COLLEGE OF Optometrists OF ONTARIO

COUNCIL MEETING

MONDAY DECEMBER 9, 2019
AT 12:00 P.M.

(PUBLIC INVITED TO ATTEND)

TELECONFERENCE

COLLEGE OF Optometrists OF ONTARIO

COUNCIL AGENDA

Monday, December 9, 2019 | 12:00 p.m.
Teleconference

Item	Item Lead	Time (mins)	Action Required	Page No.
1. Call to Order/Attendance	P. Hemami	1		1
2. Adopt the Agenda a. Conflict of Interest Declaration	P. Hemami	1	Decision	
3. Proposed Amendments to Designated Drug and Standards of Practice Regulation	B. Chisholm	45	Discussion/Decision	3
4. Consultation re: Entry-to-Practice Exam	P. Hemami	15	Discussion	47
5. Dates of Upcoming Council Meetings a. Friday January 17, 2020 b. Monday April 20, 2020 c. Thursday June 25, 2020 d. Friday September 25, 2020 e. Friday December 4, 2020			Receive for Information	
6. Adjournment	P. Hemami	1	Decision	

BRIEFING NOTE

Council Meeting – December 2019

Subject

Consultation re: Proposed amendments to Designated Drug and Standards of Practice Regulation

Background

Effective October 2, 2019, the College circulated proposed amendments to the Designated Drug and Standards of Practice Regulation to members, stakeholders, and the public for feedback. The consultation period ran until December 1, 2019.

The College received feedback from 133 individuals via the online survey (largely members of the College), as well as additional feedback from stakeholders.

Decisions for Council

That Council approve proposed amendments to the Designated Drugs and Standards of Practice Regulation (O Reg. 112/11) for submission to the Ministry of Health.

Supporting Materials

- Summary of survey feedback
- Correspondence re: stakeholder feedback

Contact

- David Wilkinson, Practice Advisor

Motion to Council

Name of committee: Clinical Practice Panel - Quality Assurance Committee

Date of submission: December 3, 2019

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

Proposed motion: That Council approve proposed amendments to the Designated Drugs and Standards of Practice Regulation (O Reg. 112/11) for submission to the Ministry of Health

Recommendation to Council and Rationale	
The Issue	The Minister of Health has requested proposed amendments to the Designated Drugs and Standards of Practice Regulation (O Reg. 112/11), to be submitted for her review by no later than December 31, 2019.
Background	At the end of May 2019, the Minister of Health requested that the College amend its drug regulation to reflect categories of drugs from which optometrists may prescribe. CPP drafted proposed categories and amendments to the drug regulation over the summer. This work was accomplished with the collaborative input of the Ministry, as well as the OAO and WOVS through the Tripartite Working Group. It was important for the committee to propose categories of topical drugs that are sufficiently broad so to capture new topical drugs, and new types of topical drugs, as they may be approved by Health Canada for use in eye care. This is achieved through the category "Ophthalmic Drugs and Preparations". In September 2019, Council approved the proposed amendments for circulation to members and stakeholders for sixty days. Stakeholder feedback has been largely supportive, however, concern was raised in three areas: a) Oral medications b) Pediatric prescribing c) Revoking the 14-day restriction on prescribing oral antibacterials To these concerns, CPP suggests that: a) The categories of oral drugs from which optometrists may prescribe is not altered in this proposal. Regulations remain in the

	proposal that require established co-management with physicians, or immediate referral to a physician or hospital, whenever oral secretagogues or oral CAIs are prescribed. b) Optometrists have been authorized to prescribe medications, both topical and oral, for children of any age, since 2011. That the College has not received complaints related to pediatric prescribing by optometrists supports that optometrists are cautious and responsible when prescribing for children. Additionally, optometrists are both trained and equipped to diagnose and manage issues affecting children's eyes. At the level of delivery of care, it is common for GPs and ERs, without the required equipment and/or training, to refer pediatric patients to optometrists for diagnosis and management. Access to pediatric ophthalmology, or general ophthalmology, is an issue in many communities across Ontario. Timely access becomes an even greater issue, e.g., in the event of an acute infection. CPP believes that optometrists remain competent and responsible when prescribing for children. c) The proposal to revoke the 14-day restriction on prescribing oral antibacterials is important in the management of patients with dry eye (OPR 7.11) featuring lid disease where oral antibacterials (tetracycline and macrolides) may be prescribed for longer duration, often at concentrations sub-MIC (minimum inhibitory concentration). Notwithstanding the fact that of the health professionals with the authority to prescribe oral antibacterials (physicians, nurses, midwives, chiropodists), optometry is the only profession with a 14-day limitation currently in regulation, CPP agree that optometrists should not prescribe oral antibacterials for longer than 14 days in the treatment of **acute infectious conditions**. To address this concern, CPP is proposing in a separate motion to update standards of practice under OPR 4.4 with the following: Optometrists must not: • prescribe oral antibacterial drugs for longer than 14 days in the treatment of acute infectious conditions of the eye and adnexa All stakeholder survey responses and feedback are included for Council's review.
Analysis, including impact on budget	

Options (are there alternatives)	The proposed amendments could be returned to committee for review, further amendment, and eventual recirculation.
Implications/expectations if approved	Staff will prepare a proposal to be submitted to the ministry before year's end.
Implications/potential consequences If not approved	The Designated Drugs Regulation will remain as is, with a list of drugs that is difficult to update.

Optometry Act, 1991
Loi de 1991 sur les optométristes

ONTARIO REGULATION 112/11
DESIGNATED DRUGS AND STANDARDS OF PRACTICE

Consolidation Period: From February 6, 2017 to the e-Laws currency date.

Last amendment: 17/17.

Legislative History: 17/17.

This Regulation is made in English only.

PART I
PRESCRIPTIONS

Drugs that may be prescribed

1. For the purposes of paragraph 2.1 of section 4 of the Act, and subject to sections 2, 3 and 4 and Part II of this Regulation, a member may prescribe a drug or a combination of drugs from ~~a~~ the ~~category~~ categories ~~and sub-category heading~~ listed in Schedule 1. O. Reg. 112/11, s. 1.

Limitations

2. Where a limitation or a route of administration is indicated with respect to a category of drug listed in Schedule 1, ~~either in a sub-category heading or with respect to that particular drug,~~ a member shall only prescribe a~~the~~ drug or a combination of drugs in compliance with the limitation or limitations and in accordance with the route or routes of administration specified. O. Reg. 17/17, s. 1.

Training required

3. No member may prescribe any drug unless he or she has successfully completed the relevant training in pharmacology that has been approved by the Council. O. Reg. 112/11, s. 3.

Recording

4. Every time a member prescribes a drug the member shall record the following in the patient's health record as that record is required to be kept under section 10 of Ontario Regulation 119/94 (General) made under the Act:

1. Details of the prescription, including the drug prescribed, dosage and route of administration.
2. Details of the counselling provided by the member to or on behalf of the patient respecting the use of the drug prescribed. O. Reg. 112/11, s. 4.

Non-prescription drugs

5. In the course of engaging in the practice of optometry a member may prescribe any drug that may lawfully be purchased or acquired without a prescription. O. Reg. 112/11, s. 5.

PART II
STANDARDS OF PRACTICE — GLAUCOMA

~~**Prescribing of antiglaucoma agents**~~

~~**6.** It is a standard of practice of the profession that in treating glaucoma a member may only prescribe a drug set out under the category of "Antiglaucoma Agents" in Schedule 1. O. Reg. 112/11, s. 6.~~

Open-angle glaucoma

7. (1) Subject to subsection (2) and to section 8, it is a standard of practice of the profession that a member may only treat a patient with glaucoma where the patient has primary open-angle glaucoma the treatment of which is not complicated by either a concurrent medical condition or a potentially interacting pharmacological treatment. O. Reg. 112/11, s. 7 (1).

(2) It is a standard of practice of the profession that a member may only treat a patient having open-angle glaucoma, the treatment of which is complicated by either a concurrent medical condition or a potentially interacting pharmacological treatment, in collaboration with a physician with whom the member has established a co-management model of care for that patient and who is,

(a) certified by the Royal College of Physicians and Surgeons of Canada as a specialist in ophthalmology; or

(b) formally recognized in writing by the College of Physicians and Surgeons of Ontario as a specialist in ophthalmology. O. Reg. 112/11, s. 7 (2).

Referral to physician or hospital

8. (1) Subject to subsections (2) and (3), it is a standard of practice of the profession that a member shall immediately refer a patient having a form of glaucoma other than primary open-angle glaucoma to a physician or to a hospital. O. Reg. 112/11, s. 8 (1).

(2) It is a standard of practice of the profession that a member may initiate treatment for a patient having angle-closure glaucoma only in an emergency and where no physician is available to treat the patient. O. Reg. 112/11, s. 8 (2).

(3) It is a standard of practice of the profession that a member shall immediately refer any patient being treated in accordance with subsection (2) to a physician or hospital once the emergency no longer exists or once a physician becomes available, whichever comes first. O. Reg. 112/11, s. 8 (3).

(4) In this section,

"hospital" means a hospital within the meaning of the *Public Hospitals Act.* O. Reg. 112/11, s. 8 (4).

9. OMITTED (PROVIDES FOR COMING INTO FORCE OF PROVISIONS OF THIS REGULATION). O. Reg. 112/11, s. 9.

SCHEDULE 1

ANTIBACTERIALS (oral) – for the purpose of treating conditions of the eye and adnexa only

ANTIVIRALS (oral) – for the purpose of treating conditions of the eye and adnexa only

CARBONIC ANHYDRASE INHIBITORS (oral) – to lower intraocular pressure only, and

i. a member shall immediately refer the patient to a physician or to a hospital in the event of acute angle closure; or

ii. only in collaboration with a physician with whom the member has established a co-management model of care

SECRETAGOGUES (oral) – for Sjögren's syndrome only and only in collaboration with a physician with whom the member has established a co-management model of care

OPHTHALMIC DRUGS AND PREPARATIONS (topical) – for the purpose of treating conditions of the eye and adnexa only

OPHTHALMIC DIAGNOSTIC AGENTS (topical)

SKIN AND MUCOUS MEMBRANE AGENTS (topical) – for the purpose of treating conditions of the eye and adnexa only

~~ANTI-INFECTIVE AGENTS~~

~~Antibacterials (topical)~~

~~azithromycin~~

~~besifloxacin~~

~~ciprofloxacin~~

- ~~erythromycin~~
- ~~framycetin~~
- ~~fusidic acid~~
- ~~gatifloxacin~~
- ~~gentamicin~~
- ~~moxifloxacin~~
- ~~ofloxacin~~
- ~~polymyxin B/gramicidin/neomycin~~
- ~~polymyxin B/neomycin/ bacitracin~~
- ~~polymyxin B/trimethoprim~~
- ~~sulfacetamide~~
- ~~tetracycline~~
- ~~tobramycin~~

~~Antifungals (topical)~~

- ~~natamycin~~

~~Antivirals (topical)~~

- ~~trifluridine~~
- ~~Acyclovir~~

~~Antibacterials (oral) – for corneal or eyelid infections only and for a duration not exceeding 14 days~~

- ~~amoxicillin~~
- ~~amoxicillin/clavulanic acid~~
- ~~azithromycin~~
- ~~cephalexin~~
- ~~ciprofloxacin~~
- ~~clarithromycin~~
- ~~clindamycin~~
- ~~cloxacillin~~
- ~~doxycycline~~
- ~~erythromycin~~
- ~~levofloxacin~~
- ~~minocycline~~
- ~~moxifloxacin~~
- ~~tetracycline~~

~~Antivirals (oral) – for corneal or eyelid infections only~~

- ~~acyclovir~~
- ~~famciclovir~~
- ~~valacyclovir~~

~~ANTI-INFLAMMATORY AGENTS~~

~~Corticosteroids (topical)~~

- ~~dexamethasone~~
- ~~difluprednate~~

- fluorometholone
- loteprednol
- prednisolone
- rimexolone

Corticosteroids (topical) – for the purpose of treating conditions of the eye and adnexa

- triamcinolone

Immunomodulators (topical)

- cyclosporine

Nonsteroidal anti-inflammatory agents (topical)

- bromfenac
- diclofenac
- ketorolac
- nepafenac

ANTI-INFECTIVE/ANTI-INFLAMMATORY AGENTS

Antibacterials /corticosteroids (topical)

- framycetin/gramicidin/dexamethasone
- gentamicin/betamethasone
- neomycin/fluorometholone
- neomycin/polymyxin B/dexamethasone
- neomycin/bacitracin/polymyxin B/hydrocortisone
- sulfacetamide/prednisolone
- tobramycin/dexamethasone

MYDRIATICS

Mydriatics (topical)

- atropine
- cyclopentolate
- homatropine
- tropicamide

ANTI-ALLERGIC AGENTS

Antiallergic agents (topical)

- bepotastine
- emedastine
- ketotifen
- levocabastine
- lodoxamide
- nedocromil
- olopatadine
- tacrolimus – for the purpose of treating conditions of the eye and adnexa and for a duration not exceeding 42 days

ANTIGLAUCOMA AGENTS

β-Adrenergic blocking agents (topical)

- betaxolol

- levobunolol
- timolol

Carbonic anhydrase inhibitors (topical)

- brinzolamide
- dorzolamide

Miotics (topical)

- carbachol
- pilocarpine

Prostaglandin analogs (topical)

- bimatoprost
- latanoprost
- tafluprost
- travoprost

α-Adrenergic agonists (topical)

- apraclonidine
- brimonidine

α-Adrenergic agonists/β-adrenergic blocking agents (topical)

- brimonidine/timolol

Carbonic anhydrase inhibitors/β-adrenergic blocking agents (topical)

- brinzolamide/timolol
- dorzolamide/timolol

Prostaglandin analogs/β-adrenergic blocking agents (topical)

- latanoprost/timolol
- travoprost/timolol

Carbonic anhydrase inhibitors (oral) — to lower intraocular pressure only and a member shall immediately refer the patient to a physician or to a hospital

- acetazolamide

SECRETAGOGUES

Secretagogues (oral) — for Sjögren's syndrome only and only in collaboration with a physician with whom the member has established a co-management model of care

- pilocarpine

O. Reg. 112/11, Sched. 1; O. Reg. 17/17, s. 2.

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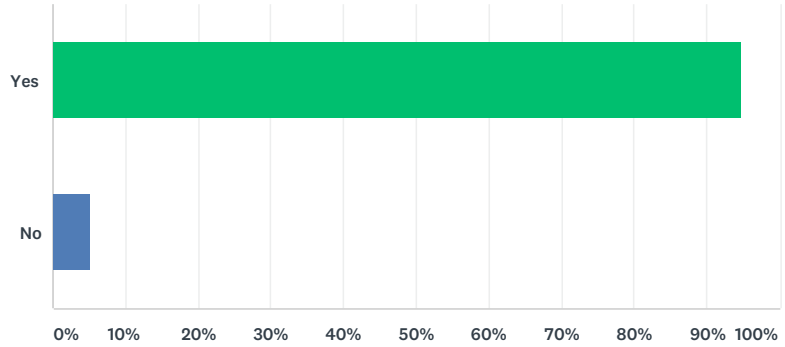
Proposed Amendments to the Designated Drugs and Standards of Practice Regulation (O Reg. 112/11) – Circulation Feedback from Members and Stakeholders

Q1 The Designated Drugs and Standards of Practice Regulation lists the drugs optometrists can prescribe. As per the Minister of Health, the College is proposing to move from listing individual drugs to categories of drugs. For oral drugs, the proposed categories include the same types of drugs currently included in the regulation list. For topical drugs, the proposed category “Ophthalmic Drugs and Preparations” captures new topical drugs, and new types of topical drugs, as they may be approved by Health Canada for use in eye care. Is the proposed list of categories complete?

Answered: 132 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	94.70%	125
No	5.30%	7
TOTAL		132

Q2 If no, what category should be included and why?

Answered: 6 Skipped: 127

Steroids, new drug catagories
10/24/2019 8:54 PM

Steroids (anti inflammatory) - needed to treat certain eye conditions
10/21/2019 2:20 PM

phenylephrin dilatig eye drops
10/4/2019 3:31 PMA

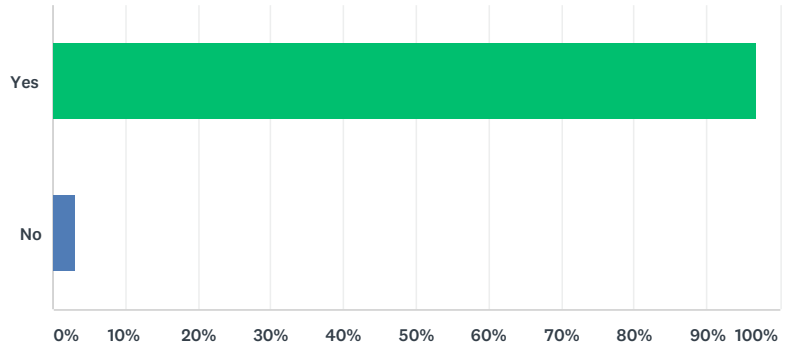
Xiidra should be included
10/2/2019 6:27 PM

Oral medications: Antiinflammatories. It would be very useful to have the ability to Rx oral steroids. 10/2/2019 4:21 PM

Topical non ophthalmic such as metro gel for rosacia
10/2/2019 6:48 PM

Q3 Do you agree that the 14-day restriction on prescribing oral antibacterials should be revoked, allowing optometrists to provide longer treatment, as needed, to manage patients with dry eye involving lid disease?

Answered: 130 Skipped: 3



ANSWER CHOICES	RESPONSES	
Yes	96.92%	126
No	3.08%	4
TOTAL		130

Q4 If no, please explain why the 14-day restriction on the prescribing of oral antibacterials should not be revoked? (Optional)

Answered: 3 Skipped: 130

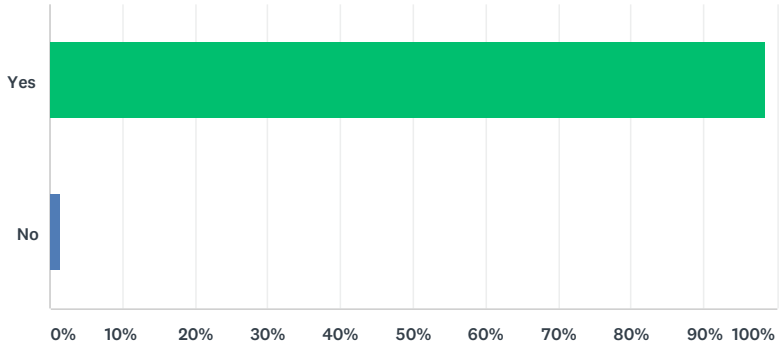
if the issue has not resolved within this period there is almost certainly something else occurring where the diagnosis has either been missed or erred upon.
10/23/2019 10:00 AM

would need refresher course on systemic interactions and potential complications with prolonged use of oral antibiotics
10/3/2019 11:52 AM

We don’t have adequate training.
10/2/2019 8:40 PM

Q5 Do you support the College's proposal?

Answered: 129 Skipped: 4



ANSWER CHOICES	RESPONSES	
Yes	98.45%	127
No	1.55%	2
TOTAL		129

Q6 If no, why not?

Answered: 1 Skipped: 132

as noted if the issue has not resolved then the diagnosis is likely in error (for infections) and referral to determine the correct diagnosis is indicated
10/23/2019 3:01 PM

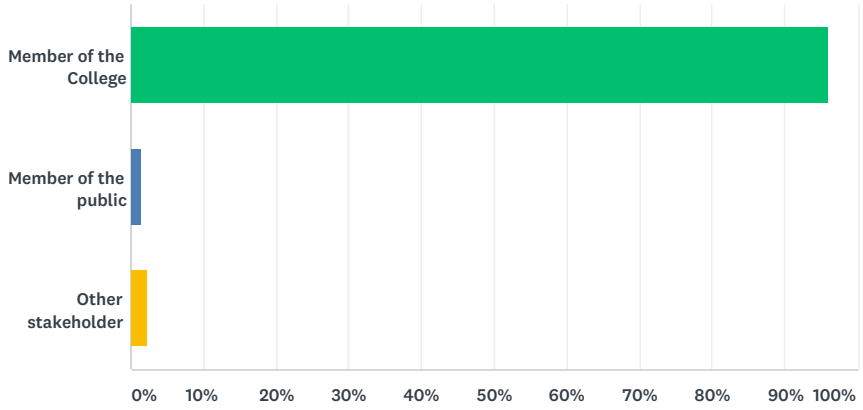
Q7 We value and will consider your additional comments (optional):

Answered: 32 Skipped: 101

• None at this time.
• I value you and your additional comments :)
• Optometrists have expertise in many areas and are the primary eye doctors. In the case of non-responsive treatments, complex patients - due to multiple eye or systemic diseases, or patients at risk -very young, immunocompromised etc the medical issue is no longer primary and should be referred urgently to a physician for definitive diagnosis and treatment as indicated.
• OD's should have the ability to order diagnostic testing such as MRI/CT and bloodwork. It is a waste of government resources to have to go back to the GP and then for an MRI. ODs in AB/MB can order these tests as can most US optometrists.
• I would also like to see a push for OCT's being covered for OD's as well, and an increase in scope of practice for glaucoma care
• I think having drug categories instead of a list is a great step forward for providing the best eye care possible!
• Why are we not removing the limitations on glaucoma treatment. I suspect one of the reasons more ODs don't treat glaucoma is that they feel 'shackled' by the narrow definition that we can treat independently. Thanks
• none
• N/a
• Optometrists should have an axcess to some primary lab. Investigations eye eye e.g. ESR - blood sugar -lipid profile - thyroid funtion -CBC ...etc. And also primary imaging e.g. x-ray especially for some cases of recurrent uveitis...etc. unfortunatelly when I refere patients of uveitis some specialists ignore the optometrists and prefer to contact with the family physician for investigations and work up. In this case I lose caee-based education and my patient as well. thank you
• Changes have been long overdue.
• Finally! This is a long time coming so we are no longer restricted from treating patients with up-to-date treatment regimens
• Excellent changes that will allow Ontarians access vision care more easily from their primary care eye doctor.
• Great step forward
• This is a great step forward however, being able to treat glaucoma with out an MD assisting us is what we should also be going for as well as scope expansion in terms of capsulotamies and minor surgical procedures.
• Excellent changes that will allow Ontarians access vision care more easily from their primary care eye doctor.
• Great step forward
• This is a great step forward however, being able to treat glaucoma with out an MD assisting us is what we should also be going for as well as scope expansion in terms of capsulotamies and minor surgical procedures.
• The amendment is great and complete ! Good for the patients and the doctors. It will also save some tax money for unnecessary referrals and consultations!
• I would like to see some proposals on increasing scope of practice for glaucoma cases. Some cases of glaucoma other than POAG can be managed initially with topical pharmaceuticals before needing surgery. Also, I think there might be some grey-areas on whether or not normal-tension glaucoma falls under POAG and if we are allowed to treat that or not.
• I believe that the required co-management of glaucoma should be removed and that optometrists can initiate treatment without consulting physicians for simple cases of glaucoma.
• Please include Xiidra to the list. Optometrists should be able to prescribe Xiidra to patients
• categories rather than lists will better serve the pupil and allow optometrists to rx current therapies
• Thank you. This is a breakthrough for expanding our patient care with therapeutic pharmaceutical agents.
• Thank you for all your hard work to improve our profession and thus, patient care.
• I would still like a broader scope that would encompass any drugs (topical, oral or other mode of delivery) that could be used for the purpose of treating our patients. I would prefer that our formulary would be "any medications required for the treatment of oculo-visual disease".
• next we need to reduce the co-management restrictions on glaucoma.
•My observation is that prescribing TPAs provides faster care to my patients and saves the "system" money by avoiding unnecessary referrals.
• The OAO app is very useful and it would also be beneficial to have a listing of the latest drugs by category on the College website. It will permit all Ontario ODs to have access regardless if they are OAO members and will better serve the public.
• This is a great step forward! Thank you!
• Red Eye Code :)
• Switching to categories of prescription medication will be a great benefit to the general public and reduce financial/resource burden (i.e. reduce wait time for patients to go to their GP to have a Rx, avoid double billing for a prescription, reduce inconveniences)
• Thank you for your efforts on behalf of your members and our patients.
• Thank you for getting this done! It is about time that we have access to all current ophthalmic medications to help treat our patients.
• Great change

Q8 Which category best describes you?

Answered: 128 Skipped: 5



ANSWER CHOICES	RESPONSES	
Member of the College	96.09%	123
Member of the public	1.56%	2
Other stakeholder	2.34%	3
TOTAL		128

November 7, 2019

Ms. Maureen Boon
Registrar
College of Optometrists of Ontario
65 St. Clair Avenue East, Suite 900
Toronto, ON M4T 2Y3

Dear Ms. Boon,

Re: Proposed Amendments to the Designated Drug and Standards of Practice Regulation

The Ontario Association of Optometrists (OAO) is pleased to voice its support of the College of Optometrists of Ontario's proposed amendments to the Designated Drugs and Standards of Practice Regulation. OAO views the amendments as helping to strengthen the role of Ontario optometrists in the delivery of primary eye care, acknowledging their extensive training and ability to effectively diagnose and treat a full range of eye conditions.

OAO takes the position that the College's submission is well-researched, reasonable, and in the public's interest. It addresses barriers while safeguarding patient care and improving the viability of a robust health care system.

While there are broader prescribing rights elsewhere in Canada, this is certainly a good first step towards providing Ontarians with better access to eye care delivered by optometrists.

Thank you for the opportunity to provide our feedback.

Sincerely,

Dr. Joshua C. Smith, OD
President

cc. OAO Board of Directors

November 28, 2019

Ms. Maureen Boon
Registrar,
College of Optometrists of Ontario
65 St. Clair Avenue East, Suite 900
Toronto, ON
M4T 2Y3

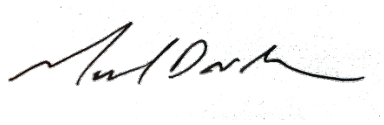
RE: Proposed amendments to the Designated Drugs and Standards of Practice Regulation

Dear Ms. Boon:

On behalf of the membership of the Canadian Association of Optometrists, please accept this letter as support for the College's proposed amendments to the Designated Drugs and Standards of Practice Regulation.

We believe that the College's submission is a positive first step in raising the standard of care for patients in Ontario with those in other parts of Canada. We are also pleased with the amendments' reinforcement of the role of optometrists in the delivery of primary eye care, and their ability to diagnose and treat the eye and visual system.

Sincerely,



Dr. Michael Nelson, OD, FAAO
President

ALBERTA college of OPTOMETRISTS

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October 8, 2019

College of Optometrists of Ontario
Consultation Feedback
65 St. Clair Ave. E., Suite 900
Toronto ON M4T 2Y3

RE: Proposed Amendments to the Designated Drugs and Standards of Practice Regulation

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Thank you for the opportunity to comment on the above proposed amendment. Although, the proposed amendment is very limited (in its scope), the Alberta College of Optometrists believes it will increase a patient's access to diagnostic and treatment care services from skilled and competent practitioners in a timely manner thus resulting in improved patient outcomes.

We understand that the College of Optometrists of Ontario (COO) will develop appropriate Standards of Practice based on the best available and most current optometric and medical clinical evidence and research, as well as specifying appropriate educational requirements for those members who wish to provide this service. This is an extremely important step for protecting the public interest.

As a final comment, the Alberta Optometrists Profession Regulation was passed in 2015. It changed the Restricted Activity of prescribing by optometrists from the previous "categories of drugs" to "any topical or oral drug for conditions within the scope of practice of optometry" as well as authorizing full, independent diagnosis, treatment and management of glaucoma by optometrists. Since that time, we have not had any patient complaints or malpractice issues related to either of these new authorizations. Hopefully, the Ontario Government will consider adopting this model (rather than the proposed model of drug categories) as:

- Patients have better and timelier access to skilled, knowledgeable and competent optometrists in their local communities with a resultant improvement in patient outcomes.
- Health care system efficiencies have improved and total health care costs have decreased due to patients being diagnosed and treated at the same initial appointment with their optometrist rather than having to be referred to another practitioner or an Emergency Room for treatment.

Sincerely,

Dr. Gordon Hensel
Registrar, Alberta College of Optometrists

EYE PHYSICIANS AND SURGEONS OF ONTARIO

November 13, 2019

Maureen Boon,
Registrar,
College of Optometrists of Ontario,
65 St. Clair Avenue East, Suite 900,
Toronto, ON, M4T 2Y3.

Dear Ms. Boon,

The Eye Physicians and Surgeons of Ontario (EPSO) appreciates the opportunity to participate in the College of Optometrists of Ontario's (COO) consultation regarding the proposed amendments to Designated Drugs and Standards of Practice Regulation (O.Reg. 112/11, under the *Optometry Act*, 1991).

The EPSO, a section of the Ontario Medical Association, represents more than 400 ophthalmologists in the province. The EPSO's Executive is comprised of comprehensive and subspecialty members, practicing in both academic and community settings (including urban and rural centres), from across the province.

Ontario Ophthalmologists support a collaborative, team-based approach to eye care and value the important role Optometry plays in delivering quality eye care to Ontarians. The important work that Optometry and Ophthalmology have done in creating guidelines for ocular disease co-management through the Eye Health Council of Ontario (EHCO) has established a number of best practice guidelines in eye care.

With this in mind, the EPSO would like to identify some considerations for the College to take in to account as it moves forward to review the proposed scope changes listed below:

Transitioning from Drug Lists to Categories

Transitioning from a list of regulated drugs to categories of drugs can reduce the legislative burden of approving new drugs. The EPSO recognize that the ocular therapeutics available to Optometry should expand as new therapies are introduced to Ontario. In implementing this transition, the EPSO would caution that new drugs added to a category without appropriate consultation may pose significant risk that can endanger patient safety if not properly monitored.

Oral medications, particularly steroids, carbonic anhydrase inhibitors, and oral secretagogues are examples of such drugs.

> Oral Pilocarpine (Salagen) is a secretagogue that is used to treat xerostomia (dry mouth) and xerophthalmia (dry eyes) in patients with Sjögren's syndrome. Some of the more dangerous side effects include CNS disturbances (mental confusion), GI disturbances (profuse vomiting and diarrhea) and may be life threatening (respiratory distress and cardiovascular compromise).
>
> Acetazolamide (Diamox) and Methazolamide (Neptazane) are carbonic anhydrase inhibitors that are useful in situations of acute increased intraocular pressure. Ophthalmologists have opposed the use of carbonic anhydrase inhibitors by optometrists. The Optometry Act was amended to allow prescribing rights for Acetazolamide in the rare situation when patients present to their offices in acute angle closure glaucoma. Methazolamide has not yet been approved. Both drugs have a number of side effects which include fatigue, tinnitus, GI disturbances, headaches, dizziness and confusion, can cause aplastic anemia and even death. These patients are typically unwell with a multitude of systemic symptoms including headaches, nausea and vomiting. They may also be elderly, acutely hypovolemic (due to emesis) and have multiple co morbidities. Ophthalmologists expressed concern with the approval of Acetazolamide: by attempting to initiate treatment with Acetazolamide in an optometric clinic, definitive surgical treatment for these patients could be unnecessarily delayed. Further, administering diuretics in a clinic setting without adequate monitoring of these patients can be unsafe.

The regulations propose prescribing of these drug categories only in collaboration with a physician with whom the optometrist has established a co-management model of care. That said, as more carbonic anhydrase inhibitor and secretagogues – which have significant side effects and associated risks - are added to the formulary for non-physicians to prescribe, there is a greater risk to patient safety and outcomes.

Protecting the Young and Vulnerable

Many ocular medications are used in children to treat common bacterial and viral infections, inflammation and allergy, uveitis and glaucoma, as well as other conditions including myopia, amblyopia, and strabismus, even if data regarding their safety and effectiveness in the paediatric population are sparse[1]. In 2000, a review of the 98 most commonly used or prescribed topical ophthalmic drugs found that only 51% provided information on paediatric use[2]. There is a particular paucity of information on drug use in patients under 2 years of age and many widely used drugs include disclaimers stating that safety and effectiveness in pediatric patients have not been established and pediatric use is "not recommended".[3]

Eye, vision, skin or orbital ailments in infants can worsen rapidly if not recognized and appropriately treated immediately (often requiring admission to hospital), and can lead to significant long-term morbidity or even death. Infections in the very young are challenging to diagnose and manage and at times require general anesthesia to conduct a proper examination. Ontario's pediatric ophthalmologists do not support optometrists treating children under the age of 2 years with systemic or topical medications, and would highly recommend that all children under the age of 6 years are immediately referred to an ER or ophthalmologist. For those between 6-16 years of age, a referral should be made within 24-36 hours if the patient does not respond to the prescribed medications.

14-day Restriction on Prescribing Oral Antibacterials

The use of oral antibacterials by non-physicians is an issue. While some conditions have less risk than others, prolonged use of an oral antibacterial in most cases indicates either an incorrect diagnosis, an incorrect treatment, or antibiotic resistance, all of which can delay necessary treatment. Research has shown that in acute conjunctivitis, a patient treated by an optometrist had significantly higher odds of receiving a prescription for a potentially unnecessary antibiotic and a higher chance of receiving a combination antibiotic corticosteroid than a patient treated by an ophthalmologist.[4] A change to this regulation may lead to delay in making a correct diagnosis and instituting appropriate treatment, and in some cases a delay may lead to increased morbidity and poorer outcome for the patient. When non-physicians are authorized to prescribe oral medications, the potential harm to patients from drug interactions, misdiagnosis, overtreatment and under-treatment is impossible to quantify.

For this reason, Ontario's ophthalmologists do not support the request to revoke the 14-day restriction on prescribing oral antibacterials.

Thank you for allowing the EPSO to comment on the proposed amendments to the Act. The EPSO would encourage open discussion of regulatory changes to take place at the Eye Health Council of Ontario which has representation from all key stakeholders including optometry, ophthalmology, and the respective regulatory colleges. Please do not hesitate to contact us if you have any questions or would like clarification.

Sincerely,

Raj Rathee, MD, FRCSC
Chair, Eye Physicians and Surgeons of Ontario

Copy: Honourable Christine Elliott, Ministry of Health

[1] Flomena Fortinguerra, Antonio Clavenna, Maurizio Bonati Ocular medicines in children: the regulatory situation related to clinical research. BMC Pediatr. 2012; 12: 8. Published online 2012 Jan 20. doi: 10.1186/1471-2431-12-8

[2] Chung I, Buhr V. Topical ophthalmic drugs and the pediatric patient. Optometry. 2000;71:511–518.

[3] Teresa M. Myers, MD; David K. Wallace, MD; Sandra M. Johnson, MD. Ophthalmic Medications in Pediatric Patients Compr Ophthalmol Update. 2005;6(2):85-101.

[4] Shekhawat NS, Shtein RM, Blachley TS, Stein JD. Antibiotic prescription fills for acute conjunctivitis among enrollees in a large United States managed care network.Ophthalmology. 2017;124(8):1099-1107. doi:10.1016/j.ophtha.2017.04.034

Ontario
Provincial Vision Task Force

November 14, 2019

Dr. David Wilkinson
Practice Advisor
College of Optometrists of Ontario
65 St. Clair E., Suite 900
Toronto, ON M4T 2Y3

Re: Proposed Amendments to the Designated Drugs and Standards of Practice Regulation

Dear Dr. Wilkinson,

Thank you for providing us the opportunity to provide feedback regarding the proposed amendments to the Designated Drugs and Standards of Practice Regulation (O. Reg. 112/11). The Provincial Vision Task Force (PVTF) is composed of a cross-sector of members including ophthalmologists, optometrists, researchers, administrators and MOH. We provide advice to the MOH on improving vision care to provide an accessible, high quality and integrated vision care system for patients in Ontario. Our feedback was discussed with the PVTF at two separate meetings. We suggest that your college consider addressing the following issues to ensure the highest quality of care for adults and children with vision issues.

- Concern was raised regarding pediatric patients (aged 12 or under) as these patients pose a higher risk of adverse outcome and require unique dosing and drug choices because of their different metabolism and body mass.
    - We would suggest dividing this group into 3 age categories, with different guidelines and policies related to each category
        - **Age 2 and under**
            - This is the highest risk category where urgent treatment is needed, most commonly with admission to hospital.
            - These patients should be immediately referred to an emergency department for care
        - **Age 2-5**
            - This age category remains at significant risk for spread of infection/or rapid worsening of disease.
            - For skin or orbital infections, or intraocular disease with any systemic changes these patients should be immediately referred to an emergency department.
            - Even for more apparently minor infections the infection may be more serious than suspected. Therefore, referral to a pediatric ophthalmologist on an urgent basis – within 24 hours, or assessment along with a pediatrician in the same time frame should be arranged.
        - **Age 6-12**
            - All major skin, adnexal and orbital infections, and all with systemic changes/ spread should be referred to an emergency department or pediatric ophthalmologist (if available to see the same day)
            - Minor conjunctival and lid margin infections with no evidence of spread that may be treated topically may be started on appropriate treatment, but if not

responding, or worsening within 24 hours should be referred to a pediatrician, pediatric ophthalmologist or emergency room for enhanced treatment.

- Concern was also raised that for adult patients, prescribing anti-bacterial (oral) and anti-viral (oral) agents should only be for very serious disease, and these should be prescribed in collaboration with a physician with whom the member has established a co-management model of care.

We would be happy to meet directly with you to further discuss this feedback.

Yours truly,

Dr. Phil Hooper
Co-chair, Provincial Vision Task Force

Dr. Jennifer Everson
Co-chair, Provincial Vision Task Force

cc. Maureen Boon, Registrar, College of Optometrists of Ontario
Marnie Weber, Admin Lead, Provincial Vision Task Force

Canadian Ophthalmological Society | Société canadienne d'ophtalmologie
EYE PHYSICIANS AND SURGEONS OF CANADA | MÉDECINS ET CHIRURGIENS OPHTALMOLOGISTES DU CANADA

November 18, 2019

Maureen Boon
Registrar, College of Optometrists of Ontario
Suite 900, 65 St. Clair Avenue East
Toronto, ON; M4T 2Y3

Dear Ms. Boon,

I am writing on behalf of the Canadian Ophthalmological Society (COS) to support the submission made on November 13 by the Eye Physicians and Surgeons of Ontario (EPSO) regarding proposed amendments to the Designated Drugs and Standards of Practice Regulation under the Optometry Act, 1991.

Transitioning From Drug Lists To Categories:
Our organization supports EPSO's position that transitioning to categories instead of lists could pose significant risks that could endanger patient safety if new drugs introduced in a category are not properly monitored. We further support the prescribing of oral medications, particularly steroids, carbonic anhydrase inhibitors and oral secretagogues *only* in collaboration with a physician who is able to immediately evaluate the patient.

Protecting the Young and Vulnerable:
Our organization also supports recommendations that optometrists should *not* treat children under the age of two with systemic or topical medications. We would recommend that all children under age six be immediately referred to an emergency room physician or an ophthalmologist who is able to immediately evaluate the patient. For children ages six to 16, a referral should be made within 24 to 36 hours if the patient does not respond to prescribed medications.

Regarding 14-Day Restrictions On Prescribing Oral Antibacterials:
When non-physicians are authorized to prescribe oral medications, the potential harm to patients from drug interactions, misdiagnosis, overtreatment and under-treatment can be significant. For this reason, COS does *not* support revoking the 14-day restriction on the prescribing oral antibacterial medications.

Thank you for receiving this letter and for considering the concerns raised by both EPSO and COS.

Sincerely yours,

Yvonne Buys, MD, FRCSC
President, Canadian Ophthalmological Society

OMA
ONTARIO MEDICAL ASSOCIATION

November 27, 2019

Dr. Pooya Hemami
President
College of Optometrists of Ontario,
65 St. Clair Avenue East, Suite 900,
Toronto, Ontario M4T 2Y3

Dear Dr. Hemami,

The Ontario Medical Association (OMA) appreciates the opportunity to participate in the consultation by the College of Optometrists of Ontario (COO) regarding a proposed scope of practice change to enable optometrists to prescribe categories of drugs, versus a specified list of individual drugs, as currently outlined in Regulation 112/11 – Designated Drugs and Standards of Practice under the *Optometry Act, 1991*. This letter will outline the OMA's perspective regarding this proposal.

The OMA is supportive of collaborative, team-based delivery of healthcare where every professional can work to their full scope of practice and be appreciated for their unique skills and experience. The OMA values the important contribution that optometrists bring to the healthcare team as primary eye care providers. To facilitate the review of proposed scope changes, the OMA has developed a list OMA Scope of Practice Principles. While not every principle will be applicable in each instance, we feel it is beneficial to utilize a framework to consider expanded scopes in a consistent, objective and evidence-based manner. We would encourage others to utilize these OMA principles and would welcome the opportunity to discuss them further.

The OMA Scope of Practice Principles state that any scope of practice change must:

1. Be subject to a rigorous regulatory structure,
2. Not raise patient safety concerns,
3. Be consistent with the knowledge, skill and judgment of the professionals involved,
4. Support a truly collaborative, team-based approach to care as opposed to parallel care,
5. Be accompanied by system initiatives/supports to ensure that no health care provider is unreasonably burdened with complications arising from expanded scopes of practice from other professions.
6. Be subject to stringent conflict of interest provisions,

7. Be applied with consideration of current best practices and lessons learned from other jurisdictions,
8. Be applied with consideration to cost effectiveness at a health system level,
9. Promote inter-professional communication and information sharing,
10. Promote continuity of care,
11. Promote positive relationships with patient,
12. Be subject to system evaluation to determine if they are leading to positive outcomes.

Rigorous Regulatory Structure

The OMA acknowledges the COO's important role in regulating the optometry profession in the public interest through the development of professional standards related to prescribing and quality assurance measures to identify practice concerns. With this in mind, the OMA would like to identify some issues for the College to consider as it moves forward to review the proposed scope changes.

Patient Safety

The OMA believes that Regulation 112/11 – Designated Drugs and Standards of Practice must continue to contain a list of specified drugs and substances that optometrists can administer or prescribe versus various categories of drugs and substances. While we acknowledge the challenge of updating lists when contained in regulation on a regular basis, there is a mechanism in place whereby patients may be referred to a family physician or ophthalmologist to obtain other medications not available to optometrists. This ensures that patients have safe and appropriate access to the most up to date and relevant treatments and therapies available, regardless of the specific drugs and substances listed in the regulation. The OMA acknowledges that optometrists should have access to new ocular therapies as they are introduced in Ontario. However, new drugs added to a category without appropriate consultation may pose significant risk that can endanger patient safety if not properly monitored.

Drug categories consist of broad ranges of substances with various drug interactions, side effects, and contraindications such that the purpose and use of each drug must be examined individually before being approved for use by other health professionals. There are many potential adverse reactions that may result from the administration of such a range of medications. Some proposed drug categories, such as antibiotics, carry a high risk of adverse reactions in patients with certain conditions, such as liver or renal issues, and may not be safe for the patient. Other oral medications, particularly steroids, carbonic anhydrase inhibitors, and oral secretagogues may also have serious side effects. For example, Oral Pilocarpine (Salagen) is a secretagogue that is used to treat xerostomia (dry mouth) and xerophthalmia (dry eyes) in patients with Sjögren's syndrome. Some of the more dangerous side effects include CNS disturbances (mental confusion), GI disturbances (profuse vomiting and diarrhea) and may be

life threatening (respiratory distress and cardiovascular compromise). Optometrists prescribing these medications must be done only in collaboration with a physician who is able to immediately evaluate the patient.

Optometrists are trained as primary eye care providers primarily trained to perform eye exams and vision tests, prescribe and dispense corrective lenses, detect certain eye abnormalities, and prescribe certain medications for some eye diseases. Eye physicians and surgeons, on the other hand, have advanced training to diagnose and treat a wider range of conditions and diseases. As such, optometrists must only prescribe for conditions that are within their scope of practice. They do not need to prescribe medications for conditions for which patients should be referred to an ophthalmologist for treatment.

For example, in the rare instance that a patient presents in an optometrist's office with acute angle closure glaucoma, the patient must be referred immediately to a hospital or ophthalmologist. The drugs that would be prescribed to address the increased intraocular pressure associated with this condition, Acetazolamide (Diamox) and Methazolamide (Neptazane), have several side effects which include fatigue, tinnitus, GI disturbances, dehydration, headaches, dizziness and confusion, to name a few. These patients are typically unwell with a multitude of systemic symptoms including headaches, nausea and vomiting. They may also be elderly, acutely hypovolemic (due to emesis) and have multiple comorbidities. Administering these drugs to patients in an optometric clinical setting, without adequate monitoring by a physician, can be unsafe. Furthermore, attempting to initiate treatment with Acetazolamide in an optometric clinic may unnecessarily delay definitive surgical treatment and cause further suffering for the patient.

In addition to optometrists not prescribing for conditions that are beyond their scope, they also must not prescribe medications to higher risk populations. For example, children under age six must immediately be referred to an emergency room physician or an ophthalmologist who is able to evaluate the patient prior to any medication use. For children ages six to 16, a referral must be made within 24 to 36 hours if the patient does not respond to prescribed medications. Many ocular medications used to treat common bacterial and viral infections, inflammation and allergy, uveitis and glaucoma, as well as other conditions including myopia, amblyopia, and strabismus, lack data regarding their safety and effectiveness in the pediatric population. Many widely used drugs include disclaimers stating that safety and effectiveness in pediatric patients have not been established and, therefore, pediatric use is "not recommended".

Furthermore, optometrists must not treat children under the age of two with systemic or topical medications. Eye, vision, skin or orbital ailments in infants can worsen rapidly if not recognized and appropriately treated immediately, often requiring admission to hospital, and can lead to

significant long-term morbidity or even death. Infections in the very young are challenging to diagnose and manage and at times require general anesthesia to conduct a proper examination.

Knowledge, Skills and Judgment of the Professionals Involved

Prescribing substances and drugs is a complex, and at times, high risk activity that must be done in the context of the whole patient. The OMA is concerned that the COO's prescribing program may lack the breadth and depth of a multi-year training program that is necessary to enable a medical professional to adequately prescribe medications safely. Practitioners must have knowledge about drug interactions, side effects, and contraindications of the drugs and substances they prescribe. More importantly, they must understand the potential drug-related risks associated with patients' medical conditions, co-morbidities, and/or underlying causes that may impact patient safety. Prescribers must have the training and clinical judgement to determine if and when medications will be beneficial to patients, as well as the knowledge and skills to identify and manage adverse drug reactions should they occur. In addition, they need regular ongoing training and learning strategies to keep up to date with new medications, techniques, and appropriate medical interventions to address possible negative outcomes.

While optometrists receive a 4-year doctorate in optometry, they do not receive in depth training in physiology, pharmacology, microbiology, infectious disease and biochemistry found in medical and/or fellowship training that is necessary to prescribe the breadth of medications listed in the proposed regulatory language. Optometrists are not medical doctors, and as indicated earlier, they must not prescribe medications for conditions that are out of their scope of practice. As well, all medications have side effects, and complications, and practitioners must be able to deal with both non-emergent and emergent complications.

For this reason, the OMA does not support the proposed regulatory change to revoke the 14-day restriction on prescribing oral antibacterials. While some conditions have less risk than others, prolonged use of an oral antibacterial often indicates either an incorrect diagnosis, an incorrect treatment, or antibiotic resistance, all of which can delay necessary and appropriate treatment. Delays to a correct diagnosis and treatment may in some cases lead to increased morbidity and poorer outcomes for the patient. The convenience of access to medication does not outweigh the potential harm to patients from drug interactions, misdiagnosis, overtreatment and under-treatment.

Continuity of Care

Continuity of care between providers is vital when more than one team member has responsibility for a patient. Optometrists must communicate with physicians about any prescriptions provided to their patients and about any negative (or positive) outcomes

experienced by the patients. The need to ensure continuity of care for patients is essential as the College and the government considers any scope of practice changes for health professionals. Appropriate processes, tools and resources will need to be established to support information sharing and coordinated care planning among the various health professionals involved in a patient's care to ensure safe treatment outcomes and the appropriate use of system resources.

Interprofessional Communication and Information Sharing

Successful interprofessional care must be supported by an infrastructure that has mechanisms in place to support ongoing, integrated communication between healthcare providers. Without timely communication between healthcare professionals and physicians, serious medical conditions may be missed, and appropriate treatment opportunities may be delayed or lost altogether. Shared access to patients' health information, including prescription information, through an integrated Electronic Health Record (EHR) is critical for patient safety and for the responsible, cost effective use of the health care system. The OMA has advocated for this over the past several years and we would encourage the COO to make this a priority as well.

System Evaluation to Determine if the Scope Change Results in Positive Outcomes

To our knowledge, the COO has not indicated what measures it is proposing to evaluate the efficacy of the proposed scope of practice change. Prior to the implementation of any scope change, it is important to have measures in place to assess the impact on the healthcare system and to determine whether patient safety is an issue.

Thank you for the opportunity to participate in the COO's consultation regarding the proposed expanded scope of practice for optometrists. The OMA values the critical role of optometrists in our shared healthcare system. We look forward to opportunities for continued collaboration between our professions to improve patient care.

Sincerely,

James G Wright

James Wright, CM, MD, MPH, FRCSC
Chief
Economics, Policy & Research

COLLEGE OF NURSES OF ONTARIO
ORDRE DES INFIRMIÈRES ET INFIRMIERS DE L'ONTARIO
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November 22, 2019

Maureen Boon, Registrar
College of Optometrists of Ontario
65 St. Clair Avenue East, Suite 900
Toronto, ON
M4T 2Y3

Dear Maureen Boon,

Thank you for the opportunity to provide feedback on the proposed amendments to the *Optometry Act, 1991*.

The College of Nurses of Ontario (CNO) agrees with the proposed amendments to Schedule I under the *Optometry Act, 1991*, that if approved would replace current list of drugs with categories of drugs. This is consistent with our proposed approach related to RN prescribing regulations as well as the direction taken by other health regulators in Ontario. As noted by the College of Optometrists of Ontario, there are significant benefits associated with the move from drug lists to categories such as: improving access to care by ensuring health professionals have the flexibility to prescribe up-to-date medication to patients as well as eliminating the need to make a regulation change every time a new drug is approved.

In order to support the regulation, you have identified the need to make a drug list available to optometrists, pharmacists and the public so that there is clarity of what drugs are available based on the proposed categories. While from a transparency perspective, there is value in making a drug list available, keeping the list up-to-date may be difficult to manage. CNO does not intend to have a separate drug list for the proposed drug categories as it is contrary to the change management goals associated with this new regulatory approach. Instead, we plan to communicate information to help nurses and others understand the scope of RN prescribing practice.

In addition, given that the categories of drugs are classified based on the American Hospital Formulary System (AHFS), the recommendation to refer members and other stakeholders to the Ontario Association of Optometrist (OAO) app which set out all the drugs optometrists may prescribe, could also create confusion.

The shift from drug lists to drug categories is a new regulatory approach for most health regulators in Ontario. Thus, inconsistencies in our implementation approach may create confusion for stakeholders, such as pharmacists and the public. Furthermore, it may undermine the broader change management goals in supporting stakeholders with this new approach.

Overall, CNO believes that the proposed amendments would improve and increase timely access to high-quality care and provide a better experience for the people of Ontario.

If you require additional information, please contact me at kmccarthy@cnomail.org.

Sincerely,

Kevin McCarthy, RN, MPPAL
Director of Strategy
College of Nurses of Ontario

/it

From:	Tina Perlman
To:	feedback@collegeoptom.on.ca
Subject:	Proposed Amendments to the Designated Drugs and Standards of Practice Regulation
Date:	Thursday, November 28, 2019 5:29:04 PM

Thank you for the opportunity to provide comments to the proposed amendments to your Designated Drugs and Standards of Practice Regulation. Although we do not have the clinical expertise to comment on the proposed list of categories and the revocation of the 14 day restriction, we do have some general comments.

OCP is supportive of the proposed amendments. The shift from drug lists to categories which are more responsive to changes when drugs are added or removed from distribution, will allow optometrists to prescribe the most appropriate drug for their patients. The implementation plan to support the regulations will provide optometrists, other health-care providers and the public with clarity about the drugs available within the categories.

If you require additional information, please do not hesitate to contact me.

Regards
Tina Perlman

Ontario College of Pharmacists
Putting patients first since 1871

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Motion to Council

Name of committee: Clinical Practice Panel - Quality Assurance Committee

Date of submission: December 3, 2019

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

Proposed motion: That Council approve proposed amendments to OPR 4.4 *The Use and Prescribing of Drugs in Optometric Practice,* contingent upon Ministry approval of the proposed drug regulation and revocation of the 14-day restriction on the prescribing of oral antibacterial drugs.

Recommendation to Council and Rationale	
The Issue	Ophthalmology stakeholders have expressed concern regarding the College's proposal to revoke the 14-day restriction on the prescribing of oral antibacterial drugs by optometrists.
Background	The proposal to revoke the 14-day restriction on prescribing oral antibacterials is important in the management of patients with dry eye (OPR 7.11) featuring lid disease where oral antibacterials (tetracycline and macrolides) may be prescribed for longer duration, often at concentrations sub-MIC (minimum inhibitory concentration). In these use cases, the condition treated is often **chronic and inflammatory**. CPP agree that optometrists should not prescribe oral antibacterials for longer than 14 days in the treatment of **acute infectious conditions**. To address this concern, CPP are proposing to update OPR 4.4 with the following: Optometrists must not: • prescribe oral antibacterial drugs for longer than 14 days in the treatment of acute infectious conditions of the eye and adnexa
Analysis, including impact on budget	
Options (are there alternatives)	The standards under OPR 4.4 may remain as is. Optometrists will use professional judgment regarding duration of treatment when prescribing oral antibacterial drugs.

Implications/expectations if approved	The OPR will be updated with this added standard of practice when the proposed drug regulation is approved.
Implications/potential consequences If not approved	The OPR will remain as is.

4.4
The Use And Prescribing Of Drugs In Optometric Practice

Description

Optometrists use diagnostic and therapeutic drugs in the course of providing patient care. The College recognizes that there is a distinction between the use of drugs within a clinical setting and the prescribing of drugs for treatment. Optometrists with authority to prescribe drugs can do so to manage patients with diseases and disorders of the eye and vision system. Such drugs are usually topically applied eye drops or ointments and oral medications for corneal or eyelid infections only.

Regulatory Standard

Commented [1]:
Note: Section will be updated with amended DDR.

The Optometry Act, 1991 states that in the course of engaging in the practice of optometry, optometrists are authorized, subject to terms, conditions and limitations imposed on his or her certificate of registration, to perform the following controlled act:

2.1 Prescribing drugs designated in the regulations.

The Designated Drugs and Standards of Practice Regulation, **(O.Reg. 112/11 under the Optometry Act, 1991)** describes the following conditions under which an optometrist may prescribe drugs and the drugs that may be prescribed:

~~**Drugs that may be prescribed**~~

~~**1.** For the purposes of paragraph 2.1 of section 4 of the Act, and subject to sections 2, 3 and 4 and Part II of this Regulation, a member may prescribe a drug set out under a category and sub-category heading in Schedule 1.~~

~~**Limitation**~~

~~**2.** Where a limitation or a route of administration is indicated in the sub-category heading set out in Schedule 1, a member shall only prescribe a drug listed under that subcategory in compliance with the limitation and in accordance with the route of administration specified.~~

~~**Training required**~~

~~**3.** No member may prescribe any drug unless he or she has successfully completed the relevant training in pharmacology that~~

has been approved by the Council.

Recording

4. Every time a member prescribes a drug, the member shall record the following in the patient's health record as that record is required to be kept under section 10 of Ontario Regulation 119/94 (General) made under the Act:

1. Details of the prescription, including the drug prescribed, dosage and route of administration.
2. Details of the counselling provided by the member to or on behalf of the patient respecting the use of the drug prescribed.

Non-prescription drugs

5. In the course of engaging in the practice of optometry a member may prescribe any drug that may lawfully be purchased or acquired without a prescription.

The standards of practice related to the prescribing of drugs for the treatment of glaucoma are as follows:

Prescribing of antiglaucoma agents

6. It is a standard of practice of the profession that in treating glaucoma a member may only prescribe a drug set out under the category of "Antiglaucoma Agents" in Schedule 1.

Open-angle glaucoma

7. (1) Subject to subsection (2) and to section 8, it is a standard of practice of the profession that a member may only treat a patient with glaucoma where the patient has primary open-angle glaucoma the treatment of which is not complicated by either a concurrent medical condition or a potentially interacting pharmacological treatment.

(2) It is a standard of practice of the profession that a member may only treat a patient having open-angle glaucoma, the treatment of which is complicated by either a concurrent medical condition or a potentially interacting pharmacological treatment, in collaboration with a physician with whom the member has established a comanagement model of care for that patient and who is,

(a) certified by the Royal College of Physicians and Surgeons of Canada as a specialist in ophthalmology; or

(b) ormally recognized in writing by the College of Physicians and Surgeons of Ontario as a specialist in

ophthalmology.

Referral to physician or hospital

8. (1) Subject to subsections (2) and (3), it is a standard of practice of the profession that a member shall immediately refer a patient having a form of glaucoma other than primary open angle glaucoma to a physician or to a hospital.

(2) It is a standard of practice of the profession that a member may initiate treatment for a patient having angle-closure glaucoma only in an emergency and where no physician is available to treat the patient.

(3) It is a standard of practice of the profession that a member shall immediately refer any patient being treated in accordance with subsection (2) to a physician or hospital once the emergency no longer exists or once a physician becomes available, whichever comes first.

(4) In this section, "hospital" means a hospital within the meaning of the Public Hospitals Act.

SCHEDULE 1

ANTI-INFECTIVE AGENTS

Antibacterials (topical)

azithromycin
besifloxacin
ciprofloxacin
erythromycin
framycetin
fusidic acid
gatifloxacin
gentamicin
moxifloxacin
ofloxacin
polymyxin B/gramicidin/neomycin
polymyxin B/neomycin/bacitracin
polymyxin B/trimethoprim
sulfacetamide
tetracycline
tobramycin

- ~~Antifungals (topical)~~
  - ~~natamycin~~
- ~~Antivirals (topical)~~
  - ~~trifluridine~~
  - ~~Acyclovir~~
- ~~Antibacterials (oral) – for corneal or eyelid infections only and for a duration not exceeding 14 days~~
  - ~~amoxicillin~~
  - ~~amoxicillin/clavulanic acid~~
  - ~~azithromycin~~
  - ~~cephalexin~~
  - ~~ciprofloxacin~~
  - ~~clarithromycin~~
  - ~~clindamycin~~
  - ~~cloxacillin~~
  - ~~doxycycline~~
  - ~~erythromycin~~
  - ~~levofloxacin~~
  - ~~minocycline~~
  - ~~moxifloxacin~~
  - ~~tetracycline~~
- ~~Antivirals (oral) – for corneal or eyelid infections only~~
  - ~~acyclovir~~
  - ~~famciclovir~~
  - ~~valacyclovir~~

~~ANTI-INFLAMMATORY AGENTS~~

- ~~Corticosteroids (topical)~~
  - ~~dexamethasone~~
  - ~~difluprednate~~
  - ~~fluorometholone~~
  - ~~loteprednol~~
  - ~~prednisolone~~
  - ~~rimexolone~~
- ~~Corticosteroids (topical) – for the purpose of treating conditions of the eye and adnexa~~
  - ~~triamcinolone~~
- ~~Immunomodulators (topical)~~
  - ~~cyclosporine~~

~~Nonsteroidal anti-inflammatory agents (topical)~~

- ~~bromfenac~~
- ~~diclofenac~~
- ~~ketorolac~~
- ~~nepafenac~~

~~ANTI-INFECTIVE/ANTI-INFLAMMATORY AGENTS~~

~~Antibacterials /corticosteroids (topical)~~

- ~~framycetin/gramicidin/dexamethasone~~
- ~~gentamicin/betamethasone~~
- ~~neomycin/fluorometholone~~
- ~~neomycin/polymyxin B/dexamethasone~~
- ~~neomycin/bacitracin/polymyxin B/hydrocortisone~~
- ~~sulfacetamide/prednisolone~~
- ~~tobramycin/dexamethasone~~

~~MYDRIATICS~~

~~Mydriatics (topical)~~

- ~~atropine~~
- ~~cyclopentolate~~
- ~~homatropine~~
- ~~tropicamide~~

~~ANTI-ALLERGIC AGENTS~~

~~Anti-allergic agents (topical)~~

- ~~bepotastine~~
- ~~emedastine~~
- ~~ketotifen~~
- ~~levocabastine~~
- ~~lodoxamide~~
- ~~nedocromil~~
- ~~olopatadine~~
- ~~tacrolimus – for the purpose of treating conditions of the eye and adnexa and for a duration not exceeding 42 days~~

~~ANTIGLAUCOMA AGENTS~~

~~ß-Adrenergic blocking agents (topical)~~

- ~~betaxolol~~
- ~~levobunolol~~
- ~~timolol~~

~~Carbonic anhydrase inhibitors (topical)~~

~~brinzolamide~~

~~dorzolamide~~

~~Miotics (topical)~~

~~carbachol~~

~~pilocarpine~~

~~Prostaglandin analogs (topical)~~

~~bimatoprost~~

~~latanoprost~~

~~tafluprost~~

~~travoprost~~

~~α-Adrenergic agonists (topical)~~

~~apraclonidine~~

~~brimonidine~~

~~α-Adrenergic agonists/ß-adrenergic blocking agents (topical)~~

~~brimonidine/timolol~~

~~Carbonic anhydrase inhibitors/ß-adrenergic blocking agents (topical)~~

~~brinzolamide/timolol~~

~~dorzolamide/timolol~~

~~Prostaglandin analogs/ß-adrenergic blocking agents (topical)~~

~~latanoprost/timolol~~

~~travoprost/timolol~~

~~Carbonic anhydrase inhibitors (oral) – to lower intraocular pressure only and a member shall immediately refer the patient to a physician or to a hospital~~

~~– acetazolamide~~

~~SECRETAGOGUES~~

~~Secretagogues (oral) – for Sjögren's syndrome only and only in collaboration with a physician with whom the member has established a co-management model of care~~

~~– pilocarpine~~

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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.(3)

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 require such referral.
13. Recommending or providing unnecessary diagnostic or treatment services.
14. Failing to maintain the standards of practice of the profession.

Professional Standard

Optometrists utilizing drugs within their practices for diagnostic and therapeutic purposes will:

- use only drugs for which they have been appropriately trained, establish a diagnosis and management plan based upon case history, clinical findings and accepted treatment modalities
- not dispense a drug
- document the drug(s) used, including concentration (when applicable) and dosage
- provide appropriate patient counselling including:
- general information, including management options, a description of the treatment(s), expected outcomes and normal healing course
- specific information including any potential significant risks and complications requiring *urgent or emergency care* **(OPR 4.6)**
    - how to access after-hours support and emergency care
    - arrange appropriate follow-up care as indicated
- refer the patient to an appropriate health care provider when clinically indicated

Prescribing of Drugs by Optometrists with Authority to Prescribe

Drugs

In addition to the above conditions, those with authority to prescribe drugs:

- will maintain appropriate continuing education relevant to the treatment of eye disease by drug therapy for patients of all ages, as specified by the College
- may issue a *prescription* **(OPR 5.2)** and document the treatment and counselling in the *patient health record* **(OPR 5.1)**
- **will not prescribe an oral antibacterial for longer than 14 days for the purpose of treating acute infectious conditions of the eye and adnexa**
  - **extended treatment courses may be indicated in the management of chronic ocular surface disease (OPR 7.11)**

Use of Drugs by Optometrists without Authority to Prescribe Drugs

Optometrists without authority to prescribe drugs have several options for the treatment of patients with conditions requiring drug therapy, such as:

- refer to another optometrist with authority to prescribe drugs;
- refer to another regulated health care provider who can provide such care appropriate to the condition;
- initiate office treatment, then, make a referral, as above, if required for the condition

It is professional misconduct if a prescription for drugs is issued by an optometrist without authority to prescribe drugs.

BRIEFING NOTE

Council Meeting – December 2019

Subject

FOR INFORMATION: Entry-to-Practice (ETP) Exam Consultation

The College is currently consulting on a proposal to proceed with the development of a new ETP exam. This note provides an update on the consultation.

Background

On October 17, the Registration Committee agreed to put forward a motion to January Council to approve the development of a new Entry-to-Practice Exam by Touchstone Institute. On November 5, the Executive Committee decided to conduct a consultation prior to the January Council meeting. The consultation materials were released to stakeholders, the public and profession on November 18, 2019.

The Registration Committee will be meeting on December 5, 2019. If there are updates, they will be provided at the meeting.

Consultation Update

Consultation deadline: January 8, 2020
Responses received as of November 28, 2019: 3

Other Feedback/Developments

Discussions have occurred or are scheduled with various stakeholders. These discussions have focussed on providing more information about the proposed direction as well as the possibility of revisiting the July 2019 proposal (new exam to be developed, administered and maintained by Touchstone Institute but ultimately owned and funded by OEBC). There has been a discussion with the OEBC Chair and CEO, but we have yet to receive a formal response. Note that OEBC CEO Tami Hynes will be leaving the OEBC at the end of the year. There will be additional opportunity for FORAC members to discuss the consultation results following the January Council meeting.

Staff also met with the Office of the Fairness Commissioner (OFC) staff. Information was provided about the consultation and the reasons for the development of a new exam. OFC staff emphasized the importance of transparency and communication with applicants, given the elimination of the bridging program and potential confusion about ETP exams.

Considerations

Early feedback on the consultation indicates some opposition to the proposal. However, it is likely that most feedback will be provided in January.

Next Steps

At its January 2020 meeting, Council will be asked to consider the Registration Committee's motion recommending approval of the development of a new ETP exam for Canadian applicants. Council will be provided with consultation feedback to inform its decision.

Contact

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