observed at SAVAHCS but not Banner (Columbus Day, President's Day, etc.), all residents are assigned to Alvernon clinic or academic time. **Note:** Vacation applies if out of town or not available.

### Bereavement

Residents are eligible for bereavement day one of employment.

- May take up to three days for immediate family.
- May take one day for other family members.
- Request through Program Director.

### Leaves of Absence

The institution and program are committed to residents continuing and completing training and taking time needed during illness, parental leave, caregiving, etc. Graduation date and schedule impact will depend upon resident specialty board requirements and program; discuss with Program Director.

### Types of Banner Health Leaves

<b>Maternity Leave</b>	<ul style="list-style-type: none"><li>• STD: 6 weeks paid at 100%, effective day 1 of employment</li><li>• Disability payments available date of disability. No waiting period (no sick bank or vacation needs to be used).</li></ul>
<b>Maternity Leave (Caesarean)</b>	<ul style="list-style-type: none"><li>• STD: 8 weeks paid at 100%, effective day 1 of employment</li><li>• Disability payments available date of disability. No waiting period (no sick bank or vacation needs to be used).</li></ul>
<b>Own Health-Short Term Disability</b>	<ul style="list-style-type: none"><li>• STD: max duration 26 weeks (182 days) paid at 100%, effective day 1 of employment.</li><li>• Disability payments available date of disability. No waiting period (no sick bank or vacation needs to be used).</li></ul>
<b>Own Health-Long Term Disability</b>	<ul style="list-style-type: none"><li>• Once residents max out their STD, transition to LTD, if approved.</li><li>• LTD: Paid out by leave vendor Matrix - \$3,000 flat rate, effective day 1 of employment.</li></ul> <p><i>*If unable to return to position, then automatically transitioned to Long-Term Disability (LTD) claim process, and claim will be re-evaluated for additional benefits. During LTD claim process, LTD examiner will contact resident 2 weeks before STD exhausts to review the LTD process.</i></p>

<b>ACGME Paid Leave</b>	<ul style="list-style-type: none"> <li>• 6 weeks paid at 100%, effective day 1 of employment.</li> <li>• Required to use sick bank first, and then ACGME benefits.</li> </ul> <p><i>*ACGME Paid Benefits: Residents eligible for up to 6 weeks at 100% base pay per program (not academic year) and may only use these paid benefits once in their program.</i></p> <p><i>*Note: Matrix may identify this type of leave as a “Parental Leave, Personal Family Leave, or Federal Medical Leave Act (FMLA)”.</i></p>
<b>Personal Leave of Absence</b>	<ul style="list-style-type: none"> <li>• Eligible day 1 of employment.</li> <li>• Must be approved by Program Director at their discretion.</li> <li>• Maximum Duration: 12 weeks.</li> <li>• Required to use sick bank first and vacation time, otherwise unpaid.</li> </ul>

## Unscheduled Time (When Faculty Cancels Clinic or Surgery)

- **Alvernon Clinic:** Residents must contact the Chief Resident for an assignment.
- **SAVAHCS:** Resident must contact the Chief Resident, who will involve the Section Chief in the decision for another assignment.

## Academic Time

### Approved Activities

Residents receive academic days to attend courses and conferences, including:

- AAO (senior residents)
- Certain courses, such as Alcon (PGY-2 and PGY-3 residents); minimal academic time provided.
- Eligible presentations at national conferences.

### Requirements

- Resident must obtain pre-approval from the Department before attending national conferences on academic time.
- Residents must arrange for travel authorization with program coordinator more than 30 days prior to the travel.

## Work Hours and Fatigue Management

### Work Hours

Clinical and educational work includes all activities related to the residency program.

### Counts toward duty hours

- Patient care (inpatient and outpatient).
- Administrative duties related to patient care.
- Patient care handoffs and transitions.
- In-house call activities.
- Scheduled lectures, rounds, and conferences.
- AAO, ARVO, and review courses.
- Hospital committee meetings (including GMEC meetings).

- On-site resident interviews.
- Internal and external moonlighting.

#### **Does not count toward duty hours**

- Reading, studying, and academic preparation away from the duty site.
- Voluntary time at the library or hospital with no planned duties for 2+ hours.
- Travel time to/from conferences.

#### **Duty Hour Limits**

- Maximum 80 hours per week, averaged over 4 weeks, including all moonlighting.
- Minimum 8 hours off between scheduled work periods.
- Maximum 24 hours of continuous scheduled duty.
- Minimum 1 day free from clinical and educational work per 7 days, averaged over 4 weeks (vacation/leave does not count).

#### **At-Home Call (Pager Call)**

- Time spent in the hospital while on at-home call counts toward the 80-hour weekly limit.
- At-home call frequency is not subject to the every third-night restriction.
- At-home call must allow adequate rest and reasonable personal time.

#### **Expectations/Required Actions**

- Residents are expected to be familiar with this policy and avoid violations.
- Residents must notify the Chief Resident or Program Director immediately if reassignment is needed to prevent a violation.

#### **When Residents May Extend Work Hours**

Residents may remain beyond their scheduled end time **only** to provide continuity of care to a single patient in these limited circumstances:

- Caring for a severely ill or unstable patient requiring continuity.
  - Attending an academically important clinical event.
  - Providing humanistic support to a patient or family in need.
  - **Required Actions:** When extending work hours, residents must:
    - Hand over care of all other patients to the covering team.
    - Document the reason for the extension.
    - Submit documentation to the Program Director in all cases.
    - Enter the extension in New Innovations under Work Hours – Violations with a full explanation.
- Note:** Extensions beyond scheduled hours must be exceptional and require justification. Routine extensions are not permitted.

### ***Fatigue Management***

#### **Recognition and Education**

All faculty and residents will be educated to recognize the signs of fatigue and sleep deprivation in themselves and others.

#### **Fatigue During On-Call**

If the primary resident is fatigued or sleep-deprived while on-call, the backup resident or faculty member will assume responsibility until recovery occurs (typically 2 hours, longer if needed).

**Fatigue after Extended Duty**

After extended duty, a 30-minute strategic nap is recommended before participating in morning activities. Residents may take the entire morning to recover, if needed.

**Safe Transportation**

Residents should not drive home if fatigued; stay in a call room.

**Moonlighting Impact**

Moonlighting hours count toward the 80-hour weekly limit and cannot interfere with required sleep and recovery periods.

**Post-Call Reporting Requirements**

Residents must notify the faculty of their assigned clinic either directly or through the Chief Resident before the start of the clinic. The program coordinator must also be notified.

## Moonlighting

Moonlighting includes all practice privileges and other activities outside the educational program.

**Eligibility**

- PGY-1 and PGY-2 residents are not eligible.
- Residents must be meeting expected academic and clinical performance standards.
- Residents with an overall score below the 30<sup>th</sup> percentile on the OKAP are not eligible.
- Residents on academic probation are not eligible.

**Required Approval**

Resident must receive prior written approval from the Program Director and Department Chair is mandatory. Moonlighting without permission is prohibited and grounds for suspension or dismissal.

**General Requirements**

- Moonlighting cannot interfere with residency training or patient care.
- Residents may not moonlight while on leave or on call.
- Schedule changes to accommodate moonlighting are not permitted.
- All moonlighting hours count toward the ACGME 80-hour duty hour limit. Hours must be logged weekly in New Innovations and reported to the program coordinator.

**Insurance and Licensing**

- Residents must have their own professional liability insurance. Banner malpractice and professional liability coverage does NOT cover moonlighting.
- Residents must have an unrestricted individual Arizona license. The training permit does NOT apply to moonlighting.
- Residents must have a personal DEA number.

**Consequences for Non-Compliance**

- Failure to report hours accurately or violate work hours results in loss of moonlighting privileges for the remainder of residency.
- The Program Director may suspend privileges immediately if residency expectations are not met.

## Counseling and Well-Being Services

Free **confidential** counseling is available to residents and their families to discuss personal or professional issues at no charge.

### Confidentiality

Counseling records are limited, securely maintained by the counselor, and are not part of the academic file.

### Scheduling

To schedule an appointment, the resident completes the online request form at <https://mentalhealthservices.medicine.arizona.edu/services/residents-fellows>. A response will be available from the GME Mental Health Services Team within 48 business hours.

### Emergency/Crisis Support

- Community Crisis Line: (520) 622-6000
- CAPS Crisis Line: (520) 621-3334
- Go to Emergency Department

## Dress Code

- Residents must wear a recently laundered white lab coat.
- Residents must wear a name tag at all times in clinic.
- Residents must follow Banner policy guidelines (see appendices and Box > Public Resident Files).

### Lab Coat Provision

- Banner provides 2 white coats for incoming residents. Additional lab coats must be purchased by the resident.
- Laundry service available at Alvernon clinic.

## SECTION 10: PROFESSIONAL DEVELOPMENT

### Professional Memberships

- **American Academy of Ophthalmology (AAO)**  
AAO membership is complimentary and required for all residents. Membership includes a subscription to *Ophthalmology* journal. Join online at [www.aao.org](http://www.aao.org) or call (415) 561-8581.
- **American Society for Cataract and Refractive Surgery (ASCRS)**  
Complimentary membership is available to residents. Members receive the *Journal of Cataract and Refractive Surgery*. Learn more at [www.ascrs.org](http://www.ascrs.org).
- **Arizona Ophthalmological Society (AOS)**  
Free membership is encouraged. The AOS provides educational, social, and professional networking opportunities for ophthalmologists statewide. The annual spring meeting in Flagstaff features distinguished speakers. Residents may apply online at [www.azeyemds.org](http://www.azeyemds.org).

### Educational and Extramural Courses

#### *Conferences/Courses*

Residents are expected to attend all ophthalmology courses and meetings held in Tucson, including:

- Tucson Ophthalmological Society meetings
- Arizona Ophthalmological Society meetings in Tucson
- Department-sponsored activities

Attendance is not required if there is a conflicting resident conference. Meeting announcements are provided throughout the year.

#### *American Academy of Ophthalmology (PGY-4 Residents Only)*

Senior (PGY-4) residents may attend the AAO meeting. The Department will provide:

- Up to 3 days academic time for attendance, including travel days. Residents must use vacation for any additional days off.
- Up to \$1,200 for reimbursement of eligible travel expenses, as well as early registration, if travel requirements are met (see page \_\_).

#### *Committees & Leadership*

Residents are encouraged to serve on hospital committees. Each year, residents select a representative and alternate for the Graduate Medical Education Committee, which oversees all aspects of residency education. Contact the program coordinator for information about available committees.

### BLS Certification

All residents must maintain current BLS certification through Banner's RQI program, accessible via Banner MyHR/Workday > Workday LINK.

**Scheduling**

Residents must complete the course to minimize clinic disruption. If scheduling during clinic or surgical hours, residents must obtain approval from the Chief Resident.

**Completion**

- Instructions are available in Box > Public Resident Files.
- Residents provide proof of current certification to the program coordinator.
- Residents may contact the program coordinator if the RQI link is unavailable.

# SECTION 11: CHIEF RESIDENT ROLE AND LEADERSHIP

## Chief Resident Core Responsibilities

### Scheduling

- The Chief Resident prepares monthly resident assignments based on core rotation.
- The Chief Resident reassigns residents as needed (illness, cancelled clinics) and update the program coordinator.
- The Chief Resident prepares medical student assignments.

### Lecture Schedule

The Chief Resident reviews the lecture schedule and report deficiencies to the Program Director. If more than six residents will miss a lecture, the Chief Residents notifies the program coordinator so the lecturer can decide whether to reschedule.

### Professional Culture

The Chief Resident fosters collegial and professional interaction among residents.

### Study Sessions

The Chief Resident prepares questions and review material for designated Friday "Study Session" lectures.

## Rotation-Specific Responsibilities

July-September (transitions to Chief in June)	Assist with PGY-2 orientation schedule. Update the "survival guide." Collect and screen vacation requests for appropriateness for July-December, then forward to the program coordinator for Program Director approval. Schedule first and back-up call for all residents for July-December. The schedule must comply with work hour standards. The program coordinator will verify compliance. Resolve scheduling conflicts with the program coordinator and Program Director, as needed. Schedule rounds presentations for July-December and ensure appropriate content. Prepare the agenda and lead discussion for semi-annual resident/faculty meeting (September).
October-December	Collect and screen vacation requests for appropriateness for January-June, then forward to the program coordinator for Program Director approval. Schedule first and backup call for all residents for January-June. The schedule must comply with work hour standards. The program coordinator will verify compliance. Resolve scheduling conflicts with the program coordinator and Program Director, as needed. Schedule rounds presentations for January-June and ensure appropriate content.
January-March	Prepare resident OKAP in-house review course.

	Prepare the agenda and lead discussion for semi-annual resident/faculty meeting (March).
April-June	Participate in annual program review. Respond to inquiries from incoming residents (via email/phone).

## SECTION 12: SUPPORT AND RESOURCES

### Faculty Advisors and Mentorship

#### Selecting a Faculty Advisor

Each resident must choose a faculty advisor from full-time, part-time, or volunteer faculty. The Program Director and Department Chair are not eligible. PGY-1 residents should select an advisor by October 1. Residents may change their advisor.

#### Advisor Meetings

Residents meet with their advisor at least twice yearly to discuss career goals, residency progress, and any challenges. The advisor serves as the resident advocate.

#### Mentoring Plan

- Residents complete a mentoring plan (self-assessment and self-reflection) in November and May using the forms (Forms, [pages 34-37](#)), which includes strengths and deficiencies, knowledge and skill gaps, and learning and improvement goals.
- Residents meet with their faculty advisor to review the assessment and obtain signature on the completed form.
- Residents submit the signed assessment to the program coordinator by the deadline on the 6-month checklist.
- The Program Director will review the assessment during the 6-month reviews.

### Academic Support within GME Office

Academic support services are available for any resident for the following:

- In-Training Exams
- Specialty and Subspecialty Board Exams
- USMLE Step 3/COMLEX-USA Level 3
- Test Taking Strategies
- Retention Challenges
- Learning Strategies
- Study Schedules
- Pre-Rounding Efficiency
- Time Management and Efficiency Issues (for studying)
- Integrating Feedback and Effectively Asking for Feedback

The link to schedule an appointment is available at:

<https://medicine.arizona.edu/education/graduate/graduate-medical-education/university/housestaff/resident-and-fellow-academic-support/services>.

## Call Rooms

- BUMCT: The work room at BUMCT is room 5607, code 0655. There is an adjacent call room 5606 entry code and the inside entry code for room is 0876.
- BUMCS: To be determined.
- SAVAHCS: There is a shared call room available at SAVAHCS. This room is adjacent to the Emergency Department. The Administrative Officer of the Day (AOD) in the Emergency Department can provide access into the room. The Surgical Services Office can also provide instructions on access.

## Lactation Rooms

- BUMCT:
  - Tower 1, Floors 6-9 – Rooms 61419, 71419, 81419, 91419
  - Tower 2, ED Room DC1229 South Pod
  - Tower 3, Rooms 33703, 43703
  - Tower 4, Room 64643 (door code 1543)
- BUMCS: There is a lactation room on the 5<sup>th</sup> floor of the main hospital—Room 500116, as well as in the ED near fast track waiting (Room 200053). Contact Security for access.
- SAVAHCS: Lactation rooms at SAVAHCS are in Building 2, Room 106D and Building 60, Room E111. The code for both room is 6477#. Engage the lock from the inside and others from the outside should not be able to open the door. Detailed information and policy available in Box > Public Resident Files.
- 655 Alvernon: There is a lactation room in the faculty area, Room 206H.

## Computer Access

Computers with word processing, graphics, presentation, and Internet software are available in the resident area (suite 208). Residents are responsible for preparing their own documents. For any computer or printer issues, contact UA IT at 626-8721 or notify the program coordinator.

## Required Equipment

### Fundus Lenses

Residents must purchase their own lenses or borrow fundus lenses from the program.

- 20-diopter lens for indirect ophthalmoscopy (panretinal 2.2 is an alternative)
- 90-diopter lens for biomicroscopy (Volk and Nikon are popular brands)
- Gonio lenses are not needed—disposable versions are available in clinic.

**Borrow Option:** The program provides 20D and 90D lenses with a \$100 refundable deposit. Lost or damaged lenses must be replaced at resident's expense.

### Loupes

Loupes are available to borrow for pediatrics and plastics rotations (PGY-1 residents may borrow during

their Ophthalmology rotation). A \$100 refundable deposit is required. Residents are responsible for replacing lost or damaged loupes.

### **Cell Phone**

Residents are required to have a cell phone.

## **Complaints Regarding Work Environment**

### **Our Commitment**

The Graduate Medical Education Office and Committee provide a confidential, safe environment for residents to raise concerns without fear of retaliation. Residents have several avenues to communicate information about their educational program.

### **How to Report Issues**

- First, the resident should consider discussing concerns with:
  - Program Director
  - Faculty mentor/advisor
  - Chief Resident
  - Department Chair
- Additional Resources
  - **Resident Ombudsmen:** David Miller, Alex Thompson
  - **Faculty Ombudsman:** Dr. Sarah Elhomosany
  - **Anonymous Reporting:** Qualtrics (reviewed by Dr. Elhomosany)

### **Questions About Confidentiality**

Residents should contact the GME Office at 626-7878 with concerns about confidentiality when raising issues.

## SECTION 13. REIMBURSEMENTS AND PURCHASES

### Authorization and Reimbursement for Travel

All travel must be approved (travel authorization) prior to incurring any travel-related expenses. The University requires some purchases (membership, early registration, and airfare) to be paid using the program coordinator's OneCard.

#### **Pre-Approval Required (Travel Authorization)**

Travel must be approved at least 30 days in advance. It may take weeks to process approval, so submit the following information to the program coordinator for authorization more than 30 days in advance of the trip:

- Conference/course name and dates
- Airline itinerary and cost
- Hotel name, address, cost, and whether it is a conference hotel
- Personal time before/after the conference

Travel expenses are not reimbursable without advance authorization.

**Note:** A travel authorization is required for all travel on academic time, even if there will be no reimbursement from the UA.

#### **Receipts and Reimbursement**

- **Membership, Early Registration, and Airfare**

The University requires payment for membership, early registration and airfare using the program coordinator's OneCard. Please coordinate payment with the program coordinator.

- **Lodging and Meal Reimbursement Rates**

Lodging and meal reimbursement rates follow University of Arizona guidelines. Receipts are not needed for reimbursement for meals. The program coordinator can provide current rates.

- **Other Eligible Travel Expenses**

Resident submits other eligible travel receipts (lodging, transportation, airport parking) to the program coordinator as soon as possible after the trip (must be within 30 days). Receipts submitted after the deadline may not be reimbursed.

- **Receipt Requirements**

Receipts must clearly show the date of purchase, the name of the establishment, the specific items bought, the total amount paid, and the payment method used.

- **Non-Reimbursable Expenses**

- Alcoholic beverages (per University policy)
- Expenses of others (only own expenses are reimbursable)

## Mileage Reimbursement

Reimbursement for mileage between clinical sites is available through Banner.

### Process

- Complete the Personal Vehicle Mileage Form (Banner Health Intranet > Tools & Services > Forms > Finance, or via the Finance Forms link).
- Sign the form.
- Submit to the program coordinator for processing.

## Departmental Purchases

All departmental purchases (such as wet lab materials) require Program Director approval before ordering.

- **Process**
  - Obtain Program Director approval.
  - Submit purchase request to the program coordinator.
  - The program coordinator will specify purchase requirements (purchase order, credit card, etc.).
- **Timeline:** Allow 2+ weeks for processing before authorization and purchase.

## SECTION 14: INSITUATION-SPECIFIC POLICIES

### BUMCT AND BUMCS

#### *Medical Records*

Medical records, for both inpatients and outpatients, must be maintained in a timely fashion and according to BUMCT and BUMCS policies. All entries must be legible and complete.

The resident's 4-digit identification code **MUST ALWAYS** be affixed to his/her signature.

All new patients or initial examinations must include the following:

- Pertinent history and notation of allergies
- Best corrected vision
- Motility
- Visual field to confrontation
- External examination
- Slit lamp
- Intraocular pressure
- Fundus examination
- Impression
- Plan

A pre-operative exam and note by the staff or resident must be recorded within 30 days of surgery. The format is as follows, and all items must be present in a single note:

- Visual acuity with manifest refraction
  - Manifest refraction
  - Slit lamp examination OU
  - Intraocular pressure OU
  - Fundus examination
  - Surgical indications (with specific functional complaints)
  - Risk and alternatives discussed
- (a) Operative notes on all resident surgeries and discharge summaries on all patients admitted by the resident must be dictated/entered by the residents; this is part of the educational experience.
- (b) Operative notes must be dictated/entered on the day of surgery and reviewed by the resident and faculty before being signed and placed in the patient's medical record.
- (c) Discharge summaries must be dictated/entered at the time of discharge and reviewed by the resident and faculty before being signed and placed in the patient's chart. At the time of surgery and discharge, all abnormal laboratory study and test results must be noted in a progress note and all these items must be addressed with an appropriate plan for follow-up.

**All medical records must be completed as soon as possible after discharge and in no case more than seven (7) days after discharge.**

- (d) Delinquent medical records are a cause for disciplinary action within the Department. Records not cleared within one week will result in temporary cessation of surgical privileges.
- (e) Within the Department, residents are required to document their clinical and surgical experience online. The scope of this responsibility is outlined in Section 14.

**Orders on Patient Charts**

- (a) It is BUMCT and BUMCS policy that all orders on patients' charts be entered at the time they are given; however, some flexibility is provided by individual nursing stations as reasonable and appropriate.
- (b) All signed orders, consult requests, progress notes, etc., must be accompanied by the physician's 4-digit identification code; this will facilitate the interpretation of illegible writing.
- (c) When a verbal order is accepted by the floor staff, that order should be countersigned by the resident before leaving the hospital if the order is given during the daytime, or first thing in the morning if the order is given during the night.

**Department of Anesthesiology Guidelines for Patient Preoperative Preparation**

<b>NPO Guidelines*</b>	
<b>Ingested Material</b>	<b>Minimum Fasting Period</b>
<b>Clear liquids**</b>	Stop <b>2</b> hours before surgery
<b>Human milk</b>	Stop <b>4</b> hours before surgery
<b>Infant formula or non-human milk</b>	Stop <b>6</b> hours before surgery
<b>Light meal (e.g., toast and clear liquids)</b>	Stop <b>6</b> hours before surgery
<b>Heavy meal (e.g., fatty foods, meat, alcohol, large volume)</b>	Stop <b>8</b> hours before surgery

\*These guidelines apply to patients with normal gastric emptying who are scheduled for elective surgery. Patients with delayed gastric emptying (e.g., diabetic, obese, opioid use) may need longer period of fasting. Patients may be fasted longer than this for surgical indications, but members of the Anesthesiology Department will not delay elective surgery for fasting if these guidelines are followed.

\*\*Clear liquids= water, sugar water, apple juice, tea, Pedialyte, black coffee

Gastric tube feedings: stop clear liquids **2** hours before surgery; stop other liquids **6** hours before surgery

Jejun tube feedings may be continued up until the times of surgery

Patients with normal gastric emptying who meet these criteria will be considered “fasted” for any elective procedure conducted under moderate sedation, deep sedation, general anesthesia, or major regional anesthesia at BUMC. These are the minimum acceptable fasting periods. Patients who have delayed gastric emptying may be instructed to fast for longer periods. Patients may also be instructed to be NPO longer for surgical indications, or to facilitate later changes in the time of surgery.

## ***Aggressive Behavior from Patients***

If a resident encounters an aggressive or potentially aggressive patient at the Banner Main or South Campus Emergency Rooms, the following steps should be taken.

With possible threats, no matter the campus, the matter would be escalated through the charge nurse and usually the Threat Team will come together to review cases and see if a Threat Alert needs to be added to the patient's chart and what steps should be taken thereafter.

If there is an assault or attempted assault, then leave the room and contact the charge nurse as soon as possible. The charge nurse is usually rounding in the EM or outside the EM. The desk clerks are usually aware of their location or can contact the charge nurse.

If you feel that a chaperone would be desirable, EM encourages asking a bedside nurse, tech or medic to accompany you in the room for the exam or any procedures. Security is always on site and may act as chaperone as well.

Below are some additional resources from Laura Vitali of Banner Human Resources.

- Workers Compensation Injury Link:  
<https://bannerhealth.sharepoint.com/sites/Connect/Business-Health/Workers-Compensation/Pages/How-to-Report-a-Work-Related-Injury-Incident.aspx> There will be another link on the page to report the injury: <https://live.origamirisk.com/Origami/IncidentEntry/Welcome>.
- The policy on how to report a security threat when there is a combative person is available in Box (Box > Ophthalmology and Vision Science > Public Resident Files), as well as in the Appendices. In addition, here is a link to Workplace Violence initiatives led by Security: <https://bannerhealth.sharepoint.com/sites/Connect/Security>.

## **Alvernon Clinics – Clinical Expectations**

### ***Glaucoma – Dr. Todd Altenbernd***

#### *Philosophy of Care*

- Emphasis on efficiency and creating a win-win situation for all parties involved.
- Focus on providing appropriate glaucoma teaching and training.

#### *Patient Management*

- Residents are encouraged to see patients in the clinic as usual, starting with the first available patient and presenting to the attending physician after completing the examination and assessment.
- In cases where the clinic is running behind schedule, residents should move on to the next available patient without waiting to present the previous case immediately, ensuring smooth clinic flow and efficiency.

#### *Pre-Clinic Preparation*

- It's recommended that residents familiarize themselves with clinic patients before their shifts, reviewing medical records, treatment plans, and relevant imaging studies to enhance

their understanding and preparedness. However, we defer this to their preferences with autonomy as long as they are efficient.

#### Debriefing and Learning Opportunities

- We will discuss every patient as the resident presents the patient, and we can have end-of-clinic debriefing sessions as needed to ensure addressing all relevant questions, management strategies, and learning points.

#### Patient Care and Follow-up

- The attending will personally see every patient before check-out, ensuring comprehensive and thorough care.
- Residents will have hands-on experience in patient care and learning opportunities during their rotations in the glaucoma clinic.

## Medical Marijuana

### **Arizona Law**

Proposition 203 (2010) permits medical marijuana for qualifying patients with certain conditions, including glaucoma.

### **Federal and Professional Standards**

- It is **illegal under federal law** to prescribe marijuana.
- The American Glaucoma Society does **not recommend** medical marijuana for glaucoma.

### **Department Policy**

Residents **may not recommend** medical marijuana under any circumstances, regardless of patient request or glaucoma diagnosis. This policy applies at all training sites (SAVAHCS, Alvernon, BUMCS, BUMCT).

## Southern Arizona VA Healthcare System

Residents rotate through SAVAHCS Ophthalmology Clinic for 3 months in their intern year, one half-day of clinic per week during their PGY-2 and PGY-3 years of residency, and nine months of the fourth year of their residency. Additionally, a second (PGY-2) or third (PGY-3) year resident manages the oculoplastics clinic. The fourth year (PGY-4) residents who are rotating full-time through SAVAHCS return to the administrative offices of the Department of Ophthalmology for didactic lectures and conferences.

The clinic at SAVAHCS is considered a "resident clinic," and residents are supervised by faculty who are present at all times. Residents may have individual clinics but function as a team and help other residents and attendings when finished with their own assignment. This allows the resident the opportunity to take significant responsibility for patient evaluation and management. This "team approach" provides a very good educational experience at all levels within the training program. In addition, the clinics offer a wide variety of general patients in addition to concentrated exposure to subspecialty patients in the subspecialty clinics.

During the fourth year VA rotations, residents are expected to become adept at:

1. Anterior segment examination techniques, including reading prescriptions and refracting
2. Posterior segment examination techniques, including indirect ophthalmoscopy and scleral depression
3. Cataract surgery
4. Corneal surgery
5. Glaucoma surgery
6. Retina surgery
7. Anterior and posterior laser of eye disease
8. Surgical management issues, both pre- and post-operatively
9. Medical management of all ocular problems
10. Managing triage and urgent patients

### **(1) Local Program Director**

The Ophthalmology Section at SAVAHCS is under the direction of the Section Chief and Site Director, Jillian Colson, MD, who administers the daily operations of the clinic. Issues which affect the overall program are brought to the attention of the Program Director and Department Chair. These are dealt with at the Department level and changes must be approved by the Department Chief and the Program Director.

SAVAHCS is considered a Dean's hospital with academic programs under control of the UA College of Medicine. Ophthalmology is considered a section and, as such, is under the direct auspices of the Surgical Service. The Surgical Service takes an active role in overseeing the financial aspects of the Ophthalmology Service and is responsible for distributions of salary funds and purchase of equipment. The UA Department of Ophthalmology with the approval of the SAVAHCS administration and Surgical Service, appoints all SAVAHCS faculty and the Program Director. Control of the SAVAHCS academic curriculum and resident assignments, and decisions in academic matters, are directed by the Section Chief who must have full approval by the Program Director and Department Chair at the UA College of Medicine.

The teaching faculty are members of SAVAHCS and UA Department of Ophthalmology faculty. These faculty include Drs. Agrawal, Belin, Colson, Lane, Thomas, Villavicencio, and Worrall.

The program at SAVAHCS is evaluated by the Department of Ophthalmology via the standard formal resident evaluation of rotations conducted twice a year by the Program Director, the annual overall evaluation of the teaching program, and the formal evaluation of the individual faculty teaching efforts.

### **(2) Facilities**

The facility at SAVAHCS is well suited for the residents and faculty members who participate in the clinic. There are thirteen fully equipped ophthalmology examination lanes. There is a separate laser room in the clinic with an indirect laser, diode laser, and Nd:YAG /SLT laser. Other equipment available include: automated perimetry, digital fundus and anterior segment photography specular microscopy, and fluorescein angiography. The eye clinic is equipped with A/B Scan Ultrasound, IOL Master, Cirrus ocular coherence tomography (anterior and posterior), and Pentacam anterior segment tomography.

The operating room is equipped with two Zeiss operating microscopes, two Centurion (Alcon) phacoemulsification units, two anterior/posterior segment vitrectomy unit (Alcon Constellation) with endolaser, and a video monitor on the operating microscope. The microscopes have recording capabilities. The operating room has capabilities for all intraocular and extraocular ophthalmologic procedures.

### **(3) Educational Experience**

The didactic lectures and clinical conferences take priority over all other activities except emergency patient care. The schedule is arranged so that there are no conflicts during lecture time or clinical conference time for any of the residents. This is recorded electronically and periodically monitored by the Program Director. Attendance by the faculty at quality improvement and patient safety conferences and weekly rounds is expected and noted by the Department Chair.

#### (4) National Mandates/OSHA and National Quality Forum

SAVAHCS implements all national quality forum initiatives, OSHA requirements, and other national mandates related to patient access and timely follow-up. All residents are expected:

- to complete annual required TMS training
- to complete TMS and in person laser safety training requirements
- to know the national patient safety goals and the yearly updates, which can be found on TUCNET.
- to know the proper procedure for the emergency “codes.”
- to know location of the fire extinguisher (in eye clinic laser room and in the back hallway across from the OmniCell room) and the code cart (adjacent to the nurses station in the medical subspecialty clinic).
- to comply with OSHA standards in their patient examining rooms.
- to comply with SAVAHCS confidentiality policy including NO patient identifiable material in paper format and, if used, with permission, the material must be locked at all times unless being visualized by the treating provider.
- to use universal protocol for all procedures, including two person time out.
- to be prepared for surprise inspections.
- to have reusable medical equipment (RME) compliant documentation on file at the VA and be signed off for competence
- to comply with care of equipment in the examining rooms
- to have the date of expiration (28 days from opening date) marked on the bottle of all drops and reusable medication vials in the examining rooms. Which need to be locked in the room’s med box when not in use. (If it is not marked, it must be thrown away during unscheduled impromptu inspections that occur every 1-2 months.)

The above is explained in the national patient safety, universal protocol and ambulatory care/surgery guidelines at the following:

- Accreditation Program: Ambulatory Health Care National Patient Safety Goals  
[https://www.jointcommission.org/assets/1/6/2019\\_AHC\\_NPSGs\\_final.pdf](https://www.jointcommission.org/assets/1/6/2019_AHC_NPSGs_final.pdf)
- Accreditation Program: Office-Based Surgery National Patient Safety Goals  
[https://www.jointcommission.org/assets/1/6/2019\\_OBS\\_NPSGs\\_final.pdf](https://www.jointcommission.org/assets/1/6/2019_OBS_NPSGs_final.pdf)

#### (5) Medical Records Documentation

There are specific components that must be completed on all EMR records of a visitation. These include:

- Double check that the correct encounter is selected before starting the note. Never start a clinic note without an appointment
- If there is a pending Eye Clinic consult, connect this with the note
- Service Connection – first box that should be reviewed and marked as needed
- Diagnosis – it is vital that all relevant diagnoses found on the patient exam be included
- Visit Type – needs to match the number/complexity of the exam diagnoses
- Modifier – include applicable modifiers. Always check ‘Service by VA Resident’
- Primary Provider – must be the attending who is signing the note
- Procedure

- Diabetic Screening Update – needs to be completed on all yearly diabetic exams
- Signature
- All Forum Eye Consults need to be closed by the end of the day

If these are not complete, the record is suspended and held for edits and will appear on a list to be completed. You will be expected to close any open encounters and Forum Eye Consults within 1 week.

All clinic notes and consult notes should be completed the same day of service. Operative Reports must be dictated within 24 hours of surgery end time and Brief Operative Notes within 1 hour of surgery end time. Post surgical instructions should be written in the EMR immediately after the surgery is complete.

#### (6) Communication and Access

- VA Email:** can only be accessed on site or through remote access. **Must be checked every time you are at the VA.** Respond to emails promptly.
- Microsoft Teams:** All residents are expected to be on Teams and available when at the VA. If Teams is not downloaded to the computer, it can be accessed at <https://teams.microsoft.com>.
- It is the responsibility of the resident to ensure credentials, license, PIV card, and computer access are up to date and active.

#### (7) Shared Calendars

- Department Call Calendar:** This is the departmental call calendar accessed by all services. <https://dvagov.sharepoint.com/sites/VHATUCIntranet/OnCall/Pages/default.aspx>
- Surgical Calendar:** All residents are given VA email access. There is a surgical scheduling calendar that is accessible to all residents via Outlook (VA email). As you book surgeries, check the faculty call calendar for vacation and then put surgery in appropriate booked spot. Try to be accurate in maintaining this calendar, as well as completing all SAVAHCS-required paperwork for booking of routine and emergency surgery. <https://dvagov.sharepoint.com/sites/SECTUCS/Surgery/Lists/Ophthalmology/>
- Resident Clinic Calendar:** Designates clinic and OR assignments and supervisory faculty.

#### (8) Non-VA Community Care Consults

Non-VA Community Care consults must be scheduled with review and approval by an attending physician. Orders should be placed for signature by an attending as they cannot be placed by a resident. SAVAHCS requires that these are distributed equally between all contracted providers. However, specific providers may be requested if they are the sole provider, other providers are not taking patients, or other “special circumstances.” Do not enter specific provider names in consults unless there is documentation of a need for a specific provider. The community care toolbox must be filled out with the reason the patient qualifies. For urgent referrals, it is the responsibility of the resident to reach out to a) the accepting practice to make an appointment and b) the community care office to ensure the referral is made.

#### (9) SAVAHCS Patients After Hours/Weekends

SAVAHCS urgent care, urgent follow-up appointments, and post-op patients **must** be seen at SAVAHCS rather than Banner. Referrals cannot be made to outside community physicians without the attending’s approval and a community care consult. Visits will not be covered by the VA if sent to outside hospitals or providers without a consult.

The only SAVAHCS patients who can be seen at the University Ophthalmology Clinic are those who have been officially referred for services that cannot be provided at SAVAHCS (ERG's, urgent IVFA's, certain subspecialty consultations, etc.)

### **SEEING ED PATIENTS AND ADMITTED PATIENTS AT SAVAHCS**

1. If the resident is contacted by the ED or admitting service, the *default action should be for the resident to go to the ED and evaluate the patient*. When the resident then comes to the VA and evaluates the patient, they are in a position to have access to the clinic schedule and should be able to find the most appropriate, or least-busy clinic in which to have outpatient follow up in the coming day(s).
2. Whenever possible, the on-call resident should schedule VA eye clinic follow-up into their own Continuity clinic, or the clinic of the senior resident on backup call, if needed. Besides placing a Return to Clinic (RTC) order, direct communication needs to be made with a colleague, attending, or Eye Clinic staff to schedule the patient. The front desk phone number is **520-792-1450, ext 12165**.
3. If the ED physician requests phone consult only, triage should still be performed to determine if a consult is needed. For cases requiring follow up only, the resident should check availability in the eye clinics in order to guide patient follow-up, directly contacting the patient, if necessary.
  - a. Do not tell the patient to show up to the eye clinic for evaluation the next morning.
  - b. Do not schedule a patient into an attending clinic without prior communication with that attending.
  - c. Do not overbook into a clinic other than your own without prior communication and approval by that resident.
4. Every resident should have off-site access to the VA system.
5. After an appropriate time/date/clinic in which to place the patient, the resident places a Return To Clinic (RTC) order into CPRS and makes sure the patient knows this.
6. Reach out to the senior, MOD, or someone else who is physically present at the VA to ensure the patient is booked.
7. Refer to the 'Must Call' list to determine if the senior or attending should be involved immediately. When in doubt, reach out to your attending. If the Senior resident is involved in the patient's care, they should call the attending.
8. All consults should be seen and evaluated in person at the time of the initial encounter.
9. Please make sure there is a consult placed and that your Consult Note is linked to the eye consult.
10. Your attending should be notified on consults involving inpatients.

### **(10) Patient/Clinic Cancellation Policy**

All clinic cancellations must receive approval of the Section Chief and Program Director. This policy is necessary to meet wait time requirements. SAVAHCS policy is no clinic cancellations less than 45 days. Exceptions can be made but should be rare. Usually a substitute will need to cover the clinic, with permission granted by the Program Director, Chief Resident, and the covering resident. All clinic cancellations must be associated with leave approved by the University Program Director and Program Coordinator

When you need to cancel a clinic(s) at the VA, Clinics will NOT be cancelled less than 45 days in advance except for emergency situations and unplanned surgical cases.

- All requests for clinic cancellation must be submitted through the automated electronic program (LEAF) available on TucNet.
- The official date of the request will be the TucNet submission date.
- Care/Service Line Chiefs are required to review leave requests and ensure that clinics are not cancelled less than 45 days in advance.
- Care/Service Line approvals/denials to requests will be processed within 72 hours.

### Steps for Clinic Cancellations

- Check your proposed days out with Pat – only one resident per PGY year is allowed out at any one time. Any exceptions to this rule must be approved by the Section Chief or Site Director.
- Cancel your clinics: Submit an electronic request on TucNet.
  - Do this when you are thinking about taking time off.
  - Rule is **45 days**
  - Print or save a copy.
  - Check to see that the clinic has been cancelled and no patients are scheduled.
- Seniors should note the absence on the shared surgery calendar so cases are not booked.
- Submit paperwork to admin for approval for time out, if needed for things like authorized absence.
  - If you are gone with no approval, then you are AWOL. This will be noted and the Program Director informed.
- 45 days before you are scheduled to leave:
  - Double check clinics to make sure they are cancelled appropriately
  - Double check OR schedule
- 1 week prior to your absence:
  - Triple check clinic schedule.
  - Triple check OR schedule.
  - Make sure ALL of your charts and alerts are clear and any unfinished patient issues (biopsy results, imaging, follow ups) are taken care of or assigned to another provider.

It is advisable to save or print a copy of your request for your records. **All requests must be submitted at least 45 days in advance.**

Also:

- All residents are expected to return to clinic on time even if surgery runs over. The attending can complete the case.
- Residents should return to the clinic after surgeries are completed if earlier than 4:30pm.
- Residents CANNOT leave clinic to go to surgery if there are patients waiting to be seen.
- Residents CANNOT reschedule patients already checked into the clinic and waiting to be seen because of time pressure.
- Residents must be in clinic and available from 8:00AM – 4:30PM (unless in scheduled OR) and should check in with the MOD and peers prior to leaving each day. Even if there are no patients in your clinic, you are required to be at the VA if this is your assignment. If you have no patients, the MOD can reassign you.
- Morning clinic starts promptly at 8:00AM, except for Wednesdays which is 8:30AM. Afternoon clinic starts promptly at 1:00PM. You are expected to arrive *prior* to this time regardless of when the first patient is booked.

### (11) Surgery/24-Hour Post-Op Patients

- One-day and one week post-op appointments should be made with patient at the time of pre-op visit.
- Residents must notify front desk personnel if patients are told to come earlier than their scheduled appointment time. This is to avoid the patient being turned away if they check in much earlier than their scheduled time.
- When scheduling patient appointments during “off” hours, especially post-op patients, it is the resident’s responsibility to arrange with patient and patient’s family. A new visit must be created in CPRS at the time of visit.
- Avoid email communication with patients. If required, then use VA email. Phone calls and Secure Messaging is best for this purpose. Front Desk MSAs can monitor and relay Secure Messages and can help send a message on your behalf.

## (12) Patient Notes

The **vital** first step in assuring proper documentation is to make sure CPRS notes are attached to the correct appointment. Notes should be written for all patient encounters. Do not start notes prior to a patient arriving as this may affect their ability to check in.

**All clinic notes must have an appointment and the correct encounter selected PRIOR to starting the note. You must click on the provider/location tab next to the patient’s name at the top of the toolbar of the patient’s chart to do this properly.** The CPRS system rejects any annual appointments that do not have notes attached. These appointments have to be tracked and replaced. A new clinic visit can and must be created for any “off” hour visits. Residents will be shown how to create a new visit during orientation.

**\*\*\*VERY IMPORTANT:** Additionally, CPRS notes created for any Emergency Department or INPATIENT visits need to be written as an Eye Clinic Consult note, **not** an emergency department or inpatient note. This will be connected to the Eye Clinic Consult.

## (13) Triage Protocol

A senior will be assigned to triage all half days except Friday morning. Rarely, when a senior is not available, a PGY-3 resident or attending will cover triage duties. We strive to follow a “chain of command” method of process these when they come up daily. This is our process for handling triages:

1. Phone call comes to the MSA. These personnel determine if it should be directed to optometry or ophthalmology. The protocol is default to optometry resident, unless
  - a. patient has been seen within 30 days by ophthalmology
  - b. surgical patient in the 90-day post-op window
  - c. the call is received Friday afternoon (during their protected didactic time)
2. MSA then writes the triage note in CPRS & alerts the Triage Team (resident, MOD, triage tech) on Teams.
3. Technician calls the patient to obtain more information.
4. Technician documents the conversation by adding the MSA phone note and messages the resident on Teams indicating the patient has been called.
5. Technician will collect information only. No recommendations unless specifically instructed by the doctor.

6. The resident will then review the chart, call the patient for additional information if needed, and complete the following:
  - a. Place RTC for all patients needing a new appointment
  - b. Addend CPRS note with any additional info collected and plan
  - c. Message MSA on teams with specific return instructions, including acceptable time frame for appointment and specific clinic(s)
  - d. Residents, if you can book in your own clinic, that is preferred.
  - e. Do not overbook someone else's clinic without permission. If an overbook is needed, please talk to your colleague directly or the MOD.

Troubleshooting:

- If triage is not addressed in a timely fashion by technician, please inform the lead technician.
- Sometimes there are exceptions. If we are understaffed and/or there are numerous triages at once, the resident may be asked to call the patient or the MOD may need to get involved and distribute the workload.

If there is a question about whether optometry or ophthalmology should be triaging and/or seeing the patient, please talk to the MOD directly.

The exception to this orderly process is the patient who shows up at the window. In that case, the MSAs will refer these to the triage tech for the information gathering and presentation to the triage resident.

### **Inpatient and Emergency Department Consults during Business Hours**

Business hours are considered 8:00AM – 4:00PM

- a. Consults received during this time will be called to the front desk staff.
- b. The front desk staff will determine if this is an optometry or ophthalmology consult according to criteria listed previously in this section.
- c. A message will be relayed to the triage resident and MOD
- d. The patient will be seen (and followed if necessary) by residents available in clinic. The triage resident is ultimately responsible if other residents in clinic are not available
- e. For the patient to be seen in clinic, the following must occur:
  - a. An appointment booked. Select the correct clinic encounter prior to starting your note. It will default to the inpatient encounter.
  - b. The Eye Clinic is an OUTPATIENT Clinic. Patient must be medically stable and meet the below criteria:
    - i. Ambulatory
    - ii. Stable enough to be on their own for 2-3 hours without supervision
    - iii. Not on continuous telemetry or continuous IV medication
    - iv. Not at risk of eloping
    - v. If in ICU, only there for ocular drop administration. Otherwise, no ICU patients should be brought to the clinic.
  - c. When the encounter is complete, if the patient is hospitalized, ask the MSAs to call the floor RN to pick the patient up. The patient may not leave on their own.

### Normal Resident Triage Schedule

Monday

AM retina resident

PM glaucoma resident

Tuesday

AM cornea resident

PM glaucoma resident

Wednesday

AM glaucoma resident

PM retina resident

Thursday

AM retina resident

PM retina resident

Friday

AM MOD

PM cornea resident

#### **(14) Dirty Instrument Policy**

Dirty instruments must be transported to the Dirty Utility Room in the designated boxes. The doctor also needs to take a transport box when they get an instrument out of the OmniCell. Once the instrument is dirty, it must be placed in the transport box and walked over to the Dirty Utility Room 2713 (across from the conference room; code 9999#).

Do not wear gloves while walking the box over. Once inside the dirty room, the doctor must don gloves to remove the instrument from the transport box. All visible soil and blood should be washed off. It is then placed in the dirty "Eye Bin" and spray with disinfectant. Then, the doctor must get a cavi-wipe and wipe the inside and outside of the box. Then, take off their gloves, wash hands and then walk the box back to the OmniCell room for safe keeping. Please make sure all disposable instruments are disposed of and not placed in the dirty room.

#### **(15) Axial Length Calculations**

See the appendix for information on axial length calculations.

#### **(16) Resident Cataract Preoperative Process**

Each surgical eye must be staffed, ideally by the attending surgeon. If the attending surgeon is not available, it is acceptable to staff with another cataract surgeon. The HP note must include who has staffed, examined, and approved the surgery. Using templates without changing or adding information individualized to the patient is prohibited. An attending may approve both eyes at time of preop. This must be clearly documented.

If the second eye is 20/30 or better, they must be staffed again, regardless of prior bilateral approval.

If an attending has decided that cataract surgery is not indicated or should be an attending case, it is not appropriate to staff with another attending, in hopes of a different outcome.

There are numerous cases that should be performed by an attending rather than a resident.

- The better seeing eye in monocular patients
- Patients requesting attending surgeons
- *It is at the attending surgeon's sole discretion whether a case is performed by a resident and what parts will be performed by a resident.*

The following complex cases will be up to the attending surgeon's discretion and the level of experience the resident has: Pseudoexfoliation, short AL <21, long AL >28, post vitrectomy or injection, capsular weakness or defect, prior trauma, narrow angles, posterior polar, Fuch's endothelial dystrophy, uveitis eye, mature cataract, difficult positioning, lack of cooperation, etc. Any patient requesting an attending physician or who has had a prior cataract surgery complication will be an attending case.

The following information should be gathered by the resident for each case and discussed with the staffing physician:

- **History**
- **Age, specific activity related vision complaint, patient's primary activities** (ex: driving, reading, etc.), dependence on glasses, desire for surgery
- **BCVA, refraction (that day), HRx**
- **Glare**
- **Relevant PMH** (including A1C if diabetic)
- **Past ocular history**
- **Relevant ocular exam findings** (Ex: Cataract grade, pseudoexfoliation, capsular weakness or defect, prior trauma, narrow angles, Fuch's endothelial dystrophy, uveitis, posterior pathology)
- **Possible intraoperative challenges**
  - Ex: positioning, cooperating, etc.
- **Review of IOLM**
  - Quality, fixation, AL, AL symmetry, ACD, Ks, K symmetry, any flagged or manually entered values
- **Pentacam**
  - Quality, Ks, pachymetry, anything flagged in red and yellow
  - If pachymetry > 600um in either, perform specular microscopy
- **For torics, present Alcon Barrett Printout**
- **IOL choice and why**

**Further details on the preoperative cataract protocol are provided in the Appendix, titled 'Cataract Surgery Scheduling Protocol.'**

## **2026-2027 BCSC Reading Schedule**

*Courtesy of Sharon L. Jick, MD, BCSC Course Chair*

Many residency programs incorporate a specific reading schedule for the BCSC volumes. For those who are not guided by such a timetable, the following may give direction for how to strategize reading the series in the window from the beginning of the academic year in July

until the OKAPs are administered in March. Of course, this schedule is open to adjustment based on individual needs and time constraints.

<b>Date</b>	<b>BCSC Section</b>	<b>Pages/Day</b>
7/5-7/11	<i>Section 2 Fundamentals and Principles</i> Part I, Chapters 1-3	20
7/12-7/18	<i>Section 2 Fundamentals and Principles</i> Part II and Part III, Chapters 4-6	15
7/19-7/25	<i>Section 2 Fundamentals and Principles</i> Part IV, Chapters 7-14	14
7/26-8/1	<i>Section 2 Fundamentals and Principles</i> Part V and Part VI, Chapters 15-18	21
8/2-8/8	<i>Section 4 Ophthalmic Pathology and Intraocular Tumors</i> Chapters 1-10	30
8/9-8/15	<i>Section 4 Ophthalmic Pathology and Intraocular Tumors</i> Chapters 11-19	26
8/16-8/22	<i>Section 5 Neuro-Ophthalmology</i> Chapters 1-5	17
8/23-8/29	<i>Section 5 Neuro-Ophthalmology</i> Chapters 6-12	23
8/30-9/5	<i>Section 5 Neuro-Ophthalmology</i> Chapters 13-18	20
9/6-9/12	<i>Section 6 Pediatric Ophthalmology and Strabismus</i> Chapters 1-10	20
9/13-9/19	<i>Section 6 Pediatric Ophthalmology and Strabismus</i> Chapters 11-20	22
9/20-9/26	<i>Section 6 Pediatric Ophthalmology and Strabismus</i> Chapters 21-28	21
9/27-10/3	<i>Section 7 Oculofacial Plastic and Orbital Surgery</i> Part I, Chapters 1-8	22
10/4-10/10	<i>Section 7 Oculofacial Plastic and Orbital Surgery</i> Part II and Part III, Chapters 9-15	25
10/11-10/17	<i>Section 8 External Disease and Cornea</i> Chapters 1-6	22
10/18-10/24	<i>Section 8 External Disease and Cornea</i> Chapters 7-11	21

10/25- 10/31	<i>Section 8 External Disease and Cornea</i> Chapters 12-14	15
11/1- 11/7	<i>Section 8 External Disease and Cornea</i> Chapters 15-16 <i>Section 11 Lens and Cataract</i> Chapters 1-5	24
11/8- 11/14	<i>Section 11 Lens and Cataract</i> Chapters 6-12	24
11/15- 11/21	<i>Section 12 Retina and Vitreous</i> Chapters 1-5	17
11/22- 11/28	<i>Section 12 Retina and Vitreous</i> Chapters 6-11	21
11/29- 12/5	<i>Section 12 Retina and Vitreous</i> Chapters 12-20	25
12/6- 12/12	<i>Section 10 Glaucoma</i> Chapters 1-8	21
12/13- 12/19	<i>Section 10 Glaucoma</i> Chapters 9-13	20
12/20- 12/26	Holiday Break	
12/27- 1/2	<i>Section 13 Refractive Surgery</i> Chapters 1-10	29
1/3- 1/9	<i>Section 9 Uveitis and Ocular Inflammation</i> Chapters 1-6	17
1/10- 1/16	<i>Section 9 Uveitis and Ocular Inflammation</i> Chapters 7-11	19
1/17- 1/23	<i>Section 9 Uveitis and Ocular Inflammation</i> Chapters 12-16	14
1/24- 1/30	<i>Section 1 Update on General Medicine</i> Chapters 1-9	22
1/31- 2/6	<i>Section 1 Update on General Medicine</i> Chapters 10-17	23
2/7- 2/13	<i>Section 3 Clinical Optics and Vision Rehabilitation</i> Quick-Start Guide – Chapter 2	19
2/14- 2/20	<i>Section 3 Clinical Optics and Vision Rehabilitation</i> Chapters 3-6	16
2/21- 2/27	<i>Section 3 Clinical Optics and Vision Rehabilitation</i> Chapters 7-10	14
2/28- 3/6	Review All Volumes	
3/7- 3/11	Review All Volumes	

