



Submitted by the Ontario Association of Optometrists in collaboration with the University of Waterloo School of Optometry and Vision Science and the College of Optometrists of Ontario



Scope of Practice Change Proposals for Ontario Optometry

June 10, 2024

Form 1: Notification to Ministry of Health

Section 1. Contact Information

1. What is the applicant/organization's name that is submitting the proposal?

Ontario Association of Optometrists

2. Please provide the date that you submitted this form.

February 14, 2024; updated version: June 10, 2024

3. What is the applicant/organization's address?

20 Adelaide Street East, Box 16, Suite 801
Toronto, Ontario, M5C 2T6

4. Who is the primary contact for this proposal?

Dr. Angela Yoon, Policy Consultant, Ontario Association of Optometrists
ayoon@optom.on.ca
(647) 388-6780

5. If the primary contact is not available, who is the secondary contact for this proposal?

Dr. Shaina Nensi, President, Ontario Association of Optometrists
oaopresident@optom.on.ca

Section 2. Summary of Proposal

1. This proposed scope of practice change may require:

- Legislative amendment to the Optometry Act, 1991, S.O. 1991, c. 35; Drug and Pharmacies Regulations Act
- Amendment to Ontario Regulation 112/1 (Designated Drugs And Standards Of Practice under the Optometry Act)
- Amendment to Ontario Regulation 107/96 (Controlled Acts)
- Revocation of Schedule 1 of the Designated Drugs Regulation (112/11)

2. Please include the Act(s) that will be impacted by the proposed scope of practice change.

- Optometry Act, 1991, S.O. 1991, c. 35
- Drug and Pharmacies Regulations Act

3. Is this scope of practice proposal endorsed by the profession's regulatory college?

Council will be deliberating on this proposal on June 21, 2024.

4. Please provide a brief summary of the proposal. Be brief. This section should only be 2 paragraphs long.

The proposed amendments would give optometrists the authority to:

- prescribe all topical and oral drugs that are within the scope of practice of the profession, giving patients access to the most appropriate drug without requiring unnecessary referrals to physicians;
- remove superficial foreign bodies from below the surface of the cornea, reducing unnecessary referrals to hospitals and ophthalmologists, and improving access to local emergency care for patients;
- dispense and sell topical ophthalmic drugs;

- independently initiate and manage open-angle glaucoma, eliminating unnecessary referrals to physicians, reducing healthcare costs, and improving patient access to care (especially in rural and remote communities);
- use diagnostic ultrasound as a prescribed form of energy (e.g. for the performance of corneal pachymetry or ocular ultrasonography), so the optometrist can maintain the required standard of care in glaucoma and the management of other ocular disease conditions;
- order diagnostic tests (Blood Tests, CT, MRIs, X-rays);
- perform laser trabeculoplasty, laser peripheral iridotomy, and YAG capsulotomy;
- perform minor surgery/procedures for superficial, non-intraocular conditions, under local anesthesia.

Form 2: Scope of Practice Change Proposal

Section 1. Please provide a plain language description of the proposal.

The requested scope of practice changes would:

- Improve patient access to safe and competent eye care services, especially in rural communities
- Reduce wait times, improve patient outcomes, and increase the efficiency of health care delivery
- Decrease patient loads in emergency departments, walk-in clinics, and the offices of physician
- Improve interprofessional collaboration between optometrists and ophthalmologists
- Decrease publicly funded eye care costs, especially for more complex care

All of the requests require amendment to existing legislation and regulation and cannot be made solely through updated standards of practice. Ontario optometrists' antiquated scope no longer reflects the realities of today's patient pathways given the growing eye care demands of an aging population and the reduction of access to ophthalmology.

The proposed amendments would give optometrists the authority to:

A. Prescribe all topical and oral drugs that are within the scope of practice of the profession, giving patients access to the most appropriate drug without requiring unnecessary referrals to physicians;

New and more efficacious ophthalmic drugs are continually approved for the treatment of eye disease in Canada and working off an outdated list of drugs in regulation results in a lag in optometrists' ability to provide the most appropriate care. The public interest is served when optometrists can prescribe the indicated best-treatment for patients in a timely manner.

Currently, optometrists must refer to physicians to access drugs not listed in regulation. This increases unnecessary costs to the healthcare system and impedes access to the best treatment plan. Often, in many parts of the province, those referrals are not even possible within a reasonable distance or timeline.

The amendment to paragraph 4.2.1 of the *Optometry Act* and related amendments to the *Designated Drugs Regulation* would revoke the current drug list and allow optometrists to prescribe any topical or oral drug that is Health Canada–approved, and within the scope of practice of optometry:

Authorized acts

4. 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:

2.1 Prescribing or dispensing, while practising within the scope of practice of optometry, a drug within the meaning of the Drug and Pharmacies Regulation Act to be administered or taken topically or orally. ~~Prescribing drugs designated in the regulations.~~

These amendments would bring Ontario in line with Alberta, Saskatchewan, New Brunswick, Newfoundland, and most U.S. states. For decades, optometrists have been educated in pharmacology and have demonstrated their competency in the use and appropriate prescribing of drugs in optometric practice.

B. Remove superficial foreign bodies from below the surface of the cornea.

Patients presenting with corneal foreign bodies are common in optometric practice. Optometrists are often the first point of access for patients with such eye emergencies and are trained to diagnose and manage these injuries competently and safely. Ocular foreign bodies are extremely painful, and their timely removal is in the public interest, particularly in rural areas where limited options for care often result in a circuitous journey by the patient and suboptimal outcomes. Busy hospitals, physician walk-in clinics, and ophthalmology clinics would be less burdened by these cases that can be easily managed by an optometrist.

Currently, gaps in the *Regulated Health Professions Act, 1991* and the *Optometry Act* create a situation in which Ontario optometrists do not have the controlled act of “performing a procedure in or below the surface of the cornea.”

The result of this present statutory status is that members may continue to remove a foreign body lodged *on* the surface of the cornea but not beneath the epithelium. An average cornea is 550 microns thick (about ½ mm) with the epithelium on the surface representing only about 50 microns. It is virtually impossible to determine if a foreign body lodged on the surface of the cornea is lodged less than or equal to 50 microns. Again, optometrists have the knowledge, training, and tools to safely remove and manage the removal of corneal foreign bodies, including those lodged deeper than 50 microns.

Optometrists in all Canadian and US jurisdictions may remove foreign bodies from the cornea and conjunctiva. However, Ontario is the only Canadian jurisdiction where there is a requirement for foreign bodies to be above the corneal/conjunctival epithelium.

Standards of practice are important for members and the public to inform what is expected when optometrists remove corneal foreign bodies. The College has already drafted standards of practice titled *OPR 7.14 Removal of Foreign Bodies from the Cornea*, which would be published in the Optometric Practice Reference (OPR) when the authority to perform the controlled act is proclaimed.

The amendment to paragraph 4.2.1 of the *Optometry Act* would be

Authorized acts

4. *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:*

2.2 *Performing a procedure, in or below the surface of the cornea*

C. Provide drug samples

The sampling of topical medication, especially in glaucoma care, would allow optometrists to determine the most appropriate drug therapy for patients before it is prescribed. Allowing optometrists to dispense samples for the sole purpose of trialling clinical effectiveness would improve patient adherence with therapy as it reduces cost barriers for patients, which can be significant at the onset of treatment.

The suggested amendment to paragraph 4.2.1 of the *Optometry Act* would permit optometrists to dispense drugs:

Authorized acts

4. *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:*

2.1 *Prescribing or dispensing, while practising within the scope of practice of optometry, a drug within the meaning of the Drug and Pharmacies Regulation Act to be administered or taken topically or orally.* ~~Prescribing drugs designated in the regulations~~

The Designated Drugs Regulation (112/11) would also need to be amended.

D. Sell topical ophthalmic drugs

There are some communities where the number of pharmacies is very limited. Not every patient has the means to be able to travel far distances. If they are commuting to an optometrist's office for diagnosis and treatment, they can pick up their eyedrops there as well, helping to ensure they receive the right treatment at the right time.

Patients routinely ask optometrists for prescriptions for Latisse, a drug indicated to increase the length, thickness, and darkness of a patient's eyelashes. This drug is not available in pharmacies and patients often request to purchase this product directly from their optometrist rather than searching for a cosmetic physician's office (which may not be available in their town).

Alberta allows optometrists to retail ophthalmic drugs.

The *Optometry Act* and *Drug and Pharmacies Regulations Act* would require amendment.

E. Manage open-angle glaucoma independently

Permitting optometrists full independent management of open-angle glaucoma would remove unnecessary restrictions on optometrists to refer to physicians for co-management, reducing health care costs and improving access for patients, especially in the very common situations where ophthalmologic glaucoma care is not readily accessible, or not available in a timely manner. Early treatment is critical to prevent vision loss, which is permanent and cannot be regained. It is not uncommon for wait times to exceed six to twelve months for an initial consultation with a glaucoma specialist in Ontario.

In Ontario, optometrists may only treat a patient with primary open-angle glaucoma, the treatment of which is not complicated by either a concurrent medical condition or a potentially interacting pharmacological treatment. For example, a patient with diabetes that an optometrist has diagnosed with glaucoma must be referred to an ophthalmologist to initiate therapy because in some more rare cases, diabetes could complicate the glaucoma. However, optometrists are trained to identify these specific diabetic changes and refer to ophthalmology only when truly necessary. Alberta and Saskatchewan optometrists have broader authority, being permitted to treat all open-angle glaucoma with full independent authority (oral and topical).

In over half of US jurisdictions, optometrists have the full range of glaucoma management authority. They may treat with both topical and oral medications (in both emergency and non-emergency settings) without an ophthalmology consultation or co-management requirement, and without any conditions imposed by state law.

Removing these restrictions would not reduce collaboration between ophthalmologists and optometrists; rather, it would permit decision-making about the best arrangement to be based on the specific needs of the patient, and to be made more expeditiously. It would also reduce duplicate testing between optometrists and physicians and reduce unnecessary health care costs.

Amending the *Designated Drug Regulation* would grant optometrists to independently manage open angle glaucoma.

E. Use diagnostic ultrasound as a prescribed form of energy for the performance of corneal pachymetry or ocular ultrasonography (A and B scans).

The use of diagnostic ultrasound by optometrists to perform corneal pachymetry is a standard of practice in glaucoma care. Pachymetry is a non-invasive diagnostic test that measures the thickness of the cornea and is required to meet the standard of care for diagnosing and managing patients with open-angle glaucoma. We include the following link that helps describe the importance of corneal thickness when managing glaucoma.
<https://glaucoma.org/the-importance-of-corneal-thickness/>

The A-scan is a diagnostic test used to determine the length of the eye (e.g. for myopia management) and measure the size of intraocular structures (e.g. ocular tumours).

B-scans produce a cross-sectional image of the eye when the view of the back of the eye is obstructed due to conditions including vitreous hemorrhage, advanced cataract, or dense corneal opacities. It can also assist in imaging a suspicious nevus and for diagnosing buried optic nerve drusen.

The controlled act of *applying a prescribed form of energy* is currently authorized to optometrists; however, *applying soundwaves for diagnostic ultrasound* is not currently prescribed in Ontario Regulation 107/96 of the Regulated Health Professions Act, 1991.

The following amendment is proposed for addition to the *Controlled Acts Regulation*:

A member of the College of Optometrists of Ontario is exempt from subsection 27 (1) of the Act for the purpose of applying soundwaves for diagnostic ultrasound in order to perform corneal pachymetry or A/B scan ocular ultrasonography.

All other Canadian and US jurisdictions are permitted to perform corneal pachymetry and ultrasound sonography.

F. Perform laser therapy

- **Laser trabeculoplasty** (eg. Selective laser trabeculoplasty (SLT), argon laser trabeculoplasty). This is a treatment for open-angle glaucoma. It uses laser light that is applied to the trabecular meshwork, which is made up of tiny channels that allows fluid to drain from the eye. The energy from the laser lets fluid drain more easily from the front part of the eye, which lowers pressure in the eye.
- **Laser peripheral iridotomy**: This procedure uses a very focused beam of light to create a small hole on the outer edge of the iris. This opening acts as a bypass, allowing aqueous fluid to flow from behind the iris where it is produced to in front of the iris where it is drained. This opening is created to prevent and treat an ocular emergency called acute angle closure. In angle closure glaucoma, a sudden buildup of pressure (within hours) within the eye can lead to permanent blindness in just days.

- **YAG capsulotomy** is a procedure that creates an opening in the posterior capsule (a membrane that holds the intraocular lens inserted during cataract surgery) when it becomes cloudy, which can happen months or years after cataract surgery.

Access to timely secondary and tertiary eye care, especially in rural Ontario, is quickly reaching crisis levels. This is not hyperbole. Again, as previously mentioned, the Canadian Ophthalmological Society has stated that the reason the Alberta government appears ready to grant this expanded scope to their optometrists “**relates to expanding access to services in rural and remote areas.**”

A substantial body of evidence supports the safety and efficacy of these procedures with minimal to no side effects regardless of whether they are trained in medicine or optometry. In addition, optometrists in Ontario are already managing the minimal side effects of these procedures done by ophthalmologists, since the side effects fall within the scope of practice.^{1,2}

Access to a YAG capsulotomy and urgent LPI is limited in Northern parts of the province. SLT treatment is quickly being considered as a preferred first line treatment choice for glaucoma. Recent evidence suggests that early glaucoma treatment with SLT prior to using glaucoma eyedrops leads to better visual outcomes (reducing cost burden of visual impairment), less cataract and glaucoma surgery (therefore less cost to health care system), less overall drop use (less cost to health care system) and better intraocular pressure control compared to eyedrops.³

There is a concerning imbalance of a projection of a significant increase in glaucoma because of an aging population and not enough ophthalmologists in practice. The insufficient number of ophthalmologists available will prevent the required paradigm treatment shift towards SLT as first line treatment, and therefore, we will not see lower health care costs and improved patient outcomes for these patients.

This shift is happening in Europe and the UK, where they are training Optometrists to do SLT and also changing their clinical practice guidelines to include SLT as first line treatment. Optometrists in Ontario are already treating glaucoma and are in a favourable position to make this paradigm shift safely. Newer technology is available making these procedures even easier and safer to do such that these procedures are delegated to nurses and physician assistants in the US and Europe.

In the US:

- 12 states permit laser for glaucoma therapy (ALT, SLT, LPI) and YAG capsulotomy (Alaska, Arkansas, Colorado, Indiana, Kentucky, Louisiana, Mississippi, Oklahoma, South Dakota, Virginia, Wisconsin, Wyoming)

¹ Konstantakopoulou, E., Jones, L., Nathwani, N et al (2022). Selective laser trabeculoplasty (SLT) performed by optometrists—enablers and barriers to a shift in service delivery. *Eye*, 36(10), 2006-2012

² Lighthizer, N., Johnson, S., Holthaus, J., Holthaus, K., Cherian, B., Swindell, R., ... & Miller, J. M. (2023). Nd: YAG Laser Capsulotomy: Efficacy and Outcomes Performed by Optometrists. *Optometry and Vision Science*, 10-1097.

³ Gazzard, Gus, et al. Laser in glaucoma and ocular hypertension (LiGHT) trial: Six-year results of primary selective laser trabeculoplasty versus eye drops for the treatment of glaucoma and ocular hypertension." *Ophthalmology* 130.2 (2023): 139-151

- Currently an additional 8 states are actively pursuing laser privileges in 2024 (Alabama, Missouri, Nebraska, New Hampshire, New Jersey, Ohio, Vermont, West Virginia)

Optometrists in the United States have been performing these laser procedures for the past thirty-five years in a safe and competent manner. No incident of incompetent or incorrect care has ever been documented in these jurisdictions.

The amendment to paragraph 4.2.1 of the *Optometry Act* would be

Authorized acts

4. 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:

2.2 Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, or in or below the surface of the cornea.

G. Perform minor surgery/procedures under local anesthesia

These include:

- Removal of benign skin/conjunctival lesions (i.e. skin tags, papilloma, verrucae, seborrheic keratosis, cysts of Moll, cysts of Zeis, sebaceous cysts, epidermal/conjunctival inclusion cysts and incision/curettage of chalazion)
- Botox for blepharospasm (involuntary spasm of the lid)
- All proposed minor surgical procedures are for superficial, non-intraocular conditions that would be performed under local anesthesia (topical and injectable) and not under general anesthesia. These are easily performed in-office.

The approval of this authorization would improve access to treatment of these benign skin lesions, reducing the burden on physicians and hospitals, especially in rural and remote areas. In most regions in Ontario, it is becoming extremely difficult to find an ophthalmologist willing to take on these simple cases regardless of wait times.

Authorization would also reduce the need for patients to purchase and treat themselves with over the counter (OTC) treatments for warts and skin tags (e.g. Dr. Scholl's®). Unfortunately, when this OTC is applied incorrectly, damage to healthy skin or the eye itself may ensue. In addition, the ingredients of dimethyl ether and propane are flammable and combustible which causes an additional health risk to the patient. As such, we do not recommend patients purchase these OTC kits and attempt to treat themselves.

All optometry programs in North America already teach and develop basic surgical skills (general skills which transfer laterally to a variety of specific procedures) and even some invasive procedures (procedures currently performed in a majority of states). Examples of transferable surgical skills that are taught at all North American optometry schools and part of a majority of optometry scope in North America and done on patients in clinical rotations:

- Embedded corneal foreign body removal
- Embedded conjunctival foreign body removal
- Corneal epithelial debridement/removal (a form of lamellar keratectomy)
- Corneal stromal rust extraction
- Naso-lacrimal duct probing and irrigation
- Intracanalicular plug insertion/removal

In addition to these skills, surgical skills are introduced and done on model skin/and human partners including: Intravenous/intramuscular injections, intralesional injections, intradermal, and subcutaneous lesions. The technique of intradermal injections is the same technique used for Botox.

Optometrists in the United States have been performing these minor surgical procedures in a safe and competent manner for the past forty-seven years. Currently, twenty states permit these minor surgical procedures for lids (e.g. chalazion removal) (Alaska, Arkansas, Colorado, Georgia, Idaho, Indiana, Iowa, Kentucky, Louisiana, Mississippi, New Mexico, Oklahoma, Oregon, South Dakota, Tennessee, Utah, Virginia, Washington, Wisconsin, Wyoming) with seven more (Alabama, Missouri, New Hampshire, New Jersey, Ohio, Vermont, West Virginia) currently pursuing in active legislation.

It is believed Alberta optometrists will soon be authorized to perform these procedures. Most other Canadian provinces have optometrists seeking similar scope.

The amendment to paragraph 4.2.1 of the *Optometry Act* would be

Authorized acts

4. 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:

2.2 Performing a procedure on tissue below the dermis or below the surface of a mucous membrane.

Summary of Excluded Procedures

To provide more clarity, the following ophthalmic procedures would be specifically excluded, except for the preoperative and postoperative care of patients undergoing these procedures:

- Retina laser procedures

- Penetrating keratoplasty (corneal transplant)
- The administration of general anesthesia
- Surgery done with general anesthesia
- Laser or non-laser procedure into the vitreous chamber of the eye to treat any retinal or macular disease
- Intravitreal injections
- Surgery related to removal of the eye
- Surgery requiring full thickness incision or excision of the cornea or sclera other than paracentesis in an emergency situation requiring immediate reduction of the pressure inside the eye
- Surgery requiring incision of the iris and ciliary body, including diathermy or cryotherapy
- Surgery requiring incision of the vitreous
- Surgery requiring incision of the retina
- Surgical extraction of the crystalline lens
- Surgical intraocular implants
- Incisional or excisional surgery of the extraocular muscles
- Surgery of the eyelid for suspect malignancies or for incisional cosmetic or mechanical repair of blepharochalasis, ptosis, and tarsorrhaphy
- Surgery of the bony orbit, including orbital implants
- Incisional or excisional surgery of the lacrimal system other than probing or related procedures
- Surgery requiring full thickness conjunctivoplasty with graft or flap
- Pterygium surgery

Does the profession's regulatory college support this scope of practice change proposal?

The Council of the College of Optometrists of Ontario will be reviewing the full proposal on June 21, 2024.

Section 2. Impact on End Users and Outcomes

1. What are the impacts that this proposed scope of practice change will have on specific populations?

All patients will benefit from the proposed changes. However, rural and northern Ontarians, seniors, low-income individuals/families, Indigenous people and persons with disabilities, residents in long-term care homes or retirement residences will especially benefit from the improved access and reduced unnecessary referrals and extra appointments. None of the changes will affect OHIP-insurance coverage.

2. What is the impact on patient/client/resident experience?

In most cases, patients will be able to directly access care from their local optometrist rather than being referred to an ophthalmologist which often leads to delays, more travel, and financial burden (time off work, travel expenses). By allowing optometrists to practice to the level of their training, patients will have a much-improved experience with a net result of more timely care, and reduced risk of vision loss.

3. What are the impacts on the profession and activities to ensure practice readiness?

Optometrists are already equipped with both the knowledge and tools to provide the care that Ontarians require and deserve. All accredited optometry schools in both Canada and the US have been providing the necessary education and training required to practice to the proposed scope changes.

Entry-to-practice examinations already ensure that competency is attained before registration; no modifications would be needed if the proposed scope expansion requests are granted.

The OAO, the College and University of Waterloo School of Optometry and Vision Science routinely provide continuing education courses to keep optometrists current on the knowledge to handle the proposed changes. The OAO and College will provide extensive communication with its members to ensure that the profession is aware of the new professional obligations.

4. What are the impacts to the healthcare system?

- Reduced pressure on physicians and hospitals (especially emergency rooms), resulting also in a decrease in costs to the government as emergency room costs are exponentially greater.
- Reduced unnecessary referrals to family physicians and ophthalmologists, and thus reduced duplicative care and freeing of resources to perform complex care

5. If applicable, please include any additional information related to this section.

Section 3. Costs and Savings

1. What are the costs and/or savings to patients?

- Some new drugs may not be covered by the Ontario Drug Benefit Plan (ODB) and are thus out-of-pocket for some patients.
- The ODB Plan will have reduced costs related to glaucoma drug trials, which are conducted before initiating life-long drug therapy; Patients not covered by ODB will also have reduced costs related to drug trialling.
- As patients will have improved access to care, closer to home, thus saving patients (especially in rural communities) from long commutes and time off work to access emergency and ophthalmology services.
- Some of the newer to market glaucoma drugs are not only more effective, but some are also less costly, saving the patient money. An example of this is given in Appendix 1 of Appendix C.

2. What are the costs and/or savings to healthcare providers?

- Physicians under the fee-for-service model will see fewer services related to emergency and glaucoma care
- Emergency departments will provide fewer services related to ocular emergencies

3. What are the costs and/or savings to the Government, ministry, and other ministries and government programs?

- There is reduced regulatory burden/costs of continually updating the drug list
- There will be reduced pressure and costs on emergency rooms

- Unnecessary referrals to physicians will be reduced, and thus reduced duplicative care and associated OHIP costs
- Some of the newer therapeutic drugs are less expensive and can save the government money
- Glaucoma laser therapy may reduce the need for publicly funded glaucoma medication, which will save the government money

4. If applicable, please include any additional information related to this section.

5. Please provide any evidence documentation that is related to this section.

Section 4. Alignment with Healthcare Priorities

1. Please identify and explain where and how the proposal aligns with current healthcare priorities.

The requested changes are in line with the current healthcare priorities of increasing patient access to care, reducing the burden on physicians and hospitals, and reducing unnecessary healthcare costs, red tape, and wait times and helping to eliminate hallway medicine. The “right care by the right provider at the right time”.

2. Please identify and explain any possible negative impacts on current healthcare priorities.

There are no negative impacts on current healthcare priorities. In many regions of Ontario, optometrists are already expected by other healthcare providers and the public to provide these services.

3. If applicable, please include any additional information related to this section.

4. Please provide any evidence documentation that is related to this section.

Section 5. Jurisdictional Comparison and Analysis

1. Please provide a detailed jurisdictional scan and analysis.

Please refer to Form 2, Section 1, Question 1 for relevant jurisdictional information. Most of the changes to scope of practice are already allowed in at least two or more provinces.

2. If applicable, please include any additional information related to this section.

3. Please provide any evidence documentation that is related to this section

Section 6. Risk Identification & Mitigation

1. Are there any legal risks related to your proposal?

We are unaware of any legal risks to this proposal. Optometrists perform to this scope in other jurisdictions in Canada and the U.S. Ontario Optometrists are sometimes providing these services under “Good Samaritan Law” because of the time sensitivity of ocular emergencies presented to them and lack of any timely options but have potential exposure to not being covered by their professional liability insurance.

2. Are there any safety and public protection risks?

These are extremely minimal, as evidenced by the near-absence of both College complaints (only one) and professional liability insurance claims (only one) related to the prescribing of

drugs over the last seven or more years. Optometrists are well trained and experienced to handle these proposed changes.

Optometrists in the United States have been performing laser procedures for the past thirty-five years in a safe and competent manner. No incident of incompetent or incorrect care has ever been documented in these jurisdictions.

3. Are there any risks to other regulated health professionals?

There are no foreseeable risks, as the expanded duties will reduce the burden on other providers (emergency rooms, family physicians, ophthalmologists, walk-in clinics, and pharmacists). In fact, often these other providers refer to optometrists to manage these cases even though they fall outside of current scope for optometrists.

4. Are there any risks to integrated care?

No. The changes will not hinder interprofessional care; they will only remove unnecessary restrictions (especially around glaucoma care), remove duplicative care and enhance integrated care. The only risk to integrated care and logical patient pathways is by not making these amendments.

Patients are becoming more and more frustrated about being bounced around from provider to provider. For example, a family physician (who has scope but not the specific training and equipment to remove a corneal foreign body) refers to an optometrist (who has the specific training and the equipment to remove a corneal foreign body but not the scope) who must then refer to an Emergency Room. This is only one example of an inefficient patient pathway that happens every day in Ontario.

5. Are there any risks to health care service delivery partners or Ontario businesses?

No. The expanded scope will only make the healthcare system more efficient and cost-effective. There are no impacts on Ontario businesses.

7. Please provide any evidence documentation that is related to this section.

8. If applicable, please include any additional information related to this section.

Section 7. Implementation Considerations

- 1. If, following ministry analysis and support, the change in scope proceeded for government approval, what steps need to be considered as part of an implementation plan.**

Most members already have the competency and knowledge to perform services in line with the requested scope change. However, continuing education providers, including the OAO and University of Waterloo School of Optometry and Vision Science, will provide refresher courses (currently happens).

The OAO and College will provide in-depth communication to optometrists, stakeholders, and the public about the changes using social media, e-newsletters, and online resources.

The College will publish updated standards of practice to relay expectations related to safe and effective care. OAO will provide online modules to update their members. Both OAO and the College are well-resourced to provide member support related to the changes, and resources can be made within 3-6 months of implementation.

- 2. If applicable, please include any additional information related to this section.**

Section 8. Approach for Ongoing Quality and Safety

- 1. Describe what mechanisms or monitoring processes need to be in place to ensure ongoing quality and safety if the scope of practice change is implemented?**

Optometrists are already required to attain 70 hours of continuing education every three years to ensure their continuing competence and quality improvement, to address changes in practice environments, and to ensure they remain current with changes in technology, scope and standards of practice. The College of Optometrists of Ontario also has a rigorous quality assurance program to ensure standards of practice levels are met.

- 2. Please provide any evidence documentation that is related to this section.**