COLLEGE OF
Optometrists
OF ONTARIO

COUNCIL MEETING

FRIDAY JUNE 18, 2021
AT 9:00 A.M.

(PUBLIC INVITED TO ATTEND)

VIRTUAL MEETING

COLLEGE OF Optometrists OF ONTARIO

COUNCIL AGENDA

Friday, June 18, 2021 | 9:00 a.m.
Virtual Meeting

Item	Item Lead	Time (mins)	Action Required	Page No.
1. Call to Order/Attendance	P. Quaid	1	Decision	5
2. Adopt the Agenda a. Conflict of Interest Declaration	P. Quaid	1	Decision	5
9:15 – 9:45 a.m. – Ministry of Health				
3. Ministry of Health: Regulatory Authority Model for Personal Support Workers	A. Henry	30	Presentation	5
4. Consent Agenda PART 1 - Minutes of Prior Council Meetings i. March 26, 2021 ii. Motions and Actions Items Arising from the Minutes PART 2 - Reports b. Committee Reports i. Executive Committee ii. Patient Relations iii. Quality Assurance: a) QA Panel b) CP Panel c) QA Subcommittee iv. ICRC v. Registration vi. Discipline vii. Governance/HR Committee viii. Audit/Finance/Risk Committee	P. Quaid	30	Decision	5 6 12 14 16 18 19 35 36 38 40 42 44
~10:10-10:20 - Morning Break		**10**		
5. Registrar's Report	J. Jamieson	45	Presentation	51
11:00-11:30 a.m. – Presentation from the Auditors				
6. Financial Matters a. Presentation from the Auditors	Auditors	30	Presentation	51

7. Motions Brought Forward from Committees				
a. Audit/Finance/Risk (AFR) Committee:				
i. Building Acquisition Fund Reallocation	L. Chan	20	Decision	53
ii. Approval of the Audited Financial Statements	L. Chan	10	Decision	57
11:40-12:00 p.m. – Lunch Break		**20**		
Motions Continued				
iii. Investment Policy Revision	L. Chan	30	Decision	58
b. Registration:				
i. Entry-to-Practice Exam	W. Ulakovic	45	Decision	70
ii. 2021 Jurisprudence Exam	W. Ulakovic	15	Decision	143
iii. 2021 Optometry Examining Board of Canada Written Exam and OSCE	W. Ulakovic	15	Decision	154
iv. 2021 National Board of Examiners in Optometry Exam	W. Ulakovic	15	Decision	156
~2:20-2:30 p.m. – Afternoon Break		**10**		
c. Clinical Practice Panel				
i. OPR 7.12 Patients with Amblyopia	C. Grewal	15	Decision	161
ii. OPR 7.13 Patients with Uveitis	C. Grewal	15	Decision	195
d. Governance/HR				199
i. Policy: Role of President	K. Biondi	15	Decision	201
ii. Policy: Role of Vice-President	K. Biondi	15	Decision	203
iii. Executive Committee Terms of Reference	K. Biondi	15	Decision	205
iv. Governance/HR Committee Terms of Reference	K. Biondi	15	Decision	209
v. AFR Committee Terms of Reference	K. Biondi	15	Decision	213
e. Executive Committee:				
i. Appointment to fill Chair and committee vacancies	P. Quaid	5	Decision	217
8. List of Acronyms			For Information	220
9. Upcoming Council Meetings				
a. September 17, 2021				
b. December 10, 2021				
10. 2022 Council Meeting Dates:	J. Jamieson		For Information	219
a. Friday, January 21, 2022				
b. Friday, March 25, 2022				
c. Friday, June 24, 2022				
d. Friday, September 16, 2022				
e. Friday, December 9, 2022				
11. Adjournment – **approximately 4:15 p.m.**	P. Quaid		Decision	

Vision and Mission

Vision: A leading regulator focused on safe eye care and progressive practice.

Mission: To regulate Ontario's optometry profession in the public interest.

1 -4 / INTRODUCTION

1. Call to Order/Attendance

2. Adopt the Agenda
   a. Conflict of Interest Declaration

3. Ministry of Health Presentation: Regulatory Authority Model for Personal Support Workers

4. Consent Agenda
   PART 1 - Minutes of Prior Council Meetings
   a. March 26, 2021
   b. Motions and Actions Items Arising from the Minutes
   PART 2 - Committee Reports
   i. Executive Committee
   ii. Patient Relations
   iii. Quality Assurance:
   a) QA Panel
   b) CP Panel
   iv. ICRC
   v. Registration
   vi. Discipline
   vii. Governance/HR Committee
   viii. Audit/Finance/Risk Committee

College of Optometrists of Ontario
Council Meeting
March 26, 2021
DRAFT #1

Attendance:

Dr. Patrick Quaid (President)
Mr. Bashar Kassir (Vice-President)
Ms. Suzanne Allen
Ms. Kathryn Biondi
Dr. Linda Chan
Dr. Lisa Christian
Mr. Ravnit Dhaliwal
Dr. Mark Eltis
Dr. Camy Grewal
Ms. Winona Hutchinson
Mr. Howard Kennedy
Dr. Richard Kniaziew
Dr. Lindy Mackey
Dr. Annie Micucci
Dr. Areef Nurani
Mr. Narendra Shah
Dr. William Ulakovic

Staff:

Mr. Joe Jamieson, Registrar and CEO
Ms. Hanan Jibry, Deputy Registrar
Mr. Chad Andrews
Mr. Edward Cho
Ms. Mina Kavanagh
Ms. Amber Lepage-Monette
Ms. Deborah McKeon
Dr. David Wilkinson
Ms. Bonny Wong

1. Call to Order: P. Quaid called the meeting to order at 9:02 a.m.

P. Quaid opened the meeting by sharing remembrances of Dr. Gina Sorbara, who passed away in February 2021.

2. Adoption of the Agenda: A draft agenda was circulated prior to the meeting.

Moved by W. Hutchinson and seconded by H. Kennedy **to adopt the agenda.**

Motion carried

a. Conflicts of Interest: P. Quaid asked Council members if anyone had a conflict of interest with any item on the day's agenda. None declared.

3. Adoption of the Consent Agenda: A draft consent agenda was circulated prior to the meeting. The following items were included in the consent agenda:

PART 1 - Minutes of Prior Council Meetings
- a. December 4, 2020
- b. January 22, 2021
- c. February 9, 2021
- d. Motions and Actions Items Arising from the Minutes

PART 2 - Reports
- a. Committee Reports
  - i. Executive Committee
  - ii. Patient Relations
  - iii. Quality Assurance:
    - a) QA Panel
    - b) CP Panel
  - iv. Inquiries, Complaints, and Reports Committee (ICRC)
  - v. Registration
  - vi. Discipline
  - vii. Governance/HR Committee
  - viii. Audit/Finance/Risk Committee

Moved by K. Biondi and R. Kniaziew **to adopt the consent agenda.**

Motion carried

Several members of Council asked to discuss the Executive Committee report and the ICRC report.

A. Nurani noted he had questions about each of the committee reports.

Executive Committee report:

A. Nurani asked about the progress to date to address transparency on the Executive Committee, noting that the legislation sets out the role of the Executive Committee and questioned the need to reduce the committee's power.

P. Quaid and B. Kassir addressed these questions, noting that the Executive Committee has been meeting to discuss roles and responsibilities. Any recommendations would go to Governance/HR Committee first; the intention is to present recommendations to Council in June.

> **Action item:** College staff will perform a jurisdictional scan of other regulatory colleges regarding the Executive committee function, composition and terms, as well as frequency of meetings.

ICRC Report:

Council noted the issue of ancillary testing and fees continues to be an issue.

J. Jamieson reminded Council that four communications, which constitute practice advise, were sent to optometrists in 2020 addressing this issue. Non-adherence to practice advice is not necessarily misconduct.

Council noted concerns related to OHIP-insured patients and ancillary testing, as well as queries from the Ministry (OHIP) about complaints on this issue. In addition, Council asked about the need for a more formal policy that is enforceable.

Council discussed challenges that arise when optometrists feel ancillary testing is necessary. It is noted by some that clinicians should be able to recommend the best care and appropriate technology; prescriptive policies would remove the ability to provide such care.

Action item: Using existing communications, the College will send a reminder to optometrists about ancillary testing and fees.

Council revisited the discussion from the December 4, 2020 Council meeting regarding the College's interest in funding research; Council clarified the intent of the funding and how it may differ from existing Canadian Optometric Trust Fund.

Council discussed the need to evaluate and measure outcomes on College training sessions, such as the sexual abuse training and cybersecurity training for staff and Council. J. Jamieson confirmed that, going forward, the College Performance Measurement Framework (CPMF) will provide some of the outcomes-based information on training and education.

Council discussed the number of Continuing Education (CE) hours provided through Quality Assurance Assessor training. It was clarified that the training is a full-day education process consistent with the CE Policy.

Council discussed the process by which the COVID-19 Infection Prevention and Control guidance is reviewed and updated. C. Grewal noted that the document was intended to be dynamic and updated over time. Updates were made throughout 2020 and she will bring the comments back to the Clinical Practice Panel for discussion.

A. Nurani asked about the need for a new auditor. It was clarified that, in keeping with best practices, the College intends to rotate auditors approximately every three years.

A. Nurani questioned why the Audit/Finance/Risk (AFR) Committee did not recommend reducing optometrists' member fees in 2020. Members from the AFR Committee noted that the question of fees was discussed, and many issues were taken into consideration. It was decided the College needed to wait until the end of 2020 to know the full impact of COVID-19 closures.

Moved by A. Nurani and seconded by W. Hutchinson **that the Audit/Finance/Risk Committee revisit a fee reduction for optometrists.**

Show of hands – none against.

Motion carried

Council took a break at 10:40 a.m. and returned at 10:50 a.m.

4. Registrar's Report

J. Jamieson provided operational updates regarding upcoming College work, including upcoming revisions to the College website and a new organizational chart. Staff provided updates on main areas of College functions: Registration, Investigations, Finance, Quality Assurance, and Governance.

Council asked about staffing, as well as the proposed topic for an upcoming e-learning module (i.e., addressing common complaints). Regarding the e-learning module, J. Jamieson noted that although the number of complaints among the profession is low, any infraction against the public is too much and the topic is felt to be appropriate.

Council asked about the online jurisprudence exam being available 24/7 as opposed to in one sitting. H. Jibry noted the online exam is remote proctored by a service that provides staff with a report of any anomalies.

5. IN CAMERA SESSION: College Performance Measurement Framework (CPMF) In accordance with Section 7 (1.1) of the *Health Professions Procedural Code* (HPPC), Council will go in camera under Section 7(2)(b) of the HPPC, whereby financial, personal or other matters may be disclosed of such a nature that the harm created by the disclosure would outweigh the desirability of adhering to the principle that meetings be open to the public.

Moved by K. Biondi and seconded by W. Hutchinson **to move the meeting in camera.**

Motion carried

Council **moved out of camera at 12:22 p.m.**

6. Motions Brought Forward from Committees:

a. College Performance Measurement Framework

Moved by C. Grewal and seconded by M. Eltis **to approve the College Performance Measurement Framework.**

Motion carried

b. Governance/HR: By-law Administrative Changes

Council noted a few typos and asked about the timing of Executive Committee elections; the revised by-laws still note the elections occurring at the first meeting of the year, which now takes place in March.

K. Biondi noted that elections will take place at a special meeting at the beginning of the year, as is best practice.

Moved by N. Shah and seconded by R. Kniaziew **to approve the proposed by-law changes that reflect the necessary administrative changes stemming from items i. and vii. from the October 15, 2020 Special Council agenda.**

Motion carried

C. Grewal presented on the following two motions regarding updates to the Optometric Practice Reference (OPR).

c. Clinical Practice Panel: OPR 7.12 Patients with Amblyopia

d. Clinical Practice Panel: OPR 7.13 Patients with Uveitis

Council discussed the proposed changes to both sections of the OPR.

Council questioned the evidenced used to support the suggested changes, as well as with the prescriptive nature of the changes suggested for 7.13.

Action item: OPR 7.12 and 7.13 will be reviewed again by the CPP.

e. Clinical Practice Panel: Public Register

Council was in favour of the broader search information being made available to the public. At this time, some information is available to staff only when responding to calls and queries from the public. This update will enable members of the public to search the public register for this information themselves.

H. Jibry clarified that staff are already working to update the search fields and this function may be available soon.

Moved by A. Nurani and seconded by L. Chan **to approve the addition of search fields for i) wheelchair accessibility, and ii) home visits, to the College public register effective late 2021.**

P. Quaid asked for a show of hands. None were against.

Motion carried

Council discussed the upcoming audit approval. R. Dhaliwal indicated that meeting dates are being reviewed.

Council asked about in-person meetings. J. Jamieson noted the College is following provincial and local public health orders and will keep Council updated once in-person meetings are possible.

9. Adjournment: The meeting adjourned at 12:51 p.m.

Council Meeting – June 18, 2021

COUNCIL ACTION LIST STATUS

Updated June 1, 2021

Date	Minute Line	Action	Status	Comments
12/04/20	130	It is agreed that the (QA) subcommittee should connect with the University of Waterloo to discuss its self-assessment module 5in5, which was presented by Dr. Woo earlier in the meeting.	Completed	The QA Subcommittee (QAS) has decided to issue an RFP for the QA Program Redevelopment Project.
03/26/21	53	College staff will perform a jurisdictional scan of other regulatory colleges regarding the Executive function, composition, and terms, as well as frequency of meetings	Completed	The results of the scan were presented to the Executive Committee.
03/26/21	72	Using existing communications, the College will send a reminder to optometrists about ancillary testing and fees.	Completed	The March e-newsletter *In Focus* contained a message from the registrar that reminded optometrists of previous communications and College expectations on ancillary testing. The communication was sent March 31, 2021.
03/26/21	183	OPR 7.12 and 7.13 will be reviewed again by CPP.	Ongoing	CPP reviewed the items, which are being presented at the June 18, 2021 Council meeting.

Council Meetings – June 18, 2021

MOTION LIST

Updated June 1, 2021

Date	Minute Line	Motion	Committee	Decision
03/26/21	101	Moved by A. Nurani and seconded by W. Hutchinson **that the Audit/Finance/Risk Committee revisit a fee reduction for optometrists.**	Council member	Motion carried
03/26/21	154	Moved by C. Grewal and seconded by M. Eltis **to approve the College Performance Measurement Framework.**	Executive	Motion carried
03/26/21	166	Moved by N. Shah and seconded by R. Kniaziew **to approve the proposed by-law changes that reflect the necessary administrative changes stemming from items i. and vii. from the October 15, 2020 Special Council agenda.**	Governance/HR	Motion carried
03/26/21	195	Moved by A. Nurani and seconded by L. Chan **to approve the addition of search fields for i) wheelchair accessibility, and ii) home visits, to the College public register effective late 2021.**	CPP	Motion carried

Executive Committee Activity Report

Reporting date: June 18, 2021

Chair: Dr. Patrick Quaid

Key Priorities

The Executive Committee is currently scheduled to meet before each Council session (approximately three weeks prior) in 2021 to review the Council meeting's agenda and committee motions. This is to ensure that Council sessions are efficient, transparent, and capable of meeting high standards in governance. Such a meeting occurred on May 27, 2021, to prepare for the June 18, 2021, Council meeting.

Discussion Items

Return to Work Policy and FAQ

During its May 27 meeting, the Executive Committee reviewed materials developed by the Clinical Practice Panel (CPP), which included the COVID-19 return-to-work guidance and a related FAQ. CPP recommended small but important changes to reflect advice from Toronto Public Health that clarify the distinction between the cleaning and disinfection of frames. The Executive Committee approved the changes so that the documents could be updated and circulated to optometrists promptly.

CPMF and the Strategic Plan

The May 27 meeting also gave Executive Committee members an opportunity to discuss operational work plans that will tie into key items from both the College Performance Measurement Framework (CPMF) and the College's strategic plan to ensure operational work is connected to benchmarks in both documents, particularly in areas that overlap.

The Process for Non-Formal Complaints

A robust discussion took place concerning the issue of non-formal complaints against a Council member by another Council member and how these complaints are processed. Although the Governance/HR Committee has a process for formal complaints, there is currently no process or guideline for handling non-formal complaints (e.g., complaints that are made anonymously). The Executive Committee has asked the Governance/HR Committee to develop a policy on professional conduct during Council and committee meetings, as well as a process for handling both formal and non-formal complaints filed by Council members against other Council members. This is to ensure a fair process for all upon receipt of non-formal complaints. All formal complaints will be handled by Governance/HR.

Meeting between OAO and College

A standing meeting once every two weeks occurs between senior leadership at the Ontario Association of Optometrists (OAO) and the College (Registrar and President) to ensure that (i) the College is kept up to date on potential job action and (ii) the OAO is aware of potential professional boundary issues within said possible job action. While members are not prohibited in participating in a job action, it is in the College's interest to ensure that the public's faith in the profession is maintained and that the OAO is aware that there is a "power imbalance" present in the exam room and that this should not be

leveraged. Both the Registrar and President attended the OAO town hall meeting on May 25, 2021 (attendance / observation only). The College continues to monitor the situation from a public confidence standpoint and offer feedback in terms of avoiding loss of public faith in the profession. It has been made crystal clear that the College does not take a position on issues of remuneration. We continue to have bi-weekly meetings to ensure the public confidence in the profession is maintained regardless of the approach taken by the OAO in any potential job action.

Decision Items

The resignation of Winona Hutchinson leaves Council with a public member vacancy as well as openings in the Discipline Committee (at the Chair level) and Quality Assurance Panel. A new public member has been requested by the Registrar. As for the committee openings, the Governance/HR Committee determined that the Quality Assurance Panel position can wait for the new public member, but that an interim Chair must be selected for the Discipline Committee. After careful deliberation, the Governance/HR Committee recommended to the Executive Committee that Dr. Dennis Ruskin be appointed to the role for the remainder of 2021. Following this recommendation, the Executive Committee recommends to Council the approval and appointment of Dr. Dennis Ruskin as the Chair of the Discipline Committee**.** A briefing note outlining the vacancies in more detail is provided with the motion.

Patient Relations Committee Activity Report

Reporting date: June 18, 2021

Chair: Ms. Suzanne Allen

Tasks Completed Since Last Council Meeting:

- The committee received a new application to the Program of Funding for Therapy and Counselling. A meeting was held on May 3, 2021, to process the materials and onboard the patient, who is now being supported.
- The committee drafted a communication item that clarifies the College's stance on the Spousal Exemption Policy. The document is attached as an FYI item for Council.

Key Priorities

The Patient Relations Committee continues to manage the Program of Funding for Therapy and Counselling, which now supports four patients. The committee is also working to develop new training on sexual abuse and victim support that will be offered to Council members and staff, as well as an e-learning module for CE credit that focuses on frequent complaints received by the College.

Discussion Items

During a meeting on May 17, 2021, committee members engaged in a broad discussion regarding the role of the Patient Relations Committee and its mandate to engage and safeguard the public. Several members expressed interest in expanding the committee's work by developing a communications initiative that spotlights the importance of comprehensive eye exams for Ontarians of all ages. The committee will continue to explore and develop this potential project and will report on its progress to Council.

Attachments

- Website Item: Clarification of the College's position on the Spousal Exemption Policy

Spousal Exemption Regulation Communication

Passed on October 8, 2020, Ontario Regulation 566/20 (Spousal Exemption Regulation), allows optometrists to treat their spouses without the treatment automatically constituting sexual abuse. The exemption benefits those who must treat their spouses under special circumstances, including optometrists who practice in remote parts of Ontario with limited access to optometric care.

A "spouse" is defined by Ontario Regulation 566/20 specifically as a) a person whom the optometrist is married to, or b) a person who has lived with the optometrists in a conjugal relationship outside of marriage continuously for at least **three years**.

While the regulation is supported by the College of Optometrists of Ontario, particularly under special or unique circumstances, as a general rule the College does not recommend that optometrists treat their spouses. Personal relationships are complex; incorporating them into professional care can lead to problematic and unforeseen situations. This is especially true in cases of chronic care that can last over years or decades. Also, in cases where a personal relationship ends, optometrists may find themselves in complicated situations that force them to balance the ethics of patient care against the complexities of personal history.

Therefore, while the treatment of spouses in now permitted under this regulation, it is not generally recommended by the College of Optometrists of Ontario.

If you are a patient or practitioner and have questions about this regulation, contact Chad Andrews, Senior Manager, Policy and Governance.

Quality Assurance Committee – Quality Assurance Panel Activity Report

Reporting date: June 18, 2021

Chair: Dr. Linda Chan

Tasks Completed Since Last Council Meeting:

- Reviewed ongoing and new random practice assessment cases
- Planned for QA Assessor Recruitment and Training Workshop
- Reviewed and approved QA policies
- Discussed random practice assessment temporary modifications
- Discussed CE audit results for the past CE cycle (2018-2020)

Information Items

Review of cases:

- Random practice assessment follow-ups: 1
- CRA and Case Manager Reports: 2
- Remediation/Coaching: 4
- New random practice assessments: 43

Discussion Items

1. **QA Assessor Recruitment and Training Workshop:**
    a. The College issued a call for volunteers for the role of QA assessor via website and email. The panel reviewed all applications and selected 19 candidates based on the requirements and eligibility criteria outlined in the *QA Assessor Eligibility and Appointment Policy*. Selected candidates and all 34 current QA assessors will be required to attend a mandatory virtual training workshop on September 10, 2021.
    b. The panel discussed the structure and content for the workshop as well as potentially inviting guest speakers (e.g., current QA assessors).

2. **QA Policies:** The panel reviewed and approved revisions to the *QA Assessor Eligibility and Appointment Policy.*

3. **Random Practice Assessment Temporary Modifications:** In light of COVID-19, temporary modifications were made to the random QA practice assessment process for optometrists randomly selected in 2020, including extending the timeframe to accumulate patient records from 60 to 90 days, as well as the timeframe to submit first-time patient records up to one year prior to the notification date. The panel decided to offer the temporary modifications to members randomly selected in 2021.

4. **CE Audit of the Past CE Cycle (2018-2020):** A total of 192 optometrists were found to be deficient in CE hours for the past CE cycle. The panel decided that optometrists deficient in CE hours for the 2018-2020 cycle would be given the opportunity to upload any missing CE credits to their OE TRACKER account before being required to undergo a practice assessment.

QA – CPP Activity Report

Reporting date: June 18, 2021

Chair: Dr. Camy Grewal

Meetings in 2021: May 20, 2021

Tasks Completed Since Last Council Meeting:

- Discussed Optometric Practice Reference (OPR) 7.12 Patients with Amblyopia and 7.13 Patients with Uveitis
- Prioritized COVID-19 Public Health Requested Change in COVID-*19 Return to Work* guidance (approved by the Executive Committee on May 27, 2021).

Key Priorities

CPP remain primarily concerned with pandemic-related standards of practice and guidance, in addition to the standards of practice under the OPR.

Discussion Items

- Review of Quality Assurance Panel memo.
- For Council's information: Revised COVID-19 *Return to Work* guidance

Decision Items

Motions are presented separately:

1. Revisions to OPR 7.12 Patients with Amblyopia
2. Revisions to OPR 7.13 Patients with Uveitis

Attachments

- Revisions to the *COVID-19 Return to Work FAQs* document and the *Return to Work: Infection Prevention and Control for Optometric Practice* document

Revised: September 2020

RETURN TO WORK: INFECTION PREVENTION AND CONTROL FOR OPTOMETRIC PRACTICE

The following document presents guidance for optometrists returning to work during the ongoing COVID-19 pandemic. This information was developed through consultation with Infection Prevention and Control for Clinical Office Practice,[1] public health information specific to COVID-19,[2] and profession-specific guidelines, and will be modified in the event of additional directives by the Ministry of Health (MOH) and as the COVID-19 pandemic evolves**. The contents of this guidance will be reviewed and updated as Ontario progresses through each phase of its recovery.**

Optometry practices must comply with both the College's Return to Work guidance and the Ministry of Health guidance *COVID-19 Operational Requirements: Health Sector Restart* when providing care.

Contents

Summary of Requirements

- Do not schedule appointments for any person who has symptoms of COVID-19,[3,4] who is living with someone that has symptoms, who has been in contact with a confirmed case of COVID-19 without wearing appropriate PPE, or who has travelled outside of Canada within 14 days.
- Hands must be cleaned before and after every patient interaction.
- Hand sanitizing stations must be available at clinic entrances and must be used by anyone entering the clinic.
- Optometrists and staff must wear personal protective equipment (PPE) covering their mouth, nose, and eyes when interacting with patients.
- Anyone entering the office, including patients, must wear a mask.
- Health Canada guidelines must be followed if reprocessing PPE.[5]
- Optometrists must consider how physical distancing can be maintained in the office (> 2 m).
- Slit lamp shields must be installed.
- Optometrists must update and document their standard operating procedures (SOPs) related to infection control.
- Every device or appliance (including eyeglass frames) that patients contact must be cleaned and disinfected before use with the next patient.
- Optometrists and their staff must not present to work when ill with symptoms of infection.
- Automated visual field assessment must only occur when necessary, and with patients wearing a properly secured mask covering their mouth and nose.

Summary of Recommendations

- Telehealth[6] is recommended if in-person care is not required.[7]
- It is strongly recommended that optometrists post their infection control SOPs on their website and in their office reception area where they will be available to patients.
- When scheduling patients, it is strongly recommended that optometrists prioritize based on clinical need.
- It is strongly recommended that optometrists provide dispensing services (spectacles & contact lenses) by appointment only, and direct delivery should be used when optometrists consider it is appropriate.

Risk Assessment and Screening

A risk assessment and screening[8] must be performed before every interaction with a patient, including at the time of scheduling an appointment, upon arrival at the office, and in the examination room. When scheduling appointments, optometrists must screen patients for symptoms of COVID-19, recent travel history, and reason for visit. Optometrists must not schedule an appointment for any person with a positive screening result for COVID-19, who has common symptoms of COVID-19 or other febrile illness, who is living with someone that has symptoms, or who has travelled outside of Canada within the past 14 days. Patients with a positive screening result for COVID-19 should be referred to Telehealth Ontario (1-866-797-0000). If a patient has possible symptoms of COVID-19, or a recent travel history, and urgent eye care may be required, optometrists should consult an ophthalmologist or access the ophthalmologist on-call, depending on the arrangements in their local communities. If no other options are available, patients with symptoms of COVID-19 who require urgent eye care can be referred to the emergency room.

Optometrists are recommended to implement a system for virtual and/or telephone consultations to replace in-person visits when and where possible. When screening the reason for a visit, optometrists should consider whether in-person care is required or whether care could be provided using telehealth to support ongoing physical distancing in the community.

Conjunctivitis (pink eye) is an atypical symptom of COVID-19, [4] however, conjunctivitis[8] represents a positive screening result[7] that should be referred to Telehealth Ontario. Optometrists screening patients with complaints of pink eye (conjunctivitis), should manage these patients using telehealth, if possible.

Optometrists should consider scheduling appointments only by telephone, email, and/or website application. 'Walk-in' appointment scheduling should be discouraged by signage outside of the office.

Optometrists should consider whether a temperature assessment, using an infrared thermometer, is appropriate as part of their risk assessment protocol for when patients arrive at the office.

Hand Hygiene

Hand hygiene[9] is considered the most important and effective infection prevention and control (IPAC) measure to prevent the spread of COVID-19. Optometrists and their staff must clean their hands before and after every patient interaction. In addition, optometrists must clean their hands before and after any contact with a patient's eye/tears, and upon the insertion and removal of gloves. Cleaning hands with soap and water for at least 20 seconds is recommended. In order for hands to be cleaned at the right time, it is necessary to be able to clean hands at the point-of-care. Where optometrists do not have a sink in their exam room, alcohol-based hand rub (ABHR) may also be used (a minimum of 70 per cent alcohol).

Optometrists must have a hand sanitizing station available at their office's entrance/reception, and elsewhere in their office, for use by patients. Optometrists must require that all persons sanitize their hands upon first entering the office. Optometrists should not use homemade hand sanitizers.[10]

Personal Protective Equipment (PPE)

PPE is worn to prevent the transmission of microorganisms from patient to staff and from staff to patient. Optometrists and staff must wear PPE covering their mouth, nose, and eyes when interacting with patients (i.e., whenever they are within 2 m of one another).

Eye protection includes safety glasses, safety goggles, face shields and visors attached to masks. Eye protection should provide both front and side coverage. Prescription glasses, without a side shield, are not acceptable as eye protection.

Optometrists should not compete with front-line workers for PPE that may be in short supply, such as N-95 respirators. Surgical masks are considered an appropriate alternative to N-95 respirators as long as optometrists are not performing aerosol-generating procedures. If N-95 respirators are not available, the risk of droplet dispersal is further reduced by the patient also wearing a mask. Optometrists should use their judgment regarding masks that may be appropriate (e.g., surgical masks, N-95 respirators, or other comparable alternatives).

Optometrists should consider wearing gloves and/or using disposable cotton tip applicators whenever they are touching patients' eyes or eyelids. Optometrists should consider the types of gloves that suit their care activities. Latex gloves are generally not recommended because of the risk of allergic reaction. Wearing gloves is not a substitute for hand hygiene.[1]

Optometrists and their staff are expected to wash any worn gowns or clothing at the end of each day.

Optometrists must not allow any person (> 2 years of age) into their office who is not wearing a mask (disposable/reusable). When scheduling appointments, patients should be advised to arrive to the office wearing a mask. Ideally, optometry offices should have inventory to sustain recommended PPE use for its workforce and patients for two weeks without the need for emergency conservation effort. Optometrists must follow Health Canada guidelines if reprocessing PPE.[6]

Optometrists are responsible for educating themselves and staff on how to safely fit, put on, take off, replace and reprocess (if appropriate) PPE.

Precautions to Maintain Physical Distancing

Physical distancing (> 2 m) – Optometrists must consider how physical distancing can be maintained in their office including, but not limited to, the frequency and interval of appointments scheduled; emphasizing punctual arrival for appointments; only admitting patients to the office by appointment and at the time of their appointment; dispensing spectacles and contact lenses by appointment only; repositioning chairs in the reception/waiting area; using ground markings; limiting the number of people allowed in the office and exam room(s) at any time; recommending to patients that they attend their appointment alone or with as few other people as possible (e.g., one parent/support-person/substitute decision maker).

Contact-less procedures – Optometrists are encouraged to adopt contact-less procedures where possible, including but not limited to, contact-less payment systems, when collecting patient information, and the electronic delivery of prescriptions and receipts (e.g., by email).

Protective barriers – Optometrists must install slit lamp shields. Other protective barriers, e.g., plexiglass barriers in the frequented areas of reception and pre-test, should be considered depending on the office layout, where possible.

Control of the Environment

Optometrists must document and update their SOPs regarding infection control of the office environment (an example is provided in Appendix 1). Every person working at an optometric clinic (optometrists, staff, and student interns) must review SOPs related to infection control.

Optometric office settings will usually feature two components:

> ***Public component*** is the public areas of the clinical office that are not involved in patient care. This includes waiting rooms, offices, corridors and service areas. Areas designated in the public component are cleaned with a detergent.
>
> ***Clinical component*** is the area involved in patient care. This comprises the clinical areas of the office, including examination rooms, procedure rooms, bathrooms and diagnostic and treatment areas. Areas designated in the clinical component are cleaned with a detergent and then disinfected with a hospital grade disinfectant. 'High-touch' surfaces may require more frequent cleaning.

Every device or appliance (including eyeglass frames) that patients come into contact with must be cleaned and disinfected before use with the next patient. Follow the manufacturer's instructions regarding appropriate contact time and the use of ~~disinfectants~~agents, in order to provide appropriate cleaning and disinfection and avoid damaging equipment or appliances.

Optometrists should refer to Health Canada's website for a list of disinfectants with evidence for use against COVID-19[11].

Equipment disinfection and hand washing should be performed in front of patients, where possible.

It is strongly recommended that optometrists post their infection control SOPs on their website and in their office reception area where they will be available to patients.

Administrative Controls

Optometrists and their staff must not present to work when ill with symptoms of infection. Any person with symptoms of COVID-19 should stay home, contact their primary care provider or Telehealth Ontario, and should not return to work until they are asymptomatic and have been cleared by their primary care provider or Telehealth Ontario of any concern of COVID-19.

Any confirmed case of COVID-19 in an optometrist, staff member or visitor to the office should be reported to the local Public Health Unit. Optometrists should follow the subsequent directions of their local Public Health Unit. In order to facilitate contact tracing, optometrists must maintain a log of every person who visits their office, including date and time.

Optometrists and staff should plan their work schedules so to minimize the number of people in contact with patients/visitors, and one another. Optometrists should also consider whether it is appropriate to continue to practice at multiple locations at this time.

Optometrists and staff should self-declare their health status at the beginning of each day. Optometrists and their staff should adhere to the recommended immunization schedule.[1]

It is recommended that staff work at individual workstations, if possible. Efforts should be made to have patients interact with as few staff as possible.

Clinical Guidance

When scheduling patients, it is strongly recommended that optometrists prioritize based on clinical need.

Optometrists performing initial (new) contact lens fittings should consider measures that would limit the amount of time spent in close proximity to patients, and the amount of time patients spend in the office.

It is strongly recommended that optometrists provide spectacle and contact lens dispensing services (OPR 6.4, 6.5) [12] by appointment only, and direct delivery should be used when considered appropriate.

Automated visual field assessment (OPR 6.8)[12] must only occur when necessary, and with patients wearing a properly secured mask covering their mouth and nose.

Optometrists should use their professional judgment regarding when the measurement of intraocular pressure (IOP) may be necessary. When performing tonometry, optometrists should consider which equipment to use, which PPE should be worn, the risk of aerosol generation, barriers that may be appropriate, and how to disinfect the equipment and immediate surrounding environment. There is no current evidenced-based consensus regarding the COVID-19 risk associated with non-contact tonometry

(NCT).[13] However, risk is certainly reduced through patient screening, wearing PPE, and disinfection of the equipment and surrounding environment. Optometrists should consider using other equipment to measure IOP, if possible.

Optometrists should refer to industry standards regarding how to clean specific devices[14] and appliances (including frames of different materials).

Optometrists should consider the use of minim diagnostic pharmaceutical agents (eye drops) at this time.

References

[1]Infection Prevention and Control for Clinical Office Practice. Provincial Infectious Diseases Advisory Committee. 2015. https://www.publichealthontario.ca/-/media/documents/B/2013/bp-clinical-office-practice.pdf?la=en.

[2]Coronavirus Disease 2019 (COVID-19). Public Health Ontario. https://www.publichealthontario.ca/en/diseases-and-conditions/infectious-diseases/respiratory-diseases/novel-coronavirus.

[3]COVID-19: Stop the spread. https://www.ontario.ca/page/covid-19-stop-spread

[4] COVID-19 Reference Document for Symptoms. Ministry of Health. Ontario. http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_reference_doc_symptoms.pdf

[5]Conservation and Decontamination N95 Facemasks and PPE. Infection Prevention and Control Canada. https://ipac-canada.org/reprocessing-of-ppe.php

[6]Telehealth Policy for Optometrists. College of Optometrists of Ontario. https://www.collegeoptom.on.ca/wp-content/uploads/2016/06/Telehealth_Policy_for_Optometrists.pdf

[7]Guidance for Primary Care Providers in a Community Setting. Ministry of Health. Ontario. http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_primary_care_guidance.pdf

[8]COVID-19 Patient Screening Guidance Document. Ministry of Health. Ontario. http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_patient_screening_guidance.pdf

[9]Hand Hygiene. Public Health Ontario. https://www.publichealthontario.ca/en/health-topics/infection-prevention-control/hand-hygiene.

[10]Homemade hand sanitizers may present health risks. Recalls and safety alerts. Canada. https://healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2020/72687a-eng.php

[11]Hard-surface disinfectants and hand sanitizers (COVID-19): List of disinfectants with evidence for use against COVID-19. Health Canada. https://www.canada.ca/en/health-canada/services/drugs-health-products/disinfectants/covid-19/list.html

[12]Optometric Practice Reference (OPR). College of Optometrists of Ontario. https://www.collegeoptom.on.ca/members/professional-practice/optometric-practice-reference-opr/

[13]Use of non-contact tonometry to measure intra-ocular pressure during COVID-19. The College of Optometrists (UK). https://www.college-optometrists.org/the-college/media-hub/news-listing/non-contact-tonometry-covid-19.html

[14]How to clean and disinfect your instruments to lower the risk of COVID-19 transmission. Cleaning, Disinfection and Safety Protocols. Innova. https://innovamed.com/covid-19-cleaning-and-disinfection-protocol

Appendix A: Sample Standard Operating Procedure

(If using this sample, it should be filled in/personalized)

Frequency legend:

1. Before direct patient contact
2. After direct patient contact
3. Before and after direct patient contact
4. End of every day
5. Weekly
6. Monthly

Who legend:

A. Optometrist
B. Staff

Disinfection Agent:

COVID-19 Return to Work

Return to Work: Infection Prevention and Control for Optometric Practice provides optometrists with guidance for working during the ongoing COVID19 pandemic. The contents of this guidance will be reviewed and updated as Ontario progresses through each phase of its recovery, and as new guidance or recommendations are made available by the provincial government.

Optometry practices must comply with both the College's Return to Work guidance and the Ministry of Health guidance *COVID-19 Operational Requirements: Health Sector Restart.*

Frequently Asked Questions

COVID-19 Symptoms and Exposure

What protocol should I follow if I've been notified that a patient or staff/optometrist has tested positive for COVID-19?

Below is a list of resources that provide guidance on next steps following a positive COVID-19 exposure. Each situation is unique; if optometrists are unclear how to proceed after reviewing these resources, they should use their best judgment to inform decisions regarding testing, isolation, and office closure.

Following exposure to COVID-19:

- Anyone exposed to COVID-19 can follow this simple, four-step process.
- Specific to health care providers:
    - A confirmed case in an optometrist or staff should be reported to your local public health unit, which will provide you with specific guidance regarding contact tracing.
    - The Ministry of Health has guidance on contact management based on exposure setting (e.g., health care), exposure type (protected/unprotected), and specific scenarios (e.g., patient vs health care worker is the positive case), on Table 5 (page 29-30).
    - Optometrists may also want to review the "Health Human Resources" section in the Ministry of Health's Operational Requirements to inform their return to work planning.

What if an optometrist or staff becomes ill with COVID-like symptoms?

Optometrists and their staff must not present to work when ill with symptoms of infection. Any person with symptoms of COVID-19 should stay home, contact their primary care provider or Telehealth Ontario, and should not return to

work until they are asymptomatic and have been cleared by their primary care provider or Telehealth Ontario of any concern of COVID-19. Any confirmed case of COVID-19 in an optometrist, staff, or visitor to the office should be reported to the local public health unit. Optometrists should follow the subsequent directions of their local public health unit.

Vaccination

Where can I find resources about the COVID-19 vaccines and/or provincial vaccination program?
Information about COVID-19 vaccination is available here for health care providers.

How should optometrists and staff deal with symptoms within 48 hours of receiving a COVID-19 vaccine?
Health care providers can review the following guidance from the Ministry of Health regarding symptoms following vaccination.

Personal Protective Equipment and Masks

Where should I purchase personal protective equipment (PPE) and what brands are recommended?
The College is not in a position to recommend or approve certain types/brands or PPE suppliers. Public Health Ontario has resources related to infection control practices that may be helpful to optometrists. Mouth, nose, and eyes must be covered by PPE. Prescription glasses are not acceptable as eye protection unless they are equipped with side shields.

The provincial government has developed a PPE supplier directory. In addition, the Ontario Association of Optometrists (OAO) is working to provide optometrists with information on accessing PPE.

Optometric colleagues, interprofessional colleagues, and the OAO may be able to answer specific questions or provide recommendations as to PPE currently in use.

What is the appropriate way to don/doff PPE?
Public Health Ontario has numerous resources (both in print and video) on proper technique for donning and doffing PPE:

- Putting on and removing PPE instruction sheet
- Posters *How to put on PPE* and *How to remove PPE*
- Video *Putting on One-Piece Facial Protection*
- Video *Taking off One-Piece Facial Protection*
- Video *Putting on Mask and Eye Protection*

What is considered suitable eye protection?

The College is not in a position to recommend certain brands of PPE. Eye protection should cover both the front and sides of the face and includes safety glasses, safety goggles, face shields and visors attached to masks. Prescription glasses are not acceptable as eye protection.

If a patient arrives to an appointment without a mask, do I cancel the appointment?
If a patient arrives without a mask, optometrists should provide patients with a mask to wear. If the optometrist is unable to provide a mask, the appointment should be rescheduled or cancelled, or provided using telehealth if possible.

If a patient doesn't bring their own mask, can I charge them for a mask I provide?
Providing equipment and supplies needed to control the spread of infection (such as personal protective equipment/masks) is a part of OHIP-insured services. Optometrists cannot charge OHIP-insured patients for these services as that would be considered extra-billing.

Any fees charged to patients who are not OHIP-insured must be reasonable and not excessive. Optometrists must consider the patient's circumstances and access to care when determining fees. Patients should be informed of any fees in advance of an appointment.

What if a patient cannot wear a mask?
Providing optometry care does not allow for physical distancing. The College guidance and recommendations were developed after careful review of infection prevention and control information from public health, specific recommendations related to COVID-19, and best practices for optometry.

Optometrists should use their professional judgement in individual circumstances and determine if they are able to safely provide care if the patient does not wear a mask. Optometrist must determine what is needed to keep themselves, staff, and other patients safest. Depending on the nature of the appointment, you may be able to provide care in person, virtually, or recommend deferring the appointment to a later date if not urgent.

What if a patient insists that it is their human right to receive a service without wearing a mask?
The Ontario Human Rights Commission (OHRC) has an FAQ that outlines human rights concerns related to COVID-19. This FAQ notes that:

- …any requirements related to health and safety and COVID-19, such as wearing a mask…do not generally
- cause concern under the Code. …service providers should recognize that health and safety requirements such as masks may have a negative impact on vulnerable populations identified by a ground under the Code who may not have access to such equipment… and
- …the Ministry of Health advises that face coverings should not be placed on or used by children under the age of two, anyone who has trouble breathing, or anyone who is unable to remove it without assistance.

Read the full FAQ on the OHRC website.

Travel

Can we see patients who live in other provinces?
Yes. The Ministry of Health Patient Screening document no longer lists travel outside of Ontario as a positive screening result (though travel outside of Canada remains so).

Can optometrists and staff work if they travel between provinces?
Health care workers and staff can continue to work, but should self-monitor for symptoms and ensure they are screening patients and wearin[Privacg y] appropriate personal protective equipment (PPE). Anyone who develops symptoms should self-isolate and contact Telehealth Ontario or their primary care provider.

Can we see patients who travel from outside of Canada?
Travel outside of Canada within 14 days remains a positive screening result for COVID. For these individuals, the first considerations should be

1. can the appointment be deferred,
2. can care be provided using telehealth, or
3. is there a 14-day window when the patient will not be traveling that may allow for scheduling and a negative screening result.

If none of the above options are feasible, then optometrists should consider

1. scheduling the patient in-person and with use of additional PPE (prescribed by the Ministry's Operational Requirements: Health Sector Restart p. 12), i.e., isolation gown and gloves, in addition to surgical/procedure mask and eye protection, or
2. referral to an ophthalmologist or optometrist with the above PPE.

Clinical Care

Optometrists are now able to resume new contact lens fittings. What are the best ways to manage this while ensuring physical distancing from patients and suitable infection prevention practices?
The College has revised its guidance so that new contact lens fittings are no longer prohibited, however, we recognize these fittings pose some challenges re: physical distancing and uncertain duration. When providing contact lens fittings, optometrists could consider measures that would limit the time in close contact with patients, including:

- Providing some of the contact lens training via telehealth (i.e., video instruction)
- Using complementary instruction videos before (e.g., insertion and removal techniques) and/or after (e.g., cleaning lenses) the training
- Using barriers (such as Plexiglas) within the office setting to separate optometrists/staff from patients learning insertion/removal

Using gloves and other PPE that may add additional protection and align with patient expectations (see: guidance from the British Contact Lens Association)

Optometrists should use their professional judgement re: readiness to provide new contact lens fittings. If an optometrists is unable to provide fittings, they should inform patients when these appointments may resume and provide patients with options for alternative care, such as referral to another optometrist.

Can I use a combination of fundus photography and imaging technology (e.g., OCT) for all patients as the only method of examining the fundus, or as a substitute for dilated fundus examination?
No. The standards of practice regarding pharmacologic dilation are unchanged and may be reviewed under OPR 6.2. Please also refer to the College's Policy on Digital Imaging/Fundus Photography in Optometric Practice.

Disinfecting

Is it OK to use 3% hydrogen peroxide to clean and disinfect Goldmann tonometer prisms? ~~Is it OK to clean eyeglass frames using soap and warm water? These are~~This is not included among the examples cited under high- and low-level disinfectants in the College's guidance (Control of the Environment).
Generally speaking, the answer ~~to these questions~~ is yes. ~~The referenced examples are cited from a source document, and m~~Many of the examples of high-level disinfectants will only be appropriate for hard surfaces and will damage clinical equipment (e.g., tonometer probes). Optometrists should refer to manufacturer and best-practice professional guidelines, and use their clinical judgment regarding choice of cleaning and ~~disinfectant~~ disinfecting agents. Optometrists should avoid cleaning and ~~disinfectants~~ disinfecting agents (and/or contact times) that will damage clinical equipment. ~~or eyeglass frames (of various materials).~~

Is it OK to clean and disinfect eyeglass frames using soap and warm water? This is not included among the examples cited under high- and low-level disinfectants in the College's guidance (Control of the Environment).

Soap and water is sufficient to clean eyeglass frames. Optometrists should still refer to manufacturer and best-practice professional guidelines, and use their clinical judgment regarding choice of cleaning and disinfectant agents and/or cloths. Optometrists should avoid cleaning and disinfecting agents (and/or contact times) that will damage clinical equipment or eyeglass frames (of various materials). Cleaning alone is not sufficient, disinfection alone does not replace cleaning, and any contact points should be cleaned and disinfected.

For further information please refer to the link: https://www.cdc.gov/coronavirus/2019-ncov/more/science-and-research/surface-transmission.html

Questions relating to practice management (e.g., billing) should be directed to the Ontario Association of Optometrists.

Cleaning and Disinfection of Optical Frames and Sunglass Frames

Quality Assurance Committee – QA Subcommittee Activity Report

Reporting date: June 18, 2021

Chair: Ms. Ellen Pekilis

Tasks Completed Since Last Council Meeting:

- The QA Subcommittee (QASC) continued working on redeveloping the QA program.

Discussion Items

1. **Requests for Proposals (RPFs):**
    a. On April 14, 2021, Dr. Patrick Quaid (President), Mr. Joe Jamieson (Registrar and CEO), Ms. Ellen Pekilis (Chair, QASC), Dr. Linda Chan (Chair, QAP), and Ms. Bonny Wong (Manager, Quality Programs) met virtually to discuss the progress and milestones of the QA program redevelopment project. Due to limited resources at the College (e.g., Ms. Bonny Wong being the only staff support for this project), the group explored a potential nexus between College research funds and the work of the QASC. It was decided to that requests for proposals (RFPs) should be circulated to support the QA program redevelopment project.
    b. At its meeting on May 26, 2021, QASC agreed with the decision to circulate RFPs seeking vendors to develop the self-assessment component and practice assessment component of the QA program.
    c. As next steps, the research fund will be discussed at the June 18, 2021 Council meeting, and then the RFPs will be circulated.

2. **QA Policies:**
    a. **QA Assessor Eligibility and Appointment Policy:** The QASC discussed the importance and challenges of ensuring consistency/standardization of assessors. On May 26, QASC revised the current *QA Assessor Eligibility and Appointment Policy* to:
        - require a regular, periodic requalification program;
        - include discussion at training and requalification sessions that covers issues with assessment consistency, risks, current standards, and issues experienced in the field, among other things;
        - clarify eligibility criteria and conditions for disqualifications; and
        - harmonize language with other College policies (i.e., replace “member” with “optometrist”).

    The revised policy was presented to the QA Panel at its May 28, 2021, meeting for final approval.

    Risk Assessment QA Assessor Working Group: At its meeting on May 26, 2021, the QASC discussed the need for a Risk Assessment Working Group (RAWG) to administer the annual risk-aligned continuous improvement process for the practice assessment component. QASC decided to develop terms of reference for the RAWG as well as a policy to outline the eligibility criteria, application process, training and appointment procedures, commitments, compensation, and conditions for disqualification for members of the RAWG.

Inquiries, Complaints and Reports Committee Activity Report

Reporting date: June 18, 2021

Committee Co-Chairs: Dr. Richard Kniaziew & Dr. David White

This report is intended to provide the Council with information on the complaints and Registrar Reports' investigations process while maintaining confidentiality required under the Regulated Health Professions Act ("RHPA") and owed to the parties. In keeping with Section 36 of the RHPA, details about specific cases are not shared as part of the committee report.

Information Items

- The Inquiries, Complaints and Report Committee (ICRC) resumed investigations in complaints and reports matters as of September 14, 2020, following a six-month suspension of the timelines in proceedings in Ontario (*Ontario Regulation 73/20 – Limitation Periods)*, which caused significant delays and affected timelines in the processing and disposition of cases.
- The panels held one meeting each, in March and April 2021, respectively.

Key Priorities

- The ICRC had previously noted an increase in cases where complainants (patients) raised allegations of optometrists presenting ancillary fees as mandatory or as a condition for the provision of an OHIP-insured examination. The committee continues to be concerned about this issue and feels that timely action from College leadership would be helpful both to the ICRC process and in assisting members in providing appropriate patient care.

Complaints Processed Since Last Reporting (March 11, 2021)

- Cases newly filed: 12
- Cases reviewed by the Panels: 24
- Cases withdrawn: 2
- Cases carried over (next Panel meeting): 10

Decision Breakdown	Total
Decisions Issued	**8**
Case Type	
• Complaints	8
• Registrar's Report	0
• Incapacity Inquiry	0
Dispositions (for complaint cases above)	
• No further action (NFA)	4
• Advice or recommendation	4
Nature of Allegations (for dispositions above, NFA excluded)	
• Care (quality, failure to diagnose/refer, unsafe care)	2
• Fees/Billing	1
• Unprofessional behaviour	1
Timeline for Resolution (for complaint cases above)	
• Less than 120 Days	0
• 121-150 Days	0
• 151-180 Days	1
• 180+ Days	7

HPARB Appeals

- New appeals: 1
- ICRC Decision Confirmed: 2
- Outstanding appeals to be heard: 2
- Appeals heard and awaiting decisions: 0

Registration Committee Activity Report

Reporting date: June 18, 2021

Chair: Dr. Bill Ulakovic

Tasks Completed Since Last Council Meeting:

- Signed a licensing agreement with the Optometry Examining Board of Canada (OEBC) regarding the Optometry Competency Framework.
- Discussed preparations for the rescheduled Internationally Graduated Optometrist Evaluating Examination (IGOEE) with Touchstone Institute.
- Discussed the registration process during COVID-19.
- Discussed the referral of an applicant for registration to the committee by the College Registrar and Chief Executive Officer.

Key Priorities

Optometry Examining Board of Canada

- The College signed a Non-Disclosure Agreement with OEBC that provides OEBC access to the National Competency Profile, which will be used to validate and refine the performance indicators for the OEBC exam blueprinting. This will enable the OEBC exam blueprinting to be completed by mid-June 2021.
- OEBC is revamping the exam scoring systems to map each item within the Optometry Competency Framework and update the exam cases.
- The College signed an updated licensing agreement with OEBC on May 31, 2021, that would oversee OEBC's use of the Optometry Competency Framework.

Touchstone Institute

- The IGOEE that was scheduled to be administered in May 2020 was cancelled due to COVID-19 and re-scheduled for January 2021. Due to the rise in COVID-19 cases, this administration was also subsequently cancelled.
- The rescheduled IGOEE administration is as follows: the MCQ on May 26 and the TPAO on May 28 using virtual proctoring with the short OSCEs scheduled on June 19-20, 2021.
- According to Touchstone Institute, there is a current IGOEE candidate pool of 34 with two to three vaccinated candidates travelling from outside of Canada.
- When Touchstone Institute notified the registered IGOEE candidates regarding the changes, the candidates were all provided with the option to withdraw from the exam.
- IGOEE results will be taken into consideration when candidates apply to the Advanced Standing Optometry Preparatory Program.
- There was one successful FORAC credential assessment appeal recommendation received.

Registration Process during COVID-19

- College staff continue accepting applications for registration electronically and validating documents with applicants.
- There were 55 candidates registered for the May 2021 online Jurisprudence exam and 23 candidates registered for the June 2021 online Jurisprudence exam.
- The April 2021 OEBC OSCE was rescheduled to July 11, 2021, due to the provincial Stay-At-Home Order. The OEBC OSCE is to be held at the University of Waterloo School of Optometry and Vision Science.
- The development of an online registration application is in progress. Launching the online application has been delayed to summer 2021, as additional programming is needed.

Further Amendments to the Registration Regulation draft amendments

- In April 2018, the College made a comprehensive regulation amendment submission to the Ministry of Health, and further amendments in 2020. While these draft amendments are under review, the College has asked that the Ministry consider introducing more flexibility in the Registration Regulation, which would be consistent with another health regulatory college that has similar flexibility. There is currently no update on this request.

Decision Items

There are three Registration Committee motions that require Council approval at the June 18 Council meeting:

- The 2021 OEBC written exam and OSCE as one of two standards assessment examinations for registration purposes;
- The 2021 National Board of Examiners in Optometry (NBEO) exam as an alternate standards assessment examination for registration purposes; and
- The 2021 Jurisprudence exam for registration purposes.
- Receive the *One Entry-to-Practice Exam is Good for Canada* Report.

Attachments

N/A

Discipline Committee Activity Report

Reporting date: June 18, 2021

Number of hearings in 2021: 1

Number of hearings since last Council meeting: 1

Activities undertaken including performance relative to strategic plan and actions directed by Council:

The Discipline Committee conducted one (1) discipline hearing:

1. Dr. Jon Barnes – March 29, 2021

Date of Referral: August 4, 2020

THE DISCIPLINE COMMITTEE FOUND that Dr. Barnes committed acts of professional misconduct, as provided by subsection 51(1) (c) of the *Health Professions Procedural Code,* being Schedule 2 to the *Regulated Health Professions Act*, 1991, S.O. 1991 C.18, and defined in the following paragraphs of Ontario Regulation 119/94:

a. paragraph 1.24 in that he failed to make and maintain records in accordance with Part IV of Ontario Regulation 119/94;
b. paragraph 1.26 in that he signed or issued, in his professional capacity, a certificate, report or similar document that contains a statement he knew or ought to have known is false, misleading or otherwise improper, or omitted statements or information that he knew or ought to have known should be included.
c. paragraph 1.28 in that he submitted or allowed to be submitted an account for professional services that he knew or ought to know is false or misleading; and
d. paragraph 1.39 in that he engaged in conduct or performed an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical.

THE DISCIPLINE COMMITTEE ORDERED:

1. That Dr. Barnes be required to appear before the Panel to be reprimanded at the conclusion of the discipline hearing on March 29, 2021;
2. That the College Registrar be directed to suspend Dr. Barnes' certificate of registration for a period of four (4) months to be served continuously and without interruption, commencing on May 31, 2021;
3. That the Registrar be directed to impose the following condition on Dr. Barnes' certificate of registration:
    a. that he complete a practice coaching program with a practice coach in the area of OHIP billing and record keeping, by March 29, 2022, as follows:
    b.
        i. he shall complete a total of six (6) practice coaching sessions of four (4) hours each, once a month for a period of six (6) months;

ii. the practice coach shall be approved by the Registrar;
iii. the practice coach shall attend Dr. Barnes' practice to review Dr. Barnes' record keeping and OHIP billing. Alternatively, the coaching sessions may be held virtually at the sole discretion of the practice coach should it be warranted by the public health situation;
iv. the practice coach will determine what if any additional reading and review of materials Dr. Barnes will be required to undertake in preparation for the practice coaching/review sessions; and
v. the practice coaching shall be at Dr. Barnes' expense.

4. That the Registrar be directed to impose the following condition on Dr. Barnes' certificate of registration:
    a. that he be required, at his own expense, to successfully complete and provide proof to the Registrar that he has done so, the Medical Record Keeping course (https://www.cpd.utoronto.ca/recordkeeping/), a one-day online interactive workshop available at the Temerty Faculty of Medicine, University of Toronto, by no later than March 29, 2022, and
5. That Dr. Barnes pay the College's partial costs in relation to this proceeding in the amount of $20,000 payable to the College of Optometrists of Ontario in four (4) installments of $5,000 by way of postdated cheques dated as follows:
    a. March 29, 2021;
    b. November 31, 2021;
    c. January 31, 2022; and
    d. March 29, 2022.

In addition, Dr. Barnes provided an oral undertaking to the College, on the record during the discipline hearing, to make restitution to OHIP in the amount of $4,905.70 and provide proof that he has done so to the Registrar by June 29, 2021.

At the conclusion of the hearing, Dr. Barnes waived his right to appeal and the Discipline Committee delivered the reprimand.

Committee training: N/A

Recommendations to Council (including rationale and impact on budget if appropriate): N/A

Respectfully submitted:
Due to temporary absence of a chair, the following report is submitted to Council on behalf of the Discipline Committee.

Governance/HR Committee Activity Report

Reporting date: June 18, 2021

Chair: Ms. Kathryn Biondi

Tasks Completed Since Last Council Meeting:

- The committee developed a workplan to guide and organize its activities over the course of 2021.
- The committee reviewed the survey feedback from Council members for the March 26, 2021, Council meeting.
- An interim replacement for the role of Chair of the Discipline Committee was discussed; the committee moved to request that the Executive Committee bring the recommendation to Council (see item below).
- Five policy documents were drafted and thoroughly discussed: The Role of the President, The Role of the Vice-President, Terms of Reference for the Executive Committee, Terms of Reference for the Governance/HR Committee, and Terms of Reference for the Audit/Finance/Risk Committee. The documents are being presented to Council for approval (see attached briefing note).

Key Priorities

The mandate of the Governance/HR Committee is to facilitate Council's ability to fulfill its functional and ethical responsibilities. Working within that mandate, a key focus for the Committee in 2021 is to conceptualize and draft a governance manual that will be shared with all Council members and function as a guidebook for effective and ethical governance as it relates specifically to the College. The five documents being presented to Council for approval (see attached briefing note) will be part of the manual, representing the Committee's first steps of this broader and more comprehensive project.

Discussion Items

The committee discussed the resignation of Winona Hutchinson and considered possible interim replacements for the Chair of the Discipline Committee vacancy. After careful consideration and review of relevant materials, the committee moved to recommended to the Executive Committee that Dr. Dennis Ruskin fill the role for the remainder of 2021. The Executive Committee will put forward the motion at the Council meeting on June 18, 2021.

The departure of Ms. Hutchinson also left a vacancy on the Quality Assurance Panel. The Committee recommends that the vacancy be left open so that it can be filled by the public member that is eventually appointed by the Public Appointments Secretariat.

Decision Items

Five separate documents have been developed and approved by the Governance/HR Committee (see the attached briefing note):

- A policy outlining the role of the President
- A policy outlining the role of the Vice-President
- New terms of reference for the Executive Committee
- New terms of reference for the Governance/HR Committee
- New terms of reference for the Audit/Finance/Risk Committee

The Committee will move to have Council approve each document separately.

Audit/Finance/Risk (AFR) Committee Report

Reporting date: June 18, 2021

Chair: Dr. Linda Chan

Tasks Completed Since Last Council Meeting:

- The audit for the fiscal year ending December 31, 2020, is nearing conclusion and the auditors are scheduled to present the draft financial statements to the Committee for review on June 14, 2021. The auditors will present to Council for approval at its meeting on June 18, 2021.
- Staff have consulted with BDO Canada regarding the question of charging HST on membership fees and a briefing note will be prepared for the committee to review at its next meeting on June 14, 2021, and a report will then be provided to Council.
- The College's Investments Policy has been revised and will be presented to Council for approval at its meeting on June 18, 2021.
- The committee reviewed the reserves set aside for the Building Acquisition Fund as set out in the approved Audited Financial Statements for the fiscal year ending December 31, 2019, and a briefing note has been prepared for Council's review. The AFR Committee recommends to Council the reallocation of funds currently held as the "Building Acquisition Fund" to fund the objectives and amounts as set out in Table 1.
- Cybersecurity training for Council members was completed on April 9, 2021.

Key Priorities

- Ongoing review/awareness of risks: IT, operational, organizational, financial, and strategic.

Information Items

- The committee has completed some revisions to the Finance – Honoraria and Expenses Policy to clarify the terminology regarding meetings and the calculation of honoraria. The revised policy is included in this report as information for Council (please see the highlighted updates).
- A summary of the current long-term investments as of December 31, 2020, has been prepared and a copy is included in this report as information for Council.

Discussion Items

1. Review of the draft Investments Policy and committee recommendations regarding financial instruments utilized for the College's reserve funds.

Decision Items

2. Approval of the draft audited financial statements for the fiscal year ending December 31, 2020.
3. Approval of the draft Investments Policy.
4. Approval of the reallocation of the reserve funds currently held as the "Building Acquisition Fund" to fund the objectives and amounts as set out in Table 1 of the AFR Committee Briefing Note dated May 13, 2021.

Attachments

- Finance – Honoraria and Expenses Policy revised May 13, 2021.
- Summary of current long-term investments as of December 31, 2020. (To be provided to Council following the AFR meeting on June 14, 2021.)
- Summary of current long-term investments as of March 31, 2021. (To be provided to Council following the AFR meeting on June 14, 2021.)

  These two Summary documents were made available here.

Policy

Type:	Finance		
Name:	Honoraria & Expenses		
Status:	Draft	**Version:**	2.1
Date Approved:	December 4, 2020	**Date Revised:**	November 6, 2020 v 2.0 May 13, 2021 v 2.1

Purpose

The purpose of this policy is to outline the honoraria and expense coverage provided to professional Council and Committee members[1] for College work.

Overview

Honoraria are paid to professional (optometrist) members of Council and committees (statutory, standing, ad-hoc) for participating in activities related to College business.

Such activities include:

- attending scheduled meetings/hearings (in-person, online or via teleconference);
- decision-writing;
- attending College-related education and training sessions; and
- participating in any other approved College event/activity.

Honoraria are also paid for time spent preparing for meetings. The College recognizes that professional members of Council and committees, may spend time preparing for some Committee meetings that exceeds two hours. These Committee members will be compensated for that time according to this policy**.**

Eligible expenses are reimbursed to professional members of Council committees and staff members when they are incurred while conducting College business.

Payments are made to the rates outlined under Schedule 1 in this policy.

Procedure

[1] Council members who are appointed by the Lieutenant Governor (i.e. public appointees) are paid by the government and as such the rules for their compensation and expenses are established and monitored by the Ministry of Health.

1. Claim(s) for honoraria and expenses are to be submitted to the College, on a completed honoraria and expense form (Appendix 1) within 30 calendar days of the claimed activity.
2. Claims should be submitted to the College's Manager, Finance and Office Administration.
3. Manager will confirm the claim with the related staff support that assists with oversight for the activity that resulted in the claim(s).
4. Once approved, the College will endeavor to pay claims within one (1) month of receiving them.
5. Any discrepancies between what this policy permits, and claims will be addressed with the individual by the Manager, Finance and Office Administration and if not available, the Registrar.

NOTE: Claims for honoraria are considered taxable income by the Canada Revenue Agency and as such are processed through the College's payroll system. In keeping with Canada Revenue Agency Rules, the College will annually prepare and provide T4s/T4As to those who claim honoraria from the College.

Interpretation

1. *Honoraria/Honorarium*: An honorarium is a payment for time spent on College-related business. Honoraria are composed of per diems and preparation time.
2. *Per Diem*: A per diem is a payment to someone for time spent working or attending meetings, training, and events for the College. Per diems are paid on an hourly or daily basis, consistent with Schedule 1 of this policy.
3. *Preparation Time*: Preparation time is a payment for time spent getting prepared for College-related business. Preparation time is paid on an hourly basis, consistent with Schedule 1 of this policy.

Honoraria

General Principles

a. A daily claim for honoraria may include any or all per diems and/or preparation time in keeping with the rules and rates outlined in this policy.
b. Honoraria will be paid to people who are requested by the College to attend a function for representation or education purposes.
c. Honoraria rates are to be reviewed annually at the beginning of each fiscal year; any update will be communicated via email once new rates are established.

Per Diem

a. Honoraria will be paid for the scheduled time of the meeting.
b. For Council and committee meetings[2] held in-person or virtually[3], the full day per diem rate may be claimed.
c. The following formulas apply to all College meetings[3] irrespective of whether the meetings are held by telephone, in-person, or virtually:
    i. For meetings with a duration of less than one (1) hour, a total amount of $187.50 may be claimed.
    ii. For meetings with a duration of one (1) to three (3) hours, the total honorarium paid will be at the half-day rate of $375.00.

[2] This includes meeting of Committee panels, College working groups or task forces and any meeting that a member attends as a College representative.
[3] This also applies to members who attend a College in-person meeting virtually.

iii. For meetings with a duration greater than three (3) hours, the full day rate of $750.00 will apply.

d. As a guideline, meetings that extend beyond the scheduled time should be noted in the minutes of the meeting and include a reason.
e. Committee chairs[4] are paid a higher per diem rate when they are acting in the capacity of the chair at a meeting/event/activity.
f. Per diem is paid in accordance with the rate section laid out in Schedule 1 of this policy.

Preparation Time

a. The amount payable for preparation time per meeting is based on a fixed and an hourly rate as follows:
    i. The first two hours will be non-billable time.
    ii. Any additional hour or part thereof will be paid at the rate of $150.00 per hour.
b. This policy provides for an average of two (2) hours of preparation time that is non-billable. For any additional hours, the Chair of the committee will seek consensus from the committee members as to the average number of hours more than two (2) hours and everyone submits the same claim for preparation time, at the discretion and approval of the Chair. The discussion and consensus among committee members should take place and be confirmed at the end of every meeting. It is expected that the preparation time will be the same for everyone but is at the discretion of the Chair. .
c. Preparation time is paid in accordance with the rate section laid out in Schedule 1 of this policy.

Expenses[5]

General Principles

i. The College expects Council and Committee members to make their hotel and travel arrangements as soon as possible after a meeting date has been confirmed to obtain the best price.
ii. Expenses submitted that are more than these guidelines because of last-minute booking of travel and hotel arrangements may not be reimbursed.
iii. Detailed itemized invoices or receipts are required for all expense claims.[6]
iv. Barring exceptional circumstances, reimbursement for claimed amounts exceeding these guidelines may be denied.

Travel

a. For trip durations (air, train) of under three hours, Economy-level fare selections are reimbursed. For trip durations over three hours, Premium Economy-level fare selections are reimbursed.
b. In extenuating circumstances (i.e. poor weather) where travel plan adjustments may be necessary and incur additional costs, compensation will be considered for alternative travel arrangements.
c. For travel within major urban centres, while it is preferred that public transportation be used, reasonable cab fare will be reimbursed for these trips. The College encourages the use of the Union Pearson Express train when travelling to and from the Toronto Pearson

[4] This also applies to the College President when acting in their capacity.
[5] Where applicable, the expense guidelines may also be applicable to College staff members.
[6] Credit card receipts or statements do not provide sufficient detail to process expense claims.

Airport.

d. For travel by car, the College will reimburse $0.485 per kilometer plus parking expenses for lots near the College, at the hotel or other such event/activity location.[7]
e. Parking and traffic violations are the sole responsibility of the individual and will not be reimbursed by the College.

Lodging

a. The College will pay for a standard room at a hotel to a maximum of $275 (excluding HST) per night.
b. Exceptions may be allowed for periods of time where lodging availability is limited, or where travel plan adjustments are necessary due to weather related or other unexpected circumstances.

Meals	**Coverage guideline (excluding HST)**
Breakfast	up to $30.00/meal
(Lunch)[8]	up to $30.00/meal
Dinner	up to $60.00/meal

Please note that expenses for alcoholic beverages or spirits will not be reimbursed.

Gratuities

a. Gratuities for lodging and transportation (i.e. taxis) should be included in the cost claimed along with the accompanying receipt.
b. Gratuities for meals at a maximum of 18% may be claimed over and above the allowable coverage under such guidelines.

Additional Expenses

a. For expenses not explicitly covered in this policy, the Audit/Finance/Risk Committee shall determine whether such an expense is compensable.

Cancellation

If a planned/scheduled College activity is cancelled and insufficient notice is provided, the College may pay some or all the honoraria and will pay all non-refundable expenses.

If the activity is cancelled within 5 business days, the College will pay 50% of the honoraria and cover any expenses incurred. If the activity is cancelled within 3 business days, the College will pay 100% of the honoraria and cover any expenses incurred.

The per diem amount will be paid based on the time scheduled for the activity. Preparation time may also be payable given the circumstances and at the discretion of the Registrar.

Review

[7] A document (i.e. Google Maps, MapQuest, etc.) outlining the route and kilometers travelled must be submitted in conjunction with this claim.
[8] Generally, lunch is included at College meetings and will only be reimbursed if not provided by the College.

To ensure and maintain currency, the Honoraria and Expense Guidelines for Professional Council and Committee Members policy will be reviewed annually by the College's Audit/Finance/Risk Committee.

Schedule 1

Honoraria (per diem & preparation time) for professional Council and Committee members:

All College Meetings *Honoraria will be paid for the scheduled time of the meeting.*		
Duration/Scheduled	*Member Rates*	*Chair Rates*
Less than one (1) hour	$187.50	$262.50
One (1) hour to three (3) hours – half day rate	$375.00	$525.00
Greater than three (3) hours – full day rate	$750.00	$1,050.00
Preparation Time		
Duration	*Member Rate*	*Chair Rate*
First two (2) hours	Non-billable	Non-billable
Additional time paid by the hour or part thereof – flat hourly rate	$150.00	$150.00

5-6 / PRESENTATIONS

5. Registrar's Report: Registrar and CEO Joe Jamieson to provide College updates via PPT presentation.

6. Financial Matters: Presentation from the Auditors

7 / MOTIONS

7. Motions Brought Forward from Committees

   a. Audit/Finance/Risk Committee:
      i. Building Acquisition Fund Reallocation
      ii. Approval of the Audited Financial Statements
      iii. Investment Policy Revision

   b. Registration Committee:
      i. Entry-to-Practice Exam
      ii. 2021 Jurisprudence Exam
      iii. 2021 Optometric Examining Board of Canada Written Exam
      iv. 2021 National Board of Examiners in Optometry Exam

   c. Quality Assurance - Clinical Practice Panel:
      i. To approve revisions to OPR 7.12 Patients with Amblyopia.
      ii. To approve revisions to OPR 7.12 Patients with Uveitis.

   d. Governance/HR Committee:
      i. Executive Committee Terms of Reference
      ii. Governance/HR Committee Terms of Reference
      iii. Audit/Finance/Risk Committee Terms of Reference
      iv. Policy: Role of President
      v. Policy: Role of Vice-President

   e. Executive Committee
      i. Appointments to fill Chair and committee vacancies

BRIEFING NOTE

Council Meeting – June 2021

Subject

Reallocation of the reserve funds currently held as internally restricted funds for the acquisition of a building for the College's office premises.

Background

At its meeting on May 13, 2021, the Audit/Finance/Risk Committee reviewed the briefing note prepared by the Registrar regarding the reallocation of the Building Acquisition Reserve Fund, which is attached for Council's reference. The committee was unanimous in a motion to recommend to Council for its consideration and approval the reallocation of funds currently held as reserves in the Building Acquisition Fund to fund the objectives and amounts as set out in Table 1 of the attached briefing note.

Decision for Council

To reallocate the reserve funds currently held as the "Building Acquisition Fund" to fund the objectives and amounts as set out in Table 1 of the attached briefing note dated May 13, 2021.

Financial Implications

A reallocation of internally restricted reserve fund originally intended for the acquisition of a building for the College's office premises to be transferred to other restricted and unrestricted funds as set out in Table 1 of the attached briefing note.

Supporting Materials

- Briefing note dated May 13, 2021, prepared by Joe Jamieson, Registrar and Chief Executive Officer.

Contact

- Deborah McKeon, Manager, Finance and Office Administration

Briefing Note – Reallocation of Building Acquisition Reserve

Background

For several years, the College has maintained a reserve for the potential of purchasing office space. Currently, the College leases office space at 65 St. Clair Ave East for a reasonable monthly rental price from the Ontario English Catholic Teachers Association (OECTA) and the College enjoys a responsive and formidable relationship with OECTA.

Given the passage of time since the establishment of the building acquisition fund, and a shift in the thinking of Council regarding ownership, retaining the fund is proving to be problematic from three key perspectives:

1. The Canada Revenue Agency (CRA) does not provide for not-for-profit organizations to amass significant reserves that are not being utilized or have the solid intention of utilization. *
2. The College is not capitalizing on opportunities to improve its capacity in areas such as strategic plan fulfillment, research, fee stabilization, fee recovery and public awareness.
3. During the continuing Covid-19 pandemic, financial hardships are mounting within our membership due to modified or absent practice constraints.

Currently, the building acquisition reserve is at 2,250,00.00 as per 2019 audited statements.

For Consideration

It is proposed to the Audit/Finance/Risk Committee (AFR) to consider bringing a motion to council to reallocate the current building acquisition fund to reduce risk, capitalize on opportunities and address realties as noted above.

The reallocation of this fund is within Council's mandate in addressing its fiduciary responsibility.

Fund Reallocation

As Registrar, I have undertaken an environmental scan of the strategic, operational and relational needs of the organization as found in the strategic plan, CPMF, committee discussions, staff perspectives and council debate.

From this undertaking, I would propose to the AFR for consideration the following reallocation table:

TABLE 1 - Items	Amount
Strategic Plan and CPMF Fund - Utilizing funds to rapidly address the areas identified in the CPMF as "not" or "partially" met to meet requirements by MOH (October 2021) - Utilizing funds to procure top priorities as identified of Strategic Plan 2020-2023	120,000 year x 5 years **600,000**
Research Fund - To add to the current envelope to fund research that supports the public interest mandate of the College. Fund is currently budgeted at 200,000 annually	100,000 year x 3 years **300,000**
Public Awareness - To provide priority funding to facilitate a sustainable program of public awareness and connection to the mandate of the College as described in the CPMF and Strategic plan	60,000 year x 5 years **300,000**
Staff Development and Succession Planning - Providing contemporary, post pandemic professional development and technology to staff. - Leadership development for succession planning within the organization - Normalization of compensation packages as determined by HR/Governance Committee	60,000 year x 5 years **300,000**
Fee Stabilization Fund - To increase reserve from 100,000 to 200,000	**100,000**
Fee Reduction for 2022 (Pandemic Response) - To provide a one-time reduction to members of 200.00 from their submitted 2022 annual membership fee.	**500,000**
Unrestricted Fund - To provide for unforeseen contingencies (e.g. legal)	**150,000**
Total	**2,250.000.00**

Potential motion to Council

"The AFR Committee recommends to Council the reallocation of funds currently held as the "Building Acquisition Fund" to fund the objectives and amounts as set out in Table 1"

Excerpt from Canada Revenue Agency – Non-Profit Organizations

¶ 9. The amount of accumulated excess income considered reasonable in relation to the needs of an association to carry on its non-profit activities and goals is a question of fact to be determined with regard to the association's particular circumstances, including such things as future anticipated expenditures and the amount and pattern of receipts from various sources (e.g., fund raising, membership fees, training course fees). For example, it is conceivable that there would be situations where an accumulation equal to one year's reasonably anticipated expenditures on its non-profit activities may not be considered excessive, while in another situation, an accumulation equal to the reasonably anticipated expenditures for a much shorter period would be considered more than adequate. Where the present balance of accumulated excess is considered excessive or an annual excess is regularly accumulated that is greater than an association's needs to carry on its non-profit activities (see ¶ 8), it may indicate that the association's aims are two-fold: to earn profits and to carry out its non-profit purposes. In such a case, the operated exclusively requirement in paragraph 149(1)(l) would not be met.

As discussed above, accumulating surplus funds in excess of its current needs may affect the association's status as a tax-exempt NPO. However, in certain cases, when an association requires a time period in excess of the current and prior year to accumulate the funds needed to acquire a capital property that will be used to achieve its declared exempt activities, the association's tax-exempt status may not be affected. For example, this could be the case if an association annually sets aside funds to provide for a special project such as the construction of a new building to replace an existing building when it deteriorates or no longer meets the association's needs. In such cases, any funds accumulated for this purpose should be clearly identified and all transactions concerning a special project should be clearly set out in the association's accounting records. Provided the funds accumulated for a special project are used for that project, an association's tax-exempt status should not be affected.

https://www.canada.ca/en/revenue-agency/services/forms-publications/publications/it496r/archived-non-profit-organizations.html

BRIEFING NOTE

Council Meeting – June 18, 2021

Subject

The College auditors will present the draft audited financial statements for the fiscal year ending December 31, 2020, to the Audit/Finance/Risk Committee on June 14, 2021. The auditors will then present to Council for approval at its meeting on June 18, 2021.

Decision(s) for Council

To approve the Audited Financial Statements for the year ending December 31, 2020.

Supporting Materials

- Draft audited financial statements will be sent to Council following the June 14, 2021, AFR Committee meeting.
  The draft audited financial statements are available here.

Contact

- Deborah McKeon, Manager, Finance and Office Administration

BRIEFING NOTE

Council Meeting – June 2021

Subject

Review of the College's current investment policy and practices.

Background

The Audit/Finance/Risk (AFR) Committee has been discussing the College's current Investment Policy and investment strategy over the course of the past year. At its meeting on May 13, 2021, the AFR Committee revised the current Investment Policy, which was last updated on September 17, 2017. The committee's discussion in support of these revisions included a review of:

- The performance of the long-term investments held in two wealth management portfolios and administered by investment managers.
- The volatility in the markets since early 2020 and best practices for protecting the College's surplus funds from membership fees, and the ability to access those funds for the College's strategic initiatives, operations, and unanticipated events as per CRA guidelines for reserve funds for NPOs.
- The cost of fees paid in 2020, and preceding years, to the investment managers.

Decision for Council

To approve the revisions to Investment Policy as presented in the attached draft document and approve the transfer of the College's long-term investments currently held in wealth management portfolios to Guaranteed Investment Certificate (GIC) or other bank instruments as provided for in the policy.

Considerations

The AFR Committee will meet to plan the transfer of these funds and develop a strategy for the purchase of bank GICs or other instruments with varying terms and rates, aligned with the approved budget and current strategic initiatives of the College.

Financial Implications

There could be interest and penalty costs associated with liquifying the investment portfolios.

Public Interest Mandate

The public interest mandate of the College is served through the protection of the College's surplus reserve funds.

Supporting Materials

- Draft Investment Policy dated May 13, 2021.
- Previous investment policy and guideline (September 2017) for reference.

Contact

- Deborah McKeon, Manager, Finance and Office Administration

Policy

Type:	Finance		
Name:	Investment Policy		
Status:	Draft	**Version:**	5
Date Approved:		**Date Revised:**	May 13, 2021

Table of Contents

Section 1. Purpose and Background

1.1. This Investment Policy governs the investment of both operating and reserve funds held by the College. In accordance with the College By-law, surplus funds, including those allocated to a reserve fund, may be deposited for safe-keeping, and withdrawn, from time to time, with one or more chartered bank, trust company or other financial institution in investment vehicles that do not present undue risk to the principal.

1.2. The College receives revenue primarily from member dues in November and December for the following fiscal year.

Section 2. Roles and Responsibilities

2.1. The roles and responsibilities concerning the administration and investment of the Accounts are allocated as follows:

The Council of the College

a) Approves the Investment Policy;

b) May establish reserve funds as required. At the end of each fiscal year, an allocation from any excess of revenue over expenses shall be made to maintain the reserve funds as established by the Council.

c) Approves the annual operating budget and type of investment income to ensure reasonable returns are maintaining the operation of the College.

The Executive Committee and Audit/Finance/Risk Committee

d) Receives policy recommendations from the Audit/Finance/Risk Committee (AFR) and moves the policy forward to Council for approval.

e) The Audit/Finance/Risk Committee actualizes the Investments Policy.

The Registrar and Audit/Finance/Risk Committee

f) Holds the assets of the Accounts in compliance with all applicable legislation.

g) Provides reports to Council on the status of the College's investments.

Section 3. Investment Objectives and Strategies

3.1. Reserve Funds

The reserve or restricted funds may be invested in short-term or long-term instruments, with the terms of up to 10 years as appropriate to the need for liquidity of the specific funds. The primary objectives of such investments shall be, in order of importance, preservation of capital and yield.

3.2. Surplus Funds

Surplus or unrestricted funds not needed to meet the College's operating expenses during the immediate 12-month period may be invested in short-term or long-term instruments with terms of up to 10 years. The primary objectives of such investments shall be, in order of importance, preservation of capital and yield.

3.3. Other Funds

Any other funds may be invested only in short-term instruments with a term of 0 days to 365 days, or in a pool of such investments. The primary objective of such investments, in order of importance, shall be preservation of capital, maintenance of liquidity, and yield.

3.4. Acceptable Investments

a) **Debt obligations issued or guaranteed by the Government of Canada or its agencies or Crown Corporations** or **managed pools of such instruments.** The College may invest in individual instruments or a managed portfolio of Government of Canada guaranteed securities.

b) **Debt obligations issued or guaranteed by Canadian, provincial, or territorial governments, banks listed in Schedule I or Schedule II under the *Bank Act (Canada)*, or Canadian corporations or managed pools of such instruments.** The College may invest in high quality debt obligations issued or guaranteed by Canadian, provincial, or territorial governments, and banks incorporated in Canada or Canadian corporations, or in a managed fund of such securities. All investments will be issuers who have a long-term credit rating of at least AA low (Dominion Bond Rating Service) or its equivalent or a short-term credit rating of R-1 Mid (DBRS) or its equivalent. A maximum of 10% of the investments will be securities from any one issuer other than government issuers.

c) **Short-term corporate paper or managed pools of such instruments** – The College may invest in individual instruments or in a managed fund that includes high quality short-term corporate paper and full collateralized loans on call. All investments in the fund will be issuers who have a credit rating of at least R-1 Mid (DBRS) or its equivalent. Each investment in the fund will have a maximum term to maturity of one year. The average term of the entire fund will generally range from seven days to 90 days. All securities will be marketable. A maximum of 10% of the investments will be securities from any one issuer other than government issuers.

Section.N Policy Review

N.1

The Audit/Finance/Risk Committee will review the policy on an annual basis with a full review of Section 3 -Investment Objectives and Strategies.

Related Policy: Reserve Funds

Approved by Council:

Policy

Type:	Finance		
Name:	Investment Policy and Guidelines		
Status:	Approved	**Version:**	4
Date Approved:	September 13, 2011	**Date Revised:**	September 19, 2017

Table of Contents

Section 1. Purpose and Background

1.1. This Investment Policy governs the investment of both operating and reserve funds held by the College. The purpose of the policy is to protect the membership fees collected by the College for operations and long-term restricted fund purposes with an objective of ensuring funds are not put at undue risk. College funds will be invested in compliance with the policies and procedures set out in this document. The goal underlying the Investment Policy is to ensure that the funds are invested in a prudent and diversified manner within the context of the *Trustee Act*. The Investment Policy also describes the monitoring procedures for College investments.

1.2. The majority of the income of the College is received as member dues in December for the following fiscal year.

1.3. The College maintains two investment accounts. The Short-term Account is used to provide the operating expenses of the College for up to 60 days. Investments in the Short-term Account must be liquid so as to be available when needed throughout the year. In addition, the College maintains a Reserve Funds Account with investments held on a longer-term basis; these may cover expenses for the fiscal year and potentially beyond, including any longer-term projects and initiatives. The budget of the College may specify an amount of investment income to be generated by the investments that is to be included in the operation of the College.

1.4. Council has appropriated some of the assets in the Reserve Funds Account for specific purposes ("Appropriated Funds"). The remainder of the assets are maintained as are considered "unappropriated" funds and are made available for operating activities.

Section 2. Roles and Responsibilities

2.1. The roles and responsibilities concerning the administration and investment of the Accounts are allocated as follows:

The Council of the College

a) Approves the Investment Policy;

b) Approves the appropriation of or changes to amounts held for specific purposes (Appropriated Funds);

c) Approves the annual operating budget and type of investment income to ensure reasonable returns are maintaining the operation of the College.

The Treasurer or Executive Committee

a) Develops and recommends the Policy and any appropriate amendments;

b) Reviews the Policy and expected rates of return on a yearly basis;

c) Approves the Custodian and the Portfolio Manager based upon the recommendation of the Registrar.

d) Monitors investment results at least quarterly according to the performance objectives defined in Section 3.

e) Monitors investments for compliance with the Policy.

f) Recommends the amount of investment income generated to be used for operational expenses in the annual budget.

g) Reports on the performance of the investment portfolio annually to Council after meeting with the Portfolio Manager.

h) Reviews the investments recommended by the portfolio manager.

The Registrar

a) After consulting with the Treasurer, makes investments in the Short-term and Reserve Funds Accounts according to applicable legislation and this Investment Policy;

b) Reports on the status of the College's investments at each Executive Committee meeting;

c) Participates in the establishment and annual review of the Policy by the Treasurer or Executive Committee.

The Custodian and Portfolio Manager

a) Holds the assets of the Accounts in compliance with all applicable legislation;

b) Provides monthly statements including information on account activity, interest payments, dividends earned, realized and unrealized returns, and book and market values;

c) Meets annually with the Treasurer and Executive Committee to report on the performance of the accounts relative to benchmarks, as well as expectations on the economic and financial market outlook and the related investment strategies for the upcoming year;

d) Explains the characteristics of various investment asset classes or investment instruments and how they may assist in achieving the College's objectives.

Section 3. Investment Objectives and Strategies

3.1. Short-term Account

The assets held in the Short-term Account are used to finance ongoing activities of the College. To the degree that funds are required to cover the operating expenses of the College, it is essential that the funds have sufficient liquidity to meet these obligations. The investment strategy employed by the College for the Short-term Account is characterized as a laddering approach with staggered maturities such that appropriate amounts of money will be available when needed throughout the year. This will dictate that the funds shall be invested conservatively in high quality securities to protect the principal. Appropriate investment instruments include government and government-backed bonds, strip coupons, "money market" investment funds, guaranteed investment certificates (GIC) and T-bills with at least investment grade quality rating. Investment grade means securities that on analysis qualify as a reasonable risk for institutional investment managers serving in a fiduciary capacity (R1). Maturities of debt instruments in the Short-term Account should not exceed 18 months.

3.2. Reserve Funds Account

The key objective of the Reserve Funds Account is to maximize long-term returns for current and future uses while keeping return volatility and other relevant risks at prudent levels. It is anticipated that the assets in the Reserve Funds Account will not be needed for the operation of the College in the current fiscal year. To the degree that investment income is required for use in the operation of the College, it is essential that the reserve funds earn sufficient income to meet these obligations. It is appropriate that assets in the Reserve Funds Account be invested in longer-term debt securities, equities or pooled funds. The College has authorized the following long-term asset mix:

- Equity –30-60%
- Debt (including Money market and cash) –40-70%

Debt Securities: Appropriate debt security investments in the Reserve Funds Account include bonds, debentures, notes, pools and other debt instruments with maturities between 1 and 15 years at the time of purchase. All debt securities must have at least an investment grade rating at the time of purchase (A or better, as rated by a recognized credit agency). The debt securities are public offerings and least 30% of the debt securities should be invested in federal or provincial Canadian government and government guaranteed bonds. A maximum value of 5% of the account market value may be held in any single corporate name. All mortgages held in the Account must be guaranteed by the CMHC or a recognized mortgage insurance company.

Bond trading should consider expectations about future interest rates, bond price sensitivity to interest rates, credit quality, liquidity and market pricing**.**

Equities: Reserve funds may be invested in quality, blue-chip equities, mutual funds, and income trust units. The equity portion of the Reserve Funds Account will not exceed 60% of the market value of the Account.

To diversify risk and enhance expected returns, equity and debt investments will be allocated among the following asset classes and will be maintained within the corresponding ranges expressed as a percentage of the Reserve Funds Account based on the market values of the investments.

Asset Class	Minimum (%)	Maximum (%)
Total Debt	**40**	**70**
Money Market and cash	0	10
Debt Instruments	40	60
Total Equity	**30**	**60**
Canadian Equity	20	30
US Equity	5	15
International Equity	5	15

3.3. Legal Restrictions

Investments in both Accounts shall comply with any legal restrictions externally imposed or contracted. The application of this Policy must take account of these legal restrictions, specifically the *Trustee Act* and any other relevant restrictions.

Section 4. Corporate Responsibility

The College is funded by its members. As such the Portfolio Manager will not knowingly invest in the following:

- Companies whose earnings are derived from the provision of ophthalmic services or goods;
- Industries/companies or countries not supported by government policies or which are subject to economic sanctions imposed by our federal government;
- Companies whose earnings are derived from production or distribution of tobacco or alcohol products.

Section 5. Performance Evaluation

5.1 Short Term Account

a) The objective of the Short-term Account is to preserve principal and earn a reasonable rate of return on short-term investments. The rates of return should equal or exceed the FTSE TMX 91-Day-T Bill Index rate over rolling one-year periods.

5.2. Reserve Funds Account

a) The Reserve Fund's investment objective is to maximize long-term returns for current and future uses while keeping return volatility and other relevant risks at prudent levels.

b) It is recommended that at least on a quarterly basis, the financial performance of the investment portfolio (as managed by the investment advisor) be compared with those of relevant investment benchmark indices. The investment portfolio is allocated into several asset classes, and asset allocation is set within the terms established through the Investment Policy Statement (IPS). The performance of each asset class within the portfolio should be compared to relevant benchmark indices for the given asset class. The choice of suitable benchmark index will be reviewed on an annual basis by the Treasurer.

   The asset classes of the College's investment portfolio and their currently-selected benchmarks are shown below.

   i. **Canadian equities.** The benchmark is the S&P/TSX Capped Composite Index Real-estate investment trusts (REITs) are considered within this class. The acceptable annual tolerance (net of expenses) would be within 200bps (2%) of the relevant index's performance.

   ii. **Canadian fixed-income.** The benchmark is the FTSE TMX Canada Universe Bond Index). Funds containing preferred shares and/or classified as "income funds" are classified as fixed income securities. The acceptable annual tolerance (net of expenses) would be within 150bps (1.5%) of the relevant index's performance.

   iii. **US equities.** The benchmark is Canadian-dollar denominated S&P 500 Index). The acceptable annual tolerance (net of expenses) would be within 300bps (3.0%) of the relevant index's performance.

   iv. **International equities**. The benchmark is Canadian-dollar denominated MSCI EAFE index. The acceptable annual tolerance (net of expenses) would be within 300 bps (3.0%) of the relevant index's performance.

   The annualized return of each of these classes is expected to be within a certain tolerance (in basis points, or hundredths of percentage-point differences) of the applicable investment index.

   Should the 12-month performance of one of these asset classes fall below the relevant tolerance level, the College would consider a more comprehensive review of the investment manager's performance and suitability for managing the College's investable assets.

Section 6. Administrative Matters

6.1 Conflict of Interest Policies and Procedures

A conflict of interest, whether actual or perceived, is defined, for the purposes of this policy, as any event in which the College or an Agent, including the Treasurer or any member of the Executive Committee, an employee of the College or any directly related party, may benefit from knowledge of, or participation in, or by virtue of, an investment decision or holding of the Funds or business transaction with the Funds.

The following sets out the steps to be taken by the above noted parties to protect the Funds from any conflicts, which may arise between the interests of the Funds, the College, the personal interests of individual Councillors or officers of the College and other related parties.

Should such an event arise, the party in the actual or perceived conflict shall immediately disclose the conflict to the President of the College. The President will immediately advise Council in writing of the actual or perceived conflict, and Council shall decide upon a course of action. The person declaring the conflict shall be absent from any discussions and voting in the matter of the conflict.

A Councillor or College staff member will declare a conflict and leave any meeting of the Council during the discussion of any matter in which she/he has a personal or business interest, which may conflict with the interests of the Accounts.

Section 7. Monitoring and Policy Review

7.1 Monitoring

The Treasurer, Executive Committee and Registrar will meet at least twice per year to review the assets, net cash flow and performance of the Accounts, the current economic outlook and investment strategies of the portfolio manager, and to take any action necessary to ensure compliance with this Policy.

7.2 Policy Review

A review of the policy will occur annually with a full review of Section 3 (Investment Objectives and Strategies) and 5.0 (Performance Evaluation)

Approved by Council - September 13, 2011
Revision to Section 5.2 (b) approved by Council - June 6, 2014
Revision to Section 3.2 approved by Council - September 30, 2015
Revised and approved by Council - September 19, 2017

BRIEFING NOTE

Council meeting – June 2021

Subject

Entry-to-Practice Exam

Background

The College President was appointed to the Board of Directors for the Optometry Examining Board of Canada (OEBC) in fall 2020. The OEBC's One Exam Working Group, which includes the College President, has been working toward having one entry-to-practice exam in Canada. The Ordre des Optométristes du Quebec (L'Ordre) and the College of Optometrists of British Columbia are also represented in this working group. The purpose of the working group is to:

- approve policy direction that achieves the objective of one Canadian entry-to-practice exam; and
- identify the items that OEBC must address to realize this objective.

The working group authored the *One Entry-to-Practice Exam is Good for Canada* report. OEBC provided the report on May 3, 2021, for distribution to the College Council.

Decision for Council

That Council receive the *One Entry-to-Practice Exam is Good for Canada* report.

Considerations

- OEBC is currently piloting changes to the OEBC exam.
- It was recently clarified by OEBC's CEO that changes to the OEBC exam are expected in spring 2022.

Financial Implications

Not applicable to the College.

Public Interest Mandate

Having a robust and defensible entry-to-practice exam is a core public interest mandate for the College.

Supporting Materials

One Entry-to-Practice Exam is Good for Canada report

Next Steps

The Registration Committee is to continue discussions with OEBC regarding piloting the changes to be made to the OEBC exam and standard-setting.

Contact

Hanan Jibry, Deputy Registrar

OPTOMETRY EXAMINING BOARD OF CANADA

BUREAU DES EXAMINATEURS EN OPTOMÉTRIE DU CANADA

One Entry-to-Practice Exam Is Good for Canada

OEBC is engaging more collaboratively with stakeholders. It is responsive to the needs of individual provincial regulators, working together to anticipate and research the next levels of assessment, and sharing richer data with the Canadian schools about student performance. With more transparency and engagement, we remain optimistic that a future with OEBC as the single assessment for Canada will be in the interests of all Canadians and the optometry community.

Report by

One Exam Team

Dr. Léo Breton, chair

Dr. Joan Hansen

Dr. Patrick Quaid

May 3, 2021

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Suggested Draft Resolution for Board/Council Consideration

Whereas the optometry regulatory authorities are the members of OEBC, control OEBC and the content of its exam and want OEBC to provide the best Canadian-based assessment of optometric competencies, at a reasonable cost;

Whereas, having a common relevant, fair, valid and defensible bilingual entry-to-practice examination for optometry that reflects the cultural and systemic values of Canada and requirements specified by optometry regulatory authorities in Canada is in the public interest;

Whereas, the optometry community in Canada widely supports having a Canadian entry-to-practice exam in optometry;

Whereas the report commissioned by FORAC concluded that the NBEO examination is not appropriate to determine if entry-level competency has been met for optometric practice in Canada;

Whereas OEBC currently captures fewer than 50 percent of possible exam candidates taking an entry-to-practice exam for registration in Canada;

Whereas the is no reciprocity of the State Boards in the United States accepting the OEBC exam to meet its registration requirements; and

Whereas OEBC is committed to serving Members, as demonstrated through the changes implemented in the past years and the significant projects underway (see chart below).

Changes Implemented *(Appendix A for details)*

- ✓ *Governance – Member representative Board*
- ✓ *Exam Oversight – Key Board responsibility*
- ✓ *Enhance communication with Members and stakeholders*
- ✓ *Comprehensive update of by-laws*
- ✓ *New management*
- ✓ *Policy changes*
- ✓ *Exam cost structure*
  - *capitalizing exam development*
  - *20% cost reduction*
  - *Fee model – to eliminate future rate shocks*
- ✓ *Competitive bid for assessment services*
- ✓ *Exam Content*
  - *Technical Skills in OSCE consultation*
  - *Pilot testing of some OSCE stations on written exam*
- ✓ *Exam Delivery*
  - *Computer-based written exam, 100% via remote proctoring spring 2021*
  - *Testing pods, successful pilot Fall 2020 (5 candidate minimum)*
  - *OSCE at optometry schools*
- ✓ *Candidate Support*
  - *Information meetings with COAS Chapters*
  - *Delivery of written exam in the US*
  - *Candidate Study Guide Published*
- ✓ *Relationship between FORAC and OEBC defined/clarified*

Changes Underway *(Appendix B for the status)*

- *Assessing key core technical skills on live patients at OSCEs (Spring 2022)*
  - *Enhancing the OSCE scoring system and new professionalism scoring scale*
- *University of Montreal students will challenge both components of the OEBC exam (first administration in Fall 2021)*
- *Adopting the new competency model developed by the College of Optometrists of Ontario*
  - *Creating a new exam blueprint*
  - *Updating Exam Topic Matrix*
- *US optometry schools allowing Canadian students to write OEBC to satisfy ACOE accreditation requirements*
- *Enhancing written exam with cases using high-resolution photographs & video (Fall 2021)*
- *Enhancing statistical reporting system*
  - *Better feedback for candidates*
  - *Performance reporting for optometry schools*
- *Policy to ensure a smooth transition from NBEO as an equivalent exam*

Be it resolved, that the {college/ordre} approves in principle of having OEBC as its exclusive supplier of entry-to-practice examinations once OEBC satisfies all Members' requirements, including the following specific requirements for the {college/ordre}:

Members created OEBC to develop and administer a common optometric examination on their behalf,

WITH EXCLUSIVITY	WITHOUT EXCLUSIVITY
CANADA WILL CONTINUE TO HAVE A ROBUST, PSYCHOMETRICALLY VALID AND DEFENSIBLE BILINGUAL ASSESSMENT TO ESTABLISH ENTRY-TO-PRACTICE COMPETENCE IN OPTOMETRY FOR UNDER $4,000.	TOO FEW CANDIDATES TO SUSTAIN OEBC OPERATIONS BEYOND 2023. RAISING EXAM FEES BEYOND $5100 WOULD FURTHER DETERIORATE ITS CAPTURE RATE.

Are OEBC and NBEO exams equivalent?

FORAC commissioned an expert report in July 2019 to answer the research question –

> "*Is the NBEO examination appropriate for the Canadian context to determine if entry-level competency has been met for optometric practice in Canada?*"

In January 2020, the FORAC members received the Report (Appendix J). It concluded that

- OEBC and NBEO exams are not equivalent
- OEBC and NBEO exams are intrinsically satisfactory for their respective jurisdictions
- NBEO is not an appropriate entry-to-practice assessment for Canada
- NBEO does not appear to satisfy the critical criteria of validity and acceptability for Canada
- Cultural and systemic differences between the Canadian and US health systems create additional barriers to have one exam that is appropriate for Canada and the US
- High fees pose an accessibility barrier for those candidates wanting to write the OEBC exam
- Some optometric regulatory authorities may face challenges if the OEBC dissolves, i.e., failure to offer an exam in both French and English to an applicant would breach legislation in some provinces, and dealing with those candidates who, for various personal reasons, may be denied entry to the United States, who would be otherwise qualified to write the OEBE exam

Note: On April 29, 2021, the Canadian Journal of Optometry (CJO) accepted the manuscript submitted by the authors of the FORAC report for publication. Their paper, *Applicability of Entry to Practice Examinations for Optometry in Canada*, will likely be published in January 2022. The manuscript is not provided as an appendix of this report as it cannot be published in two places.

CJO confirmed that the authors are able to share the document in confidence with the One Exam team and the OEBC Directors with the understanding that the report would not be published elsewhere.

OEBC is seeking to obtain permission form CJO and the authors to share the manuscript with officials of its Member organizations.

Executive Summary

After graduation, an optometrist, unlike other professions requiring residency/internship, may immediately register to practice independently in Canada. For public safety, the optometry regulatory authorities (OEBC's "Members") require applicants to have the following qualifications:

- an accredited[1] OD degree (or equivalent)
- passing the national entry-to-practice exam (or equivalent)
- passing a jurisdiction-specific jurisprudence exam

When Members rely on a third party to assess qualifications, they must take reasonable measures to ensure that the third party makes the assessment in a way that is transparent, objective, impartial and fair.

ONE EXAM ≡ ONE STANDARD FOR CANADA
as defined by the provincial optometry regulatory authorities

The validity and defensibility of a credentialing examination depend upon two critical criteria[2]:

1. The exam must measure the competence required for safe and effective entry-level job performance.
2. The exam must distinguish between candidates who do and do not possess this competence.

Members require OEBC to provide a relevant, fair, valid and defensible examination that reflects the knowledge and skills necessary for competent performance for public protection. The exam must be available in French and English.

An expert report (2020) commissioned by FORAC[3] concluded that the NBEO[4] exam is not an appropriate entry-to-practice assessment for Canada. Thus, the OEBC and NBEO exams are not equivalent. However, three jurisdictions continue to accept the NBEO exam.

To ensure the exam is objective, it must reflect the cultural and systemic values of the health care system in Canada and the competencies of a minimally qualified practitioner. During the pandemic, many in the profession and the public observed significant differences in the cultural and systemic values of the health care system in Canada and the US.

While not ideal, in 2018-19, when only two jurisdictions accepted the NBEO, OEBC administered its exam to 83 percent of potential candidates. However, in 2019, when the third jurisdiction chose to accept the NBEO examination as an equivalent entry-to-practice examination, only 47 percent of potential candidates for the OEBC exam registered for it in 2020-21[5] (Table 1).

[1] Accredited by the Accreditation Council on Optometric Education
[2] *Development, Administration, Scoring and Reporting of Credentialing/Registration Examinations*, p.1, the Council on Licensure, Enforcement and Regulation (CLEAR)
[3] The Federation of Optometry Regulatory Authorities in Canada and OEBC have the same members
[4] National Board of Examiners of Optometry (US equivalent to OEBC)
[5] OEBC's fiscal year roughly align with the school year (October-September)

Members Have Ultimate Control Over OEBC

Members have ultimate control over OEBC and can thus ensure that its entry-to-practice examination reflects the public interest. However, an optometry regulatory authority in Canada has no input into the NBEO exam.

Members can take reasonable measures to ensure that OEBC makes the assessment in a way that is transparent, objective, impartial and fair. However, they have little ability to influence NBEO's examinations.

The expectations for entry-to-practice of the exam must satisfy the critical criteria of validity and acceptability, including Canadian culture and systemic approach of the health system, as defined by the Members.

NO RECIPROCITY BETWEEN THE UNITED STATES AND CANADA.

DESPITE BEING RECOGNIZED AS AN EQUIVALENT TESTING AGENCY BY ACOE, NO STATE BOARD ACCEPTS OEBC EXAM AS MEETING IT REGISTRATION REQUIREMENTS.

The One Exam Team asked FORAC members to identify any known issues and emerging issues regarding the principles and proposed actions on February 27, 2021. This paper aims to confirm Members' interests in having a Canadian exam and identify the additional activities that OEBC must accomplish to earn their support.

The future success of OEBC is dependent upon the continued support of all of its Members. Should some Members continue to accept the NBEO exam as an alternative, administered to those candidates wanting to practice in Canada, OEBC will not generate adequate assessment fee income to fund its operating activities. This shortfall would affect the organization's ability to continue as a going concern.

OEBC is continuing to evolve the exam to meet Members' needs. However, it is not generating adequate assessment fee income to fund its operating activities.

Continuing Erosion of Exclusivity

Member buy-in was less than adequate when OEBC incorporated an objective structured clinical exam (OSCE) in 2017. OSCEs are ubiquitous in other health care professions such as medicine, nursing, and pharmacy. OEBC also failed to gain stakeholder and Members' buy-in when it attempted to collect GST/HST from stakeholders and increased its fees by 85% in a single year.

Quebec has accepted the NBEO from the inception of OEBC. However, very few applicants register in Quebec using the NBEO. BC has considered the NBEO as an "equivalent exam" since 2009. Alberta accepted the NBEO in (2009-10) and discontinued accepting it in 2010 for applicants registering in 2011.

Since OEBC's inception, the College of Optometrists of Ontario (COO) had been a strong supporter of a national entry-to-practice exam and OEBC. However, in 2019, mainly out of frustration from (i) not being listened to on clinical skills testing and (ii) learning that significant aspects of the exam had been changed without their specific consent, the COO began accepting the NBEO.

OEBC took Members' and stakeholders' dissatisfaction to heart. Since 2019, OEBC has taken numerous actions related to governance, management, exam oversight, exam cost, delivery modes, and exam content to restore its Members' and stakeholders' confidence and support.

When founded in 1995, OEBC[6] was not provided exclusive authorization by all Members in delivering its services. However, they agreed that all Members allowed by provincial legislative mandate would require OEBC qualification examinations within five years of incorporation.

Some Members have had their fair share of problems with OEBC in the past, but One Exam Team is advocating that a restructured OEBC is the best option. Continuing to transform OEBC to provide the best Canadian-based assessment of optometric competencies at a reasonable cost is a platform where OEBC can thrive, and all Members could endorse OEBC exclusively.

Cross-Jurisdictional Performance on Exams

It is worth noting that US-trained candidates' success rate on the OEBC exam is about 20% lower than those trained in Canada. The most significant gaps are in the practice areas of patient-centred care and patient management. (Appendix D – Success Rates), whereas the practice areas of assessment and diagnosis & planning show little difference in exam performance.

However, similar lower-than-expected performance occurs with Canadian-trained students challenging the NBEO.

> *"A relatively small sample of Canadian students have taken some or all parts of the NBEO, and a preliminary review at the University of Waterloo indicates that our students demonstrate a wider range of scores and trend lower than expected. For those candidates who took both the OEBC and NBEO, it may be insightful to identify any systematic bias that may be reflective of intrinsic cultural and professional differences between expectations for practice in the US versus Canada."*[7]

The conclusion above appears to align with the findings in FORAC's expert report. However, other factors may contribute to the differences in performance between the training jurisdiction, such as availability of exam preparation resources[8] and "a home-court advantage."

[6] Established as Canadian Examiners in Optometry which became Optometry Examining Board of Canada in 2017
[7] Stanley Woo, OD, MS, MBA, FAAO, Director- University of Waterloo School of Optometry and Vision Science, Jan.19, 2019
[8] NBEO preparation programs and resources have been available for students to purchase for many years; OEBC published a free study guide in March 2021

Introduction

Optometry Examining Board of Canada (OEBC) is a national not-for-profit corporation. Its members are the ten provincial optometry regulatory authorities in Canada.

- ***Vision*** *— To be the sole provider of competence assessments for optometric regulatory authorities in Canada.*
- ***Mission*** *— To continually develop and administer a legally valid and defensible entry to practice examination to assess competence in the practice of optometry in Canada that meets Members' expectations.*
- ***Values*** *— A commitment to trust, integrity, transparency, engagement, and responsibility.*

In 1995, the optometry regulatory authorities in Canada (Members) created the Optometry Examining Board of Canada[9] (OEBC) to develop and administer a common optometric qualifying examination on their behalf. The National Board of Examiners in Optometry (NBEO) supported OEBC in creating a Canadian exam. Thus, the US and Canadian exams closely paralleled each other for the first seven years.

These exams assessed the knowledge and technical skills that a student should acquire in a doctor of optometry degree program (or OD program) accredited by the Accreditation Council on Optometric Education (ACOE).

Over the ensuing years, dedicated volunteer optometrists, working with OEBC, evolved the exam to assess new entry-to-practice competence. The exam's over-arching goal is public protection — evaluating if a candidate can practice independently with competency and integrity. OEBC ensures that the exam is psychometrically valid and a defensible assessment of entry-to-practice competence in optometry.

What Went Wrong?

Over the years, OEBC's independence increased. When it transitioned to the new exam in 2017-18, members' buy-in was less than adequate. Also, Members directed OEBC to become financially independent and sustainable. Appropriately it chose to build reserve funds. However, it also decided to recover the new exam's total development cost through fees over two years. The exam fee soared by 85% to $5900. The board reduced the exam fee to $5100. However, Members have stated that the OEBC exam should target to be under $4,000.

Some Members felt they did not have appropriate oversight over OEBC and the Exam. To regain control, the Members installed their Registrars as the board in 2019.

In 2020, the OEBC by-laws were redrafted to meet Members' needs, and the board replaced the CEO.

Some Members felt it was essential to test the technical skills of candidates. OEBC has circulated a discussion paper in early 2021. At its March 2021 meeting, the OEBC board directed the CEO to incorporate technical skills testing in OSCE being in the spring of 2022.

In 2019, stakeholder support for OEBC was not unconditional. They required OEBC to engage more collaboratively with stakeholders.

[9] Established as Canadian Examiners in Optometry which became Optometry Examining Board of Canada in 2017

Being more responsive to individual Members' needs, working together to anticipate and research the next levels of assessment, and sharing data with the Canadian schools about student performance are important topics to address in earnest. With more transparency and engagement, stakeholders remain optimistic that a future with OEBC as the single assessment for Canada will be in the interests of all stakeholders.

Table 1 shows the capture rate by OEBC of candidates for the past 20 years.

Table 1- Capture Rate of Potential OEBC Candidates (2002-2021)

Examination		No. of Candidates				Capture Rate			
	Year	Total	CDN	US	Int	Total	CDN %	US %	INTL %
OEBC	2020-21	157	100	24	33	47%	64%	17%	100%
OEBC	2019-20	161	104	31	26	50%	67%	22%	100%
OEBC	2018-19	248	113	106	29	78%	72%	80%	100%
OEBC*	2017-18	260	110	125	25	83%	71%	95%	100%
CACO/OEBC	2016-17	199	92	78	29	61%	68%	49%	100%
CACO	2015-16	241	126	78	37	80%	99%	56%	100%
CACO	2014-15	257	124	80	53	80%	91%	61%	100%
CACO	2013-14	274	128	107	39	91%	97%	83%	100%
CACO	2012-13	240	131	75	34	87%	99%	69%	100%
CACO	2011-12	214	108	73	33	75%	81%	60%	100%
CSAO/CACO	2010-11	165	102	40	23	60%	78%	33%	100%
CSAO	2009-10	173	98	29	46	59%	75%	25%	100%
CSAO	2008-09	238	91	104	43	84%	69%	95%	100%
CSAO	2007-08	215	83	97	35	83%	71%	90%	100%
CSAO	2006-07	170	88	70	12	81%	77%	83%	100%
CSAO	2005-06	141	66	60	15	68%	65%	67%	100%
CSAO	2004-05	149	67	58	24	76%	63%	91%	100%
CSAO	2003-04	120	67	35	18	63%	61%	56%	100%
CSAO	2002-03	127	61	52	14	77%	92%	62%	100%
CSAO	2001-02	124	66	51	7	64%	62%	65%	100%

Key

- * 1/3 of the candidates of the written component + 2/3 of the candidates for the OSCE component
- Year means school year (September-May)
- Capture Rate is calculated by (*the number of test-takers*)/ (*possible new candidates plus the candidates who unsuccessful and have remaining eligibility*)
- CDN - students in OD programs at WOVS and EOUM
- US - Canadian students in OD programs at ACOE schools in the US
- International - Bridging programs + exempt candidates

Uncertainty Due to NBEO

The economics of supply and demand are self-evident. OEBC cannot compete with NBEO.

OEBC has a small number of candidates to amortize fixed and development costs over. Less than 20% of OEBC expenses are variable. OEBC must also provide a bilingual exam.

GOING CONCERN NOTE

OEBC earns assessment fees by providing a psychometrically valid and defensible assessment to establish entry-to-practice competence in optometry in Canada. The future success of OEBC is dependent upon the continued support of all of its members. Three of its ten members accept the NBEO exam as an alternative standard. Should these members continue to accept the NBEO exam as an alternative, administered to those candidates wanting to practice, OEBC may not generate adequate assessment fee income to fund its operating activities and this would affect the organization's ability to continue as a going concern.

Note 1—OEBC's 2019-20 Financial Statements

Eleven of the 23 ACOE accredited optometry programs in the US require their students to attempt the NBEO exam. If a Canadian attending one of these schools must pay for the NBEO, and if Members accept that exam for registration purposes, it is unlikely that the student would also register to take the OEBC exam. Even if the jurisdiction where they intend to practice does not accept the NBEO, financially, it makes sense to first register in a jurisdiction that accepts the NBEO and transfer under the mobility agreement. The additional registration may cost $2000 versus the $5100 for the OEBC exam.

Adopting the NBEO for entry to practice examination by some optometry regulatory authorities in Canada will cause the eventual demise of the OEBC. The loss of the OEBC exam creates uncertainty for registrants, the profession, and the public.

FORAC Expert Report (2020)

> ***"Is the NBEO examination appropriate for the Canadian context to determine if entry-level competency has been met for optometric practice in Canada?"***

Some Members have been seeking an answer to this question since 2009[10].

The provincial optometric regulatory authorities in Canada are the members of FORAC. Regulators often compare the OEBC exam to the NBEO exam to measure entry-level competence. In 2019, FORAC engaged the University of Waterloo, School of Optometry & Vision Science, to conduct a review based on the research question above.

The deliverables were a white paper for FORAC members and a manuscript of publishable quality for peer-review journals. A copy of the white paper is in Appendix J.

The project team consisted of Drs. Patricia Hrynchak, Natalie Hutchings, and Stanley Woo. Other interested faculty, along with graduate students, were invited to participate in the study. The authors received their optometry training in three different jurisdictions – Dr. Hrynchak received her Doctorate

[10] CORA representative agreed to ask for a comparative study of the Canadian Standard Assessment in Optometry (CSAO) and the NBEO, considering that with such a study, if it can demonstrate that these are two equivalent examinations, Canadian regulators could ask for the recognition of the CSAO by US regulators.

of Optometry from the University of Waterloo, Dr. Hutchings received her Ph.D. Vision Science, Aston University, UK, and Dr. Woo received his Doctorate of Optometry from the University of California at Berkeley, which provides a broad perspective to the assessment.

The expert report[11] was release to FORAC members in January 2020. It concluded that the exams are **not equivalent** and that the NBEO is not an appropriate entry-to-practice assessment for Canada.

> "OEBC is a more contemporary assessment than the NBEO with the incorporation of OSCEs, (Objective Structured Clinical Exam) which are ubiquitous in other health care professions such as medicine, nursing, and pharmacy."

The report concludes,

> *A framework for evaluating the appropriateness of each assessment, OEBC and NBEO, is intrinsically satisfactory for their respective jurisdictions, i.e., Canada and the US. However, when applied across jurisdictions, the NBEO does not appear to satisfy the key criteria of validity and acceptability for Canada. Parallels with the nursing profession highlight cultural and systemic differences between the Canadian and US health system, which is reflected in the expectations for entry to practice. The potential loss of a viable, bilingual OEBC assessment is also a threat to the assessment system for FORAC. Lastly, the OEBC is a more contemporary assessment than the NBEO with the incorporation of OSCEs, which are ubiquitous in other health care professions such as medicine, nursing, and pharmacy. We conclude that the NBEO is not an appropriate entry-to-practice assessment for Ontario, specifically, and Canada more broadly.*

The manuscript, Applicability of North American Entry to Practice Examinations for Canada, has been "submitted, in review" to the Canadian Journal of Optometry (CJO). CJO may publish the manuscript as early as January 2022. The publication may create some public concern that some optometric regulatory authorities continue to use the NBEO exam 24 months after receiving FORAC's expert report deemed that the NBEO not an appropriate entry-to-practice assessment for Canada.

COO had concerns about the objectivity and impartiality of the review process, which was different from its review process of the acceptance of NBEO in January 2019. COO noted that opposition could be perceived as direct opposition to their acceptance of NBEO. Still, the intent of the review was not to lay blame on any individual organization but to answer the research question noted above. The authors removed statements identified as troubling to the COO before submitting the manuscript to the CJO for publication. At this time, the manuscript is in press and embargoed.

If FORAC's third-party review concluded that the OEBC exam and NBEO were not equivalent, it would provide jurisdictions with evidence to consider reversing their decision to accept the NBEO.

[11] Woo, S., Hrynchak, P., Hutchings, N. Applicability of Entry to Practice Examinations for Optometry in Canada and the United States – Optometry Examining Board of Canada and National Board of Examiners in Optometry, Jan 2020

The Situation (2009-10)[12]

In 1995, OEBC[13] was not provided exclusive authorization by all Members in delivering its services. Within five years of incorporation, all Members allowed by provincial legislative mandate to require qualification examinations endorsed OEBC exclusively. OEBC's role expanded over time based upon its ability to deliver appropriate and relevant services for its Members and Canadians.

After discussion at the January 2009 meeting of the Council of Optometric Regulatory Authorities (CORA), the participants agreed to:

- Support the principle of the CSAO as the requirement for licensure in Canada, considering the MRA signed in 2001 (Appendix F);
- Ask for a comparative study of the Canadian Standard Assessment in Optometry (CSAO) and the NBEO, considering that with such a study, if it can demonstrate that these are two equivalent examinations, Canadian regulators could ask for the recognition of the CSAO by US regulators.

New labour mobility measures adopted by provincial governments in 2009 and some Members' decisions to accept NBEO examinations equivalent to the CSAO have radically altered the operating environment for OEBC[14]. With most of Canada's future optometrists training outside Canada, particularly in the United States, and with many of those candidates required to take the NBEO to graduate, OEBC's position eroded. Without continuing and concrete affirmation of OEBC's mission and mandates, Members face the loss of assets and their ability and authority to guide Canada's profession.

At a special meeting on October 16, 2010, Members discussed OEBC's continuity or dissolution. Excerpts of the paper that served as the background information necessary for OEBC's Members to make an informed decision about the corporation's future are provided in Appendix H.

It identified three options;

1. to restore to OEBC favoured status, by all Members endorsing its services and, where lawfully possible, to utilize only its services
2. to further reduce OEBC's favoured status, by Members making no changes to their current policies or by accepting the examinations of the NBEO as equivalent to the CSAO
3. to dissolve OEBC

At the 2009 Meeting of Members, CEO-ECO presented the following position respecting CORA's discussion of accepting the National Board of Examiners in Optometry's examinations as a replacement or substitution for the Canadian Standard Assessment in Optometry. (Appendix G)

The One Exam Team asked the Alberta College of Optometrists to provide a report (Appendix K) that outlines its move to accept NBEO and its subsequent reversal of the decision.

[12] Business Plan Options provided to Members in 2009
[13] Then known as the Canadian Examiners in Optometry – Examinateurs Canadiens en Optométrie (CEO-ECO)
[14] In 2009, Alberta joined BC, and Quebec in accepting NBEO.

What Success Looks Like

1. **One Canadian Exam** —All Members exclusively use the OEBC exam.
2. **Relevant/Robust Exam** — OEBC continually develops and administers a legally valid and defensible entry to practice examination to assess competence in optometry, the culture and systemic values of the Canadian health care systems and meeting Members' expectations.
3. **Good Governance** — Members have appropriate oversight regarding the OEBC content exam and fees through their board appointees.
4. **Effective Management** — OEBC operates with a commitment to trust, integrity, transparency, engagement, and responsibility with Members, stakeholders and the optometry community.
5. **EOUM Students Challenging the entire OEBC Exam** — Before OEBC raised the exam fee to $5900 in 2017, EOUM students challenged clinical and written components of the OEBC exam . Today, all EOUM students challenge the written exam; however, only the students intending to practice in other parts of Canada challenge the OSCE. EOUM students will challenge the entire OEBC exam, starting with the class of 2022. An OSCE administration will be held in Montreal each spring.
6. **Reasonable Fees** — The fee for the exam is under $4,000, and the capitalization of exam fees to avoid future potential rate shocks. OEBC provides remote administration, where the quality of assessment is not impacted, to reduce candidate out-of-pocket expenses.
7. **Avoid Duplication** — Canadian students trained in the US would not be required to challenge some or all of the NBEO by their institution for accreditation purposes.

One Canadian Exam

The Canadian optometry regulators founded OEBC to develop and administer a **common optometric qualifying examination** on their behalf — for the profession. Before OEBC's existence, each provincial optometric regulatory body produced its own qualifying exam to assess the new applicant's readiness to practice. In 1993, labour mobility regulations heightened the need for a Canadian entry-to-practice examination that all Canadian jurisdictions would accept as a licensure qualification.

Members supported the principle one exam — the CSAO exam as a requirement for licensure in Canada — when they signed a Mutual Recognition Agreement on September 29, 2001. (Appendix F)

As the Members would control the exam content of OEBC, it would be their exclusive provider of entry-to-practice exams. The exam is an objective, impartial, fair, valid, and defensible bilingual examination and reflects Canada's health care system and culture.

Today's Approach

OEBC formed the One Exam Team in December 2020. The team's focus is having only one accepted entry-to-practice exam for optometry in Canada. The purpose of the group is,

> *"To seek to have the Councils/Boards of the College of Optometrists of British Columbia, College of Optometrists of Ontario, and Ordre des Optometristes du Quebec to approve policy direction that achieves the objective of one Canadian entry to practice exam and identifying the items that OEBC must address to realize this objective."*

The team has prepared this report to present to the Board/Councils in BC, ON and QC in June. At these meetings, team members will seek to attain the approval of a resolution setting of Council/Board's support in principle of having only one exam in Canada and identifying the issues that OEBC can address to advance the removal of the NBEO. The expectation is that once the "checklist" of necessary conditions has been satisfied, the Councils/Board would be in a position to provide exclusivity to OEBC regarding its entry-to-practice exam. OEBC would target to have all the actions completed before the end of the year, and the candidate pool for the Spring 2022 administration would increase substantially. The Report will include the requirements that have been identified, and each Council/Board may add others as they deem necessary.

Broad Support from Stakeholders

In its recent consultation regarding technical skills assessment, stakeholders across Canada extended support for one exam. Among the themes included:

- the ability for the profession to control its destiny within the Canadian healthcare system is of paramount concern
- an appreciation that the National Competency Profile and examination for entry-level optometry in Canada for "safe, effective, and ethical practice…." was developed in Canada for the Canadian context
- the opportunity to take the examination in French or English
- the leadership in Optometry looking less and less to America, and instead of growing the opportunities in Canada
- the central pillar of FORAC's strategic plan is to work towards one single and Canadian national entry-to-practice exam that is accepted by all the provinces

OEBC must maintain this level of support for long-term success.

In 2018, the Office of the Fairness Commissioner (OFC) supported the COO's decision to accept the NBEO in addition to the OEBC for entry to practice examination. However, the OFC also acknowledged that the potential dissolution of the OEBC might create accessibility barriers which would necessitate a reversal in support.

- Specifically, "…. Failure to offer an exam in French by the COO to an applicant would be a breach of s.86(1) of Schedule 2 of the Regulated Health Profession's Act, 1991,"
- if the "…. OFC finds the potential fee increase will pose an accessibility barrier for those candidates wanting to write the Canadian OEBC exam,"
- if the "…. OFC finds accessibility barriers will exist for those candidates who for various personal reasons may be denied entry to the United States, who would be otherwise qualified to write the OEBE exam and be eligible for registration in Ontario."
- Ultimately, "the OFC opposes adopting a foreign exam as the sole accepted exam for professional registration in Ontario."

Relevant/Robust Exam

OEBC continually develops and administers a legally valid and defensible entry to practice examination to assess competence in optometry, the culture and systemic values of the Canadian health care systems and meeting Members' expectations.

Below are the changes implemented and underway.

Table 1 - Exam Enhancement Projects

Project	Benefits
Deliver the written exam 2.0 on a computer-based platform (pilot Fall 2020, implemented Spring 2021)	• enables distributed delivery of the exams • remote proctoring and testing pod options for candidates for Fall 2021
Transitioned the OEBC Examination Item bank from LXR to FastTest software to facilitate a computer-delivered platform (March 2021)	• a reduction in examination costs in several areas of the examination process (i.e., case selection, exam preparation, enriched data), reducing costly face-to-face meetings
Written exam 2.1 - Virtualization of some OSCE stations (pilot Fall 2021, implemented Spring 2022)	• delivery of some non-interactive OSCE stations that use high-resolution photos and video on the written exam • Note: assessment of other OSCE stations will occur during 2021 and subsequent project possible
New Blueprint (transition underway completion Spring 2022)	• use the COO Competency model as a foundation, map existing indicators to models • update Topic Model Matrix for the OSCE and Written exam
OSCE 2.0 scoring project (pilot Fall 2021, implemented Spring 2022)	• easier for examiners • fairness to candidates • linkages to new competency models to facilitate enhanced reporting
Professionalism Scale (parallels scoring project)	• develop a scale for use on the OSCE score sheet to reflect critical clinical indicators of professionalism
Reporting project (Development underway requires data from Spring 2022)	• better feedback for candidates • richer performance reporting for optometry schools • data at the enabling competency level
OSCE at WOVS (Spring 2021) and EOUM (Spring 2022)	• linkage with the optometry community • reduce travel/accommodation costs for the largest cohort of candidates
Consultation on technical skills (completed March 2021)	• stakeholders support for assessing technical skills at the OSCE • engagement of Members and stakeholders
Assessing key core technical skills on live patients at OSCEs (pilot Fall 2021, implemented Spring 2022)	• ensuring a minimum standard of competence of technical skills
Use of models in OSCE	• complementary to assessment on live patients, i.e., where the models fit in the exam moving forward
Case renewal protocol (implemented Fall 2020)	• cases identified as “needing work” are fine-tuned immediately following an administration and returned to service • standards reset if there are material changes • backlog of 50+ cases have placed back into circulation at a fraction of the cost of developing new cases
Annual Reporting (December 2020)	• format change reduced costs • reporting performance by practice area

Project	Benefits
Communication strategy for OCSE enhancement (plan roll out starts January 2022)	• Ensure that candidates and Members have a clear understanding of changes in the Spring 2022 examination
Update study guide	• support candidates in preparation for OSCE 2.0
Examiner Training	• robustness of standardized scoring • virtual training in advance of examine administration
Standardize patient training	• enhanced interactions with patients

Good Governance

In June 2020, the board implemented the following;

1. Adopting a Modified Policy Governance Model
   - **Governance Position**: With the Members above it and operational matters below it, the Board is a critical link in the chain of command. Its role is the commander. The Board exists to exercise that authority and empower others to act. The Board bears full and direct responsibility for the governance process and products and accountability for any authority and performance expectations delegated to others.
   - **Strategy** is the very essence of the Board, and policy is the result of its strategic deliberations. The plan to implement strategy/policy is the domain of the CEO.
   - **Governance Policy Manual** — An electronic copy is accessible and viewable on OEBC.CA

2. Focusing on
   a) Having an ongoing dialogue with the Members to discern their expectations for what results OEBC should produce
   b) Translating those expectations, plus other information and the Directors' perspectives and the Corporate values, into strategy and written criteria for success
   c) Checking to see that those criteria were met
   d) Managing risks — A Risk Register will be maintained and discussed at each Board meeting. Ranking risks by the likelihood of occurrence on the potential impact on the organization
   e) Living its corporate value of Transparency, Integrity, Trust, Engagement, and Responsibility

3. Clarifying direction by amending,
   - ***Vision*** — *"To be the sole provider of competence assessments for optometric regulatory authorities in Canada."*
   - **Mission** — *"To continually develop and administer a legally valid and defensible entry to practice examination to assess competence in the practice of optometry in Canada that meets Members' expectations."*
   - **Global Ends** — *"On behalf of Members, OEBC assesses if a candidate has met the entry-level competence required for practice and recovers all costs for this service from the candidates."*

Effective Management

Effective management is critical for the OEBC to live up to its potential and achieve relevant results for its Members. OEBC operates with a commitment to trust, integrity, transparency, engagement, and responsibility with Members, stakeholders and the optometry community.

Members are above the board, and the board is a critical link in the chain of command as the operational matters are below it. Management must recognize that the board's ultimate authority comes from the Members and must support the Board regarding,

a) Having an ongoing dialogue with the Members to discern their expectations for the results OEBC should produce;
b) Translating those expectations, plus other information and the directors' perspectives and the Corporate values, into strategy and written criteria for success
c) Checking to see that those criteria were met; and
d) Managing risks — Management maintains a Risk Register and discusses it be at each Board meeting.

The Board exists to exercise that authority and empower others to act. The Board's authority is a group authority rather than a summation of individual authorities. It makes sound decisions directed toward the CEO, directors, and committees only as a group.

The Board has a unique wealth of strategic and leadership experience available to the CEO. However, the CEO must help the Board think and act strategically — when the Board gets bogged down in detail, it is detrimental to the strategic intent. Strategy is the very essence of the Board, and policy is the result of its strategic deliberations. The plan to implement strategy/policy is the domain of the CEO. The Board's approach to strategy focuses on the problem, risks, or aspirations rather than on specific solutions.

EOUM Students Challenging the entire OEBC Exam

In 2020, OEBC developed a program for accreditation purposes (Appendix E) that enables EOUM students to challenge all the components of the OEBC exam. In February 2021, EOUM has received approval to start the program for the class of 2022. The class of 2022 will challenge the written exam on November 2, 2021, via remote proctoring or a testing pod in Montreal and the OSCE on May 7, 2022, in Montreal.

Program to Support Accreditation

Pass rates on NBEO/OEBC are an outcome measure required by the Accreditation Council on Optometric Education (ACOE). Canada has only two optometry schools, and EOUM requires an Exam in French.

> *"If the proposal is accepted, a growing number of students will likely challenge the NBEO instead of the OEBC exam, and consequently, this will yield the death knell of OEBC in the very near future. NBEO will be offered in English only, thus being unsuitable for the School of Optometry of the Universite de Montreal, where French exams are mandatory. Thus, the Montreal School will not financially support the students, and we expect that only a few of them, if any, will challenge the NBEO on their own. The absence of an external assessment of our students' qualifications will be detrimental to the students, the school, and the profession as a whole.*

The actual OEBC examination is very important, as it is one of the criteria considered in Standard I of the Accreditation Council on Optometric Education (ACOE) requirements. The absence of an external examination will have a negative impact for the future ACOE accreditation of the Montreal School OD program.

Canada has only two optometry schools. Their OD programs are already evaluated by accreditation bodies located outside Canada. Given that the approval of the NBEO will inevitably yield the disappearance of OEBC, Canadian students in all provinces except Quebec will get their right to practice from an instance located in the United States. That is to say that the assessments of Optometry Schools and OD students in Canada will be under the control of a country with different values, health systems, and interests. In addition, students from both Canadian schools will not be evaluated by the same entry-to-practice examination (NBEO vs comprehensive exam). Overall, this will be damaging to the profession in Canada.

We had our fair share of problems with OEBC in the past, but I believe that a restructured OEBC is the best option. Given that approving the NBEO examination will provoke a cascade of problems, the Montreal School strongly recommends pursuing the transformation of OEBC with the objective to provide the best Canadian-based assessment of optometric competencies, at a reasonable cost."

Christian Casanova, Ph.D., FAAO, Director and Professor – EOUM Dec. 7, 2018

Reasonable Exam Fees

The OEBC fee should be in the range (±20%) of NBEO fees. The cost of the NBEO exam (Parts I, II & III) is $2955 US ~ ($3700 CDN).

OEBC is focusing on reducing candidates' out-of-pocket costs:

- For the 2020 administrations, OEBC issued a tax receipt modelled on the Canada Revenue Agency's template. This receipt increases candidates' awareness that they may claim a tax credit and supports their claim. The practice will continue after each administration, as the candidate must take the exam to be eligible for the tax credit. NBEO does not issue a tax receipt to its candidates.
- Moving the written exam to computer-based saves candidates from having to travel to an exam centre. It also saves a couple of nights of accommodation for those choosing to write the written and OSCE at one administration.
- Providing a free study guide to help candidates prepare for the exam
- Virtualization of some OSCE stations

Candidate Pool

OEBC estimates that there is a potential candidate pool of about 335. If OEBC had 300 test-takers annually, it would meet Members' expectations to provide the exam under $4,000.

The fees provide for the ongoing investment in cases, the evolution of the exam, and fund the 5–7-year review of the competency profile.

In the longer term, the virtualization of some of the OSCE stations and increased case banks enable more frequent exam administrations. Statistically, exam cohorts of 100 candidates per administration work well.

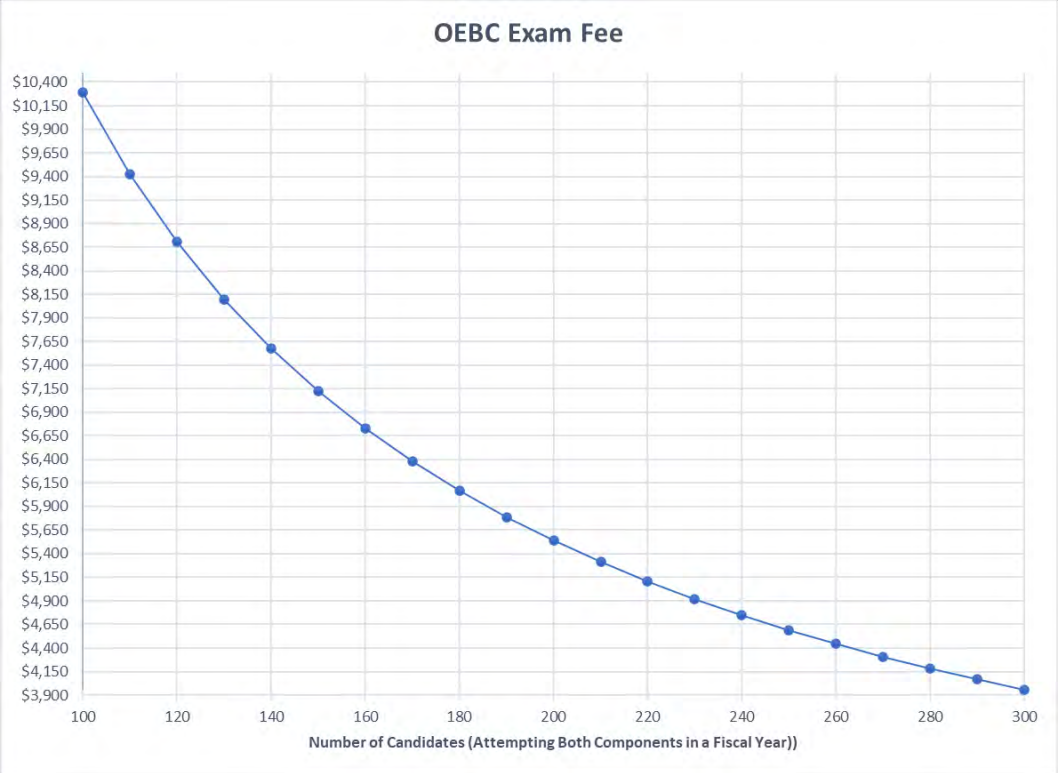

Figure 1 - OEBC Exam Fee Related to Number of Candidates

Canadian Students Trained in the US Avoid Challenging Two Set of Board Exam

The ACOE views that both the NBEO and OEBC are adequate outcome measures to meet its Standard I – Mission, Goals, and Objectives section.

> *1.3 The program must identify and use outcomes measures to evaluate its effectiveness by documenting the extent to which its goals and objectives have been met and must use such assessment to improve its performance. Such measures must include but not be limited to graduation rates, and results from the National Board of Examiners in Optometry (NBEO), Optometry Examining Board of Canada (OEBC) or equivalent testing agencies.*

Eleven of the 23 ACOE optometry programs in the US specify that its student must challenge some or all of the NBEO exam to graduate. Thus, the Canadian students attending these programs are already financially committed to challenging the NBEO.

Today, only the Southern California College of Optometry at Marshall B. Ketchum University accepts an equivalent Board Exam. OEBC has requested that schools consider OEBC as an equivalent testing agency to support its accreditation. OEBC has suggested that the schools consider challenging the OEBC written exam where it requires Part I and/or Part II of the NBEO exam and the OSCE where it requires Part III. OEBC has also reached out to the 12 ACOE optometry programs that do not make it mandatory for their students to challenge a Board Exam to graduate, offering to provide statistics on their students for accreditation purposes.

Table 2 - Some Students Must Take the NBEO exam to graduate

Optometry School	Must TAKE NBEO to graduate	If yes, which parts?	Must PASS NBEO to graduate	If yes, which parts?
Southern College of Optometry	Yes	Part I, Part II	Yes	Part I, Part II
University of Alabama at Birmingham, School of Optometry	Yes	Part I, Part II	Yes	Part I, Part II
Arizona College of Optometry, Midwestern University	Yes	Part I, Part II	Yes	Part I
Chicago College of Optometry, Midwestern University	Yes	Part I, Part II	Yes	Part I
Nova Southeastern University, College of Optometry	Yes	Part I, Part II	Yes	Part I
Inter American University of Puerto Rico, School of Optometry	Yes	Part I	Yes	Part I
University of Pikeville, Kentucky College of Optometry	Yes	Part I	Yes	Part I
Michigan College of Optometry at Ferris State University	Yes	Part I, Part II, Part III	No	
University of Missouri at St. Louis, College of Optometry	Yes	Part I, Part II, Part III	No	
Northeastern State University - Oklahoma College of Optometry	Yes	Part I, Part II	No	
Southern California College of Optometry at Marshall B. Ketchum University	Yes	Part I, Part II (or equivalent)	No	
Illinois College of Optometry	No		No	
Indiana University, School of Optometry	No		No	
MCPHS University, School of Optometry	No		No	
New England College of Optometry	No		No	
The Ohio State University, College of Optometry	No		No	
Pacific University, College of Optometry	No		No	
Salus University Pennsylvania College of Optometry	No		No	
State University of New York, College of Optometry	No		No	
University of California - Berkeley, School of Optometry	No		No	
University of Houston, College of Optometry	No		No	
University of the Incarnate Word, Rosenberg School of Optometry	No		No	
Western University of Health Sciences, College of Optometry	No		No	
Total	Yes = 11 No = 12	Part I = 11 Part II = 9 Part III = 2	Yes = 7 No = 16	Part I = 7 Part II = 2 Part III = 0

Source: Annual Student Data Report 2019-2020 — Association of Schools and Colleges of Optometry

Appendix A - Actions Completed (by June 30, 2021)

Table 2 - Actions Completed by OEBC to Restore Members' Confidence

Concern	Action Taken	Conclusion	Sustaining Principle
Governance	OEBC representative directorship provides Members with oversight of the exam.	Exam oversight must be revisited if Members chose a board structure with directors with specific competencies.	Members have ultimate oversight of the OEBC. Maintaining effective linkages with Members is a critical responsibility of the board. OEBC policy encourages Members to place items on an OEBC Board agenda at any time.
Exam Oversight	Members want meaningful input into the exam's structure and content and practical mechanisms to raise issues of concern.	The board will have a representative from each regulator Board policy directs CEO to: • Communication of significant changes to the structure or content of the exam • Communication in addition to the annual Report – a Board summary is provided after every Board meeting • A mechanism for Members to receive information about and provide input into or feedback on the exam Members have a process to raise concerns about the exam.	Exam oversight is one of the OEBC Board's critical accountabilities and may not be delegated. The board may delegate specific functions to ensure the exam is carried out to Members' satisfaction. The OEBC board approves material changes to the exam after gaining Members' consensus. NOTE: Members have no oversight or input into the NBEO exam.
Enhanced communications with Members and stakeholders	Board Summary provided to Members after each meeting. Ongoing dialogue with optometry schools and students	OEBC values are commitment to Trust, Integrity, Transparency, Engagement, and Responsibility. It must operate living these principles on every interaction.	Engaging Members and stakeholders and operating transparently with integrity build trust.
	OEBC shares financial statements and all materials to all attendees of the Annual Meeting of Members (AMM). Stakeholders' participation in AMM	OEBC had over 35 individuals attend the AMM in January 2021 and participate in a workshop regarding assessing technical skills.	Use the AMM as an opportunity to engage the Members and stakeholders.

Concern	Action Taken	Conclusion	Sustaining Principle
	Surveying candidates regarding dates and feedback on the exam	Post exam administration surveys engage and welcome candidate feedback regarding their opinion of what went well and potential improvements.	Survey candidates after each administration.
Update of by-laws	OEBC reviewed its by-laws to ensure alignment between the *Canada Not-for-Profit Corporations Act*, the board's governance model, and the organization's by-laws.	Members approved the revised by-laws in March 2020. OEBC posts its by-laws on its website.	Reviewing the by-laws every 5-7 to ensure alignment with Members' requirements, the board's governance model and organizational needs are critical parts of good governance.
Policy changes	OEBC's Governance Policy Manual is posted on the OEBC website and approved at every OEBC Board meeting.	OEBC must publish changes to specific policies in its Board Summary. Consistent with OEBC's core value of transparency, OEBC provides the Summary to Members (via their Board representative or registrar) following each Board meeting.	The Governance Manual must be a dynamic document that reflects Members' needs and direction.
	Material changes to the OEBC exam must be thoughtfully done and take time.	OEBC policy requires stakeholder consultation and Members' approval on material changes to the exam, standards-setting for the new/modified content, and pilot testing on material changes as needed.	Changes must be relevant to the current practice of optometry, and implementation must maintain a legally valid and defensible entry-to-practice examination.
Rate Stability	The Board approved the recommendations regarding its financial and accounting policies following a comprehensive review. To eliminate future significant fee spikes, like the 85% increase in 2017, OEBC adopted this new structure.	While the accounting change does not immediately reduce candidate fees, it creates a systemic means to achieve long-term fee stability.	The Board will review the fees annually. Capitalize exam development as an intangible asset and establish an Exam Development Reserve Fund.
Exam Fee as a Tax Credit	OEBC began issuing a receipt to support their tax credit claim for their OEBC examination fees. A candidate may carry the unused portion of the credit forward and apply it in a future year or transfer the unused amount to their parent, grandparent, spouse or common-law partner.	Providing a receipt is modelled on the Canada Revenue Agency's template increases candidates' awareness that they may be able to claim a tax credit, and it facilitates them making their claim.	Issue tax receipts following each administration.

Concern	Action Taken	Conclusion	Sustaining Principle
EL-9 Selection of Competency Measurement Technique Criteria	The Board approved a new policy that requires using the best practices of measuring competencies, including using a combination of live patients, standard patients and models in each OSCE administration, as practical.	The most effective means to measure critical entry-to-practice competencies must be used.	OEBC uses a process of ongoing improvement in its exam development and administration.
EL-10 Treatment of Members	This new policy recognizes that the Members are integral to the function of OEBC, as they are the owners, the authority to decide the competencies required for entry to practice if the exam is appropriately assessing such risk.	Good governance requires clarity regarding who has the authority to decide what.	Ensure that staff and volunteers recognize the hierarchy Members → Board → CEO → organization
GP-6 Board Linkage with the Members	The updates help the Board understand the Members' aspirations, ensuring clarity regarding the oversight and control that Members want to exercise, encouraging Members to raise issues of concern, providing regular communication, and offering a means for Members to add items to the Board agenda easily.	Linkages with Members are essential to OEBC's ongoing sustainability.	OEBC is the Members' organization.
Refining the Eligibility and Retake Policy	Students registered in an OD program accredited by the Accreditation Council of Optometry Education and approved bridging and certification programs will be able to challenge either component anytime during their final year — eliminating the requirement to challenge the written exam first. OEBC will identify that the competencies necessary to challenge the OSCE portion are acquired during the students' clinical work.	The current policy required students to graduate before challenging the exam. It provided an opportunity for students to early write the exam. However, to facilitate entry to practice upon graduation, most candidates would challenge both exam components before graduating.	The OEBC exam is a competency-based exam. Note: The change also facilitates programs that require their students to take/pass some components of the board exams before they can graduate to use the OEBC exam. The ACOE views that both the NBEO and OEBC are adequate outcome measures to meet its Standard I – Mission, Goals, and Objectives section. However, OEBC's time constraints did not facilitate Canadians studying in the US to take/pass the OEBC exam before they graduate.

Concern	Action Taken	Conclusion	Sustaining Principle
Exam Cost Structure	In 2016, OEBC increased the exam fee by 85% to $5,900 from $3,190 to help recover the OSCE development cost. These costs have resulted in fee spikes and the loss of candidates. The current fee is $5,100.	Members required a legally valid and defensible examination that measures the entry-to-practice competency needed in Canada. It must be a bilingual assessment. It needs to be at a reasonable cost.	Financial modelling has been completed and shows the exam's cost under $4,000 with 300 test-takers • OEBC is now capitalizing exam development to ensure long-term fee stability. OEBC has moved to computer-based testing and eliminates US-based students' need to travel to Canada for the written exam.
Competitive Bid for assessment services	OEBC did not routinely go to the marketplace with a proposal request for assessment services. In 2020, OEBC conducted a formal RFP and issued a three-year contract from January 1, 2021, to December 31, 2023.	Board policy now requires that "The CEO shall not knowingly cause or allow any practice, activity, decision or organizational circumstance which is unlawful, imprudent or in violation of any legislation, Values, or commonly accepted business and professional ethics and practices."	OEBC must follow commonly accepted business and routinely go to market for assessment services every 3-5 years.
Exam Content - Technical Skills	Members require the confirmation of the following core technical skills: tonometry, gonioscopy, slit lamp fundus biomicroscopy and Binocular Indirect Ophthalmoscopy (BIO) OEBC issued a consultation paper on February 1, 2021.	Following stakeholder consultations, the OEBC Board decided in March 2021 to incorporate technical skills assessment on live patients at OSCEs starting in the Spring of 2022. This timing permits pilot-testing the changes.	Members specific entry-to-practice competencies to be measured on the OEBC exam. OEBC confirms all candidates' technical skills and competencies in a manner acceptable to Members. The OEBC Board, in its oversight role, approves material changes.
Relationship between FORAC and OEBC	To ensure clarity regarding OEBC and the Regulators' role as a group and appropriate consultation regarding the exam. OEBC updated its policy manual in September 2020 to reflect these principles. OEBC provided a responsibility matrix to Members (Jan. 2021)	When OEBC deals with FORAC, it is treating the regulators as customers of the entry-to-practice assessment. When the regulators meet, as Members, at the AGM, they are in the role of "owners" of OEBC. A regulator representative on the OEBC Board brings their knowledge and understanding of the issues to the	OEBC carefully avoids potential conflict while respecting Members' duty of oversight.

Concern	Action Taken	Conclusion	Sustaining Principle
		deliberations. However, their fiduciary duty is to OEBC.	

Appendix B - Planned Actions for 2021 and Status of In Progress Items

Pilots for many of the exam items will occur during the Fall 2021 administration. Standard-setting of changes will follow, as needed, after that administration. The first administration using the changes to the exam occur during the spring 2022 administration. However, the majority of the work will be completed by December 2021.

Area	Issue	Principle	Status/Planned
Gain Members buy-in to only one exam	Currently, BC, ON, and QC accept the NBEO as an equivalent entry-to-practice exam. FORAC's Expert Report states the NBEO is "not an appropriate entry-to-practice assessment for in Canada." OEBC Board created the One Exam Team (Dec. 2020) to identify issues preventing Members from using only one exam. June 2021- Seek buy-in "in-principle" by the Council/Boards, setting out the issues for OEBC to address by Dec. 2021 for them no longer accept the NBEO, subject to matters addressed and an appropriate transition plan.	Moving to only one exam is best done in lockstep with other provinces currently accepting NBEO. The OEBC board is committed to resolving all issues to the mutual benefit of Members.	OEBC's new Vision (Sept. 2020)— *To be the sole provider of competence assessments for optometric regulatory authorities in Canada.* One Exam Team formed Dec. 2020 June 2021- Buy-in "in-principle" by the Council/Boards setting out the issues for OEBC to address Dec. 2021 no longer accept the NBEO, subject to issues addressed and an appropriate transition plan
Assessing key core technical skills	Members require the confirmation of the following core technical skills: tonometry, gonioscopy, slit lamp fundus biomicroscopy and Binocular Indirect Ophthalmoscopy (BIO)	Members want specific entry-to-practice competencies to be measured on the OEBC exam.	OEBC will confirm all candidates' technical skills and competencies starting at the spring OSCE 2022. Pilot testing to occur in advance. OEBC has initiated a project to make the necessary changes.
Enhanced scoring system	OEBC's scoring system did not provide an item to the enabling competency. Thus, reporting at the competency level was not possible.	All items scored on the OSCE, and written exam are mapped to the appropriate enabling competency	Written items are straightforward. A team of examiners have developed an eloquent solution to capture the data while making it easier for examiners to mark and case -writers to develop. The proposal will be piloted at the Fall 2021 exam and used in spring 2022.

Area	Issue	Principle	Status/Planned
University of Montreal students will challenge the OSCE	OEBC and EOUM have worked together to have the EOUM student challenge the OEBC exam.	The student in the class of 2022 will challenge both components of the OEBC exam.	OEBC offers a program to optometry schools with ACOE accredited OD program at a discounted rate. Students who wish to use the OEBC exam for registration pay the difference in cost to attain an OEBC certificate.
New Competency Profile	Best practices require the review of a competency profile every 5-7 years. COO has invested in developing a new entry-to-practice competency profile and offered it to OEBC under a user agreement	OEBC has signed a user agreement with the COO regarding OEBC using the new profile. Members need to accept the new profiles. OEBC has developed plans related to case writing, the exam blueprint and our candidate guide	The OEBC exam must be based on a current entry-to-practice competency profile.
US Schools Permit using OEBC Exams	ACOE requires optometry schools to provide data related to student performance on Board exams. NBEO and OEBC are both acceptable. However, US schools do not make their students from Canada aware of this information.	Students should only have to pay for one set of board exams.	OEBC has reached out to all US ACOE accredited optometry schools. All except one has indicated a willingness to permit students to write the OEBC exam. Most of the schools want assurances that appropriate data will be provided to them. OEBC provided acceptable data to WOVS and EOUM.
Smooth transition for Students	The desire is to have only one entry-to-practice exam in Canada as soon as possible, yet consideration needs to be given to students already in the NBEO.	Students before the class of 2023 who completed NEBO parts I & II can initially challenge the OEBC written exam for the cost of remote proctoring in 2022. (about $100). They will be required to pay for the OSCE. The exception does not apply to optometrists practicing in the US. Standardized treatment of all students from ACOE accredited programs in 2023.	A proper transition plan for students in the NBEO process without compromising standards. Optometric regulatory authorities should confirm that a registrant admitted via the NBEO would not be asked to requalify via the OEBC exam should they transfer to another province.

Area	Issue	Principle	Status/Planned
Loss of a bilingual exam	The potential loss of a legally valid and defensible entry-to-practice examination, bilingual assessment is also a threat to the assessment system for FORAC.	An English and French entry-to-practice examination must be available in Canada.	NB, QC, ON, MB, AB need an entry-to-practice examination in English and French. The NBEO has declined to have its exam translated into any other language.

Appendix C — Authorizing NBEO in BC, QC & ON

Authority for Council to set requirements for registration, including examinations, is established in legislation. In some jurisdictions, OEBC may be named explicitly in the regulations, by-laws or Council resolution. The ease of changing requirements varies from jurisdiction to jurisdiction.

College of Optometrists of British Columbia (Excerpt from the By-laws)

Application for registration

52. (1) A person applying for registration in any registrant class must deliver to the registrar

(a) a registration application in Form 7 including all documents required by that form,
(b) an authorization for a criminal record check in the form required by the Criminal Records Review Act,
(c) proof that he or she is a Canadian citizen or a permanent resident of Canada or otherwise authorized to work in Canada in a health care profession,
(d) in the case of applicants who have practised optometry or another health profession in another jurisdiction, an authorization for a criminal record check in that jurisdiction or a criminal record report in a form satisfactory to the registrar,
(e) the registration application fee set out in Schedule E, and
(f) any other fee, fine, levy or debt owed to the College or to the former board of examiners under the Optometrists Act.

(2) An applicant for registration who has practised or is practising optometry in another jurisdiction, or who has practiced or is practising another health profession in British Columbia or another jurisdiction, must deliver to the registrar:

(a) a letter from each regulatory body that has registered, licensed, certified or otherwise authorized the person to practise optometry or another health profession, confirming the person's good standing in the other jurisdiction at the time he or she ceased practising in the other jurisdiction or ceased practising the other health profession or both, as applicable, and confirming the person's good standing in any health profession in which he or she is currently practising, and
(b) a statement from the applicant that lists all outstanding complaints, claims, actions, inquiries or proceedings against him or her in British Columbia, or in any other jurisdiction, or
(c) both as the case may be, in relation to the practice of a health profession.

(3) Despite sections 53(1)(c), 54(1) and 55(1), a person applying for registration who has not successfully completed the **national qualifying examination or the national qualifying examination equivalent** on up to three attempts may be granted registration in the registrant class to which the person applies if that person:

(a) successfully completes a supplementary examination as directed by the registration committee, and
(b) completes retraining as specified by the registration committee.

(4) A person who fails a supplementary examination three times will not be granted registration in any registrant class.

Ordre des optométristes du Québec (website)

For non-EOUM graduates,

Recognized diplomas and Professional status

- Doctorate in Optometry from the School of Optometry and Vision Science, University of Waterloo
- Degree from a university accredited by the Accreditation Council on Optometric Education
- License to practice optometry in another jurisdiction in Canada or the United States

Other requirements

- The candidate must have completed the examination of the Optometry Examining Board of Canada Optometry or the National Board of Examiners in Optometry
- Filing of required documents
- Payment of required fees
- Participation in the familiarization activity on ethical aspects related to the practice of optometry in Quebec
- Depending on the case, meet the language requirements

College of Optometrists of Ontario (ON in regs - https://www.ontario.ca/laws/regulation/930837/v1)

7.The applicant must meet the criteria set out in one of the following subparagraphs:

i. successful completion, not more than three years before applying for registration, **of the standards assessment examinations set or approved by the College,**

The College has approved the following entry-to-practice exams:

1. the Canadian Assessment of Competence in Optometry (CACO); or
2. the Optometry Examining Board of Canada (OEBC) written exam and OSCE; or
3. National Board of Examiners in Optometry (NBEO) Exam. In order to be accepted for registration in Ontario, all three parts of the NBEO examination (Part I-ABS, Part II-PAM, and Part III-CSE) must be successfully challenged after January 18, 2019. Passing the TMOD component in Part II is required for registration in Ontario.

The OEBC written exam and OSCE replaces the CACO as the standard Canadian assessment by which competence is verified.

The College annually approves the acceptable entry-to-practice exams.

Also, the *Regulated Health Professions Act* requires

Qualifications

22.4(1) The College shall make information publicly available on what documentation of qualifications must accompany an application and what alternatives may be acceptable to the College if an applicant cannot obtain the required documentation for reasons beyond his or her control.2006, c. 31, s. 35 (3).

Same

(2) If the College makes its own assessment of qualifications, it shall do so in a way that is transparent, objective, impartial and fair and, if it relies on a third party to assess qualifications**, it shall take reasonable measures to ensure that the third party makes the assessment in a way that is transparent, objective, impartial and fair.**2006, c. 31, s. 35 (3).

Same

(3) The College shall ensure that individuals assessing qualifications and making registration decisions or reviewing decisions have received training that includes, where appropriate,

(a) training on how to assess such qualifications and make such decisions;

(b) training in any special considerations that may apply in the assessment of applications and the process for applying those considerations.2006, c. 31, s. 35 (3).

Appendix D – Success Rate of OEBC Exam Candidates

Table 2 shows the pass rates of first attempt candidates by country of training. Since the introduction of the new exam in 2016-17, candidates receiving their optometry training in the US have had lower pass rates than Canadian-trained candidates.

Table 3- Pass Rates of First Attempt Candidates 2016-2020

Year	Canadian Trained		US Trained		International		All Writers	
	OSCE	Written	OSCE	Written	OSCE	Written	OSCE	Written
2019-20	88%	97%	59%	94%	100%	100%	85%	97%
2018-19	93%	95%	78%	76%	89%	90%	86%	85%
2017-18	95%	95%	84%	84%	80%	80%	88%	88%
2016-17	94%	94%	76%	76%	77%	77%	85%	85%

The National Competency Profile and examination for entry-level optometry in Canada for "safe, effective, and ethical practice…." was developed in Canada for the Canadian context.

Reflected in the expectations for entry-to-practice of the OEBC exam are cultural and systemic approaches within the Canadian health systems, which differ from practices in other jurisdictions. The expectations in Canada regarding the competencies within the communication and professionalism practice areas are different from other jurisdictions. Table 3 sets the difference in the median scores of the other seven practice areas.

There are minor differences in median scores in the assessment, and diagnosis & planning practice areas. However, the patient-centred focus in Canada, where the patient is a partner in their health care, presents themselves profoundly in the practice areas of patient-centred care and patient management.

Table 4- Practice areas Listed by the most significant gaps between Canadian trained candidates and others

Practice Area	Difference in Median Scores	Blueprint Weight	
		Written	OSCE
Patient Centered Care	9%	3.4%	16.7%
Patient Management	7%	29.3%	33.3%
Scholarship	6%	1.7%	
Collaborative Practice	5%	5.2%	
Practice Management	3%	1.7%	
Assessment	2%	31.1%	33.3%
Diagnosis & Planning	2%	27.6%	16.7%

For candidates not trained in Canada, it is crucial to pay extra attention to the patient management and patient-centred care practice areas, as these competencies may be different from your training jurisdiction.

Appendix E – OEBC for Accreditation Purposes Program

The Accreditation Council on Optometry Education (ACOE) requires optometry programs to identify and use outcomes measures to evaluate its effectiveness by documenting the extent to which its goals and objectives have been met and must use such assessment to improve its performance. Such measures must include but not be limited to graduation rates, and results from the National Board of Examiners in Optometry (NBEO), Optometry Examining Board of Canada (OEBC) or equivalent testing agencies.

Despite being recognized as an equivalent testing agency by ACOE, no state board accepts OEBC as meeting its registration requirements. Thus, there is NO RECIPROCITY between the USA and Canada.

Special Program

A Canadian optometry program, seeking the information for accreditation purposes, may pay a bulk fee of $4,000 per optometry student to take the OEBC exam if:

a) all students in the program are be registered to write the exam on the date(s) specified by OEBC;
b) the institution provides the facilities for both the written and OSCE components of the exam; and
c) all other OEBC policies will be observed for the administration of the exam.

Some students writing the OEBC exam as part of this program will need to provide proof of successful completion of the OEBC exam to an optometric regulatory authority. To be fair to other candidates, these students would also pay an additional fee equal to the fee charged to individual candidates at the time of the administration, less the $4,000 spent on behalf of the student.

Note: The policies and fees for a retake candidate apply to a student retaking one or both exam components.

Appendix F – Mutual Recognition Agreement (2001)

MUTUAL RECOGNITION AGREEMENT
AMONG REGULATORS OF OPTOMETRY IN CANADA
April 22, 2001

1) In consideration of the terms of Chapter 7 of the Agreement on Internal Trade (AIT), this agreement is made between the Regulatory Bodies for Optometry listed below, and remains in force until replaced by further written agreements.

2) The intention of this agreement is to remove unnecessary barriers to mobility of qualified optometrists, in compliance with Chapter 7 of AIT and to establish the conditions under which an optometrist registered or licensed in a signatory jurisdiction will have his/her qualifications recognized in another signatory jurisdiction.

The Signatories:

3)(a) Agree that the basic scope of practice for optometrists is similar in each jurisdiction represented by the signatories;
(b) Require for licensure/registration:
i. the Doctor of Optometry degree conferred by a Council on Optometric Education accredited school or an equivalent degree with respect to academic credentials;
AND
ii. the passing of the Canadian Standard Assessment in Optometry (CSAO);
(c) Have no residency requirements as a condition of licensure/registration;

4)(1) Agree to recognize the qualifications of an optometrist and to provide an equivalent or comparable license or certificate of registration to an applicant who:
a) is licensed/registered in the jurisdiction of a signatory on July 1, 2001;
b) is otherwise eligible for licensure/registration;*

AND meets one of the following two requirements:

c) (i) is actively practising in a signatory jurisdiction as defined by the signatory jurisdiction to which the individual is applying;
OR
(ii) demonstrates competence through a practice assessment or quality assurance appraisal which may include an examination as required by the provincial board to which the individual is applying.

(2) Further, it is agreed to recognize the qualifications of an optometrist who is initially licensed/registered in a signatory jurisdiction after July 1, 2001 and to provide an equivalent or comparable license or certificate of registration to an applicant who:

a) has attained the academic requirements (Doctor of Optometry degree conferred by a Council on Optometric Education accredited school or an equivalent degree as approved by the regulatory body to which the applicant is applying)

b) is otherwise eligible for licensure/registration.*

AND

c) meets one of the following 3 requirements:

(i) passed the CSAO within the past 3 years.

OR

(ii) is actively practising within a signatory jurisdiction as defined by the jurisdiction to which the individual is applying and has at some point in time passed the CSAO;

OR

(iii) demonstrates competence through a practice assessment or quality assurance appraisal which may include an examination as required by the provincial board to which the individual is applying, and has at some point in time passed the CSAO.

* The requirements referred to as otherwise eligible requirements do not include academic or competency requirements but encompass administrative components such as language fluency, good standing, fees and jurisprudence requirements.

5) In recognition of jurisdictional variations in the scopes of practice of Optometry, signatories commit to seek legislative/regulation/by-law changes to permit the inclusion of a restricted or provisional registration/license for individuals applying under this agreement while they obtain the additional necessary qualifications required for full registration within a reasonable and specified period of time.

6) It is agreed to review this Agreement on an ad hoc basis or at the request of any signatory.

7) If a signatory chooses or is obligated to add or amend a licensure requirement that could impact on this agreement, the signatory agrees to notify other signatories of the proposed change(s) to give them an opportunity to review and comment prior to implementation.

8) In the event that a signatory chooses not to continue to be part of this agreement, that signatory will consult with the jurisdictional LMC and advise the other signatories, in writing, providing its rationale at least six months before the signatory withdraws from the agreement.

9) The signatories agree that they will abide by the provisions of this agreement.

SIGNATORIES

_____ **- Board of Examiners in Optometry of British Columbia**

_____ **- Alberta College of Optometrists**

_____ **- Saskatchewan Association of Optometrists**

_____ **- Manitoba Association of Optometrists**

_____ **- College of Optometrists of Ontario**

_____ **- Ordre des Optométristes du Québec***

_____ **- New Brunswick Association of Optometrists**

_____ **- Nova Scotia Association of Optometrists**

_____ **- Prince Edward Island College of Optometrists**

_____ **- Newfoundland Optometric Board**

_____ **- Yukon/Northwest Territories**

Dated Sept 29/2021

* The Ordre des optométristes du Québec will fulfill the requirements of the Agreement only if it is authorized to do so by the applicable laws and regulations, particularly with respect to the requirement of the passing of the Canadian Standard Assessment in Optometry (CSAO) mentioned at section 3 b) ii) and section 4 2) c) i) of the Agreement.

Appendix G – Equivalence of the NBEO to the Canadian Standard Assessment in Optometry

At the 2009 Meeting of Members, CEO-ECO presented the following position respecting CORA's discussion of accepting the National Board of Examiners in Optometry's examinations as a replacement or substitution for the Canadian Standard Assessment in Optometry.

Participants in Canadian Optometric Regulatory Authorities (CORA) discussed the possibility of CEO-ECO's Members accepting the examinations of the National Board of Examiners in Optometry (NBEO) as a replacement substitution for the CSAO as licensing examinations. CEO-ECO has an interest in this matter and is concerned about the impacts of a decision by one, some, or all of its Members, particularly a decision made in haste or under political pressure and without full consideration of the effects of such a decision.

THE MISSION AND ITS BENEFITS

CEO-ECO's Mission consists of acting in the shared interests of its Members. Members' interests include assuring the public that appropriately qualified and competent optometrists are authorized to practice within their jurisdictions. CEO-ECO's concerns and interests in this matter are consistent with its Mission and its Members' interests in ensuring that Canadians benefit by the good practice of qualified and competent optometrists.

Canadians have benefited from CEO-ECO's contributions in the form of improved consistency of the competencies of novice optometrists, the inhibition of professional self-interest, better access to optometric care afforded by practitioners' mobility, greater consistency of provincial standards of practice and quality assurance measures, and the recognition of internationally trained optometrists. Furthermore, at their next meeting, Members will consider a mechanism to ensure that all optometry students of l'École d'optométrie de l'Université de Montréal will have passed the major portion of the CSAO prior to graduation.

THE CSAO

CEO-ECO's Members include all ten provincial optometric regulators. Its Members have, since 1995, provided CEO-ECO with mandates to research and publish the competencies essential to safe and effective optometry practice in Canada and to administer examinations on those competencies. Representatives of CEO-ECO met with representatives of the NBEO in 1995 to discuss potentially using the NBEO examinations as Canadian entry to practice examinations. CEO-ECO concluded that the NBEO examinations did not test the practice-based competencies necessary for Canadian practice, nor were they available in both official languages. The CSAO was designed from its inception as an examination of practice-based competencies. The CSAO is now being produced in its third edition as an examination of competence, with the fourth edition under construction and implementation planned for 2010. The pending edition of the CSAO, like the current edition and its predecessors, will reflect the specific competencies necessary for Canadian practice.

CEO-ECO claims a leading position in developing examinations of competence in optometry. Research on Canadian optometric competencies was initiated in 1995. In 1998, the CSAO completed its move away from the curriculum-based model originally adapted from the NBEO's examinations. Our research on practice-based competencies has been well documented in articles in the Canadian Journal of Optometry, in presentations at the World Congress on Optometric Globalization, in posters at the American Academy of Optometry, in contributions to the Global Based Competency Model published by the World Council of Optometry, as well as at meetings of CORA, meetings of Members, at the Optometric Leaders Forum, and by way of newsletters, annual reports, and at www.ceo-eco.org. The extraordinary efforts of hundreds of Canadian optometrists have contributed to the evolution of the CSAO to its current position.

NBEO'S EXAMINATIONS

Only now is the NBEO restructuring its examinations to assess professional competencies. However, it is unclear to us what specific competencies are or are to be assessed as the existing examinations, and those proposed for

implementation in 2010 appear not to have been developed from competency statements. We do not argue that these examinations may be appropriate for qualification for American practice. However, we are certain that the NBEO's examinations were not specifically designed to test for the competencies necessary in Canadian practice as identified by CEO-ECO's current research. Canadian competencies assessed by the CSAO relate to the eye and vision care of patients, collaboration with other participants in Canada's provincial and territorial health systems, managing practice, and education.

CANADIAN AND US COMPETENCIES

The practice of optometry in Canada and in the USA has been different in the past, in scope of practice and in standards of practice. Practice in the two countries will very likely differ in the future, given the different populations, cultures, health risks, and systems of health care delivery and regulation present in each country. We do not contest that the graduates of Canadian and US schools of optometry have met common curriculum demands. We know that graduates of ACOE accredited schools generally have developed the competencies necessary for Canadian practice. We do not argue that the competencies essential to practice in Canada and the US are completely at odds, only that they are not identical and the differences are significant enough that they cannot be equated.

EQUIVALENCE TO THE CSAO

No studies have been carried out comparing the competencies assessed using the CSAO with those assessed using the NBEO's examinations. Accordingly, any claim of equivalence between the CSAO and NBEO examinations is opinion and not based on research evidence. It is CEO-ECO's view that any decision to replace or substitute the CSAO with the NBEO examinations would require substantial evidence of equivalence in order to be considered legitimate. Regulators would need to prove that the NBEO exams and the CSAO are measuring the same competencies. Regulators would need to establish that the level of measurement reliability of both exam sets was comparable. Regulators would need to show evidence that the minimum level of performance on the NBEO exams represents the same entry-level competence set by the profession in Canada by way of the CSAO. High correlations between the performances of candidates on the CSAO and NBEO examinations no more proves that the examinations are equivalent than saying that a language examination and a chemistry examination are equivalent because a group of students does well on both.

IMPACTS

With the application of the Agreement on Internal Trade, any Member's decision in this matter will have substantial impact on all other regulators and jurisdictions. CEO-ECO is concerned that substituting or replacing the CSAO with the NBEO examinations could establish an irrelevant or inappropriate standard for initial competence, authorize inappropriately qualified practitioners, and impede competent optometrists from practising in Canada. For example, the NBEO has suggested that its future examinations are to assess for skills in intravenous and intramuscular injections. These are procedures not authorized to optometrists in any jurisdiction in Canada and would set an irrelevant and inappropriate standard for initial competence in Canada. An otherwise competent applicant who failed the examinations that included these procedures would be inappropriately impeded from practising, but would likely win a legal challenge of that standard of competence. The corollary to this is the candidate who may well be able to pass the NBEO examinations, but lacks the ability to collaborate appropriately within the Canadian health system.

Irrespective of whether evidence of equivalence between the CSAO and the NBEO examinations are demonstrated, CEO-ECO is concerned that substituting or replacing the CSAO with the NBEO examinations would constitute an abdication of self-governance and self-determination by the profession. No other senior health profession in Canada vests its licensing examinations or other regulatory mechanisms with non-Canadian organizations. At present, no Canadian provincial regulator or association may be a Member or Director of the NBEO. The NBEO's articles of incorporation and by-laws, quite appropriately, have been established to ensure that the NBEO serves American optometric interests, American health care interests, American jurisdictions' interests, and the American public's interests. Canadian optometric interests, Canadian health care interests,

provincial and territorial interests, and the Canadian public's interests are not presently objects of the NBEO but are entirely the objects of CEO-ECO. Handing over responsibility for the assessment of initial competence of Canadian optometrists to an entity that does not hold Canadian interests preeminent is an abdication of responsibility. The Competition Bureau of the Government of Canada was somewhat critical of the two Canadian schools of optometry being accredited by the "US-Based Accreditation Council on Optometric Education" (ACOE). Presumably, Canadian governments would be equally critical of a decision to transfer a fundamental regulatory authority to another US-based organization.

CEO-ECO is an organization that recognizes Canada's Official Languages Act, which provides assurance to French and English-speaking Canadians that they will not be discriminated against based on ethnic origin or first language learned when it comes to employment opportunities and advancement. As such, CEO-ECO recognizes the need to make its services available in both of Canada's official languages. NBEO provides no such assurance to Members, and provision for the NBEO to be available in French will be necessary should it be accepted as an acceptable alternative to the CSAO.

CEO-ECO's concern is not for its own welfare, although decisions made by its Members in this matter may affect its continuing viability. We have heard the criticisms of the cost of the CSAO, and heard that the different cost of the CSAO and the NBEO examinations is justification for accepting the NBEO examinations in place of the CSAO. We disagree. The CSAO is a complex examination necessitated by the complexities of Canadian optometric practice. The development cost of the CSAO, from research to question writing to exam compilation, is fixed. CEO-ECO, too has a fixed cost in its existence as an organization. These fixed costs are substantial and are borne, along with the variable costs of administration, primarily by the registrants. In the last two years, increased registration has produced significant annual surpluses allowing for the discussion of reduced fees for the CSAO in the future. Our calculations suggest that the fee for the CSAO will be equal to that for the NBEO examinations when paid registrations total 400. Beyond this number, CEO-ECO could easily deliver the CSAO for a fee lower than the NBEO currently charges. Economies of scale, in microeconomics, forecast cost advantages when a business expands. Accordingly, it is typical for business costs to be higher in smaller markets. As illustration, we note that the annual registration fees for optometrists in Ontario are $950, while $345 in New York State. On the other hand, should a substantial number of potential candidates opt for an NBEO alternative, the cost of the CSAO would become prohibitive, and CEO-ECO would likely fail.

CEO-ECO is prepared to work cooperatively and collaboratively with the NBEO in establishing common standards for competence in the practice of optometry in Canada and the US, if this is a mandate decided by CEO-ECO's Members. We maintain, however, that any determination of equivalence of the CSAO and NBEO examinations must, by definition, be a two-way street. In that circumstance, American regulators should recognize the equivalence of the CSAO to the NBEO. Such recognition would presumably allow all Canadian optometrists, including graduates of the International Optometric Bridging Program and optometrists, included under the Agreement on Internal Trade, to practice in US jurisdictions under the same terms as US practitioners would be authorized to practice in Canada.

CEO-ECO respectfully suggests that CORA consider this matter carefully with a particular view to the impact on the public and the profession of a decision to substitute for or replace the CSAO.

Appendix H – Members' Support CEO-ECO 2011 (Excerpts from Business Plan 2011)

Executive Summary

In May 2010, the Board of Directors of CEO-ECO was directed by the Corporation's Members to prepare business plans under different potential mandates; exclusive authority to assess novice optometrists' competence; competitive authority; dissolution of the corporation. The three plans prepared are discussed using the traditional considerations of Products, Management and Administration, Pricing, Delivery, Facilities, Use of Assets, and Risks. Members are asked to make a clear decision among the options presented.

The Corporation

Canadian Examiners in Optometry – Examinateurs Canadiens en Optométrie (also known as CEO-ECO) was incorporated in 1995 for the purpose of developing and administering examinations to be used as a qualification for authorization (licensing or registration) to practise optometry in a province of Canada. The letters patent is attached as Appendix A.

CEO-ECO was incorporated with all ten provincial regulatory bodies as Members. Its Members went on to provide CEO-ECO with a broad mission to serve Canada's provincial and territorial optometric regulators in matters of common interest, including:

- publishing a description of the profession as practised in Canada, including its knowledge basis and competencies
- assessing individuals' competence in the practice of optometry
- assessing individuals' current learning in the profession of optometry
- publishing a description of quality practice
- providing mechanisms to evaluate the quality of the practice of individual optometrists

CEO-ECO's current By-law 1 is attached as Appendix 2. The Bylaw authorizes the governance of the organization by its Members and the administration of the organization by an elected Board of Directors and an Executive Committee.

In fulfilling its mandates, CEO-ECO has conducted substantial research on the scope, knowledge basis, competence, and quality of the Canadian profession of optometry. The results of its research have been published within the Canadian Journal of Optometry and elsewhere. Specific services essential to its Members have been developed and administered, including:

- The Canadian Standard Assessment in Optometry
- The Ocular Therapeutics Assessment
- The Prior Learning Assessment
- The Indicator of Current Learning in Optometry

The Situation

Initially, CEO-ECO was not provided exclusive authorization by all Members in providing its services. Within five years of incorporation, all Members allowed by provincial legislative mandate to require qualification examinations endorsed CEO-ECO exclusively. CEO-ECO's role expanded over time based upon its ability to deliver appropriate and relevant services for its Members and Canadians.

New labour mobility measures adopted by provincial governments in 2009, along with the decisions of some Members to accept the examinations of the National Board of Examiners in Optometry (NBEO) as equivalent to the CSAO, have radically altered the operating environment for CEO-ECO. With a majority of Canada's future

optometrists now training outside Canada, particularly in the United States, and with most of those candidates already having taken parts of the NBEO's examinations, CEO-ECO's position has been eroded. Without continuing and concrete affirmation of CEO-ECO's mission and mandates, Members face the loss of assets and their ability and authority to guide the profession in Canada.

Assets

CEO-ECO's assets are chiefly held in its human resources. CEO-ECO annually engages over 400 optometrists and 100 laypersons as volunteers within its processes. As subjects, proctors, administrators, managers, assessors, writers, editors, reviewers, selectors, translators, committee members, and Directors, these volunteers have developed expertise that would have a substantial cost to otherwise retain. Additionally, CEO-ECO's paid managers, administrators, and agents have developed professional skills and a functional network of suppliers and contacts that would be difficult to replace immediately.

The bank of examination questions developed and maintained by CEO-ECO has a replacement value of approximately $500,000. The value of these questions depreciates rapidly, however, and substantial annual reinvestment in new question development is necessary to maintain this asset. Presently, CEO-ECO's financial reserves amount to $349,647, having been retained from surpluses for use in contingencies and for the maintenance and development of services.

Options for Members

At their most recent meeting in January 2010, CEO-ECO's Members required the Board of Directors to call a special meeting of Members, subsequently scheduled for October 16, 2010, and to include an item of business related to CEO-ECO's continuity or dissolution. This paper serves as the background information necessary for CEO-ECO's Members to make an informed decision about the corporation's future.

Three options have been identified as being available to the Members:

1. to restore to CEO-ECO favoured status, by all Members endorsing its services and, where lawfully possible
2. to utilize only its services to further reduce CEO-ECO's favoured status, by Members making no changes to their current policies or by accepting the examinations of the NBEO as equivalent to the CSAO
3. to dissolve CEO-ECO

Option 1: Continuity with Exclusivity

Under the first option of restoring favoured status to CEO-ECO, Directors will continue their expedited effort in developing a new examination of competence as a qualification for practising. The Canadian Assessment of Competence in Optometry (CACO), as proposed in Appendix C, will be marked by its relevance to practice, its reliance on question formats within case studies, and its emphasis on communication skills. This would include the elimination of the Optometric Knowledge component of the present CSAO.

The Executive Committee is sensitive to the suggestions by some of an apparent conflict of interest in its administration. A review of the organization recently completed found no actual conflict of interest or corruption. However, changes to the administration of the corporation have been made to remove any appearance of a conflict of interest and to fulfill the corporate mandate efficiently and accurately.

Under a restoration of favoured status, pricing of the various services provided by CEO-ECO is estimated as follows:

- CACO $2350 per registrant
- ICLO $1000 per registrant, with reduction by subsidization
- PLA estimated $1000 per registrant

- Publications Public domain

With favoured status, the CACO will be administered first in October of 2011 as a replacement for the CSAO for new registrants. From October 2011, the CSAO will be made available through May 2012 for reassessments only. Administration of the ICLO could be resumed in 2011 if approved by the Members. The PLA will continue with changes to ensure greater robustness for the purpose to which it is evolving; an evaluation for qualification for bridging programs. Research and publications suspended in the past year in order to protect the organization's assets will be reactivated to address issues essential to CEO-ECO's Members and to provide a sound basis for CEO-ECO's mandates.

With favoured status, head office facilities will be relocated, if necessary, but otherwise, CEO-ECO will continue to use rented facilities for the delivery of its services in its current locale. The hundreds of volunteers and required contract workers will continue to be used to develop and administer CEOECO's services, furthering the legitimacy of the claim that CEO-ECO's services represent the standards and values of the profession in Canada. The Question bank will be maintained and developed as needed to supply the CACO, PLA, and ICLO. Financial reserves will be built up to appropriate levels as ratified by the Members and used only for contingencies and for the purposes of the corporation.

Option 2: Continuity Without Exclusivity

Should Members decide to sustain CEO-ECO but without favoured status afforded its services, CEOECO's Directors would be faced with conflicting mandates of delivering valid and reliable examinations on behalf of its Members, while having to appeal (presumably on price and/or pass rate) to potential registrants. Directors would be confronted with a competitor (the NBEO) with economies of scale and capital resources that dwarf CEO-ECO's but without the responsibility or accountability that CEO-ECO has to Canadian Regulators. Decisions of Directors would be made as much to minimize deficits (maximize surpluses) as to fulfill the mandate. This is at odds with the current purposes of CEO-ECO and the continuing purposes of its Members. This scenario could require a new charter of incorporation, or at a minimum, a substantial revision of by-law and mandate. Membership could be conditional on the payment of a fee or exclusive use/acceptance of CEO-ECO's services.

Nonetheless, in a competitive environment, the CACO would be produced, beginning October 2011, with the CSAO continuing for rewrites as directed by the Members. The PLA or the modified evaluation assessment would be continued but with an increase in the fee to reflect its full cost of production. The ICLO would be resumed only after time had proven the viability of CEO-ECO in a competitive business environment. Research and publications on competence and quality would be minimized with the savings redirected towards the provision of the CACO. The Board of Directors would be attenuated for cost savings but with a commensurate reduction in pro bono talent and expertise. Administrative staff would also be minimized with a commensurate reduction in service levels to registrants and Members.

In a competitive environment, the price of the CACO and other services would be set in consideration of maximizing the income and surplus of the corporation. Decisions about the delivery of services and use of facilities would need to be made based on conditions extant at the time. The use of CEO-ECO's assets, its volunteers, consultants, questions bank and financial reserves, would be altered in substantial ways.

Loss of talent and expertise could be the greatest risk to CEO-ECO's continuance should Members choose this option. It is most likely that a mandate to compete would ultimately lead to decline and failure.

Option 3: Dissolution

Dissolution is a reasonable alternative to a lack of uniform endorsement by CEO-ECO's Members.

The process of surrender CEO-ECO's charter is clearly laid out in the letter attached as Appendix D. This would occur after CEO-ECO's Members had decided upon the date for the suspension of activities.

To avoid legal and administrative challenges, CEO-ECO's activities will need to be maintained for a time. Commitments have already been made to the UW's IOBP for administering a PLA in February 2011 but not thereafter. Commitments to candidates for the CSAO have been made through the Fall of 2011 for reassessments based on initial registration for October 2010. No commitments have been made as yet to candidates for a Spring 2011 administration. Accordingly, an application for surrender of the charter may be made following the delivery of results to candidates of the Fall 2011 administration and the review of results of any candidates so requesting. The earliest that a surrender of the charter could occur under this plan would be January 2012.

Management and administration of CEO-ECO could be continued by extending the employment contracts of existing members of staff and consultants, assuming their willingness to persist. The Board of Directors would remain at ten through September 2011, after which it could be automatically reduced to six by the concluding terms of four directors. Under By-law 1, reduction to a minimum of three Directors is possible at any time if required by Members.

With a plan to surrender charter, pricing, delivery of services, facilities, and use of assets could be directed by the Members, otherwise by the Board of Directors, in accordance with whatever short-term mandate the Members see fit to provide.

The risk of incapacity to function is great under this scenario, as it is possible that volunteers would not volunteer, consultants would resign or decline contractual renewal, and some Directors resign their positions. Members would be faced with the prospect of themselves administering services traditionally provided by CEO-ECO.

Members will be asked to consider these alternatives at a special meeting of Members scheduled for October 16, 2010. The Board of Directors of CEO-ECO hereby requests a clear and unanimous commitment to CEO-ECO's future and mandates, the presence or absence of which will be responded to appropriately.

Appendix I —Achieving the objective of one Canadian entry to practice (ETP) exam, COO's Submission to AGM (March 2020)

OEBC Annual General Meeting of the Members

March 6th, 2020

Subject
Achieving the objective of one Canadian entry to practice (ETP) exam.

Background

At the February 1, 2020 meeting of FORAC, it was agreed that both live patients and models should be used where appropriate. Other key issues, including exam oversight and the role of the Touchstone Institute, were deemed to be more appropriate for discussion at the OEBC meeting.

The College of Optometrists of Ontario (the College) is interested in moving these issues forward and have set out the key issues we believe need to be addressed in order to do so.

The College recognizes that these issues represent significant potential change for the OEBC and will take time. However, as previously noted, in order to move this discussion forward, there needs to be agreement in principle on the key directions, a clear process to develop a proposal and specific timelines for completion.

The College needs to be able to report progress to its Council, which we define as a clear plan for moving forward, in the next few months.

Moving Forward

1. **Exam Content**: The College is pleased that there has been agreement that both live patients and models should be used where appropriate. As previously indicated, the College believes that, at a minimum, the following technical skills should be tested on live subjects: tonometry, gonioscopy, slit lamp fundus biomicroscopy and Binocular Indirect Ophthalmoscopy (BIO). The College looks forward to receiving information on the process for making this change and the potential timing.

2. **Exam Oversight**: The College believes that regulators need to have meaningful input into the structure and content of the exam and effective mechanisms to raise issues of concern. The current oversight structure, which appears to include the annual general meeting of the members, the board meetings and the annual report, are insufficient to generate the required confidence in the process.

   At minimum, a service agreement should be developed between OEBC and FORAC members clearly setting out the services that OEBC provides to FORAC members specifically addressing the following:

   - Communication of significant changes to the structure or content of the exam.
   - Communication in addition to the annual report.
   - A clear mechanism for regulators to receive information about and provide input into or feedback on the exam.

- A process for raising concerns about the exam, as well as how those concerns will be managed and reported on.

3. Governance

FORAC, OEBC members and OEBC directors are essentially all the same people. This creates overlap and inherent conflict. The College supports OEBC's proposed by-law revisions, which signal a move towards a competency-based board by removing the requirement for the board to be composed of a majority of regulators.

However, as long as OEBC directorship is the only way to have true oversight of the exam, regulators will continue to wish to be directors. If there were another way, this would be less important. OEBC could transition to a true board structure, with members who have experience overseeing an organization and other professional exams. Ultimately on a long-term basis, regulators of course should not be on the OEBC board, but should still be able to receive and provide information to the OEBC via FORAC or other mechanisms.

4. **Relationship between FORAC and OEBC**:

The ongoing roles of OEBC, the Regulators and Touchstone Institute needs to be clarified in any go-forward proposal.

5. Role of Touchstone

As you know, Touchstone is currently developing a new competency profile, which is expected to be completed in the spring. Regulators appear to have concerns about Touchstone and the relationship between Touchstone and the College, but it is not clear what these concerns are.

To be clear, the College has confidence in Touchstone because of its work on the IGOEE and exam development for other regulators. The College believes that the significant resources of an organization and economies of scale would protect the OEBC and improve both the exam and its administration. It believes that Touchstone could be valuable to the OEBC in one or more of the following ways:

- Using the new competency profile to replace the existing OEBC profile from 2015.
- Blueprint development.
- Exam development.
- Exam administration.
- Exam evaluation and psychometrics.

The College believes that a new approach to exam development, administration and evaluation is needed. It has suggested that Touchstone could be helpful in this regard. If OEBC does not wish to use Touchstone, we would suggest that there be a process to determine which organization would be best suited to be involved at each step of the process, with clear consultation processes and accountabilities (i.e., RFP process with clear contracts in place).

6. NBEO

Regulators are concerned about the impact of Ontario's acceptance of the NBEO on the OEBC exam. To date, the impact is not significant. Since the College's decision to accept the NBEO exam in January of 2019, we have registered 4 optometrists who have taken the exam out of a total of 143 registrants. We will continue to track these numbers and report any trends.

The College acknowledges the WOVS research project, although the conclusions warrant further discussion, given that other regulators in Canada accept US exams notwithstanding the differences in health care contexts between the two countries. The College would reiterate that it is not prepared to revisit the decision to accept the NBEO exam until there is a firm commitment to move forward with a revised Canadian ETP exam. In addition, any movement from Ontario with respect to NBEO would have to be in lock step with other current provinces currently accepting NBEO.

The College remains committed to working collaboratively towards the development of one Canadian, bilingual ETP exam. Even if, as was expressed at FORAC, this process will take time, there must be a clear objective and plan to achieve it.

Question for OEBC:
To that end, what can reasonably be accomplished by the September 11 FORAC meeting and how can this College assist OEBC in moving forward?

Applicability of Entry to Practice Examinations for Optometry in Canada and the United States – Optometry Examining Board of Canada and National Board of Examiners in Optometry

January 28, 2020

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1. Background & Introduction

Health care professions are self- regulated through Colleges in Canada. In order to protect the public, the Colleges strive to assure safe, effective, and ethical practice by their respective registrants (Canada)/licensees (United States) at the start and continuing throughout practice.[1] The Colleges of Optometry in each province are members of the Federation of Optometric Regulatory Authorities of Canada (FORAC/FAROC). The provincial governments desire their Colleges to adhere to standards that are transparent, objective, impartial and fair through mechanisms such as the Ontario Fairness Commissioner.

Colleges most often determine readiness for entry to practice by requiring that candidates pass a high stakes summative examination after they have undergone an appropriate educational program. The summative assessment provides a measure that the candidate has the minimum entry-level competencies to practice safely and effectively for the protection of the public prior to certification for registration/licensure to practice.

In North America, there are two principal assessment agencies for optometry. For Canada, the Optometry Examining Board of Canada (OEBC) provides a national examination for entry to practice.[2] In the United States (US), the National Board of Examiners in Optometry (NBEO®) administers an examination for entry to practice in the US. The NBEO results are accepted in two Canadian provinces (British Columbia and Ontario).

In 2019, the College of Optometrists of Ontario (COO) began accepting the NBEO as an entry to practice examination for the province, as an alternative to the OEBC examination. Stakeholder feedback was sought with both expressions of concern and support shared with the College. Consequently, the question arose whether the NBEO examination is appropriate for the Canadian context to determine if entry-level competency has been met for the practice of optometry in Canada?

It is essential that the summative assessments in health care are developed and implemented in a way that the result of the assessment is reliable and valid, so that the correct decision is made about the candidate. An assessment is not valid independent of the context and the education of the candidate attempting the examination.[3]

2. How are high-stakes summative assessments constructed?

The first step in designing a high stakes summative assessment is to define the competencies or abilities that are to be measured. Next, the appropriate assessment methods must be used to measure those competencies. Once those have been determined then a blueprint is created that matches content to the assessment methods in the correct proportions. Enough items need to be developed appropriately with adequate methodology and review. A cut score is then determined for the pass score using psychometrically sound methodology, such as the Angoff method. Review of the test results is done for items that might not be performing adequately, and reliability statistics are reviewed.[4,5]

There has been a shift away from what is taught in schools (content areas) to the competencies that are needed in practice.[4] The competencies are subdivided into indicators which are measurable observations of behaviour.[2,4]

Competency-based healthcare education and assessment has been a response to public and professional concerns regarding the quality and safety problems that plague the delivery of healthcare.[6,7] Competencies define the complex abilities of the practitioner beyond just the knowledge and technical skills that have dominated training in the past.[7] The competencies are an integration of the knowledge, skills and attributes of the healthcare practitioner and form a framework for assessing performance.[7] Competencies form the basis of healthcare training for the majority of the Western world.[8]

In optometry, entry to practice assessments have used the traditional knowledge test and technical skills assessment approach, and have been slower to adopt a competency-based approach. In North America, competency-based assessment has been adopted as a component of the requirements for licensure in medicine,[9–12] pharmacy,[13,14] dentistry,[15] and nursing.[16]

3. Entry to Practice Assessments for Optometry in North America

3.1. OEBC (www.oebc.ca)

The OEBC administers their summative assessment in two parts – a case-based multiple-choice written examination and an objective structured clinical examination (OSCE). The OEBCs competency profile (the set of abilities of the entry-level practitioner)[2] was developed with guidance by a consultant using a team of representative subject matter experts (SMEs), academia included. It was then validated using a survey of all optometrists in Canada and modified accordingly. Competencies are further described by OEBC as "significant job-related knowledge, skills, abilities, attitudes and judgments required for competent performance (i.e., safe and effective practice).[2] Table 1 lists the nine areas of optometric practice emergent from this process and Table 2 shows the relative number and weighting of the competencies in each area. The last update in the competency profile was in 2015.

Table 1: Nine Areas of Optometry Practice[2,17]

ENTRY LEVEL OPTOMETRY	
A1	Communication
A2	Professionalism
A3	Patient-Centered Care
A4	Assessment
A5	Diagnosis and Planning
A6	Patient Management
A7	Collaborative Practice
A8	Scholarship
A9	Practice Management

Table 2: Final Weighting and Competency Elements for the Examination[2]

Practice Area	Number of Competencies	Weighting (%)
A4 Assessment	12	22.8
A6 Patient Management	10	17.7
A3 Patient Centered Care	8	14.6
A5 Diagnosis & Planning	7	13.8
A1 Communication	5	8.9
A2 Professionalism	4	8.0
A7 Collaborative Practice	4	6.1
A9 Practice Management	3	5.2
A8 Scholarship	2	2.9
Total	**55**	**100.0**

The competencies and indicators of the competencies are mapped to the assessment format that is most appropriate. Items are then developed based on the importance and frequency of each competency area as judged by practicing optometrists in Canada.[2] This is the blueprinting process.

Specifically, the blueprint includes practice areas such as "Communication, Professionalism and Patient Centred Care" in addition to the traditional clinical areas of "Assessment, Diagnosis and Planning, Patient Management, and Practice Management."[17] The OEBC uses only practitioners for item development. They are trained by consultants to write items that are appropriate and at minimum competency level.

The intention of the assessments are designed to test the knowledge, skills, values and attitudes of health care practitioners.[9] While scope of practice may vary between provinces, the examination reflects the expected core competencies.

The OEBC emphasizes a patient-centered approach to care highlighting shared decision-making processes with the patient, involving the patient's family and support persons in care decisions where appropriate, and applying conflict resolution strategies in patient communication. The Standardized Patients (SP) are trained actors that enable an authentic and consistent clinical situation for observation of communication skills, professionalism, and patient-centeredness. Simulators are used to assess technical skills.

The pass/fail cut score used by the OEBC is determined by the Angoff method, which relies on SMEs to evaluate the content of each item and then predict how many minimally-competent candidates would answer the item correctly. The average of the SMEs predictions for an item becomes its predicted difficulty. The sum of the predicted difficulty values for each item, averaged across all SMEs and items on an assessment, is the recommended Angoff cut score.

A review of the psychometrics of each question and the assessment as a whole is an internal process to the agency administering the assessment, and allows the performance of the assessment itself to be reviewed. These processes identify any items that do not perform appropriately, such as having a low

pass score, or items that inversely correlate student scores on one particular question with their scores on the test as a whole (i.e. where overall poor performing students choose an answer correctly disproportionately to overall high performing students). The overall reliability is determined using Livingston's criterion-referenced coefficient alpha.[18]

3.2. NBEO® (www.optometry.org)

The NBEO administers their assessment in three parts – Part I Applied Basic Science (ABS), Part II (Patient Assessment and Management), and Part III Clinical Skills.[19] In aggregate, the examinations are intended to assess the cognitive, psychomotor, affective, and communication skills that are essential for entry-level optometric practice.[20] Prior examination updates are described in "Part I Basic Science Item Reengineering Pilot Report of the August 2004 Administration"[21] and "NBEO Examination Restructure Task Force"[22] report in 2006.

The "Job Analysis Survey Report for the National Board of Examiners in Optometry"[20] describes the process by which Alpine Testing Solutions applied a "survey methodology to evaluate and inform the content specification and blueprint development process." The current test blueprints are described by the content matrices based on a prior job task analysis survey conducted in 2004.[23] The NBEO has a series of examination committees and councils tasked with oversight for monitoring and maintaining the appropriateness of the entry to practice content.

The written examinations for Part 1 and 2 are defined by discipline and condition and Table 3 shows the content matrix.

Table 3: Structure of the NBEO blueprint[23]

Condition Areas (applies to Part 1, 2, and 3) 1. Refractive status/sensory processes/oculomotor processes 2. Normal health/disease/trauma		
Disciplines Part 1 ABS	**Disciplines Part 2 PAM**	**Skills Part 3 Clinical Skills**
A. Anatomy B. Biochemistry/physiology C. Immunology/microbiology /pathology D. Optics E. Pharmacology	F. Clinical presentation G. Clinical correlation of basic science principles H. Diagnosis I. Treatment/management J. Legal issues/ethics/public health	K. Communication skills L. Affective skills M. Psychomotor skills N. Clinical observation & reporting skills

The condition areas, disciplines and skills were updated in 2016, the process used the current framework used by NBEO in lieu of a clean slate for blueprint development. Typically, job analysis begins with a focus group of subject matter experts to develop a content outline that serves as the basis of the survey. "Because the NBEO examination development committees and councils already monitor and update the content of the current content matrices, this step was omitted and the current content matrices were used as the basis for the survey."[20] Since the NBEO relied on a prior framework, the

examination missed an opportunity to incorporate a more contemporary, competency profile of abilities of an entry-level practitioner.

The framework guidance included: "1. Summarize the current Conditions, Condition Areas, Disciplines and Skills, 2. Obtain updated weights for Conditions, Condition Areas, Disciplines and Skills, and 3. Identify any Conditions, Condition Areas, Disciplines or Skills that should be added or removed."[20]

The weightings remained relatively unchanged following the job analysis survey. However, given the decision to use the existing framework for the blueprint, Alpine[20] did recommend a post-hoc consultation with subject matter experts. The intent was to convene a task force of representatives of ARBO (Association of Regulatory Board of Optometry), ASCO (Association of Schools and Colleges in Optometry), and NBEO to review the job task analysis and to make recommendations to the NBEO Board of Directors. To our knowledge, there was no published report of the outcomes or recommendations from the task force.

The NBEO has retained the traditional model with live patients at the National Center for Clinical Testing in Optometry (NCCTO) with a greater emphasis on authenticity.[24] For example, tonometry on live patients captures the individual interaction reflective of practice. Results from candidate to candidate may exhibit more variation; however, this variation might be minimised if subjects for the station are "standardized" for similar anatomical features/difficulty.

In 2019, the NBEO embarked upon a systematic evaluation of the Part III Clinical Skills examination to seek stakeholder input and evaluation of best practices in health care assessment. The impetus for the update is partly a reflection of evolving scope of practice as well as a recognition that assessment of straightforward skills may not fully address the competencies required of contemporary practice.

The NBEO uses practitioners from various modes of practice as well as academics to write items. They are trained by staff to write items that are appropriate and at entry-level.

The NBEO publish pass/fail standard settings for each part.[25] Part I indicates the use of a Nedelsky/MPI, whereas Part II and III describe a cut score process.[26] More recently, an ARBO report indicates the use of the Angoff method for determining the cut score, but instead of using a percentage of minimally-competent candidates they use a yes/no method.[27,28]

For the evaluation of outcomes internal and external committees are used to review the process (National Board Examining Review Committee nominated by ARBO).[29] Individual items are reviewed to determine if they should be retained in the calculation of the score, and all student feedback on each question is discussed and acted upon as needed. Reliability statistics were not readily available.

Table 4: Comparison between OEBC and NBEO Assessment

	OEBC	NBEO
Content for Blueprinting	Competency statements developed by SME. Validated by survey of practitioners. These statements are used to determine the examination content	Job task analysis of conditions, disciplines and psychomotor skills. Not updated by a team of SME. These are used to determine the examination content.
Level of ability assessed	Minimal competency	Minimally qualified
Assessment Methods	MCQ and OSCE	MCQ and skills performance
Development of items	Practitioners with support of psychometrician	Practitioners and educators with support of psychometrician
Cut Score/Standard Setting	Angoff method Criterion referenced	Yes/no variation of the Angoff method Criterion referenced
Language	Bilingual (French and English)	English only
Review process	Internal Reliability method: Livingstone Coefficient[18]	Internal and external[29] Reliability method: not published

4. Contemporary assessment in other health professions

"Many "traditional" assessments focus on what can be done easily or has always been done, often resulting in an overemphasis on knowledge and clinical skills, at the expense of the other competencies necessary for good performance."[1]

A preferred approach is to use objective structured clinical examinations (OSCEs) and a move away from skills-based testing. The OSCE is a method of assessment design that allows multiple competency domains to be assessed, beyond the ability to obtain the data (skills assessment), at the same observation[30] while controlling for the sources of variability[31,32] that negatively impact workplace assessments. The OEBC uses an OSCE, but the NBEO uses the traditional skills assessment method.

The OSCE is an assessment format that was originally developed by Ron Harden for medical students in the mid 1970s[33] with the purpose of providing a more reliable assessment of clinical ability than the traditional observation and assessment by a senior medical practitioner of a trainee's ability in the course of provision of care. These observational assessments of clinical ability have limitations because the care may demand only a limited range of skills to be demonstrated (likely not consistent from one candidate to another), are dependent on the patients seen, and are hampered by the bias of the examiner.[34] The OSCE controls for the patient presentation and the bias of the examiner to measure competencies such as psychomotor skills, diagnosis and planning/management, while also being able to capture competencies that cannot be assessed in a written format such as communication,

professionalism and patient-centeredness.[10,35] The OSCE is at the 'shows how' level of Miller's pyramid of assessment[36], which emphasizes real-time performance.

The OSCE is a timed, simulated, performance-based examination where candidates rotate from one station to the next and are expected to perform a series of clinical tasks in each station.[37] Cases are developed to authentically represent a problem.[38] When using a strong development process including blueprinting, appropriate case development, training of examiners and training of standardized patients a valid and reliable examination can be developed.[37]

The OSCE is widely used in high stakes assessment in healthcare, such as national board examinations, and is also used extensively in undergraduate and postgraduate healthcare training in North America and abroad.[39,40] Part of the worldwide adoption of the OSCE as a high-stakes competency assessment is the ability for the content to be adapted to regional variations without impinging on its validity.

Currently, the OSCE is the only performance-based assessment with the feasibility and flexibility to assess a variety of domains of competence simultaneously and produce valid and reliable results.[41]

Using people as subjects for assessment may appear to be more authentic as it strongly resembles clinical practice. However, contemporary health care assessment has adapted technology for high fidelity simulations. Simulation-based assessment (SBA) is "the use of any device (e.g., a simulator) or set of conditions, such as a standardized patient examination, that attempts to evaluate healthcare providers' clinical competence authentically".[7] Simulation has been used for decades in high-risk fields like aviation, military and power plant operation for both training and assessment to achieve improvements in safety.[42] There are ethical concerns about the appropriateness of using "real" patients as assessment resources.[42] A simulator is able to perform the same clinical findings or scenario consistently to any number of candidates. The same would not be true for a person with weak fusion due to a binocular vision condition, for example. Several cover tests would break their fusion down and they would become strabismic. For an assessment to be reliable we must control for the patient and the examiner so that the primary variability is in the performance of the candidate, as "Without reliable data, valid interpretations and uses of that data are impossible".[42] Simulators also can produce a wide range of patient problems on demand and assess the candidate's ability to diagnose a critical presentation such as, for example, a third nerve palsy with a dilated pupil. Holmboe in his 2010 paper even at that time states, "sufficient evidence exists to incorporate more SBA into regulatory practices".[43]

5. How should we determine if the assessment is appropriate?

Both OEBC and NBEO examinations intend to assess readiness for entry to practice in optometry and both are recognized by their respective jurisdictions in Canada and the United States. To determine the appropriateness of each assessment, we applied a global consensus framework of assessment in health care developed in 2010 and subsequently updated in 2018.[1]

The framework reflects 7 criteria for good assessment[1]:

1. *Validity or coherence* – appropriate for a particular purpose; supported with a coherent body of evidence
2. Reproducibility, reliability, or consistency

3. Equivalence – same assessment across different cycles of testing
4. Feasibility – practical, realistic, and sensible
5. Educational effect - the assessment motivates those who take it to prepare in a fashion that has educational benefit
6. Catalytic effect – drives future learning forward and improves overall program quality
7. *Acceptability* – stakeholders find assessment process to be credible

The seven criteria are applicable to each examination since both national testing organizations have "…. coherent, high-quality test material, a systematic standard-setting process, and secure administration."[1] When considering regulators as stakeholders, Norcini states that "…. the most pressing need of the healthcare system and the regulators is to determine which providers are competent and safe enough to enter and remain in the workforce. This need implies correct decisions based on summative assessment, so validity-coherence, reproducibility-consistency, and equivalence are paramount. Feasibility is also important since the healthcare systems and the regulators sometimes bear these costs." In other words, are the correct decisions being made about a candidate and their ability to provide safe and effective care?

One of the challenges of addressing validity is identifying what 'type' of validity is being described. Traditionally, facets of validity developed in psychology/psychometrics were used (face validity, content validity, construct validity, etc.), which centred on the validity of the assessment method itself. More contemporary validity methods, such as Kane's contemporary validity framework[44], focus on how the outcome of the assessment *will be used*. There are certain components that need to be considered for an interpretation of the test score. These are scoring (how the score for a performance is determined), generalization (ensuring the score is reflective of the performance level), extrapolation (ensuring the score positively correlates with in-practice performance) and implication (using the score to make a decision, such as achieving competency for entry to practice). Clearly, both traditional and contemporary validity assessments are important, but the contemporary framework is directly applicable to the intention of entry to practice assessment. Most especially, assessing extrapolation is important here in that the test needs to correspond to real-world abilities of interest.

5.1. Validity/coherence

Validity/coherence are internally consistent for each jurisdiction; however, there is little evidence about the appropriateness of NBEO for the Canadian context. In Canada, the OEBC emphasizes a "patient-centred approach to care" that includes[17]

- Responding to patients' physical, emotional, intellectual and cultural backgrounds
- Shared decision-making processes with the patient
- Involving patient's family and support persons in care decisions where appropriate
- Competencies in communication – style appropriate to the situation, applying conflict resolution strategies; delivering bad news sensitively and effectively
- Maintaining professional boundaries

While each testing agency conducted a process for validating content, the sample of practitioners used to provide the context were limited to their own countries. In other words, the OEBC worked with Canadian optometrists while the NBEO worked with American optometrists.

Though North American Schools and Colleges of Optometry are accredited by the same organization, there are differences including legislated scope of practice, availability and naming of pharmaceuticals, coding and billing standards and practices, regulations and the system of healthcare among others.

In the US, Jobson Publishing distributes an annual addendum to the popular *Review of Optometry* entitled *Clinical Guide to Ophthalmic Drugs*.[45] Dr Bitton from the University of Montreal partnered with Jobson to provide a Clinical Guide to Ophthalmic Drugs 2016: Addendum for Canadian Optometrists[46], which was the last year they were published for Canada. Though not exhaustive, a comparison of the respective country 2016 lists across almost every major drug category reveals differences in availability, bottle sizes, concentrations of active ingredient, and even different names for the same formulation. Generally speaking, there are more options for brand name pharmaceuticals in the US as compared to Canada. Using ocular allergy medicines for acute care as an example, we see an additional 6 drugs with different active ingredients in the US that were not available in Canada in 2016.

In contact lenses, the Center for Ocular Research and Education (CORE) at the University of Waterloo School of Optometry & Vision Sciences publishes an on-line resource relating to contact lenses and solutions available in Canada and US.[47] Using the advanced search feature one may quickly identify variations of availability of products by manufacturer (e.g. Essilor produces gas permeable contact lenses for myopia in the US that are not available in Canada). Periodically, contacts lenses may be approved by Health Canada in advance of the US FDA, Coopervision's miSight for myopia control is a recent example.[48]

Part of the challenge in assessing suitability for either jurisdiction is the recognition that both organizations use different words and jargon to describe similar concepts. For example, OEBC follows the CanMEDs model[9] with knowledge, skills, values and attitudes of health care, whereas NBEO utilizes the terms cognitive, psychomotor, affective, and communication skills.[19] In both instances, the more colloquial way to refer to the concepts may be more easily understandable as head, heart and hands of practice.

A review of the literature did not provide any direct supporting evidence that the NBEO is appropriate for the Canadian context and the experience of the nursing profession (see section 6.) is the best indirect evidence that is available for the latent effects on the assessment of the approach to healthcare and the context in which that healthcare is being delivered.

5.2. Acceptability

The decision to accept the NBEO cited by the COO was "…. To improve choice, accessibility, and flexibility for applicants seeking registration with the college." The Manitoba Association of Optometrists response: "While admirable, this does not seem to be part of a regulatory body's mandate in protecting the public" speaks to the heart of the schism created.

As part of their process, COO held an open comment period with results published on the website[49] including a response from the Ontario Fairness Commissioner.

Favourable responses did acknowledge the convenience and lower cost of taking one set of examinations that would cover both Canada and the US, and shared experience that the examinations appeared equivalent when a candidate took both OEBC and NBEO.

However, significant opposition across Canada was also shared from professional associations, regulatory colleges, among other stakeholders. Among the principal themes included the "ability to control its own destiny within the Canadian healthcare system is of paramount concern." (CAO) and the appreciation that the National Competency Profile and examination for entry-level optometry in Canada for "safe, effective, and ethical practice…." was developed in Canada for the Canadian context, including the opportunity to take the examination in French or English. "We are looking less and less to America for leadership in Optometry and instead, growing the opportunities in Canada." (CAOS) In addition, "the central pillar of FORAC's strategic plan is to work towards one single and Canadian national entry-to-practice exam that is accepted by all the provinces." (FORAC)

Other concerns related to the potential adverse consequence to the OEBC as an alternative examination in the event that the NBEO was to be more widely adopted. A decreasing candidate pool from US-trained Canadians may result in increased costs or dissolution of the OEBC because of financial constraints.

A notable addition to the updated framework is the notion of political validity, which recognizes diversity in stakeholders and their perspectives on the role of high stakes assessments such as entry to practice examinations. Norcini[1] refers to "…. current members of the profession (e.g. consultant physicians), professional bodies (e.g. Medical Colleges), regulators (e.g. Medical Council), and the government (e.g. Ministries of Education and Health)." Easily substituted in the example would be optometrists, professional associations, colleges as regulators, and the government. While regulatory bodies have the jurisdiction to effect decisions within their purview, the implications across jurisdictions should also be weighed. Given the relatively small size of the profession of optometry in Canada the feedback shared with the COO during the open comment period resulted in several responses from regulators and professional associations.[49] The majority of regulator responses expressed opposition to the move to accept the NBEO as equivalent to OEBC.

The Office of the Fairness Commissioner supported the College's decision to accept the NBEO in addition to the OEBC for entry to practice examination. However, it also acknowledged that the potential dissolution of the OEBC may create accessibility barriers which would necessitate a reversal in support. Specifically, "…. Failure to offer an exam in French by the COO to an applicant would be a breach of s.86(1) of Schedule 2 of the Regulated Health Profession's Act, 1991," if the "…. OFC finds the potential fee increase will pose an accessibility barrier for those candidates wanting to write the Canadian OEBC exam," and if the "…. OFC finds accessibility barriers will exist for those candidates who for various personal reasons may be denied entry to the United States, who would be otherwise qualified to write the OEBE (sic) exam and be eligible for registration in Ontario." Ultimately, **"***the OFC opposes adopting a foreign exam as the sole accepted exam for professional registration in Ontario.***"**

The COO registration committee evaluated the equivalence between the two assessments without using any evidence-based guidelines for that evaluation. Without using published guidelines to determine the quality of the assessments, the results are not meaningful. Also, the equivalence was not determined by anyone who was qualified to make that judgement.

6. What can we learn from the nursing experience?

The National Council Licensure Examination – Registered Nurses (NCLEX-RN®) was adopted by Canadian Nursing regulators in 2011 to replace the Canadian Registered Nurse Exam (CRNE) as the entry-to-practice examination for nurses to be certified to practice. The National Council of State Boards of Nursing, Inc. (NCSBN®) based in the United States published 2 studies to support the applicability of the NCLEX-RN® test plan to the Canadian testing population.[50]

Since 2015 across 9 out of 10 provinces in Canada there was a significant drop in candidate pass rates[16] for first attempt Canadian writers compared to first attempt US writers (2015:69.7% vs. 84.5%, $p<0.001$);[51] an adverse impact on public perception of the profession,[52] and concerns about the appropriateness of adopting the US examination for the Canadian context were evidenced.[16]

The Council of University Programs in Nursing Ontario (COUPN) and the Council of Universities' Office of Health Sciences (OHS) issued a request to conduct an independent review of the NCBSN® studies "to assess whether they provide sufficient evidence to conclude that the NCLEX-RN® is applicable to the Canadian testing population."[16]

In one study[53], NCBSN addressed test population comparability by comparing the competency statements from the Canadian and US regulatory boards based on a framework of knowledge, skills, and abilities. Their second study was an update on a 2011 survey similar to a self-reported job task analysis for entry-level practice, which compared the activity statements from the US context to the national competency statements for Canada.[50]

Salfi et al.[16] Used four questions to guide the work of their review. The first two questions related to the two studies published by NCSBN in 2012 and 2014, respectively.

The latter two questions were:

- What are the similarities and differences in Canada and America?
- Can the NCLEX fairly test the competencies needed in Canadian nurses?

Salfi et al.[16] perceived the US activity statements to be "more prescriptive and directive in nature, versus collaborative," and suggest that "…. the patient is the object of care, rather than the partner" as suggested by the Canadian competency statements.

Two areas appeared to have weaker agreement between the US activity statements and Canadian competency statements – *service to the public* and *professional self-regulation*. Salfi et. Al. State that "… the two competency areas lie at the heart of the differences between US and the Canadian health care systems and, in all likelihood, these structural differences lead to differences in the way that nursing

competencies and expectations are framed in the two systems," and that "surface similarities in competency statements may mask actual differences in practice.".[16]

Activity statement mapping to competency statement described some process limitations including relatively few raters (4), the absence of a description of the ratings process and inter-rater reliability training. The authors infer that a narrow ratings scale that appears to have been used could result in the artifact of very high agreement.[16]

Salfi et. Al. "…. do not believe that the evidence provided by the NCSBN is sufficient to warrant the claims that the NCLEX-RN®, as currently designed, is an appropriate assessment tool for Canadian entry-level nurses." "Expectations in terms of practice are different, and language and cultural differences all lead to test results that are not reflective of what test takers have "come to know" as a result of their personal, cultural, professional and educational experiences.". [16]

"Culture, which can be defined as shared patterns of behaviors and cognitive constructs that are learned by socialization, which distinguish those of another group (The Center for Advance Research on Language Acquisition, 2014), cannot be overlooked, especially now that some of the differences between entry to practice nurses in Canada and the US have been highlighted.". [16]

Coupled with distinct health care systems, it is unsurprising that cultural values and context are different between Canada and the US as evidenced by the nursing experience with the adoption of the National Council Licensure Examination – Registered Nurses (NCLEX-RN®).

In Canada, optometry shares with nursing "…. an emphasis on client-centered care (more recently referred to as person-centered care), and it is a priority of all entry-level registered nurses to plan nursing care in collaboration with clients, and to meet mutually agreed upon outcomes along the continuum of care[54]". [16]

7. Conclusion

Adoption of the NBEO entry to practice examination in Ontario in 2019 has created uncertainty for registrants, the profession, and the public. A framework for evaluating the appropriateness of each assessment, OEBC and NBEO, is intrinsically satisfactory for their respective jurisdictions i.e. Canada and the US. However, when applied across jurisdictions the NBEO does not appear to satisfy the key criteria of validity and acceptability for Canada. Parallels with the nursing profession highlight cultural and systemic differences between the Canadian and US health system, which is reflected in the expectations for entry to practice. The potential loss of a viable, bilingual OEBC assessment is also a threat to the assessment system for FORAC. Lastly, the OEBC is a more contemporary assessment than the NBEO with the incorporation of OSCEs, which are ubiquitous in other health care professions such as medicine, nursing, and pharmacy. We conclude that the NBEO is not an appropriate entry-to-practice assessment for Ontario, specifically, and Canada more broadly.

8. Glossary

Summative assessment: End of program assessment aimed at determining if the candidate has achieved the desired outcomes

Standard setting/cut score: A method of determining the passing grade for an assessment. Commonly used methods are the Angoff method and the borderline groups method.

Criterion vs norm referenced: Assessments that measure performance against a fixed set of standards are called criterion-referenced. With norm referenced assessments the score reflects the performance in comparison to other candidates.

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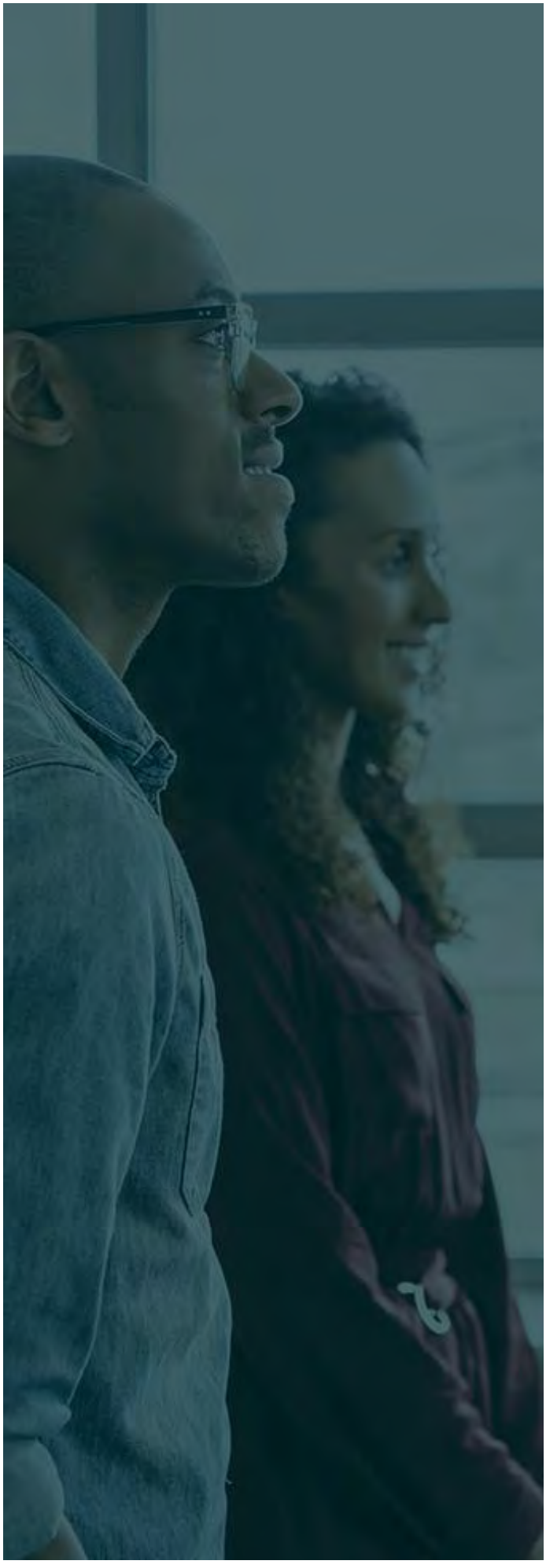
ACCEPTANCE OF THE NBEO

THE ALBERTA EXPERIENCE

January 18, 2021



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HISTORICAL PERSPECTIVE

Prior to 1995, Alberta, like many other provinces, used licensed practitioners in their province to create and administer a Registration Exam. The Alberta exam consisted of a written portion (multiple choice questions) and a verbal exam on ocular pathology using a View Master 3D viewer. Although, the exam was referred to as a Registration Exam, the exam did not fulfill all of the standard requirements for a psychometrically valid and defensible assessment to establish entry-to-practice competence in optometry in Alberta.

In 1995, Alberta joined other provinces to establish the Canadian Examiners in Optometry (CEO). CEO created and administered the Canadian Standard Assessment in Optometry (CSAO). Due to improvements in exam development, expansion of the optometry program curriculum and evolution of the scope of practice in Canada, the CSAO morphed into the Canadian Assessment of Competence in Optometry (CACO) in 2011 and finally to the Optometry Examining Board of Canada (OEBC) Exam in 2017.

In 2009, The Alberta College of Optometrists (ACO) decided to accept the National Board of Examiners in Optometry (NBEO) Exam for initial registration to our province. The main reason for doing so was the multitudes of newly graduated practitioners (especially the US trained students) telling us that it was less expensive to pay the extra $2000 to register in British Columbia with the NBEO and then transfer to Alberta than it would have been to write the CSAO / CACO Exam. Most of the US trained students had to complete Part I and Part II of the NBEO in order to graduate from their respective schools, so taking the CSAO / CACO Exam was an extra cost for them to bear.

- The ACO Registration Committee and the ACO Council conducted a rudimentary comparison of the two exams.
- The ACO Registration Committee did not agree with the decision to accept the NBEO Exam; however, the ACO Council felt that the two exams were “close enough” that it would be appropriate to accept the exam and save these newly graduated students $2000 since they were going to end up in Alberta anyways.
- As part of their decision, the ACO Council also decided to review the decision in one years’ time to ensure that the NBEO Exam was still an appropriate exam, and the public was still being protected.

COMPARISON TABLE

	CSAO	NBEO
Written Exam	Optometric Knowledge – 380 MCQ administered in three 3-hour sessions over two days. Ocular Therapeutics – 120 MCQ administered in one 3-hour session. Clinical Judgement – 100 MCQ administered in one 3-hour session.	Part I – Applied Science – 500 MCQ administered in one session. Part II – PAM & TMOD – 350 MCQ administered over two 3-hour sessions.
Clinical Exam	Clinical Skills – 28 different procedures tested at 4 different stations in one 3-hour session.	Part III – Clinical Exam – 18 different procedures tested at 4 different stations in one 3.5 hour session.
Total Cost	$3100 (Can)	$1875 (US) $2371.68 (Can – at the 2011 rate of exchange)
Future Changes to Exam	In 2011, the 3-part written exam was condensed into a two-part written exam (Ocular Therapeutics and Clinical Judgment) and renamed the CACO.	In 2011, a national Center of Clinical Testing in Optometry (NCCTO) was opened in Charlotte, NC. The previously twice a year Clinical Skills Test that was conducted in optometry school clinics in the US would now be available to students year-round.

REASONS FOR OUR ORIGINAL DECISION

The ACO Council based their decision to accept the NBEO for initial registration to Alberta on the following reasons:

- We reviewed the optometry program curriculums in Canada and the US and found that all accredited optometry programs in North America follow a similar didactic curriculum; and, that all students have similar clinical experiences.
- A quick review of the on-site Practice Visits conducted by the ACO Competence Committee showed that practice reviews for practitioners who wrote the NBEO Exam were similar to practice reviews for practitioners who wrote the CSAO Exam.
- Anecdotal evidence from students who wrote and passed both the NBEO and the CSAO Exams told us that the two exams were similar.
- The Ocular Therapeutics portion of the CSAO Exam was “similar” to the Treatment and Management of Ocular Disease portion of the NBEO Exam. Practitioners would have to pass either one to be designated as TPA certified in Alberta.
- If a newly graduated student intends to come to Alberta to practice, why make them jump through the AIT hoop of registering in BC with the NBEO (and paying an additional $2000 to register there) only to move to our province 1 day later.
- If CEO exam numbers drastically fall as a result of our decision and cause a financial hardship for CEO, perhaps the real threat of CEO going bankrupt will cause BC to reverse their decision to accept the NBEO. At the time, all other requests to BC to drop the NBEO as an entrance exam were not successful.

FEEDBACK RECEIVED

Once we announced our decision, we received the following feedback:

- The duty of a College is to protect the public, nothing more, nothing less. It is not our job to make life easier for students.
- This decision is the beginning of the end for CORA. If we cannot agree on a national registration requirement, how are we going to agree on anything else? CORA will become nothing more than an information sharing group.
- Students are more confused now than ever before.
- How long will Alberta continue to accept the NBEO as I am graduating in one year and need to know whether to sign up for the CSAO or not.
- CEO will cease to exist since more and more students will write the NBEO rather than the CSAO to enter Canada.
- Since the NBEO is not available in French, how are we going to meet our provincial requirement of offering a bilingual Registration Exam when the CEO goes under?
- This is a perfect example of how a bad decision that was made in one province affects all other provinces.
- Other than your rudimentary comparison, have you done anything else to prove that the NBEO is equivalent to the CSAO?
- What are your reasons for not accepting practitioners who passed the NBEO in previous years? Why just accept those who passed this year? Did the exam change that much?
- Why have you not also accepted the Australian and the UK Exam?
- If you continue down this path, we will go back to registering UK graduates straight out of school without any exam or Bridging Program at all.
- If CEO ceases to exist, the Maritime provinces will create and administer their own exam before we ever consider accepting the NBEO Exam.
- CORA has been working very hard for many years to try to come to some national consensus on many things. What you have done is slap us in the face; and, in a matter of a few minutes, you have managed to undo years and years of hard work.

HOW WE CORRECTED IT

As originally planned, the ACO Council did review their decision to accept the NBEO for initial registration to Alberta one year later and came to the realization that BC was not going to change their mind and that our decision was hurting CEO and all other provinces. As such, the ACO Council decided to stop accepting the NBEO Exam at the end of the year.

We did the following:

- We admitted that it was a mistake to accept the NBEO Exam as we did not wish to cause harm to any other provincial regulatory organization or the CEO.
- We informed CORA, CEO and all provincial regulatory authorities of our decision to go back to only accepting the CSAO/CACO for initial registration to our province.
- Although, we did not contact any School of Optometry directly, we did respond to all inquiries from students. Obviously, word spread through the student body very quickly. Our emails and telephone calls informed the students of our policy to only accept the CSAO/CACO starting January 1 of the following year (which was in about 7 months' time).

The end result was that:

- We did not receive any legal challenge from anyone on our decision to go back to only accepting the CSAO/CACO Exam.
- We did not have any applicant request a registration appeal through our Health Professions Act.
- The Alberta Department of Labor only asked whether we would still accept practitioners from other provinces via the labor mobility provisions of the Agreement on Internal Trade (AIT) – which we would.
- During the year immediately following our decision to go back, some students continued to use the BC "Bypass" to transfer to Alberta; however, most simply registered for the CSAO/CACO Exam and used that to register in Alberta.
- We were not obligated to continue to accept students for another 4 years with the NBEO Exam (as they started their optometry program while we were accepting the NBEO Exam). Colleges can change registration requirements at any time without having to "grandfather" any student already registered in an optometry program.

LESSONS LEARNED

- Knowing that any decision made by one province can have a dramatic effect on all other provinces and national organizations, best practice dictates that the national regulatory group (FORAC) should have the opportunity to review and discuss potentially harmful decisions that one province is thinking about making.
- A Canadian entrance-to-practice exam owned and operated by the provincial regulatory organizations is in the public's best interest as it can quickly change the national exam to continue to be a psychometrically valid and defensible assessment of the entrance to practice competencies required for practice anywhere in Canada as practice skill sets, competencies and knowledge bases evolve over time.
- FORAC should become more active in setting national Standards of Practice, Clinical Practice Guidelines, registration requirements, Letters of Good Standing, coordination of provincial scope of practice requests, continuing competence requirements, etc.
- The current, continued acceptance of the NBEO by British Columbia and Ontario is extremely harmful to the future of OEBC. If changes are not made in both provinces **this year**, we should start to look at how to best wind down OEBC operations as it cannot continue to operate under the current situation.
- Although, it is a remote possibility that an applicant may legally challenge what exam a provincial regulatory authority accepts for registration to their province, the publication of the University of Waterloo comparison study gives all provincial regulatory authorities the scientific support to state that it would be in the public's best interest to only accept the OEBC Exam for initial registration. This scientific paper is far superior to any comparison or review previously performed by British Columbia, Alberta or Ontario in the past and gives the necessary support to stand up to any challenge by a potential applicant or a provincial government.

Dr. Gordon Hensel

Registrar, ACO

BRIEFING NOTE

Council meeting – June 2021

Subject

The 2021 Jurisprudence exam for registration purposes.

Background

Applicants for registration as optometrists in Ontario are required to successfully complete a jurisprudence exam set or approved by the College as one of the requirements for registration. The College's jurisprudence exam is reviewed periodically by College staff and is approved by the College Council on an annual basis.

Paragraph 7.1 of s. 2(1) of the Registration Regulation (837/93) as amended under the *Optometry Act, 1991,* reads as follows:

"The applicant has successfully completed an examination in jurisprudence set or approved by the College …"

Decision for Council

To approve the 2021 Jurisprudence exam for registration purposes.

Considerations

- Previously held in-person, the College's Jurisprudence exam transitioned to a proctored online exam in June 2020 due to COVID-19.
- The online Jurisprudence exam pass rate is comparable to the in-person pass rate with candidates having the added benefit of being able to challenge the exam over the course of a few days at their own time without incurring travel or accommodation expenses.
- Having an online exam also facilitates exam performance reporting.

Financial Implications

There are monthly hosting fees charged by each of the remote exam proctoring service and the online exam service providers. However, these costs are offset by application fees paid by candidates for registration.

Public Interest Mandate

Having a relevant Jurisprudence exam that tests the knowledge of registration candidates about College-related legislation, governance and policies, is a core public interest mandate for the College.

Supporting Materials

Jurisprudence Exam Feedback Survey results Sept. 2020 – March 2021

Contact

Hanan Jibry, Deputy Registrar

#12

COMPLETE

Collector: Jurisprudence ...edback Survey (Web Link)
Started: Monday, September 14, 2020 11:06:32 AM
Last Modified: Monday, September 14, 2020 11:07:39 AM
Time Spent: 00:01:06

Page 1

Q1

It was easy to access the jurisprudence exam through ProctorFree.

(no label) **Agree**

Q2

I was satisfied with the technical experience of the jurisprudence exam.

(no label) **Somewhat Agree**

Please leave any comments on the technical experience of the exam.: had some issues in the middle of the exam, had to leave and come back, lost all the answers in the middle

Q3

I was satisfied with the guidance from the College regarding the exam (e.g., communication).

(no label) **Agree**

Q4

Overall, I had a good experience with the online jurisprudence exam.

(no label) **Somewhat Disagree**

Q5 **Respondent skipped this question**

Please leave any comments/feedback on any aspect of your experience with the jurisprudence exam.

#13

COMPLETE

Collector: Jurisprudence ...edback Survey (Web Link)
Started: Thursday, September 17, 2020 8:04:00 PM
Last Modified: Thursday, September 17, 2020 8:04:15 PM
Time Spent: 00:00:15

Page 1

Q1

It was easy to access the jurisprudence exam through ProctorFree.

(no label) **Agree**

Q2

I was satisfied with the technical experience of the jurisprudence exam.

(no label) **Agree**

Q3

I was satisfied with the guidance from the College regarding the exam (e.g., communication).

(no label) **Agree**

Q4

Overall, I had a good experience with the online jurisprudence exam.

(no label) **Agree**

Q5 **Respondent skipped this question**

Please leave any comments/feedback on any aspect of your experience with the jurisprudence exam.

#14

COMPLETE

Collector: Jurisprudence ...edback Survey (Web Link)
Started: Thursday, September 17, 2020 11:12:54 PM
Last Modified: Thursday, September 17, 2020 11:13:48 PM
Time Spent: 00:00:53

Page 1

Q1

It was easy to access the jurisprudence exam through ProctorFree.

(no label) **Agree**

Q2

I was satisfied with the technical experience of the jurisprudence exam.

(no label) **Agree**

Q3

I was satisfied with the guidance from the College regarding the exam (e.g., communication).

(no label) **Agree**

Q4

Overall, I had a good experience with the online jurisprudence exam.

(no label) **Agree**

Q5 **Respondent skipped this question**

Please leave any comments/feedback on any aspect of your experience with the jurisprudence exam.

#15

COMPLETE

Collector: Jurisprudence ...edback Survey (Web Link)
Started: Wednesday, October 07, 2020 1:00:25 PM
Last Modified: Wednesday, October 07, 2020 1:02:45 PM
Time Spent: 00:02:19

Page 1

Q1

It was easy to access the jurisprudence exam through ProctorFree.

(no label)	**Strongly Agree**
Please leave any comments on your experience with ProctorFree.:	Would love if there was an option to flag certain questions on the exam to skip to when I was reviewing.

Q2

I was satisfied with the technical experience of the jurisprudence exam.

(no label)	**Strongly Agree**
Please leave any comments on the technical experience of the exam.:	Straight forward and easy to use

Q3

I was satisfied with the guidance from the College regarding the exam (e.g., communication).

(no label)	**Strongly Agree**
Please leave any comments on the guidance from the College.:	Instructions were clear and given in a timely manner

Q4

Overall, I had a good experience with the online jurisprudence exam.

(no label)	**Strongly Agree**

Q5

Please leave any comments/feedback on any aspect of your experience with the jurisprudence exam.

Very impressed with the college coordinating online exams so that applicants can complete remotely. I find it organized and easy to navigate.

#16

COMPLETE

Collector: Jurisprudence ...edback Survey (Web Link)
Started: Saturday, October 31, 2020 3:11:43 PM
Last Modified: Saturday, October 31, 2020 3:12:46 PM
Time Spent: 00:01:03

Page 1

Q1

It was easy to access the jurisprudence exam through ProctorFree.

(no label) **Agree**

Q2

I was satisfied with the technical experience of the jurisprudence exam.

(no label) **Somewhat Agree**

Q3

I was satisfied with the guidance from the College regarding the exam (e.g., communication).

(no label) **Disagree**

Q4

Overall, I had a good experience with the online jurisprudence exam.

(no label) **Agree**

Q5 **Respondent skipped this question**

Please leave any comments/feedback on any aspect of your experience with the jurisprudence exam.

#17

COMPLETE

Collector: Jurisprudence ...edback Survey (Web Link)
Started: Tuesday, November 17, 2020 2:03:05 PM
Last Modified: Tuesday, November 17, 2020 2:04:25 PM
Time Spent: 00:01:19

Page 1

Q1

It was easy to access the jurisprudence exam through ProctorFree.

(no label) **Strongly Agree**

Q2

I was satisfied with the technical experience of the jurisprudence exam.

(no label) **Strongly Agree**

Q3

I was satisfied with the guidance from the College regarding the exam (e.g., communication).

(no label) **Agree**

Please leave any comments on the guidance from the College.: It was not stated in the communication that the practice exam would close when the exam opened.

Q4

Overall, I had a good experience with the online jurisprudence exam.

(no label) **Strongly Agree**

Q5 **Respondent skipped this question**

Please leave any comments/feedback on any aspect of your experience with the jurisprudence exam.

#18

COMPLETE

Collector: Jurisprudence ...edback Survey (Web Link)
Started: Sunday, November 22, 2020 1:03:25 PM
Last Modified: Sunday, November 22, 2020 1:04:09 PM
Time Spent: 00:00:44

Page 1

Q1

It was easy to access the jurisprudence exam through ProctorFree.

(no label) **Strongly Agree**

Q2

I was satisfied with the technical experience of the jurisprudence exam.

(no label) **Strongly Agree**

Q3

I was satisfied with the guidance from the College regarding the exam (e.g., communication).

(no label) **Strongly Agree**

Q4

Overall, I had a good experience with the online jurisprudence exam.

(no label) **Strongly Agree**

Q5 **Respondent skipped this question**

Please leave any comments/feedback on any aspect of your experience with the jurisprudence exam.

#19

COMPLETE

Collector: Jurisprudence ...edback Survey (Web Link)
Started: Tuesday, March 16, 2021 3:54:03 PM
Last Modified: Tuesday, March 16, 2021 3:55:00 PM
Time Spent: 00:00:57

Page 1

Q1

It was easy to access the jurisprudence exam through ProctorFree.

(no label) **Agree**

Q2

I was satisfied with the technical experience of the jurisprudence exam.

(no label) **Agree**

Q3

I was satisfied with the guidance from the College regarding the exam (e.g., communication).

(no label) **Agree**

Please leave any comments on the guidance from the College.: Could have been more clear that we were allowed to access the PDF and search through the PDF without penalty during the exam. Many of us also made study notes from the seminar and were unsure if we were allowed to look at those during the exam.

Q4

Overall, I had a good experience with the online jurisprudence exam.

(no label) **Strongly Agree**

Q5 **Respondent skipped this question**

Please leave any comments/feedback on any aspect of your experience with the jurisprudence exam.

#20

COMPLETE

Collector: Jurisprudence ...edback Survey (Web Link)
Started: Tuesday, March 16, 2021 6:12:43 PM
Last Modified: Tuesday, March 16, 2021 6:15:04 PM
Time Spent: 00:02:21

Page 1

Q1

It was easy to access the jurisprudence exam through ProctorFree.

(no label) **Strongly Agree**

Q2

I was satisfied with the technical experience of the jurisprudence exam.

(no label) **Somewhat Disagree**

Please leave any comments on the technical experience of the exam.: Through the exam process, the Proctor free program shut off. This caused some confusional whether or not to continue since the exam needed to be completed in one sitting.

Q3

I was satisfied with the guidance from the College regarding the exam (e.g., communication).

(no label) **Strongly Agree**

Please leave any comments on the guidance from the College.: The staff confirmed they had received my entire exam even with the system glitches.

Q4

Overall, I had a good experience with the online jurisprudence exam.

(no label) **Agree**

Q5 **Respondent skipped this question**

Please leave any comments/feedback on any aspect of your experience with the jurisprudence exam.

#21

COMPLETE

Collector: Jurisprudence ...edback Survey (Web Link)
Started: Wednesday, March 17, 2021 12:47:42 PM
Last Modified: Wednesday, March 17, 2021 12:48:52 PM
Time Spent: 00:01:10

Page 1

Q1

It was easy to access the jurisprudence exam through ProctorFree.

(no label) **Agree**

Q2

I was satisfied with the technical experience of the jurisprudence exam.

(no label) **Strongly Agree**

Q3

I was satisfied with the guidance from the College regarding the exam (e.g., communication).

(no label) **Strongly Agree**

Q4

Overall, I had a good experience with the online jurisprudence exam.

(no label) **Strongly Agree**

Q5

Please leave any comments/feedback on any aspect of your experience with the jurisprudence exam.

Amazing. Thank you

BRIEFING NOTE

Council meeting – June 2021

Subject

The 2021 Optometry Examining Board of Canada (OEBC) written exam and OSCE as one of two standards assessment examinations set or approved by the College for registration purposes.

Background

The committee continues to have confidence in candidates who have successfully challenged the OEBC written exam and OSCE with respect to entry-level competence and therefore, public safety.

Paragraph 7 of s. 2(1) of the Registration Regulation (837/93) as amended under the *Optometry Act, 1991*, reads as follows:

"The applicant must meet the criteria set out in one of the following subparagraphs:

i. successful completion, not more than three years before applying for registration, of the standards assessment examinations set or approved by the College…"

The Registration Committee considers which standards assessment examination for the College Council to approve on an annual basis.

Decision for Council

To approve the 2021 OEBC written exam and OSCE as one of two standards assessment examinations for registration purposes.

Considerations

- There have been positive steps undertaken by OEBC over 2020, including:
  - The installation of its new CEO in May 2020.
  - Inviting the Registration Committee to review and provide comments on its RFP and to observe its September 2020 OSCE.
- The OEBC Board approved policies to direct its CEO to create and maintain criteria for the best means (live patient, standardized patients, and models) to measure the specific entry-to-practice competencies.
- OEBC Board's unanimous support to integrate technical skills into the OSCE starting in the Spring of 2022.

Financial Implications

Not applicable to the College.

Public Interest Mandate

Having a robust and defensible entry-to-practice exam is a core public interest mandate for the College.

Contact

Hanan Jibry, Deputy Registrar

BRIEFING NOTE

Council meeting – June 2021

Subject

The 2021 National Board of Examiners in Optometry (NBEO) exam as an alternate standards assessment examination set or approved by the College for registration purposes.

Background

The committee continues to have confidence in candidates who have successfully challenged the NBEO examination with respect to entry-level competence and therefore, public safety.

Paragraph 7 of s. 2(1) of the Registration Regulation (837/93) as amended under the *Optometry Act, 1991*, reads as follows:
"The applicant must meet the criteria set out in one of the following subparagraphs:

I. successful completion, not more than three years before applying for registration, of the standards assessment examinations set or approved by the College…"

The Registration Committee considers which standards assessment examination for the College Council to approve on an annual basis.

Decision for Council

To approve the 2021 National Board of Examiners in Optometry (NBEO) exam as an alternate standards assessment examination for registration purposes.

Considerations

- In January 2019, the College Council approved the NBEO exam.
- A review of Part III of the NBEO exam, which comprises the clinical portion by NBEO, concluded in 2020 with a preliminary exam blueprint (see enclosed) and the plan to have each candidate in the remaining two stations perform the following technical skills on a standardized patient:

  ✓ Gonioscopy
  ✓ Tonometry
  ✓ Biomicroscopy
  ✓ Dilated Biomicroscopy
  ✓ Binocular Indirect Ophthalmoscopy (BIO)

- The National Board Examination Review Committee (NBERC) continues to be the independent oversight body responsible for ensuring that the NBEO exam meets all requirements for testing optometrists' entry-level competencies.

- In 2020, during COVID-19, the College was able to register approximately 30 candidates, most of whom were able to successfully challenge the NBEO exam. The remaining approximately 80

candidates were waiting to challenge the re-scheduled OEBC exam at the end of September or early November 2020.

Financial Implications

Not applicable to the College.

Public Interest Mandate

Having a robust and defensible entry-to-practice exam is a core public interest mandate for the College.

Supporting Materials

2020 Preliminary NBEO exam blueprint (Source: NBEO)

Contact

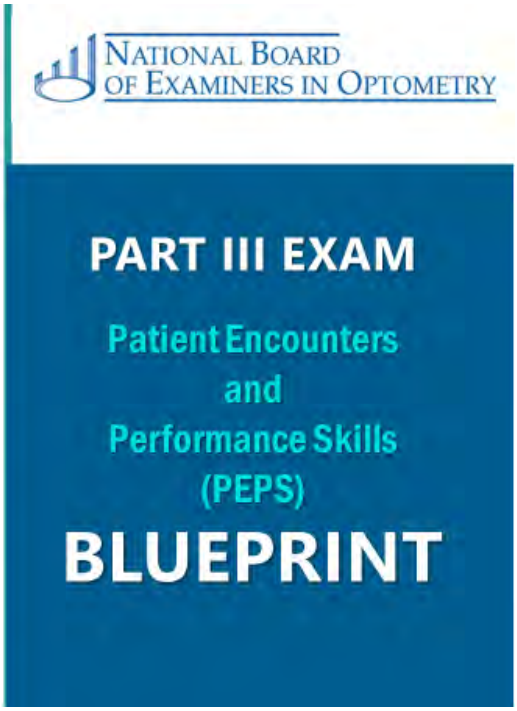
Hanan Jibry, Deputy Registrar

Blueprint

The blueprint specifies the major competency domains assessed by the exam. The competency domains represent the related sets of knowledge, skills, and abilities required for the safe and effective practice of optometry. The clinical presentation categories specify the topics of the case scenarios to be included in every version of the exam. The weight of the competency domains and clinical presentations specifies the emphasis of each of these elements on the exam.

Competency Domains	Weight
Clinical Assessment and Interpretation	29
Management and Documentation	25
Skills	22
Patient Education	13
Communication and Professionalism	11
Total	100

Clinical Presentations	Weight
Anterior Segment Disease	17
Posterior Segment Disease	16
Glaucoma	14
Systemic Disease	11
Refraction	11
Neuro-Ophthalmic Disease	9
Contact Lenses	8
Binocular Vision	8
Pediatrics	6
Total	100

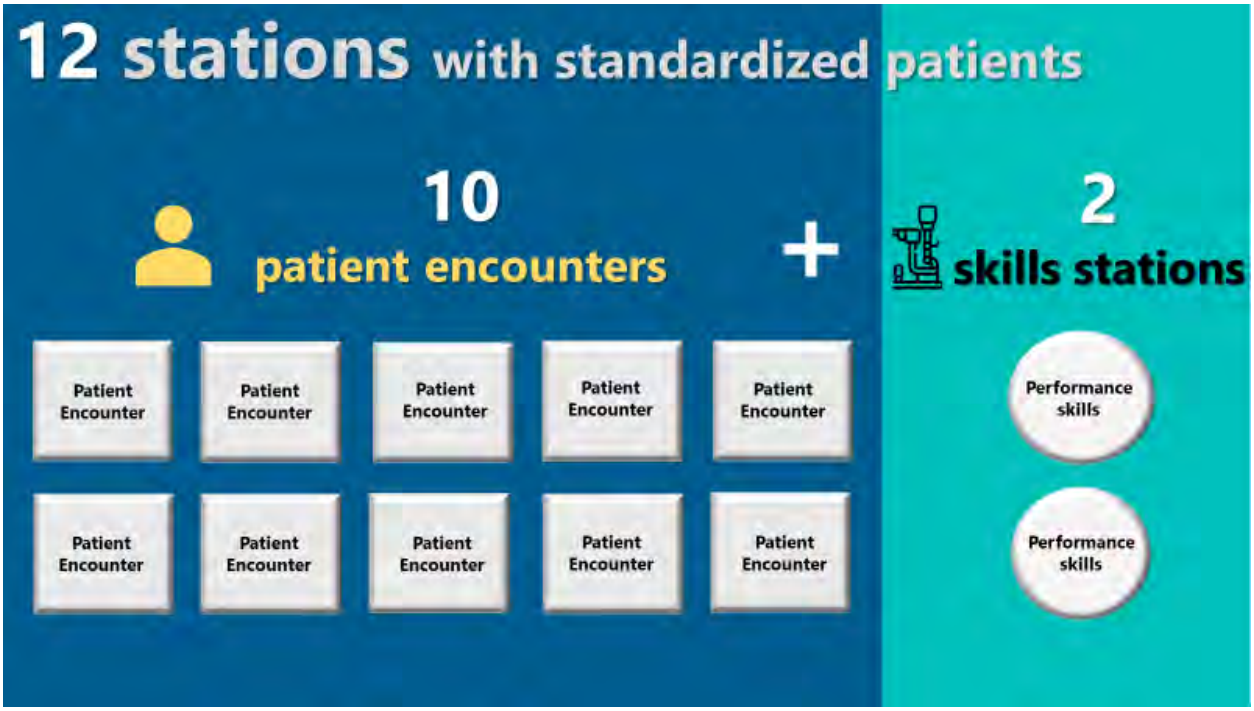


The blueprint includes five competency domains and nine clinical presentations which will be assessed on the Part III exam. The domain that carries the most emphasis is Clinical Interpretation and Assessment (29%) followed by Management and Documentation (25%). Functionally, this means the ability to interpret and synthesize clinical data will be prioritized over the collection of data or the physical performance of skills. These two domains will be evaluated through the creation of an electronic SOAP note, which will capture clinical decision-making and the generation of a treatment plan. The Skills domain (22%) will be evaluated through the physical performance of five skills on a standardized patient; no patient scenario will be included in these skills-only stations. Patient Education will comprise 13% of the exam and the candidate will be evaluated on the ability to provide information to the patient in a clear and understandable manner. Communication and Professionalism (11%) includes treating the patient with respect, sharing and receiving information in an effective manner, and collaborating with the patient and other professionals to provide optimal care for the patient.

The clinical presentation categories represent the major groups of diagnoses that an optometrist should be proficient in treating in order to protect the public. Both frequency and criticality were considered in the designation and weighting of the clinical presentations. Additionally, priority was given to those conditions that are life- or vision-threatening if not properly detected and managed.

Exam Model

The exam model is the functional depiction of the exam and represents how the blueprint will be operationalized. Although multiple versions of the exam will be used, each version will fulfill the requirements set forth in the blueprint. Each competency domain will be addressed by multiple stations, and the clinical presentations will serve as topics for the patient encounters.



The exam will consist of twelve stations. At each of the twelve stations, candidates will interact with a standardized patient. In ten of the stations, candidates will be presented with a clinical scenario in which they will be expected to perform a focused case history, interpret and synthesize clinical data, and generate a management plan. Each candidate will assess patients with conditions which fall into the nine clinical presentation categories included in the blueprint: anterior segment disease, posterior segment disease, glaucoma, refraction, systemic disease, neuro-ophthalmic disease, contact lenses, binocular vision, and pediatrics.

In the remaining two stations, each candidate will perform the following skills on a standardized patient:

Gonioscopy
Tonometry
Biomicroscopy
Dilated Biomicroscopy
Binocular Indirect Ophthalmoscopy (BIO)

Additional information regarding details of the stations will be published in the candidate guide, which is currently under development.

Frequently Asked Questions

Why is the Part III exam changing?

The Part III exam has historically focused on the physical performance of the skills that comprise an eye exam; however, it is natural that the exam evolves as the profession changes. Based on feedback from stakeholders, and to remain current with contemporary optometry, the Part III exam will shift away from the focus on motor skills to a more comprehensive measurement of optometric practice.

What are the biggest changes to the Part III exam?

The purpose of the exam is the same—to discern if candidates are competent to enter the safe and effective, independent practice of optometry--but the emphasis of the exam is changing substantially. The exam will focus on the analysis and synthesis of clinical data, and the incorporation of that data into patient management decisions. The majority of the exam (ten of the twelve stations) will focus on clinical scenarios. In the remaining two stations, the candidates will physically perform five essential skills on standardized patients: gonioscopy, tonometry, biomicroscopy, dilated biomicroscopy and binocular indirect ophthalmoscopy (BIO).

How do we know this new exam will be valid?

Evidence from other testing organizations and best practices within the psychometric community have guided the process of exam development. At every step, the best available evidence was used to make decisions, and extensive attention was given to including diverse perspectives in every decision. The process of pilot testing is central to ensuring the exam is both reliable and valid, and an extensive period of pilot testing is planned.

How was it determined which skills should be physically performed on the exam?

The process of determining which skills should be performed included many different perspectives from various optometric communities. The stakeholder survey was distributed to members of ARBO and ASCO and identified which skills were valued most highly by stakeholders. The focused job task analysis also provided information about how frequently a select number of skills were performed. The task force, comprised of 12 members who provided broad representation from optometry, discussed the results of the stakeholder survey and the focused job task analysis, and produced a final list of skills to be performed on the exam, which was approved by the Board of Directors.

When will the new exam be implemented?

The new exam will be initiated at the beginning of an administration cycle (August). The **earliest** the new exam would be implemented is August 2022, but the number and duration of pilot tests required will impact determination of the precise date when the exam will begin. The NBEO will communicate the implementation date as soon as it is finalized.

Will the current exam be offered concurrently with new exam?

Once the new exam begins administration, the current Part III exam will no longer be offered.

BRIEFING NOTE

Council Meeting – June 2021

Subject

OPR 7.12 Patients with Amblyopia

Background

A review of this standard began in 2019 and was interrupted last year by the COVID pandemic. This review is the result of contributions from CPP committees 2019-2021.

At its meeting on March 26, 2021, Council reviewed the revisions to this standard and referred the motion back to CPP for further review.

Decision(s) for Council

To approve revisions to OPR 7.12 Patients with Amblyopia

Considerations

- "Visual Sensitive Period" in OPR 7.12 refers to critical period for development of amblyopia not critical period of treatment.
- Cycloplegia needs to be conducted to rule out latent hyperope and ocular health concerns to confirm diagnosis of amblyopia. Cycloplegia is not under treatment but rather as part of a comprehensive case history and diagnosis.

Public Interest Mandate

To provide appropriate care of patients with amblyopia for a consistent standard of care in Ontario.

Supporting Materials

- OPR 7.12 revisions presented at the CPP meeting
- List of Scientific Articles
- Chen AM, Cotter SA. The Amblyopia Treatment Studies: Implications for Clinical Practice. Adv. Ophthalmol Optom. 2016;1(1):287-305

Next Steps

The OPR 7.12 Patients with Amblyopia will be updated accordingly.

Contacts

Dr. Violet Zawada Kuzio and Dr. Nisara Bandali – Practice Advisors

7.12 Patients With Amblyopia

Description

Amblyopia (a condition patients often call "lazy eye") is characterized by reduced best corrected visual acuity in one or both eyes, without disease or structural abnormality of the eye or visual pathways. It is caused by an interruption of visual sensory stimulation (due to strabismus (an eye turn), uncorrected refractive error, or visual deprivation) occurring early in life during the visual sensitive period. The level of interruption determines the reduction in acuity and subsequent suppression of the weaker eye: this is variable, and depends on the cause of the interruption. Children and adults with amblyopia commonly experience reduced vision and impaired eye co ordination that may impact academic, recreational, and occupational accomplishments. ~~Optometrists provide diagnosis and treatment of amblyopia, its causes and associated functional visual deficits.~~

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health related purpose in a situation in which a consent is required by law, without such a consent.

8. Failing to reveal the exact nature of a secret remedy or treatment used by member following a patient's request to do so.

9. Making a misrepresentation with respect to a remedy, treatment or device.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the Regulated Health Professions Act, 1991 when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

29. Charging or allowing a fee to be charged that is excessive or unreasonable in relation to the professional services performed.

Professional Standard

Diagnostic evaluation of new patients with, or suspected of having, amblyopia incorporates:

- comprehensive case history including:
- prior eye conditions, diseases and treatments (medical and/or surgical)
- family history of amblyopia, strabismus and other eye conditions
- developmental history including term of pregnancy, birth weight, and pre /peri natal history (including ~~specifically~~ maternal use of alcohol, tobacco or drugs ~~use~~ during pregnancy), as indicated
- measurement of uncorrected visual acuity
- ~~cycloplegic~~ refraction (both with and without cycloplegia) and measurement of best corrected visual acuity **(OPR 7.6)**
- assessment of ocular motility and alignment
- dilated anterior and posterior segment examinations **(OPR 6.1 and OPR 6.2)**

Given that amblyopia is considered a diagnosis of exclusion, additional investigations are performed as needed to rule out other causes of reduced vision.

Treatment[1,2] for amblyopia involves:

- consideration of prognostic factors (including but not limited to patient age, cause of amblyopia, and degree of amblyopia) and patient education regarding realistic goals, limitations and estimated time frame of available treatment options
- optical correction, including the use of iseikonic lenses and contact lenses, as required
- occlusion treatment or pharmacological penalization, as indicated
- referral for binocular vision assessment and/or optometric vision therapy for monocular and binocular visual function, as required
- referral **(OPR 4.5)** for surgical correction of associated conditions (such as strabismus, ptosis, etc.), as indicated ~~by optometric or ophthalmologic guidelines~~
- patient education regarding the impact of amblyopia on eligibility for specific occupations~~,~~
- patient education on the importance of, and providing a prescription for, protective eyewear, as indicated due to the increased risk of eye

injury ~~and the increased risk for eye injury and the importance of eye protection~~

~~• provision of a prescription for protective eyewear~~

Continuing care of established patients previously diagnosed with amblyopia is done at appropriate intervals. Patients involved in active amblyopia therapy are seen frequently, to assess progress and modify treatment as needed, while others are seen regularly, as indicated. Continuing care includes:

- history concerning any changes in vision or visual function and patient ~~compliance with~~ adherence to prescribed treatment • re assessment of best corrected visual acuity and binocular status
- re assessment of ocular health status with special attention to the ongoing health of the non amblyopic eye
- modification of the treatment plan, as indicated, to improve the effectiveness of treatment and/or to better meet patient needs and expectations

Optometrists must stay abreast of developments in evidence based treatment for amblyopia and ensure that their patients have access to such treatment where clinically beneficial.

		Patching	No difference	Binocular
Birch et al	A pilot randomized trial of contrast-rebalanced binocular treatment for deprivation amblyopia. J AAPOS. 2020 Dec; 24(6): 344.e1-344.e5 https://pubmed.ncbi.nlm.nih.gov/33069871/			TRUE
Birch et al	Baseline and Clinical Factors Associated with Response to Amblyopia Treatment in a Randomized Clinical Trial. Optom Vis Sci. 2020 May; 97(5): 316-323 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7271687/			TRUE
Editorial	New treatments for Amblyopia - To patch or play? https://jamanetwork.com/journals/jamaophthalmology/articleabstract/2579928		Neutral	
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The Amblyopia Treatment Studies: Implications for Clinical Practice

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INTRODUCTION

Amblyopia is the most common cause of monocular vision loss in children[1] with an estimated prevalence of approximately 2% in the United States.[2–4] A developmental disorder of spatial vision, amblyopia is clinically defined as decreased best-corrected visual acuity (VA) in one, or less frequently both eyes, in the absence of any obvious structural anomalies or ocular disease. It is associated with abnormal visual experience, most commonly strabismus, anisometropia, or form deprivation that occurs during a sensitive period of visual development in infancy or early childhood.

Signs, Symptoms, and Quality-of-Life Concerns

In addition to reduced best-corrected VA, there are a plethora of visual function deficits of the amblyopic eye, including abnormal contour interaction,[5] reduced contrast sensitivity,[6] positional uncertainty,[7] spatial distortion,[8] poor accommodation,[9] abnormal eye movements,[10] and suppression.[11] Because of good vision in their non-amblyopic (sound) eye, persons with unilateral amblyopia typically do not complain of blurred or poor vision under habitual binocular viewing conditions; however, recent studies have reported reduced reading speed[12] and compromised fine-motor skills[13] even with both eyes open.

There are important public health consequences when amblyopia is left untreated. Patients with amblyopia are more likely to become visually disabled because of an increased risk of

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their sound eye becoming visually impaired,[14,15] with their estimated lifetime risk of visual impairment being at least 1.2%.[15] Vision loss in the sound eye, often caused by trauma, can have a significant effect on quality of life with many employed individuals no longer being able to work because of inadequate visual function.[15,16] Although amblyopic eye VA can sometimes improve in adults after vision loss of their sound eye, most remain visually disabled.[17] Furthermore, the presence of unilateral amblyopia has a deleterious effect on binocularity, including stereopsis. Because good VA in each eye and/or normal stereoacuity are often prerequisite for careers in the military, aviation, surgery, law enforcement, firefighting, as well as obtaining a commercial driver's license,[18] amblyopic individuals are often precluded from participating in such occupations.[19]

Historical Perspective on Amblyopia Treatment

Historically, the mainstay of amblyopia treatment has been patching of the sound eye. Treatment regimens have been a matter of individual preference based on the training, observations, and clinical impressions of the treating optometrist or ophthalmologist. Generally, when it came to patching, the adage was "time was of the essence", so patching was prescribed in conjunction with the refractive correction because of the notion that treatment beyond a certain age (variously stated as between 6 to 9 years) would not be beneficial.[20] The-more-the-better-principle was followed by many eye care providers with full-time patching thought to be preferred, if not imperative, for a successful outcome, particularly for severe amblyopia. Atropine penalization was not considered to be a first-line treatment modality and thus generally advocated only for young children with moderate levels of amblyopia who had failed patching.

Amblyopia Treatment Studies

The Pediatric Eye Disease Investigator Group (PEDIG) is a clinical network of pediatric optometrists and ophthalmologists funded by the National Eye Institute to conduct clinical research studies related to pediatric eye conditions. Thus far, the majority of the PEDIG studies have focused on evaluating the comparative effectiveness of different amblyopia treatment regimens for children and adolescents. These studies are known as the Amblyopia Treatment Studies (ATS), and their results have dramatically changed amblyopia clinical practice patterns for many eye care providers. Herein, this article summarizes the key findings from these studies and provide our perspective in regard to the most relevant clinical implications.

RESULTS & CLINICAL IMPLICATIONS

Key features of the ATS studies are:

- They are randomized clinical trials (RCT) or prospective observational studies.
- The studies of unilateral amblyopia comprise participants with anisometropic, strabismic, or combined-mechanism (anisometropic and strabismic) amblyopia

- and the bilateral amblyopia study enrolled children with isoametropic amblyopia; children with deprivation amblyopia have been not been studied.

  Amblyopic eye VA of 20/40 or worse with an interocular difference of at least 3 lines was required for enrollment for most of the unilateral amblyopia studies.

- The primary outcome measure is best-corrected VA of the amblyopic eye, which is measured in a standardized fashion by examiners who are masked to participants' treatment assignment.
- VA is measured using a standardized computerized testing method that presents single-surrounded optotypes at logMAR intervals on the Electronic Visual Acuity (EVA)[21] tester using HOTV optotypes for children 3 to 6 years old[22] and the Early Treatment Diabetic Retinopathy Study (ETDRS) letters for children 7 years of age and older.[23]
- The magnitude of VA improvement found at the mostly 4- to 6-month primary outcome examinations is not the maximum benefit expected to be achieved for all participants, but instead the maximum length of time that the prescribed treatment regimens could be maintained before investigators would insist on a change of treatment in cases of poor outcome; in many cases, VA can improve further with continued treatment.
- RCT results are based on the "prescribed" treatment regimens determined by randomization, not the "actual" treatment completed.

Prescribing Guidelines for Refractive Error Correction

The following prescribing guidelines have been implemented in these studies:

- Refractive error determination is based on a cycloplegic refraction using cyclopentolate.
- Full correction of astigmatism, myopia, and anisometropia is prescribed with the goal of providing equally clear retinal images.
- Hyperopia is either fully corrected (e.g., in cases of esotropia) or undercorrected (e.g., in cases without esotropia) by no more than +1.50 D spherical equivalent (SE), with any reduction in plus sphere reduced symmetrically in the two eyes.

Optical Treatment Studies

1. Optical Correction for Unilateral Amblyopia—Two ATS studies have evaluated the effectiveness of optical correction alone as a treatment modality for previously untreated unilateral amblyopia in 3 to <7 year-old children.[24,25] The first study enrolled children with anisometropic amblyopia of 20/40 to 20/250[24] and the second study enrolled those with strabismic or combined-mechanism amblyopia of 20/40–20/400,[25] with the following key findings:

- Mean amblyopic eye VA improvement was approximately 3 lines and occurred in both moderate and severe cases of amblyopia (Figure 1).

- Resolution of amblyopia, defined as equal VA or amblyopic eye VA within 1 line of sound eye VA, occurred in 25–33% of cases (Figure 1).

- Generally, the optical treatment effect occurred within the first 16 to 18 weeks after optical correction; however, in some children VA continued to improve for up to 45 weeks (Figure 2).
- There was no relationship between amblyopic eye VA improvement and the presence or magnitude of strabismus pre- or post-spectacle correction.

Clinical Implications

- There is an actual amblyopia treatment effect that occurs over time from solely wearing an appropriate refractive correction that is distinct from the immediate VA gain that occurs initially from eliminating optical blur.
- It is reasonable to start amblyopia treatment with the refractive correction alone for young children with anisometropic, strabismic, and combined-mechanism amblyopia.
- A follow-up interval of 6 to 8 weeks, until improvement in the amblyopic eye VA plateaus, is a practical schedule for monitoring children for an optical treatment effect.
- Children still needing additional amblyopia treatment after improved VA from an optical treatment effect have better amblyopic eye VA at the start of the next treatment phase, which can result in less treatment burden and better compliance.
- Some children (i.e., those with amblyopia resolution) may not need additional amblyopia treatment beyond optical correction.

2. Optical Correction for Bilateral Refractive Amblyopia—The PEDIG conducted a prospective observational study to determine the amount and time course of VA improvement with refractive correction alone in 3 to <10-year-old children with previously untreated isoametropic amblyopia of 20/40–20/100 associated with high hyperopia (≥4.00D SE) and/or astigmatism (≥2.00D). The primary outcome measure was binocular VA. The key findings were:[26]

- The mean improvement in binocular VA was approximately 4 lines.
- Of the 113 participants, 74% achieved binocular VA of 20/25 or better.
- Continued VA improvement was seen for up to 1 year in some children.
- The worse the child's VA at the start of treatment, the greater the number of lines of improvement in VA.
- A majority of children also showed an improvement in near stereopsis.

Clinical Implications

- The time frame for VA improvement varies but can take up to 1 year; it is possible that additional improvement may occur beyond 1 year (but this was not studied).

Although participants were corrected with spectacles, it is reasonable to expect that similar improvements would occur with contact lens corrections.

Forms of Occlusion

When patients do not respond to refractive correction alone, or VA ceases to improve, occlusion treatment such as part-time patching, atropine penalization, or Bangerter filters may be prescribed.

Patching Dosage

Patching dosage was evaluated in 2 concurrent clinical trials of children 3 to <7 years of age. The effectiveness of 2 hours of daily patching was compared to 6 hours of daily patching in children with moderate amblyopia of 20/40 to 20/80[27] and 6 hours of daily patching was compared to full-time daily patching in children with severe amblyopia of 20/100 to 20/400.[28] The key findings were:

- In cases of moderate amblyopia, prescribing 2 hours of daily patching with 1 hour of near activities is as effective as prescribing 6 hours of daily patching with 1 hour of near activities (Table 1).
- In cases of severe amblyopia, prescribing 6 hours of daily patching and 1 hour of near activities is as effective as prescribing full-time daily occlusion and 1 hour of near activities (Table 1).
- There was no difference in the rate of improvement between the groups randomized to the lower and higher patching dosages.

It is noteworthy that in a subsequent clinical trial, there were children with severe amblyopia who responded to 2 hours of patching.[29]

Clinical Implications

- Full-time patching is not always needed for a successful treatment outcome. Prescribing lesser amounts of patching may promote better overall compliance with treatment.
- When patching is prescribed, it is reasonable to prescribe 2 hours of daily patching for moderate amblyopia and 6 hours of daily patching for severe amblyopia.
- Some children with severe amblyopia will respond to as little as 2 hours of patching.
- In young children, using an adhesive patch should be strongly considered so that peeking is less likely to occur.

Atropine Treatment

Another amblyopia treatment modality is pharmacological penalization by the instillation of the long-acting topical cycloplegic agent, atropine sulfate (1%), into the sound eye of a child with amblyopia. The resultant cycloplegia prevents accommodation in the sound eye

- resulting in blurred vision at near, and in instances when the full hyperopic correction is not worn, blurred vision at distance as well.

1. Atropine vs. Patching for Moderate Amblyopia—The first ATS[30] compared the effectiveness of daily administration of 1 drop of 1% atropine in the sound eye to ≥ 6 hours of daily patching in children 3 to <7 years old with moderate amblyopia of 20/40 to 20/100 and found the following:

- Both treatment groups showed a similar improvement in amblyopic eye VA (Table 1).
- VA improvement was slower with atropine penalization compared to patching, but the magnitude of VA improvement at 6 months was similar.
- Treatment effect did not differ by age, cause of amblyopia, or depth of amblyopia.
- A switch in near fixation preference from the atropinized sound eye to the amblyopic eye was not observed in a number of children with significant amblyopic eye VA improvement.[31]
- Both treatments were well tolerated with parents reporting a slightly higher degree of acceptability with atropine treatment.

2. Atropine Regimens for Moderate Amblyopia—A subsequent RCT compared less frequent administration of 1% atropine drops (weekend only) to daily atropine in children 3 to <7 years old with moderate amblyopia of 20/40 to 20/80 and found the following:[32]

- Amblyopic eye VA improvement was essentially identical (2.3 lines) in both groups at 4 months.
- Among participants, 80% reached their maximum VA improvement by 4 months, but some continued to show VA improvement for up to 10 months.
- Among participants, 50% had resolution of amblyopia (i.e., equal VA or amblyopic eye VA within 1 line of sound eye VA).

3. Atropine Augmentation with a Plano Lens for the Sound Eye—The PEDIG evaluated whether there was an additional treatment effect by augmenting weekend atropine with a plano lens for the sound eye in children aged 3 to < 7 years with moderate amblyopia of 20/40 to 20/100.[33] Because all participants had hyperopic refractive error in their sound eye, those randomized to the atropine plus plano lens group had blurred distance vision in addition to increased blur at near. The key findings were as follow:

- There was no difference in mean amblyopic eye VA improvement between the two groups at 18 weeks; mean improvement was approximately 2.5 lines.

- More children in the atropine with plano lens group reached 20/25 or better amblyopic eye VA than those in the atropine only group (40% vs. 29%, respectively).

4. Atropine for Severe Amblyopia—Historically, atropine penalization has been reserved for children with moderate amblyopia, because, presumably, treatment would not be effective if sound eye VA was not worse than amblyopic eye VA. Nevertheless, PEDIG RCTs included children with severe amblyopia of 20/125 to 20/400 who were treated with weekend atropine.[33–35] While the studies were not powered to compare treatment groups, the following noteworthy results were observed:

- In children 3 to <7 years, the average VA improvement was 4.5 to 5.1 lines.
- In children 7 to 12 years, VA improved by 1.5 lines with prescribed weekend atropine.

5. Miscellaneous Issues with Atropine Treatment for Amblyopia

Reverse Amblyopia: Although a few children had reduced sound eye VA at follow-up visits, there were no cases of persistent reverse amblyopia after discontinuation of atropine.[33,35] Initially apparent reverse amblyopia was suspected in some children, but it was then determined that sound eye VA had not been assessed through the full hyperopic correction. Because atropine can uncover additional hyperopia than found on a cyclopentolate refraction, it is important to determine if uncorrected hyperopia is present in the atropinized eye, and if so, to measure sound eye VA through the full plus prescription at follow-up visits.

Systemic Side Effects: Systemic side effects (dryness, flushing of skin, fever, confusion, unusual behavior, and irritability) that can be associated with atropine penalization rarely occurred.[30,32,33] However, when such cases occur, daily instillation of 5% homatropine eye drops can be substituted for atropine.

Clinical Implications

- Atropine penalization has a similar treatment effect as 2 and 6 hours of prescribed patching; thus, it can be considered for first-line amblyopia treatment or for patching failures.
- Daily atropine administration is not necessary; a twice-per-week schedule is also effective. There is no reason to believe that atropine needs to be administered only on weekend days or that the days need to be sequential.
- Weekend atropine penalization has been shown to be effective in treating both moderate and severe amblyopia.
- Retinoscopy should be performed over the current refractive correction of the sound eye for children on atropine to determine if there is residual uncorrected hyperopia that should be corrected before measuring sound eye VA.
- Parent education regarding atropine penalization for the amblyopia treatment is listed in [Table 2].

Bangerter Filter Treatment

A Bangerter filter (Ryser Optik AG, St. Gallen, Switzerland) is a translucent filter that is applied to the sound eye's spectacle lens for full-time wear for amblyopia treatment. There are different density filters, which produce different degrees of image defocus that degrade sound eye VA to predictable levels. An RCT to evaluate the effectiveness of Bangerter filters in in children 3 to <10 years with moderate amblyopia (20/40 to 20/80) found the following:[36]

- Full-time wear of Bangerter filter provided VA improvement (1.8 lines) similar to 2 hours of daily patching (2.3 lines).
- Parents reported fewer adverse effects and better compliance with the Bangerter filters than with patching.

Clinical Implications

- Bangerter filters can be considered for first-line amblyopia treatment or for patients who do not comply with patching or atropine treatment.
- Potential advantages of Bangerter filters are the following:

  The ability to change the density of the filter to modulate the degree of degradation.

  The possibility of better compliance because the filter is not readily apparent to casual observers.

  The filter may be less disruptive to binocular vision than patching, albeit 2 to 4 hours of part-time patching should not be very disruptive to binocular vision.
- Potential disadvantages of Bangerter filters are the following:

  Peeking around the filters is relatively easy.

  Filters may not uniformly degrade VA to the predicted level reported by manufacturer.[37]
- Clinicians should consider changing the filters periodically because the amount of degradation with filters tends to decrease over time.[37]

Treatment of Older Children with Amblyopia

Historically, there has been little consensus on the effectiveness of amblyopia treatment in older children, with many eye care professionals believing that amblyopia treatment was ineffective after some upper age limit (e.g., 6–7 years or 9 or 10 years), that any VA improvements were likely to be lost after the cessation of treatment, and that intractable diplopia was of concern.

1. Do Older Children with Amblyopia Respond to Treatment?—In an RCT investigating the effectiveness of amblyopia treatment in 2 cohorts of children (7–12 years and 13–17 years) with amblyopia of 20/40–20/400,[38] participants were randomized to optical correction alone (control group) or optical correction augmented with 2 to 6 hours of daily patching, 1 hour of near activities when patched, and 1% daily atropine in the 7–12 year cohort. The primary outcome was the proportion of treatment "responders," which was defined as ≥ 2 lines improvement in amblyopic eye VA. Data were analyzed separately for the two age groups.

- In children aged 7–12 years, 53% in the augmented treatment group showed a treatment response compared to 25% in the control group.
- In children aged 13–17 years, there was no difference in the proportion of children in the 2 treatment groups who met the responder criteria (25% and 23%, in the augmented and control groups, respectively).
- In children aged 13–17 years who had not been previously treated for amblyopia, the outcome was essentially the same as that found in children aged 7–12 years (47% in the augmented group versus 20% in the control group).
- No patients developed intractable diplopia.

2. Single Treatment Modality—Given that 7 to 12-year-old children prescribed a combined treatment regimen of daily part-time patching and 1% atropine responded to treatment, the PEDIG subsequently compared the effectiveness of 2 hours of daily patching versus weekend administration of 1% atropine in children of this age with amblyopia of 20/40–20/100 and found the following:[34]

- Mean VA improvement was essentially the same (approximately 1.5 lines) in both groups after 17 weeks of treatment.
- Children who showed improvement in amblyopic VA at the 17-week follow-up visit were monitored until reaching maximal VA improvement, which was a mean of 2.2 lines in both groups.

Clinical Implications

- Amblyopia can be successfully treated in 7 to 12 year-old children using either 2 hours of daily patching or weekend atropine as the initial treatment.
- Although many older children respond to treatment, a meta-analysis of 4 PEDIG RCTs showed that amblyopia is more responsive to treatment in children younger than 7 years of age compared with children 7 to 12 years of age.[39]
- Among children in the optical correction alone group, 25% showed ≥ 2 lines of VA improvement: thus, the optical treatment effect from simply wearing the refractive correction is not limited to younger children.
- The authors think that it is unlikely that the difference in treatment response between children 7 to 12 and 13 to 17 years was because of a difference in visual plasticity. The authors hypothesize that the lesser treatment effect in children 13

to 17 years might be because it was more difficult for them to comply with 2 to 6 hours of daily patching with their overscheduled lives and/or they were not prescribed atropine.

- There was significant individual variability in treatment response, with some 13 to 17-year-old children showing significant improvement with treatment, even with a history of prior treatment. Therefore, the authors think that one should not withhold treatment from children aged 13 to 17 years, even with a history of prior treatment.

Residual Amblyopia

Because many children have residual amblyopia after treatment, the PEDIG has evaluated several treatment approaches for residual amblyopia.

Younger Children (3 to <8 years)

1. Increasing Patching Dosage: The key findings from an RCT evaluating the effectiveness of increasing patching from 2 hours to 6 hours in children 3 to <8 years old who were originally treated with 2 hours of daily patching for at least 12 weeks, but still had stable residual amblyopia (20/32–20/160) were as follows:[40]

- Mean VA improvement at 10 weeks was 1.2 lines in the group that increased patching from 2 hours to 6 hours and 0.5 lines in the group that continued with 2 hours of patching.
- Among children in the increased patching dosage group, 40% showed at least 2 lines of VA improvement compared to 18% in the group who were to continue with patching for 2 hours.

2. Adding a Plano Lens to Atropine Treatment: In an RCT to evaluate the effectiveness of adding a plano lens to atropine treatment for 3 to <8-year-old children with stable residual amblyopia (20/32 to 20/63), children were randomly assigned to treatment with weekend atropine with or without a plano lens over the sound eye.[41] The main findings were as follows:

- Mean VA improvement was 1.1 lines in the atropine with plano lens group and 0.6 line in the atropine only group at 10 weeks.
- Although there may be a small benefit from augmenting atropine therapy with a plano lens over the fellow eye, the study results are not definitive because the difference in amblyopic eye VA improvement between the two groups was not statistically significant and the confidence interval was large.[41]

3. Combining Patching and Atropine Treatments: The PEDIG evaluated whether an intensive final push with combined patching and atropine could improve VA in children 3 to <10 years with residual amblyopia of 20/32 to 20/63 after 12 weeks of treatment with 6 hours of daily patching or daily atropine.[42] Children were randomized to either an intensive

combined treatment group (6 hours of daily patching combined with daily atropine) or a control group in whom treatment was weaned (i.e., daily patching reduced from 6 hours to 2 hours or daily atropine reduced to once-weekly atropine for 4 weeks, followed by no treatment other than spectacles alone).

- Mean VA improvement was 0.5 lines in both groups after 10 weeks.

Clinical Implications

- If an amblyopic patient does not respond fully to the prescribed treatment, verify compliance with treatment and consider repeating the cycloplegic refraction and re-examining the ocular structures to ensure there is no residual uncorrected refractive error or subtle ocular pathology present.
- When amblyopic eye VA stops improving with 2 hours of daily patching, increasing the patching dosage to 6 hours is a reasonable next approach.
- When amblyopic eye VA stops improving with weekend atropine, adding a plano lens over the sound eye may result in further improvement.
- Combined treatment of patching and atropine did not seem to further improve VA in those with residual amblyopia; however, these results should not be generalized to children with more severe residual amblyopia or those who have stopped improving after less intense treatment.
- In cases of residual amblyopia, changing the treatment modality (e.g., changing patching to atropine or changing atropine to patching) can be considered. Alternatively, active vision therapy procedures can be prescribed to improve deficiencies in accommodation, form discrimination, fixation, as well as to eliminate suppression.[43–45] Although there are no controlled trials that have evaluated these treatment approaches for residual amblyopia, the PEDIG is currently conducting an RCT that includes children with residual amblyopia to evaluate the effectiveness of a type of binocular anti-suppression treatment on an iPad.[46]

Older Children (7 to 12 years)

Treatment of Residual Amblyopia with Oral Levadopa: Because levodopa, an oral medication used to supplement dopamine deficiency in adults with Parkinson's disease and children with dopamine-response dystonia, had been used by some clinicians for amblyopia treatment, the PEDIG conducted a RTC in children 7 to 12 years old with residual amblyopia of 20/50 to 20/400 after patching treatment to assess levodopa's efficacy and short-term safety as an adjunctive treatment to patching. Children were randomized to oral levodopa or placebo administered 3 times daily with patching prescribed for 2 hours per day. The key findings were as follows:

- There was no clinically or statistically meaningful improvement in VA from adding oral levodopa to patching compared with placebo and patching.

Clinical Implication

- There is no meaningful benefit from adding oral levodopa to part-time patching for the treatment of residual amblyopia.

Recurrence of Amblyopia

Amblyopia that is successfully treated can reoccur once treatment is discontinued, particularly if the amblyogenic factor is still present. Amblyopia recurrence rate was evaluated in children 3 to <8 years old[47] and children 7 to <13 years old[48] in two separate studies. Recurrence was defined as a loss of ≥2 lines of VA in the amblyopic eye.

In children 3 to <8 years who had been successfully treated with patching or atropine:

- Approximately 25% experienced a recurrence during the first year off treatment.
- The risk of recurrence was similar for amblyopia treated with patching and atropine.
- Most recurrences occurred within 3 months after the cessation of treatment.
- The recurrence rate was 3 times greater in children who had 6 to 8 hours of patching that was stopped abruptly than in children who had 6 to 8 hours of patching that was tapered to 2 hours prior to cessation or for children who initially had been prescribed 2 hours of patching without weaning.

In children 7 to 12 years of age who responded to a treatment regimen of 2 to 6 hours of patching, atropine, and near activities:

- Only 7% of children experienced a recurrence during the first year off treatment.

Clinical Implications

- Because a majority of recurrences in children <8 years old occur within 3 months after the cessation of treatment, early follow-up is critical.
- Patching dosage should be gradually tapered rather than abruptly terminated in young children who initially patch ≥6 hours per day.
- Amblyopia recurrence is less common in older children than in younger children.

Long Term Follow-Up

A follow-up study that included a proportion of participants from the original ATS trial that compared atropine vs. patching for treatment of moderate amblyopia was conducted to evaluate the durability of treatment benefit found the following:

- The mean amblyopic eye VA after 6 months of treatment at study outcome was approximately 20/32 in both groups; approximately 25% of participants underwent additional treatment using the alternative treatment (atropine switching to patching, or vice versa) during the following 2 years.[49]

- At age 15 years, mean amblyopic VA was approximately 20/25 and 60% of children had 20/25 or better in their amblyopic eyes. VA at 15 years was similar between the two original treatment groups.[50]

Clinical Implications

- VA improvements occurring with amblyopia treatment before 7 years of age are typically maintained until at least 15 years of age (but it is wise to monitor for regression).
- Mild residual amblyopia is common.

Role of Near Activities

In many of the RCTs discussed previously, 1 hour of near activities were prescribed to be done during patching based on the clinical assumption that these activities stimulate the visual system and enhance amblyopia outcomes. Subsequently, an RCT was conducted where children 3 to <7 years old with amblyopia of 20/40–20/400 were randomized to 2 hours of daily patching with near activities (e.g., crafts, reading, writing, computer or video games) or 2 hours of daily patching with far activities (e.g., watching TV, outdoor play),[29] with the following main result:

- There was no difference in treatment effect based on whether near or far activities were prescribed.

Clinical Implication

- The activities prescribed to be performed at near in this RCT were “common” near activities. More highly structured vision therapy activities and, specifically aimed at improving accommodation, form discrimination, and fixation, and for eliminating suppression were not evaluated.[43–45] The degree of effectiveness of active vision therapy procedures has not yet been evaluated in an RCT.
- Amblyopia iNet (http://www.visiontherapysolutions.net/ambp.php), a softwarebased system of amblyopia therapy for home use, has visual activities (e.g., form discrimination and eye movements) that can be performed using the amblyopic eye only or under “monocular fixation in binocular field” (MFBF) conditions to address suppression.[44] Monocular perceptual learning activities that are performed at near have shown good promise as an adjunct to traditional amblyopia treatment.[51] Neither of these treatment approaches, however, has been examined critically in a carefully controlled trial.

CONCLUSIONS

The results from the PEDIG studies, discussed previously, have dramatically changed the amblyopia treatment landscape. Many long-held beliefs regarding amblyopia treatment, which were based primarily on observations and clinical impressions, did not stand the test of time once evaluated in a rigorous manner. Table 3 provides an overview of long-held amblyopia treatment dogma that has been challenged and mostly supplanted by the ATS

results reported herein. Figure 3 shows an evidence-based sequential treatment approach for moderate amblyopia in young children that is based on the results of these PEDIG studies.

The PEDIG studies to date have principally addressed monocular approaches to amblyopia treatment. Recently there has been an increased interest in evaluating treatments that are designed to decrease suppression and enhance binocularity.[52–54] The PEDIG is currently conducting a RCT comparing this type of binocular treatment administered daily on an iPad versus 2 hours of daily patching in children 5 to <17 years.[51] There are a number of other amblyopia treatment modalities currently under investigation and the authors are hopeful that 10 years from now, they will be writing a paper discussing amblyopia treatment regimens that are even more effective than those that exist at present.

Acknowledgments

We would like to acknowledge the National Eye Institute for funding the studies through the PEDIG network (EY011751, EY018810), and also acknowledge the dedication of the Jaeb Coordinating Center (Tampa, Florida) staff and participating PEDIG investigators and coordinators. We also acknowledge that the aforementioned PEDIG studies are not the only rigorous large-scale studies that have been conducted in recent years; however, the scope of this manuscript was limited to PEDIG studies. The interpretation of the data presented herein are solely our own and do not represent those of the PEDIG, the National Eye Institute, Marshall B. Ketchum University, or any other professional organization to which we belong.

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SYNOPSIS

A series of randomized clinical trials and prospective observation studies, the Amblyopia Treatment Studies (ATS), have recently been conducted by the Pediatric Eye Disease Investigator Group (PEDIG) to provide an evidence base for treating childhood amblyopia. Herein, we review the major findings and clinical implications from these studies that have addressed important amblyopia treatment issues, such as optical treatment, patching dosage, atropine penalization, treatment of older children, and residual amblyopia.

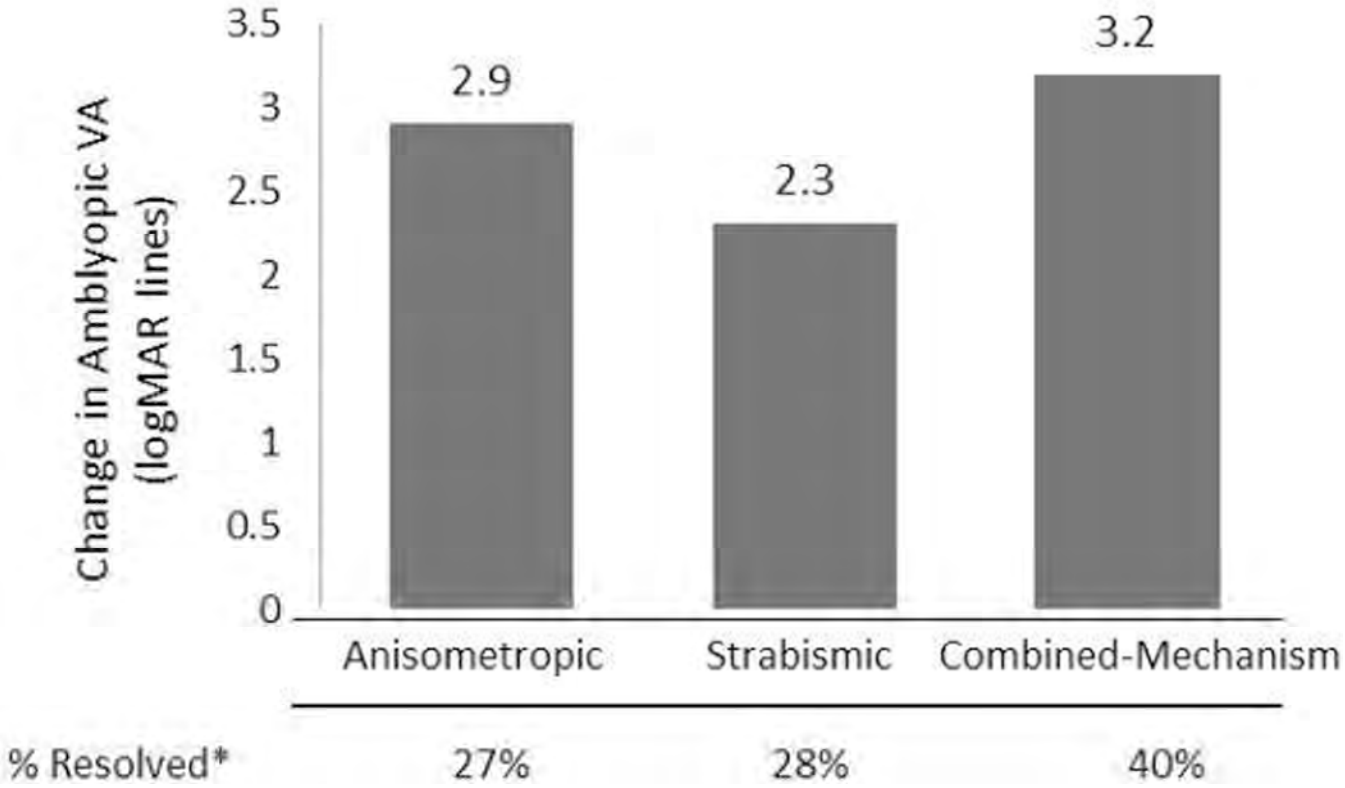
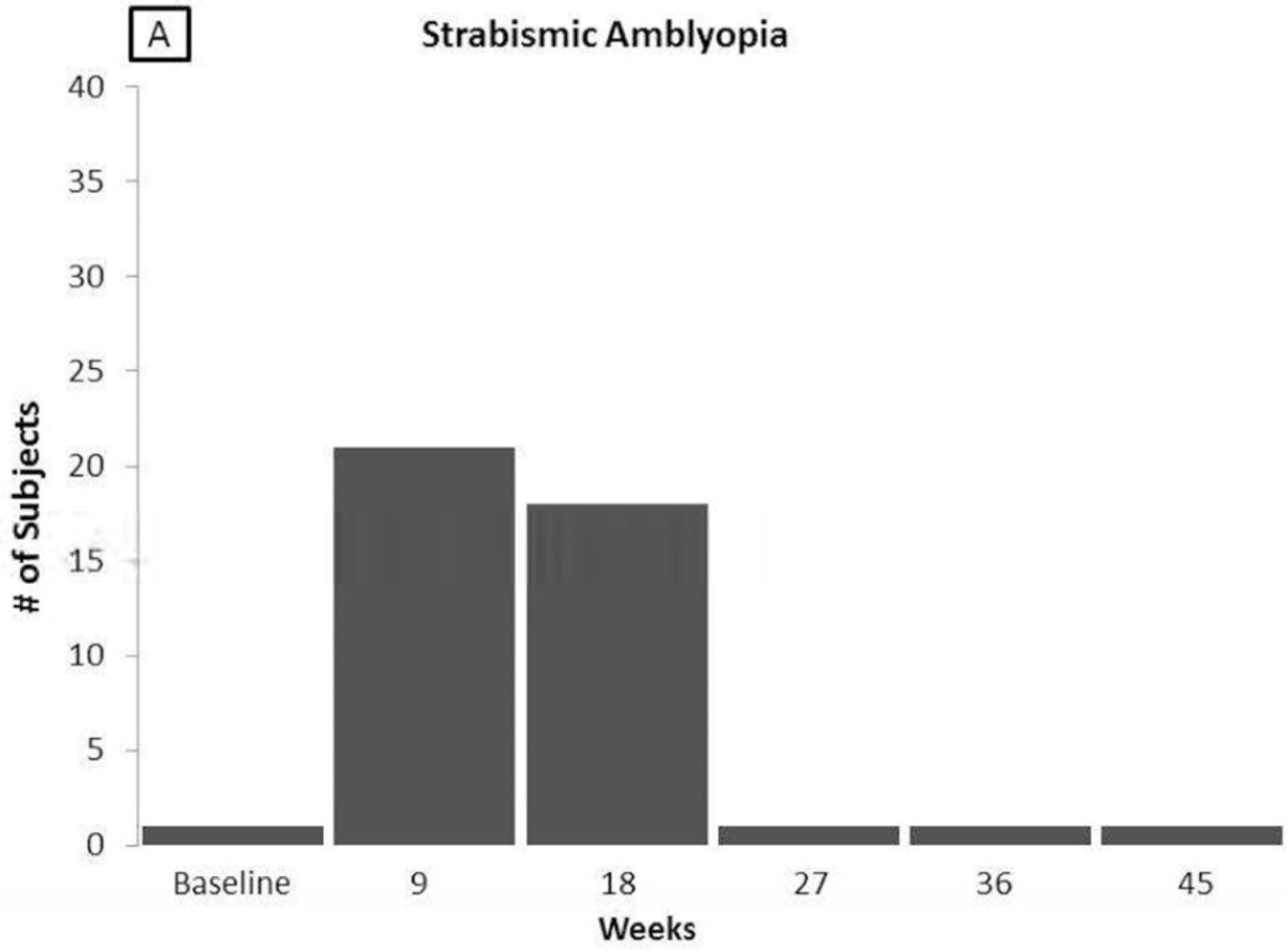


Figure 1.

Mean visual acuity improvement and proportion of children reaching resolution of amblyopia with refractive correction based on type of amblyopia. * Resolved = amblyopic eye VA equal to or within 1 line of sound eye VA


A
Strabismic Amblyopia
# of Subjects
40
35
30
25
20
15
10
5
0
Baseline
9
18
27
36
45
Weeks

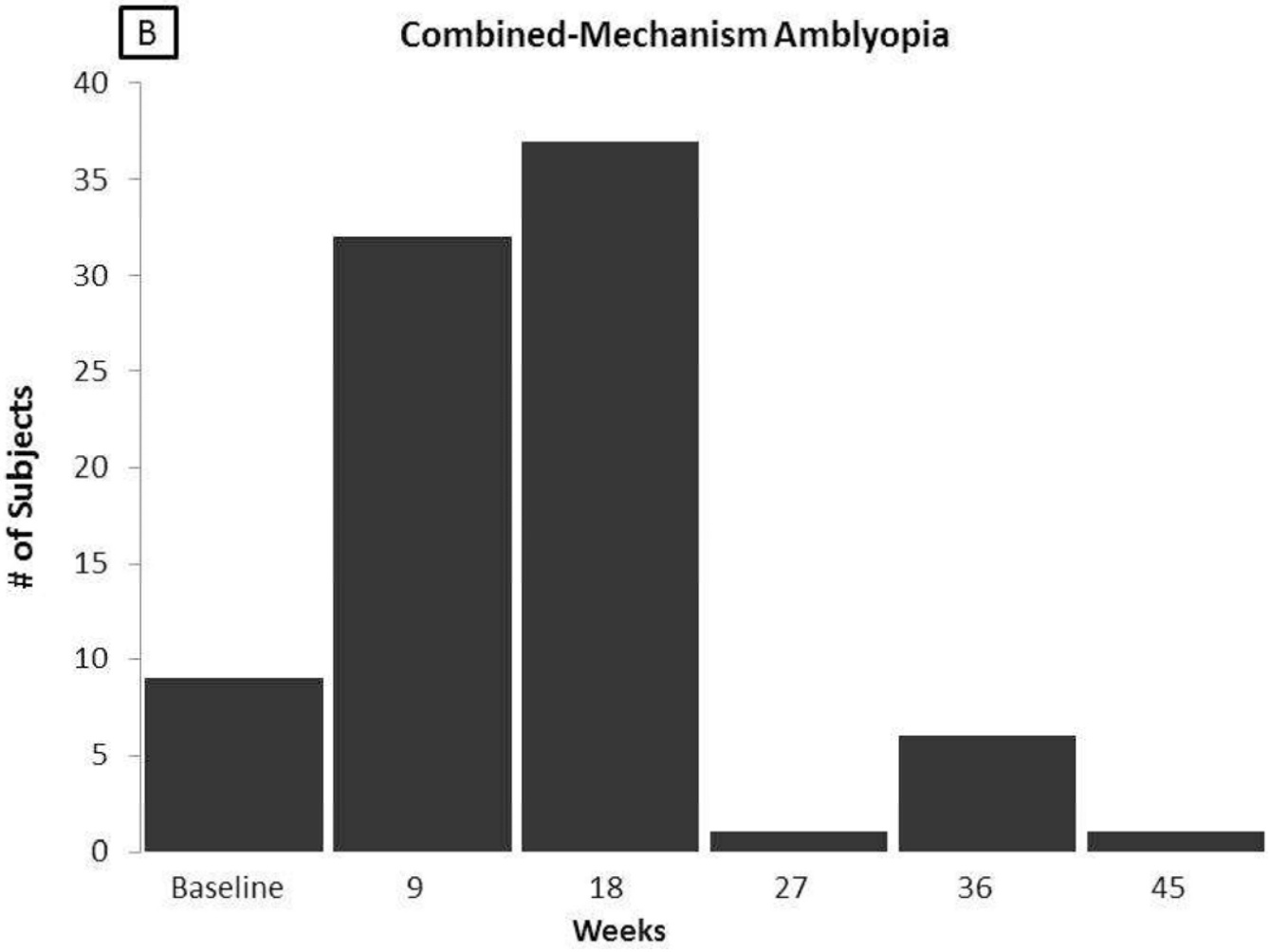


Figure 2.

Time course of maximum VA from optical treatment alone for children with strabismic amblyopia (A) and combined-mechanism amblyopia (B).

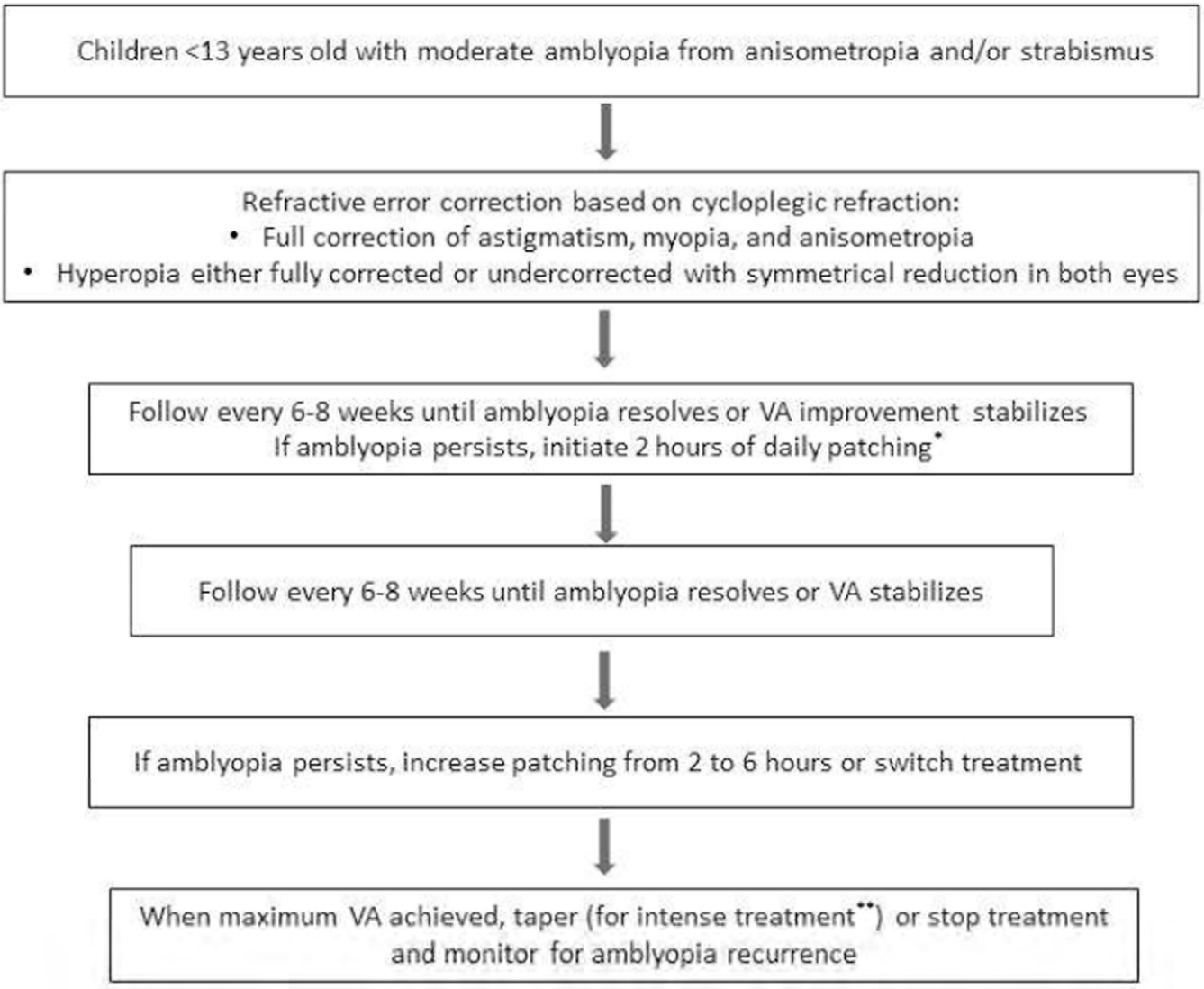


Figure 3.

Recommended evidence-based approach to treating moderate amblyopia in children <13 years of age.

*Alternative treatments include atropine penalization of the sound eye 2 times per week or full-time wear of a Bangerter filter over the sound eye. **Intense treatment is ≥ 6 hours of daily patching

Table 1

Mean visual acuity (VA) improvement by prescribed treatment in moderate and severe amblyopia in 3 to <7 years in old children.

Depth of Amblyopia	Prescribed Treatment	Mean VA Improvement[a] (logMAR lines)	Post-Treatment Mean VA	≥ 2 Lines of Improvement from Baseline (%)	
Moderate Amblyopia		2.4	20/32	79	2 hours patching
		2.4	20/32^{-1}	76	6 hours patching
Severe Amblyopia	Full-time patching	4.8	20/50	93	6 hours patching
		4.7	20/50^{-2}	85	
Moderate Amblyopia	≥ 6 hours patching	3.16	20/30	87	
	Daily atropine	2.84	20/30^{-2}	82	

a
At the primary outcome visit; does not indicate maximum improvement achieved

Table 2

Parent education regarding atropine penalization for the treatment amblyopia

Drop Administration	Administer in morning; if problematic, instill drop before child wakes
Sun Protection / Comfort	Wear brimmed hat and sunglasses when outside, particularly if sunny
Storage	Store securely out of reach of children
Systemic Reaction	Discontinue and call if facial flushing, fever, dry mouth, irritability, or confusion
Other Health Care Visits	Inform of atropine use at office visits, particularly if at emergency room

Table 3

Amblyopia treatment approaches: Historical versus current evidence-based approach

	Historical Dogma	Current Perspective
The mainstay of amblyopia treatment	Patching	Optimal refractive correction
Timing of refractive correction or atropine)	Simultaneous from optical treatment effect	Occlusion prescribed subsequent to gains and occlusion (patching
Patching dosage for amblyopianeeded	Generally, the more the better; usually ≥ 5–6 hours	moderateStart with 2 hours; can increase dosage if
Patching dosage for severe amblyopia	Full-time or most waking hours	Start with 6 hours; 2 hours is effective in some cases
Atropine penalization use	Patching failures only	First-line treatment as alternative to patching or for patching failures
Atropine penalization guidelines		
Amblyopia severity	Only for moderate amblyopia	Both moderate & severe cases
Age of child	Only in young children	Younger and older children
Age after which amblyopia can no longer be treated	Approximately 6–9 years of age	Upper age limit not established; albeit generally greater VA gains if <7 years of age
Recurrence of amblyopia after treatment cessation in 9 to		
<13year-old children	High likelihood of regression	Vast majority (>90%) do not regress

BRIEFING NOTE

Council Meeting – June 2021

Subject

OPR 7.13 Patients with Uveitis

Background

A review of this standard began in 2019 and was interrupted last year by the COVID pandemic. This review is the result of contributions from CPP committees 2019-2021.

Notably, the revised standard adds "pharmacologic dilation at first visit of each occurrence and subsequently as indicated."

At its meeting on March 26, 2021, Council reviewed the revisions to this standard and referred the motion back to CPP for further review.

Decision(s) for Council

To approve revisions to OPR 7.13 Patients with Uveitis

Considerations

- Dilation is important for patients with uveitis as it allows for improved examination of the posterior eye, appropriate classification, and treatment. Dilation also reduces eye pain in patients with uveitis.
- OPR 7.13 adapted to state "Provide treatment options as indicated, that include but are not limited to" to ensure OPR is not too prescriptive in nature.

Public Interest Mandate

To provide appropriate care of patients with uveitis for a consistent standard of care in Ontario.

Supporting Materials

- OPR 7.13 revisions presented at the CPP meeting

Next Steps

The OPR will be updated, along with a collateral edit to OPR 6.2 Posterior Segment Examination, under Pharmacologic Dilation, for consistency.

Contacts

Dr. Violet Zawada Kuzio and Dr. Nisara Bandali – Practice Advisors

7.13 Patients With Uveitis

Description

Uveitis is an inflammatory condition of the eye that ~~may be~~is classified by

i. anatomy~~ically~~ (based on the part of the eye primarily affected) as anterior, intermediate, posterior, or panuveitic,

ii. laterality (unilateral or bilateral), and

~~ii.~~iii. ~~or based on~~ duration: ~~as~~ acute when the condition lasts less than two months, chronic when it lasts longer than two months, or as recurrent when repeated episodes are separated by several months of inactivity.

Anterior uveitis, also known as iridocyclitis or iritis, is inflammation of the iris and ciliary body. As many as 90% of uveitis cases are anterior in location.

Intermediate uveitis, also known as pars planitis, is inflammation of the vitreous cavity (vitritis) sometimes with snowbanking, or deposition of inflammatory material on the pars plana.

Posterior uveitis is limited to inflammation in the posterior segment. Most of the posterior uveitis presents as a retinitis (inflammation of retina) or choroiditis (inflammation of the choroid) and can be further classified as focal or multifocal. ~~, also known as chorioditis, is inflammation of the choroid that may secondarily involve the retina (chorioretinitis).~~

Panuveitis is inflammation of the entire uveal tract involving both the anterior segment (iris and ciliary body) and the posterior segment (choroid).

These conditions may occur as a single episode, subsiding spontaneously or with proper treatment, or may become chronic or recurrent in nature.

The practice of optometry includes the diagnosis, treatment and/or, when appropriate, referral of patients with uveitis.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventati~~iv~~ive, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

7. Engaging in the practice of the profession while in a conflict of interest as described in Part II.

8. Failing to reveal the exact nature of a secret remedy or treatment used

by the member following a patient's request to do so.

9. Making a misrepresentation with respect to a remedy, treatment or device.
10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.
11. Failing to refer a patient to another professional whose profession is regulated under the Regulated Health Professions Act, 1991 when the member recognizes or should recognize a condition of the eye or vision system that appears to rev:20170123 **COLLEGE OF OPTOMETRISTS OF ONTARIO OPTOMETRIC PRACTICE REFERENCE STANDARDS OF PRACTICE 7. Specific Diseases, Disorders and Procedures** Return to Table of Contents require such referral.
13. Recommending or providing unnecessary diagnostic or treatment services.
14. Failing to maintain the standards of practice of the profession.
16. Performing a controlled act that the member is not authorized to perform.

Professional Standard

When providing care to patients with uveitis, optometrists will:

- have the required knowledge, skill and judgment to appropriately diagnose, treat and/or refer patients with uveitis
- utilize appropriate instrumentation and techniques to diagnose uveitis and identify any ocular or systemic conditions that may complicate the condition. As a minimum, this would include:
- a thorough ocular, ~~and~~ systemic and medication history
- ~~unaided and/or best corrected~~ visual acuity
- pupil reflexes
- anterior segment examination **(OPR 6.1)**
- tonometry
- posterior segment examination, with pharmacologic dilation at first visit of each occurrence and subsequently as indicated ~~–~~ **(OPR 6.2)**
- provide treatment options as~~that include, as indicated~~ indicated, that include but are not limited to:

1. topical corticosteroids to reduce inflammation

2. topical cycloplegics to relieve pain, prevent iris adhesion to the anterior lens capsule (synechiae), and prevent protein leakage from inflamed blood vessels (flare)
3. topical non-steroidal anti-inflammatory drugs (NSAIDs) to reduce inflammation leading to macular edema that may accompany uveitis
4. topical intraocular pressure (IOP) lowering medications to reduce elevated IOPs
5. over-the-counter oral analgesics to reduce pain

- arrange follow-up every 1-7 days until resolution and then as deemed appropriate to monitor for recurrence
- counsel patients regarding the serious nature of uveitis, stress compliance with the therapeutic regimen and follow-up appointments, and discuss potential side effects of long term corticosteroid use
- recommend referral (OPR 4.5) when appropriate, including initiating communication with the patient's primary care physician or another health care provider for evaluation and treatment if a systemic etiology is suspected (for example: when the condition is chronic, recurrent or bilateral, non-responsive to aggressive treatment, is accompanied by clinical signs or symptoms characteristic of systemic disease (including but not limited to: joint or lower back pain; respiratory, genitourinary or digestive difficulties; preceding or accompanying fever, malaise or skin rash) or involves the choroid as posterior uveitis), or when recalcitrant cases of uveitis require oral steroids or prescription analgesics where topical steroids or over-the-counter analgesics have produced little response

BRIEFING NOTE

Council Meeting – June 18, 2021

Subject

In keeping with its mandate to facilitate Council's functional and ethical responsibilities in the public interest, the Governance/HR Committee has prepared five governance documents that will organize and clarify key roles and committees.

Background

These policy documents include:

- A policy outlining the role of President
- A policy outlining the role of Vice-President
- New terms of reference for the Executive Committee
- New terms of reference for the Governance/HR Committee
- New terms of reference for the Audit/Finance/Risk (AFR) Committee

The terms of reference documents are intended to replace previous versions, and have been updated for clarity, consistency, and accuracy in relation to new practices and procedures. Such procedures include the Executive Committee election process—for example, the "composition" section in the Executive Committee document now shows that members are selected through an annual Council election, and the Governance/HR and AFR documents show that the chairs are elected as part of that process.

Each terms of reference document now also specifies that the Registrar shall appoint staff support to the committee as needed. Previously, a specific staff support role was mentioned (e.g., the policy lead for the Governance/HR Committee). The new versions will enable flexibility and allow for organizational change.

The President and Vice-President documents build upon the brief and very vague outlines of the roles in sections 10.02 and 10.03 of the by-laws, respectively. New information in the policies includes more detail regarding time commitment, mandate relevance, compensation, and responsibilities.

Decision(s) for Council

The Governance/HR Committee will present five motions to have Council approve each policy document separately:

- To approve the policy outlining the role of the President.
- To approve the policy outlining the role of the Vice-President.
- To approve the new terms of reference for the Executive Committee.
- To approve the new terms of reference for the Governance/HR Committee.
- To approve the new terms of reference for the Audit/Finance/Risk Committee.

Public Interest Mandate

The Governance/HR Committee is responsible for ensuring good governance in the public's interest. These documents are designed to create clarity, transparency, and operational efficiency, which will ultimately allow Council to more effectively fulfill its mandate.

Contact

- Chad Andrews, Senior Manager of Policy and Governance

Policy

Type:	Position Overview		
Name:	President		
Status:	Pending Approval (Council)	**Version:**	1
Date Approved:		**Date Revised:**	

POSITION CATEGORY:
Executive

MANDATE:
The President of the College of Optometrists of Ontario is a position elected annually by Council through an Executive Committee election process.

The President works with the Registrar and Vice-President to advance the College's mandate, objectives, and strategic plans.

The President is directly accountable to the Council and indirectly accountable to the government, the public, and the profession for the effective governance of the College.

The President presides as Chair of all Council meetings and works with the Registrar on external communications to stakeholders or media.

AUTHORITY:
The President is a Council position as set out in the *Health Professions Procedural Code* (Code), which is Schedule 2 of the *Regulated Health Professions Act*, 1991 (RHPA).

REPORTING:
The President reports to the Council at each Council meeting. Should any issues arise, the President works to bring them to the Council's attention in a timely manner.

TIME COMMITMENT and COMPENSATION:
The time commitment of the President is estimated to be an average of six hours per week. A stipend is provided for the position; its amount is determined by the Audit, Finance, and Risk Committee.

CONFLICT OF INTEREST and CODE of CONDUCT
The President shall comply with the College's Code of Conduct and Conflict of Interest Guidelines. Conflict of interest shall be declared at the start of each meeting or at the beginning of an agenda item.

RESPONSIBILITIES:
The President's duties include the following (which include those items outlined in By-laws §10.02):

- Presiding as chair of all Council meetings and providing effective leadership and representation for Council;
- May represent Council on optometric boards such as the Federation of Optometric Regulatory Authorities of Canada (FORAC) and the Optometric Examining Board of Canada (OEBC), as directed by Council;
- Serving as chair of Executive Committee meetings and providing an Executive Committee report at each Council meeting;
- Keeping the Vice-President and the Executive Committee informed of emerging issues between Council meetings;
- Overseeing the governance of Council, including working with the Registrar and Executive Committee to set the agenda for Council meetings;
- Ensuring the efficiency of Council and Executive Committee meetings and that relevant decisions are implemented;
- Working with the Registrar and the Vice-President to resolve issues relating to College responsibilities;
- Participating in the orientation of new Council members, officers, Committee members, chairs, and volunteers and encouraging members to participate in Council;
- Working with the Governance/Human Resources Committee to oversee and ensure that a process is in place to fairly evaluate the Registrar;
- Being the College’s authorized spokesperson on College policies and reporting all communications to Council. The Registrar may act as spokesperson if delegated by the President;
- Signing contracts, documents, or instruments on behalf of the College;
- Serving as ex officio member of College committees; and
- any other duty determined by Council.

Policy

Type:	Position Overview		
Name:	Vice-President		
Status:	Pending Approval (Council)	**Version:**	1
Date Approved:		**Date Revised:**	

POSITION CATEGORY:
Executive

MANDATE:
The Vice-President of the College of Optometrists of Ontario is a position elected annually by Council though an Executive Committee election process.

The Vice-President works with the President and the Registrar to advance the College's mandate, objectives, and strategic plans.

The Vice-President is directly accountable to Council and indirectly accountable to the government, the public, and the profession for the effective governance of the College.

The Vice-President presides as Chair of Council meetings in the absence, inability, or refusal of the President to act. In these cases, the Vice-President shall have all the powers and perform all the duties of the President.

AUTHORITY:
The Vice-President is a Council position as set out in the *Health Professions Procedural Code* (Code), which is Schedule 2 of the *Regulated Health Professions Act*, 1991 (RHPA).

REPORTING:
The Vice-President reports to the Council, as directed by the President. Should any issues arise, the Vice-President works with the President and the Registrar to bring them to the Council's attention in a timely manner.

CONFLICT OF INTEREST and CODE of CONDUCT
The Vice-President shall comply with the College's Code of Conduct and Conflict of Interest Guidelines. Conflict of interest shall be declared at the start of each meeting or at the beginning of an agenda item.

RESPONSIBILITIES:
(By-laws §10.03) The Vice-President's duties include:

- working closely with the President as a member of the Executive Committee on emerging issues between Council meetings;
- any duty delegated by the President, including but not limited to items concerning governance, specific stakeholder relationships, and public accountability;
- being appropriately familiar with regulatory policies and the College's strategic plan;
- signing contracts, documents, or instruments on behalf of the College; and
- any other duty determined by Council.

Policy 3.1

Type:	Terms of Reference		
Name:	Executive Committee		
Status:	Pending Approval (Council)	**Version:**	1.1
Date Approved:		**Date Revised:**	May 1, 2020

COMMITTEE CATEGORY:
Statutory Committee

MANDATE:
The Executive Committee acts on behalf of Council when circumstances require immediate action, and it ensures the College's legal and legislative adherence to College by-laws, policies, procedures and guidelines, and relevant provincial and federal legislation.

(By-laws §14.02) Between Council meetings, the Executive Committee has all the powers of Council with respect to any matter that, in the opinion of the Executive Committee, requires immediate action. However, the Executive Committee does not have the power to make, amend, or revoke a regulation or by-law.

AUTHORITY:
The Executive Committee is a statutory committee as set out in the *Health Professions Procedural Code* (Code), which is Schedule 2 of the *Regulated Health Professions Act*, 1991 (RHPA).

The duties of the Executive Committee are outlined in Section 12 of the Code and under Part 14.02 of the College by-laws.

REPORTING:
(By-laws §14.02) The Executive Committee is directly accountable to Council and indirectly accountable to the government, the public, and the profession for the effective governance of the College.

The Executive Committee reports to the Council. Should any issues arise that the Executive Committee deliberates on, it must be brought to the Council's attention in a timely manner. While the Executive Committee can exercise its powers under Section 12 of the Code, the committee may engage Council by calling a virtual meeting, if required. In all matters, it must report its actions to Council at its next meeting, whether the Executive Committee was acting as Council between Council meetings or discussing other matters to be brought to Council for approval.

STRUCTURE AND MEMBERSHIP:
(By-laws §14.02) The Executive Committee is elected by Council and shall be comprised of:

- Five positions that are determined by the election, including:
    - the President
    - the Vice-President
    - the Chair of the Governance/HR Committee
    - the Chair of the Audit, Finance, and Risk Committee
    - A Member at Large

- One more Elected Council Member than Publicly Appointed Council Member.

(By-laws §7) The officers of the College consist of a President and Vice-President. The election of officers shall take place on an annual basis at the first Council meeting of the year.

(By-laws §10.01) Each additional member of the Executive Committee shall be elected by Council.

(By-laws §14.02) The President is the Chair of the Executive Committee. In the event that the Chair of the committee is unable or unwilling to preside at the meeting, the Vice-President shall Chair the meeting. In the event the Vice-President is unable to Chair the meeting, an acting Chair from among the committee members will be chosen to preside at the meeting from among its members.
The Executive Committee shall, as needed, convene sub-committees or task forces to support its responsibilities.

STAFF SUPPORT:
(By-laws §14.02) The Registrar is the secretary of the Executive Committee.

TERM OF OFFICE:

(By-laws §14.10) The term of a committee Chair is one year. No person may serve as a committee Chair for more than three consecutive years.

When the committee Chair is not able to attend a meeting, hearing, or proceeding, the remaining committee members shall designate a Chair for the duration of the absence.

Committee members shall be elected annually.

FREQUENCY OF MEETINGS:
The Executive Committee shall meet as required under section 12 of the Code to fulfill its mandate. Approved minutes of Executive Committee meetings are circulated to Council for information with confidential information redacted as necessary.

Executive committee meetings may be called by the President or by the majority of the Executive Committee, as per its mandate. Meeting dates should be posted on the College website.

(By-laws §14.02) Executive Committee meetings are closed to the public. However, the Executive Committee may permit anyone to attend or participate in meetings.

QUORUM:

A majority of members constitutes a quorum at a committee meeting. For the purpose of determining quorum, a member may be present in person, by teleconference, or by other electronic means.

DECISION-MAKING PROCESS:

Decisions of the Executive Committee shall ordinarily be decided by a consensus of the members present at the meeting. Should consensus not be reached, the Chair shall refer the question to be decided by a majority vote of the members. The Chair of the meeting shall not normally vote except in the event of a tie, in which case the Chair of the meeting may exercise a casting vote. All Committee members will support a committee decision once it is made.

CONFLICT OF INTEREST AND CODE OF CONDUCT

All members of the Executive Committee shall comply with the College's Conflict of Interest (By-laws §11.01) and Code of Conduct (By-laws §11.06). Conflict of interest shall be declared at the start of each meeting or the beginning of an agenda item.

RESPONSIBILITIES:

GENERIC:

(By-laws §14.02) Between Council meetings, the Executive Committee has all the powers of Council with respect to any matter that, in the opinion of the Executive Committee, requires immediate action.

SPECIFIC:

- Between Council Meetings, exercise the full powers of Council in all matters of administrative urgency (including cases of unauthorized practice), reporting every action at the next meeting of Council. The Executive Committee does not have the power to make, amend or revoke a regulation or by-law.
- Work with the President in the preparation and facilitation of effective College Council meetings.
- Review and approve the agenda for Council meetings, as prepared by the Registrar in consultation with the President, for clarity and priority, identify items for which Council meetings may be closed to observers in accordance with s7(2) of the *Health Professions Procedural Code* and recommend closure, with rationale, to Council.
- Review selected briefing materials for Council for clarity, comprehensiveness, and planning the appropriate approach for presentations.
- Call special meetings of Council.
- Provide feedback and support to committees and Council as requested.
- Assist Council members, committees, and the Registrar in resolving internal conflicts.

By-laws/Legislation

- Monitor legislation of the federal and provincial government through facilitating College input to relevant legislation proposals and the assessment of relevant new legislation.

Stakeholder Engagement

- Coordinate an effective liaison with external government, private and non-profit sector bodies/agencies, including international, national and provincial optometric and health care organizations.
- Coordinate an appropriate public relations program through the development of targeted public communication efforts.
- Facilitate the development of protocol agreements with other agencies to maximize inter-agency cooperation to pursue College goals and strategic direction.

Registrar Liaison

- Provide guidance and support to the Registrar.
- Serve as an informal resource to the Registrar, at their request.

Policy 3.8

Type:	Terms of Reference		
Name:	Governance/HR Committee		
Status:	Pending Approval (Council)	**Version:**	1.1
Date Approved:		**Date Revised:**	May 1, 2020

COMMITTEE CATEGORY:
Standing Committee

MANDATE:
The purpose of the Governance/HR Committee is to facilitate Council's ability to fulfill its functional and ethical responsibilities through:

- monitoring, developing, and reviewing governance processes, policies, and by-laws;
- leading the selection and evaluation of the Registrar and reviewing the accountability of the incumbent;
- governance policy development and maintenance;
- human resource policy development and maintenance, related to the position of the Registrar/CEO;
- Council training and development programs; and
- Council member recruitment, performance, self-evaluation, and succession planning to ensure strong, balanced College leadership.

AUTHORITY:
(By-laws §14.09) Council may, by resolution, appoint and fill such ad hoc and/or Standing Committees as it deems necessary.

REPORTING:
The Governance/HR Committee reports to the Council. The committee will report to Council on a regular basis. Should any issues arise, they must be brought to the Council's attention in a timely manner.

STRUCTURE AND MEMBERSHIP:
The Governance/HR Committee is appointed by Council and shall be comprised of at least five Council members who, where possible, have relevant expertise in governance and/or human resources.

This composition will include:

- a Chair, who shall be a Council member elected annually as part of the executive election process, thereby representing the Governance/HR Committee on the Executive Committee;
- and, including the Chair, at least three Elected Council Members (Professional Members) and two Appointed Council Members (Public Members).

The Governance/HR Committee shall, as needed, convene subcommittees or task forces to support its responsibilities.

STAFF SUPPORT:
The Registrar shall appoint staff support for the Governance/HR Committee as required.

TERM OF OFFICE:
(By-laws §14.10) The term of a committee Chair is one year. No person may serve as a committee Chair for more than three consecutive years.

When the committee Chair is not able to attend a meeting, hearing, or proceeding, the remaining committee members shall designate a chair for the duration of the absence.

The term of office of the committee members shall be one year, with no limitation on renewal.

FREQUENCY OF MEETINGS:
The Governance/HR Committee shall meet as required to fulfill its mandate and based on the workload undertaken. Approved minutes of Governance/HR Committee meetings are circulated to Council for information, with confidential information redacted as necessary.

QUORUM:
A majority of members constitutes a quorum at a committee meeting. For the purpose of determining quorum, a member may be present in person, by teleconference, or by other electronic means.

DECISION-MAKING PROCESS:
Decisions of the Governance/HR Committee shall ordinarily be decided by a consensus of the members present at the meeting. Should consensus not be reached, the Chair shall refer the question to be decided by a majority vote of the members. The Chair of the meeting shall not normally vote except in the event of a tie, in which case the Chair of the meeting may exercise a casting vote. All Committee members will support a committee decision once it is made.

CONFLICT OF INTEREST and CODE of CONDUCT
All members of the Governance/HR Committee shall comply with the College's Conflict of Interest (By-laws §11.01) and Code of Conduct (By-laws §11.06). Conflict of interest shall be declared at the start of each meeting or the beginning of an agenda item.

RESPONSIBILITIES:

GENERIC:

Ongoing review and recommendations to enhance the quality and future viability of the Council.

SPECIFIC:

Governance Excellence: Policy Development and Maintenance

- Coordinate the College's policy development program and review all policy matters presented to Council.
- Review and implement any by-law changes required as a result of changes to the *Regulated Health Professions Act, 1991*, or any other relevant government legislation.
- Review governance policies and protocols found in the College by-laws and governance manual to ensure that these policies are consistent with current governance best practices.
- Regularly monitor, evaluate, and recommend practices that will promote and enhance governance excellence and best practices at both the Council and committee level.
- Ensure that policies are created and periodically reviewed which define:
    - the roles and responsibilities of the Council;
    - duties and responsibilities of Council members and officers;
    - terms of reference for committees;
    - conflict of interest procedures; and
    - procedures for nomination, selection, and removal of Council members.
- Facilitate the College's strategic planning process and monitor related activities to ensure consistency with the stated direction.
- Provide guidance and support, as requested, to policy development projects at task force or committee level and to make recommendations to Council with respect to policy direction, as required.

Council training/development programs

- Ensure that Council members are able to discuss, debate, and plan the following from a basis of knowledge:
    - the College's mandate, strategic plan, goals, objectives, programs, and services;
    - the College's budget and financial statements; and
    - the roles, duties and responsibilities of the Council, committees, individual Council members, the Registrar, and related stakeholders.
- Ensure proper orientation, support, and continuing education and training is available and provided for councillors.
- Determine councillors and committee members that should be encouraged to participate in further training and educational opportunities.
- Determine councillors and committee members that should be funded to attend educational/stakeholder conferences that the College targets for attendance.

Facilitating Effective Council/Committee Functioning

- Facilitate the effectiveness of Council, committees, and chair and member appointments, including interim appointments, by reviewing processes related to the governance of Council, making recommendations to Council where appropriate.

- Upon receipt of a written complaint, oversee an investigation that could lead to the potential sanction or disqualification of an Elected Council Member or Appointed Council Member in accordance with the provisions of Part 9 of the College by-laws.
- If required, disqualify an Elected or Appointed Committee Member in accordance with the provisions of Part 9 of the College by-laws.
- Receive and review self-assessment and succession recommendations for Council, Council leadership, and committee chair positions.
- Review the evaluations of Council meetings to identify process and other improvements.
- Participate in the strategic planning process.

Council and Council Member Requirements

- Ensure that:
    - Council does not fall below or above the number of Council members, both Elected or Appointed members, required by the *Optometry Act, 1991*;
    - Council members understand and agree with the mission of the organization and the code of conduct for Council, and comply with the obligations of Council members such as meeting attendance expectations; and
    - elections and appointments to the Council and committees comply with by-laws and other requirements.

Succession Planning

- Ensure that succession planning is in place to protect the organization and ensure its effectiveness over time.
- In the event of the Registrar's unplanned absence or departure, facilitate the search for a suitable replacement and provide recommendations to Council, seeking approval on a final decision.

Registrar Evaluation/Compensation

- Evaluate the Registrar and report findings to Council both during and after the probationary period.
- Review and recommend to Council the annual Registrar evaluation process as well as the Registrar's annual goals and objectives.
- Facilitate the annual performance review of the Registrar.
- Review and recommend to Council the compensation framework for the Registrar.
- Ensure that Council has a high-level understanding of the employment details of the Registrar and that any significant amendments are confirmed by Council.

Policy 3.9

Type:	Terms of Reference		
Name:	Audit/Finance/Risk Committee		
Status:	Pending Approval (Council)	**Version:**	1.1
Date Approved:		**Date Revised:**	

COMMITTEE CATEGORY:
Standing Committee

MANDATE:
The mandate of the Audit/Finance/Risk Committee is to facilitate Council's ability to fulfill its legal, ethical, functional, and fiscal responsibilities through:

- adequate policy development of financial and investment strategies for Council approval;
- monitoring the integrity of the College's financial reporting and management, including audits and controls;
- financial planning including an annual budget and the development of major financial assumptions and risks;
- ensuring the annual audit of College financial statements by way of contracting external auditors;
- overseeing the College's overall risk management framework (on both financial and non-financial matters); and
- any additional matters at the specific request of Council.

The committee recommends for the approval of Council quarterly and annual financial statements.

AUTHORITY:
(By-laws §14.09) Council may, by resolution, appoint and fill such ad hoc and/or Standing Committees as it deems necessary.

The committee has the authority to:

- make recommendations to Council with regard to financial and audit issues;
- authorize investigations or studies of matters that reflect on the financial integrity of the College or such other matters as deemed appropriate by Council; and
- obtain expertise and assistance from outside legal, governance, financial or other advisors as required to assist in the execution of committee responsibilities.

REPORTING:
The Audit/Finance/Risk Committee reports to the Council. The committee will report to Council on a regular basis. Should any issues arise, they must be brought to the Council's attention in a timely manner.

STRUCTURE AND MEMBERSHIP:
The Audit/Finance/Risk Committee is appointed by Council and shall be comprised of at least five Council members who, where possible, have relevant expertise in finance and/or risk management. This composition will include:

- a Chair, who shall be a Council member elected annually as part of the executive election process, thereby representing the Audit/Finance/Risk Committee on the Executive Committee;
- and, including the Chair, at least three Elected Council Members (Professional Members) and two Appointed Council Members (Public Members).

The Audit/Finance/Risk Committee shall, as needed, convene subcommittees or task forces to support its responsibilities.

STAFF SUPPORT:
The Registrar shall appoint provide staff support for the Audit/Finance/Risk Committee as required.

TERM OF OFFICE:
(By-laws §14.10) The term of a committee Chair is one year. No person may serve as a committee Chair for more than three consecutive years.

When the committee Chair is not able to attend a meeting, hearing, or proceeding, the remaining committee members shall designate a Chair for the duration of the absence.

The term of office of the committee members shall be one year, with no limitation on renewal.

FREQUENCY OF MEETINGS:
The Audit/Finance/Risk Committee shall meet as required to fulfill its mandate and based on the workload undertaken. Approved minutes of Audit/Finance/Risk Committee meetings are circulated to Council for information, with confidential information redacted, as necessary.

QUORUM:
A majority of members constitutes a quorum at a committee meeting. For the purpose of determining quorum, a member may be present in person, by teleconference, or by other electronic means.

DECISION-MAKING PROCESS:
Decisions of the Audit/Finance/Risk Committee shall ordinarily be decided by a consensus of the members present at the meeting. Should consensus not be reached, the Chair shall refer the question to be decided by a majority vote of the members. The Chair of the meeting shall not normally vote except

in the event of a tie, in which case the Chair of the meeting may exercise a casting vote. All Committee members will support a committee decision once it is made.

CONFLICT OF INTEREST and CODE of CONDUCT

All members of the Audit/Finance/Risk Committee shall comply with the College's Conflict of Interest (By-laws §11.01) and Code of Conduct (By-laws §11.06). Conflict of interest shall be declared at the start of each meeting or the beginning of an agenda item.

RESPONSIBILITIES:

Financial Planning & Reporting

- Review and recommend for approval to Council quarterly financial results of the College to ensure that Council receives timely, meaningful financial reports that keep it properly informed of the College's financial situation.
- Participate in the development of a long-term financial plan and ensure that the operations staffing plan is properly funded.
- Review the annual budget, developed by the Registrar, assess major budget assumptions, and make recommendations to Council prior to approval of the budget.
- Consider and make recommendations for changes to membership fees.

Financial Controls

- Ensure that the internal controls and information systems are operating effectively to produce accurate, appropriate, and timely management of financial information.
- Ensure that the College has in place adequate procedures for:
    - the receipt, retention, and treatment of complaints received by the College regarding accounting, internal controls, or auditing matters; and
    - the confidential, anonymous submissions by employees of the College of concerns regarding questionable accounting or audit matters.

Finance policy development and maintenance

- Develop and recommend appropriate policies and procedures to ensure sound financial and investment practices are in place and recommend revisions as required to assist Council.
- Ensure ongoing accounting and finance policy development, best practices, and other opportunities relating to regulation and non-profit that could lead to growth and improvement of the accounting and finance activities of the College.
- In consultation with Governance/HR Committee, review and make recommendations to Council regarding compensation and per diem policies, and subsequent annual increases for all members of Council, including review of President's stipend.

Investments

- Annually review the investment policy and recommend any needed revisions to Council.
- Review and advise the Council regarding the performance of investments held by the College.
- Meet with the portfolio advisor on an annual basis to monitor compliance with the investment policy.

Relationship with External Auditors

- Oversee the selection process for the engagement of the external auditors to ensure that their independence is maintained.
- Recommend to the College Council the appointment of the external auditors.
- Annual discussion with the external auditors prior to presentation of the draft audited financial statements to Council regarding the result of their audit and any issues, findings or concerns that they wish to raise relating to the College staff, accounting records, accounting practices and system of internal control.
- Assess the performance of the external auditors annually and conduct a comprehensive review every five years.

Compliance

- Review regular reports from management and others (e.g., external auditors) with respect to the College's compliance with laws and regulations relating to finances and gain reasonable assurance that the College's policies, procedures, and programs in relation thereto are operating effectively and that the College's provisions with respect to such matters are sufficient and appropriate.
- Establish expenditure policies and procedures for the College regarding contracts and other documentation.
- Review the status of the College's tax returns.
- Discuss with legal, financial, or other advisors any significant legal, compliance, or regulatory matters that may have a material effect on the financial statements or the business and affairs of the College, or on the compliance policies of the College.

Risk Oversight

- Oversee the development, implementation, and maintenance of the College's overall risk management framework, including identifying appropriate levels of risk tolerance.
- Report to the Council on its consideration of the above matters, identifying those areas where improvement is needed, and making recommendations as appropriate.

Risk Management

- Ensure Council is apprised of all legal actions and financial implications.
- Ensure the College is complying with their fiduciary and reporting responsibilities.
- Review, discuss and consider with the Registrar, staff and external auditors, their approach to risk assessment including an annual assessment and management of areas of greatest risk to the College and steps taken to mitigate or address those risks.
- Identify, document, and review the risks the College is managing coupled with the risk mitigation strategies being used.
- Review to ensure policies and procedures are in place to identify and minimize risks.

BRIEFING NOTE

Council Meeting - June 18, 2021

Subject

A public member vacancy was created following the resignation of Ms. Winona Hutchinson, who was also the Chair of the Discipline Committee and a member of the Quality Assurance Panel.

Background

Section 6(1)(b) of the *Optometry Act* states that the College requires at least seven public members to form a full Council. With Ms. Hutchinson's departure, the College is now down to six public members. Advice was sought from both Allison Henry, the Director of Health Workforce Regulatory Oversight at the Ministry of Health, and Julia Martin, the College's legal counsel, and both made it clear that Council can and should continue to hold meetings during such vacancies, and that doing so is not unusual or improper (as long as efforts to fill the vacancy are underway). The Registrar has brought our vacancy requirements to the Ministry and has been assured that they are working to replace vacant public member appointments.

Furthermore, the College's by-laws specify that quorum for Council meetings is defined as:

13.04 Quorum

(1) A majority of Council Members constitutes a quorum to hold a Council

meeting.

(2) In determining whether or not a quorum has been met, the number of

Council Members shall be deemed not to be reduced as a result of any vacancy on Council.

According to Ms. Martin, the provision allows Council to keep functioning when there is a vacancy.

Decision(s) for Council

- To approve the appointment of Dr. Dennis Ruskin as the Chair of the Discipline Committee.

While Council is able to function as it waits for new public member appointments, there is still a pressing need to fill the position of Chair of the Discipline Committee. The Governance/HR Committee met to determine an appropriate fit for the role, and after reviewing relevant materials, passed a motion to recommend that the Executive Committee move to appoint Dr. Dennis Ruskin as Chair.

The Governance/HR Committee has recommended to leave the vacancy on the Quality Assurance Panel for the time being, the rationale being that it can be filled by a new public member when one is appointed.

Public Interest Mandate

The appointment of public members to Council and Council members to committees helps ensure the effective and efficient operation and governance of the College, which acts in the public's interest.

Contact

- Chad Andrews, Senior Manager of Policy and Governance

8-11 / UPCOMING MEETINGS

8. List of Acronyms

9. Upcoming Council Meetings:
    a. Friday, September 17, 2021
    b. Friday, December 10, 2021

10. 2022 Council Meeting Dates:
    a. Friday, January 21, 2022
    b. Friday, March 25, 2022
    c. Friday, June 24, 2022
    d. Friday, September 16, 2022
    e. Friday, December 9, 2022

11. Adjournment

List of Acronyms Used by the College of Optometrists of Ontario

Acronym	Name	Description
AAO	American Academy of Optometry	Organization whose goal is to maintain and enhance excellence in optometric practice
ACO	Alberta College of Optometrists	Regulates optometrists in Alberta
ACOE	Accreditation Council on Optometric Education	A division of AOA Accredits optometry schools in US and Canada Graduates of these schools may register in Ontario without additional education
ADR	Alternative Dispute Resolution	An alternate process that may be used, where appropriate, to resolve some complaints
AGRE	Advisory Group for Regulatory Excellence	A group of six colleges (medicine, dentistry, nursing, physiotherapy, pharmacy and optometry) that provides leadership in regulatory matters
AIT	Agreement on Internal Trade	Federal/Provincial/Territorial agreement intended to foster mobility of workers
AOA	American Optometric Association	Main professional association for optometrists in the US
ARBO	Association of Regulatory Boards of Optometry	Association of optometric regulators including, US, Canada, Australia and New Zealand
BV	Binocular Vision	The assessment of the relationship and coordination of the two eyes
CACO	Canadian Assessment of Competency in Optometry	Canadian entry-to-practice examination for optometry-administered by CEO-ECO to 2017
CAG	Citizen's Advisory Group	A forum for patients and health-care practitioners to discuss issues of mutual concern
CAO	Canadian Association of Optometrists	Represents the profession of optometry in Canada; its mission is to advance the quality, availability, and accessibility of eye and vision health care
CAOS	Canadian Association of Optometry Students	The Canadian optometry student association with chapters in both Waterloo and Montreal
CE	Continuing Education	Courses, programs, or organized learning experiences usually taken after a degree is obtained to enhance personal or professional goals
CEO-ECO	Canadian Examiners in Optometry	Former name of OEBC; administered the CACO exam on behalf of the provincial and territorial optometric regulators (see OEBC)
CJO	Canadian Journal of Optometry	Journal published by CAO whose mandate is to help optometrists build and manage a successful practice

List of Acronyms Used by the College of Optometrists of Ontario

Acronym	Name	Description
CLEAR	Council on Licensure Evaluation and Regulation	International body of regulatory boards – mainly US and Canadian members
CMPA	Canadian Medical Protective Association	Professional liability insurer for physicians
CNAR	Canadian Network of Agencies for Regulation	
CNCA	*Canada Not-for-profit Corporation Corporations Act*	
CNIB	Canadian National Institute for the Blind	A voluntary, non-profit rehabilitation agency that provides services for people who are blind, visually impaired and deaf-blind
CNO	College of Nurses of Ontario	Regulates nurses in Ontario
COBC	College of Optometrists of British Columbia	Regulates optometrists in British Columbia
COEC	Canadian Optometric Evaluation Committee	Committee of FORAC that assesses the credentials of internationally educated optometrists who wish to practice in Canada
COI	Conflict of Interest	Situation in which someone in a position of trust has competing professional and personal interests
COO	College of Opticians of Ontario	A self-governing college that registers and regulates opticians in Ontario **Note:** the College of Optometrists of Ontario does not have an acronym
COPE	Council on Optometric Practitioner Education	Accredits continuing education on behalf of optometric regulatory boards
COS	Canadian Ophthalmological Society	Society whose mission is to assure the provision of optimal eye care to Canadians
CPD	Continuing Professional Development	A quality assurance program
CPP	Clinical Practice Panel	A panel of the Quality Assurance Committee that considers issues of clinical practice and updates the OPR
CPSO	College of Physicians and Surgeons of Ontario	A self-governing college as defined by the *Regulated Health Professions Act*
CRA	Complete Record Assessment	A component of the College's practice assessment process of the Quality Assurance program
DAC	Diabetes Action Canada	
DFE	Dilated Fundus Examination	Eye health exam conducted after dilating pupils with drops

List of Acronyms Used by the College of Optometrists of Ontario

Acronym	Name	Description
DPA	Diagnostic Pharmaceutical Agents	Drugs used by optometrists in practice to evaluate systems of the eye and vision
EEOC	Evaluating Exam Oversight Committee	Committee that oversees the Internationally Graduated Optometrists Evaluating Exam (IGOEE) administered by Touchstone Institute
EHCO	Eye Health Council of Ontario	A group made up of optometrists and ophthalmologists who collaborate on issues of mutual interest
ÉOUM	École d'optométrie-Université de Montréal	School of optometry at the University of Montreal-teaches optometry in French Accredited by ACOE
EPSO	Eye Physicians and Surgeons of Ontario	OMA Section of Ophthalmology
ETP	Entry-to-Practice	Describes the level of competency necessary for registration to practise the profession
FAAO	Fellow of the American Academy of Optometry	Designation issued by AAO following evaluation against standards of professional competence
FHRCO	Federation of Health Regulatory Colleges of Ontario	Comprises of the 26 health regulatory colleges in Ontario
FORAC-FAROC	Federation of Optometric Regulatory Authorities of Canada	Comprised of 10 national optometric regulators Formerly knowns as CORA
HPARB	Health Professions Appeal and Review Board	Tribunal whose main responsibility is to review decisions made by College ICRC or registration committees when an appeal is made by either the complainant or member, or applicant in the case of a registration appeal
HPPC	Health Professions Procedural Code	Schedule 2 to the *Regulated Health Professions Act, 1991*
HPRAC	Health Professions Regulatory Advisory Council	Provides independent policy advice to the Minister of Health and Long-Term Care on matters related to the regulation of health professions in Ontario
HSARB	Health Services Appeal and Review Board	Created by the *Ministry of Health Appeal and Review Boards Act, 1998*, decisions of the ORC are heard here
HSPTA	*The Health Sector Payment Transparency Act, 2017*	An Act that requires industry to disclose transfers of value to health care professionals
ICRC	Inquiries Complaints and Reports Committee	The ICRC is the statutory committee responsible for the investigation and disposition of reports and complaints filed with the College about the conduct of an optometrist

List of Acronyms Used by the College of Optometrists of Ontario

Acronym	Name	Description
IOBP	International Optometric Bridging Program	A program to assist international graduates in meeting the academic equivalency requirement for registration and housed at the University of Waterloo
IGOEE	Internationally Graduated Optometrist Evaluating Exam	Developed and administered by Touchstone Institute on behalf of FORAC
IOG	International Optometry Graduates	Optometry graduates who have received their education outside North America
MOHLTC (or MOH)	Ministry of Health and Long-Term Care	Responsible for administering the health care system and providing services to the Ontario public
MOU	Memorandum of Understanding	
NBAO	New Brunswick Association and College of Optometrists	New Brunswick Association and College of Optometrists
NBEO	National Board of Examiners in Optometry	Entry to practice examination for all US states Also accepted in BC and QC
NCP	National Competency Profile	Articulates the requirements established by the profession upon which the blueprint for the OEBC exam is based
NLCO	Newfoundland and Labrador College of Optometrists	Regulates optometrists in Newfoundland and Labrador
NSCO	Nova Scotia College of Optometrists	Regulates optometrists in Nova Scotia
OAO	Ontario Association of Optometrists	The association that looks after the interests of optometrists in Ontario
OCP	Ontario College of Pharmacists	Regulates pharmacists, pharmacies and pharmacy technicians in Ontario
OD	Doctor of Optometry Degree	Optometrists' professional degree in North America
ODSP	Ontario Disability Support Program	Offers financial assistance to Ontarians with disabilities who qualify
OEBC-BEOC	Optometry Examining Board of Canada	Administers the national standards assessment exam on behalf of the provincial and territorial optometric regulators
OFC	Office of the Fairness Commissioner of Ontario	The OFC ensures that certain regulated professions in Ontario have registration practices that are transparent, objective, impartial and fair
OLF	Optometric Leaders' Forum	Annual meeting of CAO, provincial associations and regulators
OMA	Ontario Medical Association	The association that looks after the interests of medical practitioners

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Acronym	Name	Description
OOQ	Ordre des optométristes du Québec	Regulates optometrists in Quebec
OPR	Optometric Practice Reference	A College document provided to members and available to the public providing principles of Standards of Practice and Clinical Guidelines in two separate documents
OSCE	Objective Structured Clinical Examination	An objective clinical exam; part of the OEBC exam
PEICO	PEI College of Optometrists	The optometric regulatory college in Prince Edward Island
PHIPA	*Personal Health Information Protection Act*	Provincial act that keeps personal health information of patients private, confidential and secure by imposing rules relating to its collection, use and disclosure
PLA	Prior learning assessment	Formerly part of the IOBP to ascertain the candidate's current knowledge in optometry; replaced by IOGEE in 2015
PRC	Patient Relations Committee	Promotes awareness among members and the public of expectations placed upon optometrists regarding sexual abuse of patients; also deals with issues of a broader nature relating to members' interactions with patients
QA (QAC)	Quality Assurance Committee	A statutory committee charged with the role of proactively improving the quality of care by regulated health professionals
RCDSO	Royal College of Dental Surgeons	Regulates dentists in Ontario
RHPA	*Regulated Health Professions Act*	An act administered by the Minister of Health, ensuring that professions are regulated and coordinated in the public interest by developing and maintaining appropriate standards of practice
SAO	Saskatchewan Association of Optometrists	Also functions as the regulatory College in Saskatchewan
SCERP	Specified Continuing Educational or Remediation Program	A direction to an optometrist by the ICRC to complete remediation following a complaint or report
SRA	Short Record Assessment	A component of the College's practice assessment process of the Quality Assurance program
SOP	Standards of Practice	Defined by the profession based on peer review, evidence, scientific knowledge, social expectations, expert opinion and court decision
TPA	Therapeutic Pharmaceutical Agent	Drug Generally this term is used when describing drugs that may be prescribed by optometrists for the treatment of conditions of the eye and vision system

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Acronym	Name	Description
VIC	Vision Institute of Canada	A non-profit institute functioning as a secondary referral center for optometric services located in Toronto
VCC	Vision Council of Canada	A non-profit association representing the retail optical industry in Canada, with members operating in all Canadian provinces and US states
WCO	World Council of Optometry	International advocacy organization for world optometry – assists optometrists in becoming regulated where they are not
WOVS	University of Waterloo School of Optometry and Vision Science	The only school of optometry in Canada that provides education in English Accredited by ACOE; graduates are granted an OD degree; also has Masters and PhD programs

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