OPTOMETRISTS AND DISPENSING OPTICIANS BOARD
Te Poari o ngā Kaimātai Whatu me ngā Kaiwahakarato Mōhiti

PRESCRIBING IN GLAUCOMA: GUIDELINES FOR NZ OPTOMETRISTS

Introduction

Independent prescribing relates to the capacity to use clinical judgement in respect of diagnosis and treatment. It does not mean working in isolation. The nature of glaucoma management is expected to encourage closer co-operative and collegial relationships with other health practitioners involved in the patient's care.

The common goal of the changes to Optometry's prescribing status is to extend optometric care of glaucoma beyond the diagnosis stage, giving the public easier access to treatment and management for this vision threatening condition. Amendments to the Medicines Act 1981 has increased the number of trained optometrists who are able to treat glaucoma, and thus relieve some of the burden from ophthalmology so that they may concentrate their skills on the more complex cases and problems of our aging population.

A fundamental part of glaucoma management is the ability to prescribe medications that control intraocular pressure, with the goal of preserving optic nerve structure, visual function, and the patient's quality of life. The intention of these guidelines is to assist optometrists to do this within accepted best-practice standards and to identify those patients who are suitable to treat independently.

Practitioners are reminded of their obligations regarding informed consent; that patients under their care should be made aware of all options regarding management of glaucoma including referral to an ophthalmologist, or public hospital care.

As in the management of any pathology, the Board expects that the optometrist will always act:

1. in the best interest of the patient;
2. in close consultation with the patient's other health practitioners;
3. to the current best-practice, evidence based medical standards;
4. within the optometrist's training and experience, and;
5. in the case of glaucoma, within these guidelines.

Guidelines

Before taking on the independent management of glaucoma for a patient an optometrist **must**:

1. Hold a current Annual Practising Certificate as an Optometrist without conditions that prohibit the prescribing of therapeutic medications.

2. Satisfy the Board that they have sufficient clinical experience in the management of glaucoma. In addition to Board-approved undergraduate therapeutics training or attaining a therapeutics qualification (via a Board-approved post-graduate therapeutics course), this additional experience in glaucoma management will be achieved by:

    a) Attending 20 hours in a clinical setting where glaucoma management is the major focus, under the direct supervision of an ophthalmologist and providing evidence of this to the Board in the form of a completed case log detailing a minimum of 30 glaucoma cases (specific template must be used), or

    b) Submitting 5 glaucoma case studies demonstrating clinical experience while participating in collaborative care with an ophthalmologist. Board guidance on how case studies should be structured is available on the Board's website.

It is the optometrist's responsibility to ensure they have access to an ophthalmologist or approved glaucoma peer review supervisor to meet their CPD obligations and other requirements.

As meeting these obligations allows for independent prescribing, optometrists are further encouraged to continue collaborating with a local ophthalmologist or to seek regular advice as experience develops.

Ongoing CPD requirements

Independent glaucoma prescribers have annual requirements from 1 November through to 31 October. It is the practitioner's responsibility to ensure they have the means to achieve the yearly obligations. If you become an independent prescriber part-way through the cycle, your requirements are different depending on the month you begin, please refer to the table in the *Recertification Policy.*

- Complete 4 glaucoma specific CPD points **per year**. These are known as Glaucoma Credits (GC).
- Of these, present at a **minimum** of one, two-hour structured peer review session specifically on glaucoma management **per year**. These are known as Glaucoma Peer Review (GPR) sessions.
- GPR sessions must be run in accordance with the Board policy on continuing professional development and an ophthalmologist must be present (glaucoma specialist preferred but not essential). When it is not possible to have an ophthalmologist attend, the Board may approve, at its discretion, an optometrist glaucoma prescriber to be a supervisor.
- Where an optometrist glaucoma prescriber does not have any genuine glaucoma cases to present, glaucoma suspect cases may be presented.
- 2 points per year can comprise either a further GPR session (this is the preferred method) *or* an alternative glaucoma-specific event or course, known as Glaucoma Event (GE) credits. Practitioners are expected to reflect on their glaucoma practice and experience in choosing the most relevant CPD option.
- In circumstances where frequent ophthalmologist peer-review occurs on an individual basis (e.g. in the hospital setting), evidence of such peer-review (logged by case and time spent on a pro rata basis) together with a glaucoma case report that demonstrates continued/expanded learning may be submitted in lieu of attendance and presentation at a two-hour structured peer-review session.
- If you do not meet the annual requirements, you will be suspended from glaucoma prescribing until the deficit is cleared up to a maximum timeframe of 4 months. If it is not cleared within this time, your prescribing status will be relinquished.

To summarise, glaucoma prescribers are required to achieve a **minimum of 4 glaucoma-specific points per year, where a minimum of 2 must be Glaucoma Peer Review (GPR) credits.** The other 2 points can be gained from either GPR or GE.

If at any stage you are continuously unable to meet the obligations, please consider relinquishing your independent prescribing rights and undertaking a collaborative care approach instead. Please refer to the *Statement on Glaucoma Collaborative Care* for more information.

Removal from the Independent Prescribers List

If you cannot meet the requirements and do not wish to be an independent glaucoma prescriber any longer, please email the Recertification Officer to confirm you want your independent prescribing rights relinquished and why. This includes going non-practising. This will be noted on your record and you will receive a letter confirming you have been removed from the Board's publicly available list of independent prescribers. You can then *only* manage glaucoma patients in a collaborative care relationship with your ophthalmologist colleagues(s). Please refer to the Boards *Collaborative Care Guidelines* which can be found on the Board's website. If you are planning to independently prescribe in the future, it is recommended to be up to date with CPD before removal by completing the minimum CPD requirements as stated above.

Returning to the Independent Prescribers List

If you want to manage glaucoma patients independently again, please notify the Recertification Officer. If it has been less than 18 months since your removal, your case may be evaluated by the Professional Standards Committee (PSC). The outcome is based on your reason for returning and leaving originally, alongside the length of time not managing glaucoma patients and your CPD status when removed. If it has been 18 months or more since your removal, you will have to re-apply altogether.

Expectations for Practice

Optometrists are expected to follow the National Health and Medical Research Council of Australia's Guidelines for the Screening, Prognosis, Diagnosis, Management and Prevention of Glaucoma 2010 (NHMRC Guidelines) when making decisions on how to independently diagnose and manage glaucoma. These additional Board guidelines provide guidance for New Zealand optometrists only on whom to treat, and when further consultation or referral is indicated.

An optometrist glaucoma prescriber is expected to:

1. be competent in the use of and have access to:
   (i) a Goldmann type (including Perkins) applanation tonometer;
   (ii) an anterior chamber goniolens;
   (iii) a stereo slit lamp biomicroscope with contact or non-contact lens;
   (iv) a Humphrey or Medmont automated visual field analyser, or other clinically proven method;

(v) a corneal pachymeter;

(vi) a fundus camera;

(vii) a sphygmomanometer.

2. have access to, and be competent in the interpretation of, information from at least one of the following:
   (a) a retinal or optic disc optical coherence tomographer;
   (b) other clinically proven objective measurement of retinal nerve fibre layer and/or optic disk.

Page 76 of the NHMRC glaucoma guidelines defines the use of visual fields to grade glaucoma. The Optometrist and Dispensing Opticians Board endorses a universal grading system to promote clear communication between health care providers. The definitions used are consistent with NHMRC and are taken from Burr et al (2007)[1].

All optometrists are expected to monitor those with:

- ***No glaucomatous impairment:*** Under observation as a glaucoma suspect, however not on medication, and no glaucoma visual field defect in either eye.

An optometrist glaucoma prescriber may monitor, initiate treatment and/or manage patients that have:

- ***Ocular Hypertension:*** On treatment due to significant risk factors that only under best-practice evidence based medicine requires reduction of intra-ocular pressure.
- Raised intraocular pressure secondary to topical steroids.
- ***Mild glaucoma****:* On treatment, no binocular visual field loss, progressing unilateral glaucoma visual field defect.

NB: While it is understood that binocular visual field testing is rarely performed in glaucoma management, binocular visual field loss is to be interpreted as overlapping defects – where there are corresponding points that meet the criteria for a defect for both right and left eye visual fields.

Chapter 8 of the NHMRC guidelines covers monitoring and long term care of glaucoma including glaucoma progression and indications to change regime. However, an optometrist must consult directly with, or refer the patient to an ophthalmologist for patients with:

- ***Moderate glaucoma*****:** Up to five missed points (<10 dB mean deviation, or average loss) in binocular central 20° of visual field (meaning when there are more than five missed points in the binocular central 20° of visual field).

[1] *NHMRC guidelines on Using Visual Fields to grade glaucoma, page 76. (taken from Burr et al, The Clinical cost effectiveness of screening for open angle glaucoma: a systematic review and economic evaluation. Health Technology Assessments; 11(41): 1-206*

- ***Severe glaucoma:*** Binocular visual field loss below UK driving standards (adapted from Crabb et al 2004, 2005) - Six or more adjoining missed points (<10 dB), and any additional separate missed point(s) or a cluster of four or more adjoining missed points (<10dB), either of which is either wholly or partly within the central 20-degree superior or inferior hemispheric field.
- ***Visual impairment:*** Includes as per criteria for severe, except binocular visual field loss includes both the upper partial sight, blind, and lower fields of vision.

An optometrist glaucoma prescriber is recommended to consult or refer to an ophthalmologist patients that:

1. are under 40 years of age at diagnosis;
2. have glaucoma secondary to any other pathology;
3. have IOP above the target pressure for more than 12 weeks;
4. require more than two concurrent classes of topical glaucoma medications to reach the target IOP;
5. have any clinically significant adverse effect from any prescribed medication;
6. demonstrates progression in accordance with NHMRC guidelines.

An optometrist glaucoma prescriber **must:**

1. Immediately refer a patient with angle closure glaucoma as an ocular emergency.[24] In the rare event that emergency treatment is to be initiated by an optometrist, it is expected that every attempt would be made to consult with an ophthalmologist prior to initiating treatment.

2. Maintain a written record of:

   a. Patient ocular history, which must include medication prescribed or otherwise taken by the patient. Documentation from the patient's other prescribing heath care provider should (as far as may fairly be possible) be used to validate the patient's history.

   b. Identifiable glaucoma risk factors[3]

   c. A treatment plan, including:

      i. Targets for intraocular pressure

[2] Refer to the Board's website for guidelines on managing Acute Angle Closure Crisis.
[3] NHMRC Guidelines Chapter 6 – Identifying those at risk of developing glaucoma, pg 47-64, table.

ii. Recording of the optometrists assessment of key findings and tests

iii. Clinical impression at each visit.

3. Appropriately report to all other relevant health practitioners involved in the patients care.

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