THE UNIVERSITY OF ARIZONA
College of Medicine

University of Arizona Program

DEPARTMENT OF OPHTHALMOLOGY

RESIDENCY PROGRAM MANUAL
2024-2025 Academic Year

Ophthalmology & Vision Science

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RESIDENCY PROGRAM MANUAL
2024-2025 ACADEMIC YEAR

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1. 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.

2. PROGRAM AIMS

The program's prime directive is to train physicians to become compassionate, lifelong learners with a broad knowledge of contemporary ophthalmology and a repertoire of both surgical and non-surgical management tools in which they are well versed. The broad spectrum environments including private practice, Veterans Administration, University Level 1 trauma center, outpatient referral practices and undeserved community primary care clinics provide a rich exposure to many healthcare systems, cultural diversity and medical records.

3. STATEMENT OF PURPOSE

A. Introduction

The Ophthalmology Residency Program offers a four-year program that blends clinical training, academic activities, and research opportunities. There are four residents in each of the four years of the program. This manual provides a general description of the program, the structure of the residency training at the affiliate institutions, and the standards and expectations of resident performance.

The Department of Ophthalmology staff consists of seven full-time ophthalmologistsat University of Arizona (UA). There is a large associate staff of affiliate/associate ("volunteer") faculty, four full-time optometrists, two research faculty, and a supporting staff of technical personnel. There are four full-time and three part-time physicians at the Southern Arizona Veterans Administration Health Care System (SAVAHCS). Three affiliated hospitals – Banner-University Medical Center Tucson (BUMCT), Banner-University Medical Center South (BUMCS), and SAVAHCS, each with active inpatient/outpatient services, as well as research and teaching facilities – are involved in the residency program.

Approximately 15,000 patients per year visit the Ophthalmology clinics at Alvernon. Rotations are also provided at SAVAHCS, where there are approximately 16,000 patient visits. Residents participate in state-of-the-art diagnostic and therapeutic interventions for these patients. The residents also rotate with community physicians:

- Ann McColgin, MD, and Mingwu Wang, MD, PhD; Cornea Associates
- Kathleen Duerksen, MD (oculoplastics)
- Brock Bakewell, MD, Michael Henry, MD, Brian Hunter, MD, and Jeff Maltzman, MD; Fishkind, Bakewell, Maltzman, Hunter & Associates Eye Care and Surgery Center (refractive surgery)
- Robert Fintelmann, MD, Carrot LASIK Eye Center (refractive surgery)
- April Harris, MD, Cameron Javid, MD, Anthony Joseph, MD, Mark Walsh, MD, and Ryan Wong, MD; Retina Associates (ocular oncology and retina)
- Khin Kilgore, MD, and Jason Levine, MD; Arizona Eye Consultants (glaucoma)

- Patrick Tsai, MD, MHA; Advanced Eye Care of Tucson (glaucoma)
- Ovette Villavicencio, MD, PhD; Catalina Eye Care (cornea)

Each facility has its own unique qualities. The Department of Ophthalmology provides intensive faculty contact with private practice in an academic setting. SAVAHCS has a resident-oriented program with excellent faculty presence. Corneal diseases are the focus of the rotation with Cornea Associates (Dr. Mingwu Wang) and Dr. Villavicencio (Catalina Eye Care). Drs. Bakewell, Fishkind, Maltzman, and Hunter, as well as Dr. Robert Fintelmann, provide experience in a refractive surgery private practice setting. Retina Associates Southwest provides experience in vitreoretinal conditions in private practice settings. Dr. Duerksen provides experience in oculoplastics in a private practice setting.

B. **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
- Systems-based Practice
- Interpersonal and Communication Skills

C. **Academic Program**

The foundations of the didactic program of the residency are weekly conferences in the various subspecialties and weekly clinical teaching rounds. In addition, there are wet labs, unique conferences, and journal clubs. There are conferences provided by the Tucson Ophthalmological Society, an annual conference organized by the Arizona Ophthalmological Society, and occasional guest speakers at industry-sponsored events in the Tucson community. Resident participation in the Tucson Ophthalmological Society meetings is expected, unless a meeting conflicts with a scheduled resident conference, which takes priority for resident attendance.

D. **Clinical Training**

During residency, residents assume increasing responsibility for patient care and education. Beginning residents are closely supervised, and then given increasing autonomy as they demonstrate proficiency and understanding. Residents prepare case presentations, organize journal clubs, and assist in teaching medical students and other residents rotating through ophthalmology. In addition, senior residents, with faculty supervision, are expected to supervise and teach junior residents. Faculty are assigned and available for consultation with the residents on all rotations.

(1) ***First Year (PGY-1) Resident***: The first year resident rotates in Ophthalmology for 3 months, and during that time will spend most of their time at the VA. However, some of their Ophthalmology block will be spent in consults or the Alvernon resident clinics. The resident also rotates at the VA for emergency medicine, internal medicine, neurology, otolaryngology-head and neck surgery, and rheumatology.

(2) ***Second Year (PGY-2) Resident***: The second year resident performs complete ocular examinations in the outpatient facilities, becoming proficient in gonioscopy, indirect ophthalmoscopy, tonometry, biomicroscopy, refraction, and physiologic testing. The resident rotates through the Alvernon clinics, SAVAHCS for a continuity care clinic, retina and oculoplastics, the private practice of Dr. Duerksen for oculoplastics, the private practice of Drs. Bakewell, Fishkind, Maltzman, and Hunter, as well as Dr. Fintelmann, for refractive surgery, Cornea Associates for cornea, and Retina Associates for ocular oncology and retina. The resident may rotate with Drs. Kilgore and Levine of Arizona Eye Consultants and/or Dr. Patrick Tsai of Advanced Eye Care of Tucson for glaucoma. The resident gains extensive experience in evaluating walk-in and emergency patients on a daily basis. The earliest encounters with ocular trauma are during this year; and there is exposure to the subspecialty services, including contact lenses, cornea and external disease, glaucoma, neuro-ophthalmology, oculoplastics, pediatrics, and retina. The resident begins assisting at surgery during this year, and performs minor surgical procedures.

(3) ***Third Year (PGY-3) Resident***: The third year resident rotates through cornea and external disease, general, glaucoma, pediatrics, and retina. The resident also rotates at the SAVAHCS for continuity clinic, retina and oculoplastics. The resident may rotate at the private practices of Arizona Eye Consultants and/or Advanced Eye Care of Tucson, Cornea Associates and Retina Associates.

(4) ***Fourth Year (PGY-4) Resident***: During their fourth year, the resident serves as Chief Resident for three months of the year and manages clinics at SAVAHCS for nine months. The resident at this stage of training performs surgery under faculty supervision. Based on the problem, the resident's experience, and attending preference, there will be successive levels of autonomy. The resident will be involved with the pre-operative and post-operative care of each surgery performed. As Chief Resident, the resident will have responsibility for scheduling their clinical and surgical duties. They will be given a block of time each week for administrative responsibilities. They will also assist in supervising the junior residents. At the conclusion of the final year, the residents are expected to be able to enter practice without direct supervision.

All residents participate in wet and dry labs, receiving instruction on surgical techniques and suturing. The wet lab is equipped with a microscope and phacoemulsification unit.

E. **Responsibilities of the Chief Resident**

The Chief Resident responsibilities are divided between those internal to the Department operation and external (sponsoring institution). During the senior year, the Department responsibilities (call, location, rounds presentations assignments, etc.) will be shared among the senior residents on a rotation determined by the senior residents. However, external duties may be peer selected or determined by the Program Director at the beginning of the year.

(1) The Chief Resident is responsible for collecting vacation requests, screening vacation requests for appropriateness, and passing the information to the program coordinator. The requests will be approved by the Program Director.

(2) The Chief Resident is responsible for scheduling call for first call and back-up (second) call, and providing the schedule to the program coordinator. **The schedule must comply with duty hour standards**. The scheduled will be approved by the Program Director.

(3) The Chief Resident is responsible for the content of weekly teaching rounds–creating the schedule of presenting residents and ensuring the program content is appropriate. The Chair or Program Director will approve any outside speaker.

(4) The Chief Resident is responsible for preparing the monthly resident assignments based on the core rotations, and providing the schedule to the program coordinator. The Chief Resident also responsible for reassigning residents as necessary, i.e. when a resident is off due to illness, or when a clinic is cancelled due to faculty illness, and providing the updated information to the program coordinator. The Chief Resident points out deficiencies or problem areas to the Program Director. The Chief Resident is also responsible for preparing the monthly medical student assignments.

(5) The Chief Resident surveys the lecture schedule and points out deficiencies or problem areas to the Program Director. When more than six residents are going to miss a lecture (conference, vacation, sick) on a lecture, he/she must contact the program coordinator, who will inform the lecturer, who has the option to reschedule or proceed with the scheduled lecture.

(6) The Chief Resident is responsible for the agenda at semi-annual resident/faculty meetings, which are held in fall (September) and spring (March/April).

(7) The Chief Resident facilitates collegial and professional interaction among the residents.

(8) The Chief Resident is responsible for attending the annual program evaluation committee meeting.

(9) Specific responsibilities for each chief rotation.

July-September	• Transitions in June • Assists with incoming resident orientation and updates the "survival guide" section of the residency program manual. • Prepares call/rounds presentation schedule for July-December. • Assists with scheduling VA quarterly rotations for seniors (cornea, retina, glaucoma).
October-December	• Prepares call/rounds presentation schedule for January-June.
January-March	• Prepares resident OKAP in-house review course.
April-June	• Responds to inquiries of incoming residents (via email/phone). • Participates in annual program review.

F. **Research**

The research interests of the Department of Ophthalmology center on amblyopia, cornea diseases, glaucoma, retinal diseases, strabismus, and vision development. Optics, ocular physiology, and pharmacology are integral parts of the research program. There are always ongoing clinical studies evaluating new treatment modalities. There is also a basic science lab on the second floor of the Medical Research Building (near BUMCT).

While the Department has no formal research requirement, residents are encouraged to participate in a research project. The Department offers laboratory facilities and the guidance of faculty who are involved in full- or part-time research. The faculty will also provide education on how research is conducted, research design, hypothesis testing, statistics, and epidemiology, as well as statistical assistance. Residents are encouraged to present their research at national meetings, such as those held by the Association for Research in Vision and Ophthalmology (ARVO), the American Society of Cataract and Refractive Surgery (ASCRS), and the American Academy of Ophthalmology (AAO). The Department makes every effort to support these activities through faculty mentorship, as well as cover eligible travel expenses and early registration.

Research topics may include results of basic or clinical research. The objective of this requirement is to provide an understanding of the mechanics of preparation of a scientific paper as well as to strengthen the residents' ability to critically evaluate publications. If funds are available, the Department may cover the cost of reasonable production expenses; anticipated expenditures must be pre-approved by the Department.

(1) ***Research Publication Fee***: The resident and supervising faculty must contact the Department Head before submitting an article for publication in a journal that requires a publication fee. There are many high-quality journals that do not require publication fees and we wish to focus our submissions here. We would like to spend our Department funds on research and not journal fees, but we will hear arguments for submission to fee-based journals on a case-by-case basis. For the Department to reimburse for these exceptions, approval is required prior to article submission.

(2) ***Human Subjects Protection Program (HSPP)***: Human subjects training is required for all residents. The CITI Course in The Protection of Human Research Subjects is available online through the HSPP at https://rgw.arizona.edu/compliance/human-subjects-protection-program. This program should be completed within the first two months of training (by August 31, 2022). After completion of the course, the resident is responsible for providing a copy of the certificate to the program coordinator, which will be placed in the resident's file. The resident must also to complete conflict of interest (COI) training, as well as submit a Disclosure of Significant Financial Interests at https://research.arizona.edu/compliance/office-responsible-outside-interests, even if the resident has no significant interests to disclosure.

(3) ***IRB Approval***: IRB approval must be obtained for all research projects involving human subjects. The "Determining Human Research" form must be provided for all research projects not requiring IRB approval. All forms are available on the HSPP website at orcr.vpr.arizona.edu.

4. EDUCATION

A. Basic Responsibilities

Each resident is primarily responsible for his/her own education. Learning begins with study, both of patients and text. The patient is the single most important teaching tool for residents, who must be treated with respect and dignity.

B. 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.

(1) 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.

(2) 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.

(3) **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.

(4) **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.

(5) **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.

(6) **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.

C. **Required Reading**

Residents should read about specific diagnostic entities encountered in clinic each day. In addition, residents should read the Academy of Ophthalmology (AAO) *Basic Clinical and Sciences Course* (*BCSC*) completely.

The *BCSC* mirrors the core curriculum of basic and clinical science training in the residency program. The faculty (full-time, part-time, and volunteer) is sufficiently large and diversified

to provide the clinical expertise for the didactic training. Residents are required to participate in the *BCSC* curriculum. An eBook version of *BCSC* is available to all residents (and faculty) at https://lib.arizona.edu/find/books. Residents who want a printed copy of the *BCSC* can purchase from the American Academy of Ophthalmology (AAO) at a discount rate for members. Membership forms can be obtained by calling (415) 561-8581 (www.aao.org). **AAO membership is complimentary to residents, and membership is required for all residents**.

To assist in the new resident's introduction to ophthalmology, the following specific textbooks/manuals are recommended. These are:
(1) *Practical Ophthalmology: A Manual for Beginning Residents*
(2) Video Atlas of Ophthalmic Suturing: Fundamentals and Techniques
(3) *Fundamentals and Principles of Ophthalmology* (Book 2, *BCSC*)
(4) *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). A voucher for the *Wills Eye Manual* is usually provided to PGY-2 residents by Allergan some time after July 1.

Arizona Health Sciences Library Online Textbook Access (available to UA residents): Many ophthalmology textbooks are available online through the Arizona Health Sciences Library website. Your will need to use your 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 ~200 online textbooks, which includes 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. You can also access these books via the EBSCO link below.

AAO eBook *BCSC* Series for 2019-2020 and 2020-2021: Directions below to access this resource.

1. https://libguides.library.arizona.edu/ebscoclinical
2. Sign in using your EBSCO user name and password (set one up if you don't have one).
3. In the search field, enter Ophthalmology and then click on the Search button.

4. On the left side, you can limit your 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. 225 eBooks will then be listed. You can add any of these to your personal folder by clicking on the folder icon to the right of the entry. Upon signing in next time, you can open your folder and access your books without going through the 225 choices.
7. Additionally, you may have multiple folders and you may share folders -- Cornea, BCSC, Retina, etc.
8. Checking out the book to your device is recommended as only 3 people can access the account at a time. The books can only be checked out for 7 days at a time, but they may be renewed.

Albert and Jakobiec's Principles and Practice of Ophthalmology is an excellent all-round reference work in ophthalmology (available online through the Arizona Health Sciences Library). One should not consider the Jakobiec book to be all-encompassing, and residents are expected to read other specialty textbooks and peer-reviewed literature. Residents should consult faculty members before investing in an expensive reference work.

D. **Journal Subscriptions**

Residents are required to become a member of the AAO (membership is free). The journal, *Ophthalmology*, is included in the membership. Membership in the American Society for Cataract and Refractive Surgery (ASCRS) is complimentary to ophthalmology residents, and residents are encouraged to join. Members will receive the *Journal of Cataract and Refractive Surgery* as a benefit of membership (www.ascrs.org).

E. **Arizona Ophthalmological Society Membership**

Residents are encouraged to join the Arizona Ophthalmological Society (AOS) (membership is free). The AOS serves as a source of educational, social, and ethical exchange for the ophthalmologists in the state. Their annual meeting is held each spring at the High Country Conference Center in Flagstaff with excellent invited speakers. The membership application is available online at www.azeyemds.org.

The AOS sponsors one or more residents for AAO Advocacy Day, which is held annually in Washington, DC, during spring (April 2-5, 2025). Residents are contacted by Jeff Maltzman, MD, by email when the time to apply is approaching. Interested residents should contact Dr. Maltzman and submit a completed application, including a short essay. The selected residents are required to give a short presentation to the faculty and residents at rounds after attending.

5. **EDUCATIONAL LEAVE/EXTRAMURAL COURSES**

A. **Educational Leave**

Residents are eligible for up to three (3) days of educational leave for presentations at national conferences (excluding AAO for seniors) (no case reports, no duplicate presentations). To be eligible for educational leave for conferences, see "presentations" below. To be eligible to use

educational days for courses (such as CORE), residents must provide proof of attendance or vacation will apply.

(1) ***Presentations***

Residents who present work (paper, poster, etc.) at national meetings as the presenting (first) author are eligible for up to three (3) days educational leave (the day of the presentation, in addition to a travel day immediately before and after the presentation), as well as up to $1,200 for eligible travel expenses and early registration. The resident must have a faculty member as advisor of the project and the faculty member must be a co-author. The project must also have approval from the chair.

(2) ***Conferences/Courses***

- *PGY-4 AAO*: Senior (PGY-4) residents who attend the AAO annual meeting will be granted up to three days, and up to $1,200.00 for reimbursement of eligible travel expenses, as well as early registration. Residents must use vacation for any additional days for this conference (not eligible for educational days). Residents must submit receipts for eligible travel expenses to the program coordinator within 30 days after their return. Receipts not returned within the deadline will <u>not</u> be reimbursed. *Note*: The program coordinator can use a PCard to pay for airfare so that you will not have to wait for reimbursement.

To be eligible for reimbursement for travel expenses for conferences, residents must submit the following information to the program coordinator: (1) name and dates of conference/course, (2) planned airline itinerary, (3) name and address of hotel (note if you are staying at the conference hotel), and (4) dates of personal time before/after the conference/course. **<u>This information must be provided at least 30 days in advance to allow time for the travel to be authorized</u>**. Travel expenses will not be eligible for reimbursement if authorization was not obtained in advance. Reimbursement for lodging and meals will be based on UA guidelines. The program coordinator can provide this information.

Per University policy, there will be no reimbursement for alcoholic beverages. **Residents can <u>ONLY</u> be reimbursed for their <u>OWN</u> expenses**.

B. **Extramural Courses**

Residents are expected to attend all ophthalmology courses held in Tucson unless the meeting conflicts with a resident conference. These include Tucson Ophthalmological Society meetings, Arizona Ophthalmological Society meetings in Tucson, Residents' Day event, and other Department-sponsored courses. A list of these courses is made available throughout the year.

C. **BLS Certification**

All residents must be BLS certified. Banner requires all residents complete BLS through the RQI program, which is available via Banner MyHR/Workday>Workday LINK. Instructions are available in the Public Resident Files in Box. It is each resident's responsibility to complete the BLS course in a way that minimizes clinic disruption. Residents scheduling during clinic/surgical hours must have approval from the chief resident. Evidence of current BLS certification must be provided to the

program coordinator for the resident's file. If the RQI link is not available on Banner MyHR/Workday, contact the program coordinator.

6. BASIC EQUIPMENT

Incoming residents are required to purchase lenses for viewing the fundus or borrow a set from the program (20D, 90D). A 20-diopter lens is recommended for indirect ophthalmoscopy (panretinal 2.2 is an option). For biomicroscopy, purchase a 90-diopter lens (residents usually prefer Volk or Nikon). Gonio lenses are now disposable and available in clinic. You do not need to purchase a gonio lens. If borrowing a set of lenses from the program a $100 deposit is required. The deposit will be refunded when the lenses are returned. Lost or damaged lenses must be replaced at the resident's expense. Loupes may also be checked out for those on Pediatrics or Plastics rotations.

Residents are required to have a cell phone.

7. SUPERVISION POLICY AND LINES OF RESPONSIBILITY

A. Supervision Policy

The supervision of residents in the Ophthalmology Residency program is determined by both general and situation specific considerations. General considerations include an optimal resident education experience while maintaining patient safety and quality of patient care. The principle underlying both general and situation- specific supervision is the absolute necessity that there must be a well-defined attending physician in charge who determines the level of resident supervision and the amount of responsibility allowed for the resident.

Resident training is an educational experience designed to offer residents the opportunity to participate in the clinical evaluation and care of patients in a variety of patient care settings with a goal to develop resident physicians into independent practitioners by allowing increasing responsibilities in the assessment of patients and the development of therapeutic strategies. Thus, in our program, as the resident year (PGY-2, PGY-3, PGY-4) progresses the resident is given graduated responsibility. However, all aspects of patient care rendered by resident physicians must receive close supervision and are ultimately the responsibility of the attending physician.

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* (2nd ed.), Needham Heights, MA: Allyn & Bacon, 1998.

Categories of Supervision

(1) ***Direct***: Direct supervision exists when attending faculty are in contact with the patient and participate in providing care together with the resident (e.g., attending physician in OR with resident).

(2) ***Indirect***
   a. Direct supervision immediately available: Attending physically present (e.g., outpatient clinic).
   b. Direct supervision available: Attending immediately available via phone/electronically AND ability to be physically present if necessary (e.g., in-house or page for questions).

(3) ***Oversight***: Supervising attending reviews patient care after care has been delivered (e.g., overnight call).

(4) ***General***: General supervision exists when attending faculty are involved in patient care through instruction and the establishment of a system of patient care within which the resident must function.

Supervision and Patient Settings

The Department of Ophthalmology has three major participating affiliated teaching sites (BUMCT, BUMCS, and SAVAHCS). In addition, there are several (five) affiliated teaching sites based in the offices of community ophthalmologists who have voluntary attending faculty appointments with the University of Arizona. Supervision policies will be defined for each teaching site, since there are some minor variations. However, all teaching sites have the same premise of close and careful supervision by the attending faculty who maintain the ultimate authority for patient care.

B. **Lines of Responsibility**

The lines of responsibility flow according to experience. The senior residents are held responsible for the actions of the residents junior to them. In turn, the faculty is responsible for the actions of residents under their direct supervision. The Program Director is responsible for the education and conduct of all residents in the teaching program. The chief of service at each institution is ultimately responsible for the staff and resident physicians who are participating in patient care at the respective institution.

Outpatient Clinics

BUMCT and BUMCS

Patients referred via BUMCT or BUMCS and seen as outpatients will be evaluated at the Alvernon Clinic. Attending faculty members will staff both general and subspecialty outpatient clinics. PGY-2 and PGY-3 residents will be assigned, on a monthly rotation, to most of these clinics. The PGY-4 Chief Resident is also assigned to the Alvernon Clinic. Supervision will be provided by the attending faculty member in charge of these clinics. Resident involvement will range from observation of attending examinations to partial or complete patient evaluations/examinations. All components of the resident examinations will be duplicated by the attending faculty. Any resident entry in the patient's electronic medical record will be checked for accuracy by the

attending faculty who will enter an attestation statement into the electronic medical record. The category of supervision will, therefore, be: (1) direct or (2a) indirect with direct supervision immediate availability.

SAVAHCS

At SAVAHCS, the outpatient eye clinics are managed by the residents with faculty supervision present at all times (1, direct or 2a, indirect with direct supervision, immediately available). Documentation of all patient encounters **must identify the supervising practitioner and indicate the level of involvement**. Four types of documentation of resident supervision are allowed:

(1) **Attending progress note** or other entry into the medical record.

(2) **Attending addendum** to the resident's note.

(3) **Co-signature** by the faculty implies that the supervising practitioner has reviewed the resident note, and absent an addendum to the contrary, concurs with the content of the resident note or entry. Use of CPRS function "Additional Signer" is **not acceptable** for documenting supervision.

(4) **Resident documentation** of attending supervision. [Includes involvement of the attending (e.g., "*I have seen and discussed the patient with my supervising practitioner, 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'.)]*

The following table summarizes supervision policies at SAVAHCS regarding new and return patients in the outpatient clinical setting.

New Patient or New Consult Visit	Attending must be physically present in the clinic. Every patient who is new to the facility must be seen by or discussed with the attending.	An independent note, addendum to the resident note, or resident note description of attending involvement. Co-signature by attending alone is not sufficient documentation.
Return Visit	Attending must be physically present in the clinic. Patients should be seen by or discussed with an attending at a frequency to ensure effective and appropriate treatment.	Any of the four types of documentation. The attending's name must be documented.
Outpatient Discharge	Attending will ensure that discharge from a clinic is appropriate.	Any of the four types of documentation.

Inpatient Consultation

BUMCT and BUMCS

PGY-2 and PGY-3 residents will spend a total of three months of training on a consultation rotation. Monthly rotations on the consultation service will assure maximum continuity of care. Consultations requested during working hours will receive a complete evaluation by the resident (2b, indirect supervision), who will arrange to see the patient with the on-call attending faculty that

same day who will provide direct supervision (1). The electronic medical record will be completed by the resident and each category of the exam will be documented and recorded by the faculty member. In addition to new patient consultations, residents will round with the on-call attending (1, direct supervision) on inpatients requiring daily follow-up examinations and a note will be entered in the patient's chart by both the resident and the faculty member ((1) attending progress note, (2) attending addendum, (3) attending co-signature with attestation). Consultations that are requested after 5:00 p.m. and on weekends are seen, if necessary, by the on-call resident (PGY-2 and PGY-3) and supervision is provided by the on-call attending faculty (1, direct; or 2a or 2b, indirect).

For after-hours and weekend consultation requests, the on-call resident is expected to make the appropriate decision regarding the urgency of the consult, i.e., bedside or as scheduled clinic outpatient visit. If the consultation can safely wait until the following morning, the on-call resident can communicate this to the consult resident. Senior residents and/or faculty may assist the junior resident in this decision-making process. If a particular outpatient clinic is appropriate for scheduling, then the attending faculty member staffing that clinic should provide approval.

To facilitate smooth consultative services, it is Department policy that a member of the service requesting the consultation should communicate directly with the on-call resident; the Department discourages clerical or technical staff from handling consults being called to Ophthalmology as this reduces the ability to prioritize consultations. Also, the name of the faculty member, rather than the resident, requesting the consultation is required.

When a consultation with another service is requested by Ophthalmology, it is the responsibility of the Ophthalmology on-call resident to communicate directly with a member of the requested service to facilitate the transfer of information and make arrangements for the consultation. The resident must also update the electronic consult order in Cerner.

SAVAHCS

At SAVAHCS, during regular hours, if an in-patient consultation is required, an effort will be made to transport the patient to the eye clinic for an examination by the senior resident in the clinic. Direct supervision (1) will be provided by the attending faculty member staffing the clinic. If transportation is not possible, the resident on the consult service will be requested to evaluate the patient at the bedside; the MOD attending faculty (medical officer of the day) in the clinic (2a, indirect supervision immediately available) will follow with his/her evaluation of the patient within 24 hours, and will provide an independent note or addendum to the resident's note.

If the ED has a need for a patient consultation during regular hours between 7:30 a.m. and 4:00 p.m., the patient will be referred to the Optometric Section clinic. After the evaluation, if indicated, the patient will be referred to the Ophthalmology Section and the senior resident in the clinic will evaluate the patient with direct (1) or indirect (2a) supervision by the attending faculty member staffing the clinic. Patients referred by the ED to the eye clinic after 4:00 p.m. will be seen by the senior resident in the eye clinic, again with either direct (1) or indirect (2a) supervision.

Patients seen in the ED after-hours, with a need for ophthalmic consultation, will be seen by the first-call resident in the ED; supervision will be provided by the ED attending faculty on duty (1 or 2a); and/or the back-up senior resident on-call, and/or the Ophthalmology faculty member on-call (2b), if necessary.

Inpatient Admissions

BUMCT and BUMCS

New patients may be admitted to the hospital from the clinic or ED setting. At times, the resident and the 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.

Please see table below summarizing supervision policies regarding new patients, continuing inpatient care, consultations (see section above "inpatient consultation" for more detailed information), and discharge.

New Admissions	Attending must see and evaluate the patient within 24 hours.	The attending will review the resident note, attest to the note, and addend 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

New patients may be admitted to the hospital from the clinic or ED setting. At times, the resident and the 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 the orders (2a or 2b, indirect supervision), and the supervising attending must examine and evaluate the patient within 24 hours.

Please see table below summarizing supervision policies regarding new patients, continuing inpatient care, consultations (see section above "inpatient consultations" for more detailed information), and discharge.

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 in not sufficient documentation.
Discharge	Attending must be personally involved in decisions to discharge patient.	Co-signature of the discharge summary is required.

Operating Room (OR)

Direct supervision by the attending supervising physician for ALL surgical procedures performed by the resident in the BUMCT OR, the BUMCT Surgery Centers, Private surgery centers and the SAVAHCS OR is required. There is no exception to this rule.

BUMCT and Surgery Centers

- *History and Physical*: H&P (pre-op) may be performed by resident or attending faculty. If done by resident, supervision is either direct (1) or indirect (2a or 2b). If done by resident, attending must confirm findings within 24 hours of surgery (Day of Surgery Attending H&P co-signature). H&P is valid for 30 days.
- *Surgical Consent Form*: May be performed by resident or attending faculty while in clinic (1, direct supervision). In some cases, attending fills out form; resident reviews surgery with patient and obtains patient signature during evaluation by resident in pre-op clinic (2a or 2b, indirect supervision). Surgical consent is valid for 30 days.
- *Pre-operative Note*: Pre-op note obtained by resident and signed electronically by attending the day of surgery (1, direct supervision or 2a, indirect supervision).
- *Brief-operative Note*: Completed by resident and signed electronically by attending faculty (1, direct supervision, or 2a, indirect supervision) within 2 hours of surgery (not necessary if operative note is typed into Cerner within 2 hours).
- *Operative Note*: Must be completed by resident within 24 hours of surgery (1, direct supervision, or 2a, indirect supervision); signed off electronically by attending faculty.

SAVAHCS

- Patient notes and patient procedure resident notes must be completed the same day of the visit. There are no exceptions.
- *History and Physical (as part of pre-op) by Resident*: Is valid for 30 days; beyond that must be repeated or updated verbally on the phone with a physical exam at bedside.
- *Surgical Consent Form:* Must be completed by resident within 60 days before surgical procedure; beyond that must be redone. Notify in OR consult if the patient is long distance, and then the consent can be done at bedside the morning of surgery.
- *Pre-Operative Note*: Must be completed by resident prior to the surgical procedure the day of surgery.
- *Brief Operative Note:* Must be completed by the resident within 2 hours of the surgical procedure.
- *Operative Note*: Must be completed by the resident with 24 hours of the surgical procedure.

Emergency Department (ED)

<u>BUMCT ED and BUMCS ED</u>

PGY-2 and PGY-3 residents will be on first call (with rare exceptions, for example, when seniors are attending the annual AAO meeting, PGY-3 residents will act in capacity of back-up call for after-hours emergencies.) Senior residenst (PGY-4) will act as back-up call for the ED. Ophthalmology ED call is “home call” and the Department requirement is that the resident will not be further than 30-minutes distance from the ED. The first call residents will receive extensive supervision by

PGY-4 residents and attending faculty on-call (especially PGY-2 residents in the initial six months of their training). PGY-2 residents will be required to travel to the ED for the first 6-months of their residency to examine all patients when a consultation is requested by the ED. They will present all patients to the senior resident on-call to determine the necessity of the senior resident going to the ED to examine the patient +/- the need to present the patient to the attending faculty on-call (depending on the findings some patients will fall within the "must call attending list"; see below). After this 6-month period, the PGY-2 resident (and all PGY-3 residents at beginning of academic year), if deemed competent, will be able to provide consultation by phone, with referral to an outpatient clinic the following day, if appropriate.

A comprehensive list of conditions/findings has been compiled and is intended to trigger a "must call" by the first-call resident to either the senior resident or the supervising on-call attending ophthalmologist, or both (see "Must Call List" below). This rule will be strictly enforced and adhered to by PGY-2 and PGY-3 residents.

Supervision will be available by the supervising attending in the ED for all residents (PGY-2, PGY-3, PGY-4) at all times (1, direct and 2a, indirect with direct supervision immediately available). Even though the attending ED is immediately available, if procedures are necessary, certain procedures may require (1) direct supervision by the attending ophthalmologist on-call, or residents may proceed with performance of procedures with indirect supervision by the attending ophthalmologist on-call (2b, indirect with direct supervision immediately available by phone/electronically) if proper training and "sign-off" have been attained (see lists under "Supervision of Procedures other than OR"). Oversight supervision (3) (e.g., supervising attending reviews care the following morning) by the attending faculty member on-call for the first-call and/or senior resident is always a possibility depending upon the condition and experience of the residents on-call. Supervision policies followed will depend upon situation specific considerations and the experience of the resident on-call.

The first call and back-up residents will cover inpatient consultations at BUMCT and BUMCS after-hours for the resident on the consult service (see section defining responsibilities of consult resident). A portable slit lamp is available in a storage room adjacent to the ICU at BUMCT. There are two indirect ophthalmoscopes: (1) in the cabinet in the BUMCT ED, and (2) underneath the desk in the resident work area of the BUMCS ED. At BUMCS, a portable slit lamp is available in the fast track area of the ED (this is under the desk in the South Pod EM resident area.).

A call list of supervising ophthalmology attending faculty will be maintained and easily accessible online. Duty hours will be strictly adhered to by the resident on-call.

If after-hours examinations are scheduled at the Alvernon Clinic (follow-up urgent care BUMCT and BUMCS), patients must be seen at by at least two residents or a resident and faculty member. **Residents are <u>not</u> allowed to see patients alone in the Alvernon Clinic after-hours.** It is dangerous. If there are two residents or a resident and an attending, it is permissible.

<u>SAVAHCS ED</u>

An eye call room is available in the ED, and is fully equipped for ocular examinations. ED patients will **not** be taken for examination to the eye clinic in building 80 after-hours. The only exception will be for the use of equipment that is not available in the ED, e.g., ultrasonography unit. If this is

necessary, security will be notified by the resident and security will need to escort resident and patient to the eye clinic and standby during the entire exam.

ED supervision policies defined above apply to SAVAHCS ED. An attending ED physician will be on the premises at all times to offer direct (1) or indirect (2a) supervision. The ophthalmologist attending on-call will offer either direct (1), indirect (2a or 2b), or oversight (3) supervision depending upon the situation specific conditions and the experience of the residents on-call.

If an inpatient consultation is requested of the resident on-call, equipment, including a hand-held slit lamp, must be transported to the bedside.

The call list of supervising attending faculty will be comprised of SAVAHCS attending staff, not BUMC attending staff; the call list of supervising attending faculty will be maintained and easily accessible online, if necessary. Work hours will be strictly adhered to by the resident on-call.

Affiliated Preceptor Teaching Sites (Community Rotations)

All residents have periodic rotations to several affiliated teaching sites during their PGY-2 and PGY-3 years. A primary preceptor at each teaching site has a faculty appointment with the Department of Ophthalmology at the University of Arizona. The primary preceptor at each site will act as the supervising attending with two of the sites having physician colleagues of the primary preceptor occasionally acting as the supervising physician. Categories of supervision at these teaching sites will be (1) direct or (2a) indirect (supervision immediately available). These categories will apply to all aspects of the teaching experience, e.g., clinical examinations, clinic procedures, and procedures in ASCs or hospital operating rooms. The residents on these community rotations will primarily act as an observer or assistant during performance of the clinic or surgical procedures (they will, rarely, act as the primary surgeon).

Supervision of Procedures other than OR
(In general, performed in ED or clinic)

Requires DIRECT Supervision (attending in the room)

- Lid or facial lacerations involving the lacrimal system
- Any operating room procedure
- Laser to the macula

Requires at least ONE DIRECTLY observed procedure + attending sign off before indirect supervision (attending available by phone). May also be observed by a resident that has been signed off for the procedure but sign off must be by an attending.

- Repair of eyelid or facial lacerations SIMPLE (not involving the eyelid margin and no significant disruption of the normal tissue architecture) (may also be supervised/staffed by an ED attending, but sign off must be by attending)
- Insertion and removal of punctal plugs
- Punctal cautery
- Tarsorrhaphy
- Removal of ocular sutures
- Lateral canthotomy and cantholysis (at the attending's discretion and on a case-b- case basis, this may be performed emergently without the attending's presence)
- Removal conjunctival/corneal foreign body

- Corneal or conjunctival cultures
- Excision of simple eyelid mass
- Incision and drainage of lid abscess
- Anterior segment OCT
- Intralesional injection of Kenalog
- Anterior chamber paracentesis (at the attending's discretion and on a case by case basis, this may be performed emergently without the attending's presence)

Requires at least TWO DIRECTLY observed procedures + attending sign off before indirect supervision (attending available by phone). May be observed by another resident who is signed off for the procedure but signing off is by attending only.

- Repair of eyelid or facial lacerations COMPLEX (significant disruption of normal architecture or involvement of the margin).
- Chalazion removal
- Adhesive repair of corneal perforations
- Retrobulbar or peribulbar anesthesia
- Laser suture lysis
- Subconjunctival or subtenons injections
- YAG laser capsulotomy
- Laser peripheral iridotomy
- Laser peripheral iridoplasty
- Anterior chamber and vitreous tap/inject
- Corneal scraping

Requires at least TWO DIRECTLY observed procedures + Sign off before Indirect Supervision (attending available onsite)

- Intraocular injections
- Laser trabeculoplasty
- Vitreous tap and inject

The following procedures may be performed with Indirect Supervision (attending available by phone) without prior observation

- Administer topical and oral medications, and diagnostic eye drops
- Removal of skin sutures
- Insertion of bandage or other contact lenses
- Removal or insertion of ocular prostheses
- IV injection of fluorescein for fluorescein angiography
- Administer local injection anesthesia other than as listed above

Transition of Care (Hand-offs)

The goals for transition of care are to:

- Minimize the number of transitions in patient care.
- Ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
- Ensure that residents are competent in communicating with team members in the hand-over process.

- Ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.

Protocol

Prior to or during the transition of patient responsibilities from one physician to another physician, there will be a person-to-person communication regarding the following:

- Any updates the transferring team made in the electronic transfer tool records/consult list.
- Any lab, radiology, or other tests that require follow-up, and the conditional plans for the results.
- Any pertinent recent or upcoming communication between ophthalmology and other services or patients and patient's family.
- Any foreseeable problems and conditional plans for each.
- Any patients currently on the ophthalmology inpatient service.

The transferring team will review the records in the electronic transfer tool/consult list before transferring care to the next team and make a note of the issues to be addressed in the upcoming personal communications with the receiving team.

The receiving team will also review the records in the electronic transfer tool/consult list before accepting care and make notes of the issues to be addressed in the upcoming personal communications with the transferring team.

Alternatively, the transferring and receiving physicians may review the records in the electronic transfer tool/consult list together interacting to clarify the duties and foreseeable problems which will be transferred.

Informed means of communicating specific types of information:

- Consultations that have not been staffed: verbal + [electronic tool].
- Patients to be seen in clinic: verbal + [electronic medical record note clearly stating at minimum the information that is required <u>or</u> handwritten notes with the same minimum information requirement].

Baseline Information: If a condition exists in which acute change from a baseline status is of importance, then the receiving team MUST:

- <u>Best</u>: One of the receiving team members will see the condition prior to the transfer and verbally discuss any uncertainties with a transferring team member.
- <u>Acceptable</u> (when best is not possible): The transferring team will provide a detailed drawing and/or description and discussion with a receiving team member.

<u>or</u>

- The transferring team will provide digital photographs which can be accessed by the receiving team in a HIPAA compliant manner and discussion with a receiving team member.

Requirements for transferring a consult/ED clinic patient from the hospital to an outpatient setting for follow-up is as follows:

- Address and phone number of follow-up clinic and directions, if required
- An appointment time, date, and the attending physician's name

<u>or</u>

- If the hours of clinic operation make the above impossible, then the patient name, MRN, contact number, service or physician to be seen, and the timeframe for follow-up should be given to Yvonne Borror (694-1478) or Ruben Bustamante (694-1497) at the Alvernon clinic on the next business day for scheduling.
- There will be a regular Monday clinic for the purpose of follow-up of weekend patients. The call team may establish a list of patients and follow-up times to be given to the clinic before 8:00 a.m. Monday.

Must Call Attending List

1 = Must call attending now
2 = Must call senior now
3 = Can wait < 8 hours to call attending who is seeing the patient in clinic or to be staffed next day if inpatient
4 = Can wait > 8-16 hours until being seen by an attending in clinic if outpatient or staffed as an inpatient
5 = Have patient call for appointment as instructed or staffed within 24 hours if inpatient

Trauma/General

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

Cornea

4	Probable infectious keratitis	4	Corneal graft rejection
2	Partial thickness cornea laceration		
5	Corneal foreign body outside central 5 mm	4	Cornea FB central 5 mm
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 lOPs, pH >5-<8 on arrival		
2,3	LASIX flap dislocation	4	LASIX subflap infiltrates
4	Neurotrophic corneal Ulcer	4	HSV keratitis
4	HSV uveitis, corneal edema	4	HZ uveitis, lid involvement

Lid/Lacrimal System

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

Orbit

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

Pediatric Emergencies

4	Leukocoria child	4	New onset tropia child
3	Hyperacute conjunctivitis		

Glaucoma

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

Neuro

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

Retina

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

8. CLINICAL AND EDUCATIONAL WORK

A. Clinical and Educational Work

Clinical and educational work is defined as all clinical and academic activities related to the program, i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as lectures, rounds, and conferences (AAO, ARVO, review course). It also includes hospital committee meetings and on-site resident interview time. Clinical and educational work hours do not include reading, studying, and preparation time spent away from the duty site.

Residents are expected to be familiar with the clinical and educational work hours policy (outlined below) and avoid violating the policy. Residents **MUST** notify the Chief Resident or Program Director for reassignment if necessary to avoid a violation.

(1) Residents are limited to 80 hours per week of clinical and educational work averaged over a four-week period, inclusive of all in-house call activity and moonlighting.

(2) Residents are provided with one day in seven free from clinical responsibilities and required education, averaged over a four-week period, inclusive of call. Vacation or leave days are not counted in the average. Averaging must occur by rotation.

(3) Resident must have 8 hours between scheduled clinical and educational work periods.

(4) Residents must not exceed 24 hours of continuous scheduled clinical assignments.

On-Call Activities

Continuous on-site work must not exceed 24 consecutive hours. Residents may remain on duty for up to FOUR additional hours to continue to provide care to a single patient. Justifications require continuity for severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under these circumstances, the resident must hand over the care of all other patients to the team assuming care and document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the Program Director. The resident must complete the form online. The Program Director will track these episodes and report them to the Graduate Medical Education Committee (GMEC) on a quarterly basis.

At-Home Call (or Pager Call)

Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of clinical and educational work when averaged over four weeks. At-home call must not be so frequent or taxing to preclude rest or reasonable personal time for each resident.

WHAT COUNTS TOWARD CLINICAL AND EDUCATIONAL WORK HOURS

- All clinical activities
- All scheduled activities, such as lectures and rounds
- Hours spent in the hospital while on home call
- Conference hours, such as AAO, ARVO, and review course
- Hospital committee meetings, such as GMEC meetings and resident interviews
- Internal moonlighting
- External moonlighting

WHAT DOES NOT COUNT

- Reading, studying and academic preparation time spent away from the hospital ambulatory site

- Voluntarily staying at the library or hospital when no additional duties are planned over the next ≥2 hours
- Travel time to/from conferences

HOME CALL
- Hours spent in the hospital when on at-home call count toward the 80-hour weekly limit but do not apply to the 8-10 hour "off duty" period which is reserved for in-house call.
- Frequency of at-home call is not subject to every third night or the 24+4 limit.

Exception to Maximum Duty Period Length
In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of work to continue to provide care to a single patient. Justifications for such extensions of work are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. If this occurs, the reason for the occurrence must be explained in New Innovations (Work Hours – Violations).

B. **Fatigue**

All faculty and residents will be educated to recognize the signs of fatigue and sleep deprivation in themselves and others, and must apply these policies to prevent and counteract its potential negative effect on patient care and learning. The GMEC requires that all residents and faculty complete the "Sleep, Alertness, and Fatigue Education in Residency" (SAFER) program (or similar program) yearly. This educational module, prepared by the SAFER Task Force from the American Academy of Sleep Medicine, is designed to educate on the effects of sleep deprivation. This module is presented during orientation, as well as yearly to all faculty and established residents. It is also available in the public resident files. The program will maintain a record of all who have successfully completed the training module.

If a resident has signs of fatigue or sleep deprivation after extended duty, the resident is to take a strategic nap of 30 minutes, as suggested by the SAFER program, or delay participation in the next morning's activities. If the resident's duty on the subsequent morning is at SAVAHCS, then the resident must contact the site director or chief resident either that morning or by 8:00 a.m. the morning of the clinic. The patients in that resident's clinic will be distributed amongst the other residents and faculty clinics for the first two hours. The duration of rest may be extended as needed by mutual consent of the resident and the site director or chief resident. The decision for needed rest can be made by either the resident or the faculty member and must be respected.
If a resident is scheduled to be at any of the other sites, including SAVAHCS, then the corresponding faculty of that site must be contacted directly or through the chief resident, program coordinator, or program director by the start of that clinic.

If a resident is on call and determines that fatigue and sleep deprivation from continued responsibility will compromise care, then the back-up resident and then the faculty member will assume call until which time the primary resident has recovered adequately. A two-hour period is the usual time, but this may be modified accordingly. The resident may take the entire morning to recover if needed.

C. **Emergencies, Sickness, or Other Circumstances**

If a resident is out due to an emergency, sickness, or other circumstance, the Chief Resident must be notified. The Chief Resident will make sure there is coverage for any of the resident's patient care responsibilities.

9. ON CALL DUTIES AND SCHEDULE OF ASSIGNMENTS

The resident on-call policy provides for appropriate coverage for providing the care of ophthalmologic emergencies at the BUMCT, BUMCS, and SAVAHCS. The usual policy is for two residents to be assigned at all times: a junior resident on first call and a senior resident on back-up, or second call. A faculty member is designated for on-call at BUMCT and BUMCS, and a different faculty member is designated on-call for SAVAHCS.

The first call resident may take call from home, or any other location accessible by the pager, provided the resident is never more than a half an hour away from any one of the above hospitals under ordinary travel conditions. Typically, first call coverage is provided by a given resident, one weeknight in eight and one weekend in eight. The call schedule must be agreed upon by the second (PGY-2) and third year (PGY-3) residents and MUST comply with clinical and educational work hours standards. The Chief Resident is responsible for scheduling call and giving the schedule to the program coordinator in a timely manner (by June 15 for July, July 15 for August through December, and December 15 for January through June). The program coordinator MUST be notified of any changes in the call schedule.

Second (back-up) call coverage is provided by a senior (PGY-4) resident. Second call will only be delegated to a third year (PGY-3) resident during AAO and starting Residents' Day in June. The second call coverage is routinely performed from home approximately every fourth weekend. No more than two consecutive weekend calls are allowed; and no more than two weekend calls in a four-week period are allowed. The schedule MUST comply with clinical and educational work hours standards. Again, call may be taken from home, or any other location accessible by the pager, provided the resident is never more than a half an hour away from any one of the above hospitals.

Faculty take call from home on a rotation as well, with the faculty call schedule being coordinated by the program coordinator. **A schedule of faculty "on-call" will be maintained at all times**. The schedule includes the on-call faculty member for BUMCT and BUMCS, as well as the on-call faculty member for SAVAHCS.

Whenever a resident receives an emergency call, he/she must respond appropriately. "Appropriately" usually requires the resident to see the patient; upon occasion, the inquiring service may merely be requesting guidance. If there is any chance that an injury/illness is sight or life-threatening, even if not recognized as such by the calling service, or if the ophthalmology resident is in doubt, the ophthalmology resident **MUST** see the patient. The PGY-2 residents, for the first six months of residency, **MUST** travel to the ED and see all patients if requested by the ED physician.

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

After regular hours (5:00 p.m. to 7:00 a.m.), if any potential surgical case is identified by the first-call resident (PGY-2 or PGY-3), the senior back-up call resident **MUST** personally examine the patient to verify that surgery is necessary (exceptions are allowed for obvious trauma with photo documentation reviewed electronically by senior and/or faculty). The faculty on-call is then notified by the senior on-call resident. If the faculty agrees with the management plan, the OR is booked for the surgery (in rare cases, e.g., when there is a slight delay in contacting the on-call faculty, the senior may proceed to book the OR to expedite the process). The faculty **MUST** communicate his/her desire to see the patient in the clinic, ED, pre-op holding area, etc. **BEFORE** wheeling the patient into the OR suite. The senior back-up call resident, in the process of examining the patient, will review the H&P with the first-call resident, review imaging available (MRI, CT), B-scan (should be printed), lab data, and other available data prior to surgery, and be prepared to review and discuss this material with the attending upon their arrival.

The first-call resident is responsible for staying "in-house" until the case starts. The purpose for this is for the first-call resident to observe and participate in the admitting process, complete the H&P, learn how to manage pre-operative issues, write orders, etc. (If issues, such as duty violations, etc. prevent this responsibility, the senior resident will resume these duties.) If there is considerable delay in the start time, the faculty may allow the first-call resident to return home until the case starts.

After hours, the senior back-up call resident will be expected to be the primary surgeon or assistant as deemed appropriate by the attending. The first-call resident will stay in the OR to observe the surgery. The attending surgeon will have the prerogative to alter this policy depending on the circumstances, e.g., duty hour issues, case more appropriate for first-call resident as primary surgeon or assistant, etc.

The "on call" resident will receive all requests for consultations from BUMCT and BUMCS from 5:00 p.m. until 7:00 a.m. the following day and on weekends and holidays; all consultations will be phoned in by another housestaff officer or faculty member.

A resident going "off call" remains responsible for the patient's follow-up care unless the resident makes another arrangement. Residents rotating off clinical services must notify the resident going "on call" of all patients for whom he/she is responsible. This is vital for the maintenance of continuity of care.

While on call, residents will provide emergency and consultative services in a timely fashion and 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.

There is an on-call examination room available in the Emergency Department of BUMCS, and SAVAHCS. (BUMCS has one dedicated room but usually patients are seen in any EM room and the slit lamp on wheels is moved into the room.] Residents must not transport patients to SAVAHCS Eye Clinic after hours unless escorted by the security guard. **Residents NEVER see patients alone in the Alvernon clinic after hours**.

A SAVAHCS patient must not be seen at Alvernon and vice versa unless prior authorization is obtained.

Patients Seen Through the BUMCT Emergency Room

Many patients present with ocular trauma to the emergency room. Some do not need to be seen by the Ophthalmology resident on call, but the resident is notified about the need for follow-up. Under these circumstances, when the resident receives the call from the Emergency Room, he/she should obtain the following information:

(1) Patient's name
(2) Patient's medical record number
(3) Patient's date of birth

The resident should inform the patient to obtain proper authorization for a followup visit. After the resident gets off the phone with the Emergency Room, he/she should call Yvonne Borror (694-1478) or Ruben Bustamante (694-1497) and leave a message on the answering machine containing the above information. The Front Desk staff should be provided with the patient's name, medical record number, and date of birth. When the Front Desk opens, the staff will know that patients should be coming in during the day, and will assign them times as available in attending clinics. The staff will then attempt to call the patient with the appointment time, or when the patient calls, he/she will be notified regarding the time. The resident should also record all off-hours visits with patients.

Call Rooms

- BUMCT: The call room at BUMCT is room 5606. The outside entry code and the inside entry code for room 2 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.

10. CONSULTATION POLICY

See Inpatient Consultation under Supervision.

11. RESIDENT SURGICAL EXPERIENCE

Residents may be the primary surgeons in cases that are within the scope of their training and experience. At SAVAHCS, all surgery performed by residents is subject to approval by faculty. All resident surgery must be staffed by faculty. Surgical patients at BUMCT may arise from on-call consults or from faculty clinics. Surgical patients from outpatient clinics must be approved and staffed by faculty; all cases will be evaluated for appropriateness of surgery and ability of the resident to serve as the primary surgeon. Residents will be assigned to assist faculty during surgery on specific days.

Monocular patients are not typically considered candidates for intraocular surgery by residents, and these surgical cases will usually be performed by faculty. In addition, other complicated surgical cases, as determined by the faculty, will be assigned to faculty for their surgery.

Phacoemulsification is considered an advanced surgical procedure that requires prior demonstrated proficiency by the surgeon. Prior to beginning phacoemulsification surgery as primary surgeon, the resident must carefully adhere to the guidelines regarding wet/dry lab experience and surgical logs stated under total quality improvement (Section 12.B, page 33), as well as complete required reading and video viewing.

Resident Surgical Patients (SAVAHCS)

- All patients should be given pre-op and post-op instructions on cataract surgery at the time of approval of their surgery.
- All pre-operative laboratory data should be checked one week prior to the surgical date to check for any possible contraindications to surgery. The routine labs expected are an EKG within six months, and CBC and electrolytes including glucose within one month. If the patient has other medical conditions that may affect their ability to lie flat, remain still, or has severe cardiac or pulmonary disease, anesthesia should be contacted to check for recommendations on additional work-up or specific instructions.
- All patients are contacted on the day prior to surgery by PAT for instructions and to answer any patient questions.
- 96 hours prior to the day of surgery, confirmation of an updated H&P, consent and any additional pre-op clearance, as well as clearance from attending surgeon, should be noted in the surgical OR consult, e.g.: Case reviewed and discussed with Dr. X. H&P, consent is current. Patient cleared for surgery.

Below are the operative minimum numbers per ACGME.

Ophthalmology 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

Residents are expected to input surgeries on which they are the first assistant as well as cases on which they are the primary surgeon. This is necessary for the program to show a progressive graduated and broad surgical experience.

ACGME Definitions of Surgeon and Assistant: To be recorded as **Surgeon**, a resident must be present for all of the critical portions of the procedure and must perform greater than or equal to 50 percent of the critical portions of the procedure, as determined by the supervising faculty member. To be recorded as **Assistant**, the resident must serve as the first assistant to a faculty member performing the procedure or to another resident performing the procedure under faculty supervision. Residents may log Assistant if they observe a case through the microscope and are actively engaged in the case (e.g., observing the surgeon's hands, noting how the surgeon counsels the patient, studying how the surgeon keeps the patient stabilized). Only one resident can claim credit as Assistant on a given procedure.

ACGME Case Log Entry Q&A's

If a resident participates in both sides of a bilateral procedure, can the resident enter both procedures into the Case Log?
Yes. If a resident completes both sides of a bilateral procedure and has the same role for both procedures, the resident should choose the appropriate role (Surgeon or Assistant) and add the appropriate CPT code twice to the case. The system permits the same CPT code to be added twice on the same case.

If a resident completes one side of a bilateral procedure as a surgeon and the other side as an assistant, the resident must create two cases in the Case Log System and choose the Surgeon role in one, and the Assistant role in the other. The system only permits one role per case.

> *Example*: A resident performs a bilateral blepharoplasty and acts as the surgeon on both sides. The resident chooses the Surgeon role and adds the appropriate CPT code twice to the case.

How should a resident log multiple procedures on a single patient?
As noted in the question above, if a resident performs both sides of a bilateral procedure, the procedure should be logged twice for the single patient. If a resident is involved in a case that involves multiple different procedures, the resident should log the procedures separately to ensure the Case Log accurately represents resident experience, and proper credit is given towards the required minimum category(ies).

Logging cases for the ACGME is not the same as coding for billing. While CPT codes that "bundle" more than one procedure may be used for billing, each separate CPT code should be entered in the Case Log System. This approach provides more accurate information regarding the breadth of experience obtained by the resident. As an example, an excision and repair of the eyelid can be logged with CPT code 67961 and credit for one procedure is given towards the required minimums. If the resident logs the excision and eyelid repair separately (e.g., CPT codes 67810 and 14060), the Case Log will have **two** procedures on record and credit will be given for **two** procedures.

If a resident completes one procedure as surgeon and another as an assistant, the resident must create two cases in the Case Log System and choose the Surgeon role in one and the Assistant role in the other. The system only permits one role per case.

Examples:

- A resident performs the role Surgeon in a case where a patient undergoes a combined phaco/trabeculectomy. The resident should record both procedures for this case using the Surgeon role.
- A resident performs the role of Surgeon for a bilateral medial rectus muscle recession and anterior transposition of the right superior oblique muscle on a single patient. The resident should record three procedures for this case using the Surgeon role.
- A resident acts as the Surgeon on two horizontal muscles in the same eye. The resident should enter the CPT code for one horizontal muscle (67311) twice using the Surgeon role to obtain credit for both procedures. The resident should not enter the CPT code for two horizontal muscles (67312) as credit will only be given for one procedure.
- A patient undergoes strabismus surgery on two different muscles in each eye, where the resident is the surgeon. The resident should record each muscle as a separate procedure performed during the strabismus surgery using the Surgeon role.
- A resident performs a scleral buckle procedure as the Surgeon combined with a pars plana vitrectomy where the resident is the Assistant. The resident should create two cases in the Case Log System and choose the Surgeon role for the scleral buckle procedure and the Assistant role for the pars plana vitrectomy.
- A resident performs as Surgeon a bilateral blepharoplasty combined with bilateral ptosis repair. The resident should record four procedures for this case using the Surgeon role.

If two residents participate in a case, can each enter the Surgeon role?

In most cases, only one resident may claim Surgeon credit for a given case. There are two exceptions. The first exception is if a case involves more than one procedure (i.e., more than one CPT code), residents may each claim Surgeon credit for a different procedure, provided they each met the criteria for the Surgeon role. The second exception involves bilateral procedures. If two residents each do one side of a bilateral procedure, each resident can record the procedure as the surgeon, provided they each met the criteria for the Surgeon role.

Examples:

- During a planned pars plana vitrectomy combined with phacoemulsification of cataract, one resident performs the pars plana vitrectomy while another resident performs the cataract extraction. Each resident may record the procedure they performed as surgeon.
- Two residents are involved in a case that includes an excision and repair of the eyelid. One resident performs the excision and the other performs the eyelid repair. Each resident may record the procedure they performed as surgeon.
- Two residents are involved in a bilateral blepharoplasty case. One resident performs the surgery on one side and the other resident performs the surgery on the other side. Each resident may record the procedure as surgeon.

Can residents log more than one case in a single Case Log entry?

Residents can "batch enter" procedures associated with the CPT codes that give credit to the minimum categories of cataract, YAG capsulotomy, laser trabeculoplasty, panretinal laser photocoagulation, and intravitreal injection. Residents must enter the case information (date, role, attending, and site), choose the appropriate CPT code, and enter the total number of procedures for a given day. Entering a Case ID is optional. The maximum number of cataract and laser CPT codes for one entry is five. The maximum number of intravitreal injection CPT codes for one entry is 10.

The table below lists the CPT codes that can be batch entered. The most common CPT code(s) for a category are identified in bold.

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

Do residents receive credit toward the Pterygium/Conjunctival and Other Cornea minimum when they log CPT code 65778 (placement of amniotic membrane on the ocular surface; without sutures)?
Only if the placement uses tissue glue. In this case, residents should choose the version of CPT code 65778 that lists under the description the minimum category Pterygium/Conjunctival and Other Cornea, and the Type is "Other cornea with tissue glue/not self-retained."

Residents do not receive credit if the amniotic membrane is self-retained. Should residents want to record this procedure in their Case Log, they should choose the version of the CPT code with the Type "Other cornea."

Meeting Minimum Procedural Requirements and Competence: Performance of the minimum number of procedures by a graduating resident must not be interpreted as equivalent to the achievement of competence. Resident procedural competence is determined by the program director in consultation with the Clinical Competency Committee. The Review Committee uses Case Logs to assess the breadth and depth of a program's procedural training as well as the individual resident experience. Minimum numbers represent what the Review Committee believes to be an acceptable minimal resident experience. **Minimum numbers are not a final target number and residents should continue to log their procedures in the Case Log after minimums are achieved**.

12. QUALITY ASSURANCE POLICY

A. QIPS Conference

QIPS conferences are held on a monthly basis, in a closed session limited to members of the Department of Ophthalmology. The goals of the QIPS conference are three-fold: (1) to discuss complications which have arisen during the care of patients in a free and open manner so that all may benefit from this experience without having to directly experience it themselves; (2) to provide a mechanism for monitoring the occurrence of complications, the rate of complications, and the need for remediation or modification of surgical privileges; and (3) to monitor and assess total quality improvement on an individual resident basis.

B. **Total Quality Improvement**

It is critical and imperative for residents to participate in a total quality management program for advancement of their surgical skills. This program has several requirements as enumerated below.

Wet/Dry Lab Experience

(1) Pig eyes will be utilized for wet labs (Alvernon wet lab facility only); artificial eyes utilized in the Alvernon lab and SAVAHCS OR. To acquire artificial or pig eyes for the Alvernon wet lab, contact the program coordinator; allow 7 to 10 days' notice. To acquire artificial eyes at SAVAHCS, contact Krista Rosynski (x6106). (These eyes are to be used only at SAVAHCS; do not transport to Alvernon wet lab.)

(2) Supervision for the wet/dry labs will be provided by (a) resident only, +/- video when possible; (b) senior resident; (c) company representative; or (d) attending (see "table" on the next page).

(3) All wet/dry lab resident sessions **MUST** be electronically logged with information including date, total time of session, location, type of practice, supervision (see administration section for details). The Program Director will review resident progress at the 6-month evaluation session. Incomplete resident wet/dry requirements could delay resident progression to human phaco surgery.

(4) There will be orientation sessions for PGY-2 residents for the AMO Signature Unit and for PGY-3 residents for the Alcon Infiniti Unit (see table for details)

(5) Residents are encouraged to attend extramural phaco courses sponsored by Alcon and Bausch & Lomb (B&L): CORE Alcon Course for PGY-3 residents, CPE Alcon Course for PGY-4 residents, and B&L PGY-3 course (see Program Director for details). Expenses are paid by the sponsor.

(6) A comprehensive intramural phaco course will be sponsored annually by J&J with Dr. Brian Hunter as the primary instructor. This will be held in the Alvernon conference room and attendance is mandatory for all residents.

Wet/Dry Lab Requirements

	PGY-2	PGY-3	PGY-4
1st Quarter	Lid Lac Wet Lab Canthotomy Paracentesis, cornea cultures, AC tap (Polonski, Altenbernd (Alvernon)	Artificial/Pig Eyes x2 each (Attending) Corneal Suturing (Belin, OR9)	Alcon CPE Course/Ft. Worth (or 2nd Qtr) Corneal Suturing (Belin, OR9) (Remedial PRN)
2nd Quarter	Artificial/Pig Eyes x1 each (PGY-4, Alvernon) MISCS wet lab	CORE Alcon Course (or 3rd Qtr) MISCS wet lab Artificial/Pig Eyes x2 each (Self, video PRN)	Artificial Eyes x4 (Self, video PRN) (Remedial PRN) MISCS wet lab
3rd Quarter	Artificial/Pig Eyes x2 each (PGY-4, Alvernon) Alergan Wet lab	Artificial/Pig Eyes x2 each (Self, video PRN) Allergan Wet lab MISCS Wet labe	 Allergan wet lab (Remedial PRN)
4th Quarter	Artificial Eyes x2 (Attending, ASC) SLT Model Eye x1 (Altenbernd, Alvernon) Alcon Phaco and MIGS Wet Lab J&J/Hunter, Alvernon)	Artificial Eyes x4 each (Attending, ASC or OR 9) Alcon Phaco and MIGS 9) Wet Lab J&J/Hunter, Alvernon)	Wet Lab (J&J, Hunter, Alvernon) Alcon Phaco and MIGS (Remedial PRN)

(1) # eyes listed are minimum (3) Program Director monitors at 6-month evaluation
(2) ( ) = supervision and location (4) No human phacos until requirements completed

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, 3rd 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 you 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: www.vjcrs.com and the passkey is 2389.

REQUIRED AND RECOMMENDED READING

Required Reading

1. Steinert RG, ed. *Cataract Surgery*, 3rd ed. Saunders, 2010. (Available online through Arizona Health Sciences Library, www.ahsl.arizona.edu.)
2. Chang DF. *Phaco Chop and Advanced Phaco Techniques: Strategies for Complicated Cataracts*, 2nd ed. Slack Inc., 2013.
3. *Video Atlas of Ophthalmology*, 100-page EBSCO eBook from AAO

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 (*Phaco Chop* can be checked out by the program coordinator.)

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 (*Cataract Surgery*; 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

(1) All residents will serve as a surgical assistant on a subspecialty defined, specified number of surgical procedures before primary surgery of a specific procedure can be done.

(2) Pre-operative evaluation of cases scheduled as primary surgical cases must be approved by faculty for all primary surgical cases. In addition, the pre-operative evaluation for the first three primary surgical cases must be done with faculty who will staff the first three primary surgical cases.

Surgical Logs and Evaluation Tool

(1) All residents must maintain their surgical logs and track their rate of surgical complications on the web-based ACGME case log program (mandated by ACGME). **Surgery should be logged within 24 hours of the procedure**. **Failure to have surgical logs up-to-date by the sixth working day of the month, may result in loss of surgical privileges**. Surgical privileges will be restored as soon as all cases have been entered.

(2) Resident cataract surgery skills will be evaluated by a competency-based surgical tool via a Qualtrics survey that will be emailed to the attending on the day of surgery. The attending will grade the surgery from 1 to 4.

1 is novice status with little or no experience and considerable attending assistance required.
2 is able to perform some steps.
3 is able to perform most steps but attending presence was necessary.
4 is the target indicating that the procedure could have been performed independently and the attending presence was a formality.

Additionally, the attending will provide descriptive feedback for the surgical session. The Program Director will monitor progression and update the residents regularly with reports of the surveys. If progression has stalled or the rate is suboptimal then the faculty overseeing the procedure(s) will be notified and additional wet lab practice will be assigned.

(3) At SAVAHCS, residents are expected to videotape all cataract surgery in which they act as the primary surgeon (using the recording equipment provided with the Leica Operating Microscope). In addition, at least one of the surgical videos must be reviewed and discussed with the attending surgeon for each surgical session (i.e., cataract surgical block). One video every two months (six total) must be submitted to the program coordinator for placement in the resident's file. When possible, surgical videos submitted should be reviewed by at least two attending surgeons to ensure a diversity of surgical experience and to benefit from varied expertise of attending surgeons.

(4) At SAVAHCS, residents will strive to maintain a cataract surgery complication rate of less than 5%. As a general policy, two complications in any 10 consecutive cataract surgeries will result in a remedial plan for that resident. This will be decided upon by the VA Site Director with input from the attending surgeons. The remedial plan will involve practice in the wet/dry labs with some direct observation by one or more attending cataract surgeons.

C. **Continuous Quality Improvement**

Residents are encouraged to participate in the continuous improvement process in the Department of Ophthalmology. One quality improvement project that involves all residents is an individualized surgical plan for tracking surgical complications and continued improvement (Dr. Altenbernd). The Chief Resident, or his designee, should attend the clinical faculty meetings to provide input about the residency program. Semi-annual resident/faculty meetings are held to provide direct input about the program to the Program Director and Department Head. Furthermore, residents review

the teaching program electronically on a semi-annual basis. The Program Director will meet with the residents on a monthly basis. In addition, several additional, informal meetings will take place throughout the course of the year at the conclusion of rounds to address specific program issues in a timely fashion. There is also an annual review of the program by a committee consisting of the residents, Program Director, faculty members, and program coordinator.

Residents may bring up issues anonymously. The Chief Resident may bring up issues at faculty meetings, preserving the anonymity of the source.

13. ATTENDANCE POLICY

A. Clinic/Surgery

Clinics begin at 8:00 a.m. and 1:00 p.m. at the Alvernon Clinics and SAVAHCS. Residents are expected to remain at the clinic unless excused by the supervising faculty. Residents are to be present five minutes before the start of each clinic.

The resident is expected to be in the operating room and dressed appropriately before the scheduled start–15 minutes at BUMCT and 30 minutes at SAVAHCS. In addition, residents should perform a check of laboratory and diagnostic tests, review and update the history and physical, if necessary, review the informed consent, and review any unusual lens calculations with the attending at least 48 hours in advance of the surgical case. Also, some of the surgical attendings wish to review cases prior to the surgery; others are content to review the surgical cases in the pre-op area the day of surgery. Please consult each surgical attending for their desired policy. The day of surgery, laboratory tests, consent form, surgical site, and lens calculations should be rechecked upon arrival to the operating room. At SAVAHCS, if everything is in order, the resident will proceed to enter a pre-operative note in CPRS, which the attending must review and then enter an addendum that indicates he/she agrees with the resident's findings. If the resident is late to surgery, they may lose one or more primary cases at the attending's discretion.

It is BUMCT and SAVAHCS policy that the pre-operative history and physical be completed by a member of the operative team. If the physical was performed by an outside physician, it should be reviewed and cosigned by a member of the surgical team.

B. Conferences

All residents must attend **ALL** scheduled Department conferences unless on vacation, sick leave, or involved in emergency patient care (emergency call or emergency consults).

Residents are required to attend 100% of all lectures except for vacation, sick leave, emergency call, post call, or the senior resident who is in surgery at the VA on Friday morning. Attendance at all conferences, etc., must be **PROMPT**; tardiness (more than 15 minutes late) Three (3) unexcused tardies per semester will result in a warning and additional unexcused tardies will result in probationary status.

Scheduled educational activities take precedence over all clinical activities; a resident may not be called away from any teaching activity for the delivery of patient care except in the case of an emergency which cannot await the conclusion of that activity or prior approval is given. If approval

is given for events such as VA surgery, then the excused resident must inform the faculty lecturing, the Program Director and the program coordinator.

Rounds are held on Wednesday mornings from 7:00 to 8:30 a.m., except for the first Wednesday of each month (QIPS). Lectures are held on Friday mornings from 7:00 to 11:00 a.m., and other times as scheduled. **Residents are required to submit the title of their rounds' presentation, as well as the objectives/learning objectives, to the program coordinator on the Wednesday prior to the date of their presentation. On the date of the presentation, the residents must save a copy in their electronic portfolio.** ***Guest Speakers***: Residents may recruit guest lecturers, with approval of the CME Director (Dr. Ghahari). The name and contact of the speaker must be provided to the program coordinator at least two (2) weeks in advance of the presentation so documentation can be obtained and approved by the CME Office. The resident should contact a subspecialist within the department pertinent to the case being discussed. Ideally, the faculty would have seen the patient. A brief discussion with the faculty should be undertaken as well as sharing the presentation. The goal is to involve as many faculty members as possible in the discussion and to share collective management pearls.

14. TIME OFF

A. Vacation

(1) Banners grants annual paid allowance of four weeks per year to residents. This time off must be used during each 12-month appointment (July 1 through June 30). If all 20 days are not used, the time **cannot** be carried over to the next year.

(2) Vacation must be taken in non-consecutive blocks of 5 days from Monday through Friday. Exceptions may be made for fellowship or job interviews taken as individual vacation days. Although not encouraged, an exception may be made for a 5-day block outside Monday through Friday (such as Thursday through Wednesday of the following week). Residents will not be assigned to weekend call either immediately before/after their vacation week. Other exceptions would be using time accrued from holiday compensation or when the remaining days are not multiples of five.

(3) Four residents (one per year) may be on vacation at a given time. Exceptions may be made for PGY-4 residents for fellowship/job interviews.

(4) Each resident must take one week during each quarter of the year (July through September, October through December, January through March, April through June). The week that includes Christmas is counted as a week in December. The week that includes New Year's counts as a week in January. Exceptions must be approved by the Program Director.

(5) Residents may not take the last week of one quarter and the first week of the next (for example, the last week of September and first week of October).

(6) Consecutive weeks of vacation may not be taken during 2-month rotations, such as pediatrics ophthalmology and general ophthalmology.

(7) Vacations scheduled while at SAVAHCS must be discussed and approved by the Section Chief of Ophthalmology and Program Director. **Cancellation of VA clinics must be submitted at least 45 days in advance.**

(8) Residents must submit all vacation requests to the Chief Resident by June 15 for August through December and November 19 for January through June. Vacation changes may be made with the approval of the Program Director.

(9) All vacation requests for individual vacation days must be submitted by April 1, 2025. For example, a resident uses 3 days of vacation for the week of Thanksgiving, leaving 2 individual vacation days. Requests for the 2 individual days must be submitted by April 1. **If the vacation day will involve a VA clinic, cancellation of the VA clinic must be submitted at least 45 days in advance.**

(10) ***Priority System***: Chief>PGY-4>PGY-3>PGY-2>PGY-1 when selecting weeks of vacation. Conflicts are resolved by the current Chief. The Program Director has final say over all vacation requests.

(11) ***Blackout Periods***

a. No vacation during July.
b. No vacation during the consults rotation.
c. No PGY-2 or PGY-3 vacations during the AAO meeting (October 18-21, 2024) since the senior residents will attend the meeting.
d. A resident may take vacation around resident interviews but must be present for the interviews (December 13-14, 2024).
e. Residents may take vacation the week of mock exams (TBD), but must participate in the orals, which are held on Saturday morning.
f. If a resident plans to take vacation during the week prior to or after the OKAP exam (March 13-14, 2025), he/she still must take the exam at the assigned time.
h. No PGY-2 or PGY-3 vacations during the month of June.
i. No vacation on Residents' Day (TBD).
j. Senior residents are encouraged to use vacation during the interval between Residents' Day and June 30. Residency ends at the completion of the work day on June 30. **If the resident wishes to leave before June 30, he/she MUST reserve vacation time for that purpose**.
k. A resident may take vacation the week of the LASIK (TBD) and Phaco (TBD) wet labs held by Dr. Hunter, as well as the wet lab by Alcon (Ann Pham), but must participate in the wet labs.

(12) Residents who have already taken vacation during a holiday may not take vacation during that time again in the future, until all residents have had the opportunity to choose vacation during that time.

(13) Residents must use vacation to take the USMLE Step 3 examination.

B. **Sick Leave**

Residents are allowed a maximum of five (5) days per calendar year. Sick leave is available for medical care or mental/physical illness, injury, or health condition and a public health emergency, as

well as absence due to domestic violence, sexual violence, abuse, or stalking. Sick leave should be reported to the Chief Resident who will notify the program coordinator. The Chief Resident will be responsible for notifying the attending(s) and appropriate staff connected with the rotation assigned to the sick resident. He/she will make arrangements to cover the sick resident's duties as completely as possible. Sick time should be entered as "Personal Time Off/Sick Time" in work hours in New Innovations.

If a resident is sick for three consecutive days, the resident must provide a physician's note to return to work. If a note is not provided, the days the resident was out will count as vacation.

C. **Leave of Absences**

- ***Medical, Parental, and Caregiver Leave (ACGME Paid Leave)***: All residents are entitled to 6 weeks of paid medical, parental, and caregiver leave once and at any time during the program, effective day one of the program. Residents will be provided with a minimum of one week of paid time off reserved for use outside of the first six weeks of the first approved medical, parental, or caregiver leave(s) of absence taken.

- ***Family Medical Leave (FML)***: Residents may qualify for leave under the Family Medical Leave Act (FMLA). To be eligible to request this FML, the residents must have been a Banner employee for at least one year and has worked at least 1,250 hours in the 12-month period previous to the FML leave request. This leave runs concurrently with the 6-week total medical, parental, or caregiver leave that is available to residents during their program.

- ***Maternity Leave***: Residents are eligible for up to 6 weeks of paid maternity leave effective day one of employment. There is no waiting period (no sick leave of vacation time needs to be used).

- ***Personal Leave of Absence***: Residents are eligible for up to 12 weeks of personal leave of absence effective day one of the program. Residents will be required to use sick time and vacation time first; otherwise, it is unpaid. This leave is likely to impact the completion of the program.

Residents should contact the Program Director to provide information regarding the impact of an extended leave of absence upon the criteria for satisfactory completion of the program and upon eligibility to participate in examinations by the certifying board.

Residents must complete and submit a "Leave of Absence Documentation Form" to the Program Director for signature and copy to the program coordinator. To apply for benefits, contact Matrix at (888) 295-7840 or go to their website at www.matrixabsence.com.

D. **Bereavement Leave**

Residents may take up to three paid working days as bereavement leave for immediate family and one day for other family members. This leave is available day one of employment. Residents must obtain approval of the Program Director.

E. **Holidays**

Residents have six (6) holidays per year: Independence Day, Labor Day, Thanksgiving, Christmas, New Year's Day, and Memorial Day. Residents who cannot be excused from their duties on a designated holiday will be granted another day off. The resident must notify the program coordinator of the date they will be off in place of the holiday within 10 days of the holiday worked. This "alternate" day must be one entire day.

There are SAVAHCS holidays that are not observed at Banner. On these holidays, such as Columbus Day and President's Day, all residents will be assigned to the Alvernon clinic or academic time. If a resident is taking the day off and/or is out of town, vacation must be taken.

F. **Academic Time**

Occasionally, residents will have unscheduled time due to the unforeseen need for a faculty member to cancel clinic or surgery. Residents at Alvernon clinic must attempt to contact the faculty member to whom they are assigned to determine if that faculty member has any "duties" they wish the resident to complete (and the Chief Resident should be notified.). If the faculty member cannot be contacted, the Chief Resident will make the resident assignment. (At least one resident must remain at the Alvernon clinic at all times.) At SAVAHCS, a similar protocol will be followed except that the Section Chief should be involved in the decision to assign the resident a duty. Only if cleared by the faculty member and Chief Resident (and Section Chief at SAVAHCS) can the resident be excused from duties and be allowed to spend time in the Alvernon resident area (but must be available by pager).

G. **Education Time**

Residents are granted educational days for attending courses or conferences. Typically, this includes AAO for senior residents, and a review course for the PGY-2 and/or PGY-3 residents. Educational time will also be extended to residents presenting at national conferences, if pre-approval is received from the Department.

15. RECORDKEEPING

A. **Surgical and Clinical Logs**

Every resident must maintain a log of all surgery he/she participates in. This log shall be kept in accordance with the definitions of surgeon or assistant as established by ACGME and must include:

(1) Diagnosis
(2) Procedure
(3) Surgeon or Assistant

All surgical information is entered by the resident into an online database (Resident Case Log System) maintained by the ACGME (www.acgme.org).

Under no circumstances are patient names or chart numbers to be included in this log; this protects the patient's confidentiality. Residents should, however, keep operative notes for their own records and information (complications, special management considerations, etc.).

Surgical summaries are made available monthly and at the end of the academic year (June 30) to the Program Director and respective resident. Residents are responsible for checking the accuracy and completeness of the statistics. Surgical summaries are available and discussed with the Program Director at the semi-annual reviews. The resident receives a copy of the final summary upon completion of the program.

Clinical logs are maintained to record the **number of patients** the resident sees each week. The resident should note how many patients are seen by subspecialty clinic, as well as the number of emergency patients. The resident enters the information into an Excel file located in their resident Box folder. The program coordinator prints out quarterly clinical log sheets for each resident for signature.

Maintenance of the surgical and clinical logs is the ultimate responsibility of each resident; it is impossible to assemble the log retrospectively. Timely maintenance of the surgical and clinical logs is monitored by the program. The surgical log is a requirement for Board eligibility. Surgery should be logged within 24 hours of the procedure. Clinical logs at minimum should be entered on a weekly basis.

A signed copy of the final completed log is provided to the resident upon their completion of the program.

B. Conference Attendance Log

The Department maintains current and permanent records of all conferences, lectures, rounds, and journal clubs. This record shall contain all of the following:

(1) Date and time
(2) Number of hours
(3) Topic(s) hour-by-hour
(4) Title of lecture
(5) Lecturer/conference leader
(6) Topic for all rounds presentations and path signouts
(7) Resident attendance
(8) Faculty attendance for QIPS and rounds

Sign-in sheets are provided for all lectures via email, and each resident in attendance must complete and return in a timely manner.

Patients presented and discussed for a QIPS Conference will be recorded by the faculty member in charge of the QIPS Conference 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.

16. **FACULTY ADVISOR**

Each resident will choose a faculty member (either full-time, part-time, or affiliate/associate "volunteer") to serve as a faculty advisor. The Program Director and Department Head are not eligible to serve as a faculty advisor. The resident should meet **at least twice a year** to keep the advisor apprised of career goals, progress in the residency, and difficulties as they arise. This advisor will serve as the resident's advocate. The faculty advisor can be changed by the resident, if necessary. Second year (PGY-2) residents should choose an advisor within their first three months of the academic year (by October 1). Residents must inform the program coordinator of their faculty advisor.

In November and May, each resident must complete a mentoring plan (self-assessment and self-reflection) (Forms, pages 34-37) to identify their strengths, deficiencies and limits in knowledge and expertise, as well as set learning and improvement goals. Then, the resident must meet with their faculty advisor to discuss their self-assessment, at which time the assessment will be signed. The signed assessment must be submitted to the program coordinator by the deadline on the 6-month checklist. The assessment will be reviewed with the Program Director during the 6-month evaluation (January and June). The PGY-4 resident must complete the mentoring plan for their final review, but it does not have to signed by their mentor.

17. **RESIDENT EVALUATION OF FACULTY, PROGRAM, AND ASSIGNMENTS**

A. **Faculty**

Residents evaluate the full-time clinical faculty twice a year via New Innovations (www.new-innov.com). Research and affiliate/associate ("volunteer") faculty are evaluated once a year (May/June). Resident evaluations of the faculty are anonymous (no one can see who submitted the evaluation).

In December and June, each resident will participate in an evaluation of individual full-time clinical faculty in the areas of:

(1) Clarity of lectures
(2) Completeness of curriculum
(3) Effectiveness of lectures
(4) Organization of material
(5) Suggested improvements

The evaluations will not be submitted to individuals other than the Department Head and Program Director. A sample of the evaluation form for clinical faculty is found in the Forms section (pages 40-41).

B. **Program**

Residents evaluate the overall residency program twice per year. A six-month evaluation of the program is completed in November/December (Forms, pages 42-43) via New Innovations (www.new-innov.com). In April/May, residents complete an annual review of the program (Forms, page 39) via New Innovations. Both evaluations are mandatory and anonymous (no one can see who submitted the review). The data is summarized into a single report that is provided to the Program Director and Program Evaluation Committee for review.

C. **Rotation**

Pre-Rotation Review: At the beginning (within the first week) of each rotation, the resident is required to review the goals and objectives for that rotation together with the attending, and confirm that they have done so online through New Innovations (see "Confirming Curriculum" in the Appendices for instructions). The confirmation must be done within the first week of the rotation.

Evaluation: At the end of each rotation, the faculty will review the resident's performance via New Innovations (www.new-innov.com). Once the faculty has completed the evaluation, the resident will be notified that the evaluation is available for review and signature.

18. FACULTY EVALUATION OF RESIDENTS

Each resident will meet at least twice a year with the Program Director for a formal evaluation of the resident's performance. A sample six-month resident evaluation by the faculty is found in the Forms section on pages 27-33. After the faculty complete an evaluation of the residents via New Innovations, the information for each resident is summarized into a single report and provided to the Program Director. The evaluation will be signed by both the resident and Program Director during the six-month evaluation.

All evaluations will be shared with the resident in a confidential conference; strengths, deficiencies, and plans for the correction of deficiencies, if they exist, will be discussed. An **appeals** mechanism is provided for a resident should he/she feel that the evaluation is inaccurate or unfair. To this end, the resident may request a formal meeting with the Program Director, any or all Department faculty members, and his/her faculty advisor. If the Department Head and/or Program Director then reviews and changes the evaluation, the prior evaluation will be destroyed.

In addition, at the end of each monthly rotation and quarterly (July-September, October-December, January-March, April-June) for other rotations (such as continuity clinic and senior rotations), the faculty will evaluate the resident's performance during the rotation. In the last few days of the rotation, the resident is responsible for meeting with the faculty and having an evaluation completed for that rotation. After the evaluation is completed by the faculty and signed by the resident in New Innovations, the evaluation will be printed by the program coordinator and provided to the Program Director for review at the resident's six-month evaluation. Sample rotation evaluation forms are found on in the Forms section (pages 1-33).

It will be the responsibility of the senior resident at SAVAHCS to videotape each one of his/her surgical cataract cases; at least one of these per operative session will be selected to be reviewed by the attending surgeon that same day, either between cases or at the end of the surgical session. The resident must submit one recorded case per each quarter (July-September, October-December, January-March, and April-June).

19. OTHER EVALUATIONS OF RESIDENTS

In addition to the faculty evaluations, the residents are evaluated by technicians and patients. The technicians complete an evaluation via Qualtrics (Forms, page 45) on a semi-annual basis. The

evaluation is anonymous and the program coordinator will print a single report summarizing the information and provide to the Program Director. The summary is reviewed at the resident's six-month evaluation with the Program Director.

Patient surveys are available for completion via a Qualtrics survey (Forms, page 38). Copies of all questionnaires are available for review at the resident's six-month evaluation with the Program Director.

20. ORAL AND OKAP EXAMINATIONS

A. Oral/Written Examinations

The PGY-2, PGY-3, and PGY-4 residents will participate in one mock oral examination in the spring. The topics tested include anterior segment/optics, cornea/uveitis, glaucoma, neuro-ophthalmology, oculoplastics, pediatric ophthalmology, and posterior segment. The residents will participate in a written examination each year (March). The Program Director will receive a written summary of each resident's performance, and will discuss the results of the exam with each resident individually.

B. OKAP Examination

All residents participate annually in the Ophthalmic Knowledge Assessment Program (OKAP) given by the ABO. The examination is taken at an authorized examination site. The results of each resident's examination will be used as one of the criteria for performance measurement.

Individual scores will remain confidential, known only by the Department Head, Program Director, and respective resident. The results will be used by the Program Director as one of many criteria in evaluating resident performance. In addition, the results will be used by the Department in identifying programmatic strengths and weaknesses. Each resident will meet with the Program Director to discuss the results of their exam.

The OKAP examination reports individual subject scores, overall scores, and "core knowledge" scores as a percentile for all residents at the same level of training. If the resident scores below the 30th percentile on the overall OKAP exam, the resident will be required to read all subsections in which the score was below the 30th percentile. If the resident performs in the 30th percentile or greater on the overall exam but below the 30th percentile on an individual subsection, the resident will be required to read the subsection in which the score was below the 30th percentile. The resident should meet with the faculty member who is responsible for the subsection. During the meeting, the resident will develop a written plan for study, along with a schedule of readings. The resident will be referred to Dr. Brenna Scherer, (Will find out who is doing this now) the GME learning specialist, to develop a plan for self study. **The resident who has an overall score below the 30th percentile on the OKAPs are forbidden from moonlighting.**

Residents scoring above the 75th percentile in an individual subsection will be recognized for their achievement by notification of the faculty member responsible for that area and the Department Head.

21. CLINICAL COMPETENCY COMMITTEE

The Clinical Competency Committee (CCC) will review all resident evaluations semi-annually (October/November and March/April). The CCC is also responsible for advising the Program Director regarding resident progress, including promotion, remediation, and dismissal, and for preparing and assuring that the milestones for each resident are reported to the ACGME semi-annually. The CCC consists of at least three full-time program faculty at the SAVAHCS or Banner. .

22. PROMOTION (ADVANCEMENT)

Residents are advanced to positions of higher responsibility on the basis of evidence of their progressive scholarship and professional growth. This evidence includes satisfactory completion of rotations, documented attendance at educational activities, and an assessment of the resident's progress in achieving competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice. This advancement is communicated to the GME Office by the annual submission of a promotion letter or final evaluation (for graduating residents).

23. PROBATION AND DISMISSAL

In the event that a resident's overall progress is considered to be "unsatisfactory," he/she shall be placed on **probation or given a Letter of Concern** but only after full consultation with the Department Head, Program Director, and faculty.

Probationary status and Letter of Concern shall be acknowledged in writing and accompanied by goals and objectives to be achieved in a reasonable amount of time (but in no case, greater than 6 months). If the identified deficiencies are not remedied during this period, the resident may be subject to dismissal; the **appeals** mechanism noted in Section 18 and all the College of Medicine appeals mechanisms shall pertain should they be desired by the resident.

The UA College of Medicine Resident Physician Probation Procedures, Nonrenewal Procedures, and Suspension and Dismissal Procedures are kept on file (see program coordinator).

Time spent on probation will be made up at the discretion of the Program Director. A resident may be immediately pulled from surgery and put on probation if he/she is felt to pose a risk to patients.

24. PRACTICE PRIVILEGES AND OTHER ACTIVITIES OUTSIDE THE EDUCATIONAL PROGRAM (MOONLIGHTING)

Moonlighting is discouraged because it detracts from the educational activities within the Department of Ophthalmology. Exemptions may be granted by the Program Director, in special circumstances. **Moonlighting may be done by a resident ONLY after consultation with the Program Director and Department Head. PGY-1 and PGY-2 residents are not eligible for moonlighting.** After approval, the Program Director may suspend the resident's privilege to moonlight immediately if the resident is not meeting residency expectations or it is deemed necessary for the resident's progress, including meeting

all educational, service expectations and requirements of the residency. Moonlighting without permission is prohibited and is grounds for suspension and/or dismissal.

The resident's training license will not apply to moonlighting activities. Residents involved in moonlighting must have an unrestricted, independent Arizona license to practice medicine and a personal DEA number prior to engaging in moonlighting activities. A resident moonlighting without these credentials is subject to criminal and civil penalties that could result in permanent exclusion from the practice of medicine nationally in the future. Malpractice and general liability coverage supplied by Banner Health will not apply to moonlighting. Residents must arrange for their own malpractice and general liability insurance to cover their moonlighting.

Under no circumstances will a resident be excused from residency rotations to moonlight. Schedule changes or re-arrangements for the purpose of allowing moonlighting are not permitted. Per ACGME regulations, moonlighting hours both internal and external are additive to duty hours. A resident who violates duty hours due to moonlighting or fails to truthfully report duty hours will have moonlighting privileges withdrawn for the remainder of residency training.

Residents who have received an overall score below the 30th percentile on their OKAPs, have received a "notice of deficiency," or are on academic probation are forbidden from moonlighting. Residents who do choose to moonlight must keep a log of their hours and report them to the program coordinator weekly, as well as enter the hours into work hours in New Innovations.

Hours spent moonlighting are counted toward total duty hours and may be limited if total allowable hours worked in a given period is exceeded. All moonlighting hours MUST be recorded in your duty hours.

25. **BOARD ELIGIBILITY**

For a resident to be considered Board eligible, the Department Head must certify that the resident has satisfactorily completed the prescribed length of residency training, which is 36 months in addition to the PGY-1. The resident must also hold a valid and unrestricted license(s) to practice medicine in the United States. For details, see the ABO website (www.abop.org).

In the event that a resident has been placed on formal probationary status, the Department Head will consult with the Program Director and Department faculty to determine whether the time on probationary status shall be counted toward the Board of Ophthalmology's time requirement. Typically, time accrued while a resident is on official probation is **NOT** considered time "in good standing" in the program and is **NOT** usually applicable to the required months of training. Additional training may be deemed necessary prior to granting certification of satisfactory completion of the residency program. The resident shall have the right to appeal as noted in Section 18.

26. **COMPLAINTS REGARDING WORK ENVIRONMENT**

The Graduate Medical Education Office and the Graduate Medical Education Committee strive to create an environment where residents can raise issues confidentially and without fear of retaliation. To this end, residents are provided several avenues in which they may communicate and exchange information on their working environment and their educational programs. First of all, residents are encouraged to

discuss all issues with their Program Director, faculty mentor/advisor, Chief Resident and/or Department Head. Concerns can also be reported to the resident ombudsmen, Arko Ghosh and Jonathan Han, or the faculty ombudsman, Dr. Cori Jones, or anonymously via Qualtrics. Concerns submitted via Qualtrics are reviewed by Dr. Jones. **Residents are encouraged to contact the GME Office at 626-7878 with any concerns about their ability to confidentially raise issues**.

27. COMMITTEES

Residents are encouraged to participate in hospital committees. Each year, the residents select a representative and alternate to serve on the Graduate Medical Education Committee, an institutional committee charged with the responsibility of monitoring and advising on all aspects of residency education. Residents interested in participating in a committee should contact the program coordinator for information.

28. ACADEMIC SUPPORT WITHIN GME OFFICE

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

- In-Training Exams
- Specialty and Subspeciality 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.

29. COUNSELING SERVICE

A counselor is available to discuss any issues of a personal or professional nature for residents and their families at no charge. To schedulean appointment with Dr. Julie Demetree (psychiatrist/telepsychiatry, julie@drdemetree.com) or Dr. Margery Johnson (housestaff counselor, psychiatry/telepsychiatry, Margery.johnson.md@gmail.commailto:) complete the online request form (link to form at https://mentalhealthservices.medicine.arizona.edu/services/residents-fellows) or contact the provider directly. For any emergencies or crises, please contact the Crisis Response Center at (520) 622-6000, CAPS Crisis Line at (520) 621-3334, call 911, or go to your nearest Emergency Department.

30. **DRESS CODE**

At times when patient contact is anticipated, residents must dress and present themselves in a manner which is appropriate to the profession of medicine. Residents are expected to wear recently laundered white lab coats at their faculty's instruction, and name tags at all times while in the clinic. Residents should follow the general guidelines addressed in the Banner policy (see appendices; also available in the public resident files folder in Box). Lab coats and laundry service for these coats are provided.

31. **LACTATION ROOM**

- BUMCT: There are lactation rooms in the hospital on each floor--Rooms 1229, 3703, 4703, 61419, 71419, 81419, and 91419.

- BUMCS: There is a lactation room on the 5th floor of the main hospital—Room 5403, as well as in the ED near fast track waiting. Contact Security for access.

- SAVAHCS: Lactation rooms at SAVAHCS are in Building 2, Room N191 and Building 60, Room E111.

- 655 Alvernon: There is a lactation room in the faculty area, Room 206H.

32. **ADMINISTRATIVE SUPPORT**

A secretary is not appointed for the residents, but administrative assistance is available as follows:

A. **Computer Issues**: Computers with software for word processing, graphics, presentations, and Internet access are available for use by residents in the resident area (suite 208). Residents are expected to prepare their own documents. If problems occur with the computers or printer, please contact UA IT at 626-8721, or notify the program coordinator.

B. **Poster Printer**: A printer is available for printing research posters. The maximum size for a poster is 36x56. When the document is ready for printing, submit the file to the program coordinator via email or USB drive. Posters larger than 36x56 will need to be printed elsewhere. Printing costs must be approved in advance.

C. **Travel**

- ***Travel Authorization***: All travel, including attending AAO or national conferences for presentations, must be authorized in advance. To be eligible for reimbursement for travel expenses, residents must submit the following information to the program coordinator: (1) name and dates of conference/course, (2) planned airline itinerary, (3) name and address of hotel (note if you are staying at the conference hotel), and (4) dates of personal time before/after the conference/course. **This information must be provided at least 30 days in advance to allow time for the travel to be authorized**. Travel expenses are not eligible for reimbursement if authorization was not obtained in advance. Reimbursement for lodging and meals will be based on UA guidelines. The program coordinator can provide this information.

- Per University policy, there will be **no** reimbursement for alcoholic beverages.

- **Residents can ONLY be reimbursed for their OWN expenses**.

- ***AAO***: PGY-4 residents who attend the AAO annual meeting will be granted up to three days of educational leave, and up to $1,200.00 for reimbursement of eligible travel expenses and early registration. Residents must use vacation for any additional days for this conference (not eligible for educational days). Residents must submit receipts for eligible travel expenses to the program coordinator within 30 days after their return. Receipts not returned within the deadline will not be reimbursed. Note that the program coordinator can book airfare with the department credit card if you wish to avoid waiting for a reimbursement.

- ***Conference Presentations***: To be eligible for reimbursement for travel expenses up to $1,200 and early registration to present at national conferences, pre-approval must be obtained from the Department and the travel must be authorized in advance. Residents must submit receipts for eligible travel expenses to the program coordinator within 30 days after their returns. Receipts not returned within the deadline will not be reimbursed.

- ***Travel Between Sites***: Reimbursement for mileage for travel between sites is available from Banner. Please complete the Personal Vehicle Mileage Form found on the Banner Health Intranet by going to Tools & Services, Forms, and then Finance or use the link in the Find a Form section: Finance Forms. Complete, sign, and submit the form to the program coordinator for processing.

D. **Departmental Purchases**: Any purchases (such as wet lab materials) that will be paid for by the Department must be approved by the Program Director. After approval is received, the purchase request must be submitted to the program coordinator who will inform you of purchase requirements (purchase order, credit card, etc.). Be sure to plan ahead, since it could take a couple of weeks (or longer) to get the paperwork processed before the purchase can be authorized.

33. POLICIES SPECIFIC TO INSTITUTION

A. BUMCT AND BUMCS

(1) 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 <u>abnormal</u> 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.

(2) Department of Anesthesiology Guidelines for Patient Preoperative Preparation

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

(3) **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.

B. Alvernon Clinics – Clinical Expectations

(1) General Ophthalmology – Dr. Roy Swanson

The ultimate goal during your residency is to become the best comprehensive ophthalmologist possible, whether or not you pursue subspecialty training. It is imperative that you develop the core skills of comprehensive ophthalmology, since this will prepare you to start practicing right after graduation or to maximize your potential during fellowship training. During this rotation you will have the opportunity to care for a diverse set of patients, triage a variety of problems, coordinate care with other specialties/subspecialties, and participate in cataract surgery. Patient care will be our priority, above everything else. Due to the volume and diversity of patients that we will care for, you will have a well-rounded clinical and surgical experience. This rotation is not a shadowing experience. We will not be relying on passive learning; you have to spend your own time on passive learning. This will be as hands-on as possible. We will be taking care of OUR patients. Every day I work as hard as I can to have my patients, so it is up to you to make them YOUR patients. What you achieve during this rotation will be directly proportional to your work.

The following are basic expectations that I have for an ophthalmology resident:

- You have worked extremely hard to enter an ophthalmology residency, and you are eager and excited to learn and work hard.
- You will treat every patient and staff member with utmost respect. I also expect utmost respect during any type of communication while coordinating care for our patients.
- You have internal drive and self-motivation to perform well and learn as much as you can.
- You are reading and learning outside of clinic/OR.
- You will acknowledge feedback and develop accordingly.

Clinic

We have a substantial volume of patients with a diverse set of problems in clinic. Our goal is to provide thorough and comprehensive care. We will diagnose and treat as much as we're able to, and we will triage/refer appropriately. I want you to see as many patients as you can.

Ideally you will complete your history/exam, develop your assessment/plan, and present the patient to me. We will see patients in parallel and/or together. If a patient is ready, please

start seeing them. You will then join me in the room that I'm in, I will join you, or you will continue seeing patients if we have multiple people waiting. If there are multiple patients waiting to be seen, and especially if you notice we are falling behind, please bring them into a room from the waiting area and work them up. If you see a patient, I expect you to write a complete note and edit it accordingly once we see the patient together.

As a PGY-4 try to imagine yourself taking care of our patients on your own. At this time, you should be able to handle most if not all the patients that we see. Our assessments and plans should be very similar. As a PGY-2, focus on developing a systematic approach to every patient, develop a reasonable differential, and start developing a plan for each patient. There is no substitute for seeing a lot of patients with diverse pathology, and I hope that this clinic provides you with that kind of experience. You will learn a lot from seeing, doing, troubleshooting, and working hard.

The key to success in our busy clinic is to develop a systematic approach to the history and exams. Your goal is to integrate yourself into the clinical flow and become part of the clinical team. A great part of what you're learning is also about managing a clinic and developing an efficient patient flow.

Certain aspects of the exam are especially important in general ophthalmology:

- Pupillary exam is one of the most important ocular vital signs, and I expect you to hone your pupillary exam skills during this rotation. The techs know that I prefer to be interrupted to check on patients' pupils, and eventually I will trust you to do this on your own. Please take extra care if there is any concern about a RAPD, if the diagnosis can cause pupillary abnormalities, or if we encounter a patient with profound vision loss. You will also learn how to check for a RAPD by reverse.
- Best corrected visual acuity is also an extremely important concept, which means we need to ask about glasses, measure glasses, have at least an auto-refraction, and a full refraction if necessary. It is important to develop a sense about which conditions and severity of conditions can cause different levels of decreased vision, since this will determine urgency and how we treat or investigate further.
- Patients with strabismus, I expect you to take measurements with prisms, check versions and ductions. Understand the differential for different patterns of strabismus, comitant vs. incomitant, when to refer, when to order imaging/labs.

Clinic will be very busy. There are many things that need to be done to care for every patient. I don't know what "scut work" is. I just know what "work "is, and there is plenty of it during clinic. There is always something to be done. If you are examining a patient, I will be helping with note taking, placing orders, preparing consent forms, writing instructions for patients, walking across clinic to sign up patients for testing, bringing the eye drops that we need, setting up instruments for a procedure, etc. I expect that you will do the same. These tasks are not to please me; they are tasks that need to be completed to take care of our patients. If I'm willing to do these things, I absolutely expect you to do these things too. I expect that you will work hard and make yourself a part of the team by chipping in whenever you can. I don't like being micromanaged and I don't enjoy micromanaging. I find it very uncomfortable to remind others to take care of our patients. My default is to take on whatever task needs to be completed instead of ordering you to do it.

In the future, you will be the leader of your clinic. You need to be able to do every task that your team members do for you.

- These tasks include auto-refraction, lensometry, pachymetry, tonometry with all the available devices, OCT, fundus photos, HVF, refraction, working up a patient, etc. You absolutely need to know how to do all these things, because in the future you will be asked to troubleshoot anything that needs to be fixed or redone, and when clinic is very busy you will have to take on some of these tasks.
- There are no tasks that are beneath us. The techs and staff are not here to serve us; they are our teammates. If you are standing with your arms crossed and/or looking at your phone while everyone else is working hard and running around, you should get moving and help with whatever needs to be done.

On the first day of the rotation, copy all my auto-text phrases in Cerner. I will walk you through it if you haven't done this before.

Operating Room

We will be performing cataract surgery together during this rotation. I hope this is one of the highlights of this rotation. My goal is to be as generous as possible and hand down cases as much as I reasonably can, however, I expect you work hard and earn your cases. It is our privilege that patients trust their eyes to us during surgery, and I expect you to take this responsibility with the respect that it deserves.

- My expectation is that you take the time to prepare for our surgeries by reading, watching videos, and practicing in the wet lab. During your first month with me as a PGY-2, we will go to the wet lab together to practice key steps of cataract surgery the Friday before surgery.

- Get into the habit of pre-charting the patients that we'll be operating on. I have my own method, and I'm happy to walk you through it. You will see my excel table printed for each OR the day of surgery, which you can use as an example. Start doing this for every OR day.

- During surgery days we will have a PGY-4 and a PGY-2. As a PGY-4, you will complete cases from start to finish. As a PGY-2, my goal is for you to experience every step of cataract surgery except capsulorrhexis by the end of PGY-2.

As in clinic, there are many things that need to be done on surgery days. Remember this is a hands-on experience, and this includes the time before and after surgery. The more efficient we are with perioperative tasks, the better our experience will be during surgery. Tasks that need to be completed:

- Marking the patient, setting up the microscope, setting up the pedals, loading the Callisto data to the microscope for toric lenses, positioning the patient, prepping the patient, helping with equipment during surgeries, etc.

Even if you are not in the surgeon's chair, I expect you to be engaged and actively learning. If you are dozing off or browsing your phone, that tells me you are not interested in what we're doing. Observing me or your peers operate should not be passive, and it is up to you to make this an active learning process. As a resident, you must master learning by observing before you can operate. Look at our hands under the microscope every now and then, pay attention to how we modulate our techniques for different cases, make note of what special equipment is needed, listen to the feedback given to others, learn from others' mistakes.

The work that you contribute to the clinic will directly impact what you do in the OR. You will often operate on the patients that you saw in the clinic. I have to earn my surgeries through hard work, and so do you. I hope that by letting you operate; you will have a stake in the game and feel motivated to work hard in clinic and surgery.

For your convenience here are the formal learning objectives that you will be evaluated on:

Learning Objectives, PGY-2

- Acquires relevant problem-focused history, including outside medical records.
- Performs and documents a comprehensive ophthalmic examination; distinguishes between normal and abnormal findings.
- Performs problem-focused exam with appropriate techniques (e.g., gonioscopy and scleral depression), consistently identifies common abnormalities on examination; may identify subtle findings.
- Orders, performs, and interprets basic testing (e.g., visual field testing, Optical Coherence Tomography, B-scan).
- Describes essential components of care related to office-based procedures (e.g., informed consent, indications and contraindications, anesthesia, sterile procedure prep).
- Administers anesthesia and performs procedure, with direct supervision.
- Recognizes and manages intra- and post-operative complications, with direct supervision.
- Identifies visually significant cataract.
- Demonstrates ability to scrub, prep and drape patient for surgery; performs basic suturing skill.
- Assesses patients for routine cataract surgery.
- Performs elements of cataract surgery in the hands-on surgical skills laboratory and in the operating room (OR).
- Manages common post-operative complications (e.g., post-op pain, high intraocular pressure.
- Articulates knowledge of pathophysiology and clinical findings for ophthalmic conditions routinely managed by non-ophthalmologist.
- Demonstrates basic knowledge of pathophysiology and clinical findings for common ophthalmic conditions routinely managed by ophthalmologists.
- Identifies resources to generate a focused differential.
- Generates a basic differential diagnosis based on patient symptoms and history.
- Generates comprehensive differential diagnosis based on patient symptoms and history; documents and presents differential in oral presentation clearly and concisely.
- Describes diagnostic tests to aid in the differential diagnosis.
- Describes basic concepts of ophthalmic pathophysiology and pharmacology.
- Describes basic ophthalmic anatomy and categories of procedural interventions.
- Explains relevant pathophysiology and lists indications and contraindications for planned medical therapy.
- Explains indications, contraindications, and relevant steps required for procedural intervention (e.g., anesthesia, technique, instruments.

Learning Objectives, PGY-4

- Orders and interprets advanced diagnostic tests and imaging procedures according to evidence-based medicine (i.e., when and when not to order testing).
- Administers anesthesia and performs procedure, with oversight.
- Manages intra- and post-operative complications, with oversight.

- Assesses patients who are candidates for refractive intraocular lenses to correct astigmatism and/or provide near correction.
- Performs cataract surgery requiring complex technical maneuvers (e.g., pupil expander, capsular tension ring).
- Manages complex intra- and post- operative complications (e.g., endophthalmitis).
- Demonstrates advanced knowledge of pathophysiology and clinical findings for uncommon ophthalmic conditions.
- Generates probabilistic differential diagnosis in patients with multiple ocular and medical comorbidities; modifies likely differential with new information from additional testing.
- Articulates the rationale for ordering diagnostic testing in hierarchical fashion based upon probabilistic differential.
- Describes and articulates the rationale for using emerging alternative medical therapies.
- Describes and articulates the rationale for using novel alternative procedural interventions.

(2) General Ophthalmology – Dr. Le Yu

The ultimate goal during your rotation is to learn to function like a comprehensive ophthalmologist by the end of your time with me. Learn to view the entire patient and their eye issues from their refraction needs, cataract evaluations, posterior pathology etc. Please aim to be thorough and thoughtful, especially if the clinic is not too busy or running too behind. For example, pay attention to their manifest refraction (does all that cyl make sense), and always try to explain their vision (2+ NS alone cannot account for a 20/50 BCVA vision). Also, please make sure the notes reflect your findings, thoughts, and test interpretations. You can **bold changes or new text** you're adding to old patient notes.

The following are information about clinic flow and expectations:

- Try to see as many patients as you can while maintaining a degree to thoroughness with exam and notes.
- Do not hesitate to order testing that you think may be helpful (OCT, etc). Be proactive and walk patient to imaging area and sign up the patient.
- You may place punctal plugs and remove sutures if these procedures are indicated in the last notes. Please get a consent and make sure to check for a PA with the business office.
- Edit/write notes. **Bold** your input/addition for old patients.
- Carry all A/P info from previous notes forward, even for postop visits.
- You do no need to present the patient unless there is a specific issue you want to bring to my attention. I will be looking at your notes.
- Please make sure to go back and chart review our shared patients as the clinic goes along or at the end of the day. I will try to highlight differences in exam or treatment but if I don't, you should be doing that yourself.
- You will take part in some surgeries at South Campus along with the chief resident. I will do my best to build upon your intraocular skills during this rotation.

For your convenience here are the formal learning objectives that you will be evaluated on:

Learning Objectives, PGY-2

- Acquires relevant problem-focused history, including outside medical records.
- Performs and documents a comprehensive ophthalmic examination; distinguishes between normal and abnormal findings.

- Performs problem- focused exam with appropriate techniques (e.g., gonioscopy and scleral depression), consistently identifies common abnormalities on examination; may identify subtle findings.
- Orders, performs, and interprets basic testing (e.g., visual field testing, Optical Coherence Tomography, B-scan).
- Describes essential components of care related to office-based procedures (e.g., informed consent, indications and contraindications, anesthesia, sterile procedure prep).
- Administers anesthesia and performs procedure, with direct supervision.
- Recognizes and manages intra- and post-operative complications, with direct supervision.
- Identifies visually significant cataract.
- Demonstrates ability to scrub, prep and drape patient for surgery; performs basic suturing skill.
- Assesses patients for routine cataract surgery.
- Performs elements of cataract surgery in the hands-on surgical skills laboratory and in the operating room (OR).
- Manages common post-operative complications (e.g., post-op pain, high intraocular pressure.
- Articulates knowledge of pathophysiology and clinical findings for ophthalmic conditions routinely managed by non-ophthalmologist.
- Demonstrates basic knowledge of pathophysiology and clinical findings for common ophthalmic conditions routinely managed by ophthalmologists.
- Identifies resources to generate a focused differential.
- Generates a basic differential diagnosis based on patient symptoms and history.
- Generates comprehensive differential diagnosis based on patient symptoms and history; documents and presents differential in oral presentation clearly and concisely.
- Describes diagnostic tests to aid in the differential diagnosis.
- Describes basic concepts of ophthalmic pathophysiology and pharmacology.
- Describes basic ophthalmic anatomy and categories of procedural interventions.
- Explains relevant pathophysiology and lists indications and contraindications for planned medical therapy.
- Explains indications, contraindications, and relevant steps required for procedural intervention (e.g., anesthesia, technique, instruments.

Learning Objectives, PGY-4

- Orders and interprets advanced diagnostic tests and imaging procedures according to evidence-based medicine (i.e., when and when not to order testing).
- Administers anesthesia and performs procedure, with oversight.
- Manages intra- and post-operative complications, with oversight.
- Assesses patients who are candidates for refractive intraocular lenses to correct astigmatism and/or provide near correction.
- Performs cataract surgery requiring complex technical maneuvers (e.g., pupil expander, capsular tension ring).
- Manages complex intra- and post- operative complications (e.g., endophthalmitis)
- Demonstrates advanced knowledge of pathophysiology and clinical findings for uncommon ophthalmic conditions.
- Generates probabilistic differential diagnosis in patients with multiple ocular and medical comorbidities; modifies likely differential with new information from additional testing.

- Articulates the rationale for ordering diagnostic testing in hierarchical fashion based upon probabilistic differential.
- Describes and articulates the rationale for using emerging alternative medical therapies.
- Describes and articulates the rationale for using novel alternative procedural interventions.

(3) Glaucoma – Dr. Todd Altenbernd

Philosophy of Care

- Emphasis on efficiency and creating a win-win situation for all parties involved.
- Focus on providing adequate and 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.

(4) Glaucoma – Dr. Elham Ghahari

Philosophy of Care

- Emphasis on efficiency and creating a win-win situation for all parties involved.
- Focus on providing adequate and 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.
- Residents will have the opportunity to join the attending physician in the operating room to observe and learn glaucoma surgery techniques, further enhancing their surgical skills and knowledge.

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, surgical observation, and learning opportunities during their rotations in the glaucoma clinic.

(5) Resident Clinic – Dr. Roy Swanson

Resident clinic is your time to take ownership of your patients and develop autonomy. During resident clinic, you are the leader running the clinic. This role includes ensuring adequate patient flow, working with clinic staff, fully evaluating patients, ordering appropriate ancillary testing, developing an accurate differential diagnosis, developing a management plan, coordinate referrals when needed, ordering medications/labs/imaging. You will be supervised by the attending assigned to the clinic, however, you should take on as much responsibility as you can over our patients. The sooner you truly take ownership and consider them YOUR patients, the better your experience will be.

This rotation is not a shadowing experience. We will not be relying on passive learning; you have to spend your own time on passive learning. This will be as hands-on as possible. What you achieve during this rotation will be directly proportional to your work and effort.

You have the privilege of having technicians work up your patients. Most of us did not have this luxury during residency or even early on as an attending. The techs and staff are not here to serve us; they are our teammates. There are no tasks that are beneath us. If you are standing with your arms crossed and/or looking at your phone while everyone else is working hard and running around, you should get moving and help with whatever needs to be done. If there are patients waiting and the techs are busy with other patients, you have the responsibility to work up the next patient in line.

Clinic will be very busy. There are many things that need to be done to care for every patient. I don’t know what “scut work” is. I just know what “work “is, and there is plenty of it during clinic. There is always something to be done. If you are examining a patient, I will be helping with note taking, placing orders, preparing consent forms, writing instructions for patients, walking across clinic to sign up patients for testing, bringing the eye drops that we need, setting up instruments for a procedure, etc. I expect that you will do the same. These tasks are not to please me; they are tasks that need to be completed to take care of our patients. If I’m

willing to do these things, I absolutely expect you to do these things too. I expect that you will work hard and make yourself a part of the team by chipping in whenever you can. I don't like being micromanaged and I don't enjoy micromanaging. I find it very uncomfortable to remind others to take care of our patients. My default is to take on whatever task needs to be completed instead of ordering you to do it.

You should familiarize yourself with all the skills necessary to evaluate any chief complaint or pathology that we encounter. These skills include but are not limited to a careful pupillary exam to be able to detect an RAPD, cover/uncover test, alternate cover test, measuring deviations with prisms, scleral depressed exams, everting eyelids, refraction, cranial nerve examination, gonioscopy, etc.

You are responsible for completing a full eye examination, ordering/interpreting ancillary tests, ordering medications/labs/imaging, writing patient instructions, presenting to the attending, and writing a complete and accurate note.

C. **SAVAHCS**

Residents rotate through SAVAHCS for one half-day of continuity clinic per week during their first through third year of residency, and for nine months of the fourth year of their residency. Additionally, a second (PGY-2) or third (PGY-3) year resident manages the oculoplastics clinic and PGY-1 residents have a 3-month VA ophthalmology rotation. 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 act as "consultants" and 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 Head. 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 Head 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, Lindberg, Neems, 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 eleven fully equipped ophthalmology examination lanes. There is a separate laser room in the clinic with a solid-state multi-wavelength laser, diode, Nd:YAG laser, SLT laser, and an infrared diode laser. Other equipment available include: automated perimetry, digital fundus and anterior segment photography, OCT, specular microscopy, and fluorescein angiography. The eye clinic is equipped with A/B Scan Ultrasound, IOL Master, Cirrus ocular coherence tomography, and Pentacam anterior segment tomography,

The operating room is equipped with two Zeiss operating microscopes, two Centurion (Alcon) phacoemulsification units, an 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 Head.

(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" which are located above the printer in the front office.
- 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.
- 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

- Accreditation Program: Office-Based Surgery National Patient Safety Goals
  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 in a timely fashion. Please comply and develop good habits when you start.

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**

a. ***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.
b. ***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.

(7) **Shared Calendars**

a. ***Department Call Calendar***: This is the departmental call calendar accessed by all services. https://dvagov.sharepoint.com/sites/VHATUCIntranet/OnCall/Pages/default.aspx
b. ***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.
c. ***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. 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.

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

SAVAHCS urgent care and post-op patients ***must*** be seen at SAVAHCS. When seen at the University Ophthalmology Clinic no true medical record is established and ***the visit is legally considered not to have taken place at all***. There are obvious legal implications to this, and in particular, SAVAHCS provides liability coverage only for those services provided at SAVAHCS, or those performed under a contractual arrangement and with prior authorization of SAVAHCS administration. In addition, in the absence of a BUMC medical record, the University does not provide liability coverage.

For practical purposes, 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.), and these patients become registered at the University at that time.

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 actually 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. Communication between the junior and accepting senior resident is expected. All patients seen need an RTC with a specific clinic and date/time and an email or Teams message to the MSAs.
3. If the ED physician said that he/she just needs direction, triage should still be performed to determine if a consult is needed. For cases requiring follow up only, the resident should have the ability to check availability in the eye clinics in order to guide patient follow-up, directly contacting the patient, if necessary.
    a. Do not, do not, do not – just tell the patient to show up to the eye clinic for evaluation the next morning.
    b. Do not, do not, do not – schedule a patient into an attending clinic without prior communication with that attending.
    c. Do not, do not, do not – schedule into an other-than-your-own resident clinic without prior communication with that resident. There should be no overbooks into other clinics without permission.
4. In this vein, 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. You should then inform the MSAs (LaTisha Grant, latisha.grant@va.gov; Yanssel Cota, Yanssel.cota@va.gov; Lisa Stancliffe, lisa.stancliffe@va.gov; Ken Weir, Kenneth.weir@va.gov, Brenda Aguilar, Brenda.aguilar@va.gov) by 8:00AM the following business day. Reach out to the senior or MOD if you have trouble booking follow-up.
6. For a list of conditions you definitely should be seeing in the ED/hospital, please refer to the 'Must Call' list. Everything on that list represents a condition in which you should have seen the patient in the ED.
7. When a consulting physician gives you a description that you don't understand or seems a situation where a non-ophthalmologist could miss an important finding (which are many), the patient should be seen. Don't assume that the patient's condition is straightforward and can safely be seen the following day. Take ownership of the patient's condition.
8. Please make sure there is a consult placed and that your Consult Note is linked to the eye consult.

(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 for career and fellowship interviews and emergent personal issues (such as sick leave). See the Section Chief for exceptions.

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.
- Note your 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 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.

(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 of any changes to post-op appointments prior to the patient's arrival in clinic. 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.
- **ALWAYS** use VA email when communicating with VA patients (Secure Messaging is best for this purpose).

(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 the Emergency Department or INPATIENT visits need to be written as an Eye Clinic Consult note, **not** an emergency department or inpatient note. To do this, you would again click on the New Note tab, and then type in 'TUC EYE OPHTH-URGENT', or Tuc Eye and scroll down to the Urgent designation and click it. Then, begin your note.

(13) **Triage Protocol**

Triages are a part of any eye clinic. 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 addending 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.

Normal Resident Triage Schedule

Monday
AM retina resident
PM glaucoma resident

Tuesday
AM general resident (cornea)
PM glaucoma resident

Wednesday
AM glaucoma laser resident
PM retina resident

Thursday
AM retina resident
PM general resident (retina)

Friday
AM MOD (check schedule)
PM post 2 resident (cornea)

(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 and place it 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.

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.'

34. MEDICAL MARIJUANA

In 2010, Arizona voters passed Proposition 203 to legalize medical marijuana (MMJ) for "qualifying patients" with "debilitating medical conditions," including glaucoma. The law requires patients seeking medical marijuana to receive a "recommendation" from a "doctor" to receive a MMJ card. Implementation of the state law has been delayed by a lawsuit filed in U.S. District Court challenging the law's federal legality.

It is against federal law to prescribe marijuana and this should never be done. However, patients may request that residents recommend them for MMJ based on a glaucoma diagnosis. Medically, the position of the American Glaucoma Society is that ophthalmologists NOT recommend MMJ. Legally, federal law prevails at the VA, where policy is NOT to recommend MMJ. At Alvernon, BUMCS, and BUMCT, residents work under their medical training license through the Department, and Department policy is that residents may NOT, under any circumstances, recommend MMJ.