COLLEGE OF
OPTOMETRISTS
OF ONTARIO

COUNCIL MEETING

FRIDAY, JUNE 13, 2025
AT 9:00 A.M.

(PUBLIC INVITED TO ATTEND ONLINE)

HYBRID MEETING

COLLEGE OF OPTOMETRISTS OF ONTARIO

Vision and Mission

Vision: To ensure that the public understands, trusts and has confidence in optometrists.

Mission: To regulate Ontario's Doctors of Optometry in the public interest.

1 - 4 / INTRODUCTION

1. Call to Order/Attendance
    a. Land Acknowledgement
    b. Public Interest Statement

2. Adopt the Agenda
    a. Conflict of Interest Declaration

3. Committee Updates

4. Consent Agenda
    a. PART 1 - Minutes of Prior Council Meetings
        i. March 7, 2025
        ii. Motions and Actions Arising from the Minutes

    PART 2 - Reports
    b. Committee Reports
        i. Executive
        ii. Patient Relations
        iii. Quality Assurance
        iv. ICRC
        v. Registration
        vi. Discipline
        vii. Governance/HR
        viii. Audit/Finance/Risk

COLLEGE OF OPTOMETRISTS OF ONTARIO

Council Agenda

Date: Friday, June 13, 2025 | 9:00 a.m. – 2:30 p.m.
Hybrid Meeting

Agenda Item	Item Lead	Time (mins)	Action Required	Page No.
1. Call to Order/Attendance a. Land Acknowledgement b. Public Interest Statement	M. Eltis	5	Decision	3
2. Adopt the Agenda a. Conflict of Interest Declaration	M. Eltis	2	Decision	4
3. Committee Updates	Committee Chairs	15	Presentation	
4. Consent Agenda PART 1 - Minutes of Prior Council Meetings a. Minutes and Actions i. March 7, 2025 ii. Motions and Actions Items Arising from the Minutes PART 2 - Reports b. Committee Reports i. Executive ii. Patient Relations iii. Quality Assurance iv. ICRC v. Registration vi. Discipline vii. Governance/HR viii. Audit/Finance/Risk	M. Eltis	15	Decision	7 14 15 16 18 20 22 23 25
5. Registrar's Report	J. Jamieson	60	Presentation	27
10:40–11:00 a.m. - Morning Break		20		
6. Presentation from the Auditors	BDO	15	Presentation	
7. Research Presentation from Drs. Tracey Adams and Sophia Myles	T. Adams, S. Myles	35	Presentation	

COLLEGE OF OPTOMETRISTS OF ONTARIO

11:50 a.m. – 12:45 p.m. - Lunch		55		
8. Motions Brought Forward from Committees a. Audit/Finance/Risk i. Approval of the audited financial statements for 2024	N. Shah	5	Decision	28
ii. Approval of the reappointment of BDO Canada as auditors for 2025 financial accounts	N. Shah	5	Decision	44
iii. Approval of the Finance Policy – Evaluation of External Auditors	N. Shah	5	Decision	46
b. Quality Assurance i. Approval of the updated practice assessment component of the Quality Assurance Program	K. Morcos	10	Decision	51
ii. Approval of the updated Optometric Practice Reference (OPR)	K. Morcos	10	Decision	190
c. Governance/H.R. i. Appoint Drs. Manveen Bedi, Leah Markin, Karin Simon, and Harminder Singh to the Discipline Committee for the remainder of the 2025 Council Year	L. Christian	10	Decision	
9. Upcoming Council Meetings a. Friday, September 19, 2025 b. Friday, December 12, 2025	J. Jamieson	10	For information	327
10. List of Acronyms	M. Eltis	5	Discussion	328
11. Governance Guide: Robert's Rules	M. Eltis	5	Decision	334
12. Council Feedback Survey	M. Eltis	2	Discussion	
13. Adjournment – approximately 2:17 p.m.				
Generative Discussion (optional) a. Generative Discussion Feedback Survey		30	Discussion	

COLLEGE OF
OPTOMETRISTS
OF ONTARIO

Council Meeting Evaluation Survey

General Discussion Evaluation Survey

College of Optometrists of Ontario
Council Meeting
DRAFT – March 7, 2025

Attendance:

Dr. Mark Eltis, President
Dr. Abraham Yuen, Vice President
Ms. Suzanne Allen
Dr. Lisa Christian
Dr. Pooya Hemami
Ms. Esther Jooda
Mr. Howard Kennedy
Dr. Wes McCann
Dr. Kamy Morcos
Dr. Thomas Noël
Dr. Patrick Quaid
Mr. Toye Soile
Ms. Christine terSteege
Mr. Andre Tilban-Rios
Dr. William Ulakovic
Dr. Camy Grewal

Regrets

Mr. Narendra Shah

Staff:

Mr. Joe Jamieson, Registrar & CEO
Ms. Hanan Jibry, Deputy Registrar
Mr. Chad Andrews
Mr. Edward Cho
Ms. Jaslin Facey
Ms. Debbie Lim
Ms. Sharon M.
Ms. Adrita Shah Noor

Guest:

Ms. Julia Martin, legal counsel

1. Call to Order/Attendance: Dr. Eltis called the meeting to order at 9:02 a.m.

Dr. Eltis read the land acknowledgement and public interest statement. Dr. Eltis then expressed his gratitude to Lisa Holland for her service to the College and Council, as her public appointment term has come to an end, and introduced Christine terSteege, a new public appointee with a background in public administration.

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

Moved by Dr. Yuen and seconded by Mr. Kennedy to ***adopt the agenda.***

Motion carried

2a. Conflict of Interest Declaration: Dr. Eltis asked Council members if anyone has a conflict of interest with any item on the day's agenda.

Dr. Yuen declared a conflict of interest for item 6.c.iii, citing a potential perception of bias.

3. Committee Updates: The Committee Chairs presented updates on their respective committees.

4. 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 13, 2024
- b. January 10, 2025
- c. Motions and Action Items Arising from the Minutes

PART 2 - Reports
- b. Committee Reports
  - i. Executive
  - ii. Patient Relations
  - iii. Quality Assurance:
  - iv. ICRC
  - v. Registration
  - vi. Discipline
  - vii. Governance/HR Committee
  - viii. Audit/Finance/Risk Committee

Moved by Dr. Grewal and Dr. Quaid ***to adopt the consent agenda.***

Motion carried

5. Registrar's Report

Mr. Jamieson presented his report which included the College Performance Measurement Framework and legislation updates. Mr. Jamieson welcomed Dr. Wes McCann, Dr. Thomas Noël, and Christine terSteege to Council, thanking them for the wealth of knowledge they bring to optometric care and public administration. Council learned that the OPR modernization will help the College meet the last partially met measurement of the CPMF.

Council asked if our College had a current spousal exemption, and Mr. Jamieson confirmed that the College does.

6. Motions Brought Forward from Committees

a) Executive

i. 2024 CPMF Report

Dr. Eltis presented the motion.

Moved by Mr. Kennedy and seconded by Dr. Christian ***to approve the 2024 CPMF report.***

All in favour

Motion carried

b) Quality Assurance

i. Professional Advisory: Social Media, and its distribution to College registrants

Dr. Morcos presented the motion.

Moved by Dr. Morcos and seconded by Dr. Noël ***to approve the Professional Advisory: Social Media, and its distribution to College registrants.***

Council asked for clarification on whether the Professional Advisory is an overarching advisory, or if it only applies to optometrists when using their professional business accounts. Dr. Morcos explained that the advisory is broader than that and provides guidance for optometrists representing themselves both personally and professionally on social media.

All in favour

Motion carried

ii. Updated Optometric Practice Reference (OPR) and its circulation to College registrants and stakeholders for 60 days

Dr. Morcos presented the motion.

Moved by Dr. Morcos and seconded by Dr. Noël ***to approve the Updated Optometric Practice Reference (OPR) and its circulation to College registrants and stakeholders for 60 days.***

All in favour

Motion carried

Council took a break at 9:58 a.m.

Council resumed at 10:16 a.m.

c. Registration

Moved by Dr. Grewal and seconded by Dr. Yuen ***to move in-camera.***

Motion carried

IN CAMERA Session: Financial Matters

In accordance with Section 7(2)(b) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*, Council went in camera to discuss financial matters.

Council went in-camera at 10:16am

Moved by Dr. Grewal and seconded by Dr. Eltis ***to exit camera.***

Motion carried

Council went out of camera at 11:20 a.m.

Dr. Eltis stated that Council was now out of camera.

i. Approval of funding to OEBC as member contribution for 2025

ii. Approval of a loan to OEBC to be solely used to maintain a robust and defensible entry-to-practice exam

Dr. Grewal reported that Council approved the motion to give OEBC funding as member contribution for 2025. Dr. Grewal also reported that Council approved the motion to provide a loan to OEBC to be solely used to maintain a robust and defensible entry-to-practice exam, which was passed with one vote of dissent.

iii. Cessation of the approval of the National Board of Examiners in Optometry (NBEO) exam in 2025 as a standards assessment examination for registration purposes. Candidates who have already registered for a part of the NBEO exam by March 7, 2025, be permitted to continue registering for the other parts of the NBEO exam and their NBEO exam scores would be recognized by the College

Dr. Grewal presented the motion.

Moved by Dr. Grewal and seconded by Dr. Morcos to ***approve the motion****.*

Dr. Hemami stated that he was President of Council during the term that NBEO was first accepted as an alternate entry to practice exam and explained that part of the reason for acceptance was to improve access and flexibility amongst applicants. Dr. Hemami voiced his dissent, noted that he would like the College to continue accepting the exam.

14 in favour
1 opposed
1 abstention
Motion carried

iv. Approval of the Diplomate of the American Academy of Optometry credential and the use of the following designation or its historical equivalence: Dipl AAO

Dr. Grewal presented the motion.

Moved by Dr. Grewal and seconded by Dr. Yuen ***to approve the Diplomate of the American Academy of Optometry credential and the use of the following designation or its historical equivalence: Dipl AAO.***

Dr. Yuen stated that he was in support of this motion as the College has accepted the Fellow of the American Academy of Optometry designation, which is a well-respected designation, and explained that the Diplomate is a much higher standard in comparison; less than 1% of optometrists have earned the designation.

All in favour
Motion carried

d. Governance/HR

i. To appoint Dr. Abraham Yuen to the Governance/HR Committee

Dr. Christian presented the motion.

Moved by Dr. Christian and seconded by Dr. Grewal ***to approve the appointment of Dr. Yuen to the Governance/HR Committee.***

All in favour
Motion carried

ii. To appoint Christine terSteege to the Discipline, Inquiries, Complaints and Reports, Fitness to Practise, Quality Assurance Special Projects, and Patient Relations Committees

Dr. Christian presented the motion.

Moved by Dr. Christian and seconded by Dr. Grewal ***to approve the appointment of Christine terSteege to the Discipline, Inquiries, Complaints and Reports, Fitness to Practise, Quality Assurance Special Projects, and Patient Relations Committees.***

Council expressed its full endorsement for the appointment of Ms. terSteege to these committees and thanked her for joining.

All in favour
Motion carried

7. Upcoming Council Meetings

a. Thursday, June 12, 2025 (AGM)
b. Friday, June 13, 2025
c. Friday, September 19, 2025
d. Friday, December 12, 2025

8. List of Acronyms

9. Governance Guide: Robert's Rules

10. Council Feedback Survey

11. Adjournment: *Moved by Dr. Ulakovic and seconded by Mr. Kennedy* ***to adjourn the meeting at 11:27 a.m.***

Motion carried

COLLEGE OF OPTOMETRISTS OF ONTARIO

Council Meeting – June 13, 2025

COUNCIL ACTION LIST STATUS

Updated June 6, 2025

Date mm/dd/yr	Minute Line	Action	Status	Comments
06/18/21	155	Staff, including practice advisors, will develop a practice advisory regarding advertising.	Ongoing	

Council Meeting – June 13, 2025

MOTION LIST

Updated June 6, 2025

Date mm/dd/yr	Minute Line	Motion	Committee	Decision
03/07/25	60	Moved by Mr. Kennedy Moved by Mr. Kennedy and seconded by Dr. Christian **to approve the 2024 CPMF report**.	Executive	Motion carried
03/07/25	70	Moved by Dr. Morcos and seconded by Dr. Noël to **approve the Professional Advisory: Social Media, and its distribution to College registrants**.	Quality Assurance	Motion carried
03/07/25	85	Moved by Dr. Morcos and seconded by Dr. Noël to **approve the Updated Optometric Practice Reference (OPR) and its circulation to College registrants and stakeholders for 60 days.**	Quality Assurance	Motion carried
03/07/25	112	Moved by Dr. Grewal and seconded by Dr. Yuen **to approve funding to OEBC as member contribution for 2025.**	Registration	Motion carried
03/07/25	114	Moved by Dr. Grewal and seconded by Dr. Morcos to **approve a loan to OEBC to be solely used to maintain a robust and defensible entry-to-practice exam.**	Registration	Motion carried
03/07/25	122	Moved by Dr. Grewal and seconded by Morcos to **approve cessation of the approval of the National Board of Examiners in Optometry (NBEO) exam in 2025 as a standards assessment examination for registration purposes. Candidates who have already registered for a part of the NBEO exam by March 7, 2025, be permitted to continue registering for the other parts of the NBEO exam and their NBEO exam scores would be recognized by the College**	Registration	Motion carried
03/07/25	145	Moved by Dr. Grewal and seconded by Dr. Yuen to **approve the Diplomate of the American Academy of 145 Optometry credential and the use of the following designation or its historical equivalence: Dipl AAO**	Registration	Motion carried
03/07/25	162	Moved by Dr. Christian and seconded by Dr. Grewal **to approve the appointment of Dr. Yuen to the Governance/HR Committee**	Governance/HR	Motion carried
03/07/25	173	Moved by Dr. Christian and seconded by Dr. Grewal to **approve the appointment of Christine terSteege to the Discipline, Inquiries, Complaints and Reports, Fitness to Practise, Quality Assurance Special Projects, and Patient Relations Committees.**	Governance/HR	Motion carried

COLLEGE OF OPTOMETRISTS OF ONTARIO

Executive Committee Activity Report

Reporting date: June 13, 2025

Chair: Dr. Mark Eltis

Meetings in 2025: 2 over Zoom | most recent on May 28, 2025

Key Priorities
The Executive Committee meets before each Council session 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. The Committee also meets to address emerging and time-sensitive issues when necessary and appropriate.

Discussion Items

Committee Agenda for June 13, 2025 Council Meeting

The Executive Committee reviewed a draft agenda and motions for the June 13, 2025 meeting of Council.

Process for reviewing per diem and stipend rates

The draft agenda for the June 13, 2025 Council meeting contained a motion from AFR to increase the per diem and President stipend rates.

After careful consideration, the Executive Committee decided that, as a matter of process, the AFR Committee must consult with the Gov-HR Committee before bringing the motion to Council.

The group cited the terms of reference for AFR, which states that it is within AFR's purview to: "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."

As a result, the item will be discussed at a later Council session, after such consultation has occurred.

Decision Items

- NA

Patient Relations Committee Activity Report

Reporting date: June 13, 2025

Committee Chair: Howard Kennedy

Meetings in 2025: 1 (Zoom) | most recent on February 3, 2025

Key Priorities

The Patient Relations Committee manages the Program of Funding for Therapy and Counselling.

Information Items

Committee Orientation

The Patient Relations Committee has not met after initial orientation on February 3, 2025, where the Committee received an overview of the Committee mandate, and an update on the Patient Therapy Fund.

Program of Funding for Therapy and Counselling

The patient therapy program continues to provide support for two patients.

Discussion Items

The Patient Relations Committee has no additional updates for Council at this time.

Decision Items

The Patient Relations Committee does not have any motions for Council to review at this meeting.

Attachments

N/A

COLLEGE OF OPTOMETRISTS OF ONTARIO

Quality Assurance Committee Activity Report

Reporting date: June 13, 2025

Chair: Dr. Kamy Morcos

Meetings in 2025: 4 virtual meetings

Tasks Completed Since Last Council Meeting:

- Reviewed and decided on random practice assessments
- Finalized the new Practice Assessment tools, processes, and policies
- Updated the *QA Policy – 750 Direct Optometric Care Hours Deficiency*
- Reviewed public consultation feedback for the modernization of the Optometric Practice Reference (OPR) and finalized the OPR
- Held kickoff meeting with consultants for the development of a Recordkeeping E-module

Key Priorities

- Completing the practice assessment modernization project
- Completing the OPR modernization project

Information Items

Practice Assessment Stats

	Since Last Council Meeting	Throughout 2025
CRP Reports Reviewed	0	0
CSRP Reports Reviewed	1	31
CRA and Case Manager Reports Reviewed	0	2
Ongoing Remediation Cases and Re-assessments Reviewed	13	25
New Referrals for Remediation	1	3

Discussion Items

Random Practice Assessments

- Reviewed 10 remedial programs and practice re-assessments;
- Reviewed written submissions from 2 registrant regarding their remediation requirements; and
- Referred one registrant to the Inquiries, Complaints and Reports Committee (ICRC) for professional misconduct.

Practice Assessment Modernization Project

- A half-day virtual training session for CRP assessors was held on March 27, 2025. The goal of this training was to reduce inter-rater variability among assessors prior to the official implementation of the new CRP tool. The College Practice Advisor and Senior Manager, Quality Programs led the training. The QAC Chair attended as an observer and provided guidance/feedback as needed.
- Reviewed and approved the final pilot test report completed by the external consultant
- Finalized the new assessment process and the *QA Policy - Random Selection Criteria*
- Made a motion to Council to approve the new Practice Assessment component of the QA Program

750 Direct Optometric Care Hours Audit of the 2021-2023 period

- Updated the *QA Policy – 750 Direct Optometric Care Hours Deficiency* to establish a fair and transparent process for registrants to request exceptions to the steps in the practice assessment due to direct optometric care hours deficiency.

Modernization of the OPR

- Focused on final edits to the Optometric Practice Reference (OPR) modernization project based on feedback received from registrants and stakeholders.
- Revisions to the OPR are now complete and await Council approval.

Recordkeeping E-module

- Initiated work on a Recordkeeping E-Module which will assist registrants identified by the Quality Assurance Committee as having opportunities for improvement in their medical record keeping.

Attachments

N/A

COLLEGE OF OPTOMETRISTS OF ONTARIO

Inquiries, Complaints and Reports Committee (ICRC) Activity Report

Reporting date: June 13, 2025

Committee Chair: Dr. Pooya Hemami

Meetings in 2025: 3

Information Items

This report is intended to provide Council with information on complaints and registrar's investigations while maintaining fairness throughout the process. In keeping with Section 36 of the *Regulated Health Professions Act*, *1991* regarding confidentiality, details about specific cases are not shared as part of the Committee report.

Since the Committee last reported to Council, a meeting was held on March 28, 2025, with members of Dr. Hemami's panel, and Dr. Jenna Astorino's panel held a case review meeting on April 29, 2025.

At the time of drafting this report, Dr. Hemami's panel is also scheduled to meet on June 27, 2025.

Discussion Items

The ICRC has no additional updates for Council at this time.

Decision Items

There are no ICRC decisions or motions that require Council feedback or approval at this meeting.

Cases Processed Since Last Reporting (February 22, 2025 – May 29, 2025)

- Complaints newly filed: 17
- Cases reviewed by the panels: 18
- Complaint cases resolved by Alternative Dispute Resolution (ADR): 0
- Cases carried over: 1

Decision Breakdown	Total
Decisions Issued	**6**
Case Type	
• Complaints	5
• Registrar's Investigations	1
• Incapacity Inquiry	0
Dispositions (for cases above)	
• No action/No further action (NFA)	4
• Advice/Recommendation	0
• Remedial agreement	0
• Specified Continuing Education or Remediation Program	1*

(SCERP) • Oral caution • Acknowledgement and Undertaking • Referral of specified allegations to the Discipline Committee	 1* 1 0
Nature of Allegations (for dispositions above, no action/NFA excluded)** • Failure to diagnose or misdiagnosis • Related to patient record-keeping and documentation • Inadequate eye examination and/or treatment • Unprofessional behaviour & communication • Related to eyeglasses or contact lens prescriptions • Sexual abuse and/or breach of professional boundaries • Ungovernability and failure to comply with regulatory responsibilities	 1 0 0 0 0 0 1
Timeline for Resolution of Cases Above (business days) • <125 Days • 125-175 Days • 176-225 Days • 225+ Days	 0 2 1 3

**In one case, both a SCERP and an Oral Caution was issued.*

*** Certain matters may contain more than one allegation.*

Health Professions Appeal and Review Board (HPARB) cases

- New appeals: 2
- Outstanding appeals to be heard: 3
- Appeals heard and awaiting decisions: 2
- ICRC Decision Confirmed: 2
- ICRC Decision Returned: 0

COLLEGE OF OPTOMETRISTS OF ONTARIO

Registration Committee Activity Report

Reporting date: June 13, 2025

Chair: Dr. Camy Grewal

Meetings in 2025: 2 (via videoconference)

Tasks Completed Since Last Council Meeting:

- Discussed the Ministry of Health (MOH), the Federation of Optometric Regulatory Authorities of Canada (FORAC), the Office of the Fairness Commissioner (OFC), Touchstone Institute and the Internationally Graduated Optometrist Evaluating Examination (IGOEE), the Optometry Examining Board of Canada (OEBC) and the National Board of Examiners in Optometry (NBEO) examinations, and the registration process.

Key Priorities

Ministry of Health

- College staff met with MOH staff on April 17 and 23 to clarify information associated with an updated redline version of the draft Registration Regulation amendments.

Federation of Optometric Regulatory Authorities of Canada

- A virtual May 3, 2025, FORAC Board of Directors meeting was attended by the College President, Vice President, Committee Chair, Registrar and CEO, and the Deputy Registrar.
- At the FORAC meeting, the FORAC Executive Director mentioned that FORAC should make-up the difference for the anticipated deficit in registered candidates for the 2025 IGOEE.
- Also at the same meeting, the OEBC Board Chair mentioned that the future for the OEBC has improved following the March 2025 decisions by the Ontario and British Columbia colleges associated with the NBEO entry-to-practice exam for registration. He was hopeful that the details of the bridging loan made by the member regulators to OEBC can be negotiated by December 2025.

Office of the Fairness Commissioner

- The OFC Commissioner and staff met and informed the Committee about the recently expanded OFC's legislative mandate which, among other things, require that regulators oversee the work of third-party providers, such as assessment and testing agencies. OFC staff explained the two risk factors identified for the College below:
  - The overall control that a regulator exerts over its assessment and registration processes, and its relations with third-party service providers.
  - Addressing labour market shortages.
- OFC provided information about other health regulatory colleges that adopted initiatives that facilitate the registration of internationally educated health professionals.
- College staff have continued to meet with OFC staff to discuss a proposed action plan.

Touchstone Institute

- Touchstone Institute reported that there were 18 examinees for the 2025 IGOEE with no candidates scoring high enough to challenge the OEBC exam directly; nine candidates requiring remediation; and another nine who were not OEBC exam eligible.

Optometry Examining Board of Canada

- The College provided OEBC with the 2025-member contribution following the March 7, 2025, Council decision to provide OEBC with member contribution for 2025 and a loan to be solely used to maintain a robust and defensible entry-to-practice exam.
- Following the receipt of a draft loan agreement from OEBC, the draft agreement was reviewed by the College's legal counsel and provided to the College's Audit/Finance/Risk Committee for review.
- The Registrar is awaiting OEBC's policy on what constitutes financial stability (which would trigger the commencement of the repayment of the loan) to review and approve, before signing the loan agreement.

National Board of Examiners in Optometry

- Following the March 7, 2025, Council decision to sunset the NBEO exam, the College of Health and Care Professionals of BC made a similar decision on March 14, 2025.
- The College President and Vice President worked with KMK Optometry, a company that provides exam preparatory courses for entry-to-practice exams, which offered to switch students signed up for an NBEO preparatory course to an OEBC preparatory course for a short time without penalty.

Registration Process

- There were 30 candidates registered for each of the April and May 2025 online Jurisprudence exams.
- There was a total of 94 online applications received and 19 new registrants in 2025 as of May 27. There have been six applications by internationally trained applicants and 2 applications using labour mobility since the online application portal was launched on September 1, 2023, for internationally trained, labour mobility, and Academic Certificate of Registration applicants.

Discussion Items

- The Committee discussed the following:

    - A proposed action plan associated with the OFC.
    - Candidates requesting consideration following Council's decision to sunset the NBEO exam.
    - Section of the loan agreement for OEBC; and
    - Five requests for Life Membership by retired registrants.

COLLEGE OF OPTOMETRISTS OF ONTARIO

Discipline Committee Activity Report

Reporting date: June 13, 2025

Committee Chair: Dr. William Ulakovic

Meetings in 2025: 1

Information Items

The Discipline Committee is the only committee of the College that has the authority to discipline optometrists. This authority is granted to the Committee under the *Regulated Health Professions Act, 1991* and the *Optometry Act, 1991*. When there are reasonable and probable grounds to suggest that professional misconduct has occurred, or that an optometrist may be incompetent, the Inquiries, Complaints and Reports Committee (ICRC) may refer such allegations to the Discipline Committee for a hearing.

Since its last report to Council in March 2025, the Discipline Committee has not received any new referrals from the ICRC and no reinstatement applications are currently pending.

There are 2 active matters before the Discipline Committee. In the first matter, a motion hearing took place on April 4, 2025, and the discipline hearing took place on May 15, 16, and 29, 2025. For the second matter, a pre-hearing conference was held on April 9, 2025, and the discipline hearing is scheduled for June 18, 2025.

Discussion Items

The Discipline Committee has no additional updates for Council at this time.

Decision Items

There are no Discipline Committee decisions or motions that require Council feedback or approval at this meeting.

COLLEGE OF OPTOMETRISTS OF ONTARIO

Governance-HR Committee Activity Report

Reporting date: June 13, 2025

Chair: Dr. Lisa Christian

Meetings in 2025: 2 over Zoom (most recent: May 23, 2025))

Tasks Completed Since Last Council Meeting:

- The Committee engaged in a presentation and discussion regarding topical issues related to regulatory legislation and governance (see "discussion items" below)
- The Committee reviewed feedback on the previous Council session
- The Committee selected appointees to the Discipline Committee to fill a vacancy (see "decision items" below)

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 is to review the College's governance policies and processes, and to make changes and additions where appropriate to enhance the College's governance portfolio.

Discussion Items

Registrar Update

J. Jamieson provided the group with an update on legislative and governance-related matters, including:

- "As of right" legislation, which has been passed for hospital-based professions in Ontario but is currently being planned for broader implementation, including to optometry
- The interplay between committees and Council, and the delegation and trust that is necessary for committees to perform optimally
- The function of Audit/Finance/Risk as a body that facilitates policy through financial work, as long as it is financially possible (rather than being a final approval)
- The upcoming strategic planning cycle
- Conflicts of interest and the perception of bias

Feedback on March 25 Council Session

The Group reviewed survey feedback provided by Council members on the March 2025 Council session, as well feedback on the informal discussion session that followed.

Policy on Online Meeting Decorum

The group discussed a potential policy outlining basic requirements for online meetings (for example, keeping one's video on to demonstrate actual attendance).

It was agreed that, as part of the introduction to Council meetings, the President will suggest that cameras be on for attending Council members (unless there are extenuating circumstances). A request to keep cameras on will also be part of the Zoom invitation, specifying that if this is not possible it be communicated to staff or the chair ahead of time.

Template for Executive Committee Nominations

The Committee considered the structure of a Council member's self-nomination to be considered for the Executive Committee. Currently, candidates provide their CV and then provide a verbal update on their candidacy during the meeting itself before voting occurs.

It was agreed that this structure will be changed for the Executive Committee election next year. Within the feedback survey for the June Council meeting, a new question will ask Council members what types of information (CV, bio, statement of intent, etc.) would be valuable to consider before voting. Gov-HR will consider this information at its next meeting.

Decision Items

Volunteer Appointment: Discipline Committee

The Committee considered several statements of interest from existing committee volunteers regarding a vacancy on the Discipline Committee, which needs to be filled.

After considering the statements as well as additional factors such as professional background, committee experience, etc., the group will recommend to Council that all applying volunteers who are not currently on ICRC be appointed to the Discipline Committee for the remainder of 2025.
(see "motions" below).

Motions

1. To appoint Drs. Manveen Bedi, Leah Markin, Karin Simon, and Harminder Singh to the Discipline Committee for the remainder of 2025

Attachments

NA

COLLEGE OF OPTOMETRISTS OF ONTARIO

Audit/Finance/Risk Committee Activity Report

Reporting date: June 13, 2025

Chair: Mr. Narendra Shah

Meetings in 2025: 1 Orientation + 2 regular meetings + 3 AFR Working Group – all via teleconference

Tasks Completed Since Last Council Meeting:

- The College's 2024 financial audit is substantially complete. The auditors from BDO Canada presented their findings and the draft financial statements to the Committee. It was another smooth review process, and there were no issues or concerns reported. The auditors will present the draft financial statements recommended by the Committee for Council approval at the June 13, 2025, meeting.
- Following the evaluation of the incumbent external auditors, the Committee supported the working group's recommendation to retain BDO Canada as the external auditors for 2025. A separate briefing note is being provided to Council.
- The Committee also endorses the new Finance Policy - Evaluation of External Auditors that outlines procedures for the recurring auditor's assessment.
- The financial accounts, including an update on restricted funds, for the period ending April 30, 2025, were presented to the Committee. Below are some highlights for Council's information.
- The Portfolio Manager from Royal Bank of Canada Dominion Securities (RBCDS) reported on the investment performance as of April 30, 2025. The composition of portfolio was explained, as well as current strategies following tariff announcements. Though year-to-date results were down by 1.16%, an overall growth of 8.66% was noted since July 2023.
- After deliberating on per diem rates applicable to professional Council and Committee members, as well as the President's stipend, the Committee made a recommendation which is being forwarded to Governance & HR Committee for consideration in keeping with the AFR Committee's terms of reference.
- The Committee had a chance to review and discuss the draft agreement for the loan that the Council approved extending to Optometry Examining Board of Canada (OEBC). The loan agreement which has no tax implications as confirmed by the auditors, was also reviewed by the College's legal counsel.

Key Priorities

Following the Council approval of the draft audited financial results, staff will work with the auditors in filing the 2024 corporation income tax due by June 30, 2025.

There is ongoing monitoring of potential financial and non-financial operational risks.

Information Items
The financial results for the period ended April 30, 2025, are generally in line with budget.

Highlights include:

- **$2.9M Revenue (91.7% of budget)**
  Approximately 98% of actual revenue relates to renewal fees from 2,958 registrants. As of April 30, 2025, there were 84 new applications, 35 new professional corporations, and 415 corporation renewals.

- **$1.2M Expenses (31.4% of budget)**
  Total expenses are comprised of 14% committee expenses and 86% administration expenses and were within the approved 2025 operating budget.

- **$1.6M Restricted Funds**
  Total expended restricted funds to date of $0.14M (34% of the budget) include a financial contribution to OEBC.
  An additional amount is expected to be released this year as a loan to OEBC following Council decision at its March 7, 2025, meeting.

- **$7.8M Net assets**
  Current net assets can support average expenses for 25 months based on the 2025 operating budget.

Discussion Items
- BDO Canada will present the 2024 audited financial statements for discussion with Council.
- The outcome of AFR Committee's comprehensive assessment of BDO Canada's performance as College's external auditors in the past five years, and the creation of new Finance Policy – Evaluation of External auditors.

Decision Items
The Audit/Finance/Risk Committee requests Council to approve:

1. The College's 2024 audited financial statements
2. The reappointment of BDO Canada as external auditors for 2025
3. New Finance policy – Evaluation of External auditors

Attachments
N/A

5-8 / PRESENTATIONS & MOTIONS

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

6. Presentation from the Auditors

7. Research Presentation from Drs. Tracey Adams and Sophia Myles

8. Motions Brought Forward from Committees
    a. Audit/Finance/Risk
        i. Approval of the audited financial statements for 2024
        ii. Approval of the reappointment of BDO Canada as auditors for 2025 financial accounts
        iii. Approval of the Finance Policy – Evaluation of External Auditors

    b. Quality Assurance
        i. Approval of the updated practice assessment component of the Quality Assurance Program
        ii. Approval of the updated Optometric Practice Reference (OPR)

    c. Governance/H.R.
        i. Appoint Drs. Manveen Bedi, Leah Markin, Karin Simon, and Harminder Singh to the Discipline Committee for the remainder of the 2025 Council Year

COLLEGE OF OPTOMETRISTS OF ONTARIO

BRIEFING NOTE

Council Meeting – June 2025

Subject

College's 2024 draft audited financial statements

Background

The College's auditors, BDO Canada LLP, have conducted a review of the College's 2024 financial records.

The Audit/Finance/Risk (AFR) Committee had an opportunity to formally evaluate and discuss with BDO Canada their audit findings, key elements of the audit control process, financial reporting matters, any concerns with staff and/or audit activity, and changes to reporting requirements that are relevant to the College.

BDO Canada will present the draft audit report to Council on June 13, 2025.

Decision(s) for Council

The AFR Committee recommends the approval of the College's draft audited financial statements for 2024.

Considerations

- BDO Canada has provided audit services to the College since 2020.
- The audit activities and tax filing performed by BDO Canada were consistently efficient and satisfactory.

Public Interest Mandate

An independent audit of the financial statements supports the College's commitment to transparent and accountable financial reporting.

Diversity, Equity, and Inclusion Considerations

- N/A

Supporting Materials

- Auditor's report - Draft financial statements for 2024

Next Step

- As per Section 3.10 of the College's By-Law, the results of the annual audit will be published in the College's annual report.

Contact

- Deborrah Anne Lim, Manager – Finance and Office Administration

College of Optometrists of Ontario
Financial Statements
For the year ended December 31, 2024

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Independent Auditor's Report

To the Members of College of Optometrists of Ontario

Opinion

We have audited the accompanying financial statements of College of Optometrists of Ontario (the "College"), which comprise the balance sheet as at December 31, 2024, and the statements of changes in net assets, revenue and expenditures and cash flows for the year then ended, including a summary of significant accounting policies and other explanatory information.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the College as at December 31, 2024, and its results of operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the College in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian accounting standards for not-for-profit organizations, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is responsible for assessing the College's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the College or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the College's financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Auditor's Responsibilities for the Audit of the Financial Statements (continued)

As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the College's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the College's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the College to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Chartered Professional Accountants, Licensed Public Accountants
Oakville, Ontario
June 13, 2025

College of Optometrists of Ontario
Balance Sheet

December 31	2024	2023
Assets		
Current		
Cash	**$ 535,067**	$ 746,925
Short-term investments (Note 3)	**5,780,193**	4,604,632
Accounts receivable	**31,360**	16,365
Prepaid expenses	**36,996**	45,693
	6,383,616	5,413,615
Long-term investments (Note 4)	**2,757,292**	3,167,363
Capital assets (Note 5)	**19,542**	24,292
	$ 9,160,450	$ 8,605,270
Liabilities and Net Assets		
Current liabilities		
Accounts payable and accrued liabilities	**$ 127,809**	$ 155,885
Government remittances payable	**336,175**	325,300
Deferred revenue	**2,679,353**	2,605,785
	3,143,337	3,086,970
Net assets		
Invested in capital assets	**19,542**	24,292
Internally restricted funds (Note 7)	**1,783,424**	2,083,547
Unrestricted fund	**4,214,147**	3,410,461
	6,017,113	5,518,300
	$ 9,160,450	$ 8,605,270

Approved on Behalf of the Council:

_____ President

The accompanying notes are an integral part of these financial statements.

College of Optometrists of Ontario
Statement of Changes in Net Assets

For the year ended December 31

2024	Invested in Capital Assets	Other Internally Restricted Funds	Unrestricted Funds	2024 Total
Balance, beginning of year	**$ 24,292**	**$ 2,083,547**	**$ 3,410,461**	**$ 5,518,300**
Excess (deficiency) of revenue over expenditures (Note 7)	**-**	**-**	**498,813**	**498,813**
Interfund transfers	**-**	**-**	**-**	**-**
Purchase of capital assets	**4,922**	**-**	**(4,922)**	**-**
Amortization	**(9,672)**	**-**	**9,672**	**-**
Restricted funds spending	**-**	**(300,123)**	**300,123**	**-**
Balance, end of year	**$ 19,542**	**$ 1,783,424**	**$ 4,214,147**	**$ 6,017,113**

2023	Invested in Capital Assets	Other Internally Restricted Funds	Unrestricted Funds	2023 Total
Balance, beginning of year	$ 49,746	$ 2,409,097	$ 2,838,365	$ 5,297,208
Excess (deficiency) of revenue over expenditures	-	-	221,092	221,092
Interfund transfers	-	10,903	(10,903)	-
Purchase of capital assets	2,297	-	(2,297)	-
Amortization	(27,751)	-	27,751	-
Restricted funds spending	-	(336,453)	336,453	-
Balance, end of year	$ 24,292	$ 2,083,547	$ 3,410,461	$ 5,518,300

The accompanying notes are an integral part of these financial statements.

College of Optometrists of Ontario
Statement of Revenue and Expenditures

For the year ended December 31	2024	2023
Revenue		
Annual registration fees	**$ 2,804,353**	$ 2,719,145
Professional corporation fees	**338,712**	323,414
Services and other fees and recoverables	**117,123**	18,807
	3,260,188	3,061,366
Expenditures		
Council meeting and training expense	**95,151**	86,887
Inquiries, Complaints, and Reports Committee	**33,900**	33,750
Quality Assurance Committee	**136,548**	80,585
Executive Committee	**26,175**	32,063
Stakeholder engagement	**120,125**	126,841
Discipline Committee	**20,715**	837
Registration Committee	**19,350**	21,525
Governance Committee	**10,872**	9,877
Clinical Practice Committee	**-**	2,925
Audit, Finance, Risk Committee	**4,500**	9,900
Patient Relations Committee	**1,500**	1,875
	468,836	407,065
College administration activities		
Salaries and benefits (Note 8)	**1,796,681**	1,778,939
Legal fees	**150,092**	92,538
Administration and services	**200,545**	189,522
Occupancy costs	**151,705**	159,889
IT services and maintenance	**126,528**	117,993
IT projects	**166,919**	46,975
Professional fees - consulting	**32,368**	32,668
Amortization of capital assets	**9,672**	27,751
OE tracker expense	**58,376**	56,271
Education and program delivery	**138,580**	258,688
Accounting and audit fees	**22,649**	21,470
Research	**10,175**	35,800
	2,864,290	2,818,504
Total expenditures	**3,333,126**	3,225,569
Deficiency of revenue over expenditures for the year before other income	**(72,938)**	(164,203)
Other income (expenses)		
Investment income	**277,163**	253,701
Unrealized gain on investments	**294,588**	131,594
	571,751	385,295
Net excess (deficiency) of revenue over expenditures	**$ 498,813**	$ 221,092

The accompanying notes are an integral part of these financial statements.

College of Optometrists of Ontario
Statement of Cash Flows

For the year ended December 31	2024	2023
Cash flows provided by (used in)		
Operating activities		
Excess of revenue over expenditures for the year	**$ 498,813**	$ 221,092
Adjustments for items not involving cash:		
Amortization of capital assets	**9,672**	27,751
Net unrealized gain on investments	**(294,588)**	(131,594)
Changes in non-cash working capital balances		
Accounts receivable	**(14,995)**	(7,684)
Prepaid expenses	**8,697**	2,107
Accounts payable and accrued liabilities	**(28,076)**	(37,060)
Government remittances payable	**10,875**	4,986
Deferred revenue	**73,568**	101,115
Funds in trust	**-**	(16,769)
	263,966	163,944
Investing activities		
Purchase of capital assets	**(4,922)**	(2,297)
Net increase in investments	**(470,902)**	(56,135)
	(475,824)	(58,432)
Increase (decrease) in cash during the year	**(211,858)**	105,512
Cash, beginning of year	**746,925**	641,413
Cash, end of year	**$ 535,067**	$ 746,925

The accompanying notes are an integral part of these financial statements.

December 31, 2024

1. Nature of Operations

The College of Optometrists of Ontario (the "College") was incorporated without share capital in 1963 as a not-for-profit organization exempt from taxes under the Income Tax Act. The College is a self-regulatory authority responsible for the registering (licensing) and governing of optometrists in the Province of Ontario. The College's mission is to serve the public by regulating Ontario's optometrists and uses its authority to guide the profession in the delivery of safe, ethical, progressive and quality eye care at the highest standards.

2. Summary of Significant Accounting Policies

The financial statements were prepared in accordance with Canadian accounting standards for not-for-profit organizations ("ASNPO") and includes the following significant account policies:

Short-Term and Long-Term Investments

Investments consist of guaranteed investment certificates, bonds, equities, and mutual funds. Long-term investments reflect investments that mature after the end of the following fiscal year-end or are held for long-term fund purposes. Investment income is recognized as revenue in the year in which it is earned. Gains and losses on the sale of investments are recorded as investment income when realized. For investments which have not been sold or have not matured, the unrealized gains and losses are recognized at the end of each fiscal year and are reported in the statement of revenue and expenditures.

Prepaid Expenses

Prepaid expenses are comprised of advance payments made to vendors for facility rental and membership dues, and for contracts for services to be received in the following fiscal year.

Capital Assets

Capital assets are stated at acquisition cost less accumulated amortization. Amortization is provided using the following rates and methods:

Computer hardware	- 55% diminishing balance
Furniture and equipment	- 20% diminishing balance
Leasehold improvements	- 20% straight line

Revenue Recognition

The College follows the deferral method of accounting for contributions. Restricted contributions are recognized as revenue in the year in which the related expenditures are incurred. Unrestricted contributions are recognized as revenue when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured. Investment income, which includes interest, dividend income, realized and unrealized gains, is recorded as earned.

2. Summary of Significant Accounting Policies (continued)

Revenue Recognition (continued)

Annual registration fees

Annual registration fees represent membership fees and member application fees. Fees are set annually by the Council and are recognized as revenue in the year to which they relate and when collectibility is reasonably assured. Annual registration fees received in advance of the membership year to which they relate are recorded as deferred revenue.

Professional corporation fees

Professional corporation fees represent the application fee and the related annual renewal fees to operate a profession corporation as regulated by the College. Professional corporation fees are recognized upon the successful completion of the application or renewal process.

Services and other fees and recoverables

Services and other fees and recoverables represent quality assurance, continuing education and other service fees. Revenue is recognized at the time the service has been rendered and collectibility is reasonably assured.

Internally Restricted Funds

The College maintains a number of internally restricted funds. The funds are established and managed by way of Council resolutions which designate that funds be set aside and used for specific strategic purposes. The following is a description of each of the College's internally restricted funds:

Examination fund: To set aside funding for the development of a new entry-to-practice examination.

Investigations and Hearings fund: To set aside funding to the College's Inquiries, Complaints and Reports Committee ("ICRC") and Discipline Committee for the unanticipated costs of complex investigations and hearings.

New Government Initiatives fund: To set aside funding for initiatives undertaken by the College to address the enactment of new or amended legislation and regulations.

Patient Relations fund: To set aside funding for the Patient Relations program which includes measures for preventing and dealing with sexual abuse of patients.

Public Awareness fund: To set aside funding for the enhancement of public participation and consultation in the College’s regulatory activities, and to provide priority funding to facilitate a sustainable program of public awareness and connection to the mandate of the College as described in the College Performance Measurement Framework ("CPMF") and Strategic plan.

Diversity, Equity, and Inclusion Fund: To set aside fund for building ways to pragmatically promote and reflect the principles of diversity, equity and inclusion.

2. Summary of Significant Accounting Policies (continued)

Internally Restricted Fund (continued)

Research fund: To set aside research fund that supports the public interest mandate of the College.

Staff Development and Succession Planning fund: To set aside contemporary, post pandemic professional development and technology to staff; to provide leadership development for succession planning within the College.

Strategic Plan and CPMF fund: To set aside funds to rapidly address the areas identified in the CPMF as “not” or “partially” met to meet Ministry of Health ("MOH") requirements (October 2021).

Unauthorized Practice fund: To set aside funding for unanticipated costs in pursuing legal action against unauthorized practice and dispensing.

The unrestricted fund consists of the cumulative excess of revenue over expenditures of the College less the amounts that have been internally restricted.

Financial Instruments

The College records financial instruments at fair value on initial recognition. The College subsequently measures all of its financial instruments at amortized cost except for investments, which are subsequently measured at fair value. Financial instruments are tested for impairment when changes in circumstances indicate the asset could be impaired.

Measurement Uncertainty

The preparation of financial statements in accordance with Canadian accounting standards for not-for-profit organizations requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenditures during the year. Actual results may differ from these estimates.

Contributed Services

The College uses volunteers to assist in the organization's activities. While these services benefit the College considerably, a reasonable estimate of the time spent and its fair market value cannot be made and accordingly, these contributed services are not recognized in the financial statements.

3. Short-Term Investments

	2024	2023
Cash	**$ 77,403**	$ 62,461
Fixed income and money market	**5,702,790**	4,542,171
Total	**$ 5,780,193**	$ 4,604,632

Short-term investments mature or are redeemable at various dates not exceeding 12 months within the next fiscal year. Fixed income investments include guaranteed investment certificates with interest rates ranging from 0.80% to 6.05% (2023 - 0.25% to 5.71%).

4. Long-Term Investments

	2024	2023
Fixed income	$ 1,216,361	$ 1,626,432
Canadian equities	1,150,649	1,150,649
Foreign equities	390,282	390,282
Total	$ 2,757,292	$ 3,167,363

Long-term investments mature or are redeemable at various dates exceeding 12 months. Fixed income investments include investments with effective interest rates ranging from 0.25% to 1.10% (2023 - 0.80% to 6.05%).

5. Capital Assets

			2024	2023
	Cost	Accumulated Amortization	Net Book Value	Net Book Value
Computer hardware	$ 96,361	$ 88,346	$ 8,015	$ 9,884
Furniture and equipment	111,651	100,124	11,527	14,409
Leasehold improvements	304,452	304,452	-	(1)
	$ 512,464	$ 492,922	$ 19,542	$ 24,292

6. Funds in Trust

The amount represents payments received from a member of the College subsequent to the resolution of a professional conduct ruling (such as a Discipline Committee order) arising from complaints and/or reports of sexual harassment, sexual abuse of a patient, and inappropriate professional behaviour.

	2024	2023
Balance, opening	$ -	$ 16,769
Disbursements	-	(16,769)
Balance, ending	$ -	$ -

7. Restricted Funds

December 31, 2024

	Fund												
As of December 31, 2024	**Examinations**	**Fee Stabilization**	**Investigations and Hearings**	**New Government Initiatives**	**Patient Relations**	**Public Awareness**	**Diversity, Equity and Inclusion**	**Research**	**Staff Development**	**Strategic Plan and CPMF Fund**	**Unauthorized Practice**	**Contingency for operating shortfall**	**Total**
Balance, beginning of year	$ 310,031	$ -	$ 200,000	$ 200,000	$ 39,597	$ 16,982	$ 277,213	$ 315,150	$ 79,890	$ 494,684	$ 150,000		$ 2,083,547
New allocations (Transfers from unrestricted funds)	$ 74,961	$ -	$ (50,000)	$ (95,000)	$ 23,008	$ (16,982)	$ (223,804)	$ (155,150)	$ (79,890)	$ (18,574)	$ (70,753)	$ 612,184	$ -
Spent in 2024	$ (74,991)			$ (5,000)	$ (7,605)		$ (28,409)	$ (10,000)		$ (169,870)	$ (4,247)	$ -	$ (300,123)
Balance, end of year	**$ 310,000**	**$ -**	**$ 150,000**	**$ 100,000**	**$ 55,000**	**$ -**	**$ 25,000**	**$ 150,000**	**$ -**	**$ 306,240**	**$ 75,000**	**$ 612,184**	**$ 1,783,424**

December 31, 2023

	Fund												
As of December 31, 2023	**Contingency**	**Examinations**	**Fee Stabilization**	**Investigations and Hearings**	**New Government Initiatives**	**Patient Relations**	**Public Awareness**	**Diversity, Equity and Inclusion**	**Research**	**Staff Development**	**Strategic Plan and CPMF Fund**	**Unauthorized Practice**	**Total**
Balance, beginning of year	$ 150,000	$ 270,000	$ 157,242	$ 200,000	$ 200,000	$ 46,760	$ 191,218	$ -	$ 269,281	$ 290,000	$ 488,597	$ 146,000	$ 2,409,097
New allocations (Transfers from unrestricted funds)	$ (150,000)	$ 80,000	$ (157,242)			$ 3,240	$ (91,218)	$ 300,000	$ 80,719	$ (190,000)	$ 131,404	$ 4,000	$ 10,903
Spent in 2023		$ (39,969)				$ (10,403)	$ (83,018)	$ (22,787)	$ (34,850)	$ (20,110)	$ (125,316)		$ (336,453)
Balance, end of year	**$ -**	**$ 310,031**	**$ -**	**$ 200,000**	**$ 200,000**	**$ 39,597**	**$ 16,982**	**$ 277,213**	**$ 315,150**	**$ 79,890**	**$ 494,684**	**$ 150,000**	**$ 2,083,547**

The Council approved the reallocated balance of restricted funds on December 13, 2024. A new category called 'Contingency for operating shortfall' was added, and removed 'Staff Development' and 'Public Awareness' categories.
The funds are distributed to over ten (10) categories, with overall estimated balance of $1.772M, adjusting allocation to 'Contingency for operating shortfall' based on the actual balance as of December 31, 2024. Separately, the general contingency funds are maintained following the Finance Policy - Reserve Funds.

8. Retirement Plan

The College sponsors a retirement plan covering all eligible employees. Contributions are based on a percentage of the employee's compensation. In 2021, this plan became a registered retirement savings plan ("RRSP").

9. Commitments

(a) Equipment Operating Leases

The College leases office equipment under long-term lease arrangements which require payments for the next three years as follows:

2025	$ 14,830
2026	13,190
2027	8,268
2028	2,794
	$ 39,082

(b) Premise Operating Leases

The College entered into a ten year lease agreement for their premises effective March 1, 2014, which expires February 29, 2024. The College entered into another ten year lease agreement for their premises effecitive March 1, 2024 to February 28, 2034. The monthly occupancy cost includes the base lease amount plus the College's share of property taxes and operating costs.

The minimum annual base lease payments for the next five years and thereafter are as follows:

2025	$ 68,108
2026	71,925
2027	75,744
2028	79,563
2029	83,382
Thereafter	388,265
	$ 766,987

10. Financial Instruments

The College is exposed to various risks through its financial instruments. The College has a risk management framework to monitor, evaluate and manage the principle risks assumed. The College is primarily exposed to market, interest rate, currency and liquidity risk.

Market risk
Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices, whether those changes are caused by factors specific to the individual financial instrument or its issuer, or factors affecting all similar financial instruments traded in the market. The investments in publicly traded securities exposes the College to market price risk as these equity investments are subject to price fluctuations. There has been no change in this risk assessment from the prior year.

Interest risk
Interest risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market interest rates. The College is exposed to interest rate risk through its fixed income investments. There has been no change in this risk assessment from the prior year.

Currency risk
Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates. The College is exposed to currency risk from gains and losses due to fluctuations in foreign currency exchange rates on US and international equity investments. There has been no change in this risk assessment from the prior year.

Liquidity risk
Liquidity risk is the risk that the College will not be able to meet its obligations as they come due. The College is primarily exposed to liquidity risk through accounts payable, accrued liabilities and government remittances payable. The College meets its liquidity requirements by preparing and monitoring forecasts of cash flows from operations, anticipating investing activities and holding assets that can be readily converted into cash. There has been no change in this risk assessment from the prior year.

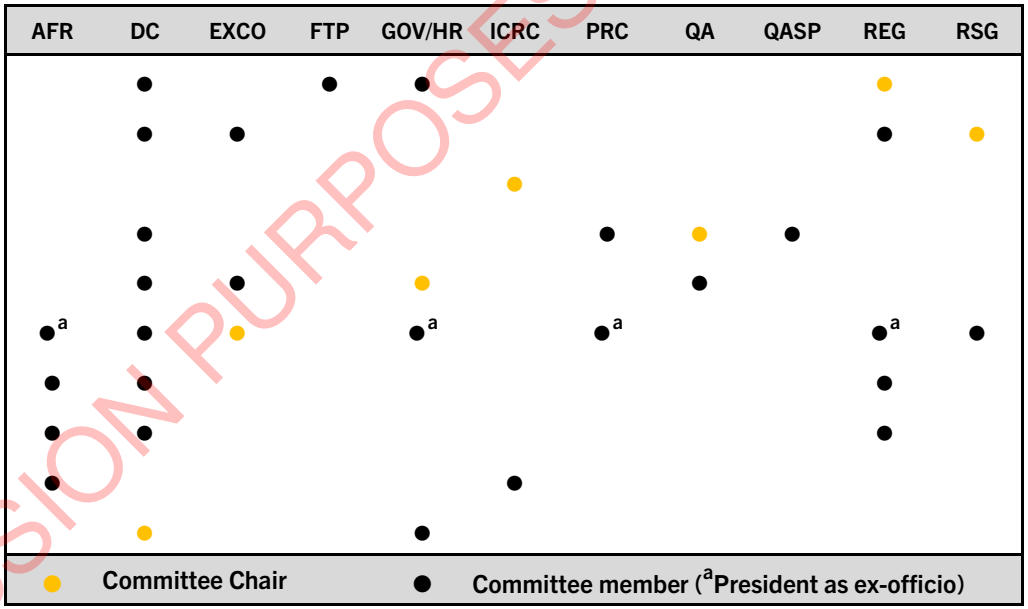
11. Comparative Figures

Certain prior year's comparative figures were reclassified to conform with the current year's financial statements presentation.

Compensation of elected Council members

In accordance with the College's honoraria policy, all elected members of Council and Committee shall be paid an honoraria (per diem and preparation time) and reimbursed for allowable expenses incurred in relation to the performance of their duties. In addition, the President receives an annual stipend approved by the Council.

Council member	Per diem	Preparation time	Total honoraria
Dr. Abraham Yuen	13,275.00		13,275.00
Dr. Camy Grewal	15,825.00		15,825.00
Dr. Dino Mastronardi	8,025.00	2,700.00	10,725.00
Dr. Kamy Morcos	14,287.50	4,125.00	18,412.50
Dr. Lisa Christian	12,825.00	3,750.00	16,575.00
Dr. Mark Eltis [1]	34,612.50	-	34,612.50
Dr. Patrick Quaid	12,000.00	300.00	12,300.00
Dr. Pooya Hemami	13,050.00	300.00	13,350.00
Dr. Richard Kniaziew	7,500.00	1,650.00	9,150.00
Dr. William Ulakovic	8,437.50		8,437.50
Grand Total	**139,837.50**	**12,825.00**	**152,662.50**



- ***The applicable per diem rate is determined by the scheduled time of the meeting, and the elected member's role in the meeting. Committee Chairs are paid at a higher rate.***
- ***Preparation time spent on reading case materials and/or decision-writing is paid on an hourly rate.***
- ***Council had six (6) sessions in 2024, plus the Annual General Meeting.***

[1] *College President and Council Chair*

The President receives an honoraria for attending committee meetings as ex-officio, engagements with stakeholders, and for participating in any other events where representation is requested by the College.

AFR	Audit/Finance/Risk (4)	**ICRC** *	Inquiries, Complaints, and Reports (8)
DC *	Discipline (4)	**PRC**	Patient Relations (1)
EXCO	Executive (4)	**QA** *	Quality Assurance (6)
FTP	Fitness to Practice (0)	**QASP**	Quality Assurance Special Projects (4)
GOV/HR	Governance HR (4)	**REG**	Registration (5)
		RSG	Research Steering Group (3)

(#) Total number of meetings in 2024

* *Statutory Committees that allow members to claim preparation time.*

COLLEGE OF OPTOMETRISTS OF ONTARIO

BRIEFING NOTE

Council Meeting – June 2025

Subject/s

- Reappointment of BDO Canada as external auditors for 2025
- Finance Policy – Evaluation of External Auditors

Background

One of the important duties of the Audit/Finance/Risk (AFR) Committee is its relationship with the College's external auditors. It is the AFR Committee that recommends to the Council the appointment of the external auditors and evaluates their performance.

On February 13, 2025, the AFR Committee formed a working group to determine whether to reappoint BDO Canada as financial auditors for 2025 or to consider a tendering process. In view of the size of the College's operations and the success of previous annual audits, the working group agreed to carry out a comprehensive evaluation of BDO Canada in its fifth audit year with the College, which aligned with the Committee's mandate.

The group identified areas of concern that are relevant to the College's operations and evaluated BDO Canada with auditor assessment tools developed by the Chartered Professional Accountants of Canada (CPA Canada). After reviewing the assessment forms completed by BDO Canada and staff, the AFR Committee supported the working group's recommendation to reappoint BDO Canada as the College's external auditors for 2025.

In conjunction with the above, the AFR Committee also endorsed the new Finance Policy for Evaluation of External Auditors. The Policy focuses on three quality audit factors such as (1) independence, objectivity, and professional skepticism, (2) quality of the engagement team, and (3) quality of communications and interactions with the external auditor. The two feedback forms appended to the policy are the same forms used in the comprehensive assessment of BDO Canada.

Decision(s) for Council

1. The approval of BDO Canada as financial auditors for 2025
2. The approval of Finance Policy – Evaluation of the External Auditors

Considerations

1. The analysis of the auditor assessment forms is summarized below:
   - The comments from BDO Canada and staff (Registrar, Deputy Registrar, and Finance Manager) are overall positive.
   - BDO Canada's thoughtful responses highlight the firm's ethics and commitment to audit quality, their knowledge of the College's operations, and the team's experience with not-for-profit organizations.

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- The audit team interacts and communicates openly with staff during the review process. Staff were satisfied with the auditor's yearly performance.
- There was no concern regarding institutional familiarity threats. Nonetheless, both the manager and audit staff have changed during the term, which in a sense, mitigate the familiarity issue.
- The discussions between the AFR Committee and BDO Canada, including the previous four annual reviews, have always been professional and efficient.
- The College's operations are non-complex, which makes it reasonable to retain BDO Canada.

2. The new Finance Policy – Evaluation of External Auditors outlines the AFR Committee's oversight responsibility in relation to monitoring the audit process and for reviewing the performance of external auditors. The guidelines in the Policy would assist the AFR Committee identify areas for improvement for the audit firm and for the Committee's own review processes.

Public Interest Mandate

Reinforcing the best practices in overseeing the work of the external auditors is in the interest of the College and the public it serves.

Diversity, Equity, and Inclusion Considerations

- N/A

Supporting Materials

- Finance Policy – Evaluation of External Auditors

Next Step/s

- Staff to communicate Council's decision to BDO Canada
- Staff to perform periodic assessments of external auditors based on the new Policy, subject to periodic review by the AFR Committee

Contact

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POLICY

Type:	FINANCE		
Name:	EVALUATION OF EXTERNAL AUDITORS		
Status:	Draft	**Version:**	1.0
Date Approved:		**Date Revised:**	

(The articles and templates developed by the Chartered Professional Accountants of Canada (CPA Canada) for organizations observing both annual and comprehensive audits were used as the basis in creating this document.)

A. PURPOSE

The purpose of this policy is to establish guidelines that will help the Audit/Finance/Risk Committee ("AFR Committee") in evaluating the performance of external auditors and identify areas for improvement for the audit firm as well as for the College's own processes.

B. INTRODUCTION

The AFR Committee of the College of Optometrists of Ontario conducts both an annual assessment of the external auditors, and a comprehensive audit assessment every five years (at minimum) prior to the reappointment of external auditors. Assessments are conducted to align with best practices. This allows the AFR Committee to provide quality improvement recommendations for the external auditor, as well as note any concerns, and recommend the external auditors for tender or reappointment.

The **annual assessment** focuses on the engagement team, the engagement partner, their independence and objectivity, and the quality of audit work performed.

The **comprehensive review** focuses on the audit firm, its independence and the application of professional skepticism. This assessment would cover not only the current audit, but also all previous audits that underwent annual assessments since the last comprehensive review.

C. ASSESSMENT GOALS

The assessment tool identifies three key factors of audit quality for the AFR Committee to consider.

1. **Independence, objectivity and professional skepticism**
   Do the auditors approach their work with objectivity to ensure they appropriately question and challenge management's assertions in preparing the financial statements?

2. **Quality of the audit team**
   Does the audit firm put forward team members with the appropriate industry and technical skills to carry out an effective audit?

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3. **Quality of communications and interactions with the external auditor**
   Are the communications with the external auditor (written and oral) clear? Is the auditor open and frank, particularly in areas of significant judgments and estimates or when initial views differ from management?

D. ASSESSMENT PROCESS

1. **Determine the scope, timing, and process**
   The AFR Committee should review the process to ensure that no alterations are required for the current year's audit. The AFR committee is expected to use and modify the tool in whatever way makes most sense to allow for effective reviews. If required, changes can be suggested at the first AFR committee meeting of the year.

   An earlier comprehensive review (before a five-year term) may be appropriate if problems have been identified, or another triggering event occurs such as a change in the entity's corporate structure.

2. **Obtain input from the College**
   The AFR Committee will require written feedback from the College staff such as the Registrar and/or Deputy Registrar, and Finance Manager for both annual and comprehensive reviews.

3. **Obtain input from the external auditors**
   An annual discussion with the auditors covers the audit results and any concerns that they wish to raise relating to the College staff, accounting records, accounting practices and internal control. The comprehensive review requires external auditors to complete a feedback survey that includes elements from annual assessments, as well as issues that may not be readily apparent in an annual review such as independence and institutional familiarity threats.

4. **AFR Committee analysis and recommendations**
   The AFR Committee concludes the assessment results and prepares a report for Council on whether to retain the current audit firm or to procure a new one.

5. **The Council reappoints the auditor or goes out to tender**
   The AFR Committee's recommendation for auditors for the following year is presented to Council for approval at its June meeting. If the procurement process is selected, this allows enough time to secure a new auditor in advance of the audit process that begins in March of the following year.

E. REVIEW OF POLICY

Changes to this policy are subject to the direction of the Council upon endorsement of the Audit/Finance/Risk Committee.

F. APPENDICES

Template for annual assessment of external auditors
Feedback form for comprehensive review – Input from External Auditors
Feedback form for comprehensive review – Input from Staff

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Points to consider during annual discussion with external auditors

Scope, timing, and process	
1	Have there been significant changes in the organization that require changes to the assessment process this year?
2	Do the results of the prior-year's assessment indicate areas that should be given particular focus this year?
3	What changes need to be made to other sections of this tool to reflect the approach to this year's annual assessment?
Input from staff	
4	To what extent is the external auditor proactive in identifying information requirements and timely in requesting information from management?
5	How were significant differences in views, if any, between management and the external auditor resolved?
6	Provide your overall views on how your relationship with the external auditor contributed to your ability to produce reliable financial reporting throughout the assessment period.
7	What additional information from the College is needed to help the AFR Committee conduct the assessment?
AFR Committee analysis	
8	Does the external auditor either confirm their independence or inform the audit Committee about matters that might reasonably be thought to compromise their independence?
9	How did the external auditor adjust the audit plan to respond to changing risks and circumstances?
10	How would you assess the external auditor's understanding of our business and industry (e.g. by demonstrating an understanding of our specific business risks, processes, systems and operations)?
11	How would you assess the external auditor's discussion about the quality of the College's financial reporting, including the reasonableness of accounting estimates and judgments, appropriateness of the accounting policies and adequacy of the disclosures?
12	How candid and complete was the dialogue between the auditor and the AFR Committee?
13	What evidence is there that the audit team challenges decisions made by management in preparing the financial statements?
14	To what extent do you have concerns about the relationship between the external auditor and College personnel that might affect the external auditor's independence, objectivity or professional skepticism?
15	How would you assess the value for money delivered by the external audit (given the size and nature of the College operations, and a cost-effective quality audit)?
16	Has sufficient information been obtained to allow the AFR committee reach a conclusion and consider the assessment complete?

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Input from external auditors

Independence, objectivity, and professional skepticism	
1	How does the audit firm maintain its integrity, objectivity, and professional skepticism throughout the audit, and/or when additional non-audit services are requested by the management?
2	How has the engagement team addressed potential risks of fraud (for example, incorporating an element of unpredictability into audit procedures during the period)?
3	What is the audit firm's approach to reviewing the computerized and manual controls over the financial reporting system, including review of the financial reporting system?
4	What steps does the engagement partner take to ensure that the engagement team exhibits the values, ethics, and attitudes necessary to support a quality audit?
5	How did the engagement team adjust the audit plan to respond to changing risks and circumstances?
6	Identify any significant observation and/or trend during the review period.
Quality of the engagement team	
1	How did the engagement partner maintain quality control over the parties performing the activities?
2	How involved was the engagement quality control reviewer (EQCR) in the audit? If EQCR were involved in the audit, did they raise specific concerns over any matters when assessing the significant judgments made by the engagement team?
3	How has the audit firm's relevant expertise in the industry and markets in which the entity operates been evolving?
4	Confirm the number of current and past not-for-profit audit clients and indicate the number of years your firm has been the auditor for each client.
5	What are the audit firm's plans to serve the entity with an engagement team with appropriate expertise?
6	How does the audit firm provide appropriate continuity of team members and perform an orderly transition when key members of the engagement team change?
7	How are the size, resources, and geographical coverage of the audit firm changing?
8	What reputational challenges, if any, are facing the audit firm and how are these being addressed?
Quality of communications and interactions with the external auditor	
1	How did the audit firm keep management informed about the progress of audit and difficulties encountered?
2	How effectively does the audit firm provide timely and informative communications about accounting and other relevant developments?
3	What area/s of the audit performance and effectiveness does the firm consider improving?
4	What institutional familiarity threats has the audit firm identified? What steps have been taken to address them?
5	How does the audit firm communicate about matters affecting the entity or its reputation, or advising management on significant matters pertaining to the firm while respecting the confidentiality of other client's information and by complying with professional standards and legal requirements?
6	What additional information the audit firm can share to help the Committee effectively conduct its own review of the financial statements?

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Input from staff

Independence, objectivity, and professional skepticism	
1	How does the external auditor demonstrate integrity, objectivity, and professional skepticism, for example, by maintaining a respectful but questioning approach throughout the audit?
2	How does the external auditor demonstrate independence, for example, by proactively discussing independence matters and reporting exceptions to its compliance with independence requirements?
3	How forthright is the external auditor in dealing with difficult situations, for example, by proactively identifying, communicating, and resolving technical issues?
4	To what extent do you have concerns about the relationship between the external auditor and entity personnel that might affect the external auditor's independence, objectivity, or professional skepticism?
Quality of the engagement team	
1	How would you assess the technical competence and ability of the external auditor to translate knowledge into practice, for example, by using technical knowledge and independent judgment to provide realistic analysis of issues and by providing appropriate levels of competence across the team?
2	How would you assess the external auditor's understanding of our business and industry, for example, by demonstrating an understanding of our specific business risks, processes, systems of operations?
3	How sufficient are resources assigned by the external auditor to complete work in a timely manner, for example, by providing access to specialized expertise during the audit and assigning additional resources to the audit as necessary to complete work in a timely manner?
4	To what extent has the engagement team consulted and used specialists on complex technical matters?
Quality of communications and interactions with the external auditor	
1	How candid and complete was the dialogue between the engagement partner and management? How well did the engagement partner explain accounting and auditing issues?
2	How effectively does the external auditor provide timely and informative communications about accounting and other relevant developments?
3	How does the audit firm communicate about matters affecting the entity or its reputation, or advising management on significant matters pertaining to the firm while respecting the confidentiality of other client's information and by complying with professional standards and legal requirements?

COLLEGE OF OPTOMETRISTS OF ONTARIO

BRIEFING NOTE

Council Meeting – June 2025

Subject

Approval of the New Practice Assessment Component of the Quality Assurance Program

Background

As part of its strategic priority to implement risk-based and proportionate regulation, the Quality Assurance Committee (QAC) has developed two new practice assessment tools in collaboration with RaECon (external consultants) and subject matter experts (SMEs). These tools are designed to enhance public safety by ensuring a more targeted and effective assessment process.

The two new tools, finalized in 2025, are:

1. **Chart Review Protocol (CRP)**; and
2. **Chart-Stimulated Recall Protocol (CSRP)**.

These will replace the existing Short Record Assessment (SRA) and Complete Record Assessment (CRA) tools. A comparison chart between the SRA/CRA and the CRP/CSRP tools and processes has been enclosed for Council reference.

Development Milestones (2023–2025)

From 2023 to 2025, several milestones were accomplished to ensure the new practice assessment is valid, defensible, and psychometrically sound, including:

- **Feasibility Study (January – February 2023):**
  - Conducted in early 2023 to identify best practices and validate the tools and processes through registrant engagement.
  - The feasibility study report has been enclosed for Council reference.

- **Cut-score Study (June – October 2023):**
  - SMEs from the QAC established the passing standard, or cut- score, for the CRP tool.
  - The cut-score study report has been enclosed for Council reference.

- **Assessor Training Sessions (2023-2025):**
  - Four CRP assessor training sessions and two CSRP assessor training sessions were held.
  - Training focused on ensuring assessor competence and minimizing inter-rater variability.
  - A registered psychotherapist also delivered training on bias mitigation and neutrality.
  - Feedback from assessors was reviewed and integrated by the QAC to refine tools and processes.

- **Platform Development (2023-2025):**
  - A user-friendly assessment platform was built within the College's existing iMIS system.
  - The platform was developed, tested, and refined based on user feedback.

- **Pre-Testing (2023 – 2024):**
  - CRP (Phase 1):
    - Involved 29 randomly selected registrants submitting 10 first-time patient records each.
    - Each registrant's set of records was independently assessed by two CRP assessors.
    - The inter-rater reliability (IRR) agreement was strong (91.6%).
    - Based on CRP results, 11 registrants were selected to participate in the CSRP, while the remaining 18 were discharged.
  - CSRP (Phase 2):
    - Of the 11 selected participants, 10 were discharged and 1 required remediation.
  - Feedback from assessors and registrants was reviewed and integrated by the QAC to refine tools and processes.
  - The pre-test report has been enclosed for Council reference.

- **Pilot Testing (2024 – 2025):**
  - CRP (Phase 1):
    - Involved 94 randomly selected registrants submitting 10 first-time patient records each.
    - Each registrant's set of records was independently assessed by two CRP assessors.
    - Based on CRP results, 32 registrants were selected to participate in the CSRP, while the remaining 62 were discharged.
    - IRR analysis showed a significant reduction in assessor disagreements compared to pre-testing.
  - CSRP (Phase 2):
    - Of the 32 selected participants, 28 were discharged, 2 required remediation, and 2 retired.
  - Feedback from assessors and registrants was reviewed and integrated by the QAC to refine tools and processes.
  - The pilot test report has been enclosed for Council reference.

- **Finalization of Assessment Process and Policy (2025):**
  - The QAC finalized the *QA Policy - Random Selection Criteria* (enclosed)
  - The QAC also finalized the random practice assessment process (flowchart enclosed).

Decision(s) for Council

Approval of the new practice assessment component of the QA Program.

Considerations

- As per the Ministry of Health, "right touch" regulation is an approach to regulatory oversight that applies the minimal amount of regulatory force required to achieve a desired outcome.
- The new assessment process exemplifies this by being:
  - Risk-based
  - Tailored to address specific identified deficiencies

- Efficient, significantly reducing registrants' time commitment.

Public Interest Mandate

This new component helps identify registrants who would benefit from improvement in skills, knowledge, and judgement—ultimately leading to safer, higher-quality patient care.

Diversity, Equity and Inclusion Considerations

- Tools and communications use plain, inclusive language.
- Assessments will be available in both English and French.
- Independent studies validated that tools are feasible, neutral, and free from bias.

Supporting Materials

1. Short Record Assessment (SRA) Tool
2. Complete Record Assessment (CRA) Tool
3. Chart Review Protocol (CRP) Tool
4. Chart-Stimulated Recall Protocol (CRSP) Tool
5. SRA/CRA versus CRP/CSRP Comparison
6. Feasibility Study Report
7. Cut-score Study Report
8. Pre-test Report
9. Pilot Test Report
10. QA Policy - Random Selection Criteria
11. Random QA Practice Assessment Flowchart

Next Steps

Upon Council approval:

- CRP and CSRP tools will be translated into French.
- Pre-implementation will include:
  - Training of College staff and College Coaches
  - Development of communication strategies (e.g., social media, emails, website)
- Official implementation is scheduled for Fall 2025.
- Post-implementation:
  - The external consultant will provide a Development and Validation Final Report for the College's records and for defensibility purposes.
  - The College will continue to collaborate with the external consultant to monitor and enhance implementation throughout the first year, incorporating any substantive feedback from registrants and assessors.

Contact

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SHORT RECORD ASSESSMENT

PATIENT	DONE/NOT APPLICABLE	OMISSION
1. Is/are the reason(s) for presenting (chief complaints) identified? (OPR 4.2, 5.1)		
2. Is the health history including the use of medications explored? (OPR 4.2, 5.1)		
3. Is the relevant family ocular health history recorded? (OPR 4.2, 5.1)		
4. Were the tissues of the anterior segment examined? (OPR 6.1)		
5. Were the tissues of the posterior segment examined (through a dilated pupil when indicated)? (OPR 6.2)		
6. Were the pupillary reflexes tested? (OPR 4.2)		
7. Were all risk factors indicating glaucoma explored (if applicable)? (OPR 4.2, 6.8, 7.2)		
8. Is the presenting monocular visual acuity at distance recorded? Is the presenting near visual acuity recorded (monocular, if indicated)?		
9. Was an appropriate measure of refraction conducted? (OPR 4.2, 6.3, 7.6)		
10. Were the monocular best-corrected visual acuities at distance recorded? (OPR 4.2)		
11. Were all appropriate measures of binocularity carried out at distance and near? (OPR 4.2, 6.7)		
12. Does the record show that the member diagnosed or addressed all problems evident in the case history and basic examination, when indicated? (OPR 5.1)		
Please provide the Committee with specific comments that you believe are critical to this file that has not been captured by the above questions.		

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COMPLETE RECORD ASSESSMENT

	Done D	Omission O	Serious Omission S	Not Applicable	Illegible I
Year of Birth					
Gender					
1. Case History (OPR 4.2, 5.1)					
1.1 Is there enough information on the file to identify and contact the patient? e.g., name, address, telephone number(s).					
1.2 Is the patient file clear as to the dates of every patient visit?					
1.3 Is it possible to tell the eye(s) and date that any documents appended to the record relate to?					
1.4 Is/are the reason(s) for presenting (chief complaints) identified?					
1.5 Is/are the reason(s) for presenting and/or other symptom(s) explored?					
1.6 Is the previous eye care history explored?					
1.7 Is the use of visual appliances explored? *(If contact lenses are used, please complete Section 7C)*					
1.8 Is the personal history of ocular disease/trauma explored?					
1.9 Is the health history including the use of medications and allergies to medications explored?					
1.10 Is the relevant family ocular health history recorded?					
1.11 Are the visual demands evident?					
2. Ocular Health Assessment (OPR 4.2, 6.1, 6.8, 7.2) *Were the following examined when indicated by the OPR:*					
2.1 The external eye and adnexa?					
2.2 The tissues of the anterior segment?					
2.3 The tissues of the posterior segment?					
2.4 The macular area?					
2.5 The tissues of the eye through a dilated pupil?					
2.6 The pupillary reflexes tested?					
Is the following information quantified appropriately for the specific patient when indicated by the OPR:					
2.7 Disc topography?					
2.8 Retinal vasculature?					
2.9 Depth of the anterior chamber					
2.10 The intra-ocular pressure?					
2.11 Central Corneal Thickness?					
2.12 Visual field results including test parameters?					
2.13 Does the record identify pharmacological agent(s) used, i.e., drug, concentration, and dosage?					

2.14 Is it possible to tell the appearance of any physical anomalies to such a degree that future changes could be detected? (Are there appropriate indications of scale and position in the eye or adnexa?)					
3. Refractive and Accommodative Assessment (OPR 4.2, 6.3, 7.6) *(when indicated by the OPR)*					
3.1 Is the presenting monocular visual acuity at distance recorded?					
3.2 Is the presenting monocular visual acuity at near recorded, if indicated?					
3.3 Was refractive status determined?					
3.4 Were the monocular best-corrected visual acuities at distance recorded?					
3.5 Were corneal curvatures measured?					
3.6 Was the accommodative system investigated, if indicated?					
3.7 Was a cycloplegic exam performed?					
3.8 Is it possible to tell from the record the focal power for any spectacle lenses is use?					
4. Oculo-Motor/Sensory Assessment (4.2, 6.7) *Is it possible to tell the following from the record when indicated by the OPR:*					
4.1 Whether the patient was strabismic or non-strabismic?					
4.2 The magnitude **and** direction of any distance horizontal phoria of a non-strabismic patient as measured by one or more methods, e.g., alternating cover test, vonGraefe, or Maddox rod? **OR** the magnitude, direction, frequency **and** laterality at distance of a strabismus?					
4.3 The magnitude **and** direction of any near horizontal phoria of a nonstrabismic patient as measured by one or more methods, e.g., alternating cover test with prisms, vonGraefe, Maddox rod? **OR** the magnitude, direction, frequency **and** laterality at near of a strabismus.					
4.4 The motor fusion limits (prism to blur or break) at distance?					
4.5 The motor fusion limits (prism to blur or break) at near					
4.6 The vertical phoria?					
4.7 The colour vision status?					
4.8 The contrast sensitivity?					
4.9 The stereoacuity?					
4.10 The sensory fusion status?					
5. Professional Judgment/Case Management (OPR 5.1) *As an aid to your analysis of this aspect of care, study the case history and findings and list all significant problems that you can identify. Consider the information available from previous examinations, where necessary.*					
5.1 Does the record show that the member investigated and diagnosed all problems evident in the case history?					

5.2 Does the record show that the member assessed and diagnosed all problems evident in the basic examination?					
5.3 Does the record show an appropriate management plan/patient counselling? (This may include patient education, further diagnostic assessment, optometric treatment, or referral.)					
5.4 In cases where a refractive correction was prescribed, can you find adequate support for the distance prescription?					
5.5 In cases where a refractive correction was prescribed, can you find adequate support for the near prescription?					
5.6 If a consultation/referral has been noted as necessary, has the member arranged the appointment and ensured that the reason(s) for referral/consultation and the relevant clinical information are conveyed to the second practitioner?					
TREATMENT SERVICES					
6. Spectacle Treatment (OPR 6.4, 6.6, 6.7) *Is it possible to tell from the patient record:*					
6.1 What information was provided to the laboratory, if the member provided spectacle therapy? Was appropriate or relevant specification provided to the laboratory if member provided spectacle therapy?					
6.2 If a prescription for spectacles was issued?					
6.3 Indications for use of appliance, e.g., constant, distance only, near only?					
6.4 In cases where the member provided spectacle treatment, does the record show the results of verification of all relevant specifications noted above?					
7A. Contact Lens Diagnosis (New Fits) (OPR 6.5)					
7A.1 Was information gathered for the purpose of contact lens consultation, i.e., previous wear, allergy, vocational and avocational requirements, medications, and any other related factors that might affect contact lens performance?					
7A.2 Was information gathered on the physical characteristics of the eye and adnexa, i.e., cornea, conjunctiva, tear film, etc.?					
7B. Contact Lens Treatment (OPR 6.5) *(Delivery of new contact lenses)*					
7B.1 Is it possible to tell from the patient file exactly what lenses had been ordered for the patient?					
If so, were the following parameters specified for the lenses: (OPR 6.5) (*Where certain parameters are "standard" and available from the manufacturer, their recording could be considered "not applicable")*					
7B.2 Does the record show that the patient was counselled regarding contact lens wear?					

7B.3 Are the care products recommended for use evident from the record?					
7C. Ongoing Care for Contact Lenses (OPR 6.5) *In progress evaluations for a new case or in monitoring of an established case, was it evident that case history, monitoring and, where necessary, modification was adequate to determine that there was:*					
7C.1 satisfactory wearing time?					
7C.2 acceptable comfort with lenses in place?					
7C.3 compliance with recommendations on lens handling, care and wearing time?					
7C.4 adequate refractive correction?					
7C.5 satisfactory spectacle acuity?					
7C.6 no significant change to the ocular surfaces from the baseline?					
7C.7 satisfactory contact lens condition and fitting characteristics?					
7D. Contact Lens Problem Solving (OPR 6.5) *In cases in which there were problems with contact lens wear, does the record show:*					
7D.1 identification and adequate exploration of the problem(s) presented by the patient?					
7D.2 collection of adequate and appropriate clinical information?					
7D.3 analysis of the symptoms and findings to determine the status of the problem being followed?					
7D.4 an outline of the treatment plan?					
8. Vision Treatment (OPR 6.7) *(Vision training or orthoptics subsequent to binocular vision work-up and prescription of a treatment plan)*					
8.1 Is it possible to tell from the record the treatment procedures carried out at each session?					
8.2 Were periodic assessments of the function(s) undergoing treatment carried out?					
8.3 Does the record show that testing to enable decisions about intensification, alteration or termination of treatment was done?					
9. Low Vision Treatment (OPR 6.8) *(Subsequent to initial diagnostic evaluation and prescription of a treatment plan)*					
9.1 Is it possible to determine from the record the exact appliance(s) provided to the patient?					
9.2 Are the appliances generally accepted as effective for the identified needs?					
9.3 Does the record show that training in the use of any appliances was given?					
9.4 Was follow-up arranged to determine the efficacy of treatment?					

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Chart Review Protocol

Chart ID#: _____ Chart Review # _____ **Date and Time of Patient Visit: _____**
Year of Patient Birth: _____ **Gender: _____**

Note to Assessors:

This Chart Review Protocol is dependent on your clinical judgement with the Standards of Practice in the Optometric Practice Reference (OPR) as your guide. In assigning your score, refer to the relevant standards, which are noted for you. If you are assigning scores of 1 (Partially Met) or 0 (Unmet), your comments are important sources of information for the registrant, the College's QA Committee, and for a possible subsequent assessment by a different assessor, using the Chart Stimulated Recall protocol.

Rating Scale Definitions:

Met (Score of 2)	Most elements of the standard for care and related competency are evident and deficiencies, if any, are minor.
Partially Met (Score of 1)	Some elements of the standard for care are lacking, but the likelihood of adverse patient outcomes is low.
Unmet (Score of 0)	Many elements of the standard for care are lacking or patient outcomes could be adversely affected.

PATIENT Initials: _____	Met (2)	Partially Met (1)	Unmet (0)	Assessor's Comments
Standard: Patient Record **Competency: Clinical Expertise- Documentation**				
1. Reason(s) for presenting chief complaint (s) identified (if any) (OPR 4.2, 5.1)				
2. Health history (ocular and systemic) including the use of medications and allergy information explored (OPR 4.2, 5.1)				
3. Relevant family ocular health history recorded (OPR 4.2, 5.1)				
4. Record shows that the member diagnosed, addressed, and properly managed all chief complaints and patient needs with respect to the findings in the case history and basic examination (OPR 5.1)				
Standard: Examination and Care of Specific Diseases **Competency: Clinical Expertise – Examinations and Judgement**				
5. Presenting monocular visual acuity at distance recorded. The presenting near visual acuity recorded (monocular, if indicated) (OPR 4.2, 5.1, 7.1)				
6. Sufficient BV testing to allow basic diagnosis and if appropriate referral of cases of binocular vision dysfunction or oculomotor dysfunction (OPR 4.2, 6.7)				
7. Monocular BCVA at distance recorded (OPR 4.2)				
8. An appropriate measure of refraction conducted (e.g., cycloplegia when indicated) (OPR 4.2, 6.3, 7.6)				

PATIENT Initials: _____	Met (2)	Partially Met (1)	Unmet (0)	Assessor's Comments
9. Pupillary reflexes tested (OPR 4.2)				
10. Tissues of the anterior segment examined (OPR 6.1)				
11. Intraocular pressure measured and documented, if indicated, and clinically practicable (OPR 4.2)				
12. Optic nerve head assessed according to standard of care (e.g., C/D ratio) (OPR 6.2)				
13. Other tissues of the posterior segment examined (through a dilated pupil if indicated) (OPR 6.2)				
14. Given all clinical information, further investigations for glaucoma were initiated (if applicable) (OPR 4.2, 6.8, 7.2).				
15. Given all clinical information, further investigations for retinal disorders (such as AMD, diabetic retinopathy etc.) were initiated (if applicable) (OPR 4.2, 6.8, 7.1, 7.4)				
16. Prescribed spectacle and/or contact lens therapy, and recommended additional treatment as indicated (e.g., vision therapy, dry eye therapy etc.) (OPR 6.3, 6.4, 6.5, 6.6, 6.7)				
Standard: The Prescription **Competency: Communication**				

PATIENT Initials: _____	Met (2)	Partially Met (1)	Unmet (0)	Assessor's Comments
17. Driver's license restriction reported to the Ministry of Transportation, if indicated (OPR 5.1)				
18. Final prescription(s) clearly stated and is legible (OPR 5.2)				
Standard: Use and Prescribing Drugs in Optometric Practice **Competency: Patient-Centered Care**				
19. Common adverse effects that different medical conditions and medications (prescribed by OD) may have on the eye and vision system identified and communicated to the patient (OPR 4.4)				
Standard: Collaboration and Shared Care **Competency: Collaboration**				
20. Appropriate healthcare professional(s) for patient referred and consulted, including other optometrists. (OPR 4.8)				
Total Score		**/40**		**Recommendation:** **Chart-Stimulated Recall** **No** **Yes**

Please provide the Committee with specific comments that you believe are critical to this chart review that have not been captured by this Chart Review Protocol.

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Chart Stimulated Recall Protocol

Case ID#: _____ **Patient File # _____** **Date and Time of Patient Visit: _____**

Year of Patient Birth: _____ **Patient Initials: _____** **Gender: _____**

INSTRUCTIONS TO ASSESSORS

In **Section A**, please ask the member all three questions.

In **Section B**, using the summary information from the previously completed Chart Review Protocol as a guide, select the appropriate questions from the list to guide your discussion. Some questions may not be relevant to the particular chart(s) you are discussing; you will need to modify accordingly.

The questions or prompts should be asked in a non-judgmental, non-biased approach. Advice and feedback may be provided to the member throughout the discussion. This assessment process is remediative.

The **Section C** questions are posed for the member's reflection.

In **Section D**, provide the member with recommendations for up to 3 key actionable areas for remediation.

[Instructions on how to submit the form when completed.]

Using the questions below, discuss with the member, their thinking about patient care. Write your comments for feedback in the Assessor's Comments column.

SECTION A: OVERALL CASE DISCUSSION

General Questions	Assessor's Comments
1. Briefly (in a couple of sentences) tell me about this patient and their chief complaint.	
2. What can you tell me about any further relevant background information in this case?	
3. Please recall your diagnostic decision-making for this patient and whether there was anything unique about this patient that influenced your decision making.	

SECTION B: Specific Discussion based on areas identified in the Chart Review process. Using the appropriate questions below, discuss with the member the specifics of the chart that prompted this further assessment.

Questions by Standard and Competency	Assessor's Comments		
Standard: Patient Record **Competency: Clinical Expertise- Documentation**			
1. Reason(s) for presenting chief complaint (s) identified (if any) (OPR 4.2, 5.1) *a. Please tell me about the presenting information that led you to this diagnosis.* *b. Were there any other diagnoses that you considered but ruled out? If yes, what were they and how did you deal with this?*		Satisfactory ☐	Unsatisfactory ☐
2. Health history (ocular and systemic) including the use of medications and allergy information explored (OPR 4.2, 5.1) *a. What questions did you ask related to the health history of the patient including the use of medications and allergy information?* *b. Is there anything about this patient's health history you wish you knew more about?*		Satisfactory ☐	Unsatisfactory ☐

3. Relevant family ocular health history recorded (OPR 4.2, 5.1) *a. Describe how you collected and recorded the family ocular health history of the patient.* *b. What additional information (if any) did you wish you had about this patient's family health?*		Satisfactory ☐	Unsatisfactory ☐
4. Record shows that the member diagnosed, addressed, and properly managed all chief complaints and patient needs with respect to the findings in the case history and basic examination (OPR 5.1) *a. What questions did you ask related to this patient's chief complaint(s).* b. *What was the rationale for your diagnostic decision making?*		Satisfactory ☐	Unsatisfactory ☐

Standard: Examination and Care of Specific Diseases **Competency: Clinical Expertise- Examinations and Judgement**			
5. Presenting monocular visual acuity at distance recorded. The presenting near visual acuity recorded (monocular, if indicated) (OPR 4.2, 5.1, 7.1) *a. What was your rationale for not recording the examination or measurement of the visual acuity?* *b. (Probe, if necessary) What was your rationale for not recording the determination after examination? e.g., for presbyopia, if needed?*		Satisfactory ☐	Unsatisfactory ☐

6. Sufficient BV testing to allow basic diagnosis and if appropriate referral of cases of binocular vision dysfunction or oculomotor dysfunction (OPR 4.2, 6.7) *a. How did you test for binocular vision dysfunction?* *b. What factors led to your decision about referring this case to other health professionals (if relevant)?*		Satisfactory ☐	Unsatisfactory ☐
7. Monocular BCVA at distance recorded (OPR 4.2) *a. Describe how you measured BCVA at distance.* *b. (Probe, if necessary) What was your rationale for not recording the examination of BCVA?*		Satisfactory ☐	Unsatisfactory ☐
8. An appropriate measure of refraction conducted (e.g., cycloplegia when indicated) (OPR 4.2, 6.3, 7.6) *a. What techniques were used to assess the refractive status of the eye?* *b. (Probe, if necessary) What was your rationale for not documenting this status?*		Satisfactory ☐	Unsatisfactory ☐

9. Pupillary reflexes tested (OPR 4.2) *a. How did you test for pupillary reflexes?* *b. (Probe, if necessary) What was your rationale for not documenting these tests?*		Satisfactory ☐	Unsatisfactory ☐
10. Tissues of the anterior segment examined (OPR 6.1) *a. Describe how you examined the tissues of the anterior segment.* *b. (Probe, if necessary) What was your rationale for not documenting this examination?*		Satisfactory ☐	Unsatisfactory ☐
11. Intraocular pressure measured and documented, if indicated, and clinically practicable (OPR 4.2) *a. What techniques were used for measuring intraocular pressure?* *b. (Probe, if necessary) What was your rationale for not documenting this measurement?*		Satisfactory ☐	Unsatisfactory ☐

12. Optic nerve head assessed according to standard of care (e.g., C/D ratio) (OPR 6.2) *a. Describe how you measured C/D ratio.* *b. (Probe, if necessary) What was your rationale for not recording this ratio?*		Satisfactory ☐	Unsatisfactory ☐
13. Other tissues of the posterior segment examined (through a dilated pupil if indicated) (OPR 6.2) *a. What techniques were used in the examination of the tissues of the posterior segment?* *b. (Probe, if necessary) What was your rationale for not documenting this measurement?*		Satisfactory ☐	Unsatisfactory ☐
14. Given all clinical information, further investigations for glaucoma were initiated (if applicable) (OPR 4.2, 6.8, 7.2) *a. Describe how you assessed all the risk factors when glaucoma is indicated or suspected.*		Satisfactory ☐	Unsatisfactory ☐

15. Given all clinical information, further investigations for retinal disorders (such as AMD, diabetic retinopathy etc.) were initiated (if applicable) (OPR 4.2, 6.8, 7.1, 7.4) a. *Describe how you assessed all the risk factors related to retinal disorders.*		Satisfactory ☐	Unsatisfactory ☐
16. Prescribed spectacle and/or contact lens therapy, and recommended additional treatment as indicated (e.g., vision therapy, dry eye therapy etc.) (OPR 6.3, 6.4, 6.5, 6.6, 6.7) a. *What factors did you consider that led to the prescribed spectacle and/or contact lens therapy?* b. *What factors led to the recommendation of the additional treatment?*		Satisfactory ☐	Unsatisfactory ☐

Standard: The Prescription **Competency: Communication**			
17. Driver's license restriction reported to the Ministry of Transportation (if indicated) (OPR 5.1) a. *What factors led to your decision about reporting or not reporting a driver's license restriction to the Ministry of Transportation?* b. *How did you counsel the patient regarding this restriction?*		Satisfactory ☐	Unsatisfactory ☐

18. Final prescription(s) clearly stated and is legible (OPR 5.2) *a. How did you review the details of the prescription with the client?* *b. What were the factors that led to the determination of the final prescription?*		Satisfactory ☐	Unsatisfactory ☐

Standard: Use and Prescribing Drugs in Optometric Practice **Competency: Patient-Centered Care**			
19. Common adverse effects that different medical conditions and medications (prescribed by OD) may have on the eye and vision system identified and communicated to the patient (OPR 4.4) *a. Describe how you identified any possible risks or side effects that may apply to this patient in relation to their care.* *b. How were these adverse effects or risks explained to the patient?*		Satisfactory ☐	Unsatisfactory ☐

Standard: Collaboration and Shared Care **Competency: Collaboration**			
20. Appropriate healthcare professional(s) for patient referred and consulted, including other optometrists. (OPR 4.8) *a. Did you collaborate with other health professionals regarding this patient's care?* *b. What was the nature of the discussion? For example, what was discussed and at what level of detail?* *c. How did you decide whether to refer to another healthcare professional and which professional(s) did you consult?*		Satisfactory ☐	Unsatisfactory ☐

SECTION C: REFLECTION ON THE CASE

Overall Questions	**Assessor's Comments**		
Take a moment to reflect on this patient's case. If seeing this patient again: *a. Is there anything in your examination, case management and recording you would do differently?* *b. Is there a question you wished you had asked or a topic you wished you had discussed?*		Satisfactory ☐	Unsatisfactory ☐

SECTION D: FEEDBACK AND RECOMMENDATION(S)

Provide succinct verbal feedback to the member. Highlight areas of strength and opportunities for improvement or ongoing (further?) support.

General Comments/Impressions:

1. **Areas of Strength:**

2. **Areas Requiring Ongoing Professional Education or Support:**

3. **Up to Three Recommendations for Remediation:** **Timeline for Completion:**

   1)

   2)

   3)

RECOMMENDATION(S): Further Remediation **YES** ☐ **NO** ☐

Short Record Assessment (SRA) versus Chart Review Protocol (CRP)

Key Items	SRA	CRP
Purpose	Screening tool to help identify registrants whose practice may require further review or clarification	Same
Number of Questions/Indicators of Quality Care	12	20
Require submissions	• 10 first-time patient records • Practice Assessment Questionnaire	Same
Assessed By	QA Assessor trained in conducting SRA and CRA	QA Assessor specifically trained in conducting CRP
Content Development	• Over 20 years ago, based only on standards of practice • Limited revisions made over the years	• Based on OPR Standards of Practice, Competencies for Optometry, literature, risk data from College sources, and input from subject matter experts • Competency-based assessment that is more thorough and objective than the SRA • Examples of new competencies being assessed: communication, patient-centered care, and collaboration
Scoring	Qualitative: “Done/Not Applicable” or “Omission”	Quantitative: a scale of 0 to 2
Validity and Defensibility	Insufficient data	Valid, defensible, and psychometrically sound

CRP Ratings

The CRP assessor must rate each indicator according to the scores below:

Score	Definition
Met (Score of 2)	Most elements of the standard for care and related competency are evident and deficiencies, if any, are minor
Partially Met (Score of 1)	Some elements of the standard for care are lacking, but the likelihood of adverse patient outcomes is low
Unmet (Score of 0)	Many elements of the standard for care are lacking or patient outcomes could be adversely affected.

CRP Passing Standard/Criteria

A cut-score study was conducted with SMEs to determine the passing standard/criteria, or cut score, for the new CRP tool. The cut score was determined through a rating process called the (modified) Angoff Method. The study resulted in a two-part quality standard (i.e., the two criteria below must be met to indicate quality care):

1. All 10 patient records meet the cut score of 31/40;

   AND

2. The 4 indicators below must be "met" (i.e., score of 2). These are called "critical competencies":

   i. #7: Monocular BCVA at distance recorded (OPR 4.2)

   ii. #11: Intraocular pressure measured and documented, if indicated, and clinically practicable (OPR 4.2)

   iii. #12: Optic nerve head assessed according to standard of care, if indicated (e.g., C/D ratio) (OPR 6.2)

   iv. #13: Other tissues of the posterior segment examined (through a dilated pupil if indicated) (OPR 6.2)

CRP Reports Review

At Panel meetings, the CRP reports will be divided as follows:

1. **Consent Agenda**: CRP reports that have met the two-part quality standard.
2. **Requires Review**: CRP reports that have failed to meet one or both of the two-part quality standard.

After reviewing the CRP Reports, the Panel may decide to:

1. Discharge with or without reminders;
2. Request for clarifications from the registrant and/or CRP assessor before decision; or
3. Escalate to Chart-Stimulated Recall Protocol (CSRP).

Complete Record Assessment (CRA) vs. Chart-Stimulated Recall Protocol (CSRP)

Key Items	CRA	CSRP
Purpose	For registrants with deficiencies identified via the screening tool	Same
Patient Records Assessed	All 10 records	QAP selects a few records (1-2) to be reviewed
Assessed by	QA Assessor trained in conducting SRA and CRA	QA Assessor specifically trained in conducting CSRP
Number of Questions/Indicators of Quality Care	76 questions/record	Significantly less. Tailored/individualized based on identified deficiencies
Format	Record assessment	Conversation-based assessment
Areas Assessed	• Different from the SRA tool • Quite broad • Does not focus on specific areas of deficiencies identified in the SRA	• Same 20 indicators as the CRP • Using the CRP report and feedback from QAP as a guide, the assessor selects appropriate questions from the CSRP tool to guide discussion • 2-3 “probe” questions for each indicator • Flexible some probe questions may not be relevant to the records discussed. Assessors can modify accordingly

Timing/Reporting	• After the CRA is completed, it is assigned to a professional member of the QAP. The professional member reviews the CRA report and patient files (as needed) and completes a Case Manager Report (CMR) • QAP reviews the CRA report and the CMR. May require clarifications from registrant/assessor • Lengthy, inefficient	• CSRP report reviewed by the QAP • Authentic, effective, and efficient

Conversational Approach

After reviewing the CRP report, the Panel may direct the registrant to undergo a CSRP. The Panel would identify specific areas of concern and select a few of the original records (usually 1-2) that need to be further explored.

CSRP uses a conversational approach to assessment and is conducted virtually between the CSRP assessor and the registrant.

The CSRP assessor uses the CRP report, selected records, and feedback from the Panel to stimulate discussion. The assessor probes the registrant's thinking to find out more than what is on the record. For example, "Can you walk me through your rationale for this part of the exam? What other factors did you consider when making these decisions?" This tool is also flexible as the CRSP assessor can modify the probe questions as needed.

This approach also provides the registrant with an opportunity to reflect and articulate their process of decision-making and rationale. This is often difficult to express through writing, which may also be interpreted differently depending on who the reader is.

The CSRP assessor summarizes their findings in a report, which goes to the Panel for review. The CSRP assessor will also provide recommendations for the next step in the report to help with Panel decision making.

A New Practice Assessment Component of the College of Optometrists of Ontario's Quality Assurance Program

Feasibility Survey Results Summary Report

February 28, 2023

Prepared by:
A. Sidiq Ali, PhD CE Managing Director
Cheryl Backlund, MEd Senior Associate

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Survey Engagement Metrics

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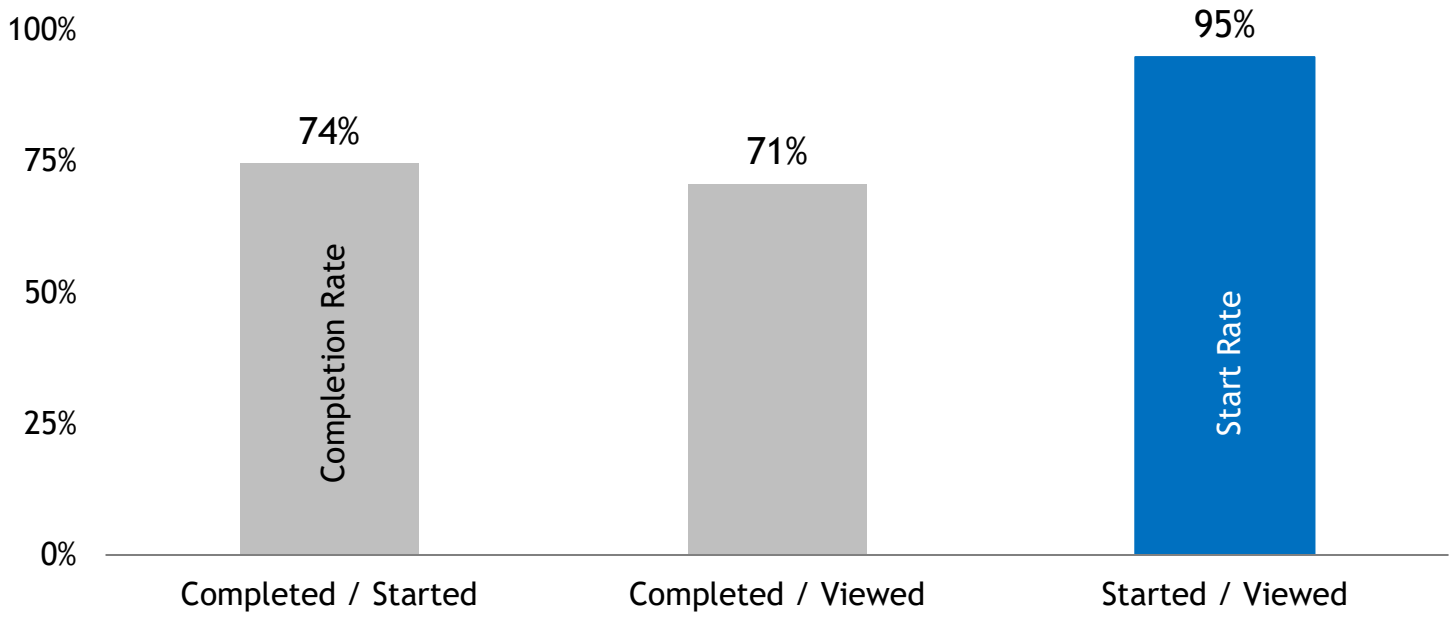
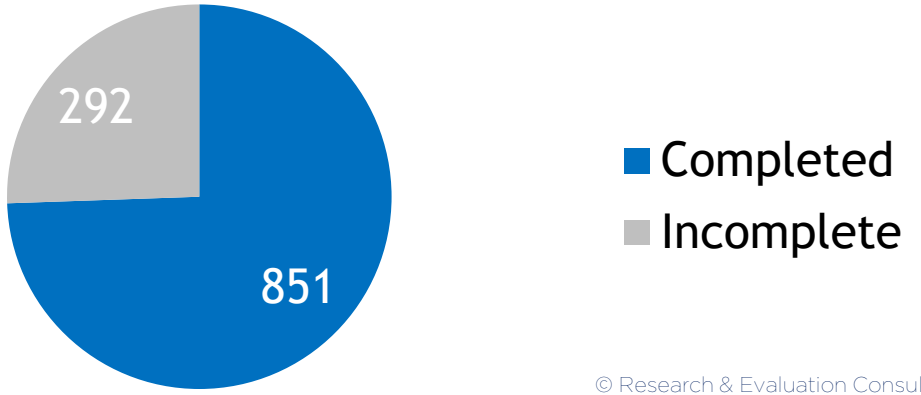
Of the ODs who viewed the survey, almost all **(95%) started** it.



About **three-quarters** of those who started the survey, **completed** it.



Survey Engagement Metrics

COLLEGE OF OPTOMETRISTS OF ONTARIO

1,143/2809 members (41%) opined on the new PA via the survey

851/2809 members (30%) completed the survey

Average completion time was 7 minutes

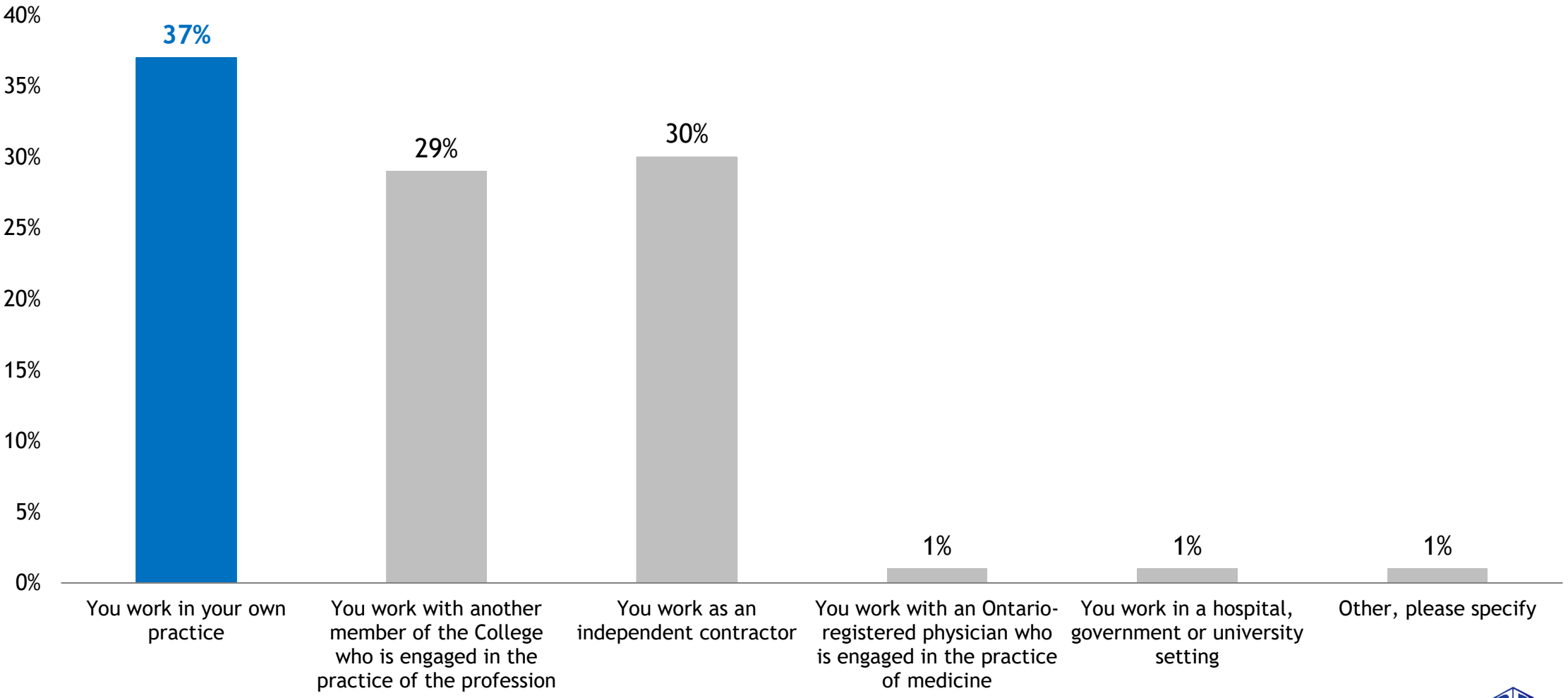
Methodology

An electronic survey was distributed via a link by the College to its members on January 27th. The survey closed at 12:15am on February 11th.

Question by Question Results

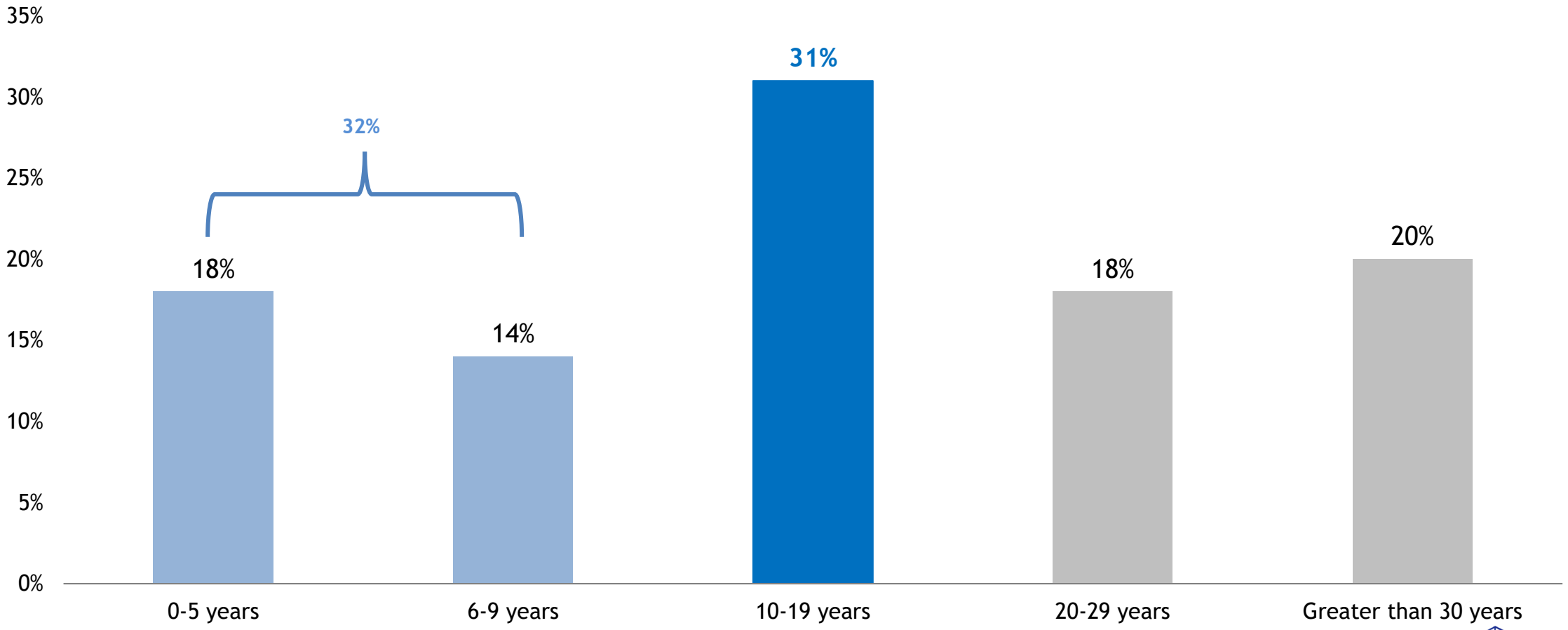
What type of setting best describes your practice? Please select the best answer.

The greatest proportion of respondents **(37%)** indicated they **work in their own practice**.



How many years have you been in practice?

The greatest proportion of respondents indicated they have been in practice for **10-19 years**, and about another **one-third** indicated they had been in practice for **9 years or less.**



In which of the following regions is your practice located?

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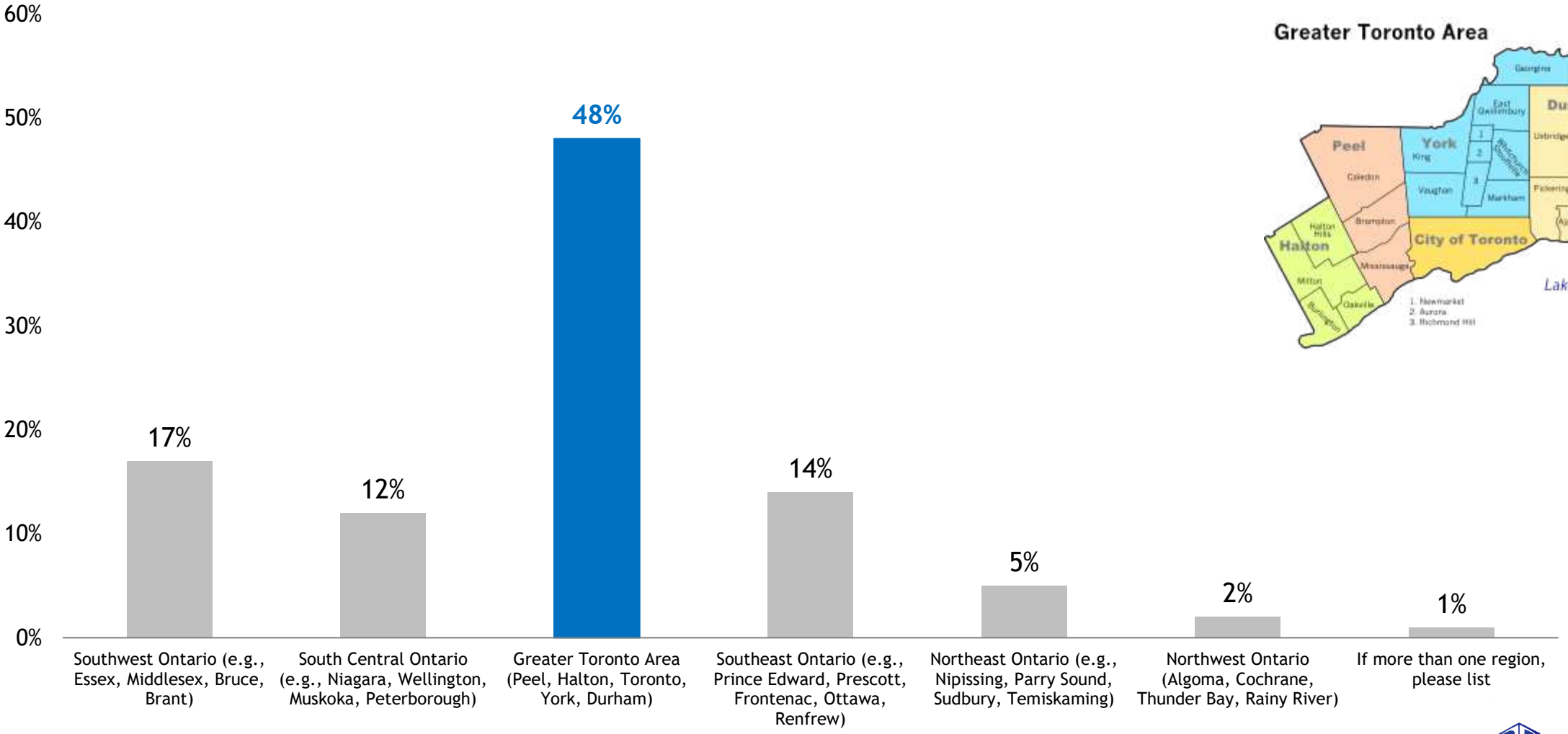
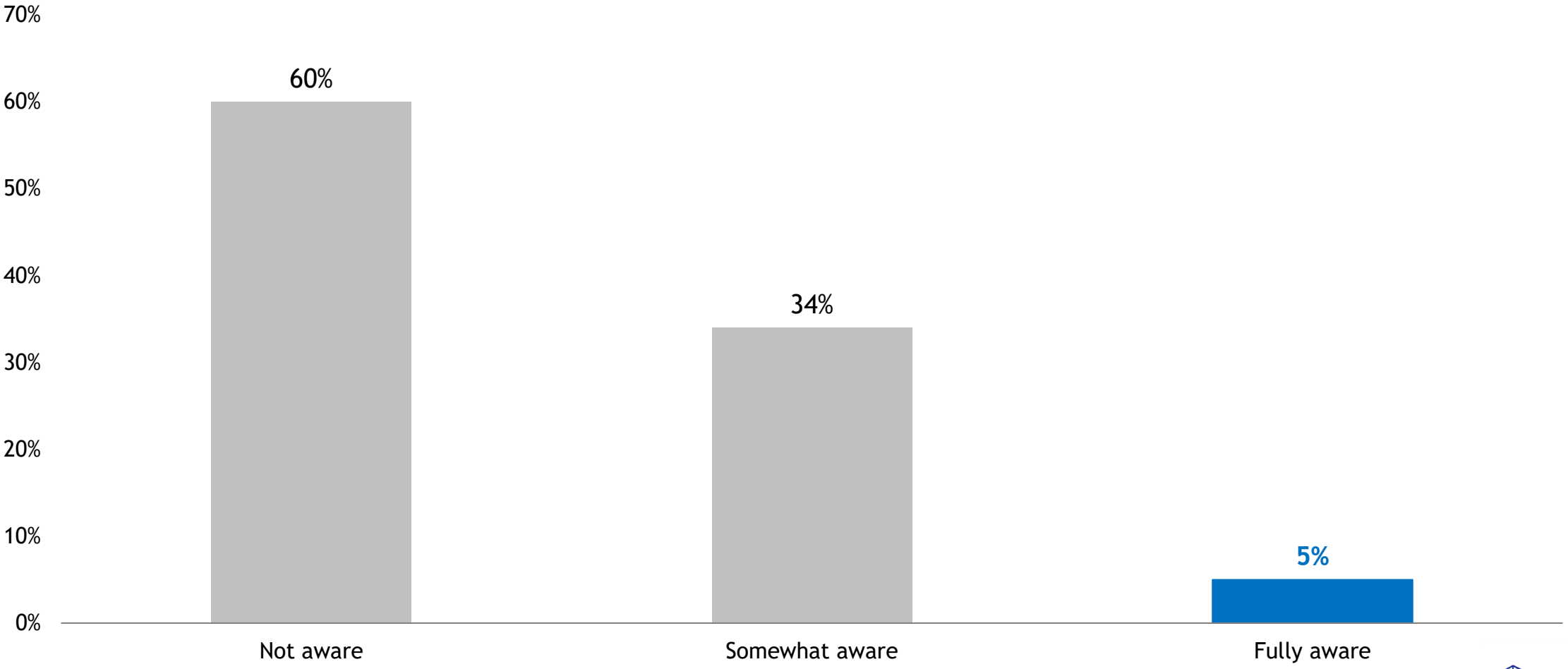
Almost half (48%) of the respondents indicated their practice is in the GTA.



How aware are you that the College was developing a new Practice Assessment?

Only **5%** of respondents indicated they were **"fully aware"** that the College was developing a new Practice Assessment.



What would be the ideal way for the College to communicate information regarding the new Practice Assessment to members?
(Select all that apply)

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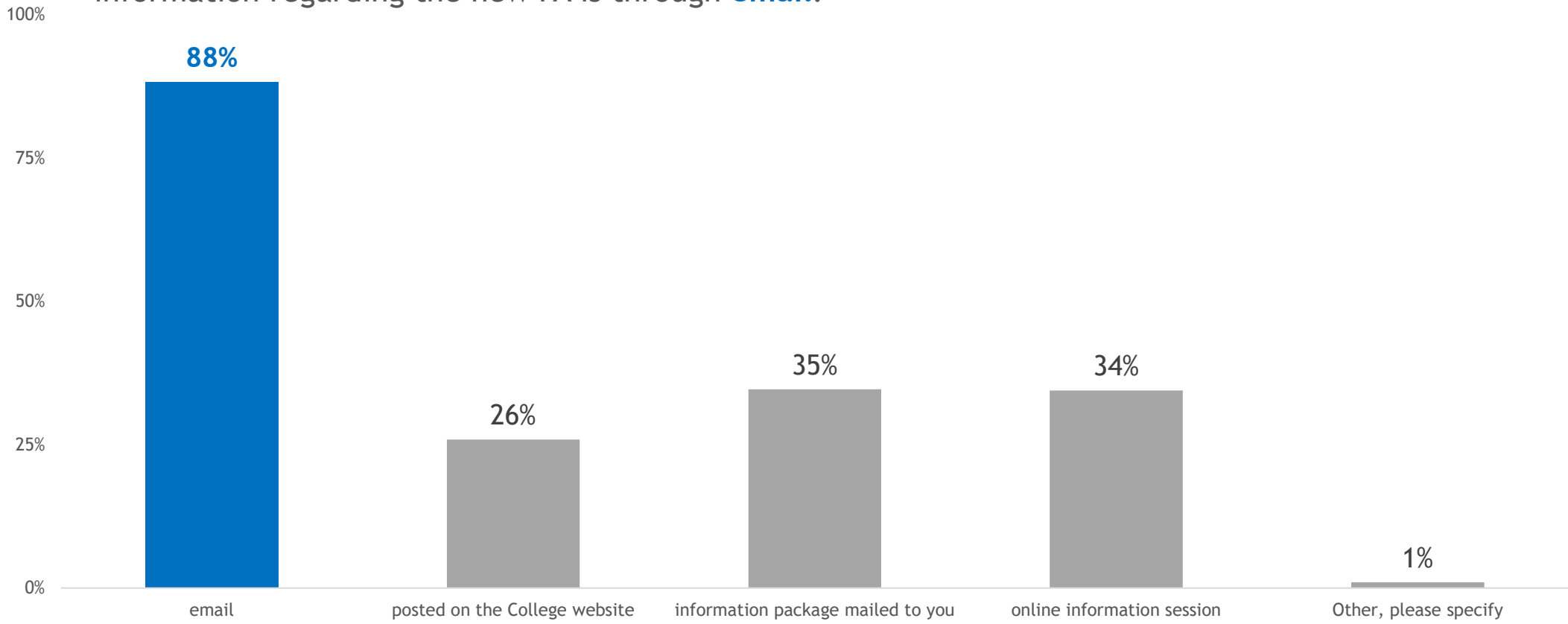
Almost 9 in 10 respondents indicated the ideal way for the College to communicate information regarding the new PA is through **email**.



What would be the ideal way for the College to communicate information regarding the new Practice Assessment to members? Summary of "Other" responses.

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A few members suggested additional ways the College could communicate information about the new Practice Assessment. Other than suggesting a combination of the current communication methods, a couple of members suggested that expanding the use of **social media** beyond the College website would be effective. Some also suggested that face to **face communication** through **AGM's**, **symposiums**, and **continuing education** would aid communication.

Based on what you currently know about the new Practice Assessment, how fearful or anxious around this new PA are you?

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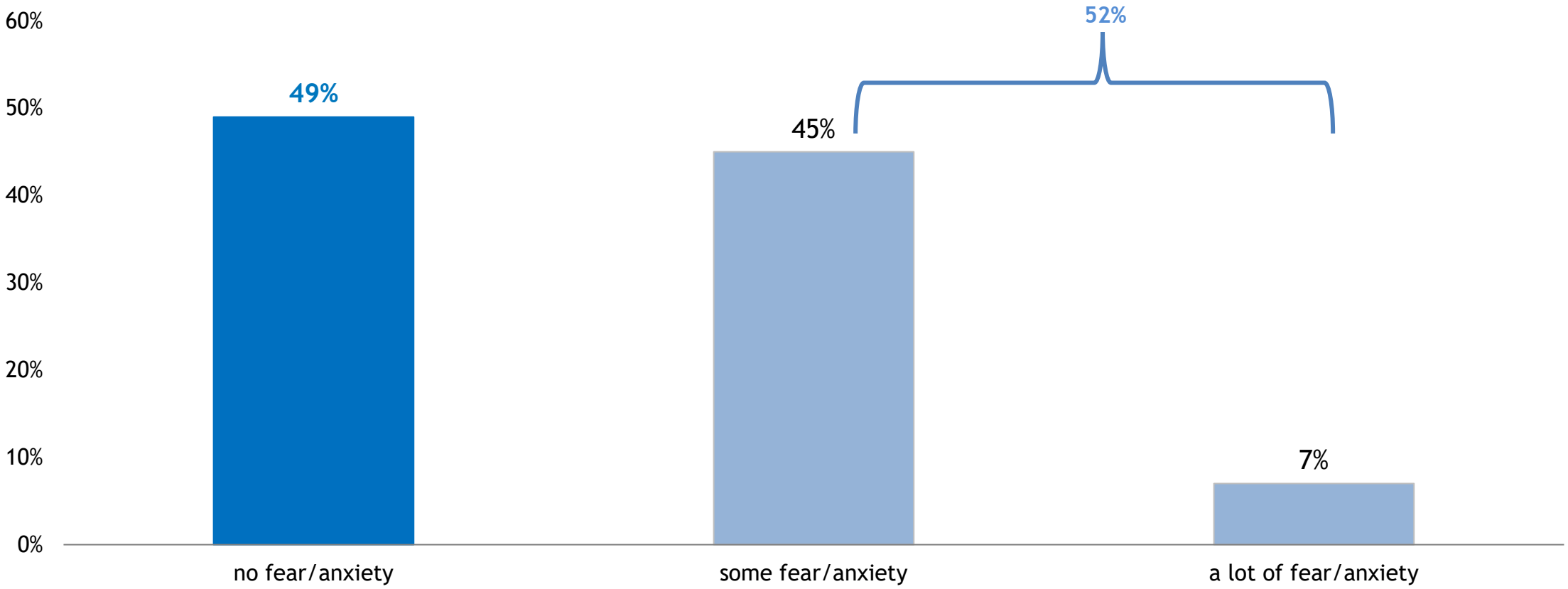
Almost half (49%) the respondents indicated they have **"no fear/anxiety"** around the new PA, but **over half indicated (52%)** they had **"some"** to **"a lot of fear/anxiety"** around the new PA.



Please briefly describe the sources of your fears/anxiety.

Members explained why they felt fear or anxiety about the new Practice Assessment (PA). In general, most felt that **not knowing what to expect** from the process caused anxiety. Conversely, knowing what was being assessed, as well as the standards and expectations would help to alleviate that fear / anxiety.

Although many respondents indicated that they were generally anxious about any type of test or assessment, some mentioned that the **video or face to face component of the assessment was concerning**. A few also mentioned that they were uncomfortable with the oral component and that it felt like a Board exam.

Many members were fearful of simply having their **competency judged**. They expressed anxiety about being found incompetent and any disciplinary consequences that might ensue. Many members were also anxious about being judged by a colleague and expressed concerns about the **quality and training** of the assessors. Some feared that the **assessor would not be familiar with their particular area of specialty** and some worried about the interpretation and bias of the individual assessor.

Many members were concerned about the **time and effort needed to prepare and submit paperwork** as well as having the adequate knowledge and technology to submit files.

Some members were anxious because they **did not feel supported by the College** and were skeptical that the new PA would lead to improved practice performance.

Please briefly describe the sources of your fears/anxiety cont'd. - Sample of Members' Comments

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"I'm not sure exactly what the college is looking for, we should be informed by the college about what exactly they want to see at the site. They should provide a check list so there is no ambiguity."

"Usual test anxiety, being put on the spot. Even if the assessor's are properly trained, always some bias. I do not like video discussions, chats etc,[sic] and would certainly not like a test done this way."

"I question the competency or judgment from other members who would be assessing me. People have different practice styles and their own internal biases and that may impact their evaluation of you."

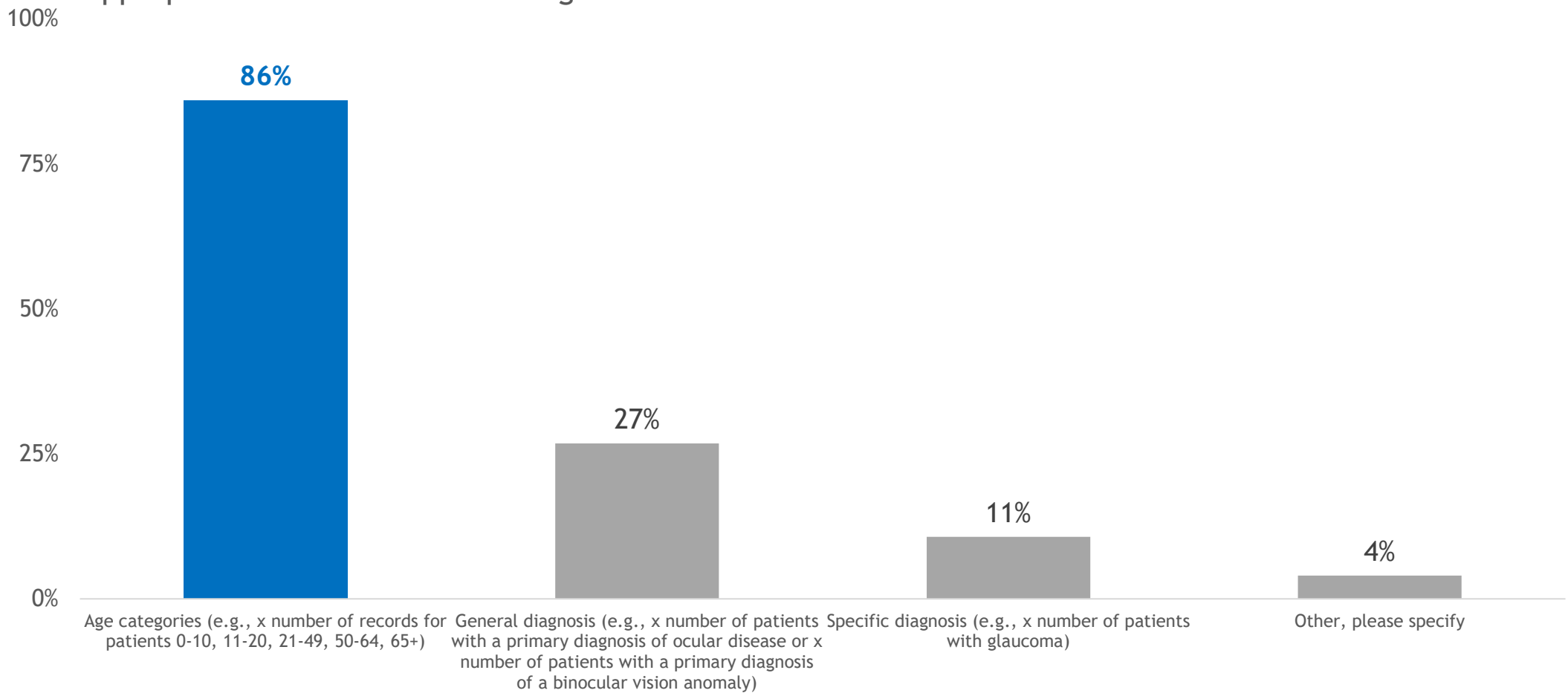
"I have been reviewed once before and although everything went extremely well, it was an enormous amount of work that I am in no hurry to repeat."

"Right or wrong, there is a perception that the College never backs up it's [sic] members and therefore members are suspicious of any intervention of the college - whether well meaning or not. So any interaction with the college can cause some amount of anxiety."

Please select the criteria you think would be most appropriate for the College to use for the chart selection (choose as many as you like).

COLLEGE OF OPTOMETRISTS OF ONTARIO

Almost 9 out of 10 respondents indicated that **"age categories"** were the most appropriate method for the College to use in chart selection.



Please select the criteria you think would be most appropriate for the College to use for the chart selection (choose as many as you like). Other criteria

COLLEGE OF OPTOMETRISTS OF ONTARIO

A few members **offered additional suggestions** and comments about the criteria used for the chart selection. While some felt that a **random selection of charts was appropriate**, others wanted to choose charts that were **representative of their practice**. There were some concerns expressed that **using certain age categories or specific diagnoses may not be feasible** for all practitioners. Some suggested that the criteria should be based on new or most recent charts only.

Please select the criteria you think would be most appropriate for the College to use for the chart selection (choose as many as you like) cont'd. - Sample of Members' Comments

COLLEGE OF OPTOMETRISTS OF ONTARIO

"depends on the patients EMR and if they can sort this data. Should be random selection of charts."

"People practice in different settings with varying demographics. For example some people rarely see children so if you ask for pediatric charts then they only have a handful to choose from whereas their colleague may have an abundance. Doctors also have varying thresholds for prescribing, diagnosis and management. Best to leave it open end or select it specific time frame apart."

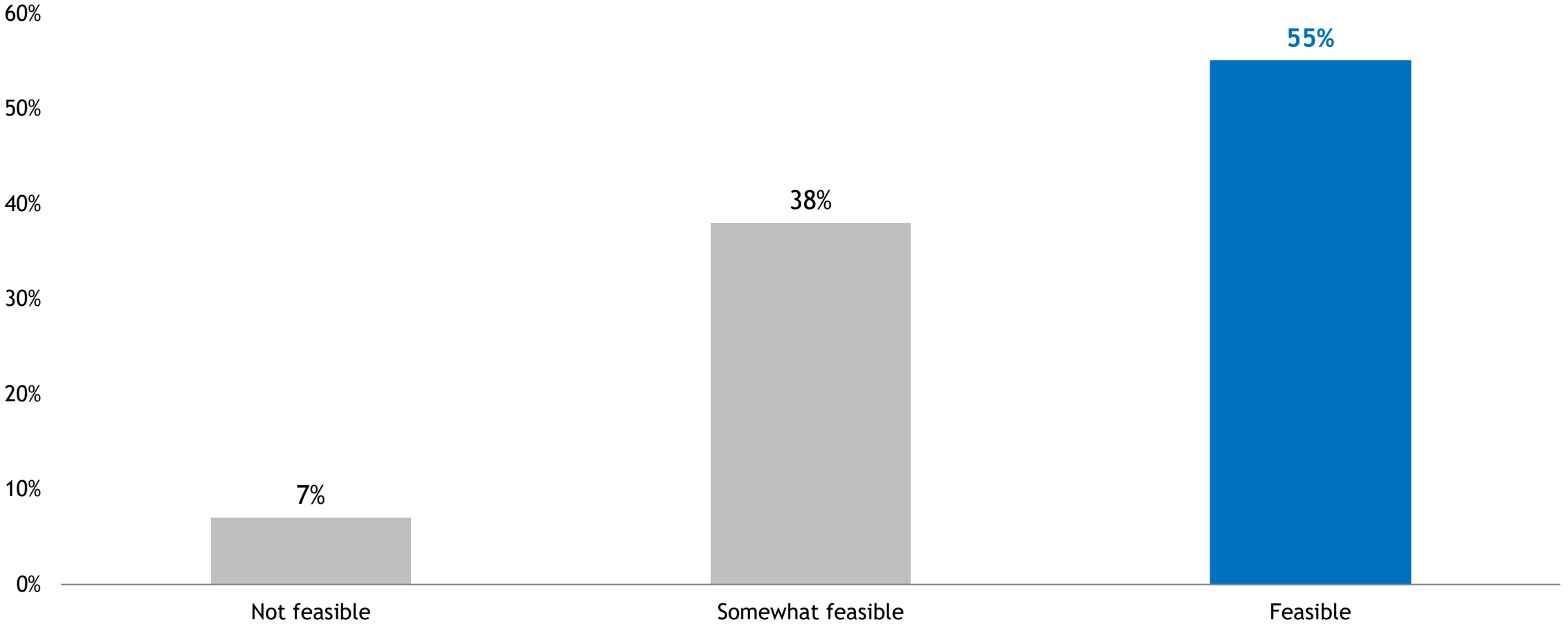
"Please don't use diagnosis as criteria. It is already time consuming to select patients based on age and sometimes difficult to get enough patients within an age category."

"Some clinicians do not see any kids or only work in laser centers. The criteria should be 10 charts of new patients, regardless of age."

Given the criteria for chart selection in the previous question, how feasible is it for you in your current practice to select charts that satisfy each of the criteria?

COLLEGE OF OPTOMETRISTS OF ONTARIO

More than half (55%) of the respondents indicated it is **feasible** to select charts based on each of the criteria in the previous question.



Briefly describe the reasons why satisfying each of the selection criteria would not be feasible for you.

Many members indicated that **selecting charts by specific diagnoses would be difficult** as they did not see or treat patients with every disease or referred outpatients with certain diagnoses.

Similarly, members mentioned that producing a **chart based on any age may be challenging** as they work primarily with patients of a particular age group.

Many members also indicated that it would require a lot of **time and effort to generate charts by disease or diagnosis** as their files were not coded this way.

Members using **paper charts** felt it would **require time to search** through their records and those using EMR mentioned that the software did not classify by diagnosis.

Some members also indicated that finding **new patients may not be feasible** as they have none to few new patients or may not see new patients with a specific diagnosis.

Briefly describe the reasons why satisfying each of the selection criteria would not be feasible for you.
- Sample of Members' Comments

COLLEGE OF OPTOMETRISTS OF ONTARIO

"I don't always have new patients with "x" diagnosis (e.g., glaucoma) within a set time period. I would have to use previous patient records if this was requested. Also, although I see patients of all ages, I may not see enough new patients of a certain age category within the set time period."

"Patients are not categorized based on diagnoses, more difficult to look back at patients and see which diagnosis it was without going through files individually."

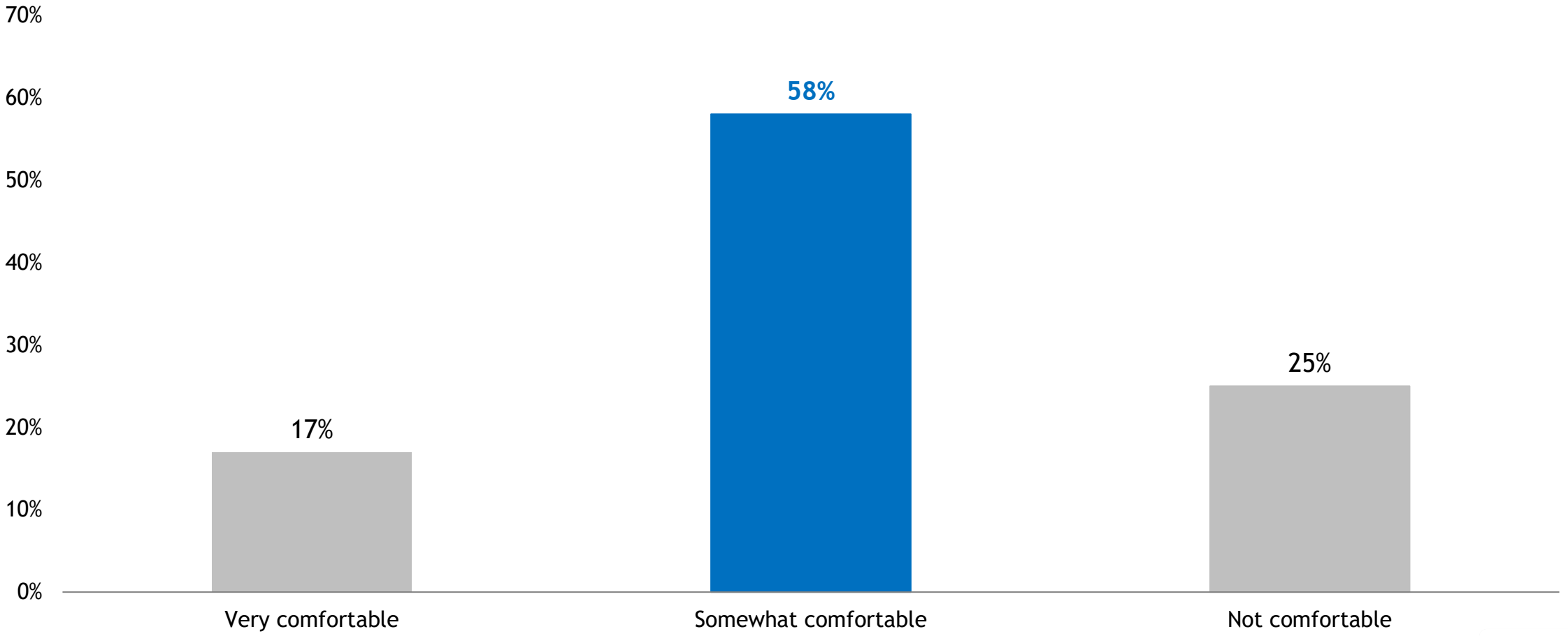
"Patient records with a particular diagnosis would take a while to find. My EMR is not searchable by diagnosis."

"May not be having enough number of new patients with a specific diagnosis within a certain specified time period. May not recall existing patients with specific diagnosis."

How comfortable are you with the conversational approach to the Chart Stimulated Recall Protocol assessment?

COLLEGE OF OPTOMETRISTS OF ONTARIO

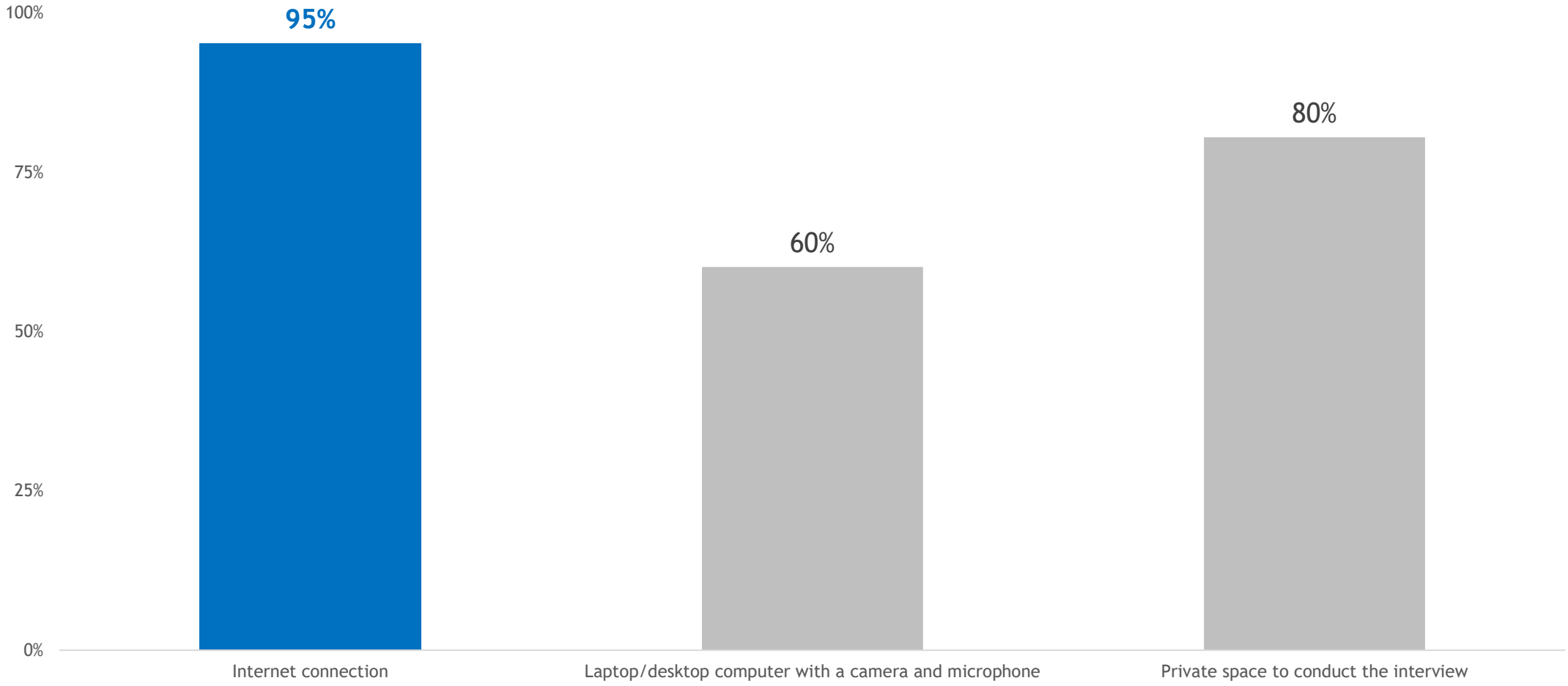
Almost **three-fifths (58%)** of respondents indicated they were **"somewhat comfortable"** with the conversational approach to the CSR.



If you are required to be assessed with the Chart Stimulated Recall Protocol, certain technological and non-technological requirements are necessary to conduct a video meeting. Please confirm if your office / place of work has the following technological / non-technological requirements. (Check the boxes to confirm)

COLLEGE OF OPTOMETRISTS OF ONTARIO

Almost all (95%) of respondents indicated they have an **internet connection**, and **8 out of 10** indicated they have a **private space** to conduct the interview.



Briefly describe any supports you may require helping you prepare for the Chart Stimulated Recall Protocol assessment.

COLLEGE OF OPTOMETRISTS OF ONTARIO

Overall, most respondents felt they **needed more information** about the process, objectives and expectations of the CSR.

Many suggested that **examples of the questions in the CSR and webinars or videos of mock interviews would be advantageous**.

Members also suggested that they would like the **time and materials** (e.g., CSR template, practice session, common errors) to prepare and practice for the CSR, as well as support to ensure they have the technological requirements in place.

Some members expressed concerns about the **knowledge of the assessor** and would like information about the person assessing them as well as **recourse if there were conflicts with the assessor**.

A few members suggested that they would like to have access to the **resources** (e.g., Will's eye manual) they normally use in their practice during the CSR.

Briefly describe any supports you may require helping you prepare for the Chart Stimulated Recall Protocol assessment. - Sample of Members' Comments

COLLEGE OF OPTOMETRISTS OF ONTARIO

"Sample CSRP previously recorded sessions to understand how the process works and type of questions being asked. An understanding of the areas being assessed by the assessor. An understanding of the bias of the assessor through minor bio or history with the College or academic history."

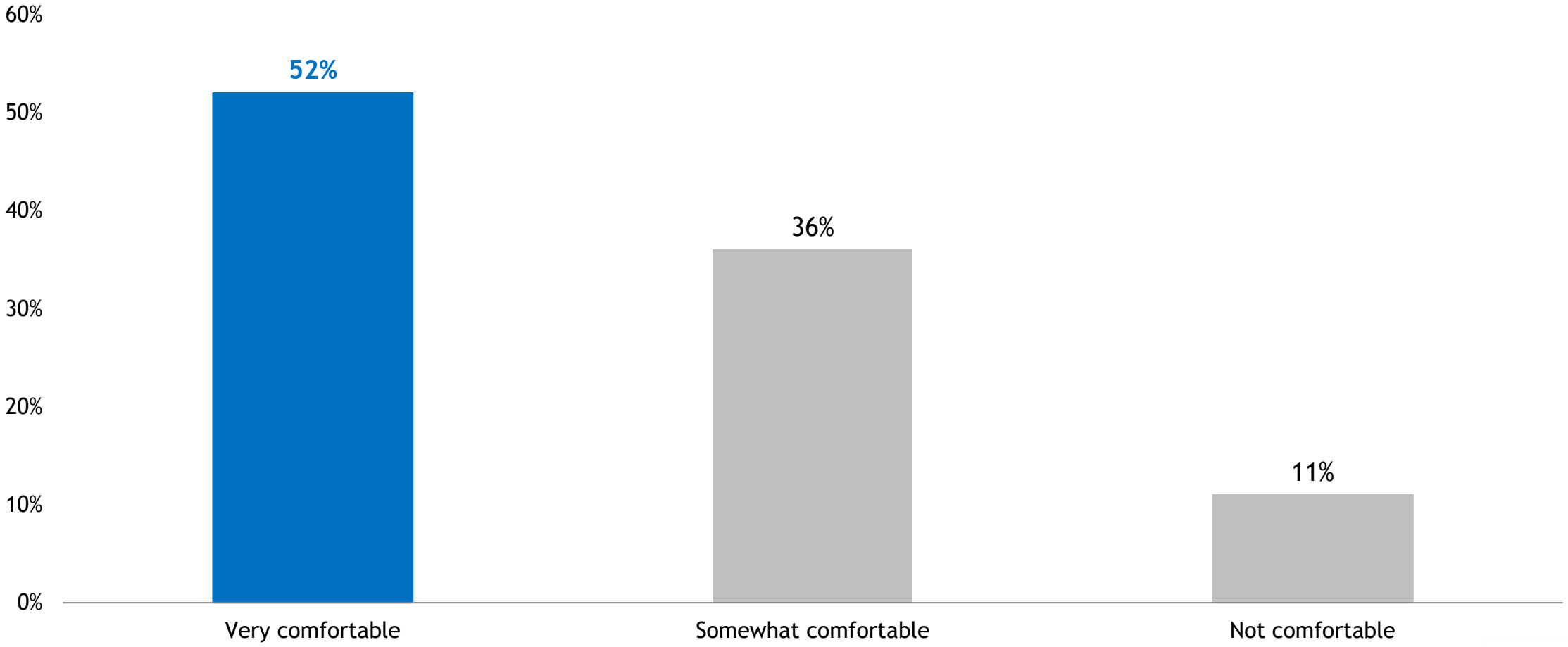
"Give us ample time. Give us a criteria of how you want charts done. Based on the opr everyone has their own interpretation. But if the CSR has a template sharing that with the members will be usefully for us to start charting like that."

"One would need to have access to the electronic equipment needed to conduct a video call and have an appropriate physical place to discuss virtually."

"The usual reference books, pharmaceutical guides that are usually on my desk would be important to have."

What is your comfort level in using a laptop / desktop computer with a camera and microphone?

Just **over half (52%)** of the respondents indicated they were **"very comfortable"** using a computer with a camera and a microphone.

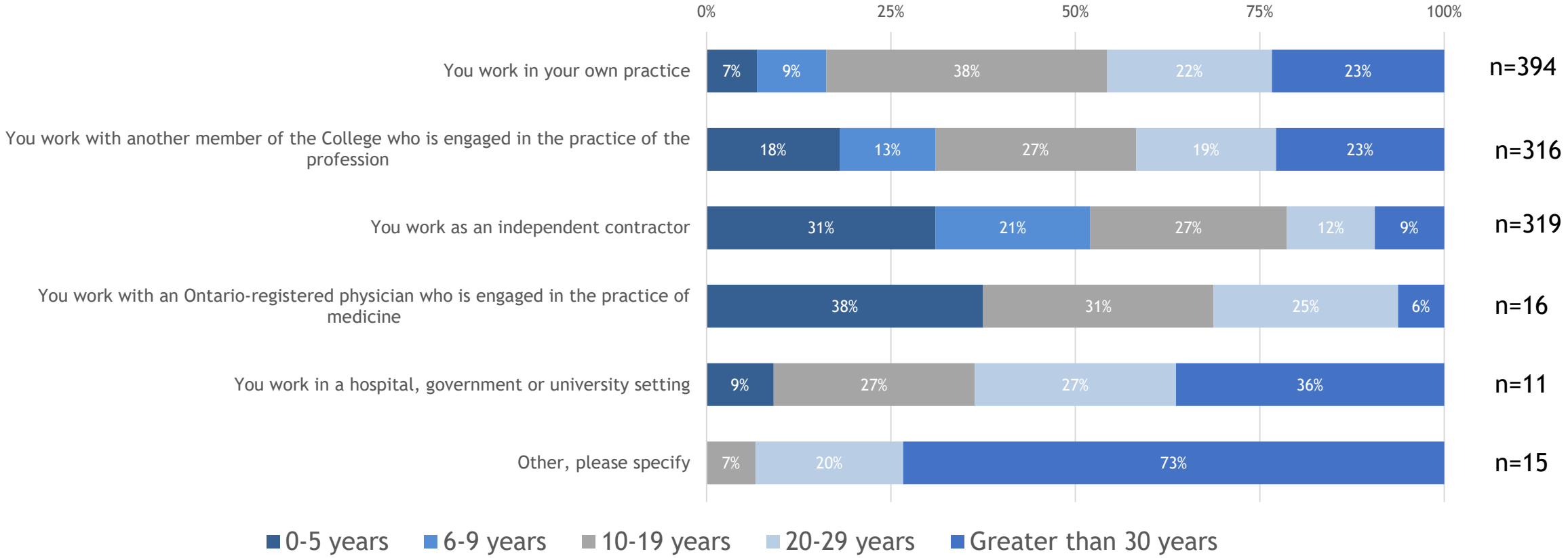


Cross-Tabulations

COLLEGE OF OPTOMETRISTS OF ONTARIO

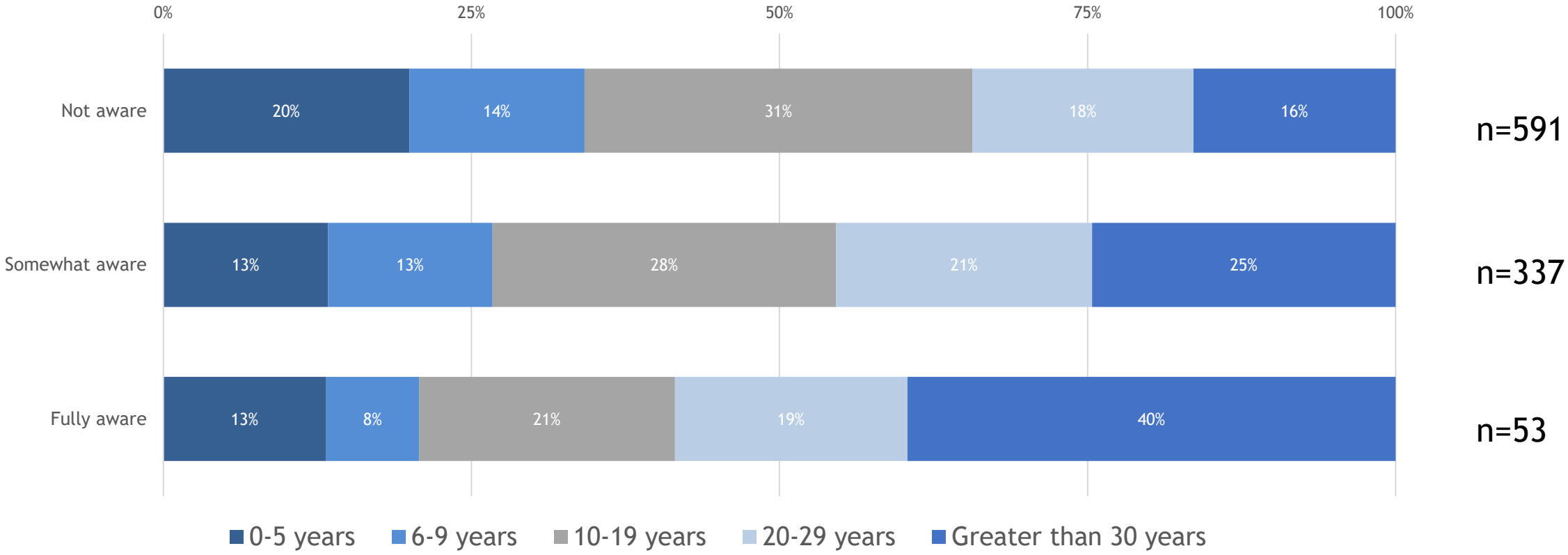
Years in Practice x Practice Setting

ODs with **6-9 years** experience work in the **least varied settings** with none of the respondents in this category indicating they work with an Ontario-registered physician, or work in a hospital, government or university setting.



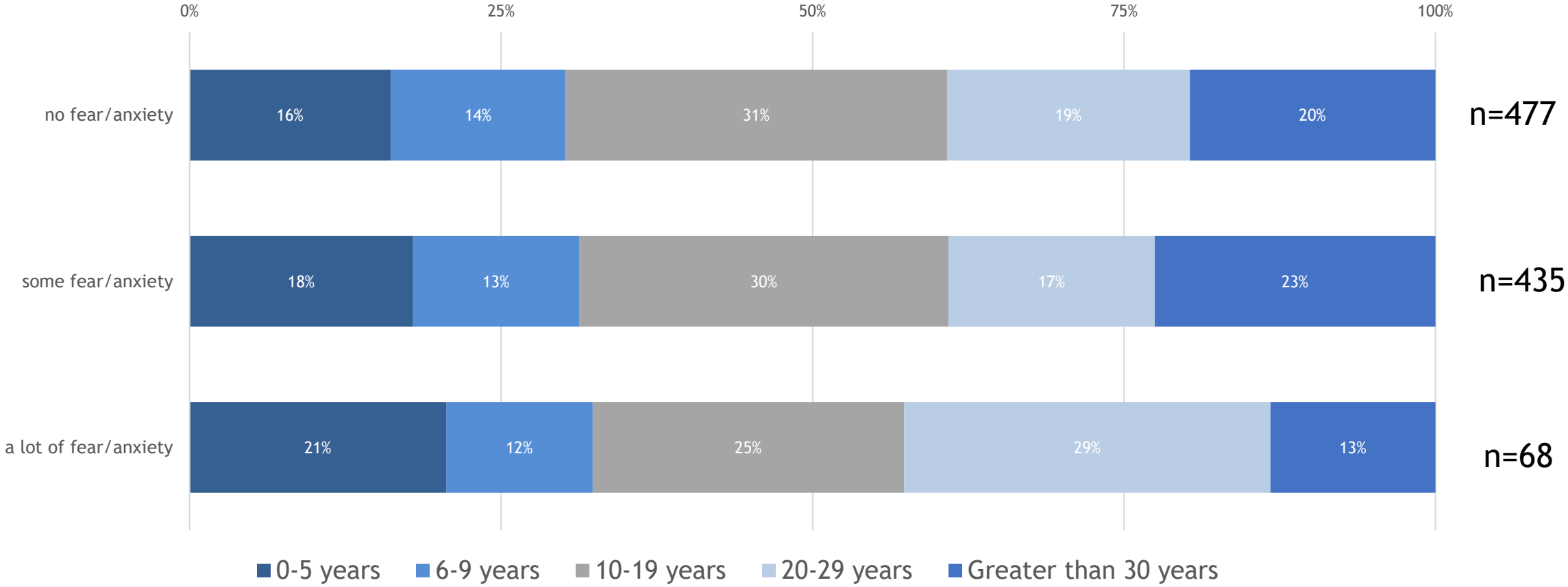
Years in Practice x Awareness

Of the relatively small number of ODs that indicated they were **"fully aware"** that the College was developing a new PA, the majority of those were in practice for **greater than 30 years**.



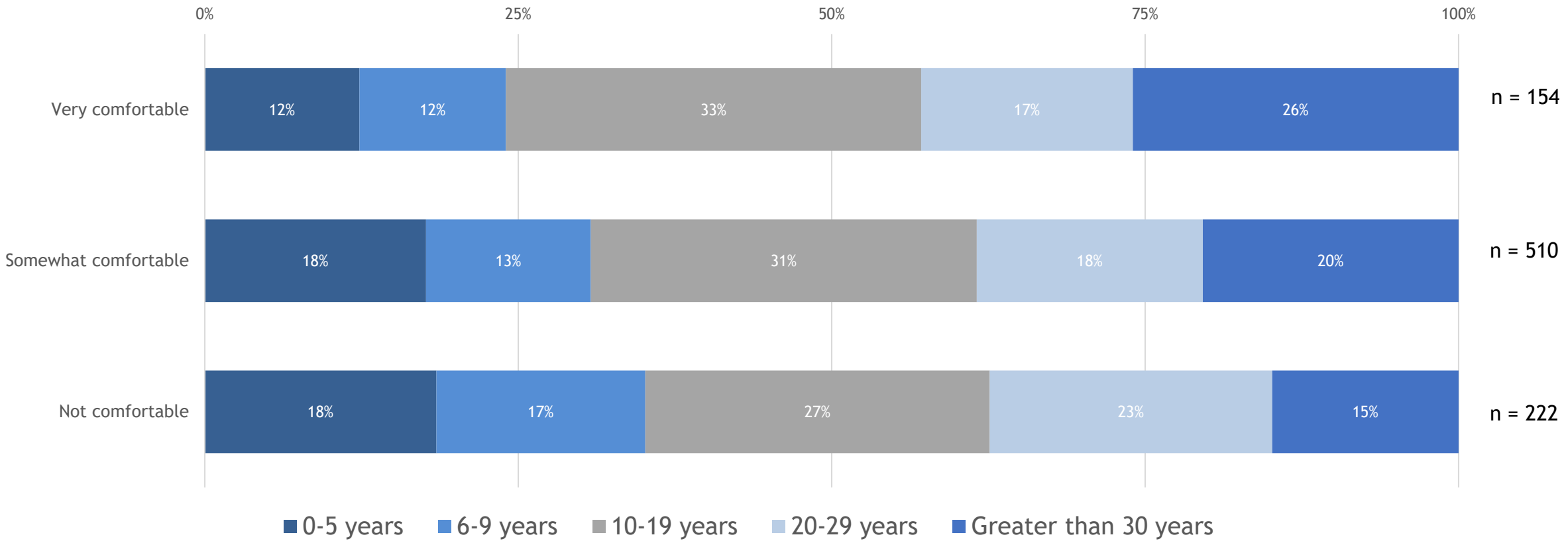
Years in Practice x Anxiety

Of the relatively few ODs that indicated they had **"a lot of fear/anxiety"** around the new PA, those with 20-29 years experience made up the largest proportion.



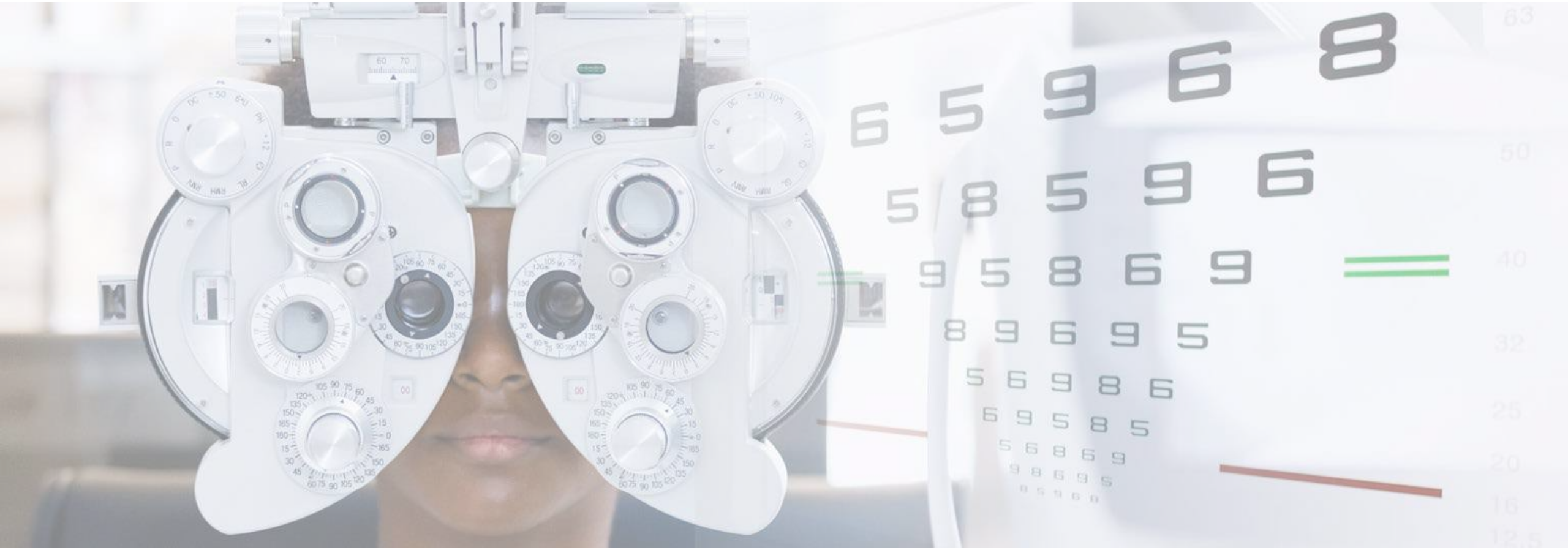
Years in Practice x Comfort

Of the relatively few ODs that indicated they were "**very comfortable**" with the conversational approach of the CSR, the **smallest proportion** were those ODs with **0-5 years experience** and those with **6-9 years experience.**



Cross-Tabulation Data Tables

COLLEGE OF OPTOMETRISTS OF ONTARIO



Years in Practice x Practice Setting

COLLEGE OF OPTOMETRISTS OF ONTARIO

Years in Practice x Practice Setting

		How many years have you been in practice?					
		0-5 years	6-9 years	10-19 years	20-29 years	Greater than 30 years	**Total**
What type of setting best describes your practice? Please select the best answer.							
You work in your own practice	Value	27	37	150	88	92	**394**
	Row Percentage	6.85%	9.39%	38.07%	22.34%	23.35%	**36.79%**
	Column Percentage	14.21%	25.52%	45.45%	44.90%	43.81%	
You work with another member of the College who is engaged in the practice of the profession	Value	57	41	86	60	72	**316**
	Row Percentage	18.04%	12.97%	27.22%	18.99%	22.78%	**29.51%**
	Column Percentage	30.00%	28.28%	26.06%	30.61%	34.29%	
You work as an independent contractor	Value	99	67	85	38	30	**319**
	Row Percentage	31.03%	21.00%	26.65%	11.91%	9.40%	**29.79%**
	Column Percentage	52.11%	46.21%	25.76%	19.39%	14.29%	
You work with an Ontario-registered physician who is engaged in the practice of medicine	Value	6	0	5	4	1	**16**
	Row Percentage	37.50%	0.00%	31.25%	25.00%	6.25%	**1.49%**
	Column Percentage	3.16%	0.00%	1.52%	2.04%	0.48%	
You work in a hospital, government or university setting	Value	1	0	3	3	4	**11**
	Row Percentage	9.09%	0.00%	27.27%	27.27%	36.36%	**1.03%**
	Column Percentage	0.53%	0.00%	0.91%	1.53%	1.90%	
Other, please specify	Value	0	0	1	3	11	**15**
	Row Percentage	0.00%	0.00%	6.67%	20.00%	73.33%	**1.40%**
	Column Percentage	0.00%	0.00%	0.30%	1.53%	5.24%	
Total	**Value**	**190**	**145**	**330**	**196**	**210**	**1071**
	Column Percentage	**17.74%**	**13.54%**	**30.81%**	**18.30%**	**19.61%**	

Years in Practice x Awareness

Years in Practice x Awareness

		How many years have you been in practice?					
		0-5 years	6-9 years	10-19 years	20-29 years	Greater than 30 years	**Total**
How aware are you that the College was developing a new Practice Assessment?	Not aware	Value	118	84	186	106	97	**591**
		Row Percentage	19.97%	14.21%	31.47%	17.94%	16.41%	**60.24%**
	Somewhat aware	Value	45	45	94	70	83	**337**
		Row Percentage	13.35%	13.35%	27.89%	20.77%	24.63%	**34.35%**
	Fully aware	Value	7	4	11	10	21	**53**
		Row Percentage	13.21%	7.55%	20.75%	18.87%	39.62%	**5.40%**
	Total	**Value**	**170**	**133**	**291**	**186**	**201**	**981**
		Column Percentage	17.33%	13.56%	29.66%	18.96%	20.49%	

Years in Practice x Anxiety

COLLEGE OF OPTOMETRISTS OF ONTARIO

Years in Practice x Anxiety

			How many years have you been in practice?					
			0-5 years	6-9 years	10-19 years	20-29 years	Greater than 30 years	**Total**
Based on what you currently know about the new Practice Assessment, how fearful or anxious around this new PA are you?	no fear/anxiety	Value	77	67	146	93	94	**477**
		Row Percentage	16.14%	14.05%	30.61%	19.50%	19.71%	**48.67%**
		Column Percentage	45.56%	50.38%	50.00%	50.27%	46.77%	
	some fear/anxiety	Value	78	58	129	72	98	**435**
		Row Percentage	17.93%	13.33%	29.66%	16.55%	22.53%	**44.39%**
		Column Percentage	46.15%	43.61%	44.18%	38.92%	48.76%	
	a lot of fear/anxiety	Value	14	8	17	20	9	**68**
		Row Percentage	20.59%	11.76%	25.00%	29.41%	13.24%	**6.94%**
		Column Percentage	8.28%	6.02%	5.82%	10.81%	4.48%	
	Total	**Value**	**169**	**133**	**292**	**185**	**201**	**980**
		Column Percentage	**17.24%**	**13.57%**	**29.80%**	**18.88%**	**20.51%**	

Years in Practice x Comfort

COLLEGE OF OPTOMETRISTS OF ONTARIO

Years in Practice x Comfort

			How many years have you been in practice?					
			0-5 years	6-9 years	10-19 years	20-29 years	Greater than 30 years	**Total**
How comfortable are you with the conversational approach to the Chart Stimulated Recall Protocol assessment?	Very comfortable	Value	19	18	51	26	40	**154**
		Row Percentage	12.34%	11.69%	33.12%	16.88%	25.97%	**17.38%**
		Column Percentage	12.67%	14.75%	18.96%	15.48%	22.60%	
	Somewhat comfortable	Value	90	67	157	92	104	**510**
		Row Percentage	17.65%	13.14%	30.78%	18.04%	20.39%	**57.56%**
		Column Percentage	60.00%	54.92%	58.36%	54.76%	58.76%	
	Not comfortable	Value	41	37	61	50	33	**222**
		Row Percentage	18.47%	16.67%	27.48%	22.52%	14.86%	**25.06%**
		Column Percentage	27.33%	30.33%	22.68%	29.76%	18.64%	
	Total	**Value**	**150**	**122**	**269**	**168**	**177**	**886**
		Column Percentage	**16.93%**	**13.77%**	**30.36%**	**18.96%**	**19.98%**	

CUT SCORE STUDY SUMMARY REPORT

For the

COLLEGE OF OPTOMETRISTS OF ONTARIO'S

COLLEGE OF OPTOMETRISTS OF ONTARIO

NEW PRACTICE ASSESSMENT

CHART REVIEW PROTOCOL

Prepared by A. Sidiq Ali, PhD CE – Psychometric Consultant
Managing Director
Research & Evaluation Consulting, Inc.

October 19, 2023

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INTRODUCTION AND PURPOSE

The purpose of the Cut Score Study is to engage subject-matter experts (SMEs) from the Regulator (the College of Optometrists of Ontario, the College) to determine the passing standard /criteria, or cut score, for the new Quality Assurance (QA) Program's Chart Review Protocol (CRP). In a cut score study, the SMEs are considered as cut score raters or judges.

The desired outcome of the Cut Score Study is for the SME judges, through rating competencies, discussing, and reconciling disagreements where necessary, to establish the minimum standard or criteria indicative of quality practice on the CRP. This minimum standard, or a "pass," for the CRP was determined through a rating process called the (modified) Angoff Method[1].

When used in QA practice, the College's Assessors will rate registrants' selected patient charts with the CRP and use the prescribed cut score or standard of quality to determine their recommendations to the Quality Assurance Committee.

PROCEDURE

During the Cut Score Study, SME judges will determine the minimum score required on each competency that is indicative of quality practice. Further, the Cut Score SME judges will also determine which of the competencies are "critical" to be "met" for indication of quality of practice. Together, these ratings will determine the overall **two-part cut score or standard of quality** for the CRP.

On June 12, 2023, an online (virtual) training session was conducted for ten SME judges (7 female and 3 male), various practicing registrants of COO highly familiar with the quality Assurance process. Training in the Angoff Method is an essential component of the validity evidence for the cut score. The training session included an orientation to the *Optometric Practice Reference* (OPR) Standards and the *Competencies for Optometry* (2020) that make up the CRP. SME judges were instructed to be familiar with each of these documents before the training session.

SMEs were trained to apply a modified Angoff Method to each of the Competencies on the CRP. Each Competency will be scored by an Assessor on a scale of 0 to 2, with 0 being "un-met," 1 being "partially met" and 2 being "met," as they review a registrant's patient record.

Because of the virtual nature of the Cut Score Study, after the training was completed, the raters (SME judges) conducted their own individual ratings of the competencies on the CRP using an electronic, web-based ratings form. The judges had 48 hours to complete the ratings. After the judges completed and submitted their ratings, this author compiled the ratings and prepared for the discussion and reconciliation component of the study, which occurred on June 16, 2023.

During the vital discussion and reconciliation session (June 16), all ten SME judges' ratings were shown. This author facilitated a discussion of competency ratings. Judges had an opportunity to discuss overall ratings, as well as their own ratings. If through the discussion, a judge wished to change their ratings for any competency, they were permitted to do so. After the discussion and reconciliation, an average rating (across judges) for each competency was determined. These average ratings per competency were then

[1] Angoff, W. H. (1971). Scales, norms and equivalent scores. In R. L. Thorndike (Ed.), *Educational measurement* (2nd ed., pp. 508-597). American Council on Education.

summed up to arrive at a minimum total score on the CRP. This minimum score would be indicative of a "pass." A similar method of discussion was employed to arrive at a consensus for the critical competencies. The summed average competency ratings, together with the critical competencies identified, were then applied to the overall CRP to arrive at the two-part cut score or minimum quality standard.

TWO-PART CUT SCORE OR STANDARD OF QUALITY

It was determined that in review of a registrant's patient record, the cut score on the CRP would be **31 out of 40**. Supplemental to this cut score, it was determined that the **Competencies of 7, 11, 12 and 13 would be "critical,"** and that a pass would need to include a "met" score of 2 on each of these competencies as well as the minimum score of 31.

VALIDATION OF THE CUT SCORE AND QUALITY STANDARD

The two-part pass or quality standard was recommended to the College. During Assessor training in July 2023, however, some guidance was provided to the Assessors on how to determine "unmet" on several competencies. It became apparent during the training that this "guidance" complicated the ratings process and limited the Assessors' use of their clinical judgement, a key aspect of the rating process. Some Assessors also believed that Competency 4 on the CRP should be deemed "critical," as it related to communication, and communication issues were a significant source of patient complaints about registrants to the College.

On August 4, 2023, this author attended a virtual meeting with the College's QA Special Projects Committee to discuss the Assessors' feedback on the CRP's two-part pass / quality standard. The QA Special Projects Committee then determined that the "unmet" guidance was not necessary, and thus asked for it to be removed from the CRP instrument. The Committee also determined that the 4 "critical" competencies were appropriate, and that Competency 4 did not need to be considered "critical," as communication-based complaints were focused on registrant and patient interactions that are not typically documented in the patient's chart. The Committee confirmed that CRP is a chart review tool, and as such Competency 4 would not be deemed "critical."

As a result of this meeting, the two-part quality standard was confirmed, a score of 31 or higher plus a score of 2 on each of Competencies 7, 11, 12 and 13 would indicate a "pass," or in other words that the patient record was of sufficient quality.

COLLEGE OF OPTOMETRISTS OF ONTARIO

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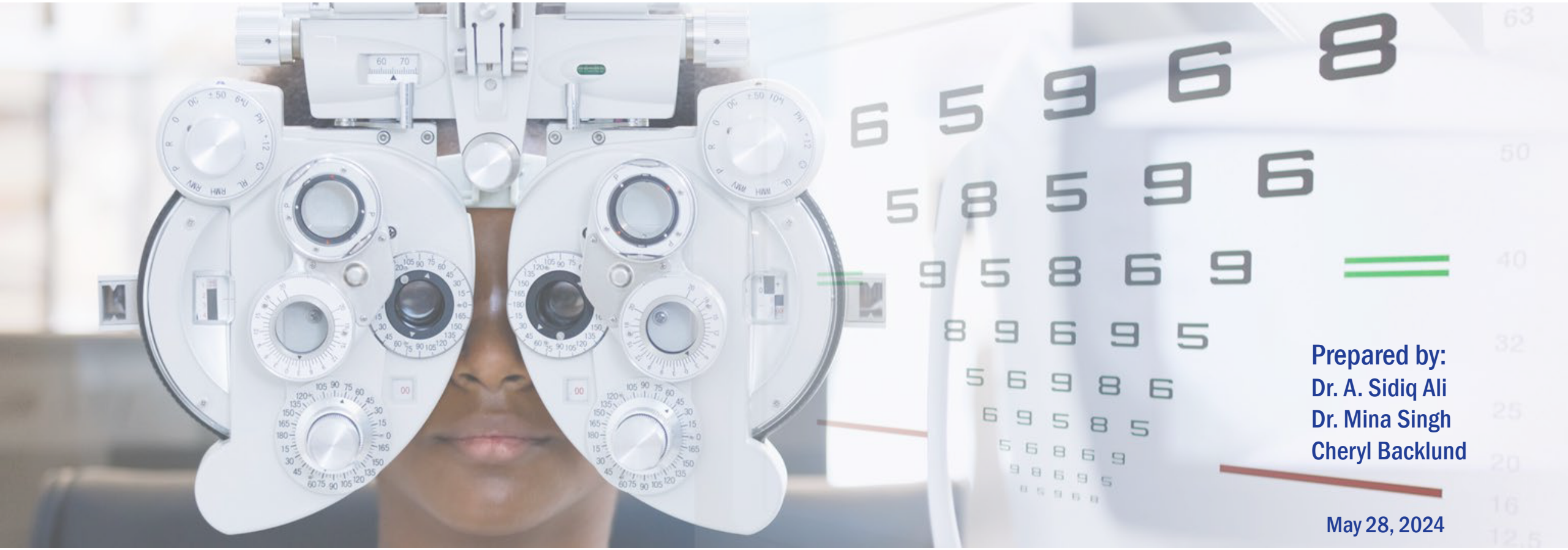
Pre-Test Study Results
(for the Peer Assessment Component of the new QA Program)



Prepared by:
Dr. A. Sidiq Ali
Dr. Mina Singh
Cheryl Backlund

May 28, 2024

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Overview

The pre-test of the new Practice Assessment (PA) component of the College of Optometrists of Ontario's (COO) Quality Assurance (QA) Program occurred in October and November of 2023 for the Chart Review Protocol and completed in May of 2024 for the Chart - Stimulated Review Protocol.

The new PA consists of two instruments. First, a Chart Review Protocol (CRP), like the previous Short Record Assessment, but with a 3-point scale on 20 indicators derived from the Optometric Practice References (OPR) Standards of Practice, the 2020 Competencies for Optometry and common areas of complaints. The CRP relies on assessors' application of clinical judgement using the OPR as guidance. For a registrant's chart to be considered high quality, the 4 critical indicators must be scored a '2' or 'met' and the total score must exceed 31 out of 40. For any chart that does not meet these quality standards, the registrant may be recommended by the assessor to undergo the second new PA component, the Chart –Stimulated Recall (CSR).

Twenty-eight COO registrants were selected for the pre-test, each submitting ten patient records. Each record was rated by two trained assessors using the CRP.

Eleven registrants were selected, some based on actual scores, some randomly, to undergo a CSR review, which consists of three general questions, a selection of questions aligned to each indicator on the CRP, and some follow-up queries. In addition to the general questions and follow-up queries, the CSR assessor asks the registrant only questions related to the indicators that were found to be deficient on a particular chart. So, each CSR assessment has the potential to be unique to the registrant and the charts they submitted.

Overview cont.

We collected and analyzed data on the pre-test of the CRP and the CSR through Assessor Surveys and Registrant Surveys about each instrument and its related processes.

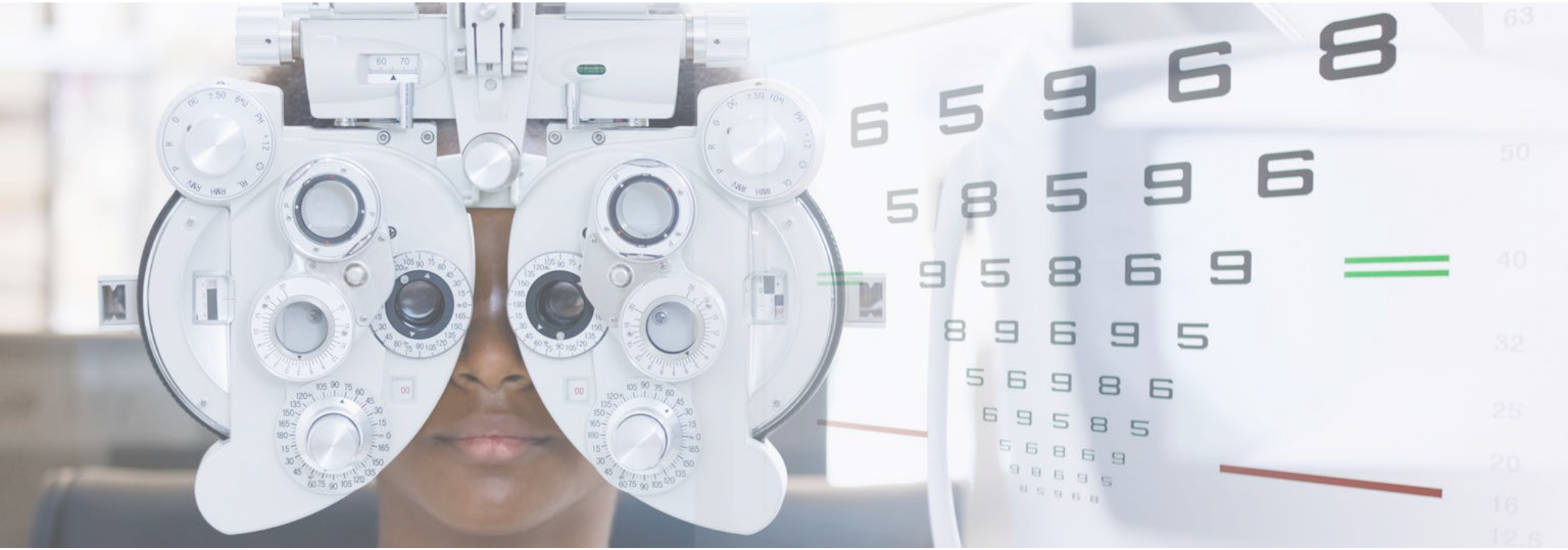
We also conducted an Interrater Reliability analysis on the CRP assessment that examined:

- Assessors Overall Agreement % on each patient record;
- Decision Consistency among the assessors to recommend/not recommend a CSR; and
- A Tally of Disagreement per Indicator.

Findings from the CRP assessment process were further investigated through interviews with the assessors, and issues with ratings and decision consistency among CRP assessors were addressed in a supplemental training for CRP assessors.

We conclude this brief report with a Discussion of results.

The Chart Review Protocol



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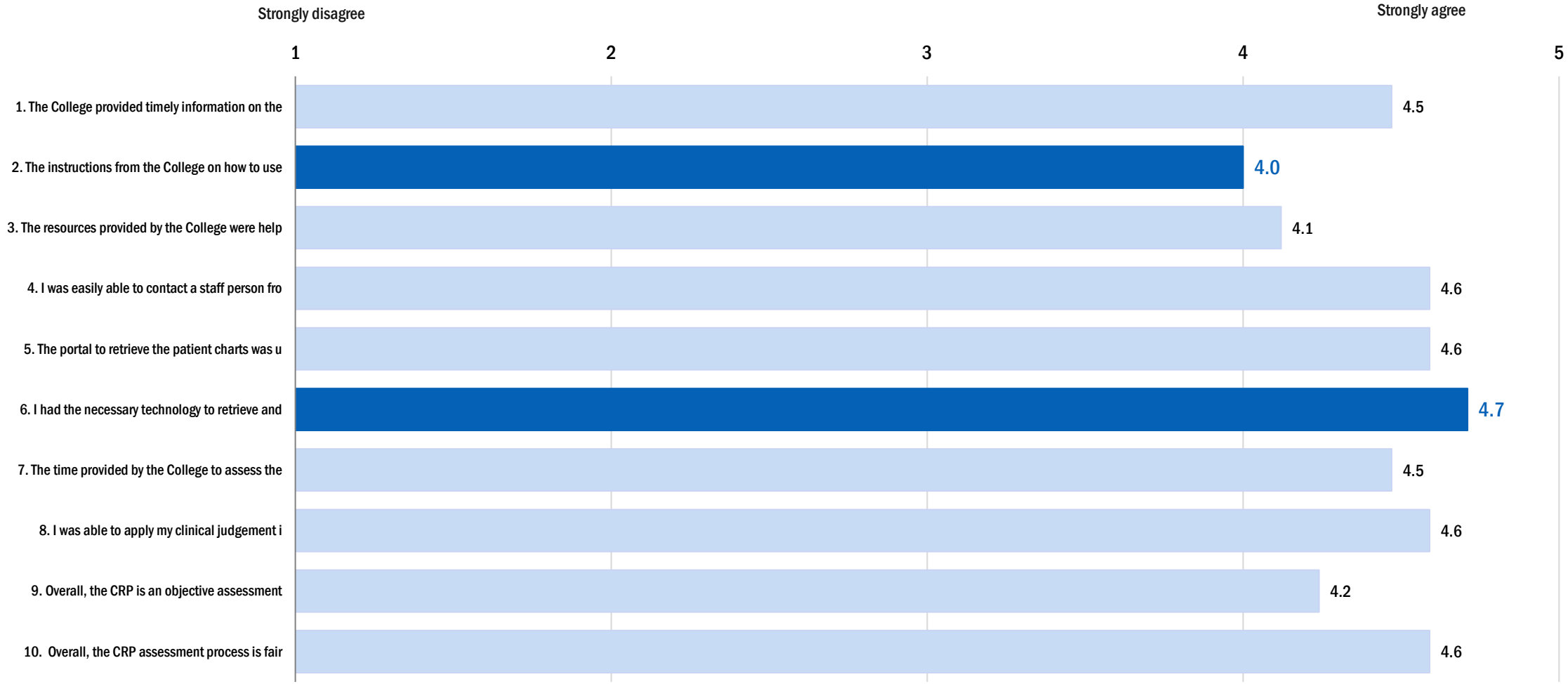
Assessors were asked to rate their agreement with the following statements regarding the Chart Review Protocol. Summary results are provided by count and percentage, with **highest percentages** noted.

Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Overall
1. The College provided timely information on the chart review process for new Quality Assurance program.	0	1	0	6	10	17
	0.00%	5.88%	0.00%	35.29%	**58.82%**	100.00%
2. The instructions from the College on how to use the CRP to assess the registrant's charts were clear.	0	2	1	9	5	17
	0.00%	11.76%	5.88%	**52.94%**	29.41%	100.00%
3. The resources provided by the College were helpful (e.g., CRP training, written materials, Standards, CRP template).	0	0	4	7	6	17
	0.00%	0.00%	23.53%	**41.18%**	35.29%	100.00%
4. I was easily able to contact a staff person from the College for further information.	0	0	1	5	11	17
	0.00%	0.00%	5.88%	29.41%	**64.71%**	100.00%
5. The portal to retrieve the patient charts was user friendly.	0	0	1	5	11	17
	0.00%	0.00%	5.88%	29.41%	**64.71%**	100.00%
6. I had the necessary technology to retrieve and re-load the patient charts.	0	0	0	5	12	17
	0.00%	0.00%	0.00%	29.41%	**70.59%**	100.00%
7. The time provided by the College to assess the 10 charts was appropriate.	0	0	3	3	11	17
	0.00%	0.00%	17.65%	17.65%	**64.71%**	100.00%
8. I was able to apply my clinical judgement in the assessment process where required.	0	0	0	7	10	17
	0.00%	0.00%	0.00%	41.18%	**58.82%**	100.00%
9. Overall, the CRP is an objective assessment of the quality of patient records.	0	1	1	8	7	17
	0.00%	5.88%	5.88%	**47.06%**	41.18%	100.00%
10. Overall, the CRP assessment process is fair to the registrant.	0	0	0	7	10	17
	0.00%	0.00%	0.00%	41.18%	**58.82%**	100.00%

Overall, **Assessor** ratings were high, averaging 4.4 out of 5, with the highest rating belonging to **"6. I had the necessary technology to retrieve and re-load the patient charts,"** and the lowest rating to **"2. The instructions from the College on how to use the CRP to assess the registrant's charts were clear."**



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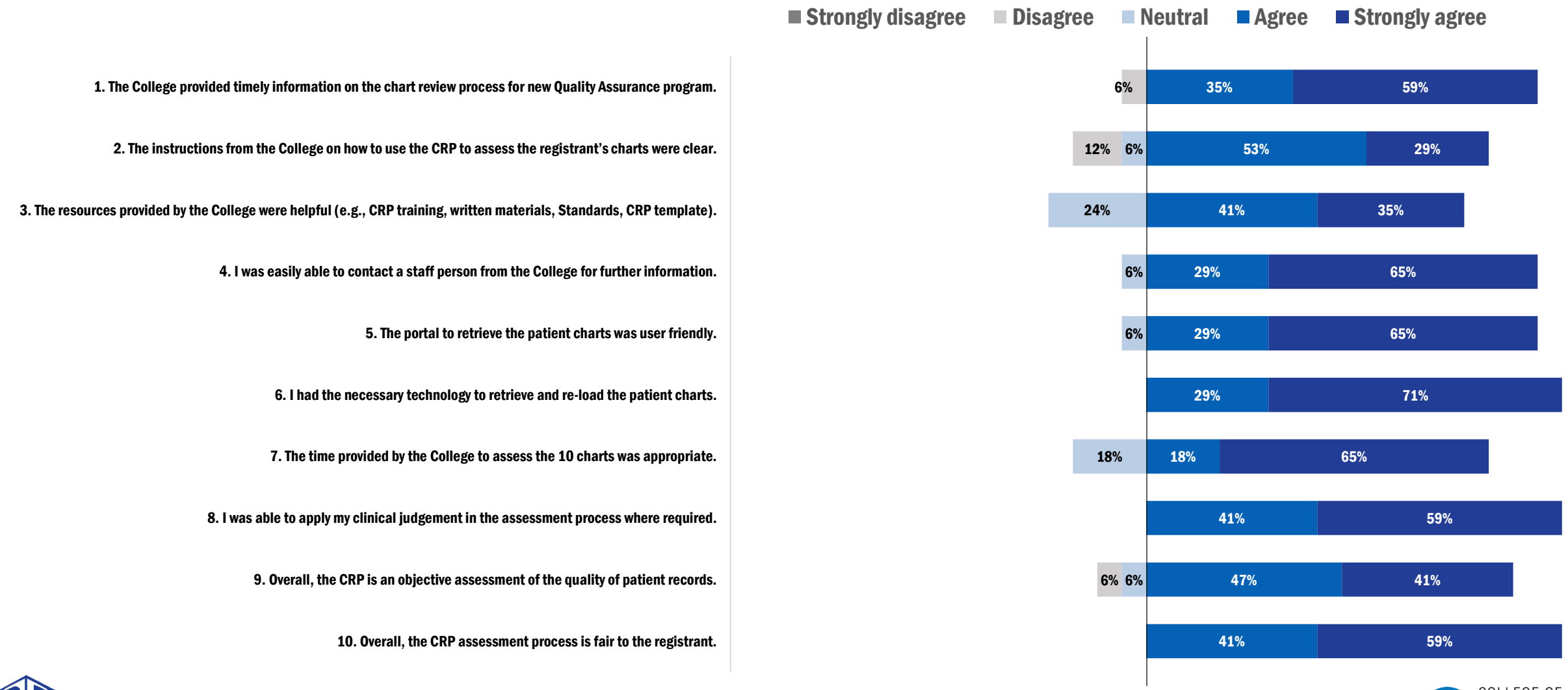
Assessors mostly **agreed** with all the statements on the Chart Review Protocol.

Overall, there was no "Strongly disagree" and very few "Disagree" with the statements on the Chart Review Protocol.



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Most of the **Assessors'** comments were positive regarding the **Chart Review Protocol**.

"As a previous assessor, I do like the changes made in the new Chart Review Protocol. It is nice to have the "partially met" option rather than pure pass/fail and the chance to record reasons behind the assessment choice. When I became a new assessor a couple of years ago, I found the training day put on by the quality assurance panel very valuable in understanding what was expected of the assessors. The virtual meeting, prepared slides/handouts, and "do's and don'ts" were all very helpful in understanding how to look at and review charts. Although the training for the CRP was fine for previous, experienced assessors I do wonder if they missed out a bit on some of this information. A follow up training / re-training might be warranted."

"Only comment is that the assessment can't be completely objective since it needs professional judgement, but it does give enough leeway so that only those with serious concerns are filtered out."

"I valued being able to leave chart specific and positive feedback for the registrant. Perhaps those fields can be added or the wording of the comments section at the bottom of each file can be edited to include that? I had some charts that didn't include follow up (e.g., if cycloplegic exam was deferred for a child). Is that specified for members to include that?"

"I found the CRP assessment process to be fair and objective. There were a few instances where I had some comments that were not critical to meeting the requirements for a specific question/item of the chart review but were useful clinically. From the questions asked on the CRP, I was not sure where to include these comments, so I placed them in the "Comments Section" at the bottom of the CRP although my comments were not "critical" but were clinically helpful, e.g., recording the grade for a school-age patient."

"Based on the CRP and training we have received; I believe that this is a good and fair protocol for assessing optometrist charts. Any concerns or justifications for scores can be expanded upon in the comments section, which will allow for those reviewing the notes to determine if the participant needs further assessment outside of the one CRP assessment done."

Some of the **Assessors'** comments offered constructive criticism.

"MTO part is unclear. A lot of charts don't record license status."

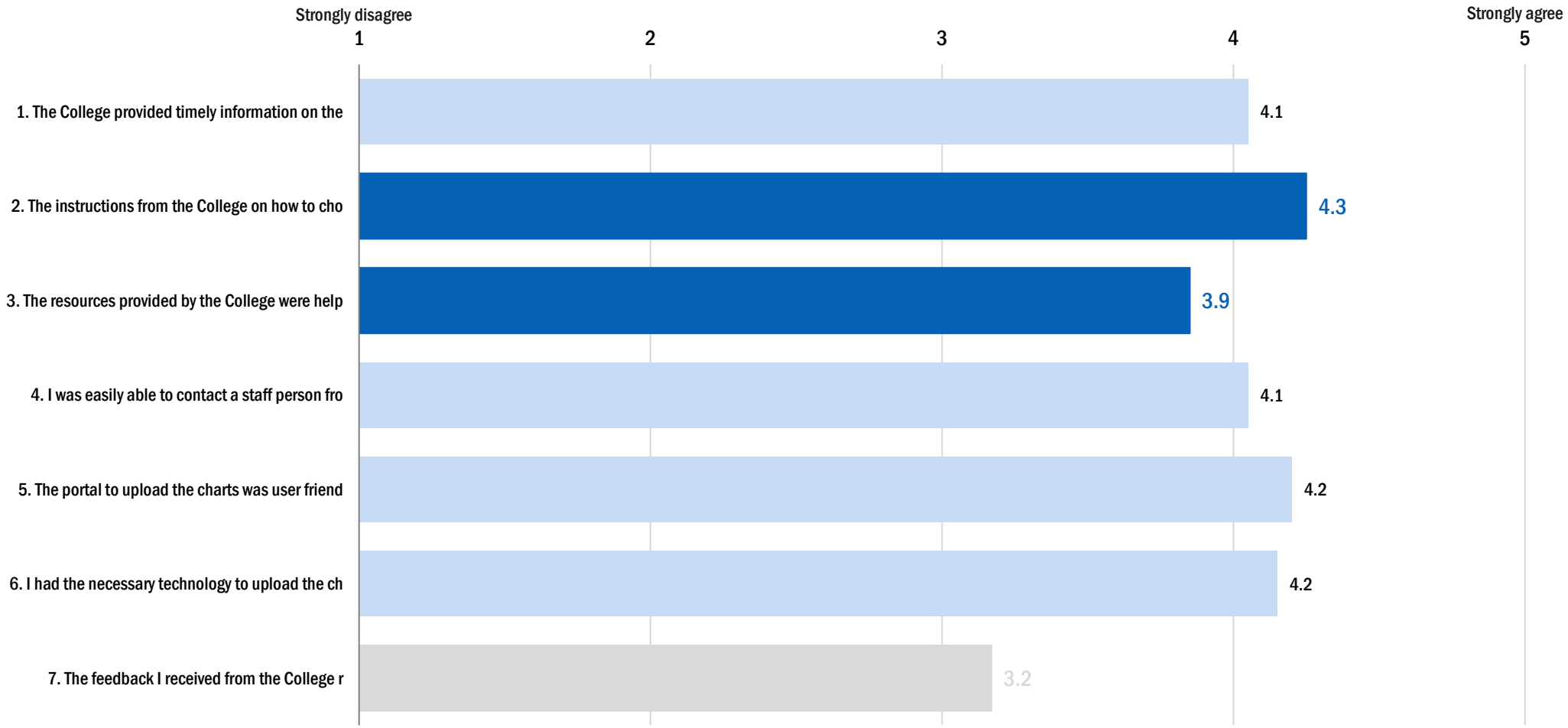
"My concern about the objective nature of the chart review is that it requires significant assessor opinion based on OPR generalizations and that a new graduate opinion and an elder optometrist will have significantly different standards based on the OPR with respect to met and partially met. Partially met is very ambiguous. Second concern is the chart selection when using 10 charts. A good cross section should include at least 1 glaucoma patient, 1 glaucoma suspect, 1 diabetic, 1 macular degeneration, 1 contact lens patient if the member fits or sees patients with contacts and at least 3 in each age group (child/adult/senior) that are "normal" which would mean a sample size of approximately 15 to get a "fair" cross section of patients to assess member competencies. I would also suggest the OPR detail specifically the minimum required components (i.e., CD ratio) to permit a uniform assessment criteria regardless of the assessor experience."

"The question regarding drivers' license should be reviewed further. Sometimes it's difficult to see whether a patient requires restriction or not since UCVA is not required as per OPR. Only monocular BCVA is required."

Registrants were asked to rate their agreement with the following statements regarding the **Chart Review Protocol**. Summary results are provided by count and percentage, with **highest percentages** noted.

Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Overall
1. The College provided timely information on the new Quality Assurance program.	0	2	2	9	7	20
	0.00%	10.00%	10.00%	**45.00%**	35.00%	100.00%
2. The instructions from the College on how to choose the charts to be reviewed were clear.	0	1	1	10	8	20
	0.00%	5.00%	5.00%	**50.00%**	40.00%	100.00%
3. The resources provided by the College were helpful (e.g., Standards).	1	1	4	8	6	20
	5.00%	5.00%	20.00%	**40.00%**	30.00%	100.00%
4. I was easily able to contact a staff person from the College for further information.	0	2	3	7	8	20
	0.00%	10.00%	15.00%	35.00%	**40.00%**	100.00%
5. The portal to upload the charts was user friendly.	0	1	2	9	8	20
	0.00%	5.00%	10.00%	**45.00%**	40.00%	100.00%
6. I had the necessary technology to upload the charts.	0	1	1	12	6	20
	0.00%	5.00%	5.00%	**60.00%**	30.00%	100.00%
7. The feedback I received from the College regarding my submitted charts was fair.	0	1	14	2	1	18
	0.00%	5.56%	**77.78%**	11.11%	5.56%	100.00%

Overall, **Registrants'** ratings were not as high as the Assessors, averaging 4.0 out of 5, with the highest rating belonging to **"2. The instructions from the College on how to choose the charts to be reviewed were clear,"** and the lowest applicable rating to **"3. The resources provided by the College were helpful (e.g., Standards)."**



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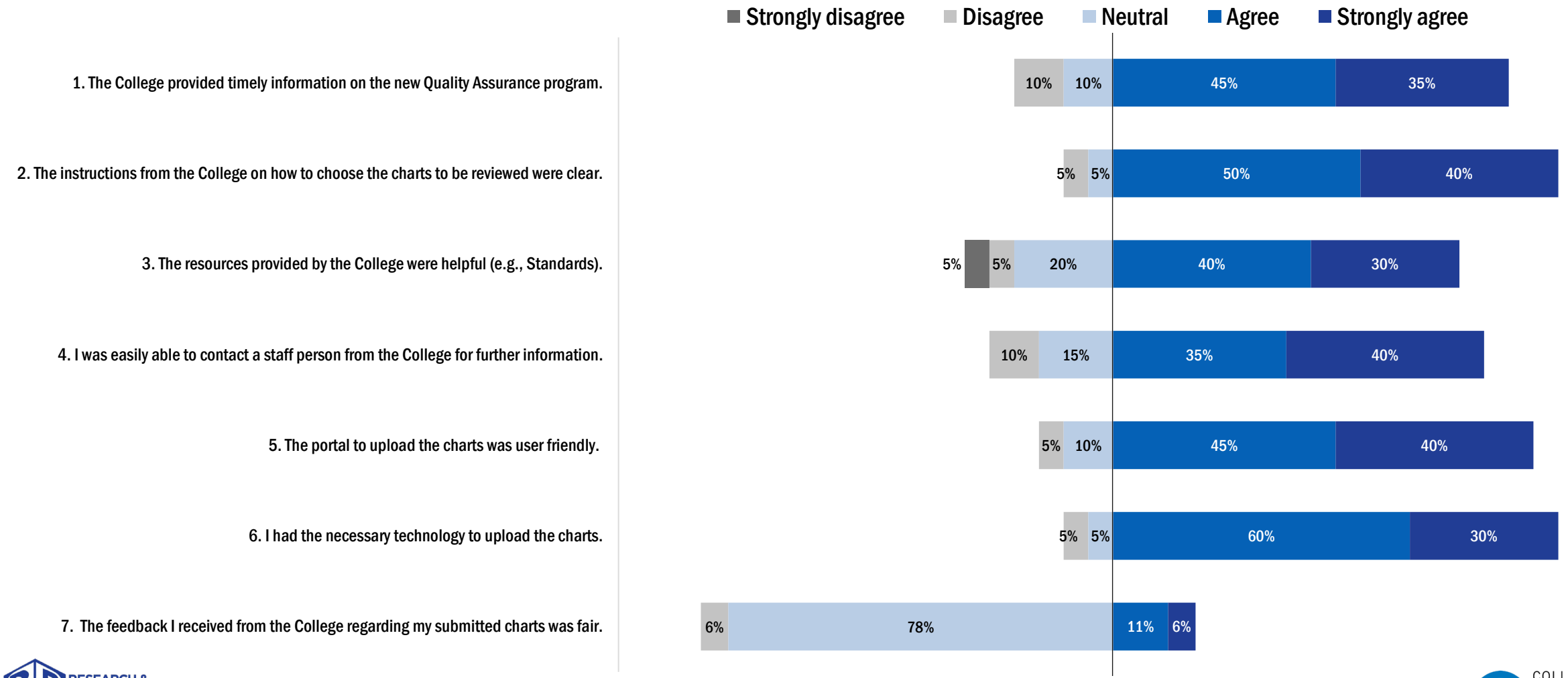
Registrants mostly **agreed** with all the statements on the Chart Review Protocol, but there was a notable amount of disagreement with the statement on resources.

Overall, results were positive with only the statement on resources from the College garnering strong disagreement.



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Some of the **Registrants'** comments were focused only on Feedback, as we note that the College's feedback to them was not ready when they were asked to complete the survey.

I have not received feedback yet regarding the charts. Not sure if I was supposed to by now since it was a question on the survey?

Feedback regarding charts is neutral because I have yet to receive feedback and due date for survey is 1 week from today.

Have yet to receive feedback on the charts

I never received feedback RE charts so could not really comment yet.

One of the Registrant's comments was positive.

I don't have anything specific to add, the process was clear and easy to follow. Instructions were good and email questions about the process were responded to promptly.

Some of the **Registrants'** comments offered constructive criticism, particularly regarding the timing of the pre-test.

"I was informed of the chart review in June or July. With the OHIP changes (that were to be implemented on Sept 1, 2023(and it being the busiest months for optometrists, I do not think that this is the best time to be doing chart reviews. I think the chart reviews should be done either in the Fall or Winter when in general things are not so busy at an office. Also, I was not informed of the directions or method by which to upload them on the original email. It was good. I would give it an 85%, it could be done better."

"My only suggestion would be perhaps doing the chart review in the winter months rather than the summer, I'm not sure if practitioners are selected for a practice assessment at various times throughout the year, but the summer always a busy time to have to add to our workload. Otherwise, the instructions/guidelines were clear and upload process was easy."

"More time to submit would be appreciated (especially if the submission period is in the summer when many people take time off/holidays)."

"I have not received any feedback on my charts so Q7 was irrelevant. Also, I think the chart review system is flawed and the QA questionnaire is irrelevant and tedious - especially for associates. There are some really bad charts and EMRs out there that will never be evaluated because Chart Review allows the doctor to select only their best charts. It annoys me that we have to do a silly exercises like this while the College isn't addressing the things that are actually problematic in our profession in Ontario. Also, submission date was due on August 21st, the person who provided the secure links was out of office during that time and then the submission deadline was extended. Just wondering what/how much forethought was put into this pilot program."

"I have had no feedback to date on my submissions which is confusing and concerning at the same time. This should be much more timely going forward. My only other comment is that this will be more difficult to execute for optometrists who are not tech savvy."

Summary of **Assessors' Agreement** on a **Registrant's** Submitted Patient Records

Registrant	Overall Agreement %	Decision Consistency Qualitative	Decision Consistency Numeric	Point-biserial Correlation
RPA5	1.00	Yes	1	
RPA30	0.99	Yes	1	
RPA60	0.99	Yes	1	
RPA82	0.98	Yes	1	
RPA78	0.97	Yes	1	
RPA26	0.97	Yes	1	
RPA75	0.96	Yes	1	
RPA63	0.95	Yes	1	
RPA23	0.95	Yes	1	
RPA42	0.94	Yes	1	
RPA40	0.94	Yes	1	
RPA8	0.94	No	0	
RPA11	0.94	Yes	1	
RPA77	0.94	Yes	1	
RPA17	0.92	Yes	1	
RPA81	0.92	Yes	1	
RPA36	0.92	No	0	
RPA1	0.91	Yes	1	
RPA67	0.90	Yes	1	
RPA57	0.89	Yes	1	
RPA16	0.89	No	0	
RPA80	0.89	Yes	1	
RPA31	0.89	No	0	
RPA48	0.88	Yes	1	
RPA9	0.88	Yes	1	
RPA59	0.86	No	0	
RPA83	0.79	Yes	1	
RPA28	0.72	No	0	
	0.916			**0.429**
	Very Strong			**Strong**

All decision inconsistencies must be investigated to ascertain the root causes of the disagreement.

Further, on RPA83 and RPA28, where the total agreement percentage is <80%, a follow up conversation with the assessors is recommended.

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Summary of **Assessors' Agreement** on a **Registrant's** Submitted Patient Records

Registrant	Overall Agreement %	Decision Consistency Qualitative	Decision Consistency Numeric	Point-biserial Correlation
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RPA60	0.99	Yes	1	
RPA82	0.98	Yes	1	
RPA78	0.97	Yes	1	
RPA26	0.97	Yes	1	
RPA75	0.96	Yes	1	
RPA63	0.95	Yes	1	
RPA23	0.95	Yes	1	
RPA42	0.94	Yes	1	
RPA40	0.94	Yes	1	
RPA8	0.94	No	0	
RPA11	0.94	Yes	1	
RPA77	0.94	Yes	1	
RPA17	0.92	Yes	1	
RPA81	0.92	Yes	1	
RPA36	0.92	No	0	
RPA1	0.91	Yes	1	
RPA67	0.90	Yes	1	
RPA57	0.89	Yes	1	
RPA16	0.89	No	0	
RPA80	0.89	Yes	1	
RPA31	0.89	No	0	
RPA48	0.88	Yes	1	
RPA9	0.88	Yes	1	
RPA59	0.86	No	0	
RPA83	0.79	Yes	1	
RPA28	0.72	No	0	
	0.916			**0.429**
	Very Strong			**Strong**

Even where both raters agreed on the decision to recommend the CSR or not:

In RPA80 (89% agreement), Assessor 1 gave critical misses (<2 on a critical indicator) on 5 of the 10 charts and did not recommend a CSR, while Assessor 2 gave critical misses on just 2 of 10 charts.

In RPA57 (89% agreement), Assessor1 gave critical misses (<2 on a critical indicator) on 7 of the 10 charts and did not recommend a CSR, while Rater 2 gave critical misses on just 2 of 10 charts.

In RPA11 (94% agreement), Assessor 2 gave critical misses (<2 on a critical indicator) on 5 of the 10 charts and did not recommend a CSR, while Assessor 1 gave critical misses on just 3 of 10 charts.

In RPA 81 (91% agreement), Assessor 1 did not make a recommendation, but based on the ratings, their decision was considered a "No" that a CSR would not be required.

The assessors in these cases must be interviewed to ascertain their rationale for their decisions.

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Assessor interviews and further training

As a result of the findings from the CRP pre-test, specifically, the inter-rater reliability analyses, some assessors were contacted by the College to ascertain the rationale behind some of their ratings. For example, some assessors did not select registrants for a chart stimulated review assessment even though they rated several of the registrants' charts deficient in critical indicators.

Slides 18 through 20 show the summary of the assessors' rationale for their ratings. In two cases, the assessor simply was not aware of the criteria for a CSR assessment.

Slides 18 through 20, as well as a summary of the CRP pre-test data were shared with all assessors in a supplemental training session that took place, virtually, on April 29th, 2024. In this training session, the College's practice lead reviewed indicators where there was some inconsistencies with assessors' ratings in the CRP pre-test.

No policy or procedural changes were made to the CRP assessment process, as inconsistencies in some assessors' ratings were due to the lack of assessors' thorough understanding of the CRP assessment process.

Summary of reasons for **CRP Assessors' not Recommending a Chart Stimulated Review (CSR) assessment**

Registrant	Overall Agreement %	Decision Consistency Qualitative	Decision Consistency Numeric	Point-biserial Correlation
RPA5	1.00	Yes	1	
RPA30	0.99	Yes	1	
RPA60	0.99	Yes	1	
RPA82	0.98	Yes	1	
RPA78	0.97	Yes	1	
RPA26	0.97	Yes	1	
RPA75	0.96	Yes	1	
RPA63	0.95	Yes	1	
RPA23	0.95	Yes	1	
RPA42	0.94	Yes	1	
RPA40	0.94	Yes	1	
RPA8	0.94	No	0	
RPA11	0.94	Yes	1	
RPA77	0.94	Yes	1	
RPA17	0.92	Yes	1	
RPA81	0.92	Yes	1	
RPA36	0.92	No	0	
RPA1	0.91	Yes	1	
RPA67	0.90	Yes	1	
RPA57	0.89	Yes	1	
RPA16	0.89	No	0	
RPA80	0.89	Yes	1	
RPA31	0.89	No	0	
RPA48	0.88	Yes	1	
RPA9	0.88	Yes	1	
RPA59	0.86	No	0	
RPA83	0.79	Yes	1	
RPA28	0.72	No	0	
	0.916			**0.429**
	Very Strong			**Strong**

Had misses on several charts for #7 BCVA, which are grounds for a CSR.

"In all the cases that I marked BCVA as partially met , the candidate was only missing near (reading) VA. They always recorded monocular best corrected distance acuities. I don't consider failing to record best corrected reading vision as anything that requires further action, except for maybe a reminder to record it. If they were missing distance BCVA I would have recommended CSR.

Maybe the criteria for #7 could be changed to specify 'monocular BCVA at distance'."

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Summary of reasons for **CRP Assessors' not Recommending a Chart Stimulated Review (CSR) assessment**

Registrant	Overall Agreement %	Decision Consistency Qualitative	Decision Consistency Numeric	Point-biserial Correlation
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RPA26	0.97	Yes	1	
RPA75	0.96	Yes	1	
RPA63	0.95	Yes	1	
RPA23	0.95	Yes	1	
RPA42	0.94	Yes	1	
RPA40	0.94	Yes	1	
RPA8	0.94	No	0	
RPA11	0.94	Yes	1	
RPA77	0.94	Yes	1	
RPA17	0.92	Yes	1	
RPA81	0.92	Yes	1	
RPA36	0.92	No	0	
RPA1	0.91	Yes	1	
RPA67	0.90	Yes	1	
RPA57	0.89	Yes	1	
RPA16	0.89	No	0	
RPA80	0.89	Yes	1	
RPA31	0.89	No	0	
RPA48	0.88	Yes	1	
RPA9	0.88	Yes	1	
RPA59	0.86	No	0	
RPA83	0.79	Yes	1	
RPA28	0.72	No	0	
	0.916			**0.429**
	Very Strong			**Strong**

Indicators #7 (BCVA), #11 (IOPs), #12 (optic nerve head), and #13 (posterior segment) are critical competencies and must be met (i.e., receive a score of 2) to indicate quality care. For several patient records, you rated 'partially met' or 'unmet' (i.e., score of 1 or 0) for the critical competency #7 (BCVA); however, you did not recommend CSR as next step. The other assessor assigned to the same case also noted similar deficiencies for the critical competency #7 (BCVA), but they recommended CSR as next step.

"I have reviewed the charts and realized I did not recommend CSR as the minimum standard of 31 out of 40 for each of the 10 records were met.

Going through the criteria for referral for CSR , as the core indicators were not met over many records then yes, these set of records should be referred to CSR for assessment."

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Summary of reasons for **CRP Assessors' not Recommending a Chart Stimulated Review (CSR) assessment**

Registrant	Overall Agreement %	Decision Consistency Qualitative	Decision Consistency Numeric	Point-biserial Correlation
RPA5	1.00	Yes	1	
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	Very Strong			**Strong**

Indicators #7 (BCVA), #11 (IOPs), #12 (optic nerve head), and #13 (posterior segment) are critical competencies and must be met (i.e., receive a score of 2) to indicate quality care. For both Case ID #RPA11-23 and #RPA31-23, you rated 'partially met' or 'unmet' (i.e., score of 1 or 0) for several critical competencies; however, you did not recommend CSR as next step.

"Thanks for bringing this to my attention. I think I may have misunderstood the requirements for the recommendation for the Chart Stimulated Recall. I thought that as long as the member was getting 31/40 on most charts that a CSR was not required. Also, I thought that the decision with regards to a CSR was not based on my recommendation but rather the actual scores of the member and how he/she did on the critical competency areas. Since I am used the previous method of the short record assessment, I thought the QA committee would look through my chart assessment and make that decision. My apologies for the confusion.

So, to clarify:
- If a member scores less than 31/40 on any one or more of the 10 charts reviewed;
- and/or if he/she has not scored a 2 on any one of the critical competencies in any of their 10 charts, a CSR should be recommended?"

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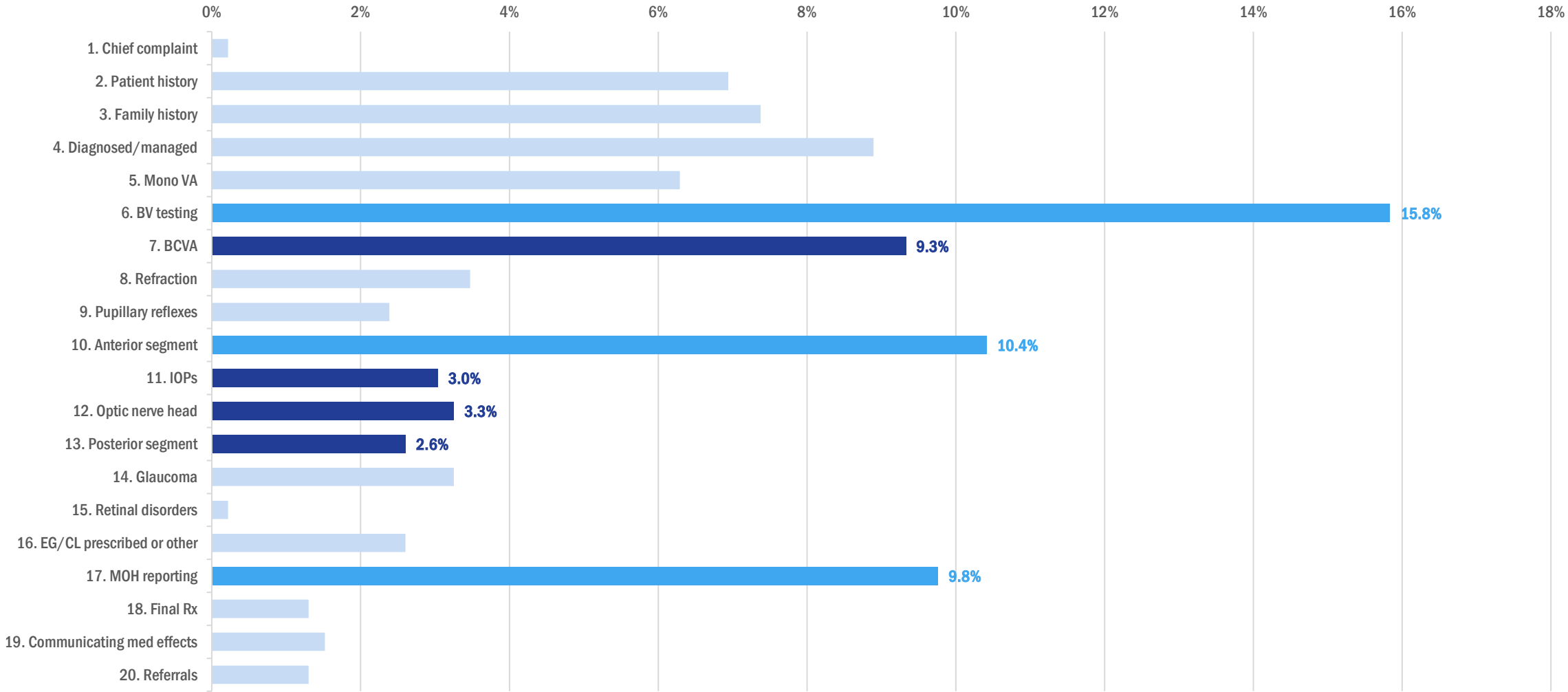
Occurrences of **Assessors' Disagreement** by Chart Review Protocol **Indicators**

The **largest proportion of disagreements** among raters occurred in **BV testing, Anterior segment, and MOH reporting**, while of the **critical indicators**, **BCVA** had the highest proportion of disagreements among raters.



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Occurrences of **Assessors' Disagreement** by Chart Review Protocol **Indicators and Number of Charts**

Indicator	Occurences of Disagree	Percent of Occurrences	Percent of Charts
1. Chief complaint	1	0.2%	0.4%
2. Patient history	32	6.9%	11.4%
3. Family history	34	7.4%	12.1%
4. Diagnosed/managed	41	8.9%	14.6%
5. Mono VA	29	6.3%	10.4%
6. BV testing	73	15.8%	**26.1%**
7. BCVA	**43**	**9.3%**	15.4%
8. Refraction	16	3.5%	5.7%
9. Pupillary reflexes	11	2.4%	3.9%
10. Anterior segment	48	10.4%	17.1%
11. IOPs	**14**	**3.0%**	5.0%
12. Optic nerve head	**15**	**3.3%**	5.4%
13. Posterior segment	**12**	**2.6%**	4.3%
14. Glaucoma	15	3.3%	5.4%
15. Retinal disorders	1	0.2%	0.4%
16. EG/CL prescribed or other	12	2.6%	4.3%
17. MOH reporting	45	9.8%	16.1%
18. Final Rx	6	1.3%	2.1%
19. Communicating med effects	7	1.5%	2.5%
20. Referrals	6	1.3%	2.1%
Totals	**461**	**100.0%**	

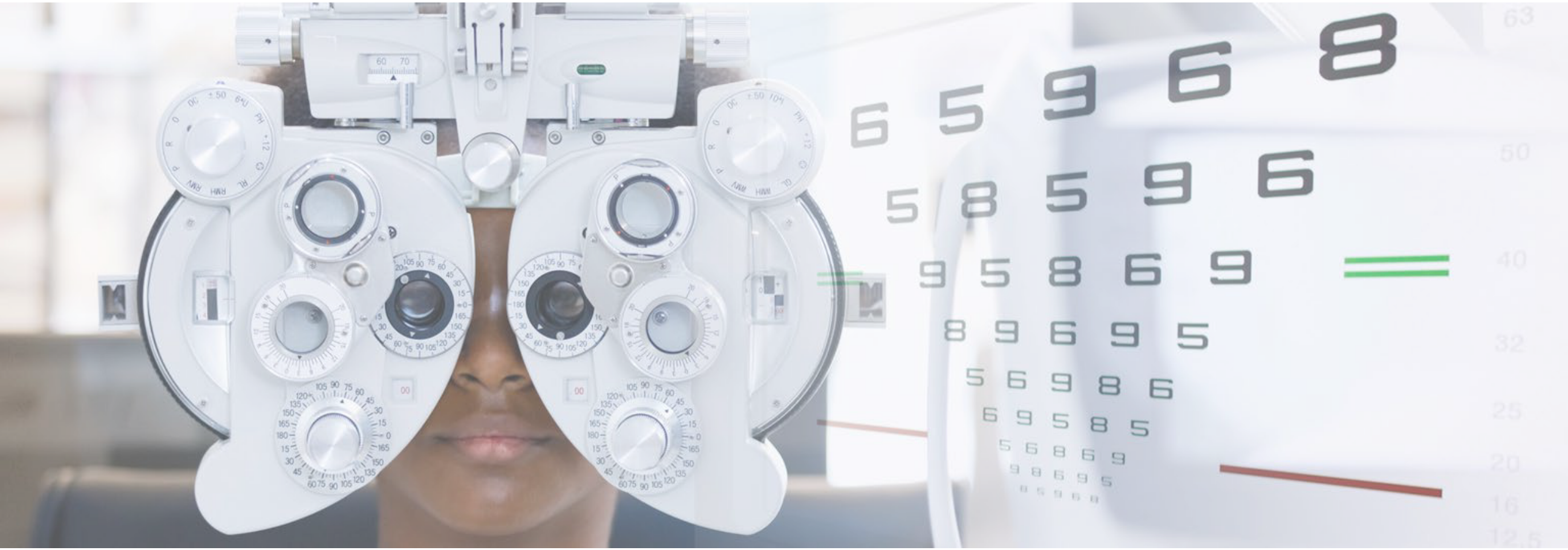
The occurrences of disagreements among assessors is most on BV testing, Anterior segment and MOH reporting, as well as **BCVA, a critical indicator.**

Further training is required on these indicators where the most disagreement occurred.

This training must be carried out by experienced PA assessors and/or subject matter experts.

Addendum: The supplemental training occurred on April 29, 2024, and was led by the College's practice lead.

The Chart-Stimulated Review Protocol



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Assessors were asked to rate their agreement with the following statements regarding the **Chart-Stimulated Recall Protocol**. Summary results are provided by count and percentage, with **highest percentages** noted.

Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Overall
1. The College provided timely information on the new Quality Assurance program.	0	0	0	2	3	5
	0.00%	0.00%	0.00%	40.00%	**60.00%**	100.00%
2. The instructions from the College on how to conduct the Chart Stimulated Recall were clear (e.g., Training, written materials).	0	0	0	2	3	5
	0.00%	0.00%	0.00%	40.00%	**60.00%**	100.00%
3. The resources provided by the College were helpful (e.g. Standards, recording template).	0	0	0	2	3	5
	0.00%	0.00%	0.00%	40.00%	**60.00%**	100.00%
4. I was easily able to contact a staff person from the College for further information.	0	0	0	1	4	5
	0.00%	0.00%	0.00%	20.00%	**80.00%**	100.00%
5. I had the necessary environment (e.g., quiet space, internet access, video equipment) to conduct the interview with the registrant.	0	0	0	1	4	5
	0.00%	0.00%	0.00%	20.00%	**80.00%**	100.00%
6. The questions/probes asked were able to elicit the necessary information for clarification on the patient's chart.	0	0	0	3	2	5
	0.00%	0.00%	0.00%	**60.00%**	40.00%	100.00%
7. The Chart Stimulated Recall assessment process was fair to the registrant.	0	0	0	2	3	5
	0.00%	0.00%	0.00%	40.00%	**60.00%**	100.00%

Assessors generally agreed with the statements regarding the **Chart-Stimulated Recall** Protocol, and most strong in their agreement on statements 4 and 5, relating to the support of the College's staff and having the necessary equipment and environment to conduct the assessment, respectively.

Statement 6 relating to the questions and probes to elicit information from the registrant had the lowest percentage of "strongly agree," with only 40%.

The average Assessor rating across each of the seven statements was 4.63 / 5.

There was only one **Assessor** that commented, and they had a suggestion and some questions regarding the process.

"Suggestion: Assuming that reference to 'member' will be updated to 'registrant'. Further guidance in completing the template: Section D: Recommendations for remediation: Specific options to consider for remediation dependant *[sic]* upon the nature of the incompetency with the appropriate timeline. Recommendation(s): Further remediation: Further remediation after the other recommendations are completed or dependant *[sic]* upon the nature of the incompetency? This response to be completed by the assessor or later by committee?"

Registrants were asked to rate their agreement with the following statements regarding the **Chart-Stimulated Recall** Protocol. Summary results are provided by count and percentage, with **highest percentages** noted.

Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Overall
1. The College provided timely information on the new Quality Assurance program.	0	2	1	1	4	8
	0.00%	25.00%	12.50%	12.50%	**50.00%**	100.00%
2. The information from the College was clear on the reason why a Chart Stimulated Recall assessment was needed.	0	1	1	3	3	8
	0.00%	12.50%	12.50%	**37.50%**	**37.50%**	100.00%
3. The resources provided by the College were helpful (e.g., Standards).	0	1	2	2	3	8
	0.00%	12.50%	25.00%	25.00%	**37.50%**	100.00%
4. I was easily able to contact a staff person from the College for further information.	0	0	1	2	5	8
	0.00%	0.00%	12.50%	25.00%	**62.50%**	100.00%
5. I had the necessary environment (e.g., quiet space, internet access, video equipment) to participate in the CSR interview.	0	0	0	4	4	8
	0.00%	0.00%	0.00%	**50.00%**	**50.00%**	100.00%
6. The questions/probes asked were able to elicit the necessary information for clarification on the patient's chart.	0	0	2	2	4	8
	0.00%	0.00%	25.00%	25.00%	**50.00%**	100.00%
7. The information provided to me by the assessor during the interview (e.g., the QA steps, report process) was sufficient.	0	0	1	4	3	8
	0.00%	0.00%	12.50%	**50.00%**	37.50%	100.00%

Registrants were not as strong in their agreement as assessors in their ratings of the **Chart Stimulated Recall** Protocol, which is similar to how the former rated the CRP. Registrants were most positive on statements, relating to the support of the College's staff.

Statements 2 and 3, relating to the information from the College as to why a CSR was necessary and resources provided by the College, respectively had the lowest agreement.

The average Registrant rating across each of the seven statements was 4.18 / 5.

Four **Registrants** added comments. Two comments were related to the time the assessment process took from start to completion, and one comment was very positive, and aligned to the purpose of the CSR.

"The process is excessively long. As the process is the punishment, taking one year to complete it is too long to be concerned about potential ramifications of the chart review."

"From the time information was submitted until the review was over 6 months. This seems like an inordinate amount of time to wait. The process itself was helful *[sic]* and useful for clarification however it was stated that it may be up to another 6 months before the entire process is finished. (That will make it over one year since information was submitted) I really do not think this is an acceptable amount of time."

"Nothing to add."

"The Chart-Stimulated Recall process went very smoothly and gave me an opportunity to address any further questions that the quality assurance assessors may have had."

Discussion

Overall, assessors commented that the new Chart Review Protocol was objective and fair. They felt the option of assigning partially met scores was beneficial. They valued the opportunity to provide comments and feedback for registrants. They suggested that the comment area at the end of the form be used for general or follow up comments to registrants in addition to any critical chart review comments.

Assessors would like more clarity around the statement about driver's license restrictions, and this reported lack of clarity was also manifested in the number of assessor disagreements on this indicator (#17) . Questions around the objectivity of clinical judgement as well as number and breadth of charts selected were also raised, but these issues were not deemed as unfair.

Critical comments from the registrants were mostly focused on the timing of the pretest of the CRP and not on its objectivity or fairness. Though one registrant suggested that allowing practitioners to select their own charts was not going to identify "bad charts." Still, the registrants' relatively low rating for agreement with the statement on resources requires follow-up.

Finally, the IRR analysis suggests there is strong agreement on most indicators but there are several [e.g., BV testing (#6), Anterior segment (#10) and MOH reporting (#17)] where there is cause for concern in the different interpretations of the assessors. This difference in interpretation is especially an issue on the critical indicators where BCVA (#7) had just over 9% of the overall disagreements. Through another lens, the 45 occurrences of disagreement on the BCVA means there was disagreement between the raters on this indicator on 16% of the charts.

Discussion cont.

Further, decision inconsistency occurred for one in five registrants. Taken at face value, this is troubling. However, some of this decision inconsistency may be due to the assessors not understanding the cut score and/or the implications of sub- 2 ratings on the critical indicators. This issue is not evidence that the CRP is unfair or overly subjective, rather the assessors in some cases did not know what chart score profile should lead to a recommendation for a CSR assessment.

We recommended some supplemental assessor training/communication on interpretation of the indicators where there was the most disagreement, and training on the chart score profile that should lead to the recommendation of a CSR assessment. It was clear from the assessor surveys that instructions were not clear on how to use the CRP, and this likely contributed to the disagreements on ratings and recommendations.

Training on the interpretation of the indicators is more clinical in nature and should be carried out by experienced assessors. Finally, since the College knows the identity of the assessors, the College must conduct follow-up discussions with the assessors who scored multiple critical misses across several charts but did not recommend a CSR and use this information in the supplemental training.

Addendum: The College's outreach to CRP assessors that had inconsistencies in their ratings and/or did not recommend a CSR assessment when criteria for the recommendation was met occurred in April of 2024 and the supplemental training session for all CRP assessors, led by the College's practice lead took place virtually on April 29, 2024.

Discussion cont.

Feedback on the pre-test of the Chart-Stimulated Recall Protocol was generally positive from assessors. Registrants were not as positive, but this trend occurred with the CRP as well.

Registrants' comments on the CSR were critical of the time the assessment took from beginning to the end. There are two factors that contributed to this extended timeline. First, the CRP and CSR are two, separate assessments, functioning as the new Practice Assessment component of the College's QA program. Registrants are likely used to the old Short Record Assessment's timeline. Second, due to the nature of the pre-test of the new PA, support systems and "normal" operating procedures are not fully operational, likely adding time to the assessment process.

As the College begins the pilot testing phase, we recommend that registrants be notified that the assessment process may take longer than in the past due to the potential for two assessments, rather than one. The College should also be tracking the assessment time – from start to completion – for each registrant in the pilot test, to further inform the live implementation and to look for efficiencies in the process.

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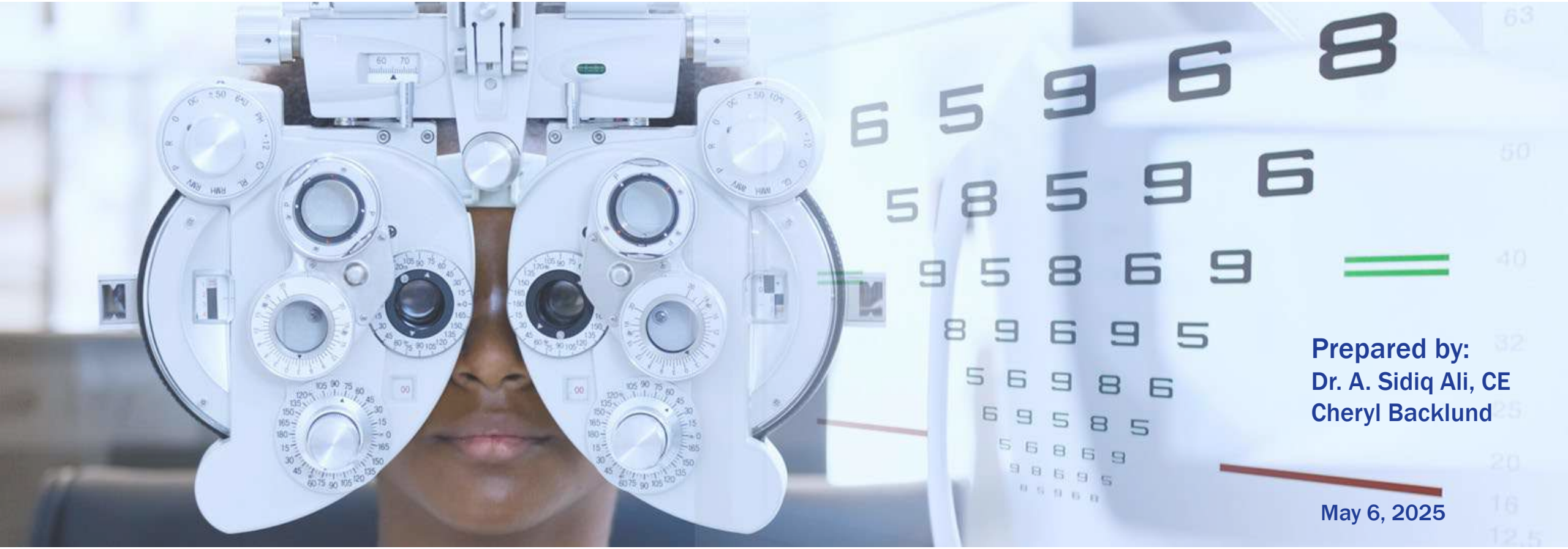
Pilot-Test Results
(for the new Peer Assessment Component of the QA Program)



Prepared by:
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May 6, 2025

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Overview

The pilot-test of the new Practice Assessment (PA) component of the College of Optometrists of Ontario's Quality Assurance Program occurred from October of 2024 through January of 2025. The pilot was conducted after learnings from a smaller-scale pre-test of the new PA were implemented.

The new PA consists of two instruments, focused on the assessment of ten patient files from each registrant. First, is a Chart Review Protocol (CRP), like the previous Short Record Assessment, but with a 3-point scale (0 – unmet, 1 – partially met, 2 – met) on 20 indicators derived from the Optometric Practice References (OPR) Standards of Practice, the 2020 Competencies for Optometry, and common areas of complaints. The CRP relies on assessors' application of clinical judgement using the OPR as guidance. For a registrant's chart to be considered high quality, 4 critical indicators (#s 7, 11, 12 and 13) must be scored a '2' or 'met' and the total score must meet or exceed 31 out of 40. This is a two-hurdle, objective standard of quality. This instrument, however, also allows for the assessor to use their clinical judgement rather than just checking boxes.

For any chart that does not meet the quality standard, the registrant **may be** recommended by the assessor to undergo the second new PA component, the Chart–Stimulated Recall Protocol (CSRP). The CSRP is a guided interview protocol where the assessor asks the registrant specifically about the deficits or issues identified by the CRP review. This second assessment provides the registrant with an opportunity to explain their rationale for their charting and provides the assessor with more information on which to make their recommendations to the QA Panel.

Overview cont.

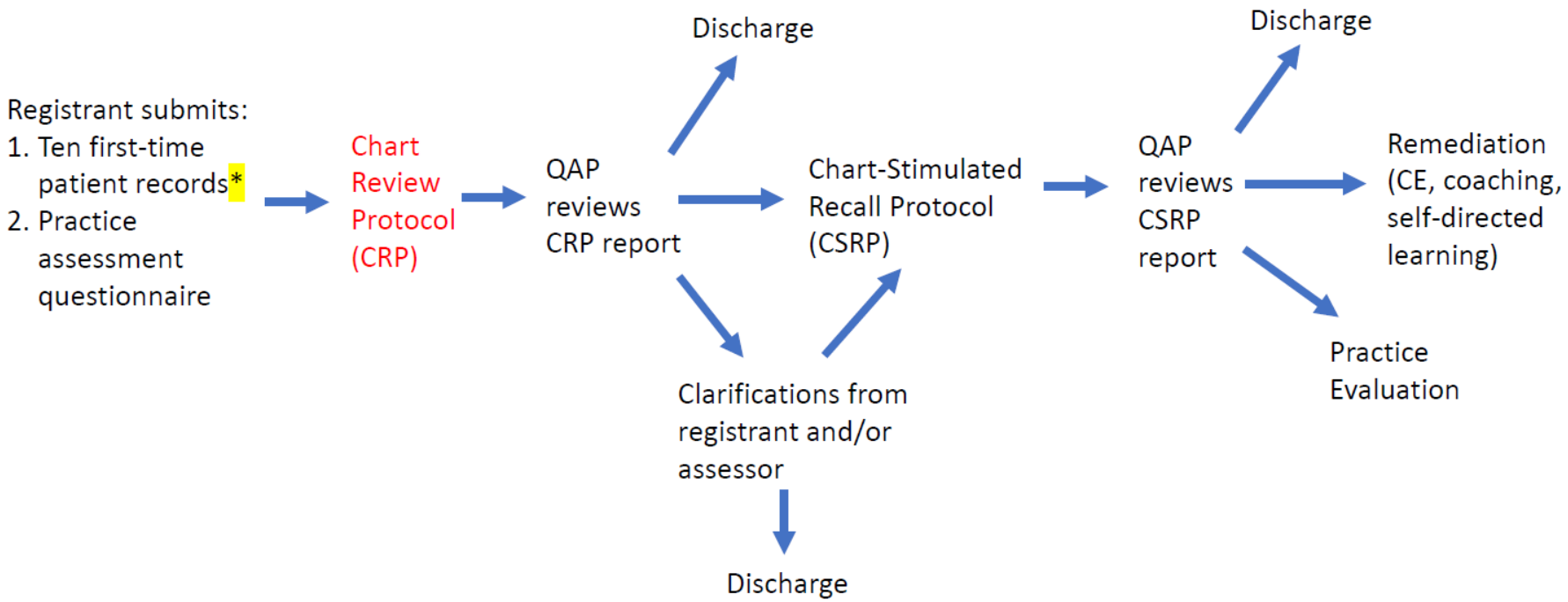
A pilot test of the new PA, with its two new assessment instruments, was intended to put the instruments and the PA assessors through real-world use, though on a limited, purposeful sample of registrants. In all, 84 registrants were selected for the pilot. All 84 had their 10 prescribed patient files (records) assessed by **two** assessors. Two assessors were used to measure their agreement or alignment, technically referred to as interrater reliability (IRR), as we aimed to ensure that each assessor was approaching the assessment and using the instruments in the same way.

One of the goals of the new PA was to have consistency in decision making (i.e., implementing objective quality standards/pass scores) while also allowing assessors to exercise their clinical judgement. This approach would help us achieve another goal of the new PA, which was fairness to the registrant.

Learnings from the pilot test will inform any updates/refinements to the indicators as well as further assessor training on the assessment process before the new PA is rolled-out system-wide later in 2025.

Overview cont.

The New Practice Assessment Process



Overview cont.

Collection and Analyses of the Pilot Data

Using data provided from the assessors on the College's data collection portal, we downloaded pairs of anonymized reports on each registrant. The reports were in PDF, but analysis in Excel was necessary. The PDF data could not be copied and pasted or converted directly to Excel data due to extraneous lines and spaces in the files. So, we transcribed much of the data. A transcription quality and accuracy check was conducted by the College, and some identified discrepancies were corrected.

We conducted an Interrater Reliability (IRR) analysis on the CRP results that examined:

- Assessors' Overall Agreement % (across the registrant's 10 submitted patient files)
- Decision Consistency (to recommend a CSRP); and
- Indicators with the most Disagreement.

Our learnings from the IRR analysis are provided in this summary report.

Further, we collected and analyzed perceptual data on the pilot-test of the CRP and CSRP through assessor and registrant surveys about the new PA instruments and related processes; the results are also included in this report.

Finally, we conclude this summary report with a Discussion of results and some data-based recommendations.

Inter-rater Reliability (IRR) Analysis: Overview

Inter-rater reliability measures the agreement between subjective ratings by multiple raters – in this case, peer assessors. It answers the question, is the rating system (application of the instruments) consistent? High inter-rater reliability indicates that multiple raters' ratings for the same criteria (the registrant's submitted patient files) are consistent. Conversely, low reliability means they are inconsistent. High levels of assessor consistency in the pilot gives us strong evidence that the assessors will rate registrants' patient files reliably in the live rollout of the New PA, when only a single assessor is assigned to a registrant's patient files.

Our chosen metric for expressing IRR is the percent of all possible agreements between assessors for each of the 20 indicators across the registrant's ten submitted patient files.

There are 20 possible agreements (1 for each indicator) for each patient file provided by the registrant. Ten patient files from each registrant are submitted for assessment, giving us 200 possible agreements. The percentage of agreements for each registrant's submitted patient files is summed and divided by 10 to provide the overall IRR for the registrant's patient files.

We then looked at the decision consistency between the two assessors; that is whether they agreed, based on their ratings and clinical judgement that the registrant required a follow-up CSRP or not.

Inter-rater Reliability (IRR) Analysis: Results

The results of the IRR show much agreement among assessors for each registrant's submitted patient files. There are, however, **three patterns** revealed in the data that will be explained in the following two slides.

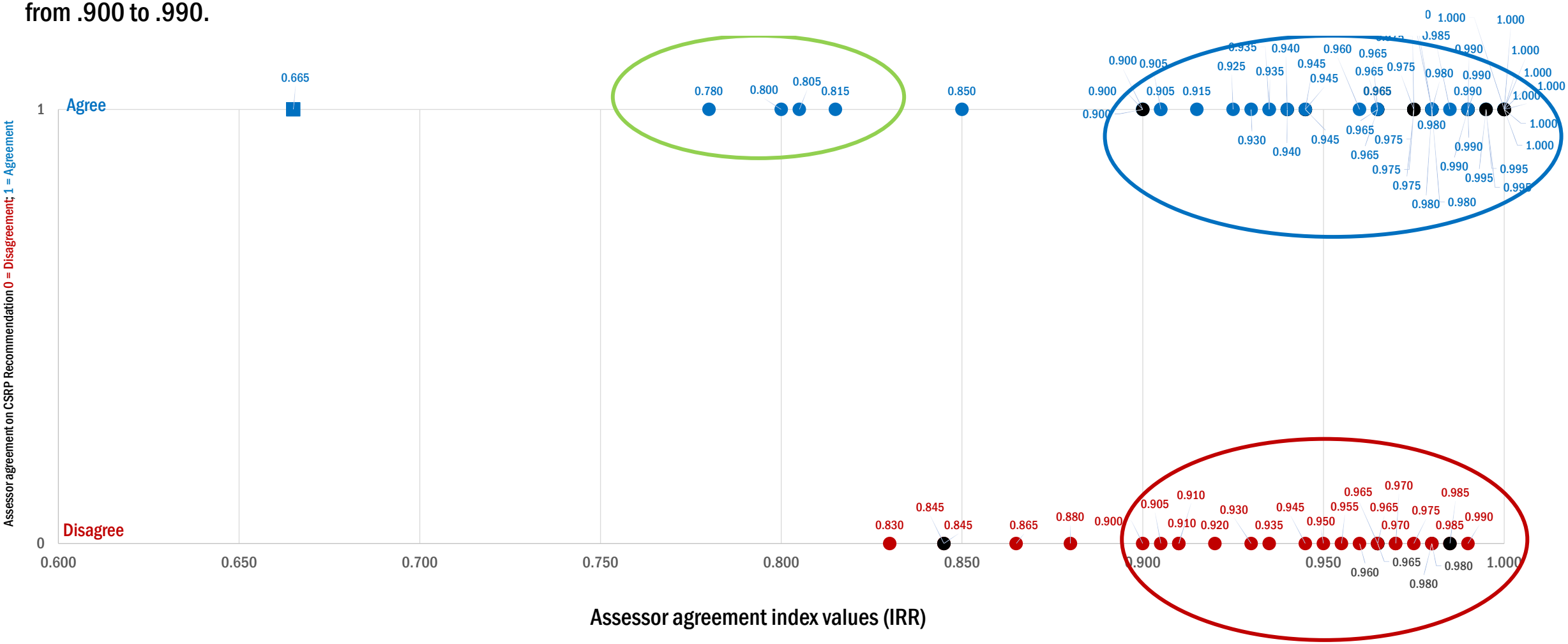
The first pattern is among the assessors that **agreed** on their data-based and clinical judgement-guided recommendation for a CSRP based on the results of the CRP. On the following slides this pattern is denoted by a blue oval.

The second pattern is among assessors that **disagreed** on their data-based and clinical judgement-guided recommendation for a CSRP based on the results of the CRP. On the following slides this pattern is denoted by a red oval.

The third pattern is found in the assessors that **agreed** on their recommendation for a CSRP but had very low IRR at the indicator-level. On the following slides, this pattern is denoted by a green oval.

Pilot Test IRR Results

When assessors had IRR greater than or equal to .990 on a registrant's records, they were considerably more likely to **agree** on a decision to recommend a CSRP. In all **56 cases** where assessors **agreed** on the recommendation for a CSRP, 91% of the IRR scores ranged between .900 and 1.00; however, in the 28 cases where the assessors **disagreed** on a recommendation for a CSRP, 79% of the IRR scores ranged from .900 to .990.



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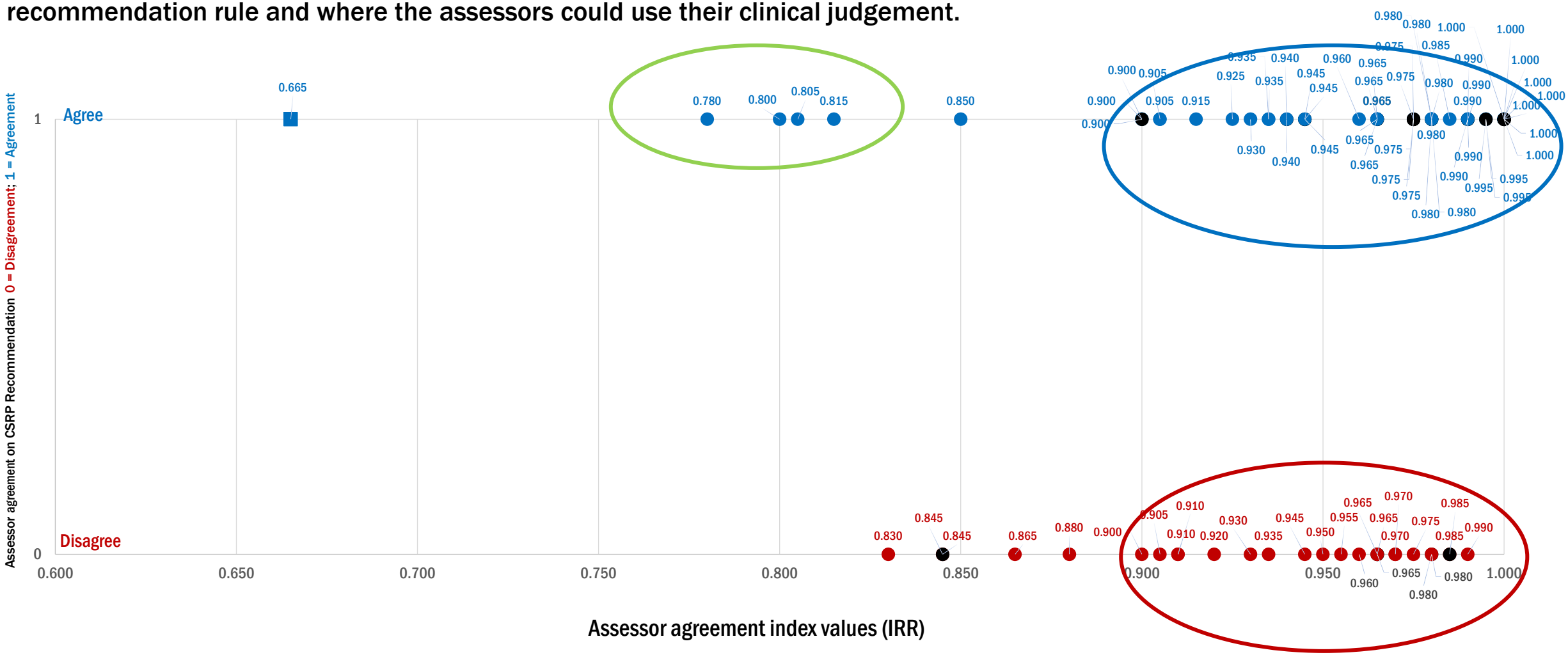
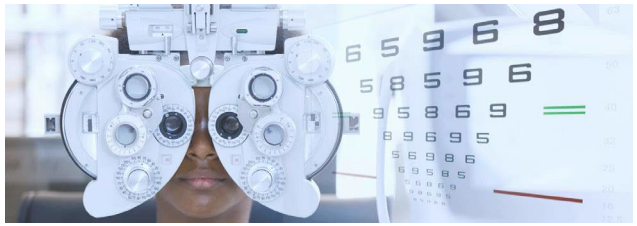
Pilot Test IRR Results: Follow-up

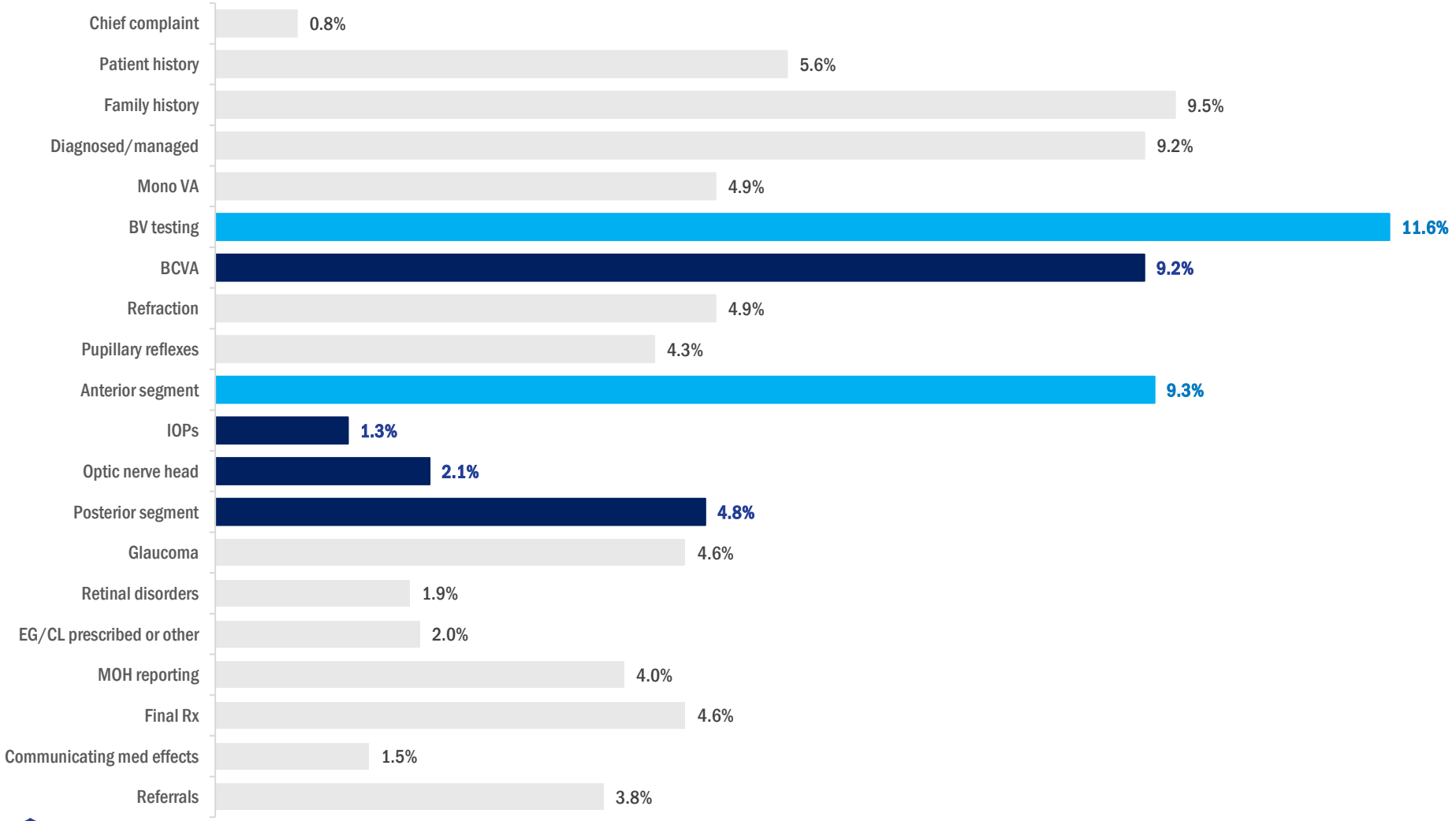
When we investigated further, we found out that where there was high agreement at the micro-level (on the indicators) but there was not consistency in decisions to recommend the CSRP (red oval), it was a misunderstanding of the "automatic" recommendation rule and where the assessors could use their clinical judgement.



Pilot Test IRR Results: Disagreements



The greatest proportion of assessor disagreements (~12%) occurred in (#6) BV Testing and (#10) anterior segment (~9%), while among the mandatory indicators, (#7) BCVA had the greatest percentage of assessor disagreements (~9%).



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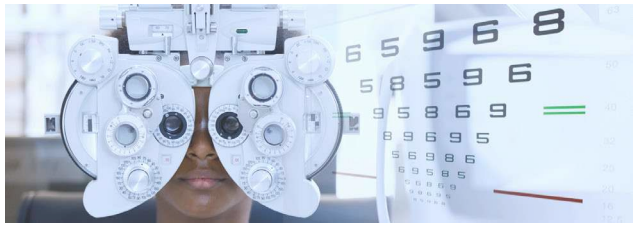
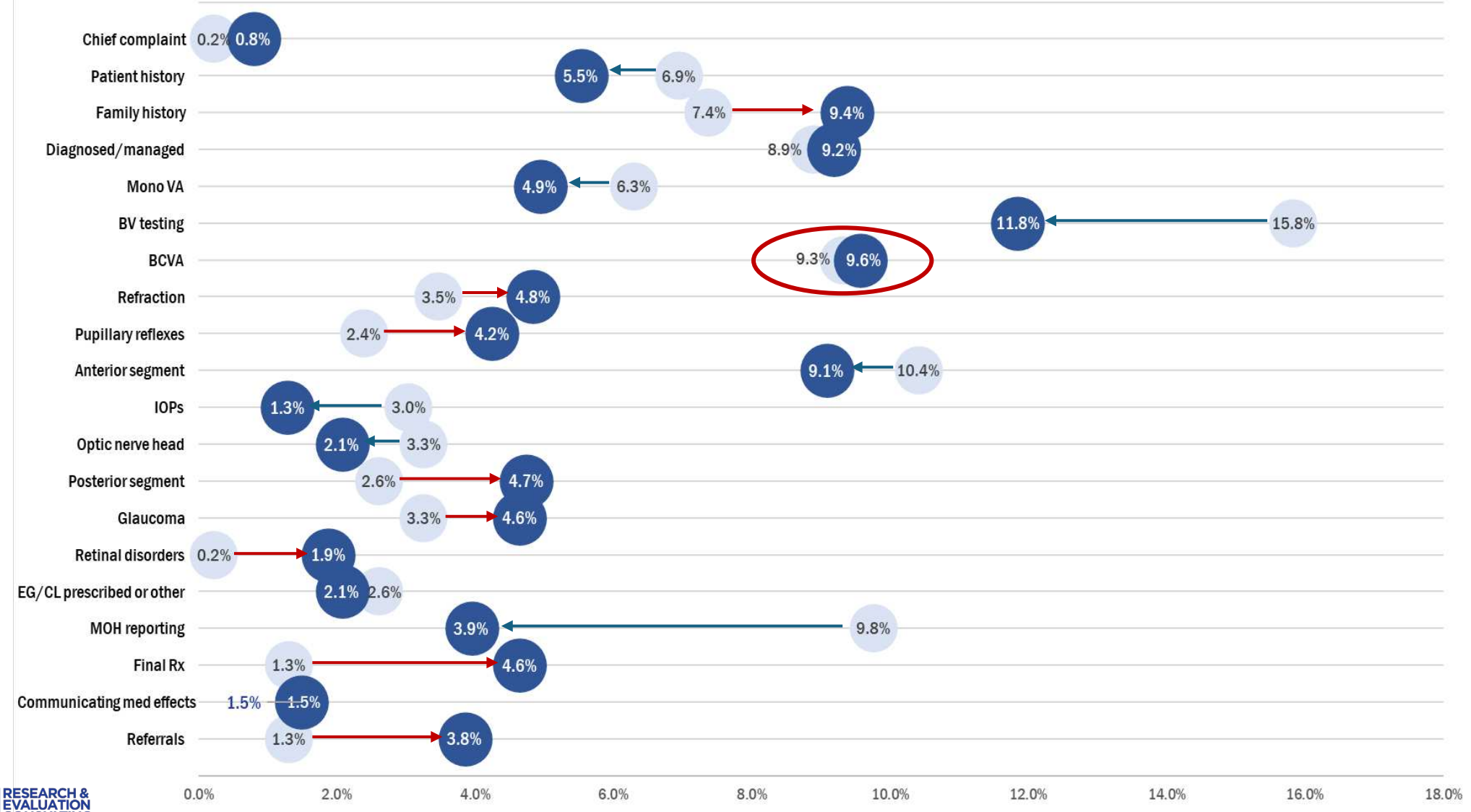
Pilot Test IRR Results: Disagreements



About half the indicators showed a decrease in disgreements from the Pre test to the Pilot test, with *MOH reporting* and *BV testing* showing the most decreases, but *Family history* and *Final Rx* showed the most increase in disagreements from Pre test to Pilot



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Pilot Test Learning: Rater Disagreement

Here we present information on our investigations into the sources of rater disagreements.

There were two main issues:

1) wording of a critical indicator and
2) a lack of clarity around the automatic triggers for a CSRP and the application of assessors' clinical judgement.

Each of these issues will be explored further in the forthcoming slides.

Finally, the indicators where assessors disagreed the most, have been identified for further training.

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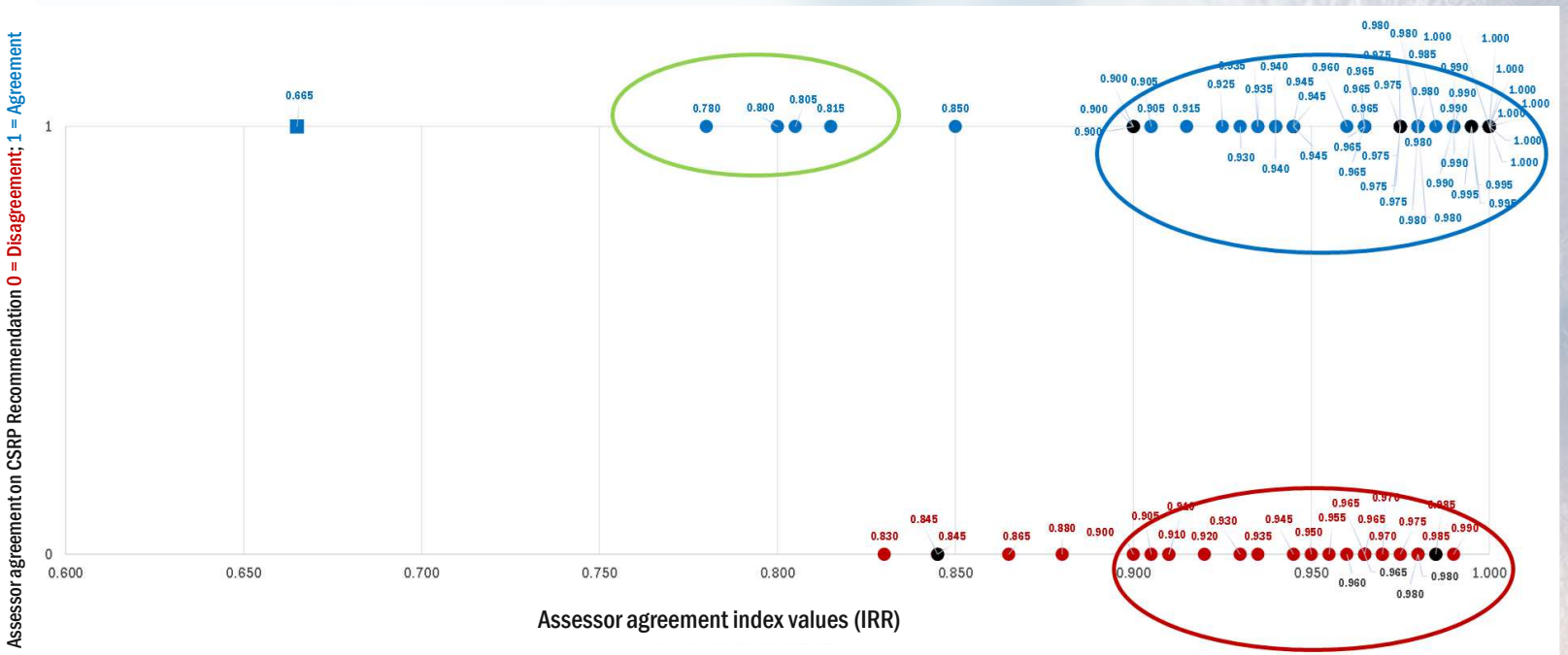
Pilot Test Learning: Indicator Wording

7. Monocular BCVA at distance recorded; ~~[BCVA at near (binocular or monocular) recorded, if indicated]~~ (OPR 4.2)

BCVA – Indicator 7 (Critical) continues to be problematic – the pilot test revealed that the description of the indicator, specifically the bracketed text, was not grounded in the OPR. The bracketed description was then difficult for assessors to interpret, hence the high (9.6%) number of disagreements. Clear and correct interpretation is paramount, especially on a critical indicator. As a result, it was decided mutually between the QA panel and the psychometric consultants that the bracketed wording be excluded from the indicator on the CRP moving forward.

Pilot Test Learning: Rater Agreement and CSRP Automatic Trigger



Investigation by COO uncovered that where there was high IRR agreement but inconsistent CSRP recommendations (i.e., red oval); this was due largely to the lack of clarity re: the automatic trigger for a CSRP recommendation and application of assessors' professional judgement to recommend a CSRP. We learned that clearer direction as to when an "automatic CSRP" would be triggered, and when an assessor could recommend a CSRP for a registrant was needed. COO and RaECon worked collectively to better define the "automatic" CSRP trigger and when and how the assessor may exercise their clinical judgement in making or not making the recommendation for a CSRP (see next slide).

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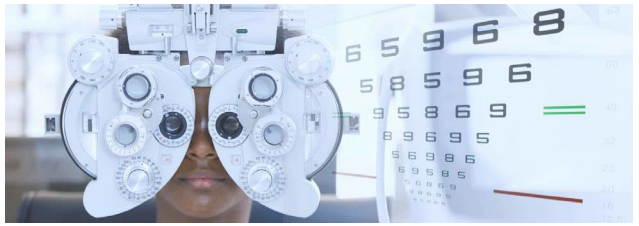
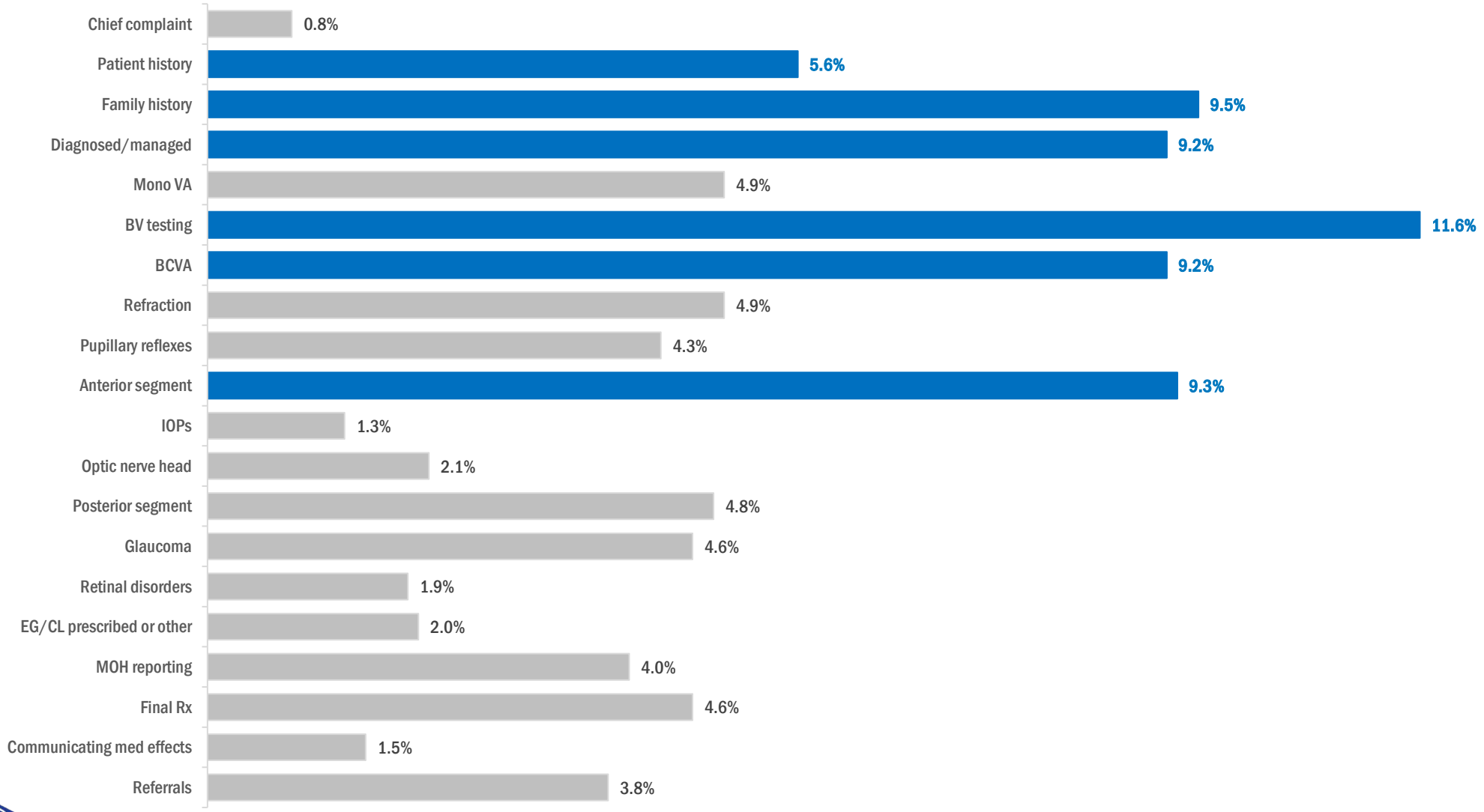
Pilot Test Learning: Clarifying the Automatic CSRP Trigger and the use of Assessors' Clinical Judgement

Scenario	Ratings and Professional Judgement	Select the CSRP Recommendation Box	Expected Frequency	General Notes
1.	Failed cut-score and/or did not meet a critical competency, *and you agree that a CSRP is warranted*	Yes	Most cases will fall under Scenario 1 or 3	Optional: Add context, if needed
2.	Failed cut-score and/or did not meet a critical competency, *but you feel that a CSRP is not warranted*	Yes	Infrequent	Provide a comment explaining why a CSRP *is not* warranted
3.	Met all cut-scores and critical competencies, *and you agree that a CSRP is not warranted*	No	Most cases will fall under Scenario 1 or 3	
4.	Met all cut-scores and critical competencies, *but you feel that a CSRP is warranted*	Yes	Infrequent	Provide a comment explaining why a CSRP *is* warranted

Pilot Test Learning: Focusing on Assessor Disagreements



The six indicators with greater than 5% disagreements should be targeted for further assessor training.



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Pilot Test: Observational Results

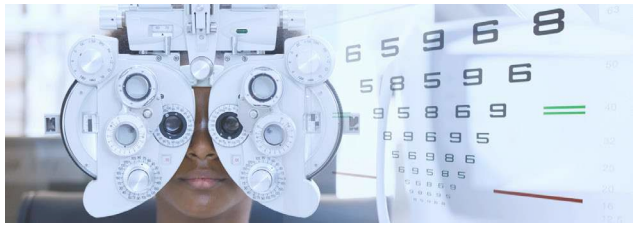
Data sources here included:

1) Outcomes of the CRP and CSRP assessments;
2) Surveys on the CRP and CSRP processes for Assessors and Registrants, and
3) Learnings from follow-up Assessor Training

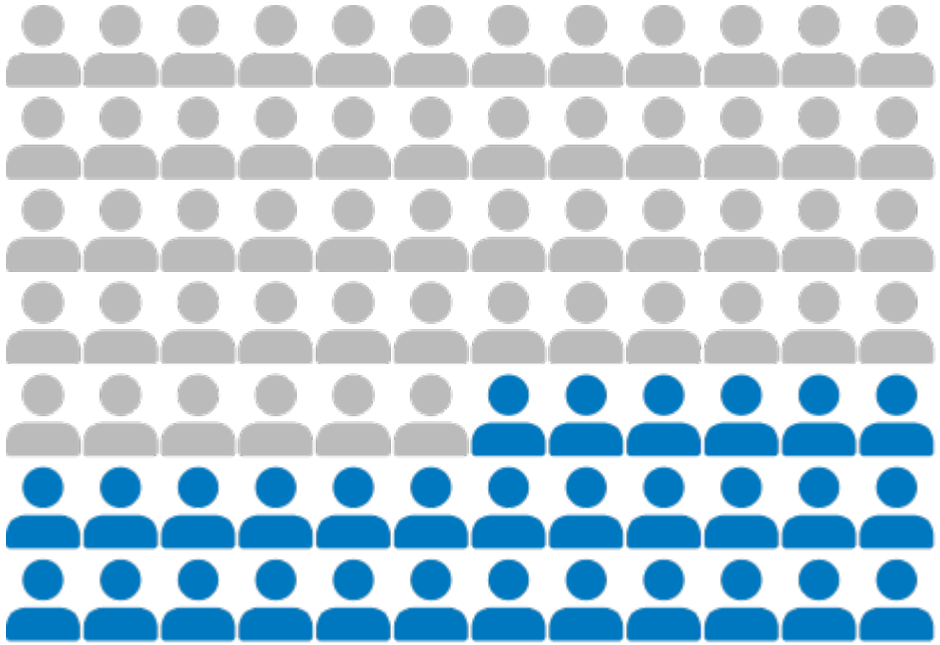
Surveys for the CRP were administered in the November and December of 2024, and surveys for the CSRP were administered in March of 2025.

A follow-up Training Session for Assessors was conducted on March 27, 2025.

Pilot Test Results of CRP and CSRP Assessments



In total, no more than **36%** of those registrants assessed using the CRP were recommended for a **CSRP**.



Based on results from the CRP assessment, the QA Panel decided **30** of 84 registrants would undergo a **CSRP assessment.**

In total, no more than **3.6%** of those registrants assessed required **remediation**.

27 of 30 were **discharged** after the result of their CSRP assessment.

2 required remediation

1 requires further clarification from the assessor before a decision can be made (as of late February 2025).

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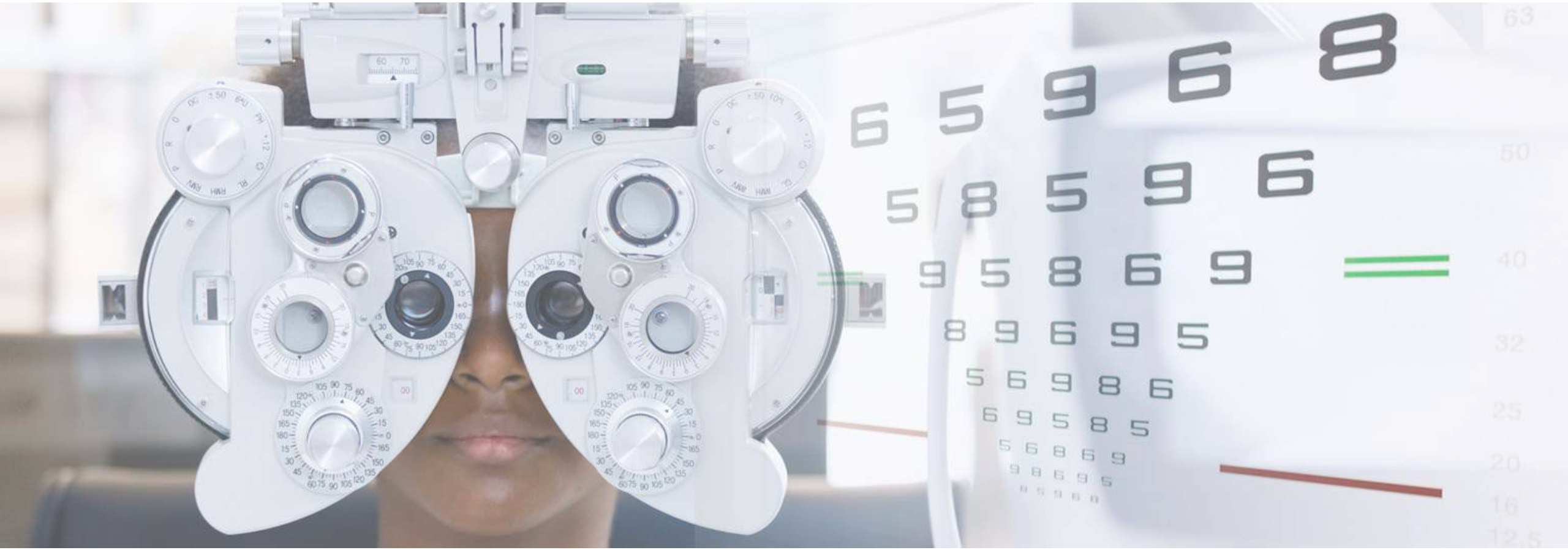
The Chart Review Protocol (CRP): Survey Results



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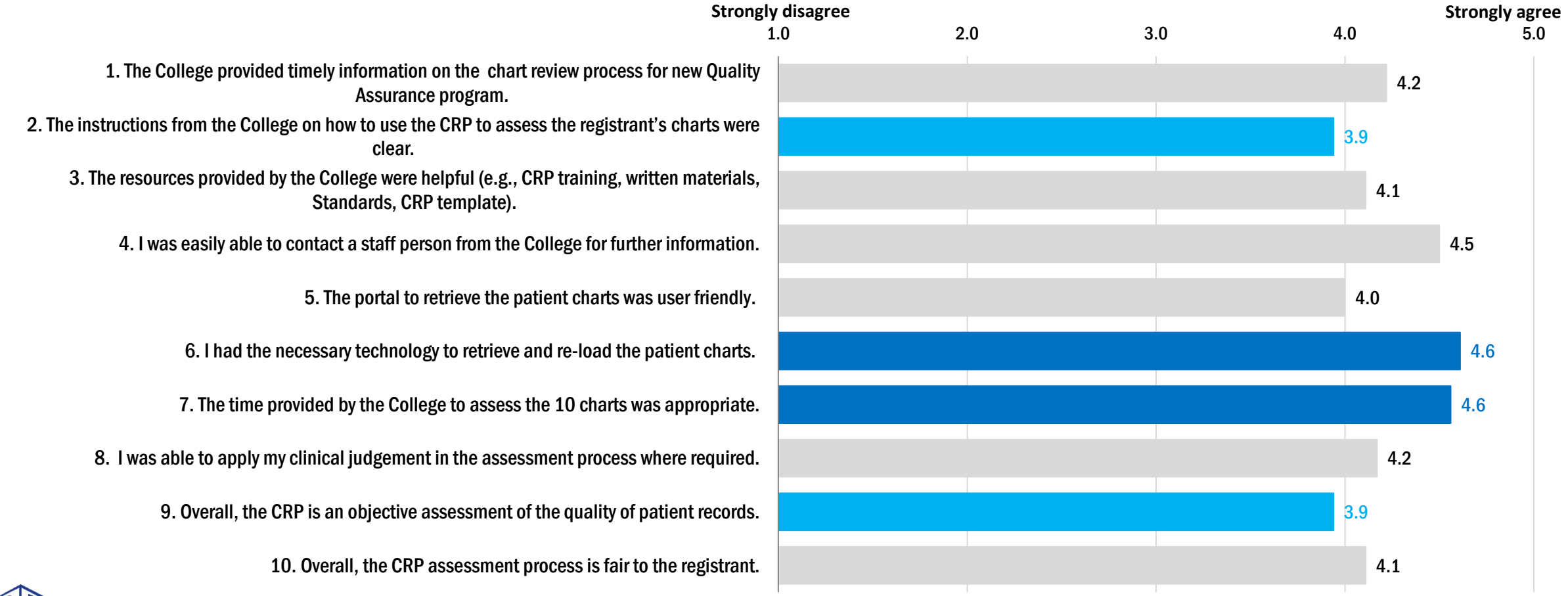
Assessor Survey: CRP

Assessors were asked to rate their agreement with the following statements regarding the Chart Review Protocol. Summary results are provided by count and percentage, with **highest percentages** across categories noted.

Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Overall
1. The College provided timely information on the chart review process for new Quality Assurance program.	0	0	4	6	**8**	18
	0.00%	0.00%	22.22%	33.33%	**44.44%**	100.00%
2. The instructions from the College on how to use the CRP to assess the registrant's charts were clear.	0	3	0	10	**5**	18
	0.00%	16.67%	0.00%	55.56%	**27.78%**	100.00%
3. The resources provided by the College were helpful (e.g., CRP training, written materials, Standards, CRP template).	0	2	2	6	**8**	18
	0.00%	11.11%	11.11%	33.33%	**44.44%**	100.00%
4. I was easily able to contact a staff person from the College for further information.	0	0	2	5	**11**	18
	0.00%	0.00%	11.11%	27.78%	**61.11%**	100.00%
5. The portal to retrieve the patient charts was user friendly.	0	0	4	**10**	4	18
	0.00%	0.00%	22.22%	**55.56%**	22.22%	100.00%
6. I had the necessary technology to retrieve and re-load the patient charts.	0	0	0	7	**11**	18
	0.00%	0.00%	0.00%	38.89%	**61.11%**	100.00%
7. The time provided by the College to assess the 10 charts was appropriate.	0	1	0	5	**12**	18
	0.00%	5.56%	0.00%	27.78%	**66.67%**	100.00%
8. I was able to apply my clinical judgement in the assessment process where required.	0	0	4	**7**	**7**	18
	0.00%	0.00%	22.22%	**38.89%**	**38.89%**	100.00%
9. Overall, the CRP is an objective assessment of the quality of patient records.	0	1	4	**8**	5	18
	0.00%	5.56%	22.22%	**44.44%**	27.78%	100.00%
10. Overall, the CRP assessment process is fair to the registrant.	0	1	2	**9**	6	18
	0.00%	5.56%	11.11%	**50.00%**	33.33%	100.00%

Assessor Survey: CRP

Overall, Assessors were in high agreement with the statements on the CRP Survey, averaging 4.2 out of 5. The highest rating belonged to *"6. I had the necessary technology to retrieve and re-load the patient charts,"* and *"7. The time provided by the College to assess the 10 charts was appropriate."* Agreement was lowest on statement *"2. The instructions from the College on how to use the CRP to assess the registrant's charts were clear,"* and *"9. Overall, the CRP is an objective assessment of the quality of patient records."*



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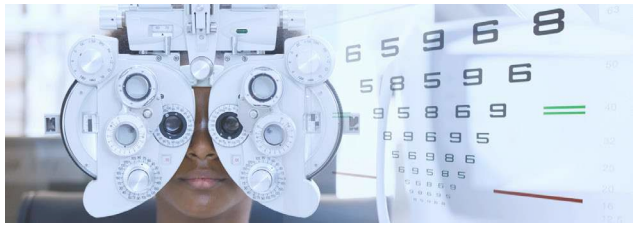
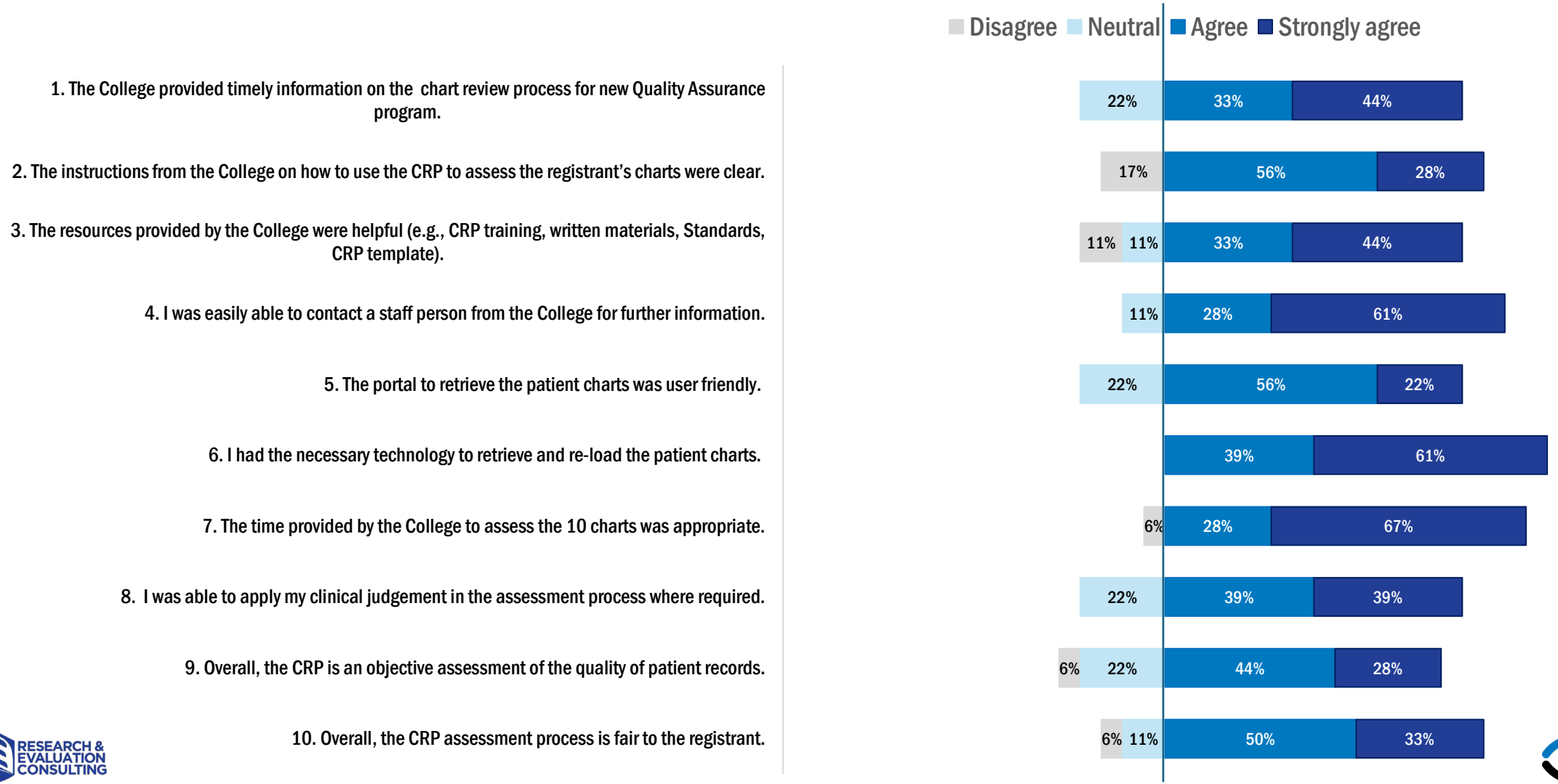
Assessor Survey: CRP



Assessors mostly agreed with all the statements on the Chart Review Protocol.

Overall, results were strongly positive in agreement, and like in the Pre-test, there were no responses in the Strongly Disagree category.



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Assessor Survey: CRP

Some of the Assessors' comments were focused on the concept of objectivity.

"I don't believe the CRP can be purely objective because clinical judgement of the assessor is required. For example, a 1-year-old child who cannot do VA's would technically fail the VA indicator #7 if we were to be objective. I also think it needs to be made clear what are the indications to which a CSR should be recommended. For example, if objectively a 1-year old's chart was failed because of indicator #7, I would not recommend a CSR because it wouldn't make sense - the doctor in this case did not harm the patient nor exercised malpractice. another example would be a 20-year-old mild myope with zero complaints, 20/20 near entering and 20/20 BCVA distance, normal BV findings, would not need BCNear VA's measured yet some assessors have failed this indicator. Many charts have additional testing (fundus imaging, OCT, neurolens measurements) with no interpretation of the testing. This to me seems like poor quality of care for the patient either because of unnecessary testing or missing diagnostic clinical findings. There is no indicator for this and it is unclear if this qualifies for a CSR."

"Objective but still some clinical judgment needed by assessor when things are not as black and white"

One of the Assessors' comments was positive.

"This new format of evaluating patient records is much more efficient."

One of the Assessors' comments was aimed at seeking help with decision-making.

"If a member did not fully meet the criteria depending how strict/easy the assessor is a member would either fail or pass. It would be nice to be able to ask other assessors how they would mark a member for those borderline cases. Perhaps have an anonymous email an assessor can email where other assessors could give their opinions. Or some poll system (vevox) they could take a poll and ask other assessors or have an A/Q page where it can guide the assessor. Similar to how you held the extra training for the driver's requirement."

Assessor Survey: CRP

Some of the Assessors' comments offered constructive criticism.

"The CRP is fine as is but what I found interesting were the unsolicited comments I received when I received my own CRP results for my clinical charts from other assessors. The comments given to me were often clinically incorrect and were just the personal opinion or misconception of the assessor, with one comment from an assessor saying "I don't think it's likely that this result was x y z". Whether an assessor thinks it's likely or not is not the most appropriate comment and strays from the overall CRP - the idea should be to the assess the charts at face value. I think the CRP comments from assessors should be as objective as possible."

"It may be helpful to provide more clear directions on certain questions. For ex- IOPs- there should maybe be an age (ex over 15) that IOPs are expected for? These general standards could be agreed upon by the assessors."

One of the Assessors' comments was negative.

"I believe the new process is very cookie cutter and while maybe more geared toward the member it minimizes the assessor to be nearly an AI type job rather than looking at the charts as a whole."

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Registrant Survey: CRP

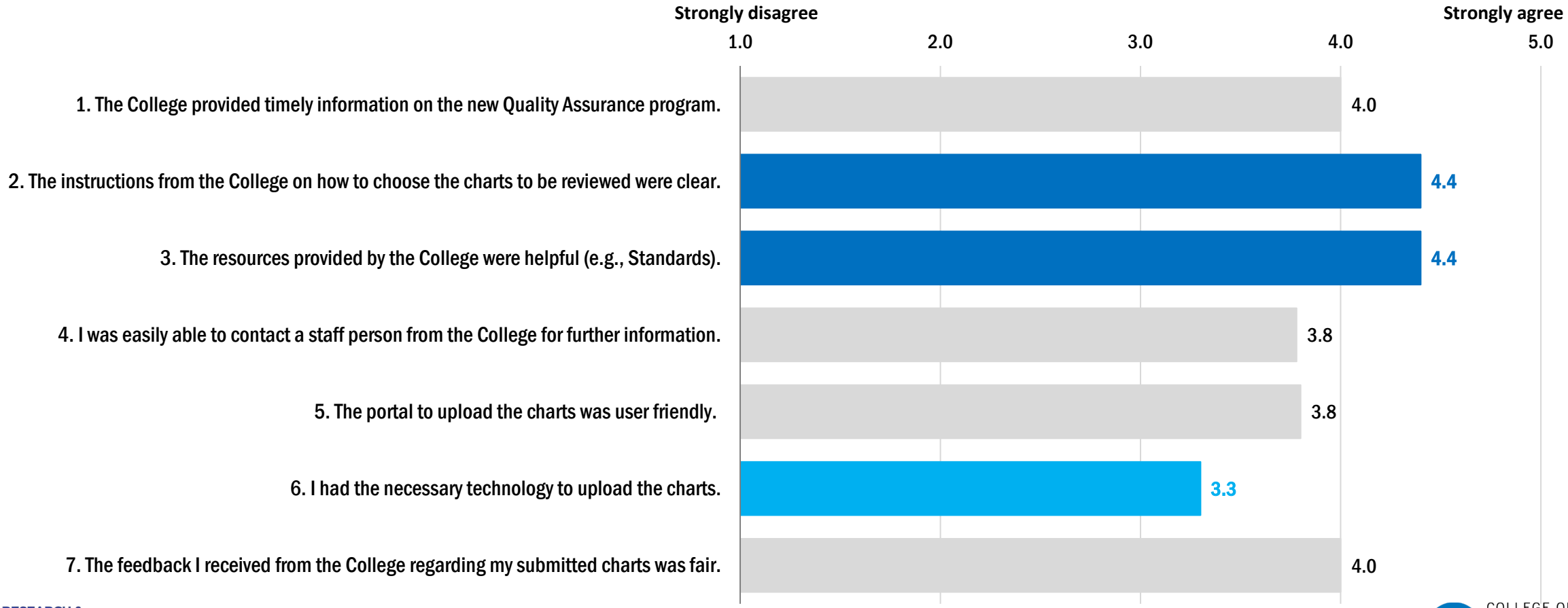
Registrants were asked to rate their agreement with the following statements regarding the **Chart Review Protocol**. Summary results are provided by count and percentage, with **highest percentages** across categories noted.

Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Overall
1. The College provided timely information on the new Quality Assurance program.	2	0	0	2	**6**	10
	20.00%	0.00%	0.00%	20.00%	**60.00%**	100.00%
2. The instructions from the College on how to choose the charts to be reviewed were clear.	1	0	1	0	**8**	10
	10.00%	0.00%	10.00%	0.00%	**80.00%**	100.00%
3. The resources provided by the College were helpful (e.g., Standards).	1	0	0	2	**7**	10
	10.00%	0.00%	0.00%	20.00%	**70.00%**	100.00%
4. I was easily able to contact a staff person from the College for further information.	1	0	3	1	**4**	9
	11.11%	0.00%	33.33%	11.11%	**44.44%**	100.00%
5. The portal to upload the charts was user friendly.	1	1	1	3	**4**	10
	10.00%	10.00%	10.00%	30.00%	**40.00%**	100.00%
6. I had the necessary technology to upload the charts.	1	**3**	1	2	**3**	10
	10.00%	**30.00%**	10.00%	20.00%	**30.00%**	100.00%
7. The feedback I received from the College regarding my submitted charts was fair.	1	0	2	2	**5**	10
	10.00%	0.00%	20.00%	20.00%	**50.00%**	100.00%

The response rate for the Registrants' survey on the CRP was very low, so results should be viewed with caution.

Registrant Survey: CRP

Overall, **Registrants'** agreement ratings were not as high as the Assessors, averaging 4.0 out of 5 across the statements. The highest rating belonging to *"2. The instructions from the College on how to choose the charts to be reviewed were clear,"* and *"3. The resources provided by the College were helpful (e.g., Standards)."* Statement #3 was rated lowest on the Pre-test CRP Survey, so the improvement to the Pilot-test CRP Survey is noted. The lowest agreement on the Pilot-test CRP Survey was for statement *"6. I had the necessary technology to upload the charts."*



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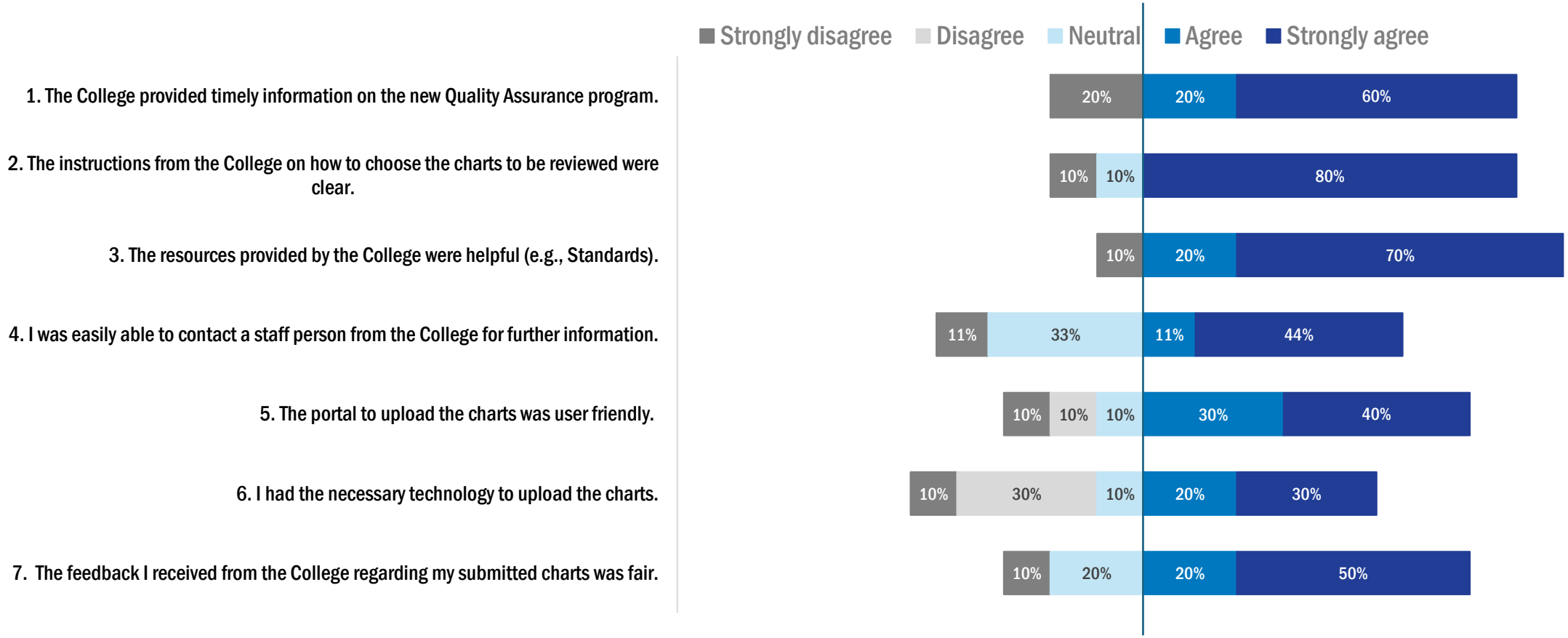
Registrant Survey: CRP

Registrants mostly agreed with all the statements on the Chart Review Protocol Survey, but there was a notable amount of disagreement with the statements on being able to contact a staff person (#4) and having the necessary technology to upload charts (#6).



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Registrant Survey: CRP

Most of the Registrants' comments were focused on the Technological issues of uploading their patient files.

"Combining charts into a single PDF was challenging. I had to do a free trial of adobe pro in order to do it. I could just do one with the free account and wouldn't allow me to do more than that. That was really my only hiccup during this process. Grace was an amazing help and got back to me right away with questions."

"I had assumed that my practice assessment was forgotten about because I did not expect it to take 6 months from my submission due date to receive the results. I would recommend providing an expected timeframe to receive results once charts are submitted. I chose "neutral" for the last question because there really wasn't any feedback included in the results, only that I was maintaining the professional standard."

"Unfortunately, I had to pay for a program to turn my files to pdf to merge and submit my charts and the required information needed to submit. The majority of my time for completing the practice review was spend trying to merge pdf files. I am not sure if there may be an easier platform that could be used."

"Although I know this may take more time, I think that more feedback would be great. We put in a lot of work to complete these random assessments, and I think it would be nice to feel like we too are getting something out of it! It will keep people up to date on charting as well as improving their charting over time."

One of the Registrant's comments was positive.

"Everything was easy to understand and complete."

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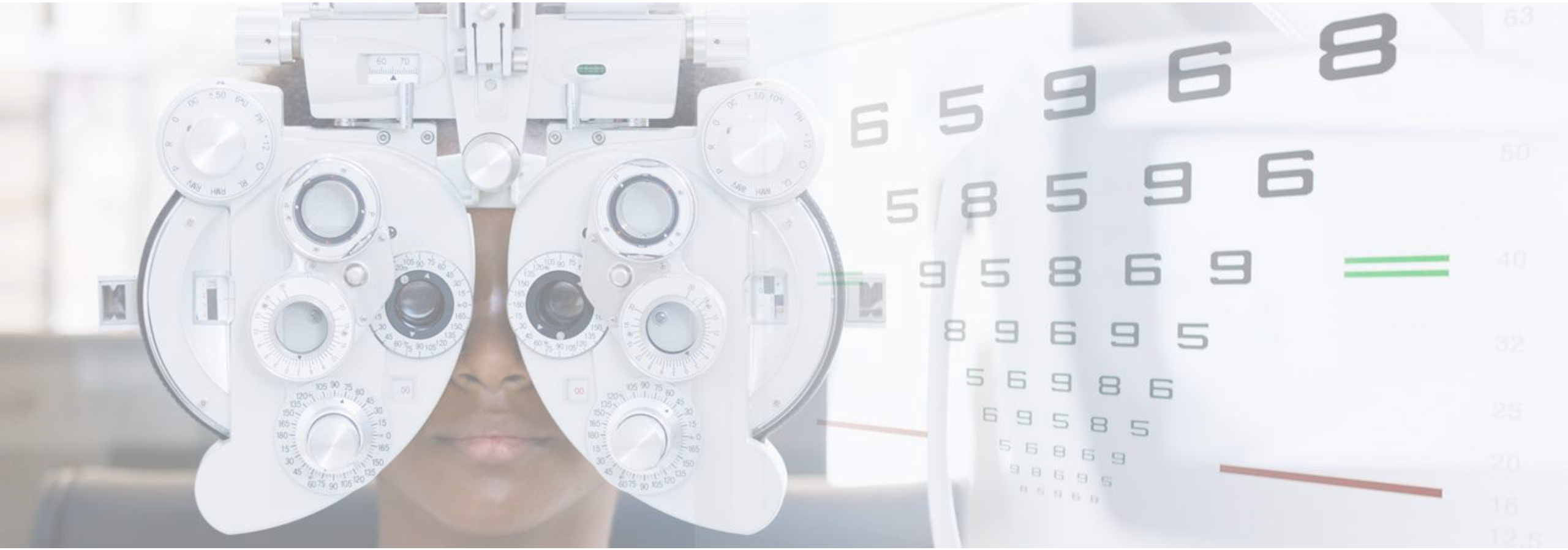
The Chart-Stimulated Recall Protocol (CSRP): Survey Results



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Assessor Survey: CSRP

Assessors were asked to rate their agreement with the following statements regarding the Chart-Stimulated Review Protocol. Summary results are provided by count and percentage, with highest percentages across categories noted.

Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Overall
1. The College provided timely information on the new Quality Assurance program.	0	1	0	2	2	5
	0.00%	20.00%	0.00%	40.00%	40.00%	100.00%
2. The information from the College was clear on the reason why a Chart Stimulated Recall assessment was needed.	0	0	0	2	3	5
	0.00%	0.00%	0.00%	40.00%	60.00%	100.00%
3. The resources provided by the College were helpful (e.g., Standards).	0	0	0	4	1	5
	0.00%	0.00%	0.00%	80.00%	20.00%	100.00%
4. I was easily able to contact a staff person from the College for further information.	0	0	0	2	3	5
	0.00%	0.00%	0.00%	40.00%	60.00%	100.00%
5. I had the necessary environment (e.g., quiet space, internet access, video equipment) to participate in the CSR interview.	0	0	0	2	3	5
	0.00%	0.00%	0.00%	40.00%	60.00%	100.00%
6. The questions/probes asked were able to elicit the necessary information for clarification on the patient's chart.	0	0	1	1	3	5
	0.00%	0.00%	20.00%	20.00%	60.00%	100.00%
7. Overall, I found the new QA process to be fair.	0	0	0	3	2	5
	0.00%	0.00%	0.00%	60.00%	40.00%	100.00%

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The number of responses from the Assessors' survey on the CSRP was very low, so results should be viewed with caution.

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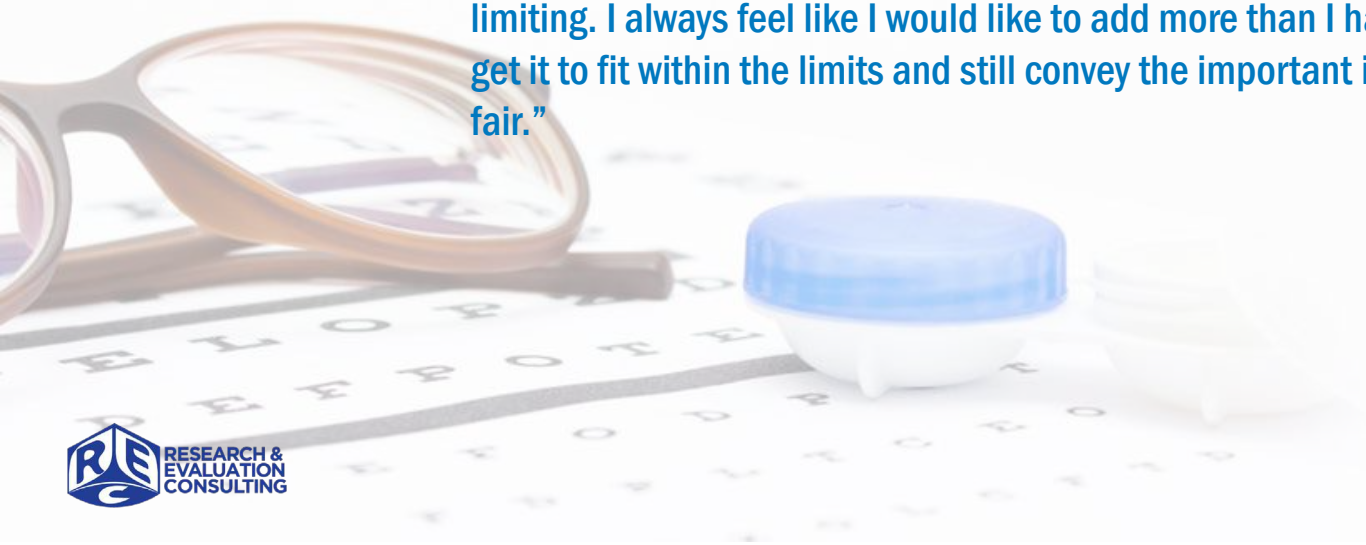
Assessor Survey: CSRP

The 2 comments from Assessors were generally positive, supporting the design goal of fairness to the registrant and offered some constructive criticism aimed at the wording on the CSRP and the character limits of the data entry fields.

"Template Section D: Feedback and Recommendations #3. "Up to Three Recommendations for Remediation" - followed by "Recommendation(s): Further Remediation" Y/N I understand that the assessment process is considered remediative, but I find the word "further" implies additional remediation over and above the recommendations provided. I feel that it would make more sense to have this noted at #3 as "Remediation: Y/N" followed by "Recommendations for Remediation" Interviews: I found that the CSRP process allowed registrants to reflect on their exam practices and patient record documentation in general as well as with the particular case being reviewed. Some commented on areas where they would make improvements based in this reflection."

"I believe some of the question probes in each area could be improved to help further guide the assessor in drawing out the relevant information from the registrant. I also feel that the character limits on the text fields for the assessor to fill out are very limiting. I always feel like I would like to add more than I have space for and am rewording and editing my text ten time over to try get it to fit within the limits and still convey the important information in my report. Overall, the process is very good, and I feel very fair."



Registrant Survey: CSRP

Registrants were asked to rate their agreement with the following statements regarding the Chart-Stimulated Review Protocol. Summary results are provided by count and percentage, with highest percentages across categories noted. The response percentages here are identical to those of the Assessors.

Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Overall
1. The College provided timely information on the new Quality Assurance program.	0	1	0	**2**	**2**	5
	0.00%	20.00%	0.00%	**40.00%**	**40.00%**	100.00%
2. The information from the College was clear on the reason why a Chart Stimulated Recall assessment was needed.	0	0	0	2	**3**	5
	0.00%	0.00%	0.00%	40.00%	**60.00%**	100.00%
3. The resources provided by the College were helpful (e.g., Standards).	0	0	0	**4**	1	5
	0.00%	0.00%	0.00%	**80.00%**	20.00%	100.00%
4. I was easily able to contact a staff person from the College for further information.	0	0	0	2	**3**	5
	0.00%	0.00%	0.00%	40.00%	**60.00%**	100.00%
5. I had the necessary environment (e.g., quiet space, internet access, video equipment) to participate in the CSR interview.	0	0	0	2	**3**	5
	0.00%	0.00%	0.00%	40.00%	**60.00%**	100.00%
6. The questions/probes asked were able to elicit the necessary information for clarification on the patient's chart.	0	0	1	1	**3**	5
	0.00%	0.00%	20.00%	20.00%	**60.00%**	100.00%
7. The information provided to me by the assessor during the interview (e.g., the QA steps, report process) was sufficient.	0	0	0	2	**3**	5
	0.00%	0.00%	0.00%	40.00%	**60.00%**	100.00%
8. Overall, I found the new QA process to be fair.	0	0	0	**3**	2	5
	0.00%	0.00%	0.00%	**60.00%**	40.00%	100.00%

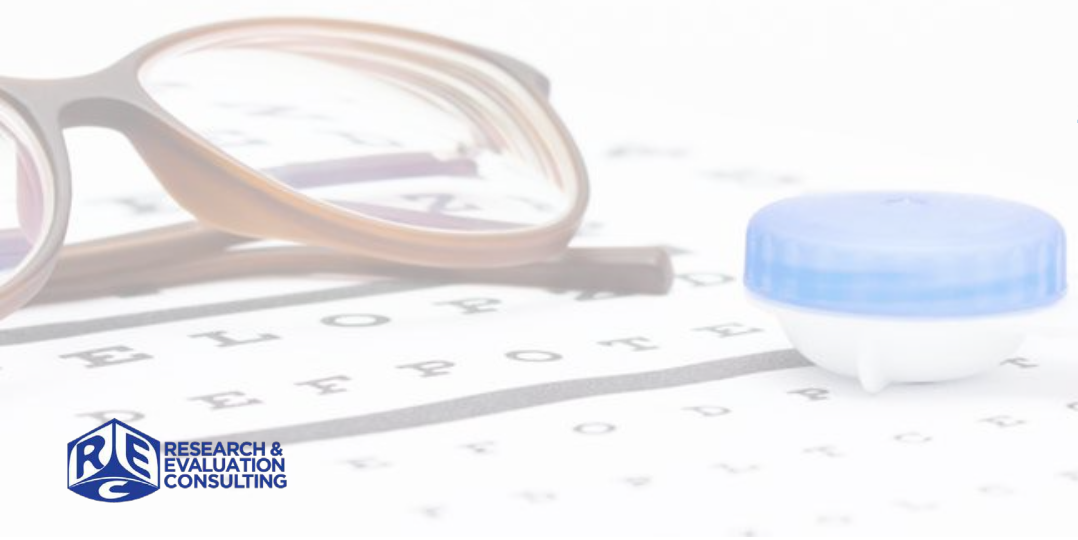
The number of responses from the Registrants' survey on the CSR was very low, so results should be viewed with caution.

Registrant Survey: CSRP

The 3 comments from Registrants identified issues with Assessor consistency, and application of the intent of the CSRP, which is to be focused on specific issues identified by the CRP, as well as the timing of the overall new PA process.

"I found large differences between my two assessors - may be helpful to have feedback for assessors from the QA committee on what is reasonable and unreasonable feedback."

"My understanding of the CSRP prior to the interview was that it was to clarify the specific concerns that were made about the selected chart during the Chart Review. I was surprised at how general and comprehensive the interview questions were, and I felt I was inadequately prepared for that as my preparation was focused on those specific concerns. I expected more direct reference to the concerns raised during the Chart Review, and discussion centered around those aspects of the chart - I felt like I had to intentionally bring up the points of concern myself so I could explain and justify some of my decision-making. I feel like the comprehensive nature of the chart discussion during the CSRP could be better clarified in the information given prior to the interview, and I feel like the purpose of the interview would be better fulfilled by directly referencing the concerns in the Chart Review."



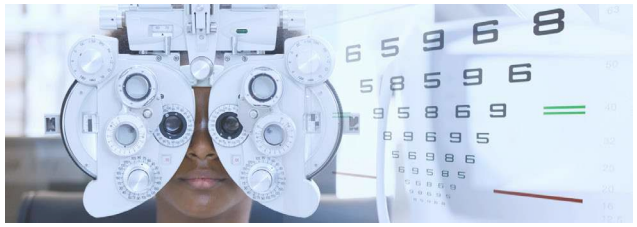
"I felt the time frame from when I needed to provide the charts until when I was told the results was too long. It was over 5 months and I was told I failed just before Christmas which was very upsetting. My zoom assessor's video during our video call did not work which was tough as I could not gauge their response and I was being seen but I could not see them. I had understood that being able to see each other was important. I am glad the assessor was able to arrange our zoom meeting before Christmas. It has been over 2 months since I was verbally assessed which is reasonable; I'm glad it wasn't another 5 months. I do value the assessment and it did help me clarify my EMR forms to help me be more accurate in how I record things which is very good. All in all, it was a beneficial process."

Assessor Follow-up (Post-Pilot) Training: Overview

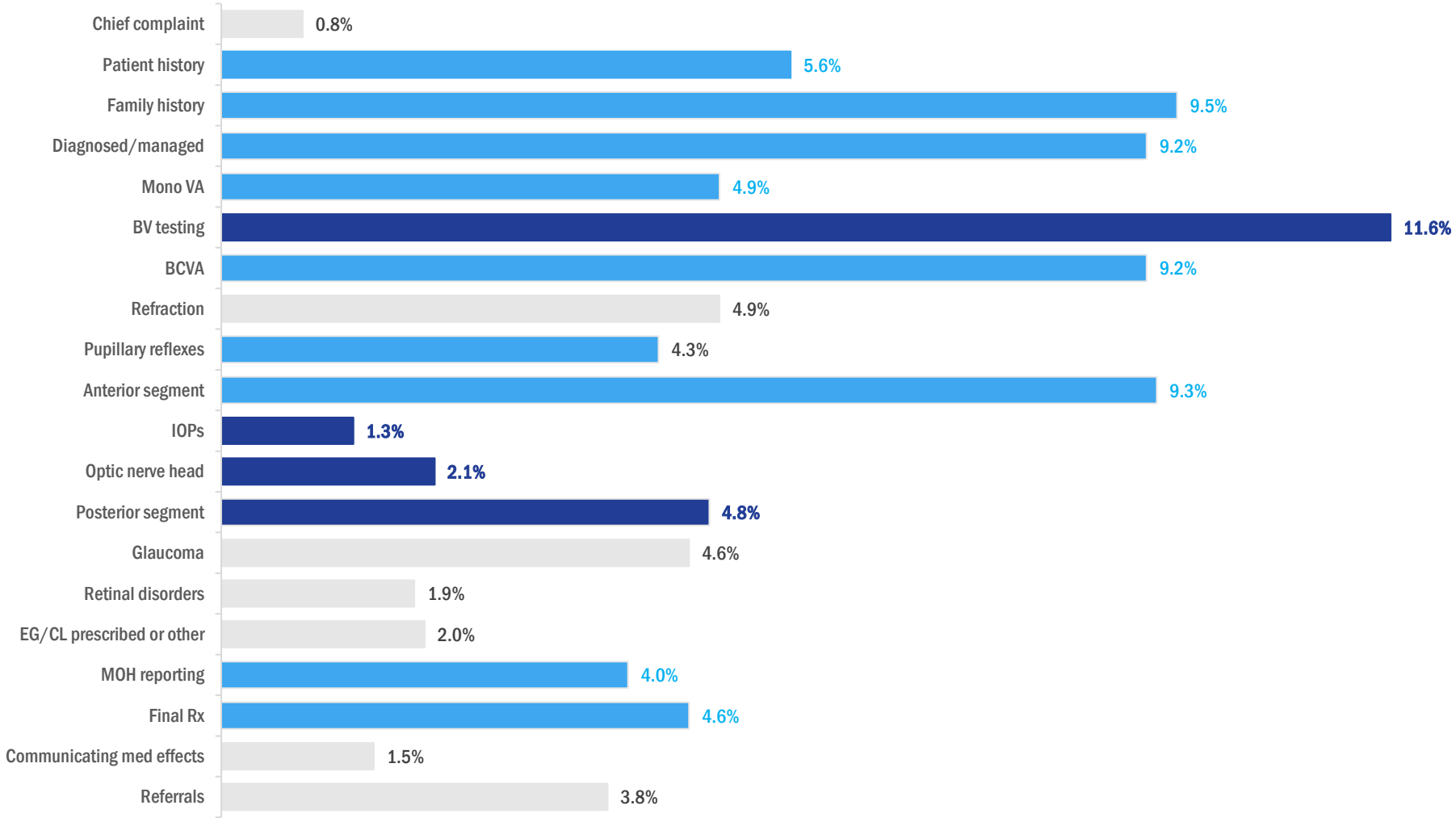
Led by COO staff (Senior Manager of QA) and Practice Advisor. The Chair of the QA Committee was also in attendance.

1. Overview of the QA practice assessment process
2. High-level review of the Pilot
3. Purpose and goal of the training
4. General tips and reminders
5. When to recommend a CSRP (see slide #11)
6. CRP Indicators #2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 17 and 18 (see next slide)

Assessor Follow-up Training



The percent of assessor disagreement among indicators, with the **indicators** discussed at the March 27, 2025 assessor Training Session identified; **mandatory indicators** were also discussed and are also identified.



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Assessor Follow-up Training: Specifics

The follow-up training for assessors took place on March 27, 2025, and was facilitated by the COO Practice Advisor and the Senior Manager of QA Programs. An overview of the new PA process was provided, including registrants' patient file/record selection requirements. Next, general tips and reminders about the assessment process was made, highlighting when criteria should be rated as "met," "unmet," or "partially met," as well as stressing the inclusion of assessors' comments in the boxes provided on the instrument.

Recommendations for a CSRP were also covered in the training, highlighting the chart in Slide 15 . Specifically, it is noted that an automatic CSRP is recommended if:

1. Any patient file scored 30/40 or less; and/or
2. Any of the 4 critical competencies scored less than 2

Use professional judgement if:

- A CSRP is automatically triggered but you feel a CSRP is not warranted
  - Comment on why the CSRP is not warranted in the General Notes section
- CSRP is warranted when all cut-score and critical competencies are met
  - Select the CSRP recommendation box
  - Justify reasoning in General Notes section of the report

Exemplars were also presented for CRP Indicators 2, 3, 4, 5, 6, 7, 9, 10, 11,12, 13, 17, and 18

Discussion

Overall, the new PA component of the College's QA program was met with mostly positive feedback from both Registrants and Assessors. The new PA proved to be fair, objective (when standards are applied), but also adaptive to better facilitate assessors' clinical judgement in making recommendations to the QA Panel. Registrants suggested that reconsidering the timing and duration of the assessments and improving feedback from the College would be beneficial. We must note, however, that survey response rates were low, and any conclusions drawn should be done so with caution. Assessor feedback was mostly positive and constructive, coming from both surveys and the post pilot training.

The pilot allowed for the revision of a critical indicator that in turn increased the consistency of Assessor interpretations and further emphasized the abilities of Assessors to exercise their clinical judgement in conducting peer assessments.

Recommendations

We have two main recommendations as we move from the Pilot into full system implementation.

1. The College needs to monitor the assessor ratings for Indicator #20 (Referrals) as it showed an increase in rater disagreement from Pre-test to Pilot-test but was not included in the assessor training session on March 27th. If this indicator shows to be a disproportionate source of deficits for registrants, then follow-up training/communication with assessors is necessary.
2. The College needs to better facilitate the technology required for registrants to upload their patient records. It seems that some registrants did not have the necessary software (e.g., Adobe Acrobat) to upload records as PDFs.

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POLICY

Type:	QUALITY ASSURANCE		
Name:	RANDOM SELECTION CRITERIA		
Status:	Approved (QAP)	**Version:**	4
Date Approved:	March 27, 2020	**Date Revised:**	January 24, 2025

A. PURPOSE

The purpose of this policy is to outline the random selection criteria for the annual practise assessments as part of the Quality Assurance Program.

B. PARTICIPATION IN PRACTISE ASSESSMENTS

One component of the Quality Assurance Program is assessment to evaluate a registrant's clinical ability (O. Reg. 119/94).

C. RANDOM SELECTION PROCESS AND STRATIFICATION

At the beginning of each year, the College utilizes the College's registrant database software to randomly select optometrists to participate in the annual practise assessments. The Quality Assurance Panel implements the following stratification:

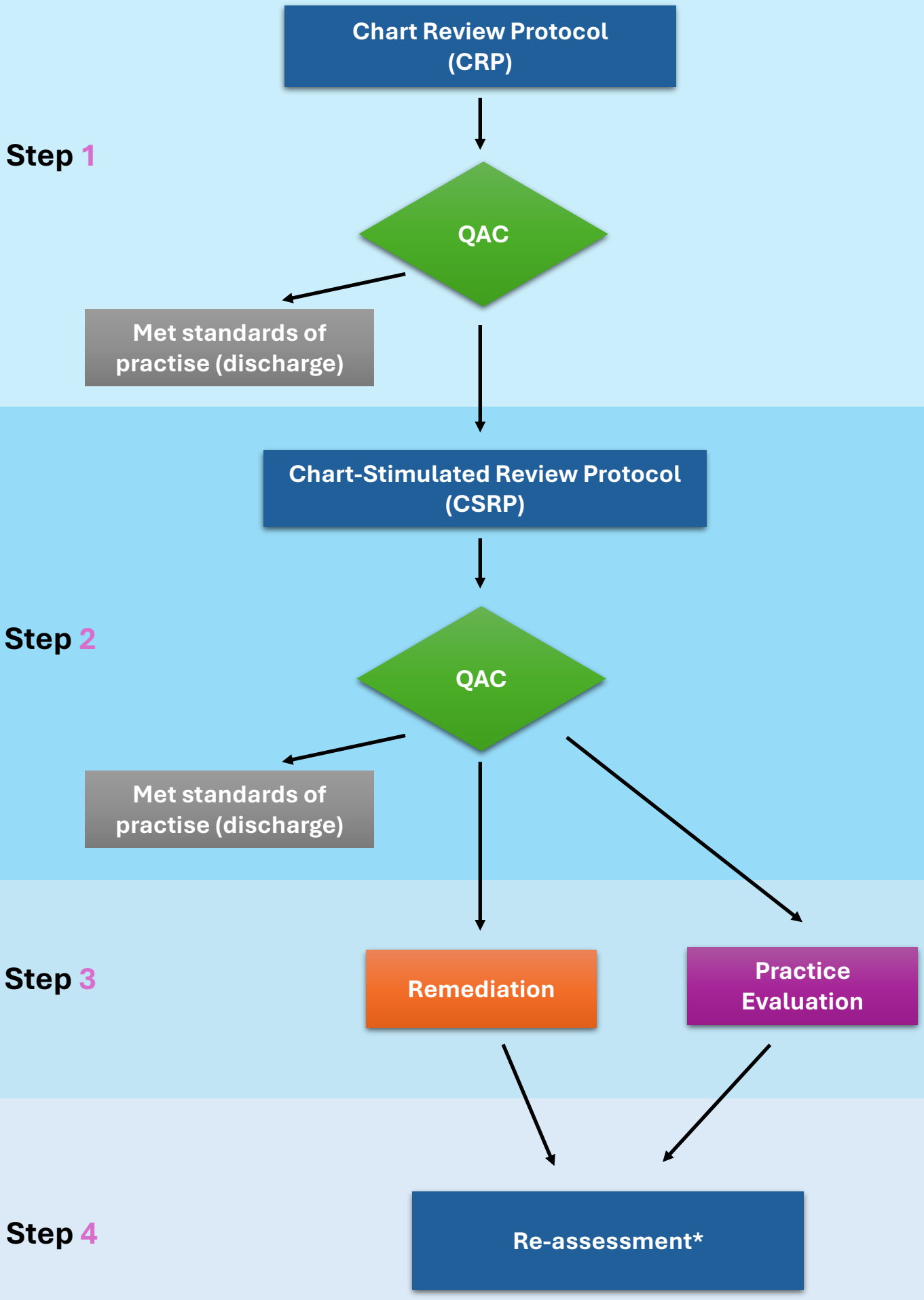
Strata	Years in Practise	Percentage of Registrants Assessed
1	1-5	10%
2	6-24	2.5%
3	25 or more	5%

Exclusions

The following group of optometrists are not included in the pool for random QA selection:

1. Optometrists who are not in active practise (i.e. non-practising, suspended);
2. Optometrists who are currently undergoing a practise assessment;
3. Optometrists who have undergone a random QA assessment in the previous 10 years having only completed a Chart Review Protocol or Chart-Stimulated Recall Protocol;
4. Optometrists who have undergone a random QA assessment in the previous 5 years and required remediation or a practise evaluation for discharge; and
5. Optometrists who have been registered within the calendar year of the selection.

Practice Assessment Process



*Repeat assessment process, starting with **Step 1 – CRP** and the submission of new patient files. The QAC may only require **2 re-assessments.** If deficiencies are still present, then the QAC may:

1. Direct the Registrar to impose terms, conditions or limitations (TCLs) on the registrant's certificate of registration; and/or
2. Refer allegations of professional misconduct or incompetence/incapacity to the Inquiries, Complaints and Reports Committee (ICRC)

COLLEGE OF OPTOMETRISTS OF ONTARIO

BRIEFING NOTE

Council Meeting – June 2025

Subject

Approval of the updated Optometric Practice Reference (OPR)

Background

The Optometric Practice Reference (OPR) replaced The Guide to the Practice of Optometry in 2007. Over the years, the Clinical Practice Panel (CPP) has revised the document to articulate and clarify new and existing standards of practice. The rotating nature of the CPP members resulted in a piecemeal document written in various voices and formatting styles. Therefore, a modernization project of the OPR was initiated to ensure it is written in a clear, concise, and consistent manner that aligns with new Quality Assurance practice assessment tools.

In 2023, a Request for Proposal (RFP) was created to invite organizations and professions to submit proposals for the modernization of the OPR. Requirements included:

- Reflect current public needs, health care systems, and societal values (e.g., diversity, equity, and inclusion principles)
- Be relevant to current optometry practice and advances in health care sciences and technologies
- Be consistent with current legislative requirements
- Be evidence-based and risk-informed (e.g., from sources such as College data, environmental scans, literature reviews, and stakeholder feedback)
- Ensure clear, concise, and consistent language understood by the profession and public
- Address gaps in content
- Increase accessibility

The vendor was selected at the QASP meeting in November 2023. Ms. Robin Marwick and Ms. Jennifer Guest are experienced editors who have worked in highly regulated industries (including healthcare and finance) for over 20 years each.

After initial review by the Council in February 2025, the document was circulated to registrants and shareholders. A total of nine comments were received and are enclosed for Council's reference. QASP reviewed the feedback and incorporated changes into the final document of the OPR.

A summary of the changes based on the feedback includes:

COLLEGE OF OPTOMETRISTS OF ONTARIO

Original OPR	Revised OPR	Rationale
All standards included relevant portions of the Act and Regulations	The text of the regulations were removed and replaced with links to *Regulated Health Professions Act* and *Optometry Act*	The Regulations are not included in the OPR to reduce length and repetition; and allow for potential updates to the legislation
Section 4.2 Required Clinical Information, states: Intraocular pressure in adults and, when indicated, in children	Guidance remains the same in Section *D.1. The Initial Assessment:* Intraocular pressure in adults and, when indicated, in children	Risk of glaucoma in children is low; the practitioner should use their professional discretion to determine when it is appropriate to measure IOP in children (i.e. family history, high C/D ratio)
Section *7.7 Dilation and Irrigation of the Naso-Lacrimal Ducts*	The section was removed from the revised version	The revised OPR does not have guidance on specific procedures. Section B.3.2. emphasizes the practitioner must ensure that any procedure is supported by peer-reviewed literature, appropriate education and training, and that it abides by infection control principles.
Section *6.2 Posterior Segment Examination* states dilation is indicated in the the use of medication that may affect ocular tissues (including but not limited to hydroxychloroquine, phenothiazine, long-term steroids)	Guidance remains the same in Section D.6. Pharmacological Dilation: The use of medication that may affect ocular tissues (e.g., hydroxychloroquine, phenothiazine, long-term steroids)	The list in not meant to be extensive but rather lists a few examples. Registrants are responsible for maintaining knowledge of medications that may affect ocular tissues.
Research Conducted by a University: An exception exists for delegation and assignment where medical direction is delegated with indirect supervision, with the informed consent of the subject, and where the research has received research ethics board approval from an accredited university	Replaced with section E.4.3. Research: An exception exists for delegation and assignment where medical direction is delegated with indirect supervision, with the informed consent of the subject, and where the research has received approval from a research and ethics board (following the Tri-Council Policy).	The exception included research that has research ethics board approval, not solely University research

Original OPR	Revised OPR	Rationale
Section 7.14 Myopia Management states: Necessary testing is dependent on the form of treatment; however, practitioners should consider axial length measurements as a definitive way of monitoring treatment efficacy over time.	Similarly, *F.1.3. Myopia Management states*: Axial length measurements may be used to monitor treatment efficacy over time.	Myopia management should be strongly considered for all emerging myopes, even if the registrant does not have access to equipment to measure axial length.
No guidance on section regarding forms of energies (e.g. IPL, RF)	*B.2.1. Form of Energy, states*: when considering any emerging technology or therapy, registrants must consider whether it is within their scope of practice, whether they have the knowledge and skills to adopt it safely and effectively, that it does not compromise patient safety and that it complies with the standards of practice.	The revised OPR does not have guidance on specific procedures. Registrants must ensure the procedures are in scope, and abide by evidence-based practices, safety and infection control. Additional guidance is available on College Website: Policies & Guidelines - College of Optometrists of Ontario

Decision(s) for Council

Approval of the updated Optometric Practice Reference (OPR).

Considerations

- The OPR is accessed by registrants and committees within the College (i.e. QA and ICRC) as well as the public for reference on Standards of Practice for optometrists practicing in Ontario
- The OPR is a reference document outlining standards of practice not clinical guidelines or best practices

Public Interest Mandate

The goal of this project was to overhaul the OPR to create a clear, concise document that would meet current public needs and societal values, address gaps in content, and increase accessibility.

Diversity, Equity and Inclusion Considerations

COLLEGE OF OPTOMETRISTS OF ONTARIO

To protect the public interest, there is the need to ensure that resources are accessible to anyone who requires them. Plain language principles are used, with attention to the audience, ensuring that communication is clear and easily understood. The contact information for the practice advisors will continue to accompany the document when clarification is required.

Supporting Materials

- Current OPR
- Updated OPR
- Consultation Feedback
- Summary of Changes (Prior to Feedback)

Next Steps

Upon Council approval, the modernized OPR will be shared with registrants and posted on the College Website.

Contact

- Bonny Wong, Senior Manager, QA Programs
- Kate MacNeill, Practice Advisor
- Violet Zawada Kuzio, Practice Advisor

OPR

OPTOMETRIC PRACTICE REFERENCE

STANDARDS OF PRACTICE

COLLEGE OF OPTOMETRISTS OF ONTARIO

Publishing History

The Guide to the Clinical Practice of Optometry

FIRST PUBLISHED	November 1972
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	September 1982
REPUBLISHED	July 1987
REVISED	January 1991

The Guide to the Practice of Optometry

FIRST PUBLISHED	August 1998
REVISED	January 1999

Optometric Practice Reference

FIRST PUBLISHED	April 2007	
REVISED	May 2007	September 2017
	June 2009	January 2018
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	April 2014	April 2020
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	September 2014	October 2021
	February 2015	November 2022
	April 2015	December 2022
	June 2015	
	October 2015	
	January 2016	

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PART 1. The Fundamentals

1. Introduction and Purpose

1.1 Introduction

The College of Optometrists of Ontario is the regulatory body for the optometric profession in Ontario. In order to assist the College in meeting its objects, documents relating to optometric practice are periodically developed and published. This Optometric Practice Reference (OPR) represents a complete revision of The Guide to the Practice of Optometry and supersedes previous versions of The Guide. It will be periodically updated in response to changes in public need, economic forces, advances in health care sciences, and statutory and regulatory requirements.

1.2 The Purpose of the OPR

The OPR fulfills three key functions, as follows:

- **To provide information to the public and patients** and/or their representatives regarding the services and behaviour that can be expected from a member of the College.
- **To inform members of the College** of the principles and criteria which underlie the standards of practice and behaviour of the profession.
- **To assist committees of the College** to carry out their work. Some statutory committees of the College are required to assess the practice of members in the course of fulfilling their mandate to protect the public. The principles, standards, and guidelines described herein serve as a basis for their assessment. The Quality Assurance Committee employs regulatory and professional standards when assessing the practice of individual members and uses the clinical guidelines to help members move towards best practices. The Complaints and Executive Committees consider standards and guidelines for the purpose of case disposition. An alleged breach of a regulatory or professional standard is usually required before a member will be referred to either the Quality Assurance or Discipline Committee.

2. The Practice of Optometry

2.1 Scope of Practice

The *Optometry Act* specifies the scope of practice of optometry as follows:

The practice of optometry is the assessment of the eye and vision system and the diagnosis, treatment and prevention of:

a) disorders of refraction;

b) sensory and oculomotor disorders and dysfunctions of the eye and vision system; and

c) prescribed diseases.

2.2 Authorized Acts

The Province of Ontario uses the concept of *controlled acts* to describe healthcare procedures and responsibilities that are not within the domain of the public. This forms the basis for regulation of healthcare services in the province. Fourteen of these *acts* are described in the *Regulated Health Professions Act* and each profession-specific act, such as the *Optometry Act*, specifies those that are authorized to the professional group.

In the course of engaging in the practice of optometry, optometrists are authorized, subject to the terms, conditions and limitations imposed on their certificate of registration, to perform the following:

1. Communicating a diagnosis identifying, as the cause of a person's symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system or a prescribed disease.

2. Applying a prescribed form of energy.

2.1 Prescribing drugs designated in the regulations.

3. Prescribing or dispensing for vision or eye problems, subnormal vision devices, contact lenses or eye glasses.

2.3 The Practice of Optometry

There are several key principles that form the foundation for the optometric profession. The practice of optometry is:

Professionally based

Above all, the purpose of the optometric profession is to provide for the healthcare needs of patients, by placing the patient's best interest foremost.

Scientifically based

The profession of optometry is founded on research and education in the life and vision sciences, combined with scientific and technological expertise.

The College supports the use of evidenced-based techniques, instrumentation and therapies that have the support of peer-reviewed literature.

Primary health care

Optometrists are independent practitioners who work within Ontario's healthcare system in co-operation with other providers of related services for the ultimate benefit of patients.

Related to eyes and vision

The services generally provided in primary care optometry include:

- the assessment, diagnosis, management and prevention of conditions of the eye and vision system;
- the treatment, correction or rehabilitation of conditions of the eye and vision system;
- the dispensing of eye glasses, contact lenses, and low vision devices;
- referral to, or shared care with, allied health professionals; and
- the promotion of good vision and health through education.

Accountable to the public

The practice of optometry in Ontario is governed by the College of Optometrists of Ontario under the authority of the Regulated Health Professions Act and the Optometry Act. Accountability is assured in a number of ways including public representation on Council and College committees, and open (public) Council meetings and Discipline hearings. In addition, the College publishes an Annual Report and provides annual reports to the Minister of Health and Long-Term Care.

2.4 The Practitioner/Patient Relationship

With reference to the practitioner/patient relationship, the optometrist will:

Be accountable

Optometrists are accountable to their individual patients and to the College for all services provided, both personally and by others who are under their direction and supervision.

Act in the patient's best interest

Optometrists are responsible for fostering a relationship of trust with the patient and putting the patient's interest above their own. The Professional Misconduct

Regulations protect such interests. Examples of acts that are considered to be professional misconduct include:

- 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; **(O.Reg. 119.94 Part I under the Optometry Act (1. s.10))**
- failing to refer a patient to a regulated health professional when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral and examination. **(O. Reg. 119/94 Part I under the Optometry Act (1. s.11))**

Encourage patient decision-making

Consistent with patient-centered care, optometrists give patients the information and counselling necessary for them to make informed choices about treatment and ongoing care, and respect the choices their patients make.

When employing techniques, instrumentation and/or therapies that lack the support of peer-reviewed literature, optometrists are expected to discuss the risks and benefits with the patient and obtain informed consent with documentation where appropriate.

Protect confidentiality

Historical and clinical information is gathered in a manner respecting patient privacy. All records are kept confidential and secure. Release of information requires the consent of the patient or their representative(s), except as required or allowed by law, such as the *Personal Health Information Protection Act*.

Be ethical

Optometrists' behaviour and business practices conform to the profession's accepted ethical standards. This is emphasized in the Professional Misconduct Regulation which includes the following as an act of professional misconduct:

- engaging in conduct or performing an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical. **(O. Reg. 119/94 Part I under the Optometry Act (1. s.39))**

Effective Date: April 2014

Revised: September 2014

3. Standards: Definitions

The Optometric Practice Reference contains **standards of practice** (both regulatory and professional).

3.1 Regulatory Standards

Regulatory standards are found in the legislation of the Province of Ontario, such as the *Regulated Health Professions Act*, the *Ontario Regulations*, and the *Optometry Act*. These standards are mandatory requirements for the profession, and **must** be complied with by the optometrist. Non-compliance with these standards could result in an allegation of professional misconduct.

3.2 Professional Standards

Professional standards describe what a *consensus of prudent practitioners would do in certain circumstances.* Every profession has standards of practice that come from a variety of sources such as educational programs, clinical training, evidence-based literature, informal professional dialogue, and the decisions of a College and the Courts. In addition to writing standards into a regulation, a College may also publish documents that describe the existing generally accepted standards on recurring and /or significant issues. These publications are more valuable if they are the result of a consultation process.

The requirement to maintain the standards of practice is supported by the Professional Misconduct Regulation under the Optometry Act. While the strongest evidence of professional standards of practice is usually expert testimony, College publications and evidence based literature may support or reinforce the expert testimony and make it more likely to be accepted.

Revised: April 2014

PART 2. Optometric Care

4. General Clinical Matters

4.1 Clinical Equipment

Description

Optometrists are expected to be equipped with the instrumentation and supplies required to provide services that meet the standards of practice of the profession.

Regulatory Standard

The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

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.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Optometrists have access to, and ensure proficient use of equipment, instrumentation, drugs and supplies for the following:

- measurement of visual acuity at distance and near;
- evaluation of visual fields and colour vision;
- determination of refractive status of the eyes, both objectively and subjectively;
- measurement of corneal curvature and thickness;
- assessment of ocular motility and binocular function;
- examination of the eye and ocular adnexa
- measurement of intraocular pressure;
- pupillary dilation, cycloplegia, topical ocular anesthesia, staining ocular tissues;
- measurement of the parameters of spectacles and contact lenses;
- in-office treatment of common primary ocular emergencies;
- disinfection of instruments and diagnostic contact lenses;
- infection control and cleanliness **(OPR 4.7)**.

When optometrists do not have a specific instrument, they must have arrangements in place whereby the tests may be performed elsewhere, by requisition or referral, and the results obtained for analysis and retention in the clinical record.

Optometrists are expected to maintain their equipment and instrumentation in good working order, including the provision of regular re-calibration.

Last Reviewed: November 2018

First Published: September 2007
Revised: May 2009
April 2014
February 2015
November 2018

4.2 Required Clinical Information

The provision of optometric care relies on acquiring, updating and maintaining a complement of information about each patient. Analysis of this data enables optometrists to develop an accurate understanding of the ocular status of patients and devise appropriate management plans. Standards relating to required clinical information are intended to ensure the provision of optimal and efficient patient care.

Regulatory Standard

The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

2. Exceeding the scope of practice of the profession.

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.

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

Required clinical information to be obtained about patients at their first presentation includes:

- the chief concern or request(s);
- a review of ocular or visual symptoms or experiences;
- a general health history, with emphasis on eyes and vision, including medications used and applicable family history;
- the occupational and avocational visual environment and demands;
- the measurement and description of their ophthalmic appliances including purpose and effectiveness; and
- the results of the observation, examination or measurement of:
    - apparent and relevant physical, emotional and mental status;
    - the external eye and adnexa;
    - pupillary function;
    - the *anterior segment* **(OPR 6.1)** and, when indicated, corneal thickness;
    - ocular media;
    - the *posterior segment* **(OPR 6.2);**
    - intraocular pressure in adults and, when indicated, in children;
    - presenting monocular visual acuities at distance;

- presenting visual acuity at near, monocularly when clinically indicated;
- refractive status and best-corrected monocular visual acuity at distance;
- accommodative function, when clinically indicated and for school-age children;
- oculomotor status and, when indicated, fusional reserves;
- other sensory functions, when indicated, such as visual fields, colour vision, stereoacuity, sensory fusion and contrast sensitivity.

All required clinical information must be clearly documented in the *patient's health record* **(OPR 5.1)**. In situations where it is not possible to obtain specific required information, justification must be documented.

The information will be kept current by re-evaluation at subsequent examinations. Patient signs, symptoms and risk factors influence decisions optometrists make about the frequency of re-evaluation.

In emergency or urgent situations, it may be impractical to obtain all clinical information at the first visit. In such cases, specific assessment is appropriate. The practitioner may advise the patient to seek a full comprehensive eye exam within a reasonable time frame or send a report to their primary optometrist for continuation of care **(OPR 4.6)**.

The full complement of required clinical information may not be necessary when providing specific assessments or consultation services for referring optometrists, physicians or nurse practitioners. The same applies to patients who have not been directly referred but are already under the established care of another optometrist or ophthalmologist. In such cases, optometrists will determine what is clinically necessary based on the reason for presentation **(OPR 4.8)**

Optometrists completing third party reports involving the clinical information of patients (e.g. MTO, CNIB, employment application reports), must verify the identity of patients using government issued photo identification cards.

Last Reviewed:July 2022

First Published: September 2007
Revised: April 2012
April 2014
June 2014
January 2018
June 2018
April 2020
September 2022

4.3 Delegation and Assignment

Introduction

The Province of Ontario utilizes the concept of "controlled acts" to control who may perform healthcare procedures and responsibilities that have a high risk of harm associated with their performance. The controlled acts are listed in the Regulated Health Professions Act, 1991 (RHPA). Each profession-specific act, such as the Optometry Act, 1991, specifies any controlled acts that the members of the profession are authorized to perform (the profession's "authorized acts"). Each regulated profession has a defined scope of practice and some have corresponding authorized acts set out in the profession-specific Act.

There are also numerous non-controlled procedures, some of which are limited to objective data collection and others, which carry a potential risk of harm to the patient. Although these procedures are in the public domain (i.e. they are NOT controlled acts), they may require specific training and skills.

The term delegation refers to the process whereby a regulated health professional (RHP), who has a controlled act within his/her scope of practice, orders another person who would not otherwise be authorized to do so to perform this act.

The term assignment refers to the process of an RHP assigning the performance of a non-controlled procedure to another person.

Both delegation and assignment of optometric procedures in appropriate circumstances may allow a more timely and efficient delivery of optometric care, making optimal use of time and personnel. In every instance of delegation and assignment, the primary consideration should be the best interests of the patient.

It is a general expectation that optometrists will be responsible for, and appropriately supervise all delegated and assigned activities within their practices. The level of supervision varies with the risk associated with the delegated or assigned procedure. ***Direct supervision*** refers to situations in which the optometrist is physically present in the same clinical location. This allows the optometrist to immediately intervene when necessary. Direct supervision is expected for ALL delegation (controlled acts), and of any assigned activities, which require interpretation in the performance of the procedure and/or may present a risk of harm to the patient. ***Remote supervision*** refers to situations in which the presence of the optometrist is not necessarily required since there is no potential risk of harm to the patient. This would be appropriate for certain clinical procedures and objective data collection.

The responsibility for all aspects of any delegated acts or assigned procedures always remains with the optometrist.

Optometrists may also *receive delegation* of a controlled act not authorized to optometry.

Collaboration with other health professionals

Collaboration with other health professionals is a common occurrence in clinical practice. When an optometrist collaborates with another health professional, the College standards and guidelines on *collaboration* **(OPR 4.8)** will apply.

Regulatory Standards

Controlled Acts

The *Regulated Health Professions Act* identifies 14 controlled acts that may only be performed by members of certain regulated health professions:

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.

2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.

3. Setting or casting a fracture of a bone or a dislocation of a joint.

4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.

5. Administering a substance by injection or inhalation.

6. Putting an instrument, hand or finger,

i. beyond the external ear canal,

ii. beyond the point in the nasal passages where they normally narrow,

iii. beyond the larynx,

iv. beyond the opening of the urethra,

v. beyond the labia majora,

vi. beyond the anal verge, or

vii. into an artificial opening into the body.

7. Applying or ordering the application of a form of energy prescribed by the regulations under this Act.

8. Prescribing, dispensing, selling or compounding a drug as defined in the Drug and Pharmacies Regulation Act, or supervising the part of a pharmacy where such drugs are kept.

9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.

10. Prescribing a hearing aid for a hearing impaired person.

11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.

12. Managing labour or conducting the delivery of a baby.

13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.

14. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning.

Optometrists are authorized by the Optometry Act to perform 4 of the 14 controlled acts, as follows:

i. communicating a diagnosis identifying, as the cause of a person's symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system, or a prescribed disease;

ii. applying a prescribed form of energy;

iii. prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses; and

iv. prescribing a drug designated in the regulations.

The RHPA also discusses delegation of controlled acts:

27. (1) No person shall perform a controlled act set out in subsection (2) in the course of providing health care services to an individual unless,

a. the person is a member authorized by a health profession Act to perform the controlled act; or

b. the performance of the controlled act has been delegated to the person by a member described in clause (a). 1991, c. 18, s. 27 (1); 1998, c. 18, Sched. G, s. 6.

28. (1) The delegation of a controlled act by a member must be in accordance with any applicable regulations under the health profession Act governing the member's profession.

Exceptions

29. (1) An act by a person is not a contravention of subsection 27 (1) if it is done in the course of,

b. fulfilling the requirements to become a member of a health profession and the act is within the scope of practice of the profession and is done under the supervision or direction of a member of the profession.

The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act)**, includes the following acts of professional misconduct:

14. Failing to maintain the standards of practice of the profession.
15. Delegating a controlled act in contravention of the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts.
16. Performing a controlled act that the member is not authorized to perform.
17. Permitting, counselling or assisting a person who is under the supervision of a member to perform an act in contravention of the Act, the *Regulated Health Professions Act, 1991* or the regualtions under either of those Acts.
18. Permitting, counselling or assisting any person who is not a member to perform a controlled act which should be performed by a member.

Professional Standard

Delegation

Optometrist-Patient Relationship

Delegation will only occur after the optometrist has established a formal relationship with the patient, which normally will include an interview, an assessment, recommendations if appropriate, and informed consent about any clinical investigations and proposed therapy. In some cases where an established patient/practitioner relationship exists, delegation may take place before the optometrist sees the patient.

Presence of the Optometrist

Delegation of an authorized act must only take place when the optometrist is present in the same clinical location as the patient and is available to intervene when required.

Process for Delegation

The optometrist must establish a process for delegation that includes:

- education and assessment ensuring the currency of the delegate's knowledge, skills and judgement;
- documentation/references for performance of procedures; and
- ensuring the delegate has been delegated only those acts that form part of the optometrist's regular practice.

Informed Consent

Delegation occurs with the informed consent of the patient. Whether the consent is implicit or explicit will depend on the particular activity being proposed to be delegated.

Supervision

The optometrist supervises the delegated procedure by direct supervision.

Quality Assurance

The optometrist is expected to ensure there is an ongoing quality assurance mechanism.

Assignment

Optometrist-Patient Relationship

Assignment of certain procedures that are not controlled acts may occur as part of the optometric examination and may occur prior to the optometrist assessing the patient. For example, pre-testing using automated instruments may occur prior to the optometrist seeing the patient.

Presence of the Optometrist

Procedures that are completely objective, present no inherent risk of harm and require no interpretation by the person performing the procedure may be performed without the presence of the optometrist and are considered to be remotely supervised. This could include automated procedures such as objective auto-refraction, auto-perimetry and non-mydriatic retinal photography. However, the optometrist is expected to review the results of these remotely supervised procedures and communicate appropriately with the patient. Direct supervision must occur whenever the procedure poses an immediate (e.g. tonometry) or potential (e.g. subjective refraction) risk of harm.

Process for assignment

As with delegation, it is expected that assignment will only occur with certain processes in place, including:

- education and assessment ensuring the currency of the assignee's knowledge, skills and judgement;
- documentation/references for performance of procedures; and
- ensuring only those procedures that form part of the optometrist's regular practice are assigned.

Research Conducted by a University

An exception exists for delegation and assignment where medical direction is delegated with indirect supervision, with the informed consent of the subject, and where the research has received research ethics board approval from an accredited university.

Professional Standard for Receiving Delegation of Controlled Acts

In the public interest, there are situations when an optometrist could receive delegation from another regulated health professional (RHP) to perform a controlled act not authorized to optometry. Other RHP's have delegation regulations and established protocols for delegation of which the member should

be aware. In order for an optometrist to receive delegation from another RHP, all of the following criteria must be met:

i. a process for receiving delegation is in place;

ii. the member will have a reasonable belief that the RHP delegating the act is authorized to delegate the act, has the ability to perform the act competently, and is delegating in accordance with relevant regulations governing his or her profession;

iii. the optometrist should be competent to perform the act safely, effectively, and ethically;

iv. appropriate resources, such as equipment and supplies, are available and serviceable;

v. the delegated act is clearly defined;

vi. the duration of the delegation will be clearly defined and relate to a specific patient;

vii. the optometrist ensures that patient consent to having the act performed under delegation to the optometrist is obtained and recorded in the patient's health recordt;

viii. a mechanism exists to contact the RHP who delegated the act if there is an adverse or unexpected outcome; and

ix. the identity of the RHP delegating the controlled act and of the member

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April 2014
January 2018
January 2019

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

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) formally 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 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)**

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.

Last Reviewed: September 2017

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(The Guideline for the Use of Drugs by Optometrists)

Revised: April 2011
(The Use and Prescribing of Drugs in Optometric Practice)

April 2014

February 2017

4.5 Referrals

Description

A referral is a request for consultation and/or the provision of treatment made to another regulated health professional when a patient requires care that exceeds the optometrist's scope of practice or ability.

Regulatory Standard

The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

2. Exceeding the scope of practice of the profession.

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.

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 must be proficient in determining the necessity of appropriate referral for care. Their decisions, about the urgency and choice of consultant are influenced by the ocular and/or systemic conditions and risk factors of patients, the community in which optometrists practise and the availability of appropriate consultation.

Once the decision has been made to make a referral, appropriate documentation in the patient's *health record* **(OPR 5.1)** is necessary, including:

- confirmation of when the referral was requested (e.g. fax information or written documentation of telephone conversation);
- appointment date, time, and consultant;
- confirmation with the patient of the appointment time and location; and
- a copy of the pertinent clinical information forwarded to the consultant.

Timeliness of Referral

Acute conditions that pose an immediate threat to the health and/or vision of the patient require a prompt referral. Examples of these conditions include, but are not limited to:

- acute glaucoma;
- retinal detachment;
- papilledema;
- wet AMD
- central corneal ulcer;
- sudden, unexplained vision loss; or
- vision-threatening trauma.

If the patient is placed at risk because the referral appointment is not available within an appropriate amount of time, optometrists are required to advocate on their patient's behalf to attempt to arrange a more timely appointment. Otherwise, optometrists may need to seek an alternative source of care such as a hospital emergency department.

Last Reviewed: July 2022

First Published: January 2007
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September 2014
September 2022

4.6 Ocular Urgencies and Emergencies

Description

Urgencies and emergencies represent potential threats to the ocular and/or systemic health and well being of patients if not dealt with appropriately. Accordingly, specific examinations are performed to provide prompt assistance, intervention, and/or action to limit potential sequelae.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

2. Exceeding the scope of practice of the profession.

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation which a consent is required by law, without such a consent.

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.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

In urgent or emergency situations, any treatment initiated by optometrists will be within the profession's scope of practice **(OPR 2.1)**, and will not exceed their experience or competence. An exception to this would be if a controlled act has been delegated **(OPR 4.3)** by a member of another regulated health profession with that authority; optometrists receiving such delegation must be properly trained to do so. Generally, optometrists are expected to:

- establish appropriate protocols and ensure that staff members are trained to recognize and respond to urgent and emergency situations;
- conduct a specific examination to evaluate the immediate problem;
- counsel 'at-risk' patients about signs and symptoms that may require further care (for example, possible retinal detachment symptoms following a posterior vitreous detachment);
- counsel patients to whom they have prescribed drugs regarding potential adverse reactions, and when the need for emergency services may be required; and
- make themselves available for contact by patients to whom they have initiated treatment of an urgent condition.

If the treatment involves a *referral* **(OPR 4.5)** to another health professional, the timeliness of the appointment will be appropriate to the condition and remains the responsibility of optometrists even if a staff member makes the appointment.

Last Reviewed: September 2012

First Published: September 2007

Revised: May 2009

February 2013

April 2014

4.7 Infection Control in the Optometric Office

Description

Within all health care facilities there is a risk of transmission of infectious agents. Standards demand that all health care workers must mitigate that risk by being educated and proactive in the area of infection control. Documents and guidelines on the topic of infection control are published and periodically updated by government agencies, health care groups and academic institutions. All optometrists must be cognizant of current information on infection control and take appropriate measures within their practices.

Regulatory Standard

The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

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.

14. Failing to maintain the standards of practice of the profession.

39. Engaging in conduct or performing an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical.

Professional Standard

Optometrists must take reasonable and appropriate measures to minimize the risk of contamination and subsequent transmission of infectious agents within their professional practices.

Optometrists should follow the recommendations of their local public health units.

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April 2014

June 2022

4.8 Collaboration and Shared Care

Description

The term "collaboration" has arisen to describe sharing of care between professionals. Such shared care is usually complementary. It has become apparent that professionals who provide complementary health care services to patients often will find ways to work together to co-manage/share care of patients. This is often beneficial to patients as it may allow better accessibility to the health care system, lower costs to the system and patients and allow more specialized practitioners to devote more time to their area of expertise.

Optometrists collaborate with many health care professionals including other optometrists, ophthalmologists, family physicians, other medical practitioners, nurse practitioners and opticians. This document describes the characteristics and conditions of collaboration as they apply to the profession of optometry.

History

Optometrists have the regulatory obligation to refer patients to an appropriate regulated health professional (RHP) when the patient's condition and/or treatment is beyond the scope of practice of the optometrist. This has usually resulted in referral to family physicians or ophthalmologists to institute medical and/or surgical care. Various shared care relationships have developed in this regard including *glaucoma* management **(OPR 7.2)**, *cataract* surgery **(OPR 7.3)** and *refractive surgery* **(OPR 7.8).** Although these relationships are common, formal arrangements are usually not developed.

The Health Professions Regulatory Advisory Counsel (HPRAC) made recommendations in its New Directions report (2006) that optometrists and physicians develop formal collaborative relationships with opticians regarding the latter professional group providing refractive data to assist in the development of a *prescription* **(OPR 6.3)** for vision correction. HPRAC also recommended that optometrists and ophthalmologists develop collaborative relationships with regards to the management of *glaucoma* patients. **(OPR 7.2)**

Regulatory Standards

Controlled Acts

The *Regulated Health Professions Act* (RPHA) identifies 14 controlled acts that may only be performed by members of certain regulated health professions. Optometrists are authorized by the *Optometry Act* to perform 4 of the 14 controlled acts, as follows:

- communicating a diagnosis identifying as the cause of a person's symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system, or a prescribed disease;
- applying a prescribed form of energy;
- prescribing or dispensing, for vision or eye problems, subnormal vision devices,

contact lenses or eye glasses; and
- prescribing a drug designated in the regulation.

The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

2. Exceeding the scope of practice of the profession.

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.

7. Engaging in the practice of the profession while in a conflict of interest as described in Part II.

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.

15. Delegating a controlled act in contravention of the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts.

16. Performing a controlled act that the member is not authorized to perform.

17. Permitting, counselling or assisting a person who is under the supervision of a member to perform an act in contravention of the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts.

18. Permitting, counselling or assisting any person who is not a member to perform a controlled act which should be performed by a member

Professional Standard

When an optometrist establishes a collaborative relationship with another RHP, that relationship must be in the best interests of the patient. A formal collaborative relationship will:

- have a verifiable agreement between collaborating professionals which outlines the various responsibilities, accountabilities and exchange of appropriate information for each person;
- ensure that patients fully understand the roles and responsibilities of the professionals involved and any associated fees;

- ensure that patients understand their options for care;
- have a mechanism for conflict resolution amongst all parties; and ensure the collaborating professionals adhere to any applicable standards of practice and conflict of interest regulations for each profession.

Intra-professional Collaborative Practice Among Optometrists:

An optometrist may refer to another optometrist for specific assessment and treatment, for example, dry eye therapy, binocular vision therapy, myopia management, imaging, visual fields.

The primary, referring optometrist, must communicate to the patient what their role will be during the referral process and protocol for further follow up. A requisition to the referring optometrist must include pertinent clinical information.

The optometrist who accepts the requisition must communicate to the patient the nature of their role, including which elements of care they are responsible for and the anticipated duration of care. The optometrist must maintain a patient health record including the requisition information and results.Any new symptoms or concerns should be referred back to the primary optometrist as they are responsible for the components of a comprehensive eye examination.

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September 2017
September 2022

5. Documentation

5.1 The Patient Record

Description

The Patient Record is comprised of two essential parts: the Patient Health Record, including all clinical documentation, and the Financial Record, summarizing diagnostic and treatment fees charged to and paid by the patient. The record is a legal document, with a purpose of meeting professional regulatory requirements, and shall be available for use in the following College processes: Inquiries Complaints and Reports, Discipline and Quality Assurance.

Regulatory Standard

Optometrists shall take all reasonable steps necessary (including verification at reasonable intervals) to ensure that records in relation to their practice are kept in accordance with the regulations.

The regulations governing record keeping are contained in **O.Reg.119/94, Part IV, s. 7-12** as follows:

PART IV
RECORDS

7. (1) A member shall take all reasonable steps necessary to ensure that records in relation to his or her practice are kept in accordance with this Part. **O. Reg. 749/94, s. 3.**

(2) Reasonable steps under subsection (1) shall include the verification by the member, at reasonable intervals, that the records are kept in accordance with this Part. **O. Reg. 749/94, s. 3.**

8. Every member shall keep a daily appointment record that sets out the name of each patient whom the member examines or treats or to whom the member provides any service. **O. Reg. 749/94, s. 3.**

9. (1) Every member shall keep a financial record for each patient. **O. Reg. 749/94, s. 3.**

(2) The financial record must include the member's fees for services and any commercial laboratory costs charged to the member. **O. Reg. 749/94, s. 3.**

10. (1) Every member shall keep a patient health record for each patient. **O. Reg. 749/94, s. 3.**

(2) The patient health record must include the following:

1. The name and address of the patient and the name of the member who provided the service.

2. The date of each visit of the patient.

3. The name and address of any referring health professional.

4. The patient's health and oculo-visual history.

5. The clinical procedures used.

6. The clinical findings obtained.

7. The diagnosis, when possible.

8. Every order made by the member for examinations, tests, consultations or treatments to be performed by any other person.

9. Particulars of every referral to or from another health professional.

10. Information about every delegation of a controlled act within the meaning of subsection 27 (2) of the Regulated Health Professions Act, 1991, delegated by the member.

11. Information about a procedure that was commenced but not completed, including reasons for non-completion.

12. A copy of every written consent to treatment. **O. Reg. 749/94, s. 3.**

(3) Every part of a patient health record must be dated and have a reference identifying the patient or the patient health record. **O. Reg. 749/94, s. 3.**

(4) Every entry in the patient health record must be dated and the person who made the entry must be readily identifiable. **O. Reg. 749/94, s. 3.**

(5) Every patient health record shall be retained for at least 10 years following,

(a) the patient's last visit; or

(b) if the patient was less than 18 years old at the time of his or her last visit, the day the patient became or would have become 18 years old. **O. Reg. 749/94, s. 3.**

11. (1) The following are acts of professional misconduct for the purposes of clause 51 (1) (c) of the Health Professions Procedural Code:

1. Allowing any person to examine a patient health record or giving a copy of a document or any information from a patient health record to any person except as required by law or as required or allowed by this section.

2. Failing to provide copies from a patient health record for which the member has primary responsibility, as required by this section. **O. Reg. 749/94, s. 3.**

(2) A member shall provide copies from a patient health record for which the member has primary responsibility to any of the following persons on request:

1. The patient.

2. A personal representative who is authorized by the patient to obtain copies from the record.

3. If the patient is dead, the patient's legal representative.

4. If the patient lacks capacity to give an authorization described in paragraph 2,

i. a committee of the patient appointed under the Mental Incompetency Act,

ii. a person to whom the patient is married,

iii. a person, with whom the patient is living in a conjugal relationship outside marriage, if the patient and the person,

A. have cohabited for at least one year,

B. are together the parents of a child, or

C. have together entered into a cohabitation agreement under section 53 of the Family Law Act,

iv. the patient's son or daughter,

v. the patient's parent. **O. Reg. 749/94, s. 3; O. Reg. 390/06, s. 1.**

(3) It is not an act of professional misconduct under paragraph 2 of subsection (1) for a member to refuse to provide copies from a patient health record until the member is paid a reasonable fee.

(4) A member may provide copies from a patient health record for which the member has primary responsibility to any person authorized by or on behalf of a person to whom the member is required to provide copies under subsection (2).

(5) A member may, for the purposes of providing health care, allow a health professional to examine the patient health record or give a health professional a copy of a document or any information from the record. **O. Reg. 749/94, s. 3.**

12. For record keeping required by this Part, a member may use computer, electronic or other equipment for recording, storing and retrieval of records if,

(a) the record keeping system provides ready access by an authorized investigator, inspector or assessor of the College, or the patient or the patient's representative to the records;

(b) ancillary equipment is readily available for the making of hard copies of the record at no expense to an authorized investigator, inspector or assessor of the College;

(c) the equipment or software being used is such that no amendment, correction, addition or deletion can be made to any record which obliterates the original record or does not show the date of the change. **O. Reg. 749/94, s. 3.**

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the Optometry Act)** includes the following act of professional misconduct:

27. If a member closes his or her office or retires from practice, failing to make reasonable efforts to make arrangements with a patient or his or her authorized representative to transfer the patient's records to,

i. the patient or his or her authorized representative,

ii. another member, if the patient or his or her authorized representative so requests, or

iii. another member, with notice to the patient that his or her records have been transferred to that other member.

Optometrists maintain the information contained within their records in trust, and in compliance with Ontario's Personal Health Information Protection Act (PHIPA).

Professional Standard

In addition to the regulatory requirements, the patient health record shall also:

- be legible and complete;
- be maintained in either English or French;
- include the date of birth;
- include proposal(s) for care and advice offered;
- include a description of the care rendered and recommendations for ongoing care;
- include details of all patient communication (both in person and electronic);
- be maintained to allow for easy identification and location of all documentation related to the provision of care;
- indicate deviations from usual care due to patient refusal or inability to cooperate; and
- make specific notation in the event that a test was performed or a question asked and the result was 'negative' or 'normal'.

Patient Access to Records

The right of patients to access the information in their record or direct that the information be transferred to another health care provider must not be limited in any manner, except as allowed by regulation. It is the right of patients to choose who provides care to them.

Relocation of a Patient Health Record

In situations where optometrists relocate their practice or entrust the custody of records to another optometrist in another location, optometrists entrusted with the maintenance of the records must make a reasonable attempt to inform patients of the location of the records.

Electronic Records

Members must produce complete financial records and patient health records (as defined by the regulation **(O. Reg. 119/94 Part IV, S.12)** upon request.

In addition to the regulatory requirements, optometrists are expected to utilize reasonable and reliable backup systems.

Where patient information is stored on mobile devices or offsite in an identifiable form, the information must be encrypted.

Last Reviewed: November 2018

First Published: September 2006
Revised: June 2012
June 2014

5.2 The Prescription

Description

A prescription is an order between an optometrist and a patient. A prescription is based upon the analysis of all available clinical information and subsequent diagnoses from optometric examination. Optometrists may issue two distinct types of prescriptions: **optical prescriptions,** which when combined with further appliance-specific information, enable the patient to obtain eyeglasses, contact lenses or subnormal vision devices; and **prescriptions for drugs,** which specify topical or oral drugs used to treat certain ocular diseases.

Regulatory Standard

The *Optometry Act, 1991(as amended 2007)* lists four authorized acts that can be performed by optometrists subject to the terms, conditions and limitations on their certificate of registration. Two of those acts are:

- Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eyeglasses. (1991, c. 35, s. 4".)
- Prescribing drugs designated in the regulations

The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act, 1991)** includes the following acts of professional misconduct:

12. Failing, without reasonable cause, to provide a patient with a written, signed and dated prescription for subnormal vision devices, contact lenses or eye glasses after the patient's eyes have been assessed by the member and where such a prescription is clinically indicated.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

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

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 sub-category 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.

Professional Standard

Optometrists issue a prescription only after establishing a professional relationship with the patient, completing an appropriate examination and obtaining a full understanding of the relevant aspects of the patient's needs, ocular health, refractive status and/or binocular condition. The prescribed therapy must be within the scope of practice of the optometrist and in the patient's best interest. Optometrists are responsible to counsel their patients in the use of any prescribed therapy and required follow-up. The prescription and appropriate counselling must be documented in the patient record. In the event that a patient experiences an adverse or unexpected response to the prescribed therapy, optometrists will provide additional diagnostic and/or counselling services and, if required, make appropriate modifications to the management plan.

***All* prescriptions** must contain information that:

- Clearly identifies the prescribing optometrist, including name (with degree and profession), address, telephone number, license (registration) number and signature;
- Clearly specifies the identity of the patient; and
- Specifies the date prescribed.

If optometrists determine that a prescribed therapy is required, a prescription **must** be provided as part of the assessment without additional charge, regardless of whether the examination is an insured or uninsured service.

Patients have the right to fill their prescriptions at the dispensary or pharmacy of their choice.

A. Optical Prescription

An optical prescription must also:

- Contain information that is used by a regulated professional to dispense eyeglasses, contact lenses or a subnormal vision device that will provide the required vision correction **(OPR 6.3)** for the patient; and
- Specify an expiry date.

A spectacle prescription (prescription for eyeglasses) must be provided to the patient without request and without additional charge, regardless of whether the examination is an insured or uninsured service. Charges for additional copies of the prescription are at the discretion of the optometrist.

When optometrists have performed the necessary services to prescribe a specific appliance (e.g. contact lens), an appliance-specific prescription including the parameters of that appliance must be provided to the patient upon request. Optometrists may withhold this information pending payment for the related service.

B. Prescription for Drugs

A prescription for drugs must also contain:

- the drug name, dose, dose form;
- directions to the pharmacist such as quantity to be dispensed, refills allowed and an indication if **no** substitutions are permitted;
- directions to the patient; and
- the optometrist's **original** signature.

To provide timely care, it may be necessary to fax a prescription for drugs to a pharmacy. This fax must contain appropriate information verifying that it originates at the prescribing optometrist's office.

When it is necessary to verbally communicate a prescription for drugs to a pharmacy, the details must be fully documented in the patient record, including the name of the pharmacy and any staff members assisting in the calll.

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January 2019

6. General Procedures

6.1 Anterior Segment Examination

Description

The anterior segment can be considered as the front third of the eye, encompassing the structures in front of (that is, anterior to) the vitreous humour, including, the lids and lashes, conjunctiva and sclera, cornea, anterior chamber, iris, and crystalline lens. The anterior segment examination consists of a thorough assessment of these structures to facilitate the diagnosis of diseases, disorders and dysfunctions of the eye and vision system. Information obtained from an anterior segment examination is part of the *required clinical information* **(OPR 4.2)**.

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.

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 must be proficient in and equipped for examining the anterior segment. The equipment customarily used for the assessment is the slit-lamp biomicroscope.

A complete anterior segment examination must include an inspection of the following anatomical areas:

- lids and lashes/adnexa;
- conjunctiva/sclera;
- cornea/tear film (and corneal thickness when indicated);
- anterior chamber and angle;
- iris; and
- crystalline lens.

All patients will receive an anterior segment examination as a part of initial and ongoing optometric care. Emphasis is given to the evaluation of the anterior

chamber angle prior to pupillary dilation and in patients with diagnosed or suspected glaucoma. The optometrist's decision regarding the frequency and extent of the examination and the specific techniques utilized will be influenced by a patient's signs, symptoms and risk factors.

An anterior segment examination is an essential component of all *contact lens assessments* **(OPR 6.5)**.

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April 2014
September 2022

6.2 Posterior Segment Examination

Description

The posterior segment can be considered as the back two-thirds of the eye, encompassing the structures posterior to the crystalline lens, including the vitreous humour, optic nerve head, retina and choroid. The posterior segment examination consists of a thorough assessment of these structures to facilitate the diagnosis of diseases, disorders, and dysfunctions of the eye and visual system. Information obtained from a posterior segment examination is part of the *required clinical information*. **(OPR 4.2)**.

Examination Procedures

METHOD	CHARACTERISTICS
1 Direct Ophthalmoscopy	Maximum magnification Minimum field of view
2 Binocular Indirect Ophthalmoscopy	Maximal field of view Minimal magnification Scleral indentation view Minimal range of condensing lens, fixed objective lens
3 Monocular Indirect Ophthalmoscopy	Moderate field of view Moderate magnification
4 Slit Lamp / Biomicroscopy (slit lamp photography)	High magnification and a very bright light source permit better appreciation of the optic nerve, macula, retinal vessels and other posterior pole structures.
5 Fundus Photography / Fundus Autofluorescence	Moderate to wide field of view and magnification with a wide range of filters and recording media. Colour, black and white, film or digital recording.
6 Imaging Technologies	Include, but are not limited to: • optical coherence tomography (OCT) • confocal scanning laser ophthalmoscopy (SLO) • scanning laser polarimetry (GDx) • multi-spectral imaging • macular pigment optical density (MPOD) measurement

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.

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 must be proficient, and *equipped* **(OPR 4.1)**, to examine the posterior segment.

A complete posterior segment examination must include an inspection of the following anatomical structures:

- vitreous humour
- optic nerve head
- macula and fovea
- retinal vasculature
- retinal grounds including, posterior pole, mid-periphery and where clinically indicated and/or possible, peripheral retina, and ora serrata.

All patients will receive a posterior segment examination as a part of initial and ongoing optometric care. An optometrist's decision about the frequency of examination, extent of view and methods of examination of the posterior segment, including the use of pharmacological pupillary dilation, will be influenced by a patient's signs, symptoms and risk factors.

Pharmacologic Dilation

Pharmacologic dilation **(OPR 4.4)** of the pupil is generally required for a thorough evaluation of the ocular media and posterior segment. Dilation can also facilitate examination of the anterior segment structures when certain conditions are present or suspected. The results of the initial dilated examination usually indicate the appropriate timing for subsequent pupillary dilation.

The following lists some of the situations/patient symptoms that indicate dilation is required (unless contraindicated) with the informed consent of the patient. These situations/patient symptoms include but are not limited to:

- symptoms of flashes of light (photopsia), onset of or a change in number or size of floaters;
- unexplained or sudden vision change, loss, or distortion (metamorphopsia);
- the use of medication that may affect ocular tissues (including but not limited to hydroxychloroquine, phenothiazine, long-term steroids);
- the presence of systemic disease that may affect ocular tissues (including but not limited to diabetes, hypertension);
- a history of significant ocular trauma, or ocular surgery that increases risk to the posterior segment;

- a history of moderate to high axial myopia;
- when a better appreciation of the fundus is required (including but not limited to choroidal nevus, optic nerve anomaly);
- when the ocular fundus is not clearly visible through an undilated pupil (including but not limited to cataract);
- when there is a known or suspected disease of:
  the vitreous (including but not limited to vitreous hemorrhage);
  the optic nerve (including but not limited to glaucoma);
  the macula (including but not limited to age-related macular degeneration);
  the peripheral retina (including but not limited to lattice degeneration);
  the choroid (including but not limited to melanoma).

Optometrists choose the dilating agent after considering the extent of pupillary dilation desired, the patient's health history and clinical ocular characteristics, as well as the implications of expected side effects on the patient's activities and safety.

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6.3 Refractive Assessment and Prescribing

Description

Assessing the patient's refractive error and, where required, *prescribing* **(OPR 5.2)** an optical correction is an integral part of optometric care. Assessment methods include objective and subjective techniques.

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.

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.

12. Failing, without reasonable cause, to provide a patient with a written, signed and dated prescripton for subnormal vision devices, contact lenses or eye glasses after the patient's eyes have been assessed by the member and where such a prescription is clinically indicated.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

The process of obtaining *required clinical information* **(OPR 4.2)** includes determination of the refractive status and best-corrected visual acuities. When possible, objective and subjective refraction techniques are used to assess the refractive status of the eye, at the initial visit and as clinically indicated thereafter. *Cycloplegic refraction* is employed when clinically necessary. **(OPR 7.6)**

Refractive assessment alone does not provide sufficient information to allow an optometrist to issue an appropriate prescription for subnormal vision devices, contact lenses or eyeglasses.. The effects of ocular and systemic health conditions, binocular vision status and the occupational and avocational visual environment and demands must also be considered.

The College standard on *delegation and assignment* **(OPR 4.3)** and *collaboration* **(OPR 4.8)** must be followed when refractive data is obtained from a person to whom the procedure has been assigned, including another regulated health professional (RHP). Specifically, there must be direct supervision of the subjective refractive assessment when this procedure is assigned.

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6.4 Spectacle Therapy

Description

Optometrists are authorized to dispense spectacles for the treatment of disorders of refraction and/or sensory and oculomotor disorders and dysfunctions of the eye and vision system. The patient must present a valid prescription written by an optometrist or physician.

Regulatory Standard

Ophthalmic dispensing is defined as "the preparation, adaptation and delivery" of vision correction, and is a controlled act in Ontario authorized to optometrists, physicians and opticians:

- Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses **(Optometry Act, 1991, c.35,s.4)**.

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the Optometry Act, 1991)** 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 consent is required by law, without such a consent.

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.

12. Failing, without reasonable cause, to provide a patient with a written, signed and dated prescripton for subnormal vision devices, contact lenses or eye glasses after the patient's eyes have been assessed by the member and where such a prescription is clinically indicated.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

29. Charging pr allowing a fee to be charged that is excessive or unreasonable in relation to the professional services performed.

30. Failing to issue a statement or receipt that itemizes an account for professional goods or services to the patient or a third party who is to pay, in whole or in part, for the goods or services provided to the patient.

33. Charging or accepting a fee, in whole or in part, before providing professional services to a patient unless

i. the fee relates to the cost of professional goods to be used in the course of performing the services, or,

ii. the member informs the patient, before he or she pays the fee, of the patient's right to choose not to pay the fee before the professional services are performed.

Professional Standard

Optometrists providing spectacle therapy must satisfy all Regulatory and Professional Standards, regardless of whether or not technology (including the internet) is used as a tool to facilitate the provision of spectacle therapy to patients.

The provision of spectacle therapy involves:

- **Reviewing with the patient any relevant environmental, occupational, avocational, and/or physical factors affecting spectacle wear:** If this review is not performed in-person, optometrists should include a precaution for patients that in-person reviews are recommended for individuals with special needs or atypical facial and/or postural features. If optometrists choose specific patient factors by which to limit their internet dispensing services, including, but not limited to, a specific age range, this should be disclosed on the website where patients can easily find it.
- **Reviewing the details of the prescription:** Optometrists are responsible for confirming the validity and/or veracity of prescriptions. Prescriptions provided using the internet must be provided in a secure manner and collected in an unaltered form (pdf/image). All prescriptions must contain information that clearly identifies the prescriber (including name, address, telephone number and signature), and specifies the identity of the patient and the date prescribed **(OPR 5.2 The Prescription)**. All prescriptions must include an expiry date.
- **Advising the patient regarding appropriate ophthalmic materials:** In the event that this is not performed in-person, patients must be given clear directions on how to contact the office/optometrist with any questions they may have.
- **Taking appropriate measurements (including but not limited to interpupillary distance and segment height) to ensure proper function of the spectacles:** If computer applications are used (in-office or remotely) to determine dispensing measurements, optometrists must be satisfied that the application determines these measurements with equal accuracy to traditional in-person measurements, including the production of supportable evidence should this matter come to the attention of the College.
- **Confirming the suitability of the order and arranging for the fabrication of the spectacles**
- **Verifying the accuracy of the completed spectacles to ensure that they meet required tolerances**
- **Fitting or adjusting the spectacles to the patient:** Optometrists providing spectacle therapy will possess the equipment required to fit and adjust spectacles. In-person fitting and adjusting of spectacles provides a

final verification and mitigates risk of harm by confirming that patients leave the clinic with spectacles that have been properly verified, fit and adjusted. Further, it establishes a patient/practitioner relationship in circumstances where patients are new to the clinic and spectacle therapy was initiated through the optometrist's website. That being said, patients have the right to agree to, or decline the performance of any procedure, including in-person fitting and adjustment of spectacles. When patients require or request delivery of prescription eyeglasses prior to in-person fitting, optometrists must use their professional judgment in determining whether this is appropriate, with consideration to factors including, but not limited to, the age of the patient, the degree of ametropia and/or anisometropia, and prescribed multifocality or prism.

- **Counselling the patient on aspects of spectacle wear including, but not limited to: the use, expectations, limitations, customary adaptation period and maintenance requirements of the spectacles:** This may be done in person or virtually.

The principle of informed consent applies to spectacle therapy whether the service is provided in-person or virtually. Optometrists use professional judgement in determining when consent must be specifically documented in the patient record. While implied consent can be assumed to apply to the in-person provision of spectacle therapy, the same cannot be said for virtual encounters, when express written documentation of informed consent is preferable.

Additional Considerations

Patients experiencing unexpected difficulty adapting to new spectacles should be counselled to seek re-examination by the prescriber to assess the appropriateness of the prescription. Optometrists dispensing appliances based on a prescription from another practitioner are expected to ensure that this has been filled appropriately, however they are not responsible for the efficacy or accuracy of that practitioner's prescription.

Delegation: Optometrists who delegate elements of spectacle dispensing (for example, the fitting and adjusting of spectacles) to staff who are not authorized to independently perform the controlled act, must be present in the same physical location and able to intervene, unless another optometrist is present to provide appropriate delegation **(OPR 4.3 Delegation and Assignment)**.

Most Responsible Dispenser: In collaborative or multi-optometrist practices, where multiple optometrists may participate in dispensing spectacles to an individual patient, the College considers that the last optometrist to provide care, or "touch the patient", typically the optometrist fitting or adjusting the spectacles, is the most responsible dispenser. This optometrist is responsible for all preceding steps in the dispensing process, as well as the performance of the spectacles and any potential risk of harm to the patient. Similarly, where optometrists practice in working arrangements with opticians, the most responsible dispenser is the last regulated professional to provide care to the patient.

Jurisdiction: Ontario-based optometrists providing care to patients in other jurisdictions (provinces/states) may need to be registered in those jurisdictions and should consult with the appropriate regulatory authorities. Optometrists participating in any aspect of ophthalmic dispensing in Ontario must be registered with the College of Optometrists of Ontario.

The Patient Record: Internet prescriptions and orders must be maintained in the patient record **(OPR 5.1 The Patient Record)**.

Internet Sites: Where the internet is used in the provision of spectacle therapy, websites utilized by member optometrists must:

- comply with College advertising guidelines and relevant paragraphs in the Professional Misconduct regulation **(O. Reg. 119/94, Part I under the Optometry Act)**;
- identify the website as belonging to or referring to a member registered with the College of Optometrists of Ontario;
- collect and record patient information in a private and secure manner respecting patient confidentiality;
- identify the physical location of the clinic/dispensary, including address and city/town, and the hours of operation of the clinic; and
- include the telephone number to contact the clinic/dispensary.

Conflicts of Interest: Under the Optometry Act (O. Reg. 119/94, Part II Conflict of Interest p. 3.(2)(h)), optometrists are prohibited from sharing fees with other than another Ontario-registered optometrist or physician. Optometrists providing spectacle therapy in working arrangements with corporations must not share fees, and must practice as an independent contractor as outlined under the Optometry Act (O. Reg. 119/94, Part II Conflict of Interest p. 4.(5)).

Expired Prescriptions: Optometrists must use professional judgment in determining whether it is appropriate to provide spectacle therapy to patients presenting expired prescriptions. Optometrists must advise patients of any appreciated risks and obtain their informed consent before dispensing their expired prescriptions.

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6.5 Contact Lens Therapy

Description

Optometrists are authorized to prescribe and dispense contact lenses for the treatment of:

- disorders of refraction, and/or sensory and oculomotor dysfunctions of the eye and vision system, and/or
- diseases/disorders affecting ocular health, and/or
- anatomical, structural and/or cosmetic concerns

The provision of this service to patients involves an initial assessment to determine suitability of patients for contact lens therapy, a determination of the parameters of a contact lens appropriate for patients, and ongoing monitoring of the efficacy of treatment. Contact lenses are classified by Health Canada as a medical device, not a consumer commodity, and should be treated accordingly.

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.

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.

12. Failing, without reasonable cause, to provide a patient with a written, signed and dated prescripton for subnormal vision devices, contact lenses or eye glasses after the patient's eyes have been assessed by the member and where such a prescription is clinically indicated.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Initial Contact Lens Fitting

Before contact lens fittings, optometrists obtain required clinical information **(OPR 4.2)** to determine the suitability of patients for contact lens wear. Special emphasis is given to the analysis of:

- the health of the cornea, conjunctiva, lids, tarsal and bulbar conjunctiva, and the integrity of the tear layer;

- corneal curvature;
- refractive status and visual acuity;
- the effects that contact lens wear may have on the function of the accommodative, oculo-motor and sensory systems; and
- relevant environmental, occupational, avocational, emotional and systemic health factors affecting contact lens wear.

To allow patients to make informed decisions about proceeding with treatment, optometrists provide information about the advantages, risks, limitations, and costs of contact lens wear and on the prognosis for successful treatment. Patients may choose to proceed with the contact lens fitting by their optometrist, or may obtain a copy of the spectacle prescription to be used for contact lens fitting by other qualified practitioners.

In fitting contact lenses, optometrists will determine, by diagnostic fitting or calculation, lenses that are appropriate for their patients. The initial lenses are evaluated on a patient's eyes and subsequent modifications of the lens parameters are made as required.

Instructions are provided to patients with respect to:

- hygiene;
- lens insertion and removal;
- use of specific lens care products;
- recommended wearing times and replacement schedules;
- normal and abnormal adaptive symptoms;
- contraindications to lens use;
- progress evaluations; and
- appropriate instructions on how and when to access emergency care **(OPR 4.6)**.

Patients are examined during the adaptation period to assess lens performance, adaptation and compliance.

Once optometrists are satisfied that the adaptation process is complete, and that the parameters of the contact lenses are correct, a contact lens prescription can be finalized. Optometrists are entitled to remuneration for all professional services involved in the determination of these prescriptions. At this point, patients have the option of obtaining contact lenses from their optometrist, or requesting a copy of the contact lens prescription in order to obtain contact lenses elsewhere.

Continuing Care

Optometrists provide continuing care to established contact lens patients. In providing continuing care, optometrists:

- maintain a history concerning:
  - the specifications, age and wearing schedule of current contact lenses;
  - the current lens care regime;
  - any adverse reactions associated with contact lens wear; and

    - any health or medication changes.

- assess patients to determine if they are achieving acceptable:
    - lens appearance and fit;
    - wearing time;
    - comfort with lenses in place;
    - corneal clarity and integrity;
    - conjunctival and lid appearance;
    - tear characteristics;
    - over-refraction for best visual acuity;
    - spectacle acuity; and
    - compliance with recommendations on lens handling, lens care, lens replacement and wearing times.
- identify any problems and counsel patients as necessary.
- provide and implement management plans for any problems identified, making recommendations for further care.

Replacement Contact Lens Services

When providing replacement contact lens services, optometrists are responsible for:

- determining the currency of clinical information and providing diagnostic services as required;
- determining the need for alteration of previous lens specifications and makes adjustments accordingly;
- advising patients as to the need for and extent of continuing care;
- confirming the parameters of contact lenses as ordered; and
- providing follow-up services as needed.

The College standards on Delegation and Assignment **(OPR 4.3)** and Collaboration **(OPR 4.8)** must be followed when any procedures are assigned, including to another regulated health professional (RHP).

Internet Sites

Where the internet is used in the provision of contact lens therapy, websites must:

- comply with College advertising guidelines and relevant paragraphs in the Professional Misconduct regulation (O. Reg. 119/94, Part I under the Optometry Act);
- identify the website as belonging to or referring to a member registered with the College of Optometrists of Ontario;
- collect and record patient information in a private and secure manner respecting patient confidentiality;

- identify the physical location of the clinic/dispensary, including address and city/town, and the hours of operation of the clinic; and
- include the telephone number to contact the clinic/dispensary.

The College standards on Delegation and Assignment **(OPR 4.3)** and Collaboration (OPR 4.8) must be followed when any procedures are assigned, including to another regulated health professional (RHP).

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6.6 Low Vision Assessment and Therapy

Description

Patients are considered to be visually impaired when there is a measurable loss of vision, including but not limited to visual acuity, contrast sensitivity, and visual field.

Patients are considered to have low vision when their visual impairment results in a reduction in best-corrected visual acuity or visual field that is inadequate for their activities of daily living.[1,2,3]

Patients with low vision may benefit from a low vision evaluation. This includes review of ocular and general (systemic) health conditions, identification of patient-defined goals, extended evaluation of visual function, prescription of and training in the use of various optical and/or non-optical low vision aids and/or rehabilitation strategies directed towards previously-defined patient-defined goals, and counseling and education.

The need for a low vision evaluation will generally be determined as the result of an exploration of patient-reported limitations and goals, and will be informed by specific clinical findings from a comprehensive optometric examination **(see OPR 4.2 - Required Clinical Information)**.

Other reasons for conducting a low vision evaluation include but are not limited to referral from another practitioner or direct referral from a patient or family member. Repeat or ongoing examinations may be required to determine the response to the rehabilitation plan or to monitor the status of patients with low vision.

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 consent is required by law, without such a consent.

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.

12. Failing, without reasonable cause, to provide a patient with a written, signed and dated prescripton for subnormal vision devices, contact lenses or eye glasses after the patient's eyes have been assessed by the member and where such a prescription is clinically indicated.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

24. Failing to make or maintain records in accordance with Part IV.

Professional Standard

A low vision examination generally will include the following components:

- a comprehensive patient history that explores:
  - personal ocular and general health history (including medications);
  - family ocular and general health history;
  - personal social history, including patient-identified impact of visual impairment (specific limitations in activities of daily living and goals (vocational/educational/avocational requirements));
  - personal perspective regarding stability of vision;
  - current access to services;
  - current devices and usage/satisfaction;
- consideration of common issues that affect people with low vision;
- a review of the results of the patient's most recent optometric examination, and re-assessment, as necessary;
- patient education regarding visual status, treatment options, and prognosis;
- assessment of rehabilitation options that includes discussion and/or demonstration of potential optical, non-optical, and electronic aids and devices, lighting requirements, environmental modifications, and adaptive strategies;
- creation of a rehabilitation plan individualized for the patient's needs;
- referral to other professionals/service providers, as indicated;
- generation of a report to individuals in the patient's circle of care, when indicated; and
- appropriate follow-up, arranged as needed, to assess the effectiveness of the rehabilitation plan and to monitor the visual condition and needs.

1. Leat SJ, Legge G, Bullimore M. What is low vision - a re-evaluation of definitions. Optom. Vis. Sci. 1999; 76:198-210.
2. THE ICF: AN OVERVIEW **https://www.cdc.gov/nchs/data/icd/icfoverview_finalforwho10sept.pdf**
3. Strong G Jutai J, Plotkin A, Bevers P. Competitive enablement: a consumer -oriented approach to device selection in device-assisted vision rehabilitation. Aging Disability & Independence. 2008; 175-195.

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April 2019

6.7 Binocular Vision Assessment and Therapy

Description

Binocular vision is defined as the ability to maintain visual focus on an object with both eyes, creating a single visual image. Binocular vision enables good depth perception and allows clear, comfortable vision to be maintained throughout visual activities. Optometrists diagnose and treat both congenital and acquired disorders of binocular vision. Clinically, binocular vision is assessed through investigation of the oculomotor and sensory systems.

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.

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

The initial binocular vision assessment includes:

- appropriate case history;
- refraction and determination of best-corrected visual acuities, including use of cycloplegic **(OPR 7.6)** agents, when indicated;
- assessment of ocular alignment and comitancy;
- assessment of ocular motility;
- assessment of saccadic and pursuit function;
- assessment of vergence function;
- assessment of accommodative function;
- assessment of sensory function;
- identification of postural adaptations, including anomalous head posture, if present,
- assessment of nystagmus, if present;
- consideration of etiology (congenital versus acquired disorders).

The initial binocular vision assessment includes distance and nearpoint testing in primary gaze, at minimum. Follow-up evaluations may be limited to re-assessment of pertinent areas of binocular function.

Management of binocular vision disorders includes:

- refractive and prismatic corrections;
- full or partial occlusion;
- amblyopia **(OPR 7.12)** therapy;
- vision therapy;
- periodic monitoring of the condition;
- collaboration with other service providers involved, including educators, occupational and physical therapists, physicians, neurologists, etc.; and/or
- tertiary care referral **(OPR 4.5)**, including but not limited to surgery and/or imaging, when indicated.

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January 2019

6.8 Visual Field Assessment

Description

Assessment of the field of vision is an essential part of evaluation of the oculo-visual system. Assessment strategies used may be either screening or detailed (threshold) in nature, utilizing manual or computerized instruments and can assess patients' central and/or peripheral field of vision. Visual field assessment is used in the diagnosis and monitoring of conditions of the eye and vision system including, but not limited to, glaucoma, neurological and retinal disease, and to fulfil third party reporting requirements. Information obtained from visual field assessment and analysis is part of the patient health record **(OPR 5.1)** and must be retained.

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 health-related purpose in a situation in which a consent is required by law, without such consent

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 for the profession.

Professional Standard

The required clinical information **(OPR 4.2)** includes the results and analysis of visual field assessment when indicated by patient signs, symptoms or history. The nature of the signs, symptoms or history will determine the test strategy used and the frequency of re-assessment.

Indications for visual field assessment include, but are not limited to:

- assessment of visual disability
- assessment of patients' ability to operate a motor vehicle
- unexplained headaches
- unexplained photopsia or other visual disturbances
- use of medications with potential neuro-ophthalmic or retinal toxicity
- eyelid or anterior segment anomalies that may affect the visual field

- some retinal diseases and abnormalities
- glaucoma or risk factors for glaucoma
- diseases of the optic nerve and visual pathway
- neurological disease

Visual field screening provides a rapid assessment of the sensitivity and/or extent of the visual field to determine if a more detailed evaluation of the visual field is required. Screening strategies include, but are not limited to:

- confrontation methods
- amsler grid
- tangent screen and arc perimeter methods
- automated techniques specifically designed for screening

When a more detailed evaluation is required, it is appropriate to utilize techniques including but not limited to:

- Goldmann perimetry (kinetic and/or static)
- automated threshold perimetry

If optometrists do not have the required instrumentation, arrangements must be in place whereby the appropriate testing will be performed elsewhere in a timely fashion. For guidance, see **OPR 4.8 Collaboration and Shared Care.**

Last Reviewed: July 2022

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January 2019
September 2022

7. Specific Diseases, Disorders and Procedures

7.1 Patients with Age-related Macular Degeneration

Description

Age-related Macular Degeneration (AMD) is an acquired retinal disorder that affects central visual function. Nonexudative AMD, also known as "dry" AMD, results in a gradual, progressive loss of central visual functioning, whereas patients with exudative AMD, also known as "wet" AMD, notice a more profound and rapid decrease in central visual functioning.

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.

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

In addition to required clinical information, the evaluation of patients with retinal changes suggestive of AMD, or patients suspected of having AMD, includes:

- patient history of any symptoms associated with AMD; and
- ocular examination including the following:
  - measurement of best corrected monocular visual acuity, distance and near;
  - additional assessment of macular function (for example Amsler grid testing); and
  - posterior segment examination with pupilary dilation **(OPR 6.2)**.

The management of patients with AMD includes:

- continued assessment for differential diagnosis;
- monitoring patients at a frequency that is dependent on the risk of progression of the disease;

- educating patients to be aware of symptoms such as decreased vision, scotomata and dysmorphopsia by monocular assessment;
- educating patients on the potential benefits of the use of supplements (vitamins, antioxidants) where clinically indicated;
- educating patients on the benefit of lifestyle changes (use of UV protection, cessation of smoking) where indicated;
- instructing patients on the importance of monitoring for the onset of new symptoms between in-office assessments, and to return immediately for assessment should they be noted; and
- making a timely referral **(OPR 4.5)** for treatment assessment for patients suspected of having choroidal neovascularization (CNV), particularly given the advent of anti-vascular endothelial growth factor (anti-VEGF) treatments that may afford an improvement in central vision.

In developing a treatment plan, consideration should be given to the patient's visual demands and abilities.

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7.2 Patients with Glaucoma

Description

Glaucoma* is a clinical term referring to a spectrum of conditions resulting in damage to the optic nerve and progressive reduction in sensitivity within the field of vision. Patients with glaucoma or patients with significant risks of having glaucoma (hereafter referred to as "glaucoma suspects" for consistency with current professional literature) are commonly encountered in optometric practice. Early diagnosis and therapy may reduce the rate of progression of this disease.

When glaucoma develops without an identifiable cause, it is termed primary.1 Primary open angle glaucoma is the most common form of this disease and may be managed by optometrists with therapeutic qualifications. Glaucoma with an identifiable cause is termed secondary.

Regulatory Standard

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)** describes the following conditions under which an optometrist may prescribe drugs for the treatment of glaucoma:

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.

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* Glaucoma is a clinical term referring to a variety of conditions with the common feature of an optic neuropathy (i.e. glaucomatous optic neuropathy [GON]) characterized by a distinctive loss of retinal nerve fibres and optic nerve changes. GON can develop under a number of circumstances with varying contributions by several known and as yet unidentified risk factors. The clinical term glaucoma is sometimes used when 1 risk factor, elevated intraocular pressure (IOP) is very extreme and GON is impending but not yet present (i.e. acute glaucoma). Glaucoma is often pluralized to reflect the variety of clinical presentations of this optic neuropathy. (Canadian Ophthalmological Society)2. rev:20170123

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 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.

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.

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.

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 must be knowledgeable and competent in the diagnosis and management of glaucoma.

The examination of patients with either glaucoma, or a suspicion of developing glaucoma, must include an appropriate assessment of any patient-specific risk factors. The core considerations for the diagnosis and management of glaucoma include:

- case history with attention to risk factors for glaucoma
- biomicroscopic examination of the anterior segment and anterior chamber angle
- measurement of the intraocular pressure
- evaluation and description of the optic nerve head through dilated pupils **(OPR 6.2)**
- gonioscopy*
- investigation of threshold visual fields*; and
- measurement of central corneal thickness, when clinically indicated.

*These tests may not be required if the patient's signs and/or symptoms indicate a referral to a secondary or tertiary eye care provider for the continuing diagnosis and/or management of glaucoma.

Members are expected to use instrumentation and techniques consistent with current professional standards of practice.

Management Options

For patients with glaucoma or glaucoma suspects, options include:

1. follow-up examinations at suitable intervals

2. drug therapy when indicated:

   a. by referral to an ophthalmologist,

   b. by an optometrist with authority to prescribe drugs for the treatment of primary open angle glaucoma

   c. by an optometrist with authority to prescribe drugs in collaboration **(OPR 4.8)** with an ophthalmologist for the treatment of primary open angle glaucoma when complicated by a concurrent medical condition or potentially interacting pharmacological treatment;

d. by referral to a physician or hospital, for secondary glaucomas

e. the immediate application of drugs in an emergency situation, such as angle-closure glaucoma, where no physician is available, then, immediately refer the patient to a physician or hospital once the emergency no longer exists or once a physician becomes available, whichever comes first.

Optometrists must discuss the appropriate option(s) with the patient and obtain informed consent.

The management plan must be clearly documented in the *patient health record* **(OPR 5.1)**

In summary:

Optometrists with authority to prescribe drugs are required to refer patients with primary open angle glaucoma to an ophthalmologist if the treatment is complicated by either a concurrent medical condition or a potentially interacting pharmacological treatment. Treatment may be provided in collaboration with an ophthalmologist with whom the member has established a co-management model of care for that patient.

Optometrists are required to refer patients with secondary glaucoma to a physician or hospital.

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7.3 Patients with Cataract

Description

The practice of optometry includes the diagnosis, care and, when appropriate, referral of patients with cataract. Optometrists also work in collaborative arrangements **(OPR 4.8)** providing preoperative and postoperative care to patients requiring cataract surgery.

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.

7. Engaging in the practice of the profession while in a conflict of interest as described in Part II.

9. Making a misrepresentation with respect to a remedy, treatment or device.

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.

19. Performing a controlled act that the member is not authorized to perform.

Professional Standard

When providing care to patients with cataract, optometrists will:

- have the required knowledge, skill and judgement to diagnose and appropriately manage patients with cataract;
- utilize appropriate instrumentation and techniques to diagnose cataract and identify any ocular or systemic conditions that may complicate the surgical procedure or limit the postsurgical visual outcome. As a minimum, these techniques would include the taking of a thorough ocular and systemic history (including medications) as well as refraction, slit lamp examination and funduscopic examination;
- counsel patients regarding their visual status and recommend surgical referral when appropriate;
- arrange *referral* **(OPR 4.5)** as required;
- disclose to patients any financial interest in a surgical centre to which patients are referred;

- comply with the College standards on collaboration/shared care when providing preoperative and/or postoperative care to patients **(OPR 4.8)**; and
- comply with College standards on delegation when performing a controlled act that is outside the scope of practice of optometry. **(OPR 4.3)**

Last Reviewed: June 2017

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September 2017

7.4 Patients with Diabetes

Description

Diabetes mellitus (DM) is a very common systemic condition that can have numerous ocular manifestations. While retinopathy and macular edema pose the greatest long-term threat to vision for most patients with diabetes, optometrists should also be alert to the development of many other possible complications ranging from transient fluctuations in refractive error and dysfunctions of accommodation and colour vision, to abnormalities in the cornea, iris, retina, lens, vitreous, and optic nerve. Also, neuro ophthalmic conditions/anomalies may arise from neuropathies affecting cranial nerves.

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.

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.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Due to the high prevalence of ocular manifestations of diabetes and the increasing incidence of retinopathy as the duration of the disease increases, all patients with diabetes require periodic assessment of the eye and vision system. Patients are advised as to the appropriate frequency of such assessments, depending on factors such as the duration of the disease, the nature of the condition (e.g. Type I versus Type II), the quality of blood glucose control, and the clinical findings. The normal complement of required clinical information **(OPR 4.2)** is updated regularly with particular emphasis on a detailed case history and thorough anterior and posterior segment examination with pharmacological pupil dilation. Any abnormalities found are carefully documented in the patient record.

Optometrists should be familiar with the classification and current management standards for the various stages of diabetic retinopathy. *Referral* **(OPR 4.5)** to an appropriate healthcare professional is required when indicated.

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June 2015

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7.5 Patients with Systemic Hypertension

Description

A number of ocular diseases are directly or indirectly associated with systemic hypertension. Hypertensive retinopathy is the most common direct ocular consequence, while hypertensive choroidopathy and optic neuropathy are less common sequelae. Hypertension is a risk factor for the development of retinal artery and vein occlusions and extraocular muscle palsies, and can increase the risk and severity of age-related macular degeneration, diabetic retinopathy, and glaucoma (the latter may also be affected by the aggressive treatment of systemic hypertension). A collaborative approach with medicine is needed for the management of patients with systemic hypertension who have ocular complications.

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.

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.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

The frequency of assessments of the eye and vision system depends on factors such as the history and status of the condition, the clinical findings, and the presence of other cardiovascular risk factors, most commonly dyslipidemia and diabetes. Any abnormalities found are documented and the patient's primary healthcare practitioner (such as family physician, or nurse practitioner) is advised as necessary of any findings that may pose a threat to the patient's ocular or systemic health.

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January 2019

7.6 Cycloplegic Refraction

Description

Objective and subjective refraction done under cycloplegia can provide useful information in situations where sustained accommodative effort is suspected to be contributing to symptoms or obscuring a full diagnosis of the clinical problem.

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.

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

Cycloplegic refraction is indicated on the initial assessment of children and young adults, including but not limited to those:

- with suspected clinically significant latent hyperopia;
- with unexplained reduced visual acuity;
- with suspected amblyopia; or
- who are at risk of developing amblyopia secondary to accommodative esotropia or asymmetric refractive error.

Cycloplecic refraction is repeated when clinically indicated.

When *using cycloplegic agents* **(OPR 4.4)**, optometrists will:

- be familiar with the properties of any cycloplegic agents they use;
- counsel patients appropriately regarding the expected effects and anticipated duration of action of the agent; and
- consider the presence of any significant contraindications to the use of a cycloplegic agent prior to instillation (e.g., narrow anterior chamber angle, past history of angle closure attacks or other adverse reactions or hypersensitivities to similar agents, etc.).

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7.7 Dilation and Irrigation of the Naso-Lacrimal Ducts

Description

Dilation and irrigation of the naso-lacrimal ducts may be used as diagnostic or treatment procedures. These procedures temporarily enlarge the punctal opening to the canaliculi for insertion of occlusion devices and/or the irrigation of material from the canaliculi and the naso-lacrimal ducts and/or to maintain complete patency of the system.

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.

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

Members providing this service must be competent in performing this technique and have a thorough understanding of the anatomical features and fluid dynamics of the lacrimal system to determine the location of an obstruction.

- dilation and irrigation of the naso-lacrimal ducts will follow a diagnostic process to determine if the procedure is warranted.
- appropriate infection controls must be used.

Last Reviewed: September 2017

First Published: September 2006

Revised: April 2014

7.8 Shared Care in Refractive Surgery

Description

The term 'Refractive Surgery' (RS) is a general term for the various forms of surgery used to correct refractive errors of the eye. This includes techniques that use lasers and other forms of electromagnetic energy, implantable lenses and devices, and incisional techniques. Optometrists provide preoperative and postoperative care to RS patients both in their offices and within surgical centres.

Refractive surgery is one of the situations in which optometrists often participate in a shared care relationship **(OPR 4.8)** with another healthcare practitioner. Shared care arrangements are intended to assist in the delivery of effective, efficient, high quality patient care. This standard and guideline addresses the sharing of responsibilities, the communication of patient information, and the financial arrangements within shared care situations.

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.

7. Engaging in the practice of the profession while in a conflict of interest as described in Part II.

9. Making a misrepresentation with respect to a remedy, treatment or device.

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.

16. Performing a controlled act that the member is not authorized to perform.

Conflict of Interest **(O. Reg. 119/94 Part II under the Optometry Act)** includes the following conflicts of interest:

3. (1) A member shall not engage in the practice of the profession while the member is in a conflict of interest. **O. Reg. 24/14, s. 1.**

(2) A member is in a conflict of interest where the member,

(a) Has a personal or financial interest that influences or is likely to influence the exercise of the member's professional expertise or judgment in respect of the treatment or referral of a patient;

(d) accepts a benefit that is related to the member referring a patient to any other person;

(h) shares fees related to the practice of the profession with any person other than,

(i) another member, or

(ii) a member of the College of Physicians and Surgeons of Ontario engaged in the practice of medicine. **O. Reg. 24/14, s. 1.**

Professional Standard

Optometrists providing care to patients pursuing RS will:

- maintain current knowledge of surgical procedures and competence in delivering the various types of preoperative and postoperative procedures in which they participate;
- acquire the normal complement of required clinical information **(OPR 4.2)**;
- identify preoperative ocular health, binocular, refractive or systemic conditions that may complicate the surgical procedure or limit the postsurgical outcome;
- inform patients of the various risks and benefits of the procedure, their options for care providers and all associated fees;
- make a referral **(OPR 4.5)** to an ophthalmic surgeon that includes relevant history and clinical findings;
- follow postoperative protocols indicated by refractive surgeons;
- disclose to patients any financial interest in a surgical centre to which the optometrist refers the patient; and
- comply with the College standards on collaboration/shared care **(OPR 4.8)** and delegation **(OPR 4.3)**.

Last Reviewed: February 2014 First Published: September 2006

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7.9 Patients with Learning Disorders

Description

Learning disorders are genetic, congenital, developmental and/or acquired factors that affect the acquisition, organization, retention, understanding or use of gross motor, fine motor, auditory, verbal, or visual information. Optometrists play a role in investigating whether visual signs and symptoms could be a contributing factor for a patient with a suspected or recognized learning disorder(s).

By assessing and managing vision problems associated with a learning disorder, optometrists act as members of a multidisciplinary team that may also include one or more of the following professionals:

- another optometrist who is proficient in visual information processing (visual perception) evaluation;
- educator;
- psychologist;
- physician;
- occupational therapist;
- audiologist; and/or
- speech-language pathologist.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

2. Exceeding the scope of practice of the profession.

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation which a consent is required by law, without such a consent.

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

All patients with a suspected or recognized learning disorder require initial and periodic assessment of the eye and vision system. The frequency of such assessments depends on factors such as the history and clinical findings, and the visual demands of the patient's academic /vocational circumstances.

In addition to required clinical information **(OPR 4.2)**, the care of patients with a suspected or recognized learning disorder(s) includes:

- Case history questions related to, but not limited to, pregnancy and birth of the patient, reading level, and performance in school;
- Baseline assessment of distance and near visual acuity for patients with sufficient letter recognition and verbal communication;
- Refractive assessment **(OPR 6.3)** and cycloplegic refraction as indicated **(OPR 7.6)**;
- Binocular vision assessment **(OPR 6.7)**;
- Counselling patients regarding options for further investigation and/or consultation with another professional as indicated; and
- Referral for treatment including optometric vision therapy (OVT) to manage diagnosed conditions related to binocular vision and visual function as indicated **(OPR 6.7)**.

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December 2022

7.10 Orthokeratology

Description

Orthokeratology (Ortho-K) involves the wearing of specially designed rigid gas permeable (RGP) contact lenses, generally overnight, to progressively and temporarily alter the curvature of the cornea. This procedure may be offered by optometrists as an option for vision correction (most commonly myopia and/or astigmatism), and for myopia control in children.

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 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 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.

12. Failing, without reasonable cause, to provide a patient with a written, signed and dated prescription for subnormal vision devices, contact lenses or eye glasses after the patient's eyes have been assessed by the member and where such a prescription is clinically indicated.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

15. Delegating a controlled act in contravention of the Act, the Regulated Health Professions Act, 1991 or the regulations under either of those Acts.

22. Publishing or using, or knowingly permitting the publication or use of an advertisement or announcement or information that promotes or relates to the provision of professional services by a member to the public, whether in a document, business card, business sign, website, or any other format, which,

i. is false or deceptive, whether by reason of inclusion or of omission of

information,

ii. suggests that the member is a specialist or is specially educated, trained or qualified other than where the reference is to an educatioal acheivement and the reference has been approved by Council.

v. is not factual, objectively verifiable or readily comprehensible to the persons to whom it is directed.

Professional Standard

Optometrists performing Ortho-K must be competent in the fitting of RGP contact lenses and follow the contact lens standards outlined in section 6.5 of the OPR. They must stay abreast of developments in Ortho-K technologies, and consult peer-reviewed literature and professionally developed practice guidelines.

Optometrists must present a realistic prognosis when offering Ortho-K, especially as it pertains to the amount of myopia reduction and/or the realistic myopia management prognosis for patients **(OPR 7.14)**. The risks, as well as benefits, of corneal reshaping procedures and overnight contact lens wear must be explained to prospective patients and these individuals must be carefully monitored, both through the initial wear phase as well as the retainer wear phase. In addition, patients must be counseled to be compliant with lens care, wearing schedule instructions, and follow-up assessments.

The full complement of required clinical information may not be necessary when providing specific assessments or consultation services for referring optometrists, physicians or nurse practitioners. In such cases, optometrists will determine what is clinically necessary based on the reason for presentation. **(OPR 4.2)**

Optometrists accepting referrals for Ortho-K must review the results of the referring practitioner's optometric and/or medical examination(s), and assess, or re-assess the referred patient, should any additional clinical information or clarification be necessary.

Preliminary and ongoing examination follows the standards articulated in Contact Lens Therapy **(OPR 6.5)**, and also includes:

- refraction and visual acuities (unaided and best corrected)
- corneal topography measurements (pre-treatment, during follow-up until refractive stability is achieved, and thereafter at the discretion of the practitioner)

Consent

Optometrists must obtain informed consent from patients, including information regarding the fitting method, concerns and precautions of overnight contact lens wear, realistic expectations, the pre-and post-fitting appointment obligations, the itemized costs involved, the warranty/exchange of material policies, and what to do in the event of an emergency. If patients are incapable of providing consent

(i.e. young children undergoing Ortho-K for myopia management), consent must be obtained from their substitute decision-makers (usually a parent or guardian in the previous example).

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7.11 Patients With Dry Eye Disease

Description

Dry eye disease (DED) is a complex disorder, as noted in the contemporary definition articulated by the Tear Film and Ocular Surface Society Dry Eye Workshop II (TFOS DEWS II)[1] in 2017:

> *'Dry eye is a multifactorial disease of the ocular surface characterized by a loss of homeostasis of the tear film, and accompanied by ocular symptoms, in which tear film instability and hyperosmolarity, ocular surface inflammation and damage, and neurosensory abnormalities play etiological roles.'*

Although DED can be broadly categorized as aqueous deficient dry eye (ADDE, secondary to inadequate tear production primarily due to lacrimal gland insufficiency) or evaporative dry eye (EDE, secondary to excessive tear evaporation primarily due to meibomian gland dysfunction (MGD)), these conditions exist on a continuum and are not mutually exclusive. In fact, patients typically present with mixed-mechanism disease. Regardless of etiology, the common endpoints of DED include tear film instability, hyperosmolarity, and inflammation leading to variable signs and symptoms that are frequently discordant (that is, one may exist in the absence of the other), and may be episodic or chronic.

A number of tests to diagnose and establish the severity of DED are available. Like signs and symptoms, the results of these tests are often dissonant, but inform patient-specific management strategies aimed at re-establishing tear film and ocular surface homeostasis.

A detailed discussion of diagnosis and management of DED is beyond the scope of this document: a brief synopsis is provided under Professional Standard (below), and the reader is referred to the TFOS DEWS II Report for its comprehensive review **(https://www.tearfilm.org/dettreports-tfos_dews_ii_report/32_30/eng/)**.

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 which a consent is required by law, without such a consent.

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

The DED assessment begins with the case history, with special attention to risk factors including but not limited to older age, female sex, general health conditions (including but not limited to connective tissue and autoimmune disease), topical and systemic medications (including but not limited to antihistamines, antidepressants, diuretics, and preservatives accompanying topical medications), environment, and occupational/avocational demands (including but not limited to computer use and contact lens wear).

Patients are questioned regarding symptoms suggestive of DED: the use of a validated questionnaire may be helpful.

Optometrists must perform a clinical examination of the anterior segment of the eye **(OPR 6.1)**, with special attention to eyelid anatomy and health, the blink mechanism, meibomian gland integrity and function, and the integrity of the precorneal tear film and cornea itself. The presence of reduced tear break-up time, elevated or interocular asymmetry in tear osmolarity, or ocular surface staining are signs of the loss of homeostasis that characterizes DED. Optometrists recognize that signs and symptoms of DED are often discordant and that no single diagnostic test can be relied upon to the exclusion of others.

Treatment of DED aims to restore homeostasis of the tear film and ocular surface. It involves a staged, step-wise approach that includes but is not limited to:

- education about DED, and its management and prognosis;
- recommending modification of the patient's environment (including but not limited to increasing humidity, reducing air movement, and encouraging frequent breaks from prolonged use of digital devices), and considering alternative topical and/or systemic medications when feasible;
- use of non-prescription lubricating agents (artificial tears) of varying viscosities (solutions, emulsions, gels, and ointments) and/or osmolarities, including consideration of preserved versus non-preserved products (including autologous serum tears) and the component of the natural tear layer deemed most deficient;
- encouraging and providing instruction for proper eyelid hygiene (both in-office and home-based treatment of meibomian gland dysfunction may be considered);
- recommending the use of oral OTC products (including but not limited to polyunsaturated (omega-3) fatty acid supplements);

- employing mechanisms to promote retention of natural and artificial tears (including but not limited to the use of punctal occlusion (only when concurrent inflammation is under control), or moisture goggles);
- judicious use of topical and/or systemic prescription medications (including but not limited to topical anti-inflammatory and antibiotic agents, and oral antibiotics with anti-inflammatory properties (tetracyclines and macrolides)) within the parameters established by Ontario Regulation 112/11 – Designated Drugs and Standards of Practice **(OPR 4.4);**
- the use of therapeutic contact lenses (including but not limited to the use of bandage soft or scleral contact lenses) or amniotic membranes.

Depending upon the severity of DED and its response to treatment, referral **(OPR 4.5)** to another regulated health professional for further assessment and medical and/or surgical intervention may be necessary.

———————————————

[1]Craig JP, et al. TFOS DEWS II Report Executive Summary. The Ocular Surface 2017;15:802-12.

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7.12 Patients With Amblyopia

Description

Amblyopia is clinically defined as best corrected visual acuity worse than or equal to 20/30 in one eye or both eyes and/or interocular difference of 2 lines or more in visual acuity, without disease or structural abnormality of the eye(s) or visual pathway(s). 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.

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 and/or abnormalities such as, but not limited to, term of pregnancy, birth weight, and pre-/peri-natal history (including maternal use of alcohol, tobacco or drugs during pregnancy),
- measurement of uncorrected visual acuity
- 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 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
- 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

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 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.

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7.13 Patients With Uveitis

Description

Uveitis is an inflammatory condition of the eye that is classified by

i. anatomy (based on the part of the eye primarily affected) as anterior, intermediate, posterior, or panuveitic,

ii. laterality (unilateral or bilateral), and

iii. duration: 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.

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, preventative, 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 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, systemic and medication history
  - 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 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 involvesw 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

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7.14 Myopia Management

Description

Myopia, also known as nearsightedness, is a refractive condition, categorized as axial, refractive, or secondary. Myopia typically presents as low (SE ≤ -0.50D and > -6.00 D) and may progress to high (SE ≤ -6.00D) over time.

The risk factors for myopic progression include:

a. Family history: A child with 1 or 2 myopic parents has a greater chance of being myopic compared to a child with no family history of myopia.

b. Refractive error: Children presenting with less hyperopia than age appropriate are at a higher risk for developing myopia

c. Ethnicity: Asian ethnicity has been linked to an increased risk for onset and progression.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

2. Exceeding the scope of practice of the profession.

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.

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 device10. 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.

12. Failing, without reasonable cause, to provide a patient with a written, signed and dated prescription for subnormal vision devices, contact lenses or eye glasses after the patient's eyes have been assessed by the member and where such a prescription is clinically indicated.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

15. Delegating a controlled act in contravention of the Act, the Regulated Health Professions Act, 1991 or the regulations under either of those Acts.

22. Publishing or using, or knowingly permitting the publication or use of an advertisement or announcement or information that promotes or relates to the provision of professional services by a member to the public, whether in a document, business card, business sign, website, or any other format, which,

i. is false or deceptive, whether by reason of inclusion or of omission of information,

ii. suggests that the member is a specialist or is specially educated, trained or qualified other than where the reference is to an educational achievement and the reference has been approved by Council.

v. is not factual, objectively verifiable or readily comprehensible to the persons to whom it is directed

29. Charging or allowing a fee to be charged that is excessive or unreasonable in relation to the professional services performed.

Professional Standard

Optometrists who choose to consider interventions that slow the progression of myopia (known as 'myopia control' or 'myopia management') should be competent and must monitor patients at appropriate intervals. Necessary testing is dependent on the form of treatment; however, practitioners should consider axial length measurements as a definitive way of monitoring treatment efficacy over time.

Treatment options for the management of myopia include:

- **Specialty contact lenses that alter the corneal shape** including orthokeratology **(OPR 7.10)**:
  - Optometrists performing myopia management with these lenses must be competent in the fitting of contact lenses and follow the contact lens standards outlined in **OPR 6.5** and **7.10**.
- **Specialty contact lenses** including soft lenses:
  - Optometrists performing myopia management with these lenses must be competent in the fitting of contact lenses and follow the contact lens standards outlined in **OPR 6.5**.
- **Specialty spectacle lenses**:
  - Optometrists performing myopia management with specialty spectacle lenses must follow regulatory standards outlined in **OPR 5.2** (A).
- **Pharmaceutical treatment:**
  - Optometrists performing myopia management with pharmaceutical agents must follow standards outlined in **OPR 4.4**. Patients should be screened for potential contraindications of the pharmaceutical agent and aware of the potential side effects associated with the drug.

With all forms of management, a realistic prognosis should be presented to patients, especially those with high myopia. Risks, benefits, itemized costs, and alternatives should be outlined, and informed consent should be obtained by the patient and/or when required the parent/guardian prior to proceeding.

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[1] Flitcroft DI, He M, Jonas JB, et al. IMI - Defining and Classifying Myopia: A Proposed Set of Standards for Clinical and Epidemiologic Studies. Invest Ophthalmol Vis Sci. 2019;60(3):M20-M30. doi:10.1167/iovs.18-25957

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COLLEGE OF
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OF ONTARIO

OPTOMETRIC PRACTICE REFERENCE

Standards of Practice

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A. INTRODUCTION & PURPOSE

A.1. INTRODUCTION

The College of Optometrists of Ontario is the regulatory body for the optometric profession in Ontario. Under the authority of the *Regulated Health Professions Act* and the *Optometry Act*, the College is responsible for registering (licensing) and governing optometrists in Ontario. To assist in meeting its legislated duty to protect the public interest, the College develops and publishes documents relating to optometric practice, such as the Optometric Practice Reference (OPR).

The OPR is periodically reviewed and updated in response to changes in public need, economic forces, advances in health care sciences, and statutory and regulatory requirements.

Additional administrative and clinical practice policies and guidelines not contained in the OPR are listed online: Policies & Guidelines – College of Optometrists of Ontario (collegeoptom.on.ca/resources).

A.2. REGULATORY REQUIREMENT

Health professions are required, by the legislation of the Province of Ontario, to have standards. These standards are mandatory requirements for the profession. Non-compliance with these standards could result in an allegation of professional misconduct.

A.3. STANDARDS OF PRACTICE

Professional standards describe what a consensus of prudent practitioners would do in certain circumstances. Every profession has standards of practice that come from a variety of sources such as educational programs, clinical training, evidence-informed literature, informal professional dialogue, and the decisions of a College and the courts.

In addition to writing standards into a regulation, a College may also publish documents that describe the existing generally accepted standards on recurring and/or significant issues. These publications are more valuable if they are the result of a consultation process.

The requirement to maintain the standards of practice is supported by the Professional Misconduct Regulations under the *Optometry Act*.

A.4. THE PURPOSE OF THE OPR

The OPR fulfills three key functions:

- To inform College registrants of the principles and criteria that underlie the standards of practice and behaviour of the profession.
- To assist committees of the College to carry out their work.
- To provide information to the public and patients regarding the services and behaviour that can be expected from a registrant of the College.

B. THE PRACTICE OF OPTOMETRY

B.1. SCOPE OF PRACTICE

Ontario's *Optometry Act* specifies the scope of practice of optometry as follows:

> The practice of optometry is the assessment of the eye and vision system and the diagnosis, treatment and prevention of:
>
> - disorders of refraction;
> - sensory and oculomotor disorders and dysfunctions of the eye and vision system; and
> - prescribed diseases.

B.2. AUTHORIZED ACTS

The Province of Ontario uses the concept of **controlled acts** to describe health care procedures and responsibilities that are not within the domain of the public. This forms the basis for regulation of health care services in the province. Fourteen such controlled acts are described in the *Regulated Health Professions Act*; each profession-specific Act specifies the controlled acts that are authorized to that professional group.

The *Optometry Act* specifies that:

> In the course of engaging in the practice of optometry, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:
>
> - Communicating a diagnosis identifying, as the cause of a person's symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system or a prescribed disease.
> - Applying a prescribed form of energy.
> - Prescribing drugs designated in the regulations.
> - Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses.

B.2.1. Form of Energy

When considering any emerging technology or therapy, registrants must consider whether it is within their scope of practice, whether they have the knowledge and skills to adopt it safely and effectively, that it does not compromise patient safety and that it complies with the standards of practice.

B.3. PRINCIPLES OF PRACTICE

There are several key principles that form the foundation for the optometric profession.

B.3.1. Professionally Based

Above all, the purpose of the optometric profession is to provide for the health care needs of patients, by placing the patient's best interest foremost. Registrants must disclose to patients any conflict of interest, such as a financial relationship with a surgical centre or other practice to which the registrant refers the patient.

B.3.2. Scientifically Based

The profession of optometry is founded on research and education in the life and vision sciences, combined with scientific and technological expertise. The College supports the use of evidence-informed techniques, instrumentation and therapies that have the support of peer-reviewed literature and professionally developed practice guidelines. As such, registrants must stay abreast of developments in evidence-informed treatments and new technologies and ensure that their patients have access to them if appropriate.

The practitioner must ensure that any procedure is supported by peer-reviewed literature, appropriate education and training, and that it abides by infection control principles.

B.3.3. Primary Health Care

Registrants are independent practitioners who work within Ontario's health care system in co-operation with other providers of related services for the ultimate benefit of patients.

B.3.4. Related to Eyes and Vision

The services generally provided in primary care optometry include:

- assessment, diagnosis, management and prevention of conditions of the eye and vision system
- treatment, correction or rehabilitation of conditions of the eye and vision system
- dispensing of spectacles (eye glasses), contact lenses and low vision devices
- referral to, or shared care with, allied health professionals
- promotion of good vision and health through education

B.3.5. Accountable to the Public

The optometric profession's accountability to the public is promoted through the inclusion of public representatives on committees of the College and the College Council, which serves as

the board of directors of the College. In addition, Council meetings and discipline hearings are open to the public.

The College publishes an Annual Report on its website and provides reports to the Minister of Health and Long-Term Care.

B.4. THE REGISTRANT/PATIENT RELATIONSHIP

With reference to the registrant/patient relationship, the registrant will:

B.4.1. Be Accountable

Registrants are accountable to their individual patients and to the College for all services provided, including services related to telehealth, both personally and by others who are under their direction and supervision.

B.4.2. Act in the Patient's Best Interest and Support Patient Decision-Making

Registrants are responsible for fostering a relationship of trust with the patient and putting the patient's interest above their own.

To make informed choices about their treatment and ongoing care, patients need accurate information about the risks and benefits of treatment options. Consistent with patient-centred care, registrants give patients the information and counselling they need, and registrants respect the choices patients make.

Registrants are expected to obtain and document informed consent where appropriate.

B.4.3. Protect Confidentiality

Historical and clinical information is gathered in a manner respecting patient privacy. All records are kept confidential and secure in accordance with the *Personal Health Information Protection Act*. Release of information requires the consent of the patient or their representative(s), except as required or allowed by law (e.g., mandatory reporting to the Ministry of Transportation in accordance with the *Highway Traffic Act*).

B.4.4. Be Ethical

Registrants' behaviour and business practices conform to the profession's accepted ethical standards.

B.4.5. Act with Professional Integrity and Respect

Registrants are expected to:

- comply with legislation that protects human rights and ensures safe and respectful clinical environments
- be familiar with the College's anti-discrimination policies and practice advisories and to implement them as appropriate

B.5. CLINICAL EQUIPMENT

Registrants are expected to be equipped with the instrumentation and supplies required to provide services that meet the standards of practice of the profession, and to be proficient in their use.

When registrants do not have a specific instrument, they must have arrangements in place whereby the tests may be performed elsewhere, by requisition or referral, and the results obtained for analysis and retention in the clinical record.

Registrants are expected to maintain their equipment and instrumentation in good working order, including regular re-calibration.

B.6. INFECTION CONTROL

Within all health care facilities there is a risk of transmission of infectious agents. All health care workers must mitigate that risk by being educated and proactive in the area of infection control.

Registrants must take reasonable and appropriate measures to minimize the risk of contamination and subsequent transmission of infectious agents within their professional practices.

Registrants should also follow the recommendations of their local public health units.

B.7. TELEHEALTH

Optometrists engaged in telehealth have the same ethical duties and obligations as for in-person care. They will use their judgment when deciding whether telehealth is appropriate for patients. They will communicate and collaborate effectively with patients, optometrists and other health care providers while protecting patient privacy.

As technology is rapidly evolving, current guidance for telehealth is available on the College website.

B.8. MANAGEMENT & CONTINUING CARE

Continuing care for patients may include some or all of the following:

- patient education regarding visual status, treatment options and prognosis
- discussion and/or demonstration of potential treatment or rehabilitation options, including optical, non-optical and electronic aids and devices, lighting requirements, environmental modifications and adaptive strategies
- creation of a treatment or rehabilitation plan individualized for the patient's needs
- referral to other professionals/service providers

- reports to individuals in the patient's circle of care, when indicated
- follow-up, as needed, to assess the effectiveness of the treatment or rehabilitation plan and to monitor the patient's visual condition and needs
- re-assessment of best-corrected visual acuity and ocular health status
- history concerning any changes in vision or visual function and patient adherence to prescribed treatment
- modification of the treatment or rehabilitation plan, as indicated, to improve the effectiveness of treatment and/or to better meet patient needs and expectations

Registrants are responsible to counsel their patients in the use of any prescribed therapy and required follow-up. The prescription and appropriate counselling must be documented in the patient record. In the event that a patient experiences an adverse or unexpected response to the prescribed therapy, registrants will provide additional diagnostic and/or counselling services and, if required, make appropriate modifications to the management plan.

C. PRACTICE MANAGEMENT

C.1. THE PATIENT RECORD

Providing optometric care involves acquiring, updating and maintaining information about each patient. Analyzing this data helps registrants develop an accurate understanding of the patient's ocular status and devise appropriate management plans. The patient record includes:

- the patient health record of all clinical documentation
- the financial record of diagnostic and treatment fees charged to and paid by the patient

The patient record is a legal document and must be produced on request under Ontario Regulation 119/94 Part IV, S.12. It shall be made available for use in the following College processes:

- inquiries, complaints and reports
- discipline
- quality assurance

Document the findings of the patient's initial assessment. Patient information is kept current by re-evaluation at subsequent examinations. The following information should be documented on all visits:

- proposal(s) for care and advice offered
- a description of the care rendered and recommendations for ongoing care
- indication that risks and benefits of a proposed in-office procedure or course of treatment were discussed and addressed with the patient, and that informed consent was given
- any deviations from usual care as a result of the patient's refusal or inability to cooperate, including if a test, procedure or treatment plan was recommended but declined by the patient
- specific notation if a test was performed, or a question asked, and the result was "negative" or "normal"

In addition, the patient health record shall:

- be legible and complete
- be maintained in either English or French
- include the patient's date of birth
- include details of all patient communication (both in person and electronic)

- be maintained to allow for easy identification and location of all documentation related to the provision of care
- be retained for at least 10 years following the patient's last visit or, if the patient was less than 18 years old at their last visit, for 10 years after the day they became or would have become 18

C.1.1. Referred Patients

The full complement of required clinical information may not be necessary when providing specific assessments or consultation services for referring optometrists, physicians or nurse practitioners. The same applies to patients who have not been directly referred but are already under the established care of another optometrist or ophthalmologist. In such cases, registrants will determine what is clinically necessary based on the reason for presentation.

C.1.2. Patient Access to Records

The right of patients to access the information in their record or direct that the information be transferred to another health care provider must not be limited in any manner, except as allowed by regulation. It is the right of patients to choose who provides care to them.

C.1.3. Relocation of a Patient Health Record

In situations where registrants relocate their practice or entrust the custody of records to another optometrist in another location, registrants entrusted with the maintenance of the records must make a reasonable attempt to inform patients of the location of the records. Further information is available on the College website.

C.1.4. Electronic Records

Registrants are expected to use reasonable and reliable backup systems for storing electronic records. Where patient information is stored on mobile devices or offsite in an identifiable form, the information must be encrypted.

D. ASSESSMENT

D.1. THE INITIAL ASSESSMENT

At a patient's first presentation, registrants must obtain and document the following clinical information:

- the chief concern or request
- a review of ocular or visual symptoms or experiences
- a general health history, with emphasis on eyes and vision, including medications used, allergies and applicable family history
- the occupational, educational and avocational visual environment and demands
- apparent physical, emotional and mental status, when relevant
- the measurement and description of their ophthalmic appliances including purpose and effectiveness
- a clinical examination of the patient, including the observation, examination or measurement of:
    - presenting monocular visual acuities at distance
    - presenting visual acuity at near, monocularly when clinically indicated
    - refractive status and best-corrected monocular visual acuity at distance
    - binocular vision assessment
    - pupillary function
    - intraocular pressure in adults and, when indicated, in children
    - the anterior segment
    - the posterior segment

Signs, symptoms and risk factors obtained at this initial assessment influence registrants' decisions about additional assessments (such as visual fields, colour vision, stereoacuity, sensory fusion and contrast sensitivity), the appropriate course of treatment and referral, and how often to re-evaluate a patient.

D.1.1. Emergencies

In emergency situations, it may be impractical to obtain all clinical information at the first visit. In such cases, specific assessment is appropriate. The registrant may advise the patient to seek a full comprehensive eye exam within a reasonable time frame or send a report to their primary optometrist for continuation of care.

D.2. REFRACTIVE ASSESSMENT

The refractive assessment includes determining the patient's refractive status and best-corrected visual acuities. When possible, objective and subjective refraction techniques are used to assess the refractive status of the eye at the initial visit and as often as clinically indicated afterward. Cycloplegic refraction is used when clinically necessary.

Refractive assessment alone does not provide enough information to allow a registrant to issue an appropriate prescription for subnormal vision devices, contact lenses or spectacles (eye glasses). The effects of ocular and systemic health conditions, binocular vision status, and the occupational and avocational visual environment and demands must also be considered.

D.2.1. Cycloplegic Refraction

Cycloplegic refraction is indicated on the initial assessment of some children and young adults, including but not limited to those:

- with suspected clinically significant latent hyperopia
- with unexplained reduced visual acuity
- with suspected amblyopia
- who are at risk of developing amblyopia secondary to accommodative esotropia or asymmetric refractive error

D.3. BINOCULAR VISION ASSESSMENT

The initial binocular vision assessment includes, at minimum, ocular alignment and, in school-age children, accommodation. As indicated, it may also include:

- comitancy
- ocular motility
- saccadic and pursuit function
- vergence function
- consideration of etiology (congenital versus acquired disorders)
- nystagmus
- sensory function
- identification of postural adaptations

D.4. ANTERIOR SEGMENT EXAMINATION

A complete anterior segment examination must include an inspection of the following anatomical structures:

- lids/adnexa
- conjunctiva/sclera
- cornea (tear film and corneal thickness, when indicated)
- anterior chamber and angle (and gonioscopy, when indicated)
- iris
- pupillary function
- crystalline lens

D.5. POSTERIOR SEGMENT EXAMINATION

A complete posterior segment examination must include an inspection of the following anatomical structures:

- vitreous humour
- quantitative optic nerve assessment
- macula/fovea
- retinal vasculature
- retinal tissues including posterior pole, mid-periphery and, where clinically indicated and/or possible, peripheral retina and ora serrata

Fundus photography is not considered a replacement for a complete posterior segment examination.

D.6. PHARMACOLOGIC DILATION

The situations or patient symptoms indicating that dilation is required (unless contraindicated) include:

- symptoms of flashes of light (photopsia), onset of or a change in number or size of floaters
- unexplained or sudden vision change, loss or distortion (metamorphopsia)
- the use of medication that may affect ocular tissues (e.g., hydroxychloroquine, phenothiazine, long-term steroids)
- the presence of systemic or ocular disease that may affect the posterior segment (e.g., diabetes, hypertension)
- a history of significant ocular trauma, or ocular surgery that increases risk to the posterior segment
- a history of moderate to high axial myopia

- when a better appreciation of the fundus is required (e.g., choroidal nevus, optic nerve anomaly)
- when the ocular fundus is not clearly visible through an undilated pupil (e.g., cataract)

D.7. VISUAL FIELD ASSESSMENT

Indications for visual field assessment and analysis include:

- assessment of visual disability
- assessment of patients' ability to operate a motor vehicle
- unexplained headaches
- unexplained photopsia or other visual disturbances
- use of medications with potential neuro-ophthalmic or retinal toxicity
- eyelid or anterior segment anomalies that may affect the visual field
- some retinal diseases and abnormalities
- glaucoma or risk factors for glaucoma
- diseases of the optic nerve and visual pathway
- neurological disease

Visual field screening provides a rapid assessment of the sensitivity and/or extent of the visual field to determine if a more detailed evaluation is required.

TOC

E. PATIENT MANAGEMENT

E.1. THE PRESCRIPTION – OPTICAL

Registrants issue a prescription only after establishing a professional relationship with the patient, completing an appropriate examination and obtaining a full understanding of the relevant aspects of the patient's needs, ocular health, refractive status and/or binocular condition.

A spectacle (eye glass) prescription must be provided to the patient without request and without additional charge, regardless of whether the examination is an insured or uninsured service. Charges for additional copies of the prescription are at the discretion of the registrant.

When registrants have performed the necessary services to prescribe a specific appliance (e.g., contact lens), an appliance-specific prescription, including the parameters of that appliance, must be provided to the patient. Registrants may withhold this information pending payment for the related service.

Patients have the right to fill their prescriptions at the dispensary of their choice.

Electronic prescribing must be done securely and in an unaltered form.

E.1.1. Required Information

An optical prescription must contain information that:

- clearly identifies the prescribing registrant, including name (with degree and profession), address, telephone number and licence (registration) number
- includes the registrant's authentic and unaltered signature
    - electronic signatures are acceptable
- clearly specifies the identity of the patient
- specifies the date prescribed and an expiry date
- is used by a regulated professional to dispense spectacles, contact lenses or a subnormal vision device that will provide the required vision correction for the patient

E.2. USE & PRESCRIBING OF DRUGS IN OPTOMETRIC PRACTICE

Registrants with authority to prescribe drugs can do so to manage patients with diseases and disorders of the eye and vision system.

Registrants using 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
    - 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

E.3. THE PRESCRIPTION – DRUGS

Registrants will issue a prescription only after establishing a professional relationship with the patient, completing an appropriate examination and obtaining a full understanding of the relevant aspects of the patient's needs, ocular health, refractive status and/or binocular condition.

If registrants determine that a prescribed therapy is required, a prescription must be provided as part of the assessment without additional charge, regardless of whether the examination is an insured or uninsured service.

Patients have the right to fill their prescriptions at the pharmacy of their choice.

When it is necessary to verbally communicate a prescription for drugs to a pharmacy, the details must be fully documented in the patient record, including the name of the pharmacy and any staff members assisting in the call.

E.3.1. Required Information

All prescriptions for drugs must contain information that:

- clearly identifies the prescribing registrant, including name (with degree and profession), address, telephone number, and licence (registration) number
- includes the registrant's authentic and unaltered signature
    - electronic signatures are acceptable
- clearly specifies the identity of the patient
- specifies the date prescribed
- specifies the drug name, dosage, dose form and any specific directions to the patient
- includes directions to the pharmacist, such as quantity to be dispensed, refills allowed and an indication if substitutions are not permitted

E.4. DELEGATION & ASSIGNMENT

In some circumstances, registrants may order another person, who would not otherwise be authorized to do so, to perform a controlled act that is within the registrant's scope of practice. This is known as **delegation**, and the person performing the act(s) is known as the **delegate**. Registrants may also receive delegation of a controlled act that is not authorized to optometry.

There are also numerous non-controlled procedures that may still require specific training and skills. Registrants may **assign** one or more of these procedures to another person.

Registrants are responsible for all delegated and assigned activities within their practices and are expected to supervise them as required.

E.4.1. Delegation

Delegation will only occur after the registrant has established a formal relationship with the patient, which normally will include an interview, assessment, recommendations, if appropriate, and informed consent about any clinical investigations and proposed therapy. In some cases, when an established registrant-patient relationship already exists, delegation may take place before the registrant sees the patient.

Delegation of an authorized act must only take place when the registrant is present in the same clinical location as the patient and is available to intervene if required. The registrant directly supervises the delegated procedure.

Registrants must establish a process for delegation that includes:

- education and assessment, ensuring the currency of the delegate's knowledge, skills and judgement
- documentation/references for performance of procedures
- ensuring the delegate has been delegated only those acts that form part of the registrant's regular practice
- an ongoing quality assurance mechanism

Delegation occurs with the informed consent of the patient. Whether the consent is implicit or explicit depends on the particular activity being delegated.

E.4.2. Assignment

Assignment of certain procedures that are not controlled acts may occur as part of the optometric examination and may occur prior to the registrant assessing the patient.

Procedures that are completely objective, present no inherent risk of harm and require no interpretation by the person performing the procedure may be performed without the presence of the registrant and are considered to be remotely supervised. This may include automated procedures such as objective auto-refraction, auto-perimetry and non-mydriatic retinal photography. The registrant is expected to review the results of these remotely supervised procedures and communicate appropriately with the patient. Direct supervision must occur whenever the procedure poses an immediate (e.g., tonometry) or potential (e.g., subjective refraction) risk of harm.

As with delegation, it is expected that assignment will only occur with certain processes in place, including:

- education and assessment ensuring the currency of the assignee's knowledge, skills and judgement
- documentation/references for performance of procedures
- ensuring assignment of only those procedures that form part of the registrant's regular practice

E.4.3. Research

An exception exists for delegation and assignment where medical direction is delegated with indirect supervision, with the informed consent of the subject, and where the research has received approval from a research and ethics board (following the Tri-Council Policy).

E.4.4. Receiving Delegation of Controlled Acts

In the public interest, there are situations when a registrant could receive delegation from another regulated health professional to perform a controlled act not authorized to optometry. Other regulated health professionals have delegation regulations and established protocols for delegation of which the registrant should be aware.

In order for a registrant to receive delegation from another regulated health professional, all of the following criteria must be met:

- A process for receiving delegation is in place.
- The registrant has a reasonable belief that the regulated health professional delegating the act is authorized to do so, has the ability to perform the act competently, and is delegating in accordance with relevant regulations governing their profession.
- The registrant is competent to perform the act safely, effectively and ethically.
- Appropriate resources, such as equipment and supplies, are available and serviceable.
- The delegated act is clearly defined.
- The duration of the delegation is clearly defined and relates to a specific patient.
- The registrant ensures that patient consent to having the act performed under delegation to the registrant is obtained and recorded in the patient's health record.
- A mechanism exists to contact the regulated health professional who delegated the act if there is an adverse or unexpected outcome.
- The identity of the regulated health professional delegating the controlled act and of the registrant are added to the patient record.

E.5. DISPENSING

Registrants are authorized to dispense spectacles and contact lenses to patients who have a valid prescription. Patients may choose to have their prescription filled by the prescriber or by another dispenser.

All dispensing services provided online must meet the same professional standards as those provided in person.

Patients have the right to decline in-person fitting and adjustment of spectacles. Registrants must use their professional judgement in determining whether to agree to a patient's request for delivery of prescription spectacles prior to in-person fitting.

The last regulated professional to provide eye-related care to the patient is considered the most responsible dispenser.

E.6. REFERRALS

A referral is a request to another regulated health professional for consultation and/or the provision of treatment when a patient requires care that exceeds the registrant's scope of practice or ability. Timeliness of the referral is influenced by the ocular and/or systemic conditions and risk factors of patients.

Once the decision has been made to make a referral, appropriate documentation in the patient's health record is necessary, including:

- confirmation of when the referral was requested
- appointment date, time and consultant
- confirmation with the patient of the appointment time and location
- a copy of the pertinent clinical information forwarded to the consultant

Registrants may need to advise patients on seeking an alternative source of care, such as a hospital emergency department, if a referral appointment is not available within an appropriate amount of time for their condition, or if their condition worsens.

E.7. SHARED CARE

Registrants must refer patients to an appropriate regulated health professional when the patient's condition and/or treatment is beyond the scope of their own practice. This usually results in referral to family physicians or ophthalmologists to institute medical and/or surgical care.

E.7.1. Referrals to Physicians

When making a referral to a physician, registrants shall ensure the patient fully understands:

- their diagnosis
- the options for care
- why they are being referred
- the roles and responsibilities of the professionals involved and any associated fees

E.7.2. Referrals to Optometrists

A registrant may refer a patient to another optometrist for specific assessment and treatment (e.g., dry eye therapy, binocular vision therapy, myopia management, imaging, visual fields).

The primary optometrist must communicate to the patient what their role will be during the referral process and the protocol for follow-up. The requisition to the second optometrist must include pertinent clinical information.

The second optometrist must:

- communicate to the patient the nature of their role, including the anticipated duration of care
- ensure that an up-to-date, comprehensive oculovisual assessment has been conducted
- maintain a patient health record, including the requisition information and results

Any new symptoms or concerns should be returned to the primary optometrist, who is responsible for the components of a comprehensive eye examination.

F. APPENDIX: SPECIFIC DISEASES, DISORDERS & PROCEDURES

F.1. REFRACTIVE ERRORS

F.1.1. Spectacle Therapy

Registrants are authorized to dispense spectacles. The provision of spectacle therapy involves:

- reviewing with the patient any relevant environmental, occupational, educational, avocational and/or physical factors affecting spectacle wear
- reviewing and confirming details and validity of prescriptions
- advising the patient regarding appropriate ophthalmic materials and lens design
- taking appropriate measurements (e.g., interpupillary distance and segment height) to ensure proper function of the spectacles
- confirming the suitability of the order and arranging for the fabrication of the spectacles
- verifying the accuracy of the completed spectacles to ensure they meet required tolerances
- fitting or adjusting the spectacles to the patient
- counselling the patient on aspects of spectacle wear including expectations, limitations, customary adaptation period and maintenance requirements of the spectacles

F.1.2. Contact Lens Therapy

Registrants are authorized to prescribe and dispense contact lenses for the treatment of:

- disorders of refraction, and/or sensory and oculomotor dysfunctions of the eye and vision system
- diseases/disorders affecting ocular health
- anatomical, structural and/or cosmetic concerns

The provision of this service to patients involves:

- an initial assessment to determine their suitability for contact lens therapy
- a determination of the parameters of a contact lens appropriate for patients
- ongoing monitoring of the efficacy of treatment

Contact lenses are classified by Health Canada as a medical device, not a consumer commodity, and must be treated accordingly.

F.1.2.1. Initial Contact Lens Fitting

Before contact lens fittings, registrants obtain required clinical information to determine the suitability of patients for contact lens wear, with special emphasis on:

- the health of the cornea, conjunctiva, lids, tarsal and bulbar conjunctiva, and the integrity of the tear film
- corneal curvature
- refractive status and visual acuity
- the effects that contact lens wear may have on the function of the accommodative, oculo-motor and sensory systems
- relevant environmental, occupational, avocational and systemic health factors affecting contact lens wear

Patients must be instructed with respect to:

- hygiene
- lens insertion and removal
- use of specific lens care products
- recommended wearing times and replacement schedules
- normal and abnormal adaptive symptoms
- contraindications to lens use
- progress evaluations
- appropriate instructions on how and when to access emergency care

Patients are examined during the adaptation period to assess lens performance, adaptation and compliance.

Once the registrant is satisfied that the adaptation process is complete, and that the parameters of the contact lenses are correct, a contact lens prescription can be finalized. Registrants are entitled to remuneration for all professional services involved in the determination of these prescriptions.

F.1.2.2. Continuing Care

Registrants provide continuing care to established contact lens patients, including:

- maintaining a history concerning:
  - the specifications, age and wearing schedule of current contact lenses
  - the current lens care regimen

  - any adverse reactions associated with contact lens wear
- assessing patients to determine if they are achieving acceptable outcomes of contact lens wear

F.1.3. Myopia Management

Myopia management involves the use of certain interventions as options for vision correction or to slow the progression of myopia in children. It should be strongly considered for all emerging myopes.

Management of myopia must include patient education regarding proper visual hygiene and environmental risk factors and may include:

- specialty contact lenses that alter the corneal shape, including orthokeratology (Ortho-K)
- specialty contact lenses, including soft lenses
- specialty spectacle lenses
- pharmaceutical treatment

Axial length measurements may be used to monitor treatment efficacy over time.

F.1.4. Low Vision Assessment

A low vision examination generally will include:

- a comprehensive patient history that explores:
  - personal social history, including patient-identified impact of visual impairment, such as specific limitations in activities of daily living and goals (vocational/educational/avocational requirements)
  - personal perspective regarding stability of vision
  - current access to services
  - current devices and usage/satisfaction
- results of the patient's most recent optometric examination, and re-assessment, as necessary

F.2. BINOCULAR VISION DYSFUNCTION & VISUAL REHABILITATION

When the initial assessment and binocular vision testing identifies areas of concern, management of binocular vision disorders includes:

- refractive and prismatic corrections
- full or partial occlusion
- amblyopia therapy

- vision therapy (including the management of visual symptoms related to learning disorders, concussion and traumatic brain injury)
- consultations with other health care professionals

F.2.1. Amblyopia

Amblyopia is a diagnosis of exclusion. Diagnostic evaluation of new patients with suspected amblyopia includes:

- prenatal and perinatal case history
- reading level and performance in school
- impact on visual function and activities of daily living

F.2.2. Vision Therapy

Registrants do not diagnose learning disorders, concussion or traumatic brain injury (TBI). They do play a role in investigating and managing visual signs and symptoms that may be associated with these diagnoses.

Assessment of such patients must include:

- case-specific history
- impact on visual function and activities of daily living

F.3. PRESCRIBED DISEASES

F.3.1. Dry Eye Disease

When providing care to patients with dry eye disease (DED), registrants will begin with a specific case history, with special attention to risk factors including:

- relevant health conditions (e.g., connective tissue and autoimmune disease)
- topical and systemic medications (e.g., antihistamines, antidepressants, diuretics and preservatives accompanying topical medications)
- environmental and occupational factors

Treatment of DED aims to restore homeostasis of the tear film and ocular surface and address patient symptoms.

F.3.2. Uveitis

Beyond the initial assessment requirement, registrants must include:

- case-specific history and review of systems
- dilated fundus exam
- macular imaging when indicated

Treatment options include:

- addressing inflammation and pain
- monitoring intraocular pressure, including control thereof if needed
- recommending referral when appropriate, including initiating communication with the patient's primary care physician or another health care provider when systemic conditions are suspected

F.3.3. Age-Related Macular Degeneration

The evaluation of patients suspected of having age-related macular degeneration (AMD) includes:

- case history with attention to specific risk factors for or symptoms of AMD
- ocular examination, including:
  - additional assessment of macular function and structure (e.g., Amsler grid and optical coherence tomography (OCT) if indicated)
  - posterior segment examination with pupillary dilation

The management of patients with AMD includes:

- patient education regarding
  - potential benefits of supplements, where clinically indicated
  - benefits of smoking cessation or other lifestyle changes
  - home monitoring with monocular Amsler grid or equivalent
- making a timely referral for patients with progression of neovascular disease

F.3.4. Glaucoma

The diagnosis and management of patients with glaucoma or a high suspicion of developing glaucoma may include:

- case history with attention to specific risk factors for glaucoma
- measurement of intraocular pressure
- evaluation and description of the optic nerve head through dilated pupils
- quantitative assessment of the angle
- investigation of threshold visual fields
- measurement of central corneal thickness, when clinically indicated
- imaging of the optic nerve head and retinal nerve fibre layer

If a referral to a secondary or tertiary eye care provider is indicated for the continuing diagnosis and/or management of glaucoma, some of these tests may be performed by that provider.

Registrants are only authorized to treat primary open angle glaucoma (POAG). All other subtypes of glaucoma must be referred to an ophthalmologist. Patients with POAG must be referred to an ophthalmologist if the treatment is complicated by a concurrent medical condition or a potentially interacting pharmacological treatment.

F.4. HEALTH CONDITIONS WITH OCULAR RISK

All patients with systemic disease with high risk of retinal/vascular complications (e.g., diabetes, hypertension) require periodic assessment of the eye and vision system. For such patients:

- Dilation is indicated
- OCT/imaging is highly recommended

Patients must be advised as to the appropriate frequency of such assessments, depending on factors such as the duration of the disease, the nature of the condition and the clinical findings.

Any abnormalities found are documented, and the patient's primary health care provider is advised as necessary of any findings that may pose a threat to the patient's ocular or systemic health.

#	Feedback
1	What was outlined as changes looks good to me, re:OPR. I did have a question... there was a similar type of email sent out maybe a year or so ago regarding proposed changes to our scope of practice and the college asked for feedback. What happened with that? Has there been an update on that that I have missed?
2	The proposed modernized OPR is much more streamlined and easier to read than the previous version. I am curious as to why the section pertaining to "Dilation and Irrigation of NL Ducts" was eliminated. The rationale states that this is incorporated into the dry eye section of the modernized OPR. I don't agree; I would have maintained that section.
3	responding to the call for comments on the draft of the new modernized OPR 1. the delegation exemption should not be limited to "University research". Why can't it be any research with a Research Ethics Board approval? 2. all law references have been removed in the new version, example of such reference in the old OPR "(O.Reg. 119.94 Part I under the Optometry Act (1. s.10))". I think it's important to have the references to the specific sections of the act in the OPR, to highlight sections of the OPR that are rooted in law.

4	I would like to commend the College for the on-going attention to modernization of the College itself and many aspects that are needed for the process of self-regulation. The OPR was always intended to be a fluid document with regular updating. I was among the early contributors to the initial versions in the 1990's and many subsequent updates. Our original goal was to provide a structured and defensible document to assist Committees of the College in assessing a member's delivery of clinical care. While we realized that regulatory requirements were the main consideration, it was accepted that ultimately it always came down to "what would an average, right-thinking optometrist (in Ontario) do in a certain situation". We had hoped that the OPR would allow both College members and committees guidance for the majority of clinical situations. However, we also recognized that it may require "expert analysis and/or testimony" in some instances for specific situations. As you know, the original OPR design usually had three sections - Regulatory standards, Professional standards (to hopefully reflect what the "average, right thinking member" would do) and Guidelines (to promote excellence in care - above the average requirement). At some point after my involvement, the Guidelines were dropped as they were apparently confusing to some assessors in the Quality Assurance process. I will admit I was not in agreement with this decision as I always believed the College should be involved in encouraging care above the minimum requirements. On reviewing the current updated OPR, I am impressed by the simplification and flow of the document. It is definitely more "reader-friendly" and likely easier for the public to read and understand. I was grateful to see that the Introduction and general overview was very similar to the original versions. We always thought these general concepts were fairly timeless and wouldn't require much future amendment. I am somewhat concerned that the removal of many details for clinical procedures may create some difficulty for assessment and interpretation by College committees. There will likely be a need for a return to more "expert analysis" when judging a member's records and approach to care. Presumably, this has been anticipated by the Committee during the OPR update and a new approach will be available when required. I also would recommend consideration of some way to return to the idea of promoting excellence in care. For instance, more visible attention to accepted and detailed clinical guidelines (such as the American Optometric Association, American Academy of Ophthalmology, etc.) . Thank you for your on-going commitment to the governance and regulation of our profession and I appreciate the opportunity to provide feedback.

5	The amendments put forth to modernize the OPR are consistent and relevant to modern day Optometry. Much of what we saw in the original version had multiple repetitions whereas these new amendments make it clear and far easier to navigate. In addition revisions and suggested diagnostic testing (i.e OCT) for many of the ocular diseases are well received. With respect to the College addressing diversity and inclusion, it reflects our professional organization's commitment to our Canadian values as Optometrists. Thank you to the College for its continued dedication to uplifting our profession.
6	There are two things that stood out to me. F1.3 Myopia Management- states that "axial length measurements should be considered as a way of monitoring treatment efficacy over time". Since axial length is not currently standard of care based on the variable presence of biometry instruments available for testing in optometry practices (the only true barometer of standard of care for an instrument is the presence of the instrument in the vast majority of clinics) this statement is premature and unnecessary and could be used to put an undue burden on optometrists. OPR4.2 Required clinical information to be obtained about patients at their first presentation includes: "intraocular pressure in adults and when indicated, in children" is vague and allows ODs to ignore IOP testing for kids until they are 18yo.
7	I occasionally perform forensic assessments for lawyers and the 2 most frequent lawsuits are RD failure to diagnose and contact lens issues. There really isn't a specific protocol for RD assessment which I think is lacking.
8	I have looked over the new OPR and I think it looks great. My only feedback is: -It would be helpful to have more information on what dry eye treatments can be delegated to staff. For example, IPL and RF. I have asked the practice advisor and she as unable to give me an answer. - Under the examples of when dilation is warranted, patients on certain medications with ocular side effects are listed as an example. The medication used as an example is Phenothiazine. It would be helpful to list: hydroxychloroquine, ethambutol, tamoxifen and chloroquine as examples, as these are the medications that if patients are on, their eye exams are covered by the Ministry.

9	Hello, Hope this email finds you well. Pls kindly find below summarized points for the feedback for the OPR modernization: - appreciated the reduction in length and repetition as the OPR is a lengthy document so in the registrant and QA assessor perspective it helps with understanding the content and getting the main points -7.1: pts with AMD, I appreciate it now includes amsler grid for monitoring and also for 7.4 OCT imaging is highly recommended for patients with systemic conditions so we can objectively track for changes over time -7.2: I appreciate that OPR states that tests may not be required if we are referring on to ophthalmology for further testing however I question as a QA assessor why we need to deduct points on their CRP if they are already referring to OMD for further testing (eg - hvfs/oct/pachymetry etc), if this was the case should the College make it a mandate that each clinic needs to have the min equipment of eg hvfs/OCT/pachymeter - 7.14: It's great that it is mentioned that axial length 'should' be included but perhaps it could state Must be or as an option to truly manage myopia management as I understand that many clinics do not have the equipment to manage axial length - Telehealth: pls correct me if I'm wrong but I am unable to find the telehealth section as I would really appreciate an updated version to help guide optometrists on telehealth policies in Ontario

COLLEGE OF OPTOMETRISTS OF ONTARIO

Summary of Changes:

Original OPR	Revised OPR	Rationale
OPR Last revised December 2022	Reordered and grouped sections to align with the five standards developed in the updated new QA practice assessment tools; removed numbering	Consistency across the College's quality assurance tools
All standards included relevant portions of the Act and Regulations	The specific wording was deleted, and links to this information were added in the introduction	Reduce length and repetition; allow for potential updates to the legislation
Some Standards contained repeated information that is applicable to optometric practice more broadly, such as conflicts of interest, registrants' obligation to stay current with practice guidelines and scientific developments, equipment, infection control and record-keeping	Content related to this kind of core information was moved out of individual Standards and into their own sections	Ensure that content with a wider relevance is clearly visible; reduce repetition
Many Standards repeated information about the initial assessment	Content related to the initial assessment was given its own section and subsequent repetitions were deleted	Ensure that content with a wider relevance is clearly visible; reduce repetition; distinguish between initial and subsequent examinations
Information about dispensing appeared in multiple places, sometimes with overlapping information	A new section on dispensing (s. E7) was created	Reduce repetition and ensure that this content is clearly visible
Contained references to "members", "optometrists", and "practitioners"	Changed references to "registrants" except when discussing referrals to other optometrists	Consistency and clarity
Standards included information about general and specialist care, as well as health conditions with higher risk of ocular effects (OPR, s. 7)	Moved information on specific diseases, procedures, visual rehabilitation and health conditions that pose a risk to eye health to the Appendix and organized in logical order	Ensuring the longevity of the core Standards while preserving the information contained in these sections.
7.1 Patients with Age-related Macular Degeneration	Updated in F3.3 Macular Degeneration (AMD)	Additional assessment of macular function and structure (e.g., Amsler grid and OCT if indicated) was added to the core considerations for the diagnosis and management of AMD.
7.2 Patients with Glaucoma	Updated in F3.4 Glaucoma	Imaging of the optic nerve head and retinal nerve fiber layer was added to the core considerations for the diagnosis and management of glaucoma.

COLLEGE OF OPTOMETRISTS OF ONTARIO

Original OPR	Revised OPR	Rationale
		The test may not be required if the patient's signs and/or symptoms indicate a referral to a secondary or tertiary eye care provider for the continuing diagnosis and/or management of glaucoma.
7.3 Patients with Cataract and 7.8 Shared Care in Refractive Surgery	Incorporated into E7 Shared Care	Shared care relationships include but are not limited to glaucoma management, cataract surgery and refractive surgery. The optometrist is responsible for maintaining collaboration and communication with the practitioner, upholding standards of practice and acting in the patient's best interest.
7.4 Patients with Diabetes and 7.5 Patients with Systemic Hypertension	Incorporated into F4 Health Conditions with Ocular Risk	All patients with systemic disease with high risk of retinal/vascular complications require periodic assessment of the eye and vision system. For such patients dilation is indicated and OCT/imaging is highly recommended.
7.6 Cycloplegic Refraction	Incorporated into D2 Refractive Assessment	Indications for cycloplegia remain the same. Indications include those with suspected clinically significant latent hyperopia, unexplained reduced visual acuity, suspected amblyopia and those who are at risk of developing amblyopia secondary to accommodative esotropia or asymmetric refractive error.
7.7 Dilation and Irrigation of the Naso-Lacrimal Ducts	Incorporated into F3.1 Dry Eye Disease	Registrants may choose evidence-informed techniques, instrumentation and therapies that have the support of peer-reviewed literature, do not compromise patient safety and that comply with the standards of practice.
7.9 Patients with Learning Disorders	Incorporated into F2.2 Vision Therapy	Registrants do not diagnose learning disorders, concussion or TBI, but they play a role in investigating whether visual signs and symptoms could be a contributing factor for a patient

COLLEGE OF OPTOMETRISTS OF ONTARIO

Original OPR	Revised OPR	Rationale
		with a suspected or recognized learning disorder. Management may involve vision therapy and/or consultations with other healthcare professionals.
7.10 Orthokeratology	Incorporated into F1.3 Myopia Management	Specialty contact lenses that alter the corneal shape, including orthokeratology (Ortho-K) are listed as a treatment option for myopia management.
7.11 Patients With Dry Eye Disease	Updated in F3.1 Dry Eye Disease	Treatment of dry eye disease aims to restore homeostasis of the tear film and ocular surface and address patient symptoms. Specific treatments were removed from OPR to reflect expanded treatment modalities available. Thereby, broadening the option for registrants to choose evidence-informed techniques, instrumentation and therapies that have the support of peer-reviewed literature, do not compromise patient safety and that comply with the standards of practice.
7.12 Patients With Amblyopia	Updated in F2.1 Amblyopia Therapy	Recognition that amblyopia is a diagnosis of exclusion. Diagnostic and management considerations remained similar to original OPR.
7.13 Patients With Uveitis	Updated in F3.2 Uveitis	Case-specific assessment and treatment options with referral when indicated.
7.14 Myopia Management	Updated in F1.3 Myopia Management	Assessment and treatment considerations that should be considered for emerging and existing myopic children.
Addition:	Section on Telehealth (s. B7) and Form of Energy (s. B2.1)	To address emergent modes of optometric service provision, as well as diagnostic and treatment technology.
	Incorporated information on acting with respect and integrity	Reflecting the College's commitment to diversity, equity and inclusion
	Plain language edit	Remove redundant or confusing language and improve clarity and readability
	Numbering updated to reflect revised structure	To provide quick reference for users.

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Original OPR	Revised OPR	Rationale
Word count: 23,301	Word count: 6,373	

9-13 / UPCOMING MEETINGS

9. Upcoming Council Meetings
    a. Friday, September 19, 2025
    b. Friday, December 12, 2025
10. List of Acronyms

11. Governance Guide: Robert's Rules

12. Council Feedback Survey

13. Adjournment – approximately 2:17 p.m.
    - Generative Discussion (optional)
    a. Generative Discussion Feedback Survey

COLLEGE OF OPTOMETRISTS OF ONTARIO

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
ASOPP	Advanced Standing Prepatory Program	An education pathway for individuals who have completed optometry training outside of North America and who wish to obtain a license to practice in Canada
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)

COLLEGE OF OPTOMETRISTS OF ONTARIO

List of Acronyms Used by the College of Optometrists of Ontario

Acronym	Name	Description
CJO	Canadian Journal of Optometry	Journal published by CAO whose mandateis to help optometrists build and manage a successful practice
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
CPMF	College Performance Measurement Framework	The CPMF is a reporting tool developed by the Ontario Ministry of Health (the Ministry) in close collaboration with Ontario's health regulatory Colleges (Colleges), to assess how well Colleges are executing their mandate to act in the public interest.
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*

COLLEGE OF OPTOMETRISTS OF ONTARIO

List of Acronyms Used by the College of Optometrists of Ontario

Acronym	Name	Description
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
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	Comprised of the 26 health regulatory colleges in Ontario. Now known as *Health Profession Regulators of 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
HPRO	Health Profession Regulators of Ontario	Comprised of the 26 health regulatory colleges 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

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List of Acronyms Used by the College of Optometrists of Ontario

Acronym	Name	Description
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
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

COLLEGE OF OPTOMETRISTS OF ONTARIO

List of Acronyms Used by the College of Optometrists of Ontario

Acronym	Name	Description
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 theinterests of medical practitioners
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

COLLEGE OF OPTOMETRISTS OF ONTARIO

List of Acronyms Used by the College of Optometrists of Ontario

Acronym	Name	Description
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
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

Updated May 2023

ROBERTS RULES CHEAT SHEET

To:	You say:	Interrupt Speaker	Second Needed	Debatable	Amendable	Vote Needed
Adjourn	"I move that we adjourn"	No	Yes	No	No	Majority
Recess	"I move that we recess until…"	No	Yes	No	Yes	Majority
Complain about noise, room temp., etc.	"Point of privilege"	Yes	No	No	No	Chair Decides
Suspend further consideration of something	"I move that we table it"	No	Yes	No	No	Majority
End debate	"I move the previous question"	No	Yes	No	No	2/3
Postpone consideration of something	"I move we postpone this matter until…"	No	Yes	Yes	Yes	Majority
Amend a motion	"I move that this motion be amended by…"	No	Yes	Yes	Yes	Majority
Introduce business (a primary motion)	"I move that…"	No	Yes	Yes	Yes	Majority

The above listed motions and points are listed in established order of precedence. When any one of them is pending, you may not introduce another that is listed below, but you may introduce another that is listed above it.

To:	You say:	Interrupt Speaker	Second Needed	Debatable	Amendable	Vote Needed
Object to procedure or personal affront	"Point of order"	Yes	No	No	No	Chair decides
Request information	"Point of information"	Yes	No	No	No	None
Ask for vote by actual count to verify voice vote	"I call for a division of the house"	Must be done before new motion	No	No	No	None unless someone objects
Object to considering some undiplomatic or improper matter	"I object to consideration of this question"	Yes	No	No	No	2/3
Take up matter previously tabled	"I move we take from the table…"	Yes	Yes	No	No	Majority
Reconsider something already disposed of	"I move we now (or later) reconsider our action relative to…"	Yes	Yes	Only if original motion was debatable	No	Majority
Consider something out of its scheduled order	"I move we suspend the rules and consider…"	No	Yes	No	No	2/3
Vote on a ruling by the Chair	"I appeal the Chair's decision"	Yes	Yes	Yes	No	Majority

The motions, points and proposals listed above have no established order of preference; any of them may be introduced at any time except when meeting is considering one of the top three matters listed from the first chart (Motion to Adjourn, Recess or Point of Privilege).

PROCEDURE FOR HANDLING A MAIN MOTION

NOTE: Nothing goes to discussion without a motion being on the floor.

Obtaining and assigning the floor

A member raises hand when no one else has the floor

- The chair recognizes the member by name

How the Motion is Brought Before the Assembly

- The member makes the motion: *I move that (or "to")* ... and resumes his seat.
- Another member seconds the motion: *I second the motion* or *I second it* or *second*.
- The chair states the motion: *It is moved and seconded that ... Are you ready for the question?*

Consideration of the Motion

1. Members can debate the motion.
2. Before speaking in debate, members obtain the floor.
3. The maker of the motion has first right to the floor if he claims it properly
4. Debate must be confined to the merits of the motion.
5. Debate can be closed only by order of the assembly (2/3 vote) or by the chair if no one seeks the floor for further debate.

The chair puts the motion to a vote

1. The chair asks: *Are you ready for the question?* If no one rises to claim the floor, the chair proceeds to take the vote.
2. The chair says: *The question is on the adoption of the motion that ... As many as are in favor, say 'Aye'.* (Pause for response.) *Those opposed, say 'Nay'*. (Pause for response.) *Those abstained please say 'Aye'.*

The chair announces the result of the vote.

1. *The ayes have it, the motion carries, and* ... (indicating the effect of the vote) or
2. *The nays have it and the motion fails*

WHEN DEBATING YOUR MOTIONS

1. Listen to the other side
2. Focus on issues, not personalities
3. Avoid questioning motives
4. Be polite

HOW TO ACCOMPLISH WHAT YOU WANT TO DO IN MEETINGS

MAIN MOTION

You want to propose a new idea or action for the group.

- After recognition, make a main motion.
- Member: "Madame Chairman, I move that _____."

AMENDING A MOTION

You want to change some of the wording that is being discussed.

- After recognition, "Madame Chairman, I move that the motion be amended by adding the following words _____."
- After recognition, "Madame Chairman, I move that the motion be amended by striking out the following words _____."
- After recognition, "Madame Chairman, I move that the motion be amended by striking out the following words, _____, and adding in their place the following words _____."

REFER TO A COMMITTEE

You feel that an idea or proposal being discussed needs more study and investigation.

- After recognition, "Madame Chairman, I move that the question be referred to a committee made up of members Smith, Jones and Brown."

POSTPONE DEFINITELY

You want the membership to have more time to consider the question under discussion and you want to postpone it to a definite time or day, and have it come up for further consideration.

- After recognition, "Madame Chairman, I move to postpone the question until _____."

PREVIOUS QUESTION

You think discussion has gone on for too long and you want to stop discussion and vote.

- After recognition, "Madam President, I move the previous question."

LIMIT DEBATE

You think discussion is getting long, but you want to give a reasonable length of time for consideration of the question.

- After recognition, "Madam President, I move to limit discussion to two minutes per speaker."

POSTPONE INDEFINITELY

You want to kill a motion that is being discussed.

- After recognition, "Madam Moderator, I move to postpone the question indefinitely."

POSTPONE INDEFINITELY

You are against a motion just proposed and want to learn who is for and who is against the motion.

- After recognition, "Madame President, I move to postpone the motion indefinitely."

RECESS

You want to take a break for a while.

- After recognition, "Madame Moderator, I move to recess for ten minutes."

ADJOURNMENT

You want the meeting to end.

- After recognition, "Madame Chairman, I move to adjourn."

PERMISSION TO WITHDRAW A MOTION

You have made a motion and after discussion, are sorry you made it.

- After recognition, "Madam President, I ask permission to withdraw my motion."

CALL FOR ORDERS OF THE DAY

At the beginning of the meeting, the agenda was adopted. The chairman is not following the order of the approved agenda.

- Without recognition, "Call for orders of the day."

SUSPENDING THE RULES

The agenda has been approved and as the meeting progressed, it became obvious that an item you are interested in will not come up before adjournment.

- After recognition, "Madam Chairman, I move to suspend the rules and move item 5 to position 2."

POINT OF PERSONAL PRIVILEGE

The noise outside the meeting has become so great that you are having trouble hearing.

- Without recognition, "Point of personal privilege."
- Chairman: "State your point."
- Member: "There is too much noise, I can't hear."

COMMITTEE OF THE WHOLE

You are going to propose a question that is likely to be controversial and you feel that some of the members will try to kill it by various maneuvers. Also you want to keep out visitors and the press.

- After recognition, "Madame Chairman, I move that we go into a committee of the whole."

POINT OF ORDER

It is obvious that the meeting is not following proper rules.

- Without recognition, "I rise to a point of order," or "Point of order."

POINT OF INFORMATION

You are wondering about some of the facts under discussion, such as the balance in the treasury when expenditures are being discussed.

- Without recognition, "Point of information."

POINT OF PARLIAMENTARY INQUIRY

You are confused about some of the parliamentary rules.

- Without recognition, "Point of parliamentary inquiry."

APPEAL FROM THE DECISION OF THE CHAIR

Without recognition, "I appeal from the decision of the chair."

Rule Classification and Requirements

Class of Rule	Requirements to Adopt	Requirements to Suspend
Charter	Adopted by majority vote or as proved by law or governing authority	Cannot be suspended
Bylaws	Adopted by membership	Cannot be suspended
Special Rules of Order	Previous notice & 2/3 vote, or a majority of entire membership	2/3 Vote
Standing Rules	Majority vote	Can be suspended for session by majority vote during a meeting
Modified Roberts Rules of Order	Adopted in bylaws	2/3 vote