



Optometrists Association Australia

Submission to the Optometry Board of Australia's public consultation on amendments to Guidelines for use of Scheduled Medicines

ABOUT OPTOMETRISTS ASSOCIATION AUSTRALIA

Optometrists Association Australia is a non-profit organisation registered under the Victorian Companies Act. It is a federation of the six state optometric associations and has been in existence since 1904.

Around 93 per cent of practising optometrists in Australia are members of Optometrists Association Australia.

Contact details for the National and State Division Offices are at www.optometrists.asn.au.

Executive Summary

Optometrists Association Australia (the Association) welcomes the opportunity to provide this submission to the Optometry Board of Australia (OBA) on amended Guidelines for use of Scheduled Medicines (the Guidelines). The Association is the peak professional body for Australian optometrists, representing over 4,000 members (around 93% of optometrists registered with the Optometry Board of Australia).

The Association believes the amendments proposed to the Guidelines, in particular the opportunity for optometrists to independently prescribe glaucoma medications, are relevant and align with the objectives of the National Registration and Accreditation Scheme (NRAS) and the growing eye health and vision care needs of the Australian public. The proposed changes recognise the experience and training of optometrists to undertake this role.

The Association strongly supports the major amendment to the Guidelines, as outlined in *section 7*, allowing optometrists with the experience, interest and patient base, the opportunity to prescribe glaucoma medicines, when indicated.

If agreed the change would continue to uphold the NRAS principles that focus on increased access to services provided by health practitioners in accordance with the public interest - as well as the principle of facilitating practical regulatory arrangements making effective use of the relevant trained primary eye health workforce in Australia to meet the increasing needs of the Australian public.

The current regulatory arrangements are in place to ensure that only health practitioners suitably trained and qualified to practise would be able take advantage of this proposed change - those electing to independently manage glaucoma must so within their competence and individual scope of practice.

The proposed amendments clearly enable a more flexible, responsive and sustainable eye health workforce in Australia and the care provided by this workforce, a core ideal of NRAS. In particular they will provide greatly increased flexibility for glaucoma patients in rural and remote Australia where medical specialist services are relatively inaccessible. This regulatory change would support an overall decrease in vision loss from glaucoma over time. Without such regulatory change it is generally accepted that Australia will continue to experience increasing demands on, and challenges for, specialist services in managing chronic eye diseases like glaucoma.

The proposed amendments are not contrary to the findings of the NHMRC's Guidelines for Screening, Prognosis, Diagnosis, Management and Prevention of Glaucoma and provide a mechanism for convenient, affordable early treatment and regular monitoring of glaucoma.

Additionally, the Association urges eye health stakeholders, including consumer groups, eye care practitioners, professional bodies and government, to work collaboratively in delivering change and innovation to build a sustainable eye health workforce that meets the healthcare needs of Australia

now and into the future. Critical to this is promoting the importance of seeking a regular eye health examination to assist in combating the increasing prevalence of chronic eye disease.

Submission on proposed changes to the Optometry Board of Australia's amendments to Guidelines on the use of Scheduled Medicines 2013

Section 7: Guidelines for care of patients with, or at high risk of developing, chronic glaucoma.

The introduction of the NRAS in 2010 was underpinned by an objective of enabling the continuous development of a flexible, responsive and sustainable Australian health workforce and enable innovation in education and service delivery.¹ The Association believes the amendments to the Guidelines in *section 7* strongly reflect the continued advancement of optometrists as highly trained and skilled eye care practitioners and support a flexible, responsive and sustainable eye health care workforce to meet the future eye care needs of Australians.

Essential elements underpinning a change such as this to the Guidelines include:

- the optometrist being qualified to prescribe the medicine; and
- the existing regulatory structure that requires an optometrist to recognise and work within their competence and scope of practice, including having the experience to prescribe independently and where necessary, consult and take advice from colleagues.

The context for such a regulatory amendment is supported by and is the natural progression of the following:

1. Foundational training of optometrists:

- Both postgraduate and undergraduate programs of study include significant glaucoma elements that are delivered by glaucoma experts.

2. Prescribing:

- Australian optometrists have been able to prescribe schedule 4 medicines since 1996, the first such state being Victoria. Progressively, authorisation to prescribe has been granted to optometrists in all state and territory jurisdictions.
- Authorised optometrists are able to prescribe for the treatment of conditions of the eye from a common national list of scheduled medicines (the National List)², which includes anti-glaucoma drugs.

¹Intergovernmental agreement for a national registration and accreditation scheme for the health professions:
<http://www.ahwo.gov.au/natreg.asp>

² Note there are minor differences in the way State and Territory Drug and Poison legislation provide access to this common National List

- In 2008, anti-glaucoma drugs were listed on the Optometric Pharmaceutical Benefits Scheme (PBS) list, further supporting optometric prescribing in glaucoma and greater patient affordability, and increasing the number of optometrists managing patients with glaucoma in shared care arrangements with ophthalmology.
 - The Optometry Council of Australia and New Zealand (OCANZ) has included prescribing competencies in its accreditation programs to address prescribing education and training. All pre-registration university programs have expanded to include additional elements to meet these prescribing training competencies in all undergraduate optometry courses.
 - Postgraduate programs are available for currently practising optometrists who seek this endorsement to prescribe scheduled medicines.
3. Currently 29% of the profession has completed additional training and holds a scheduled medicines endorsement.
 4. From 2014, all initial optometric registrants will be required to hold a scheduled medicines endorsement.
 5. The continuing professional development requirements set by the Optometry Board of Australia require endorsed optometrists to complete half of their professional development in learning activities related to the scheduled medicines endorsement.
 6. Rural and remote eye care in Australia is provided almost entirely by optometrists, most of whom have undergone the additional training and qualified to provide therapeutic services. This more flexible approach will improve services available to rural and remote people with glaucoma.

The Association agrees with the inclusion of the new scope section of the Guidelines that states optometrists must have the equipment, expertise and skills to practice safely. This sits alongside pre-existing requirements under the OBA's Code of Conduct. *Section 7* would benefit from additional wording and focus on this theme.

In addition to the list of resources to be read in conjunction with the guidelines at the beginning of *section 7* we suggest a paragraph be included that references evidence based medicine principles. For example: *'all registered optometrists must integrate their individual clinical expertise with the best available clinical evidence from peer reviewed research in their clinical decision making in the care of patients with, or suspected of having, glaucoma'*. This is the duty of care that registered optometrists must abide in all aspects of their professional practice however emphasis in this section would add value.

The sentence ‘when a diagnosis of chronic glaucoma is made, or a patient...monitoring of the patients response’ may be strengthened by division into two bullet points. Such differentiation clearly identifies the stratagems for managing chronic glaucoma, or those at a high risk of developing the disease

The two bullets points would clearly differentiate that when an optometrist makes an initial diagnosis of chronic glaucoma, or a patient is at high risk of developing the disease, they must either refer the patient for specialist assessment (applicable to endorsed and non-endorsed optometrists) or develop and implement a management plan that includes initiation of treatment and monitoring of patient response (applicable to endorsed optometrists with the equipment, expertise, skills and experience and with the consent and in the best interests of patients).

The addition of a paragraph setting out that optometrists can still choose to enter into a collaborative or shared care arrangement with an ophthalmologist may also be beneficial to the final Guidelines. This recognises that practitioners, where access to specialist care is not an issue, are likely to choose to manage patients with glaucoma in collaboration with ophthalmologists in a formal shared care arrangement and that collaborative and shared care agreements will remain.

Finally, the Guidelines would also be strengthened if the OBA develops a summary sheet of the NHMRC guidelines as a quick reference for endorsed optometrists. An alternative approach may be for the Board to consider referencing guidelines developed over time by the Association or the Centre for Eye Health.

Comments on specific sections of the Guidelines are provided below.

Scope

This Association supports this inclusion of this section in the amended Guidelines and recommends that there be an additional statement which recommends that all registered optometrists who collaborate with other healthcare professionals in patient management relating to scheduled medicines understand and consider the principles contained in the Guideline.

Section 1: Endorsement for scheduled medicines

This section references table 1 in appendix C. For the purpose of consistency, we note the table is titled table C1 in the appendices which needs amending.

Section 1.2 Approval programs of study and assessments

The reference to the title of appendix A in this paragraph differs from the actual title of appendix A in the appendices.

Section 2.3: Prescriptions

In order to reduce confusion the Association suggests that the wording ‘*In some jurisdictions*’ be expanded to detail those jurisdictions that allow optometrists who may give oral instructions to a pharmacist (for example, in an emergency). This could be achieved by footnote similar to those used elsewhere in the Guidelines.

In the second paragraph commencing “*When prescribing a Schedule 2 or 3 medicine, the Board encourages endorsed optometrists to issue a prescription....*” we suggest that that additional wording be noted that guides non-endorsed optometrists of the expectation that they provide a written recommendation to patients that can then be used to present to pharmacists.

Section 2.4: Practice procedures

Suggest remove the word ‘the’ at the end of the first line. The third dot point may be better expressed as ‘adhere to local legislation regarding the notification of relevant authorities of the loss or theft of a scheduled medicine’

Section 2.5: Adverse Event Reporting

The Association agrees with the introduction of this new subsection in relation to Therapeutic Goods Administration (TGA) reporting. As a professional Association we remind practising optometrists to comply with reporting as part of everyday good professional practice.

Section 3: Sale of Scheduled Medicines

The Association strongly supports the Board’s emphasis of the division of responsibility between a prescriber and a pharmacist. At the beginning of the 3rd paragraph in this section the Association feels this could be detailed further by rewording the paragraph as follows:

...It is the expectation of the Board that this division of responsibility between prescriber and pharmacist is maintained at all times unless exceptional circumstances arise. Such exceptional circumstances when it is possible for an optometrist to sell a scheduled medicine to a patient include in an emergency, in a remote ...

Section 6: Collaborative Care guidelines

The Association feels that the opening paragraph of this section may be aided by the inclusion of some wording that states that shared care has been shown to maximise health outcomes and that even in the absence of an official collaborative care arrangement, optometrists should communicate to other health practitioners involved in the patient’s care all relevant information. This also reflects the OBA’s Code of Conduct.

Furthermore, it may be useful to expand on the definition of ‘collaborative care’ provided in the Guidelines to note the role of the patient at this point. Collaborative care not only requires the input

and consent of the patient but critically, should be in the best interest of the patient to optimise health outcomes. While this is touched upon in *section 6.2 Patient Involvement*, the Guidelines may be improved by inclusion of similar wording in the beginning paragraphs of *section 6* to emphasise the role of the patient at all times.

Appendix D: First aid for acute angle closure event

The Association notes that the Board has provided for publishing a list of states and territories that provide authorisation to hold acetazolamide in a first aid kit. We encourage this and hope such a list is sufficiently detailed to guide optometrists rather than a simple listing of legislative instruments.