Optometrists and Dispensing Opticians Board

Te Poari o ngā Kaimātai Whatu me ngā Kaiwhakarato Mōhiti

STATEMENT ON COLLABORATIVE CARE

Background

From 1 July 2014, Medicine (Designated Prescriber: Optometrists) Regulations and the corresponding schedule of medicines optometrists could prescribe were revoked and optometrists obtained the status of 'Authorised Prescribers'. This change in status entitled those optometrists authorised by the Board to prescribe freely within their scope of practice for patients under their care.

One of the key impacts of this change for these optometrists is the extension of optometric care of glaucoma beyond the monitoring and detection stage, into medical management under guidelines developed by the Board. To view these guidelines, please see the 'Therapeutic Prescribing' page of the Board's website located at www.odob.health.nz.

The Board recognises that not all prescribing optometrists will wish to take this next step of applying to the Board for approval to independently prescribe for glaucoma patients, and that they may therefore wish to form a collaborative care relationship with their ophthalmologist colleague/s to assist in managing the care of glaucoma patients. The purpose of this statement is to ensure that all prescribing optometrists, irrespective of their decision to apply for approval to prescribe independently or not, are aware of the distinction between collaborative care and independent prescribing.

Statement

(1) 'Collaborative care' is when the care of a patient is provided by two or more health practitioners, each practising within their sphere of expertise in consultation with the patient.

(2) The Board expects all prescribing optometrists managing glaucoma in a collaborative care arrangement with an ophthalmologist, first and foremost, to be familiar with the National Health and Medical Research Council of Australia's (*NHMRC) Guidelines for the screening, prognosis, diagnosis, management and prevention of glaucoma 2010* (NHMRC Guidelines).

(3) In line with the NHMRC Guidelines, "..*any collaborative care arrangement should be formalized in writing between parties with clear criteria for monitoring intervals, treatment plans and timeframes for referral between parties. As the welfare and safety of the patient is paramount, they should give fully informed consent and understand the nature of the collaborative care offered. They need to be informed who are their care providers and what level of care and treatment options each can provide with full practice contact details should they have queries. It also should be made clear as to what level of responsibility each party assumes for their care. Ideally, this should be provided in a written information sheet given to the patient.*" The NHMRC Guidelines also provide a *recommended management plan* that practitioners may find helpful.

(4) Collaborative care providers need to be willing to communicate readily and in a timely manner with their colleagues. Ideally this should be through secure electronic transfer of records/letters/imaging but hard copy transfer is adequate. Thought should be given to preparing referral and monitoring forms.[1]

Issues

Management pathway

(5) The working party of the NHMRC Guidelines note that there are three essential issues that direct the most appropriate management pathway for a patient. These issues are:

1. *"Degree of diagnostic suspicion: In the primary health care setting, if the degree of diagnostic suspicion of glaucoma is low, unnecessary referral of a patient to an ophthalmologist may lead to system overload. Low-risk patients should be monitored by the most appropriate primary health care provider (usually a TPA or DPA optometrist) within the patient's location, using advice as required. If the degree of diagnostic suspicion of glaucoma is high however, the appropriate decision should be direct referral to a health care provider able to initiate treatment.*

2. *Degree of urgency and severity: If suspicion is very high with marked signs of nerve damage, and/or the IOP is very high (e.g. cupped disc with IOP >35) then patients need urgent referral, with or without IOP-lowering treatment in the meantime, depending upon the waiting period for referral. Acute angle closure presents as a medical emergency and requires immediate referral to a specialist.* [ODOB - Under no circumstances may an optometrist who has not met the requirements for independent prescribing initiate treatment without first discussing this with an ophthalmologist and therefore establishing a collaborative care relationship.]

3. *Referral/cooperative management [collaborative care]: The [Board] recommends that* ***the professional roles, responsibilities and referral pathways are best determined in individual cases based on location, resources, skill-base of local health care providers and patient choice****."*

Skills and equipment

(6) Irrespective of the location and manner in which patients with glaucoma are managed, optometrists involved in collaborative care of glaucoma should have the skills and equipment to measure:

- IOP by Goldmann Applanation Tonometry (GAT), (NCT is not appropriate except when GAT is contraindicated for some reason, and this should be agreed in collaboration with the ophthalmologist);
- visual fields – ideally this should be of the same type as the collaborative care partner to enable accurate progression analysis;
- photographic imaging of the fundus and optic disc at baseline and to chart progression;

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[1] RANZCO 'Guidelines for the collaborative care of glaucoma patients and suspects by ophthalmologists and optometrists in Australia'. Clinical and Experimental Ophthalmology 2014; 42: 107-117.

- stereoscopic slit lamp with diagnostic lenses to view the posterior segment and gonioscopy.

Issuing repeat prescriptions

(7) Where a patient requests that a prescribing optometrist provide them with a repeat prescription, the Board considers that this is collaborative care and the prescribing optometrist must ensure they meet all requirements of communication and informed consent with the patient as mentioned in points 3 and 4 above.

Moving to independent management

(8) Any prescribing Optometrist may apply to become a glaucoma prescriber. As stated in the Board's document *Prescribing in Glaucoma: Guidelines for NZ Optometrists*, "Before taking on the independent management of glaucoma for a patient an optometrist **must**:

1. Hold a current Annual Practising Certificate as an Optometrist and be authorised by their scope of practice to prescribe.
2. Satisfy the Board that they have sufficient clinical experience in the management of glaucoma. In addition to the therapeutics qualification this 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 or board approved optometrist glaucoma prescriber, or
    b. Submitting 5 glaucoma case studies demonstrating clinical experience while participating in collaborative care with an ophthalmologist or board approved optometrist glaucoma prescriber.

While 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."

There are restrictions as to the scope of independent prescribing and the full document can be found on the 'Therapeutic Prescribing' page of the Board's website located at www.odob.health.nz.

Related documents

ODOB - Prescribing in Glaucoma: Guidelines for NZ Optometrists
RANZCO - Guidelines for the collaborative care of glaucoma patients and suspects by ophthalmologists and optometrists in Australia

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