COLLEGE OF Optometrists OF ONTARIO

COUNCIL MEETING

FRIDAY SEPT. 17, 2021
AT 9:00 A.M.

(PUBLIC INVITED TO ATTEND)

VIRTUAL MEETING

COLLEGE OF Optometrists OF ONTARIO

COUNCIL AGENDA

Friday, September 17, 2021 | 9:00 a.m.
Virtual Meeting

Item	Item Lead	Time (mins)	Action Required	Page No.
1. Call to Order/Attendance	P. Quaid	2	Decision	5
2. Adopt the Agenda	P. Quaid	2		
a. Conflict of Interest Declaration			Decision	5
3. Consent Agenda	P. Quaid	30	Decision	5
PART 1 - Minutes of Prior Council Meetings				6
a. June 18, 2021				
b. Motions and Actions Items Arising from the Minutes				17
PART 2 - Reports				
b. Committee Reports				
i. Executive Committee				20
ii. Patient Relations				22
iii. Quality Assurance:				
a) QA Panel				23
b) CP Panel				24
c) QA Subcommittee				25
iv. ICRC				26
v. Registration				28
vi. Governance/HR Committee				30
vii. Audit/Finance/Risk Committee				32
PART 3 – Correspondence				
a. Ontario Association of Optometrists				38
4. Registrar's Report	J. Jamieson	45	Presentation	41
5. In Camera Session: Legal Opinion Council will go **in camera** under: Section 7(2)(e) of the *Health Professions Procedural Code*, which is Schedule 2 to the Regulated Health Professions Act	P. Quaid	30	Discussion	41
10:45-11:05 - Morning Break		**20**		
6. Motions Brought Forward from Committees				
a. Executive Committee – Research Grant Panel	P. Quaid	25	Decision	43
b. Quality Assurance				
a. Clinical Practice Panel – OPR 7.12 Patients with Amblyopia	C. Grewal	25	Decision	46

7. List of Acronyms			Receive for Information	79
8. Dates of Upcoming Council Meetings a. December 10, 2021 b. Friday, January 21, 2022 c. Friday, March 25, 2022 d. Friday, June 24, 2022 e. Friday, September 16, 2022 f. Friday, December 9, 2022				78
9. Adjournment **(approx. 12:00 p.m.)**	P. Quaid		Decision	

Vision and Mission

Vision: A leading regulator focused on safe eye care and progressive practice.

Mission: To regulate Ontario's optometry profession in the public interest.

1 -3 / INTRODUCTION

1. Call to Order/Attendance

2. Adopt the Agenda
   a. Conflict of Interest Declaration

3. Consent Agenda

   PART 1 - Minutes of Prior Council Meetings
   - a. June 18, 2021
   - b. Motions and Actions Items Arising from the Minutes

   PART 2 - Committee Reports
   - i. Executive Committee
   - ii. Patient Relations
   - iii. Quality Assurance:
     - a) QA Panel
     - b) CP Panel
     - c) QA Subcommittee
   - iv. ICRC
   - v. Registration
   - vi. Governance/HR Committee
   - vii. Audit/Finance/Risk Committee

   PART 3 – Correspondence
   - a. Ontario Association of Optometrists

College of Optometrists of Ontario
Council Meeting
June 18, 2021
DRAFT #1

Attendance:

Dr. Patrick Quaid (President)
Mr. Bashar Kassir (Vice-President)
Ms. Suzanne Allen
Ms. Kathryn Biondi
Dr. Linda Chan
Dr. Lisa Christian
Mr. Ravnit Dhaliwal
Dr. Mark Eltis
Dr. Camy Grewal
Mr. Howard Kennedy
Dr. Richard Kniaziew
Dr. Lindy Mackey
Dr. Annie Micucci
Dr. Areef Nurani
Mr. Narendra Shah
Dr. William Ulakovic

Staff & Guests:

Mr. Joe Jamieson, Registrar and CEO
Ms. Hanan Jibry, Deputy Registrar
Mr. Chad Andrews
Ms. Raj Bhatti
Mr. Edward Cho
Ms. Allison Henry, Ministry of Health
Ms. Amber Lepage-Monette
Ms. Deborah McKeon
Mr. Marcus Sconci, BDO Canada
Mr. Michael Upenieks, BDO Canada
Ms. Bonny Wong

1. Call to Order: P. Quaid called the meeting to order at 9:03 a.m.

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

Moved by M. Eltis and seconded by C. Grewal **to adopt the agenda.**

Motion carried

a. Conflicts of Interest: P. Quaid asked Council members if anyone had a conflict of interest with any item on the day's agenda. None were declared.

J. Jamieson provided background to the upcoming presentation from A. Henry.

Moved by M. Eltis and seconded by H. Kennedy **to add an additional 15 minutes to the agenda for questions following the Ministry of Health presentation.**

Motion carried

3. Ministry of Health: Regulatory Authority Model for Personal Support Workers – Allison Henry

A. Henry provided Council with an update on the Health and Supportive Care Providers Oversight Authority and the College Performance Measurement Framework (CPMF).

On June 3, the *Advancing Oversight and Planning in Ontario's Health System Act, 2021* received Royal Assent. The act creates three new acts: the *Health Supportive Care Providers Oversight Authority Act, 2021*; the *Psychology and Behaviour Analysis Act, 2021*; and the *COVID-19 Vaccination Reporting Act, 2021.*

Previously, the *Regulated Health Providers Act, 1991* (RHPA) was the only oversight framework for health professions. The Ministry wanted to look at how oversight could be done differently, especially for professions where the risk of harm is lower. This follows trends in other jurisdictions such as B.C., the U.K., Australia, and New Zealand.

The new framework provides for corporate objects, establishes education and registration qualifications. It does not provide title protection, rather it sets out a quality mark system and a code of ethics for each class of registrant. The initial Board of Directors will be appointed by the Ministry of Health based on competencies. Although not self-regulating, it is designed to focus on public interest and safety and allows for the addition of other professions over time.

The intention is to begin set up this fall and register Personal Support Workers in early 2022.

A. Henry also provided an update on the CPMF. The Ministry of Health is looking to publish a summary report from all 26 regulated health colleges this summer.

Council asked if there were plans to reopen the RHPA and move anything that falls under the RHPA to the new model.

A. Henry confirmed that Personal Support Workers are intended to be the first group regulated under the new authority. No decision has been made whether other professions will follow, which professions would follow, or when.

A. Henry noted the government is probably not looking to remodel the RPHA completely, but there are ways to streamline governance processes (e.g., the nurses' proposals with Vision 2020), including smaller boards, bifurcation of the Executive and statutory committees from the board, etc.

The intention is to move away from the procedural rigidity in the RHPA and provide the tools to allow regulators to be good governors.

Council asked about the best ways to strengthen governance practices, such as term limits for professional members.

A. Henry replied that term limits are set out in by-laws, not regulation. Best practice favours shorter terms vs. longer terms.

Council asked if the Ministry should mandate governance revisions if it would like to see cohesion across regulatory bodies.

A. Henry clarified that the College has been given the authority to administer the *Optometry Act*; the Ministry is providing colleges with flexibility in how they represent the public interest. If regulatory bodies would like the government to have a more unified approach, that suggestion can be made to the Ministry.

Council asked about impending job action, given media coverage from the summer 2020. A. Henry clarified the government is not intending to step in regarding the College proceedings and job action.

A. Henry left the meeting at 9:56 a.m.

4. Adoption of the Consent Agenda: A draft consent agenda was circulated prior to the meeting. After having confirmed that all councilors had read the consent agenda materials. The following items were included in the consent agenda:

PART 1 - Minutes of Prior Council Meetings
- a. March 26, 2021
- b. Motions and Actions Items Arising from the Minutes

PART 2 - Reports
- b. Committee Reports
  - i. Executive Committee
  - ii. Patient Relations Committee
  - iii. Quality Assurance:
    - A. QA Panel
    - B. CP Panel
    - C. QA Subcommittee
  - iv. Inquiries, Complaints and Reports Committee (ICRC)
  - v. Registration Committee
  - vi. Discipline Committee
  - vii. Governance/HR Committee
  - viii. Audit/Finance/Risk Committee

Moved by M. Eltis and seconded by S. Allen **to adopt the consent agenda.**

Motion carried

Several Council members wished to discuss items from the consent agenda, including the previous minutes, the Patient Relations Committee, the Quality Assurance, the ICRC and Audit/Finance/Risk committee reports.

Council discussed the minutes from the March 26, 2021, meeting, including the issue of staff participation in Council meetings. Council noted it would like to keep staff participation where needed (to clarify or provide background information). J. Jamieson outlined new processes for virtual meetings and clarified parliamentary procedure re: staff.

Council clarified a few items in the previous minutes, including the Registrar's jurisdictional scan, which was reviewed with the Governance/HR Committee.

Council asked that comments from some members in past meetings be addressed. P. Quaid noted that the issue had been dealt with and that he would address Council behaviour in the Registrar's Report.

Council asked about donations made in memorial and whether there is an official process or policy in place to outline circumstances in which these donations are made. P. Quaid clarified the donation in question was voted on by Council, however, the Audit/Risk/Finance Committee is working on a policy.

Regarding the audited financial statements, Council asked about the increase to staff salary in 2020. J. Jamieson clarified that staffing anomalies in 2020 resulted in an inflated salary budget item. It is expected to return to normal in 2021.

Council asked to discuss the President's stipend. P. Quaid noted that the Governance/HR Committee, which determines roles and responsibilities, discussed the stipend, and determined that it was in order.

Council discussed the communication item included in the Patient Relations Committee report. Some wording changes were suggested; it is clarified that education and communication fall under the committee's Terms of Reference.

Council asked about the hours allotted to Quality Assessment Training. It is noted that the eight-hour allotment was approved by Council as part of the Continuing Education (CE) policy and has previously been discussed.

Council also asked about the extension provided for CE audit hours. L. Chan clarified that a one-month extension to submit outstanding CE was provided. R. Dhaliwal further clarified that the CE hours were performed in 2020, it is simply an administrative matter of inputting those hours into the tracker. Since the panel is intended to be assistive rather than punitive, the extension was felt to be reasonable.

Council discussed the ICRC report and continuing issue of complaints regarding auxiliary testing.

R. Kniaziew noted the committee has asked that the issue of eye exams and required testing be addressed in the form of some type of communication or policy. In addition, issues are arising due to advertising and marketing and lack of understanding over the rules. R. Kniaziew asked if a document can clarify rules around advertising and the conflict-of-interest regulation.

J. Jamieson noted that both issues are being discussed. A practice advisory will be developed regarding advertising. The ongoing issue of patient complaints related to auxiliary testing will be addressed by the committee, with input from practice advisors.

Action item: Staff, including practice advisors, will develop a practice advisory regarding advertising.

Council took a 10-minute break and resumed at 11:00 a.m.

J. Jamieson invited D. McKeon to join the meeting. D. McKeon introduced the auditors, M. Sconci and M. Upenieks.

6. Financial Matters – Presentation from the Auditors

M. Sconci and M. Upenieks from audit firm BDO Canada presented the draft audited financial statements, specifically highlighting areas where wording or presentation would have differed from previously statements.

Council asked about Note 13 re: suspending the collection of professional corporation fees in 2020. H. Jibry clarified that there was a reduction in professional corporation fees in 2020 that accounts for the reduced amount noted in the statements. M. Upenieks confirmed the decrease seen in statements relates to fee reduction, not deferred collection.

Council asked about fees listed under stakeholder engagement and the increase seen in the third quarter. It is clarified that these amounts relate, in part, to membership fees for stakeholder organizations (e.g., FORAC, CLEAR and ARBO etc.).

5. Registrar's Report

J. Jamieson provided operational updates, as well as plans to operationalize the strategic plan and achieve those domains in the College Performance Measurement Framework (CPMF) that are currently "partially" completed. Staff have developed SMART goals for numerous projects that directly align with both the strategic plan and CMPF, including focus groups with optometrists and the public; a website refresh project; and a welcome package for new registrants.

Staff provided updates on registration, finances, and the Quality Assurance Program.

Council took a 20-min break for lunch, and resumed at 12:40 p.m.

Council discussed the upcoming job action directed by the Ontario Association of Optometrists (OAO), including OAO communication to optometrists and perceived conflict of interest.

Regarding OAO communication: J. Jamieson noted the College has clearly communicated its expectations to optometrists re: job action and professionalism.

Action item: The Registrar will seek a legal opinion regarding perceived conflict of interest for professional Council members who may be participating in the upcoming optometry job action.

Council asked if SMART goals related to personnel were under development. J. Jamieson confirmed that there are SMART goals targeted at retention, succession, leadership, and training.

P. Quaid noted a minor reordering of the motions following the AFR motions.

7. Motions Brought Forward from Committees:
a. Audit/Finance/Risk Committee

i. Building Acquisition Fund Reallocation

L. Chan was unable to attend the most recent Audit/Finance/Risk Committee meeting and deferred to J. Jamieson and R. Dhaliwal regarding this item. J. Jamieson provided Council with background information: previously, the College maintained a reserve fund with the intention of purchasing office space. As per the Canada Revenue Agency, not-for-profit organizations cannot maintain significant reserves without immediate plans for use. COVID-19 has changed the workplace landscape and purchasing office space is no longer a priority.

The reallocation proposal is looking to use these funds to support projects that will operationalize the College's strategic plan; staff have developed SMART goals to identify priority areas, including public awareness and staff professional development and succession planning.

The reallocation funds would also support a research fund for projects that focus on the public interest; as well as a one-time fee reduction for members in recognition of COVID-19 hardships, which was moved at the previous Council meeting.

Moved by B. Kassir and seconded by L. Chan **to reallocate the reserve funds currently held as the "Building Acquisition Fund" as set out in the briefing materials.**

Motion carried

ii. Approval of the Audited Financial Statements

Moved by N. Shah and seconded by S. Allen **to approve the Audited Financial Statements for the year ending December 31, 2020.**

Motion carried

Moved by R. Kniaziew and seconded by R. Dhaliwal **to reappoint the auditors for the upcoming year.**

Motion carried

iii. Investment Policy Revision

R. Dhaliwal provided an overview of the revisions made: As a not-for-profit, the College can't build up reserve funds and its key responsibility is to reserve capital. The committee is putting forward this policy to transfer of the College's long-term investments currently held in wealth management portfolios to Guaranteed Investment Certificate (GIC) or other bank instruments.

Moved by B. Kassir and seconded by H. Kennedy **to approve revisions to the Investment Policy as presented and approve the transfer of the College's long-term investments currently held in wealth management portfolios to GICs and other bank instruments.**

Motion carried

e. Executive Committee

i. Appointment to fill Chair and committee vacancies

The committee recommended the appointment of Dr. Dennis Ruskin as Chair of the Discipline Committee to fill the current vacancy.

Moved by R. Kniaziew and seconded by C. Grewal **to appoint Dr. Dennis Ruskin as the Chair of the Discipline Committee.**

Motion carried

b. Registration Committee

i. Entry-to-Practice Exam

W. Ulakovic presented the Registration Committee motions.

Council discussed seeking a response from NBEO on the one-exam report and the College's direction to support one exam.

It is clarified that a motion is not needed for this item; rather it is recording that Council has received the report and continues to support one entry-to-practice exam.

Action Item: The Registrar will follow up on the response from NBEO re: OEBC One Entry-to-Practice Exam report.

ii. 2021 Jurisprudence Exam

W. Ulakovic presented the motion, noting that the Registration Committee is looking to keep the online exam that has been in use.

Council asked about the issue of promotion and advertising and whether the rules should be reinforced in the Jurisprudence exam. W. Ulakovic noted he would take this suggestion to the committee.

Moved by R. Kniaziew and seconded by C. Grewal **to approve the 2021 Jurisprudence exam for registration purposes.**

Motion carried

iii. 2021 Optometry Examining Board of Canada Written Exam and OSCE

Moved by A. Nurani and seconded by M. Eltis **to approve the 2021 OEBC written exam and OSCE as one of two standards assessment examinations for registration purposes.**

Motion carried

iv. 2021 National Board of Examiners in Optometry (NBEO) Exam

Council asked about the process for those currently writing the NBEO exam and confirmed that if the NBEO is not approved next year, those currently in the cycle will be able to proceed with registration. H. Jibry confirmed that the Registration Committee is discussing transition periods for future years.

Moved by R. Kniaziew and seconded by K. Biondi **to approve the 2021 National Board of Examiners in Optometry (NBEO) exam as an alternate standards assessment examination for registration purposes.**

Motion carried

c. Clinical Practice Panel

i. OPR 7.12 Patients with Amblyopia

C. Grewal presented the motion. Council had previously asked for evidence to support recommendations; raised questions about testing without cycloplegia; occlusion treatment; and ophthalmology guidelines provided as reference.

The new revisions provide additional research and wording has been clarified on these issues.

Council asked about the wording related to visual acuity.

Several Council members noted the section is still prescriptive in its approach, which can affect the Quality Assurance program. It is noted that more clarity is needed for wording and recommendations regarding the visual sensitive period.

Council also asked how the committee selects which section of the OPR should undergo review.

C. Grewal noted the committee is looking to move regulatory standards to the beginning of the OPR but has not yet had the chance in part due to staff turnover.

Council asked the committee to review the section again.

ii. OPR 7.13 Patients with Uveitis

C. Grewal presented the motion. Council had previously noted the section was too prescriptive. Changes were made to clarify the wording.

Moved by M. Eltis and seconded by W. Ulakovic **to approve revisions to OPR 7.13 Patients with Uveitis.**

Motion carried

d. Governance/HR Committee

K Biondi presented the following motions, noting these policies serve as the start of a governance manual that the committee is developing.

i. Policy: Role of President

Council discussed the number of hours set out for compensation and whether it was sufficient. B. Kassir asked about delegating to the Vice-President to reduce the hours and increase the Vice-President's involvement.

Council discussed the Vice-President's involvement in stakeholder meetings, whether this would be appropriate. It is noted that the by-laws indicate the President and Registrar are the designated College spokespeople.

Moved by A. Nurani and seconded by W. Ulakovic **to approve the Policy: Position Overview, President.**

Motion carried

ii. Policy: Role of Vice-President

K. Biondi noted the Vice-President is a part of the Executive Committee and expected to step in for the President, if unavailable. The committee decided not to require the Vice-President be a succession role.

Council discussed how closely the roles of President and Vice-President work together, how often the two have meetings and/or whether dedicated meetings are needed. P. Quaid and J. Jamieson noted dedicated meetings (outside of the Executive Committee) would only be needed in instances of delegation.

B. Kassir noted that, should the need arise for the Vice-President to step in for the President, he would need to be more informed.

Council discussed whether to have the Vice-President attend more stakeholder meetings and be engaged on strategic issues, such as impending job action. Council discussed this in relation to A. Henry's presentation and the government's push for smaller boards.

Moved by R. Kniaziew and seconded by W. Ulakovic **to approve the Policy: Position Overview, Vice-President.**

Motion carried

iii. Executive Committee Terms of Reference

Council discussed the morning presentation from A. Henry and notes on good governance, specifically the need for more efficient boards and the implications for the Executive Committee.

J. Jamieson clarified that the purpose of the proposed Council Retreat would be to clarify these kinds of questions. Terms of reference can be revised as needed in the future, should there be a change to committee organization.

Moved by K. Biondi and seconded by R. Kniaziew **to approve revisions to the Terms of Reference: Executive Committee.**

Motion carried

iv. Governance/HR Committee Terms of Reference

Moved by S. Allen and seconded by R. Kniaziew **to approve revisions to the Terms of Reference: Governance/Hr Committee.**

Motion carried

v. AFR Committee Terms of Reference

Moved by R. Dhaliwal and seconded by H. Kennedy **to approve revisions to the Terms of Reference: Audit/Finance/Risk Committee.**

Motion carried

Council asked whether the COVID-19 Infection Prevention Return to Work guidance would be revised following vaccination, specifically the mask requirement. C. Grewal clarified the guidance follows public health recommendations and once public health revises its recommendations, the College guidance will reflect those changes.

Council discussed the timing for the proposed Council Retreat. Late October 2021 was under consideration, however, Council noted that five professional member seats are up for election this fall. A retreat may be better suited for the 2022 when the new Council is in place.

Council thanks outgoing staff for their work.

8. List of Acronyms

9. Upcoming Council Meetings

- September 17, 2021
- December 10, 2021

10. 2022 Council Meeting Dates:

a. Friday, January 21, 2022
b. Friday, March 25, 2022
c. Friday, June 24, 2022
d. Friday, September 16, 2022
e. Friday, December 9, 2022

11. Adjournment: Moved by M. Eltis and seconded H. Kennedy **to adjourn the meeting at 3:39 p.m.**

Motion carried

COLLEGE OF Optometrists OF ONTARIO

Council Meeting – September 17, 2021

COUNCIL ACTION ITEM LIST STATUS

Updated Aug. 19, 2021

Date	Minute Line	Action	Status	Comments
03/26/21	183	OPR 7.12 and 7.13 will be reviewed again by CPP.	Ongoing	OPR 7.13 was approved at the June Council meeting. OPR 7.12 has been reviewed by CPP and is being presented at the September Council meeting.
06/18/21	155	Staff, including practice advisors, will develop a practice advisory regarding advertising.	Ongoing	
06/18/21	192	The Registrar will seek a legal opinion regarding perceived conflict of interest for professional Council members who may be participating in the upcoming optometry job action.	Completed	The Registrar will present the opinion at the September Council meeting.
06/18/21	271	The Registrar will follow up on the response from NBEO re: OEBC One Entry-to-Practice Exam report.	Completed	Noted in the Registration Committee Report.

Council Meetings – June 2021

MOTION LIST

Updated Aug. 19, 2021

Date	Minute Line	Motion	Committee	Decision
06/18/21	221	Moved by B. Kassir and seconded by L. Chan **to reallocate the reserve funds currently held as the "Building Acquisition Fund" as set out in the briefing materials.**	AFR	Motion carried
06/18/21	227	Moved by N. Shah and seconded by S. Allen **to approve the Audited Financial Statements for the year ending December 31, 2020.**	AFR	Motion carried
06/18/21	231	Moved by R. Kniaziew and seconded by R. Dhaliwal **to reappoint the auditors for the upcoming year.**	AFR	Motion carried
06/18/21	242	Moved by B. Kassir and seconded by H. Kennedy **to approve revisions to the Investment Policy as presented and approve the transfer of the College's long-term investments currently held in wealth management portfolios to GICs and other bank instruments.**	AFR	Motion carried
06/18/21	255	Moved by R. Kniaziew and seconded by C. Grewal **to appoint Dr. Dennis Ruskin as the Chair of the Discipline Committee.**	Executive	Motion carried
06/18/21	283	Moved by R. Kniaziew and seconded by C. Grewal **to approve the 2021 Jurisprudence exam for registration purposes.**	Registration	Motion carried
06/18/21	289	Moved by A. Nurani and seconded by M. Eltis **to approve the 2021 OEBC written exam and OSCE as one of two standards assessment examinations for registration purposes.**	Registration	Motion carried

06/18/21	300	Moved by R. Kniaziew and seconded by K. Biondi **to approve the 2021 National Board of Examiners in Optometry (NBEO) exam as an alternate standards assessment examination for registration purposes.**	Registration	Motion carried
06/18/21	332	Moved by M. Eltis and seconded by W. Ulakovic **to approve revisions to OPR 7.13 Patients with Uveitis.**	CPP	Motion carried
06/18/21	351	Moved by A. Nurani and seconded by W. Ulakovic **to approve the Policy: Position Overview, President.**	Governance/HR	Motion carried
06/18/21	371	Moved by R. Kniaziew and seconded by W. Ulakovic **to approve the Policy: Position Overview, Vice-President.**	Governance/HR	Motion carried
06/18/21	383	Moved by K. Biondi and seconded by R. Kniaziew **to approve revisions to the Terms of Reference: Executive Committee.**	Governance/HR	Motion carried
06/18/21	389	Moved by S. Allen and seconded by R. Kniaziew **to approve revisions to the Terms of Reference: Governance/HR Committee.**	Governance/HR	Motion carried
06/18/21	396	Moved by R. Dhaliwal and seconded by H. Kennedy **to approve revisions to the Terms of Reference: Audit/Finance/Risk Committee.**	Governance/HR	Motion carried

Executive Committee Activity Report

Reporting date: September 17, 2021

Chair: Dr. Patrick Quaid

Key Priorities

The Executive Committee is currently scheduled to meet before each Council session in 2021 to review the Council meeting's agenda. This is to ensure that Council sessions are efficient, transparent, and capable of meeting high standards in governance. The Executive Committee met on August 19, 2021, to prepare for the September 17, 2021, Council meeting.

Discussion Items

Research Grant Panel

The committee discussed the establishment of a Research Grant Panel to review and approve research projects that address a range of issues within the College's mandate – not only clinical projects but also those that explore issues central to regulation, governance, patient protection, and more.

The Executive Committee is presenting a motion seeking Council's approval on the establishment of the panel as described in the provided briefing note.

Conflict of Interest Legal Opinion

Julia Martin provided a legal opinion regarding the nature of conflicts of interest as they pertain to Council members who decide to engage in the Ontario Association of Optometrists (OAO) job action. Her position is that being a member of the OAO or engaging in the job action does not automatically constitute being in a conflict of interest as a member of the College's Council. The position is supported by the College's by-laws.

College Opening and December Council

An operational return-to-office policy was developed, outlining that staff will return to the office on October 4, 2021. The Executive Committee discussed the policy in detail.

Meeting with Allison Henry

The Executive Committee discussed the following situation in detail:

The Vice-President self-initiated a meeting request with Ms. Allison Henry, the Director of Workforce Regulatory Oversight at the Ministry of Health.

Ms. Henry subsequently agreed to the meeting via email, inviting the President and Registrar to also attend. At the meeting, conducted via Zoom, the VP asked questions regarding conflicts of interest and legal opinions as they relate to the OAO job action, as well as the role of public members generally. All questions were clearly answered by Ms. Henry, who also emphasized that public members do not represent the Ministry and that the Ministry receiving such a request for input on a legal opinion is not only unnecessary but inappropriate, and they would "decline to even receive the opinion from the College." Members of the Executive Committee were reminded that all future stakeholder engagement

should follow the by-laws, which state that the Registrar and President are the sole designated spokespeople for the College to all external stakeholders.

Decision Items

The Executive Committee developed a proposal for the establishment of a Research Grant Panel, which is outlined in a briefing note. The committee will motion to have Council approve the establishment of the panel.

Patient Relations Committee Activity Report

Reporting date: September 17, 2021

Chair: Suzanne Allen

Tasks Completed Since Last Council Meeting:

- The committee reviewed the status of the Program of Funding for Therapy and Counselling, including how much funding has been access by each patient.
- The committee is working to develop a sexual abuse and victim support training session and reviewed a CV and training outline provided by a potential presenter.
- The committee reviewed a prototype e-learning module on top complaints from patients and how optometrists can avoid them.

Key Priorities

The Patient Relations Committee continues to manage the Program of Funding for Therapy and Counselling, which now supports four patients. The committee is also working to develop a new training session on sexual abuse and victim support that will be offered to Council members and staff, as well as an e-learning module for CE credit that focuses on frequent complaints received by the College.

Discussion Items

E-Learning Module

After going through a prototype of the module, the committee agreed that it should be reconceptualized to focus on correct action from optometrists instead of common complaints. The committee concluded that the emphasis on common complaints, as well as the associated scenarios, were too straightforward and would only benefit optometrists who lack familiarity with well-known best practices (the same optometrists who would be unlikely to engage with an e-learning module). The scenarios will be reworked to focus on complex situations and how optometrists can manage them, as opposed to straightforward scenarios that can be avoided. C. Andrews is working with ILS Canada to incorporate the changes and produce a new prototype for the committee's review.

Communications Initiatives

The group agreed to develop a piece for the College's website that covers what patients can expect during an eye exam, as well as what is covered by a routine, publicly covered exam and what is considered additional by current regulations (OCT, fundus photography, etc.).

Quality Assurance Committee – Quality Assurance Panel Activity Report

Reporting date: September 17, 2021

Chair: Dr. Linda Chan; Interim Chair, Dr. Karin Schellenberg

Tasks Completed Since Last Council Meeting:

- Reviewed ongoing and new random practice assessment cases
- Finalized plan for QA Assessor Recruitment and Training Workshop held on Sept 10

Information Items

Review of cases:

- Random practice assessment follow-ups: 3
- CRA and Case Manager Reports: 5
- Remediation/Coaching: 2
- New random practice assessments: 47

CE Audit:

- Still in the process of following up with deficient members and providing one-month extensions to report information from previous CE cycle. Looking to confirm the total number of deficient members by next Council meeting.

Discussion Items

N/A

Decision Items

N/A

Attachments

N/A

QA – CPP Activity Report

Reporting date: September 17, 2021

Chair: Dr. Camy Grewal

Tasks Completed Since Last Council Meeting:

- Discussed OPR 7.12 *Patients with Amblyopia*
- Prioritized eye exams for patients who cannot wear a mask due to a disability

Key Priorities

CPP remain primarily concerned with pandemic-related standards of practice and guidance, in addition to the standards of practice under the Optometric Practice Reference (OPR).

Information Items

- The committee discussed the issue of eye exam for patients who cannot wear a mask due to a disability with Julia Martin, the College's legal counsel.
- The committee drafted a response to the "First Nations Evacuee Letter", which has been sent to the Registrar for review.
- The committee reviewed Theralens in Optometric practice by J&J.
- The committee discussed the College Performance Measurement Framework in relation to practice advisors and the support provided to members; in addition to the possibility of hosting a town hall with legal representatives to allow optometrists to ask questions.
- Updates made to FAQ - COVID-19 Return to Work:
    - What if a patient cannot wear a mask?
    - Can optometrists work if they travel outside of Canada?

Decision Items

- To approve revisions to OPR 7.12 *Patients with Amblyopia*. Revisions include: definition of amblyopia and change to the questions that an optometrist needs to ask the patient or the parent during the initial exam.

Quality Assurance Committee – QA Subcommittee Activity Report

Reporting date: September 17, 2021

Chair: Ms. Ellen Pekilis

Tasks Completed Since Last Council Meeting:

- The QA Subcommittee (QASC) continued working on redeveloping the QA program.

Discussion Items

1. **Requests for Proposals (RPFs):**
    a. RFPs for development of self-assessment and practice assessment components were posted on June 21, 2021, with closing date of July 23, 2021.
    b. A total of five proposals were submitted.

2. **Evaluation, Interviews, and Selection of Consultant:**
    a. RaECon has been selected to carry out the Practice Assessment development project.
    b. Independent Learning Systems (ILS) has been selected to carry out the Self-assessment development project.

3. **QA Project Development**
    a. Touchstone Competencies to be used as blueprint for Practice Assessment and Self-assessment development (in-hand with key risk data)
    b. Subject matter experts to be selected to assist with content creation

Decision Items

N/A

Attachments

N/A

Inquiries, Complaints and Reports Committee Activity Report

Reporting date: September 17, 2021

Committee Co-Chairs: Dr. Richard Kniaziew & Dr. David White

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* regarding confidentiality, details about specific cases are not shared as part of the committee report.

Pursuant to *Ontario Regulation 73/20 – Limitation Periods*, the timelines in proceedings in Ontario were suspended for six months in 2020 (between March 2020 until September 2020). This temporary suspension of timeliness, as well as adjustments to the investigation process due to the pandemic, caused delays and affected timelines in the processing and disposition of cases.

Since the committee last reported to Council, Dr. White's panel held two meetings (in June and July 2021) and Dr. Kniaziew's panel held one meeting (in August 2021). The committee intends to hold three more case review panel meetings before the end of the year in an effort to reduce case completion times. Both panels have been and will continue to review ideas and processes to improve efficiencies in order to shorten timelines.

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.

Complaints Processed Since Last Reporting (June 1 to August 31, 2021)

- Cases newly filed: 19
- Cases reviewed by the panels: 24
- Cases to Alternative Dispute Resolution: 0
- Cases carried over: 6

Decisions Issued	**8**
Case Type • Complaints • Registrar's Report • Incapacity Inquiry	 8 0 0

Dispositions (for complaint cases above)	
• No further action (NFA)	5
• Advice or recommendation	3
• Remedial agreement	0
• Specified Continuing Education or Remediation Program	0
• Signed undertaking	0
Nature of Allegations (for dispositions above, NFA excluded)	
• Care (quality, failure to diagnose or refer, unsafe care)	1
• Unprofessional behaviour	1
• Improper billing	1
• Related to eyeglasses or contact lens prescriptions	0
• Breach of patient confidentiality	0
Timeline for Resolution (for complaint cases above)	
• >120 Days	0
• 121-150 Days	0
• 151-180 Days	0
• 180+ Days	8

HPARB Appeals

- New appeals: 0
- Outstanding appeals to be heard: 2
- Appeals heard and awaiting decisions: 0
- ICRC Decision Confirmed: 1

Registration Committee Activity Report

Reporting date: September 17, 2021

Chair: Dr. Bill Ulakovic

Tasks Completed Since Last Council Meeting:

- Met with Touchstone Institute and the Federation of Optometric Regulatory Authorities of Canada (FORAC) to discuss the exam process as well as results for the 34 candidates who challenged the 2021 Internationally Graduated Optometrist Evaluating Examination (IGOEE).
- Met with the Optometry Examining Board of Canada (OEBC) to discuss the fall 2021 piloting of a new scoring system for the OSCE portion, as well as how the new Competency Profile would be reflected in the OEBC exam blueprint.
- Reviewed a document provided by the National Board of Examiners in Optometry (NBEO) (see below).
- Discussed the registration process during COVID-19.
- Continued to discuss the referral of an applicant for registration to the committee by the College Registrar and Chief Executive Officer.

Key Priorities

<u>Touchstone Institute</u>

- The IGOEE was administered as follows: the Multiple-Choice Question exam on May 26 and the Therapeutics Prescribing Assessment for Optometry exam on May 28 using virtual proctoring with the short OSCEs on June 19-20 and the long OSCEs on June 22-24, 2021.
- Thirty-three of the original 34 IGOEE candidates completed the exam. One candidate, travelling from outside of Canada, was unable to secure a visa in time.
- Two candidates scored high enough to challenge the OEBC entry-to-practice exam directly and had sufficient time to register for the fall 2021 OEBC exam. In May 2020, FORAC approved the following policy after the issue was raised by the committee:

  That internationally trained candidates who have had their credentials assessed and deemed to be substantially equivalent to an optometry degree from WOVS by FORAC, will be allowed to attempt the IGOEE three times in total within five years of their first attempt.

- According to FORAC staff, there is sufficient candidate interest to have an IGOEE administration in 2022.
- IGOEE results will be taken into consideration when candidates apply to the Advanced Standing Optometry Preparatory Program (ASOPP) that is scheduled to launch in April 2022. ASOPP replaces the International Optometric Bridging Program.
- Two successful FORAC credential assessment recommendations were received.

Optometry Examining Board of Canada

- The College received the OEBC exam results directly from OEBC on August 12, 2021. The April 2021 OEBC OSCE exam was deferred to July 11, 2021, due to the third wave of COVID-19.
- Following the signing of the signing of the updated licensing agreement with OEBC, the College provided the National Competency Profile to OEBC.
- The OEBC exam blueprinting took place during summer 2021 and indicators were generated for each competency.
- The new OSCE scoring system is scheduled to be piloted during the fall 2021 exam administration.
- Changes to the OEBC exam are scheduled to be made in spring 2022.

National Board of Examiners in Optometry

- The College received a rejoinder to *Applicability of Entry to Practice Examinations for Optometry in Canada and the United States – Optometry Examining Board of Canada and National Board of Examiners in Optometry* by Woo, Hrynchak, & Hutchings (2020) on August 12, 2021, from NBEO. The University of Waterloo School of Optometry and Vision Science document was referenced in OEBC's *One Entry-to-Practice Exam Is Good for Canada* document, which was provided to Council at its meeting in June 2021. The committee reviewed the rejoinder at its August 19 meeting; it was then provided to FORAC for transparency.

Registration Process during COVID-19

- College staff continue accepting applications for registration electronically and validating documents with applicants.
- There were 23 candidates registered for the June 2021 online Jurisprudence exam and 18 candidates registered for the August 2021 online Jurisprudence exam.
- The College received the July 2021 OEBC exam results on August 12. As of September 2, the College has registered 41 candidates. The registered candidates include 26 who challenged the OEBC exam, 14 who challenged the NBEO exam, and one candidate who used labour mobility provisions. There are 30 candidates in the pre-registration pool.
- From January 1 to September 2, 2021, 43 candidates have been registered who successfully challenged the NBEO exam; 32 candidates have been registered who successfully challenged the OEBC exam; and four candidates have been registered who used labour mobility provisions.
- The development of an online registration application is in its final stages. Launching the online application has been delayed to the fall of 2021 due to additional programming.

Further Amendments to the Registration Regulation draft amendments

- In April 2018, the College made a comprehensive regulation amendment submission to the Ministry of Health, and further amendments in 2020. While these draft amendments are under review, the College has asked that the Ministry consider introducing more flexibility in the Registration Regulation, which would be consistent with the College of Homeopaths of Ontario that has similar flexibility. There is currently no update on this request.

Governance/HR Committee Activity Report

Reporting date: September 17, 2021

Chair: Kathryn Biondi

Tasks Completed Since Last Council Meeting:

- The committee reviewed survey feedback from the June 18, 2021, Council meeting.
- A harassment policy was drafted and thoroughly discussed. The committee provided detailed feedback that will be incorporated into a next draft.
- The committee pinpointed four additional policies that will be developed and included within the governance manual for 2021: Conflict of Interest, Rules of Order, Role of Committees, and Role of Committee Chairs.

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 in 2021 is to conceptualize and draft a governance manual that will be shared with all Council members and function as a kind of guidebook for effective and ethical governance as it relates specifically to the College. The harassment policy that was discussed at the committee's last meeting will be part of the manual, as will the other policies identified for development.

Discussion Items

Council Governance Retreat

The committee discussed a Council retreat that is being scheduled for 2022. The agenda is in development and will include topics such as: differences between regulatory boards and non-profit boards, role of public members vs. professional members, the College's mandate, and more.

Council Training in 2022

The committee discussed various options for Council training sessions next year and agreed that the training should focus on the specific nuances of the health regulatory environment (as opposed to something more generic).

Registrar Performance Review

The group discussed the format for the Registrar review that will take place this year, recognizing that the Registrar will have only been in the role for 10 months at the time of the review and that there is no existing review template. The committee continues to review and discuss the format for the review, with the goal of refining and developing it for 2022 and beyond.

The committee also reviewed a survey instrument that was shared by J. Jamieson, and which could be used to gather feedback on the Registrar's performance.

Harassment Policy

Staff developed a draft harassment policy, which was shared with the committee. The committee's discussion will inform the next draft, which the committee will review at its next meeting.

Audit/Finance/Risk (AFR) Committee
Activity Report

Reporting date: September 17, 2021

Chair: Ravnit Dhaliwal

Tasks Completed Since Last Council Meeting:

- Discussed the opinion letter from BDO Canada regarding HST charged on membership fees. The committee is going to review the HST issue next year in view of the fee reduction in 2022 membership fees for practising members.
- Rearrangement of investments is pending advice from bank / financial advisors.

Key Priorities

- Updating financial records (current budget vs YTD actuals) for the period ending August 31, 2021, to be presented at the next AFR committee meeting on September 13, 2021.
- Establishing cash requirements for the current financial year and beyond, to be presented at the next AFR committee meeting on September 13, 2021.
- Staff to speak with financial/bank advisors about investment options.
- Ongoing review/awareness of risks: IT, operational, and financial.

Information Items

- The updated Finance – Honoraria and Expense Policy and Claim form (revised May 13, 2021, and included for information at June 7, 2021, Council meeting) was circulated to committee chairs and support staff.

Attachment

- Letter from BDO Canada regarding HST charged on membership fees

Tel: 289 881 1111
Fax: 905 845 8615
www.bdo.ca

BDO Canada LLP
360 Oakville Place Drive, Suite 5600
Oakville ON L6H 6K8 Canada

To	College of Optometrists of Ontario Audit Finance and Risk Committee
From	Jason MacNeil, Director, Indirect Tax
Date	July 27, 2021
Subject	HST Implications for revoking the election to collect GST/HST on Memberships.

This memo summarizes the HST implications if the College of Optometrists of Ontario ("COO") were to revoke the election, which allows COO to collect GST/HST on memberships and recover input tax credits ("ITCs") on GST/HST paid for inputs used to provide these memberships.

Facts & Assumptions

Our understanding of the facts and our assumptions are set out below. Please review carefully and advise immediately if our understanding is incomplete or inconsistent with your understanding, so that we may evaluate the impact of these omissions on our analysis.

- COO is a non-profit organization ("NPO") for GST/HST purposes;
- COO is a GST/HST registrant under the GST registration number 106953912RT0001;
- COO is a quarterly filer for GST/HST purposes;
- COO is a self-regulatory authority responsible for registering (licensing) and governing optometrists in the Province of Ontario;
- Revenues for the year ending December 31, 2020:
    - Annual Registration fees - $2,513,595
    - Professional Corporation Fees - $226,689
    - Services, other fees and recoverables - $27,707
- Annual Registration Fees represent membership fees and member application fees;
- COO is currently collecting GST/HST on Annual Registration fees;
- Membership is required to maintain a professional status recognized by statute;
- Professional corporation fees represent the application fee to operate a professional corporation as regulated by COO and the related annual renewal fees;
- COO is currently collecting GST/HST on Professional corporation fees;
- Services and other fees and recoverable represent quality assurance, continuing education and other fees which include discipline, investigation and complaint costs;

- COO collects HST on fees relating to quality assurance assessments and on continuing education (where the optometrist providing the coaching has charged COO GST/HST);
- COO does not collect HST on recovery of discipline related costs;
- COO has elected to make its memberships taxable by completing form GST 24 – Election to Tax Professional Memberships;
- The election has been on file since the beginning of 2018;
- Members have raised concerns about the GST HST on memberships, as some members are not entitled to ITCs.

Issues

What are the implications of revoking the GST 24 Election and Revocation of the Election to Tax Professional Memberships?

Summary

As the percentage of revenues from memberships is more than 90% of total revenues, no ITCs would be available where COO revokes the election to treat professional memberships as taxable supplies for GST/HST purposes.

Additionally, COO would be required to repay previously recovered GST/HST paid on capital property, based on the basic tax content calculation.

Recommendation

An analysis should be completed to determine the impact of forgoing ITCs if COO were to revoke the election.

Analysis

Election to tax Memberships

Section 18 of Schedule V of Part VI to the ETA (see legislation in Appendix A) provides an exemption for membership in an organization where the membership is required to maintain a professional status recognized by statute. Therefore, the memberships provided by COO would be exempt unless an election was made to make these memberships taxable.

COO has completed the election to tax memberships and has the election on file. If COO chooses to revoke the election, memberships would become exempt and would not be subject to tax for GST/HST purposes.

The election form is not clear on how long an election must remain in place before a revocation can be completed. It is our view that an election or a revocation of an election must remain in place for a minimum of one fiscal year.

It is recommended that an election or revocation of the election be completed with an effective date of the first day of a fiscal year.

Input tax credits

As a non-profit organization that is a GST/HST registrant, COO can recover the GST/HST paid or payable on purchases related to its commercial activities by claiming an ITC on its quarterly GST/HST return. COO cannot claim ITCs for the GST/HST paid or payable on purchases consumed in the course of exempt activities.

For general operating and overhead expenses, the ITC rules are as follows:

- Full ITCs may be claimed for GST/HST paid where all or substantially all (generally 90% or more) of your consumption or use of the property or service is intended to be used in commercial activities (making taxable supplies);
- No ITC for GST/HST paid where all or substantially all of your consumption or use of the property or service is intended to be used in exempt activities;
- An apportioned ITC may be claimed for GST/HST paid where the property is acquired for use in commercial activities, where the intended use is more than 10% and less than 90% in commercial activities.

For Capital Property the ITC rules are as follows:

- A full ITC if commercial use is more than 50%;
- No ITC if commercial use is 50% or less.

Change-in-use –rule

Where capital property was previously used more than 50% in commercial activities and the use of the capital property is reduced to 50% or less in commercial activities, the change-in-use-rule will apply.

The change-in-use-rule states that where the use of capital property changes from more than 50% in commercial activities to 50% or less in commercial activities, the registrant is required to repay all or part of the tax claimed as an ITC at the time the property was last acquired.

In order to determine the repayment of GST/HST, the basic tax content of the property must be determined at the time the change-in-use occurs.

The basic tax content is calculated using the following formula:

(A - B) x C

Where:

A - is the GST/HST payable at the time of the last acquisition of the property and for any improvements made to the property subsequent to the last acquisition;

B - is any rebate or refund COO was entitled to claim (or would have been entitled to claim if COO had not been entitled to claim an ITC) for the GST/HST payable for the last acquisition of the property and for later improvements made to it, but not including ITCs COO was entitled to claim; and

C - is the lesser of:

- 1; and

- the fair market value of the property at the time of the change in use divided by the total cost (not including the GST/HST) for the last acquisition of the property and for later improvements made to the property.

For example, if COO purchased computer hardware in 2018 for $100,000 and paid $13,000 in HST, COO would have likely claimed an ITC for the full amount of HST paid. Then on January 1, 2022, OCC revokes the election to make memberships exempt and the use of the computer hardware has now changed to be used in exempt supplies. In this case, you would be required to pay back the previously claimed ITC using the basic tax formula. Assuming the computer hardware's fair market value at the time of change in use is $80,000, the ITC repayable is calculated as follows:

($13,000 - $0) x ($80,000/$100,000) = $10,400

<u>Services, other fees and recoverables</u>

In an email dated July 12, 2021, an enquiry was made with respect to whether HST should be charged on the recovery of discipline related costs. It was noted that in the past, HST was not charged on these rebilled costs.

Although this query is outside the scope of our engagement, we would like to make the following comments:

Section 6 of Schedule V of Part VI of the ETA (See Appendix A) provides an exemption where the rebilled costs do not exceed the direct cost. Where COO can show that the rebilled expenses and services do not exceed the direct cost, the supply will be exempt.

If you require further information, please contact Jason MacNeil at 905-272-7840

Appendix A

Section 18 of Schedule V of Part VI of the ETA

[Professional membership] A supply of a membership made by an organization membership in which is required to maintain a professional status recognized by statute, except where the supplier has made an election under this section in prescribed form containing prescribed information.

Section 6 of Schedule V of Part VI of the ETA

[Supplies for charge not exceeding direct cost] A supply by way of sale made by a public service body (other than a municipality) to a recipient of tangible personal property (other than capital property of the body or, if the body is a person designated to be a municipality for the purposes of section 259 of the Act, designated municipal property), or of a service purchased by the body for the purpose of making a supply by way of sale of the service , if the total charge for the supply is the usual charge by the body for such supplies to such recipients and

(a) if the body does not charge the recipient any amount as tax under Part IX of the Act in respect of the supply , the total charge for the supply does not, and could not reasonably be expected to, exceed the direct cost of the supply ; and

(b) if the body charges the recipient an amount as tax under that Part in respect of the supply , the consideration for the supply does not, and could not reasonably be expected to, equal or exceed the direct cost of the supply determined without reference to tax imposed under that Part and without reference to any tax that became payable under the first paragraph of section 16 of An Act respecting the Québec sales tax , R.S.Q., c. T-0.1, at a time when the body was a registrant as defined in section 1 of that Act.

August 27, 2021

Mr. Joe Jamieson
Registrar
College of Optometrists of Ontario
65 St. Clair Avenue East, Suite 900
Toronto, ON M4T 2Y3

Dear Mr. Jamieson and College Council,

Re: Optometrists and their Constitutional Right to Withdraw Services

I am writing to you, on behalf of the Ontario Association of Optometrists (OAO) and its 1800-plus members practicing across Ontario, to explain why optometrists have the constitutional right to withdraw their services in a compensation dispute with the Ontario Government.

Background Facts

The OAO is the principal representative of optometrists practicing in Ontario. Among other activities, the OAO engages with the Ontario Government on behalf of its members concerning the optometric services that are covered by OHIP; the compensation paid to optometrists for providing those services; and other aspects of the conditions under which optometrists practice. There has been no agreement between OAO and the Ontario Government in over a decade. Despite this, Ontario optometrists continue to provide optometric services, including services (annual eye examinations plus follow-up assessments) for children aged 0-19 and seniors aged 65+ (the **"Insured Services"**) below operating costs. Today, Ontario optometrists are deeply challenged by a broken eye care system with the worst compensation in the entire country to provide Insured Services.

Against this backdrop, the Government is refusing to negotiate a new OAO Agreement that would see them pay for the operating costs to provide Insured Services. This situation has continued over many months despite the OAO's best efforts to convince the Government to adopt a new, fair approach.

The *Charter* Protection for Freedom of Association

The main legal protection that applies to government action (or inaction) in the context of collective negotiations over compensation is the constitutional protection for freedom of association established in section 2(d) of the *Canadian Charter of Rights and Freedoms* (the **"*Charter*"**). This protection applies to all working people who join together to advance their employment-related interests, whether or not they are "unionized" workers.

…/2

This general principle has been settled for decades. For example, in 1989 the Manitoba Court of Queen's Bench specifically concluded that the *Charter* right to freedom of association applies to doctors in private practice:[1]

> …the [Medicare] experience in Canada has in the past two decades likened [doctors] to industrial workers who have to associate and bargain collectively for their daily bread, for rewards for the fruits of their labour, if you will. The lifeblood of the doctors' remuneration is found in their fee schedules which are negotiated and bargained for with provincial government Canada-wide. And the experience and realities of these negotiation, repugnant as they may be to many in the medical profession, have on occasion required the doctors to withdraw their services and go on strike and walk the picket line so they might obtain what they consider their just desserts…. While it is clear that the [Manitoba Medical Association] is not and never has been a union, and doctors are not union members, I find that that is a distinction which I cannot draw either inferentially or legally. To do so would be to look through the glass blindly to the realities that exist. The result then is that whatever *Charter* jurisprudence which has evolved over the past few years in the labour law field must be applied equally to doctors…

The Supreme Court of Canada has similarly concluded that the *Charter* protection for freedom of association applies to professionals (such as lawyers) working in private practice.[2] Furthermore, over the last 15 years, the Supreme Court and other Canadian courts have significantly expanded the protection for freedom of association, finding that section 2(d) of the *Charter* includes a constitutional right to "collective bargaining" and a "right to strike." These cases involved a range of workers outside of traditional unionized workplaces, including, for example, non-unionized agricultural workers in Ontario,[3] and appointed "members" of the RCMP.[4]

On this basis, it is clear that optometrists are entitled to the protection of section 2(d) of the *Charter* in their negotiations with Government concerning Insured Services.

Service Withdrawal and Freedom of Association

The Supreme Court's 2015 decision in *Saskatchewan Federal of Labour v. Saskatchewan*[5] indicates that Ontario optometrists have a constitutional right to engage in service withdrawal under section 2(d) of the *Charter* (a "right to strike") in a compensation dispute with the Ontario Government.

…/3

[1] *Merry v. Manitoba and Manitoba Medical Association*, 1989 CanLII 7322 (MB QB), para. 20.
[2] See, for example, *Black v. Law Society of Alberta*, 1989 CanLII 132 (SCC).
[3] *Ontario (Attorney General) v. Fraser*, 2011 SCC 20.
[4] *Mounted Police Association of Ontario v. Canada (Attorney General)*, 2015 SCC 1.
[5] 2015 SCC 4

This means that Ontario optometrists are entitled to collectively withdraw their labour to pressure the Government to negotiate in a balanced process for a fair and reasonable agreement. It also means that if the Government or other government authority took legislative, regulatory, or other action to prohibit optometrists from withdrawing their services in connection with compensation negotiations, then a violation of section 2(d) could occur.

While we continue to hope that both parties will return to the negotiating table by committing to terms that would avoid a September 1st service withdrawal, we are concerned that the Ontario Government has left engagement until the 11th hour and patient impact will be unavoidable. The OAO will continue to fight for our patients' rights to sustainable high quality eyecare services in this province by exercising our constitutional rights to fair treatment by the Ontario Government.

Should you have any questions, or would like more information, please do not hesitate to let me know.

Yours Truly,

Dr. Sheldon Salaba
President

cc. Council of the College of Optometrists of Ontario
Mr. Justin Brown, CEO, OAO

4-5 / PRESENTATIONS AND OTHER MATTERS

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

5. In Camera Session: Legal Opinion

   Council will go **in camera** under:
   Section 7(2)(e) of the Health Professions Procedural Code, which is Schedule 2 to the Regulated Health Professions Act

6 / MOTIONS

6. Motions Brought Forward from Committees

   a. Executive Committee:
      i. Research Grant Panel

   b. Quality Assurance - Clinical Practice Panel:
      i. To approve revisions to OPR 7.12 Patients with Amblyopia.

BRIEFING NOTE

Executive Committee – September 17, 2021

Subject

The College has currently allocated a reserve fund for the purpose of providing research that is rooted in the public interest regarding excellence in eye care and effective professional practice.

Background

In its mandate of regulating the profession of Optometry in the public interest, specific areas include:

- setting the qualifications required to enter practice;
- setting the conditions to maintain registration;
- developing quality assurance programs to promote clinical excellence;
- promoting safe and ethical practice by our members;
- developing professional and ethical standards and guidelines; and
- responding openly, fairly, and with authority when complaints arise.

Furthermore, the College *Strategic Plan 2020-2023* focuses on several areas to enable the College to work "with the changing delivery and technology landscape, we envision the College being more responsive, gathering more and better data, and taking advantage of the most advanced regulatory tools and techniques to fulfill its mission. Being "a leading regulator" in these and other respects is therefore an aspiration for the College going forward." These aspects include:

- Potentially monitor developments and ensure professional standards appropriately reflect emerging delivery models and technologies
- Confirming the entry-to-practice examination ensures safe and competent practitioners
- Developing a renewed quality assurance program
- Guiding and supporting optometrists to maintain practice requirements in Ontario
- Potentially investigate and prepare for specialization to achieve high-quality patient care
- Promoting meaningful continuing education, professionalism, and excellent clinical care

The allocation of annual funds for practitioners or stakeholders (by College request) to access funding through a robust application and criterion-based process will be required to fully implement the program.

Research applications can be considered from two sources.

(A) A committee or Council may request research support in the consideration of policy development within the committee mandate. If a committee requests such, an RFP will be circulated to the membership and stakeholders for consideration.

(B) An individual member of the College can submit (bi-annually) a research proposal that meets the criteria established by the panel (public interest mandate) for consideration by the panel.

Process

It is proposed that Council approve through motion by the Executive Committee to Council, a Research Grant Panel. The panel will be formed as a panel of the Executive Committee with the following terms of reference:

1. To establish a metric-based criterion using most effective practices to evaluate submitted grant proposals from members of the College (research candidates).
2. To apply ethical research standards while evaluating a submission and safeguard the process and recipients from conflict-of-interest matters.
3. To allocate proportionate funding based on the merits of each application and fund capacity.
4. To receive and assess research applications twice yearly from research candidates.
5. To receive, archive and provide impact feedback to Council regarding funded research.

Research Panel Composition

The Research Grant Panel will consist of:

Chair of Panel	Vice-President of Council
Vice Chair of Panel	President of Council
Panel Member	Additional Council member selected by the Executive Committee after reviewing applications from interested members
Member-at-Large	A College Member appointed by the Registrar with research background and credentials
Originating Committee	The Chair/Delegate of a committee that requests an RFP for research support

Funding

The College current holds a reserve for research in its annual budget. It is proposed from a reallocation initiative to increase this funding by 100,000 a year for three years. The budget will also cover all infrastructure and associated costs in funding the program.

Decision(s) for Council

Council is being asked to approve the establishment of the Research Panel as outlined above. This motion is as follows:

To approve the establishment and funding of a Research Grant Panel as outlined in the briefing note.

Public Interest Mandate

All approved research will have a public interest element and will further the College's efforts to protect the public.

Contact

- Chad Andrews, Senior Manager, Policy and Governance

BRIEFING NOTE

CPP Meeting– September 2021

Subject

OPR 7.12 Patients with Amblyopia

Background

A review of this standard began in 2019 and was interrupted last year by the COVID pandemic. This review is the result of contributions from CPP committees 2019-2021.

At its meeting on June 18, 2021, Council reviewed the revisions to this standard and referred the motion back to CPP for further review. Dr. Camy Grewal, Chair of CPP, will provide an update at the meeting.

Decision(s) for Council

To approve revisions to OPR 7.12 Patients with Amblyopia

Considerations

- Definition of Amblyopia in the OPR
- Considerations when asking about patient ocular and birth history

Public Interest Mandate

To provide appropriate care of patients with amblyopia for a consistent standard of care in Ontario.

Supporting Materials

- OPR 7.12 with track changes - revisions presented at the CPP meeting
- List of Scientific Articles
- Chen AM, Cotter SA. The Amblyopia Treatment Studies: Implications for Clinical Practice. Adv. Ophthalmol Optom. 2016;1(1):287-305

Next Steps

The OPR 7.12 Patients with Amblyopia will be updated accordingly.

Contact

- Dr. Violet Zawada Kuzio and Dr. Nisara Bandali – Practice Advisors

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 or interocular difference of 2 lines or more in visual acuity, without disease or structural abnormality of the eye(s) or visual pathway(s). ~~Amblyopia (a condition patients often call "lazy eye") is characterized by reduced best-corrected visual acuity in one or both eyes, without disease or structural abnormality of the eye or visual pathways.~~ 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. ~~Optometrists provide diagnosis and treatment of amblyopia, its causes and associated functional visual deficits.~~

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 ~~including~~ such as, but not limited to, term of pregnancy, birth weight, and pre-/peri-natal history (including~~specifically~~ maternal use of alcohol, tobacco or drug~~s use~~ during pregnancy), ~~as indicated~~
- measurement of uncorrected visual acuity
- ~~cycloplegic~~ 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[1,2] 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 ~~by optometric or ophthalmologic guidelines~~

- 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 ~~and the increased risk for eye injury and the importance of eye protection~~
- ~~provision of a prescription for protective eyewear~~

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 ~~compliance with~~ 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.

		Patching	No difference	Binocular
Birch et al	A pilot randomized trial of contrast-rebalanced binocular treatment for deprivation amblyopia. J AAPOS. 2020 Dec; 24(6): 344.e1-344.e5 https://pubmed.ncbi.nlm.nih.gov/33069871/			TRUE
Birch et al	Baseline and Clinical Factors Associated with Response to Amblyopia Treatment in a Randomized Clinical Trial. Optom Vis Sci. 2020 May; 97(5): 316-323 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7271687/			TRUE
Editorial	New treatments for Amblyopia - To patch or play? https://jamanetwork.com/journals/jamaophthalmology/article-abstract/2579928		Neutral	
Hess et al	The iPod binocular home-based treatment for amblyopia in adults: efficacy and compliance. Clin Exp Optom 2014;97(5):389-98. https://pubmed.ncbi.nlm.nih.gov/25131694/			TRUE
Hess et al	A new binocular approach to the treatment of amblyopia in adults well beyond the critical period of visual development. Restor Neural Neurosci. 2010; 28(6): 793-802 https://pubmed.ncbi.nlm.nih.gov/21209494/			TRUE
Jayakumar et al	Effect of monocular fixation binocular field (MFBF) on amblyopia - a pilot study comparing it with patching. Strabismus 2020 DOI:10.1080/09273972.2020.1789677 https://pubmed.ncbi.nlm.nih.gov/32877266/		TRUE	
Jost et al	Randomized clinical trial of binocular iPad treatment for amblyopia versus patching. Journal of AAPOS Vo 20(4): August 2016 https://pubmed.ncbi.nlm.nih.gov/27832248/			TRUE

Kelly et al	Binocular iPad game vs patching for treatment of amblyopia in children: a randomized clinical trial. JAMA Ophthalmol 2016:134(2):1402-08 https://pubmed.ncbi.nlm.nih.gov/27832248/			TRUE
Lamprogiannis et al	A Review of Binocular Treatment for Amblyopia. Touch Ophthalmology. Eur Ophthalmic Review. 2020; 14(1): 34-8 https://www.touchophthalmology.com/neuro-ophthalmology/journal-articles/a-review-of-binocular-treatment-for-amblyopia/			TRUE
Li et al	A binocular iPad treatment for amblyopic children. Eye. 2014:28(10):1246-1253 https://pubmed.ncbi.nlm.nih.gov/25060850/			TRUE
Papageorgiou et al	The treatment of amblyopia: current practice and emerging trends, January 2019 https://pubmed.ncbi.nlm.nih.gov/30706134/	TRUE		Small effects: further research recommended
PEDIG	Effect of a binocular iPad game versus part- time patching in children aged 5 to 12 with amblyopia: a randomized clinical trial. JAMA Ophthalmol 2016;134(12):1402-8. https://pubmed.ncbi.nlm.nih.gov/27812703/			TRUE
PEDIG ATS 2A/2B	Patching Protocol: Mild to moderate: 2 hrs/day; severe: 6 hrs/day with 1 hr near activity https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1609192/			
PEDIG Holmes et al (Aniso-strab)	Effect of a binocular iPad game vs part-time patching in children aged 5-12 years with amblyopia: a randomized clinical trial. JAMA Ophthalmol 134(2): 1301-1400 https://pubmed.ncbi.nlm.nih.gov/27812703/		TRUE	
PEDIG: Holmes et al	Effect of a binocular iPad game vs part-time patching in children aged 5-12 years with amblyopia: a randomized clinical trial. JAMA Ophthalmol 134(2): 1391-1400	TRUE		

	https://pubmed.ncbi.nlm.nih.gov/27812703/			
PEDIG: Manh et al	A randomized trial of a Binocular iPad Game versus part-time patching in children aged 13 to 16 years with Amblyopia. American Journal of Ophthalmology. 2017 doe:1016/j.ajo.2017.11.017 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6206863/	TRUE		
Pineles et al	Binocular Treatment of Amblyopia: A Report by the American Academy of Ophthalmology. Ophthalmology 2020 Feb; 127(2): 261-272. https://pubmed.ncbi.nlm.nih.gov/31619356/	“binocular therapy cannot be recommended as a replacement for standard amblyopia therapy”		
Rajavi et al	Comparison between patching and interactive binocular treatment in Amblyopia: a randomized clinical trial. Journal of Current Ophthalmol 2019 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6896467/		TRUE	
Rajavi et al	The role of interactive binocular treatment system in amblyopia therapy. J Curr Ophthalmol 2016 28:217-22. WHEN COMBINED WITH PATCHING https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5093783/			TRUE
Shuai et al	Binocular treatment in adult amblyopia is based on parvocellular or magnocellular pathway. Our J Ophthalmol 2020 Jul; 30(4): 658-667 https://pubmed.ncbi.nlm.nih.gov/31014078/	Aniso: improvemnet in acuity; strab: improvement in stereo		
Yao et al	Binocular game versus part-time patching for treatment of anisometropic amblyopia in Chinese children: a randomized clinical trial https://bjo.bmj.com/content/104/3/369.long	TRUE		
Zhou et al	A new form of rapid binocular plasticity in adult with amblyopia. Scientific Reports Sept 2013 TRANSLUCENT PATCHING https://www.nature.com/articles/srep02638	TRUE		

Cycloplegia

Cycloplegia	
Major et al	Cycloplegia in Children: An Optometrist's Perspective. Clinical Optometry. 2020:12, 129-133 https://pubmed.ncbi.nlm.nih.gov/32904515/

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The Amblyopia Treatment Studies: Implications for Clinical Practice

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INTRODUCTION

Amblyopia is the most common cause of monocular vision loss in children[1] with an estimated prevalence of approximately 2% in the United States.[2–4] A developmental disorder of spatial vision, amblyopia is clinically defined as decreased best-corrected visual acuity (VA) in one, or less frequently both eyes, in the absence of any obvious structural anomalies or ocular disease. It is associated with abnormal visual experience, most commonly strabismus, anisometropia, or form deprivation that occurs during a sensitive period of visual development in infancy or early childhood.

Signs, Symptoms, and Quality-of-Life Concerns

In addition to reduced best-corrected VA, there are a plethora of visual function deficits of the amblyopic eye, including abnormal contour interaction,[5] reduced contrast sensitivity,[6] positional uncertainty,[7] spatial distortion,[8] poor accommodation,[9] abnormal eye movements,[10] and suppression.[11] Because of good vision in their non-amblyopic (sound) eye, persons with unilateral amblyopia typically do not complain of blurred or poor vision under habitual binocular viewing conditions; however, recent studies have reported reduced reading speed[12] and compromised fine-motor skills[13] even with both eyes open.

There are important public health consequences when amblyopia is left untreated. Patients with amblyopia are more likely to become visually disabled because of an increased risk of

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their sound eye becoming visually impaired,[14,15] with their estimated lifetime risk of visual impairment being at least 1.2%.[15] Vision loss in the sound eye, often caused by trauma, can have a significant effect on quality of life with many employed individuals no longer being able to work because of inadequate visual function.[15,16] Although amblyopic eye VA can sometimes improve in adults after vision loss of their sound eye, most remain visually disabled.[17] Furthermore, the presence of unilateral amblyopia has a deleterious effect on binocularity, including stereopsis. Because good VA in each eye and/or normal stereoacuity are often prerequisite for careers in the military, aviation, surgery, law enforcement, firefighting, as well as obtaining a commercial driver's license,[18] amblyopic individuals are often precluded from participating in such occupations.[19]

Historical Perspective on Amblyopia Treatment

Historically, the mainstay of amblyopia treatment has been patching of the sound eye. Treatment regimens have been a matter of individual preference based on the training, observations, and clinical impressions of the treating optometrist or ophthalmologist. Generally, when it came to patching, the adage was "*time was of the essence*", so patching was prescribed in conjunction with the refractive correction because of the notion that treatment beyond a certain age (variously stated as between 6 to 9 years) would not be beneficial.[20] The-*more-the-better*-principle was followed by many eye care providers with full-time patching thought to be preferred, if not imperative, for a successful outcome, particularly for severe amblyopia. Atropine penalization was not considered to be a first-line treatment modality and thus generally advocated only for young children with moderate levels of amblyopia who had failed patching.

Amblyopia Treatment Studies

The Pediatric Eye Disease Investigator Group (PEDIG) is a clinical network of pediatric optometrists and ophthalmologists funded by the National Eye Institute to conduct clinical research studies related to pediatric eye conditions. Thus far, the majority of the PEDIG studies have focused on evaluating the comparative effectiveness of different amblyopia treatment regimens for children and adolescents. These studies are known as the Amblyopia Treatment Studies (ATS), and their results have dramatically changed amblyopia clinical practice patterns for many eye care providers. Herein, this article summarizes the key findings from these studies and provide our perspective in regard to the most relevant clinical implications.

RESULTS & CLINICAL IMPLICATIONS

Key features of the ATS studies are:

- They are randomized clinical trials (RCT) or prospective observational studies.
- The studies of unilateral amblyopia comprise participants with anisometropic, strabismic, or combined-mechanism (anisometropic and strabismic) amblyopia and the bilateral amblyopia study enrolled children with isoametropic amblyopia; children with deprivation amblyopia have been not been studied.

- Amblyopic eye VA of 20/40 or worse with an interocular difference of at least 3 lines was required for enrollment for most of the unilateral amblyopia studies.
- The primary outcome measure is best-corrected VA of the amblyopic eye, which is measured in a standardized fashion by examiners who are masked to participants' treatment assignment.
- VA is measured using a standardized computerized testing method that presents single-surrounded optotypes at logMAR intervals on the Electronic Visual Acuity (EVA)[21] tester using HOTV optotypes for children 3 to 6 years old[22] and the Early Treatment Diabetic Retinopathy Study (ETDRS) letters for children 7 years of age and older.[23]
- The magnitude of VA improvement found at the mostly 4- to 6-month primary outcome examinations is not the maximum benefit expected to be achieved for all participants, but instead the maximum length of time that the prescribed treatment regimens could be maintained before investigators would insist on a change of treatment in cases of poor outcome; in many cases, VA can improve further with continued treatment.
- RCT results are based on the "prescribed" treatment regimens determined by randomization, not the "actual" treatment completed.

Prescribing Guidelines for Refractive Error Correction

The following prescribing guidelines have been implemented in these studies:

- Refractive error determination is based on a cycloplegic refraction using cyclopentolate.
- Full correction of astigmatism, myopia, and anisometropia is prescribed with the goal of providing equally clear retinal images.
- Hyperopia is either fully corrected (e.g., in cases of esotropia) or undercorrected (e.g., in cases without esotropia) by no more than +1.50 D spherical equivalent (SE), with any reduction in plus sphere reduced symmetrically in the two eyes.

Optical Treatment Studies

1. Optical Correction for Unilateral Amblyopia—Two ATS studies have evaluated the effectiveness of optical correction alone as a treatment modality for previously untreated unilateral amblyopia in 3 to <7 year-old children.[24,25] The first study enrolled children with anisometropic amblyopia of 20/40 to 20/250[24] and the second study enrolled those with strabismic or combined-mechanism amblyopia of 20/40–20/400,[25] with the following key findings:

- Mean amblyopic eye VA improvement was approximately 3 lines and occurred in both moderate and severe cases of amblyopia (Figure 1).
- Resolution of amblyopia, defined as equal VA or amblyopic eye VA within 1 line of sound eye VA, occurred in 25–33% of cases (Figure 1).

- Generally, the optical treatment effect occurred within the first 16 to 18 weeks after optical correction; however, in some children VA continued to improve for up to 45 weeks (Figure 2).
- There was no relationship between amblyopic eye VA improvement and the presence or magnitude of strabismus pre- or post-spectacle correction.

Clinical Implications

- There is an actual amblyopia treatment effect that occurs over time from solely wearing an appropriate refractive correction that is distinct from the immediate VA gain that occurs initially from eliminating optical blur.
- It is reasonable to start amblyopia treatment with the refractive correction alone for young children with anisometropic, strabismic, and combined-mechanism amblyopia.
- A follow-up interval of 6 to 8 weeks, until improvement in the amblyopic eye VA plateaus, is a practical schedule for monitoring children for an optical treatment effect.
- Children still needing additional amblyopia treatment after improved VA from an optical treatment effect have better amblyopic eye VA at the start of the next treatment phase, which can result in less treatment burden and better compliance.
- Some children (i.e., those with amblyopia resolution) may not need additional amblyopia treatment beyond optical correction.

2. Optical Correction for Bilateral Refractive Amblyopia—The PEDIG conducted a prospective observational study to determine the amount and time course of VA improvement with refractive correction alone in 3 to <10-year-old children with previously untreated isoametropic amblyopia of 20/40–20/100 associated with high hyperopia (≥4.00D SE) and/or astigmatism (≥2.00D). The primary outcome measure was binocular VA. The key findings were:[26]

- The mean improvement in binocular VA was approximately 4 lines.
- Of the 113 participants, 74% achieved binocular VA of 20/25 or better.
- Continued VA improvement was seen for up to 1 year in some children.
- The worse the child's VA at the start of treatment, the greater the number of lines of improvement in VA.
- A majority of children also showed an improvement in near stereopsis.

Clinical Implications

- The time frame for VA improvement varies but can take up to 1 year; it is possible that additional improvement may occur beyond 1 year (but this was not studied).

- Although participants were corrected with spectacles, it is reasonable to expect that similar improvements would occur with contact lens corrections.

Forms of Occlusion

When patients do not respond to refractive correction alone, or VA ceases to improve, occlusion treatment such as part-time patching, atropine penalization, or Bangerter filters may be prescribed.

Patching Dosage

Patching dosage was evaluated in 2 concurrent clinical trials of children 3 to <7 years of age. The effectiveness of 2 hours of daily patching was compared to 6 hours of daily patching in children with moderate amblyopia of 20/40 to 20/80[27] and 6 hours of daily patching was compared to full-time daily patching in children with severe amblyopia of 20/100 to 20/400.[28] The key findings were:

- In cases of moderate amblyopia, prescribing 2 hours of daily patching with 1 hour of near activities is as effective as prescribing 6 hours of daily patching with 1 hour of near activities (Table 1).
- In cases of severe amblyopia, prescribing 6 hours of daily patching and 1 hour of near activities is as effective as prescribing full-time daily occlusion and 1 hour of near activities (Table 1).
- There was no difference in the rate of improvement between the groups randomized to the lower and higher patching dosages.

It is noteworthy that in a subsequent clinical trial, there were children with severe amblyopia who responded to 2 hours of patching.[29]

Clinical Implications

- Full-time patching is not always needed for a successful treatment outcome. Prescribing lesser amounts of patching may promote better overall compliance with treatment.
- When patching is prescribed, it is reasonable to prescribe 2 hours of daily patching for moderate amblyopia and 6 hours of daily patching for severe amblyopia.
- Some children with severe amblyopia will respond to as little as 2 hours of patching.
- In young children, using an adhesive patch should be strongly considered so that peeking is less likely to occur.

Atropine Treatment

Another amblyopia treatment modality is pharmacological penalization by the instillation of the long-acting topical cycloplegic agent, atropine sulfate (1%), into the sound eye of a child with amblyopia. The resultant cycloplegia prevents accommodation in the sound eye

resulting in blurred vision at near, and in instances when the full hyperopic correction is not worn, blurred vision at distance as well.

1. Atropine vs. Patching for Moderate Amblyopia—The first ATS[30] compared the effectiveness of daily administration of 1 drop of 1% atropine in the sound eye to ≥ 6 hours of daily patching in children 3 to <7 years old with moderate amblyopia of 20/40 to 20/100 and found the following:

- Both treatment groups showed a similar improvement in amblyopic eye VA (Table 1).
- VA improvement was slower with atropine penalization compared to patching, but the magnitude of VA improvement at 6 months was similar.
- Treatment effect did not differ by age, cause of amblyopia, or depth of amblyopia.
- A switch in near fixation preference from the atropinized sound eye to the amblyopic eye was not observed in a number of children with significant amblyopic eye VA improvement.[31]
- Both treatments were well tolerated with parents reporting a slightly higher degree of acceptability with atropine treatment.

2. Atropine Regimens for Moderate Amblyopia—A subsequent RCT compared less frequent administration of 1% atropine drops (weekend only) to daily atropine in children 3 to <7 years old with moderate amblyopia of 20/40 to 20/80 and found the following:[32]

- Amblyopic eye VA improvement was essentially identical (2.3 lines) in both groups at 4 months.
- Among participants, 80% reached their maximum VA improvement by 4 months, but some continued to show VA improvement for up to 10 months.
- Among participants, 50% had resolution of amblyopia (i.e., equal VA or amblyopic eye VA within 1 line of sound eye VA).

3. Atropine Augmentation with a Plano Lens for the Sound Eye—The PEDIG evaluated whether there was an additional treatment effect by augmenting weekend atropine with a plano lens for the sound eye in children aged 3 to < 7 years with moderate amblyopia of 20/40 to 20/100.[33] Because all participants had hyperopic refractive error in their sound eye, those randomized to the atropine plus plano lens group had blurred distance vision in addition to increased blur at near. The key findings were as follow:

- There was no difference in mean amblyopic eye VA improvement between the two groups at 18 weeks; mean improvement was approximately 2.5 lines.
- More children in the atropine with plano lens group reached 20/25 or better amblyopic eye VA than those in the atropine only group (40% vs. 29%, respectively).

4. Atropine for Severe Amblyopia—Historically, atropine penalization has been reserved for children with moderate amblyopia, because, presumably, treatment would not be effective if sound eye VA was not worse than amblyopic eye VA. Nevertheless, PEDIG RCTs included children with severe amblyopia of 20/125 to 20/400 who were treated with weekend atropine.[33–35] While the studies were not powered to compare treatment groups, the following noteworthy results were observed:

- In children 3 to <7 years, the average VA improvement was 4.5 to 5.1 lines.
- In children 7 to 12 years, VA improved by 1.5 lines with prescribed weekend atropine.

5. Miscellaneous Issues with Atropine Treatment for Amblyopia

Reverse Amblyopia: Although a few children had reduced sound eye VA at follow-up visits, there were no cases of persistent reverse amblyopia after discontinuation of atropine.[33,35] Initially apparent reverse amblyopia was suspected in some children, but it was then determined that sound eye VA had not been assessed through the full hyperopic correction. Because atropine can uncover additional hyperopia than found on a cyclopentolate refraction, it is important to determine if uncorrected hyperopia is present in the atropinized eye, and if so, to measure sound eye VA through the full plus prescription at follow-up visits.

Systemic Side Effects: Systemic side effects (dryness, flushing of skin, fever, confusion, unusual behavior, and irritability) that can be associated with atropine penalization rarely occurred.[30,32,33] However, when such cases occur, daily instillation of 5% homatropine eye drops can be substituted for atropine.

Clinical Implications

- Atropine penalization has a similar treatment effect as 2 and 6 hours of prescribed patching; thus, it can be considered for first-line amblyopia treatment or for patching failures.
- Daily atropine administration is not necessary; a twice-per-week schedule is also effective. There is no reason to believe that atropine needs to be administered only on weekend days or that the days need to be sequential.
- Weekend atropine penalization has been shown to be effective in treating both moderate and severe amblyopia.
- Retinoscopy should be performed over the current refractive correction of the sound eye for children on atropine to determine if there is residual uncorrected hyperopia that should be corrected before measuring sound eye VA.
- Parent education regarding atropine penalization for the amblyopia treatment is listed in [Table 2].

Bangerter Filter Treatment

A Bangerter filter (Ryser Optik AG, St. Gallen, Switzerland) is a translucent filter that is applied to the sound eye's spectacle lens for full-time wear for amblyopia treatment. There are different density filters, which produce different degrees of image defocus that degrade sound eye VA to predictable levels. An RCT to evaluate the effectiveness of Bangerter filters in in children 3 to <10 years with moderate amblyopia (20/40 to 20/80) found the following:[36]

- Full-time wear of Bangerter filter provided VA improvement (1.8 lines) similar to 2 hours of daily patching (2.3 lines).
- Parents reported fewer adverse effects and better compliance with the Bangerter filters than with patching.

Clinical Implications

- Bangerter filters can be considered for first-line amblyopia treatment or for patients who do not comply with patching or atropine treatment.
- Potential advantages of Bangerter filters are the following:
  - The ability to change the density of the filter to modulate the degree of degradation.
  - The possibility of better compliance because the filter is not readily apparent to casual observers.
  - The filter may be less disruptive to binocular vision than patching, albeit 2 to 4 hours of part-time patching should not be very disruptive to binocular vision.
- Potential disadvantages of Bangerter filters are the following:
  - Peeking around the filters is relatively easy.
  - Filters may not uniformly degrade VA to the predicted level reported by manufacturer.[37]
- Clinicians should consider changing the filters periodically because the amount of degradation with filters tends to decrease over time.[37]

Treatment of Older Children with Amblyopia

Historically, there has been little consensus on the effectiveness of amblyopia treatment in older children, with many eye care professionals believing that amblyopia treatment was ineffective after some upper age limit (e.g., 6–7 years or 9 or 10 years), that any VA improvements were likely to be lost after the cessation of treatment, and that intractable diplopia was of concern.

1. Do Older Children with Amblyopia Respond to Treatment?—In an RCT investigating the effectiveness of amblyopia treatment in 2 cohorts of children (7–12 years and 13–17 years) with amblyopia of 20/40–20/400,[38] participants were randomized to

optical correction alone (control group) or optical correction augmented with 2 to 6 hours of daily patching, 1 hour of near activities when patched, and 1% daily atropine in the 7–12 year cohort. The primary outcome was the proportion of treatment "responders," which was defined as ≥ 2 lines improvement in amblyopic eye VA. Data were analyzed separately for the two age groups.

- In children aged 7–12 years, 53% in the augmented treatment group showed a treatment response compared to 25% in the control group.
- In children aged 13–17 years, there was no difference in the proportion of children in the 2 treatment groups who met the responder criteria (25% and 23%, in the augmented and control groups, respectively).
- In children aged 13–17 years who had not been previously treated for amblyopia, the outcome was essentially the same as that found in children aged 7–12 years (47% in the augmented group versus 20% in the control group).
- No patients developed intractable diplopia.

2. Single Treatment Modality—Given that 7 to 12-year-old children prescribed a combined treatment regimen of daily part-time patching and 1% atropine responded to treatment, the PEDIG subsequently compared the effectiveness of 2 hours of daily patching versus weekend administration of 1% atropine in children of this age with amblyopia of 20/40–20/100 and found the following:[34]

- Mean VA improvement was essentially the same (approximately 1.5 lines) in both groups after 17 weeks of treatment.
- Children who showed improvement in amblyopic VA at the 17-week follow-up visit were monitored until reaching maximal VA improvement, which was a mean of 2.2 lines in both groups.

Clinical Implications

- Amblyopia can be successfully treated in 7 to 12 year-old children using either 2 hours of daily patching or weekend atropine as the initial treatment.
- Although many older children respond to treatment, a meta-analysis of 4 PEDIG RCTs showed that amblyopia is more responsive to treatment in children younger than 7 years of age compared with children 7 to 12 years of age.[39]
- Among children in the optical correction alone group, 25% showed ≥ 2 lines of VA improvement: thus, the optical treatment effect from simply wearing the refractive correction is not limited to younger children.
- The authors think that it is unlikely that the difference in treatment response between children 7 to 12 and 13 to 17 years was because of a difference in visual plasticity. The authors hypothesize that the lesser treatment effect in children 13 to 17 years might be because it was more difficult for them to comply with 2 to 6 hours of daily patching with their overscheduled lives and/or they were not prescribed atropine.

- There was significant individual variability in treatment response, with some 13 to 17-year-old children showing significant improvement with treatment, even with a history of prior treatment. Therefore, the authors think that one should not withhold treatment from children aged 13 to 17 years, even with a history of prior treatment.

Residual Amblyopia

Because many children have residual amblyopia after treatment, the PEDIG has evaluated several treatment approaches for residual amblyopia.

Younger Children (3 to <8 years)

1. Increasing Patching Dosage: The key findings from an RCT evaluating the effectiveness of increasing patching from 2 hours to 6 hours in children 3 to <8 years old who were originally treated with 2 hours of daily patching for at least 12 weeks, but still had stable residual amblyopia (20/32–20/160) were as follows:[40]

- Mean VA improvement at 10 weeks was 1.2 lines in the group that increased patching from 2 hours to 6 hours and 0.5 lines in the group that continued with 2 hours of patching.
- Among children in the increased patching dosage group, 40% showed at least 2 lines of VA improvement compared to 18% in the group who were to continue with patching for 2 hours.

2. Adding a Plano Lens to Atropine Treatment: In an RCT to evaluate the effectiveness of adding a plano lens to atropine treatment for 3 to <8-year-old children with stable residual amblyopia (20/32 to 20/63), children were randomly assigned to treatment with weekend atropine with or without a plano lens over the sound eye.[41] The main findings were as follows:

- Mean VA improvement was 1.1 lines in the atropine with plano lens group and 0.6 line in the atropine only group at 10 weeks.
- Although there may be a small benefit from augmenting atropine therapy with a plano lens over the fellow eye, the study results are not definitive because the difference in amblyopic eye VA improvement between the two groups was not statistically significant and the confidence interval was large.[41]

3. Combining Patching and Atropine Treatments: The PEDIG evaluated whether an intensive final push with combined patching and atropine could improve VA in children 3 to <10 years with residual amblyopia of 20/32 to 20/63 after 12 weeks of treatment with 6 hours of daily patching or daily atropine.[42] Children were randomized to either an intensive combined treatment group (6 hours of daily patching combined with daily atropine) or a control group in whom treatment was weaned (i.e., daily patching reduced from 6 hours to 2 hours or daily atropine reduced to once-weekly atropine for 4 weeks, followed by no treatment other than spectacles alone).

- Mean VA improvement was 0.5 lines in both groups after 10 weeks.

Clinical Implications

- If an amblyopic patient does not respond fully to the prescribed treatment, verify compliance with treatment and consider repeating the cycloplegic refraction and re-examining the ocular structures to ensure there is no residual uncorrected refractive error or subtle ocular pathology present.
- When amblyopic eye VA stops improving with 2 hours of daily patching, increasing the patching dosage to 6 hours is a reasonable next approach.
- When amblyopic eye VA stops improving with weekend atropine, adding a plano lens over the sound eye may result in further improvement.
- Combined treatment of patching and atropine did not seem to further improve VA in those with residual amblyopia; however, these results should not be generalized to children with more severe residual amblyopia or those who have stopped improving after less intense treatment.
- In cases of residual amblyopia, changing the treatment modality (e.g., changing patching to atropine or changing atropine to patching) can be considered. Alternatively, active vision therapy procedures can be prescribed to improve deficiencies in accommodation, form discrimination, fixation, as well as to eliminate suppression.[43–45] Although there are no controlled trials that have evaluated these treatment approaches for residual amblyopia, the PEDIG is currently conducting an RCT that includes children with residual amblyopia to evaluate the effectiveness of a type of binocular anti-suppression treatment on an iPad.[46]

Older Children (7 to 12 years)

Treatment of Residual Amblyopia with Oral Levadopa: Because levodopa, an oral medication used to supplement dopamine deficiency in adults with Parkinson's disease and children with dopamine-response dystonia, had been used by some clinicians for amblyopia treatment, the PEDIG conducted a RTC in children 7 to 12 years old with residual amblyopia of 20/50 to 20/400 after patching treatment to assess levodopa's efficacy and short-term safety as an adjunctive treatment to patching. Children were randomized to oral levodopa or placebo administered 3 times daily with patching prescribed for 2 hours per day. The key findings were as follows:

- There was no clinically or statistically meaningful improvement in VA from adding oral levodopa to patching compared with placebo and patching.

Clinical Implication

- There is no meaningful benefit from adding oral levodopa to part-time patching for the treatment of residual amblyopia.

Recurrence of Amblyopia

Amblyopia that is successfully treated can reoccur once treatment is discontinued, particularly if the amblyogenic factor is still present. Amblyopia recurrence rate was

evaluated in children 3 to <8 years old[47] and children 7 to <13 years old[48] in two separate studies. Recurrence was defined as a loss of ≥2 lines of VA in the amblyopic eye.

In children 3 to <8 years who had been successfully treated with patching or atropine:

- Approximately 25% experienced a recurrence during the first year off treatment.
- The risk of recurrence was similar for amblyopia treated with patching and atropine.
- Most recurrences occurred within 3 months after the cessation of treatment.
- The recurrence rate was 3 times greater in children who had 6 to 8 hours of patching that was stopped abruptly than in children who had 6 to 8 hours of patching that was tapered to 2 hours prior to cessation or for children who initially had been prescribed 2 hours of patching without weaning.

In children 7 to 12 years of age who responded to a treatment regimen of 2 to 6 hours of patching, atropine, and near activities:

- Only 7% of children experienced a recurrence during the first year off treatment.

Clinical Implications

- Because a majority of recurrences in children <8 years old occur within 3 months after the cessation of treatment, early follow-up is critical.
- Patching dosage should be gradually tapered rather than abruptly terminated in young children who initially patch ≥6 hours per day.
- Amblyopia recurrence is less common in older children than in younger children.

Long Term Follow-Up

A follow-up study that included a proportion of participants from the original ATS trial that compared atropine vs. patching for treatment of moderate amblyopia was conducted to evaluate the durability of treatment benefit found the following:

- The mean amblyopic eye VA after 6 months of treatment at study outcome was approximately 20/32 in both groups; approximately 25% of participants underwent additional treatment using the alternative treatment (atropine switching to patching, or vice versa) during the following 2 years.[49]
- At age 15 years, mean amblyopic VA was approximately 20/25 and 60% of children had 20/25 or better in their amblyopic eyes. VA at 15 years was similar between the two original treatment groups.[50]

Clinical Implications

- VA improvements occurring with amblyopia treatment before 7 years of age are typically maintained until at least 15 years of age (but it is wise to monitor for regression).
- Mild residual amblyopia is common.

Role of Near Activities

In many of the RCTs discussed previously, 1 hour of near activities were prescribed to be done during patching based on the clinical assumption that these activities stimulate the visual system and enhance amblyopia outcomes. Subsequently, an RCT was conducted where children 3 to <7 years old with amblyopia of 20/40–20/400 were randomized to 2 hours of daily patching with near activities (e.g., crafts, reading, writing, computer or video games) or 2 hours of daily patching with far activities (e.g., watching TV, outdoor play),[29] with the following main result:

- There was no difference in treatment effect based on whether near or far activities were prescribed.

Clinical Implication

- The activities prescribed to be performed at near in this RCT were “common” near activities. More highly structured vision therapy activities and, specifically aimed at improving accommodation, form discrimination, and fixation, and for eliminating suppression were not evaluated.[43–45] The degree of effectiveness of active vision therapy procedures has not yet been evaluated in an RCT.
- Amblyopia iNet (http://www.visiontherapysolutions.net/ambp.php), a software-based system of amblyopia therapy for home use, has visual activities (e.g., form discrimination and eye movements) that can be performed using the amblyopic eye only or under “monocular fixation in binocular field” (MFBF) conditions to address suppression.[44] Monocular perceptual learning activities that are performed at near have shown good promise as an adjunct to traditional amblyopia treatment.[51] Neither of these treatment approaches, however, has been examined critically in a carefully controlled trial.

CONCLUSIONS

The results from the PEDIG studies, discussed previously, have dramatically changed the amblyopia treatment landscape. Many long-held beliefs regarding amblyopia treatment, which were based primarily on observations and clinical impressions, did not stand the test of time once evaluated in a rigorous manner. Table 3 provides an overview of long-held amblyopia treatment dogma that has been challenged and mostly supplanted by the ATS results reported herein. Figure 3 shows an evidence-based sequential treatment approach for moderate amblyopia in young children that is based on the results of these PEDIG studies.

The PEDIG studies to date have principally addressed monocular approaches to amblyopia treatment. Recently there has been an increased interest in evaluating treatments that are designed to decrease suppression and enhance binocularity.[52–54] The PEDIG is currently conducting a RCT comparing this type of binocular treatment administered daily on an iPad versus 2 hours of daily patching in children 5 to <17 years.[51] There are a number of other amblyopia treatment modalities currently under investigation and the authors are hopeful that 10 years from now, they will be writing a paper discussing amblyopia treatment regimens that are even more effective than those that exist at present.

Acknowledgments

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SYNOPSIS

A series of randomized clinical trials and prospective observation studies, the Amblyopia Treatment Studies (ATS), have recently been conducted by the Pediatric Eye Disease Investigator Group (PEDIG) to provide an evidence base for treating childhood amblyopia. Herein, we review the major findings and clinical implications from these studies that have addressed important amblyopia treatment issues, such as optical treatment, patching dosage, atropine penalization, treatment of older children, and residual amblyopia.

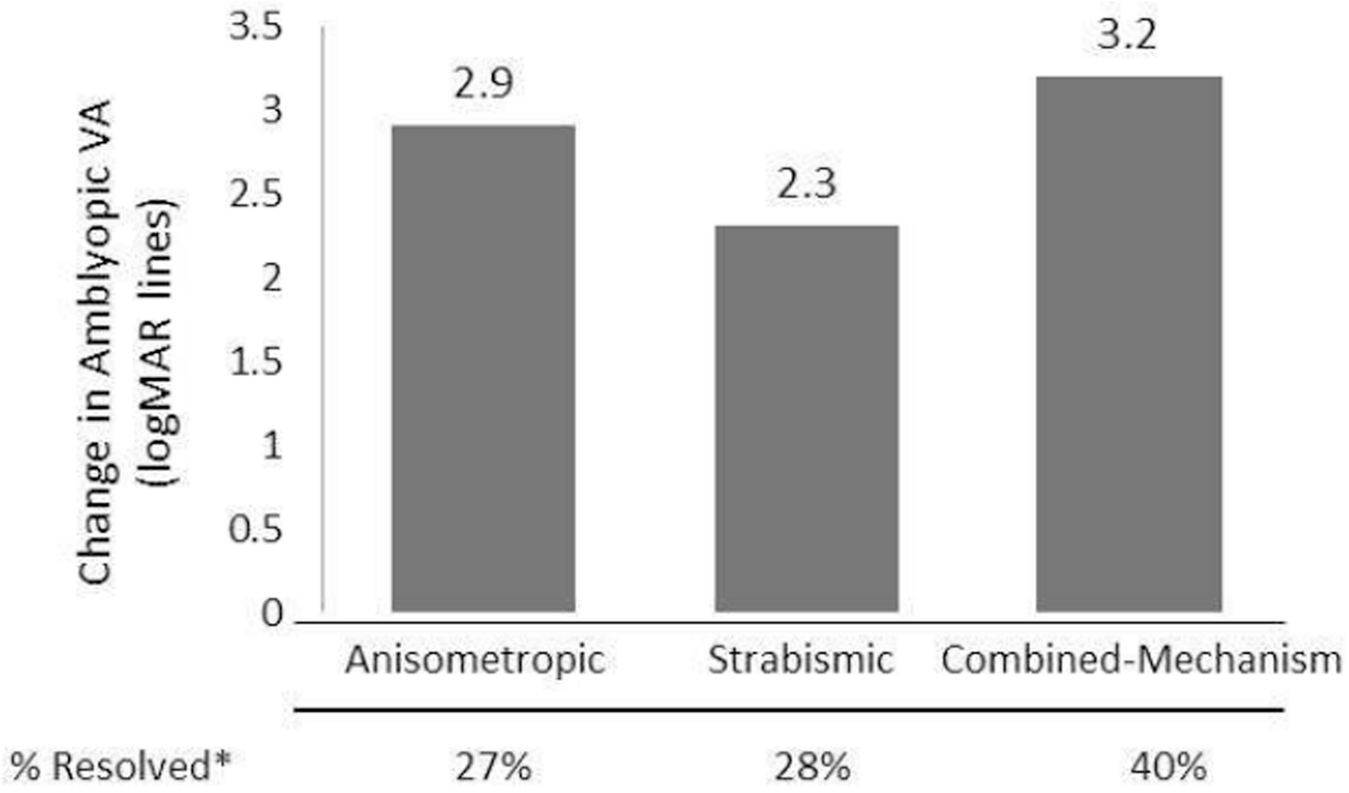
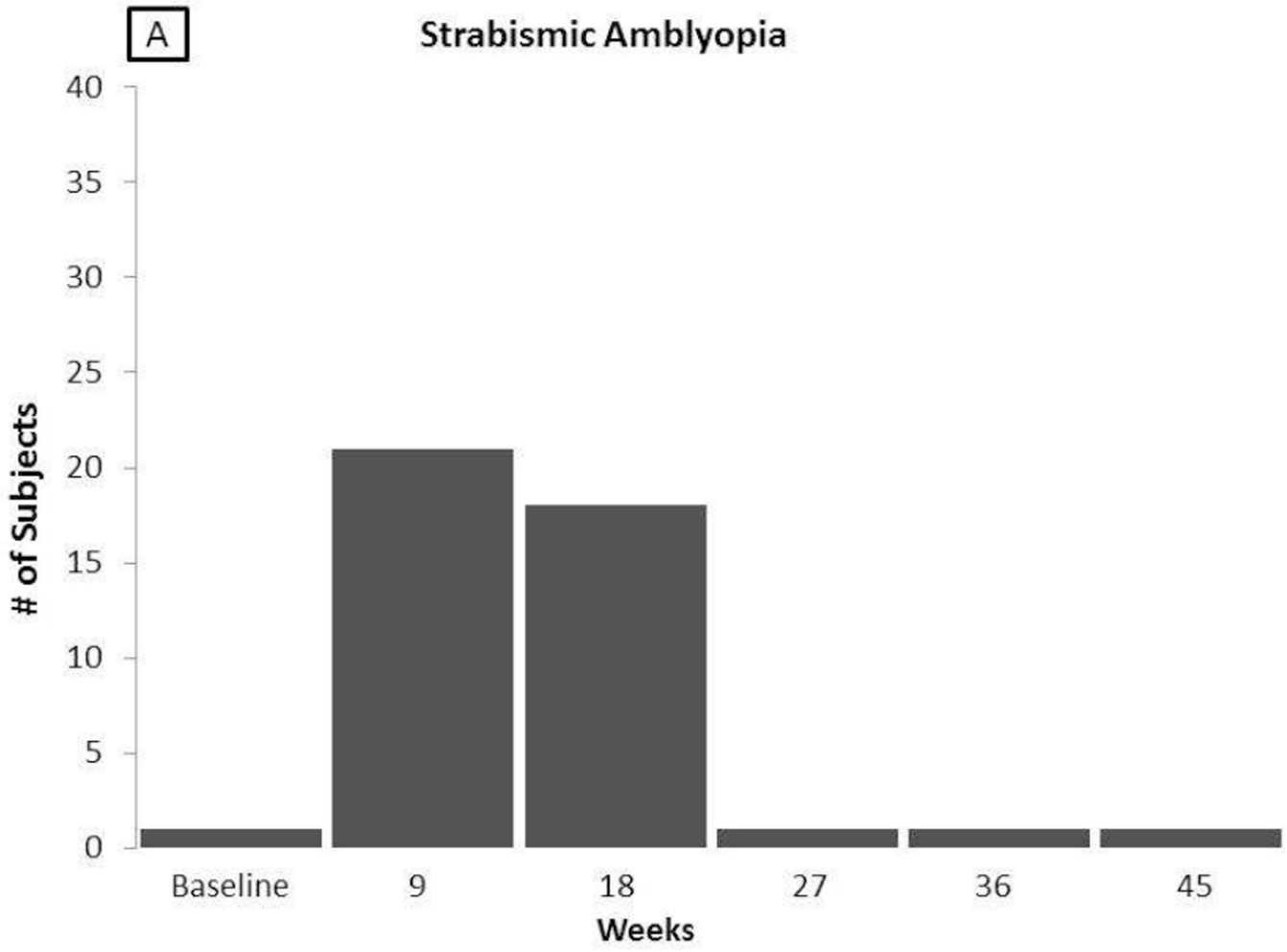


Figure 1.

Mean visual acuity improvement and proportion of children reaching resolution of amblyopia with refractive correction based on type of amblyopia.

* Resolved = amblyopic eye VA equal to or within 1 line of sound eye VA



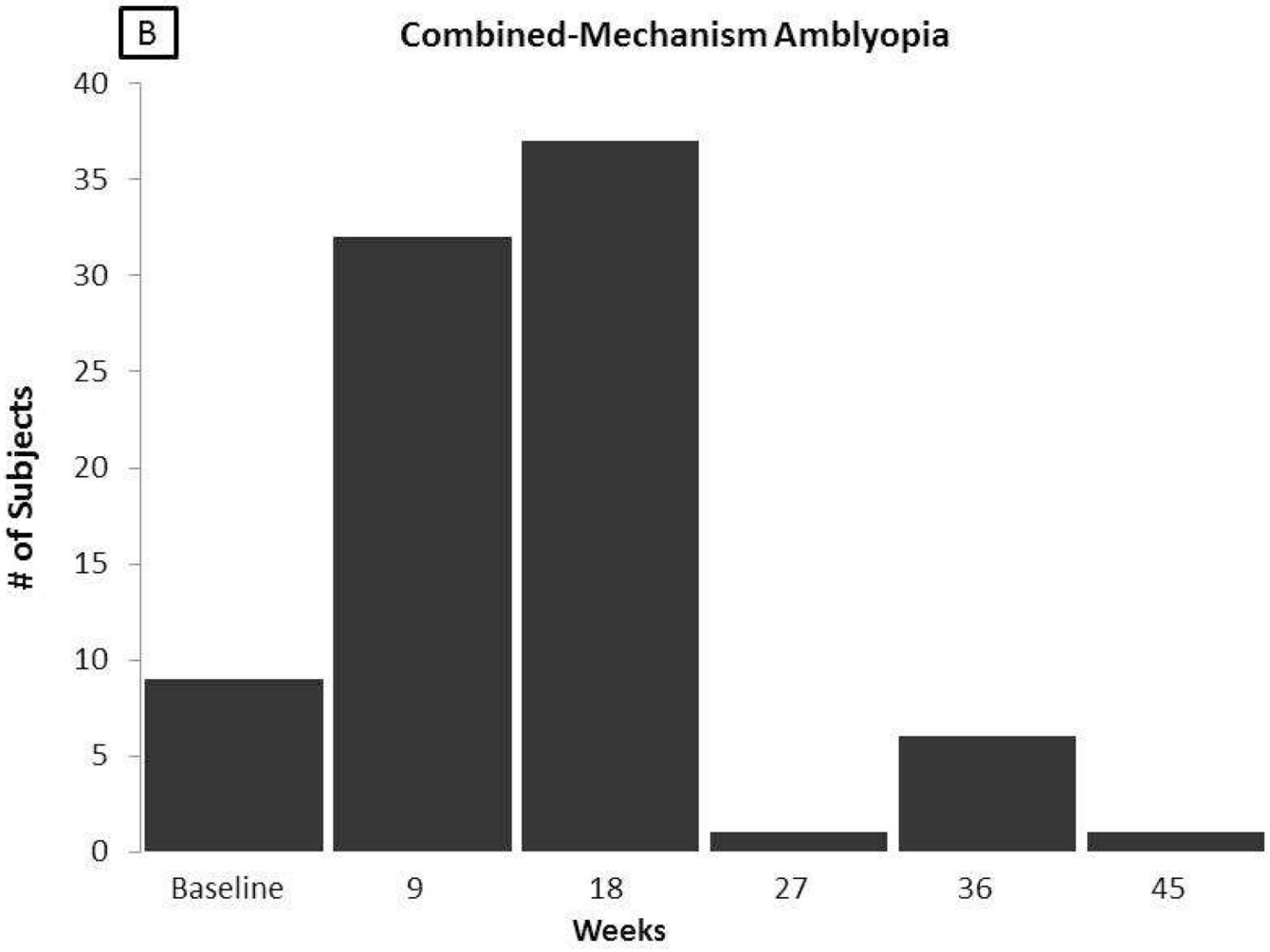


Figure 2.
Time course of maximum VA from optical treatment alone for children with strabismic amblyopia (A) and combined-mechanism amblyopia (B).

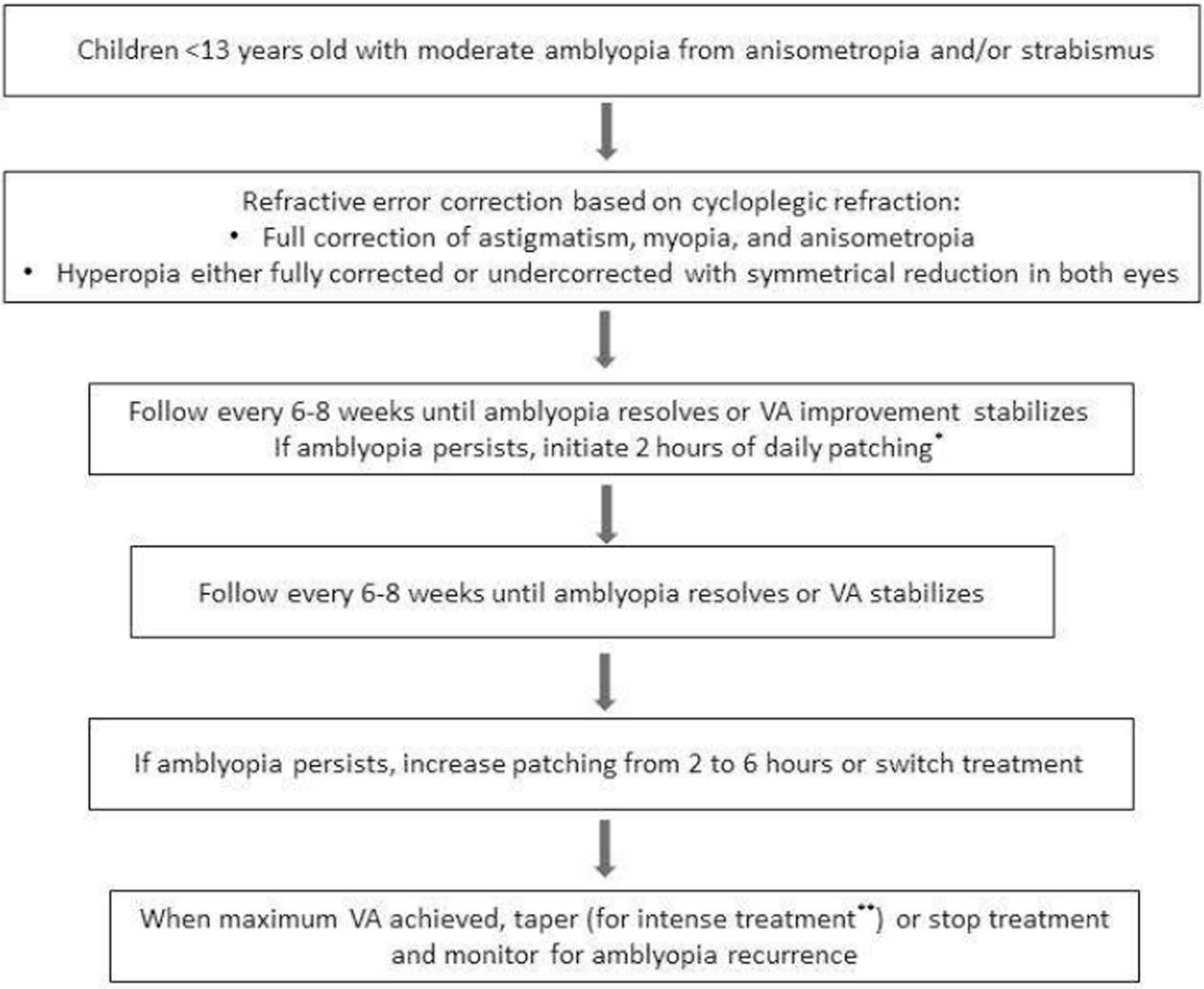


Figure 3.

Recommended evidence-based approach to treating moderate amblyopia in children <13 years of age.

*Alternative treatments include atropine penalization of the sound eye 2 times per week or full-time wear of a Bangerter filter over the sound eye.

**Intense treatment is ≥ 6 hours of daily patching

Table 1

Mean visual acuity (VA) improvement by prescribed treatment in moderate and severe amblyopia in 3 to <7 years in old children.

Depth of Amblyopia	Prescribed Treatment	Mean VA Improvement[a] (logMAR lines)	Post-Treatment Mean VA	≥ 2 Lines of Improvement from Baseline (%)
Moderate Amblyopia	2 hours patching	2.4	20/32	79
	6 hours patching	2.4	$20/32^{-1}$	76
Severe Amblyopia	6 hours patching	4.8	20/50	93
	Full-time patching	4.7	$20/50^{-2}$	85
Moderate Amblyopia	≥ 6 hours patching	3.16	20/30	87
	Daily atropine	2.84	$20/30^{-2}$	82

[a] At the primary outcome visit; does not indicate maximum improvement achieved

Table 2

Parent education regarding atropine penalization for the treatment amblyopia

Drop Administration	Administer in morning; if problematic, instill drop before child wakes
Sun Protection / Comfort	Wear brimmed hat and sunglasses when outside, particularly if sunny
Storage	Store securely out of reach of children
Systemic Reaction	Discontinue and call if facial flushing, fever, dry mouth, irritability, or confusion
Other Health Care Visits	Inform of atropine use at office visits, particularly if at emergency room

Table 3

Amblyopia treatment approaches: Historical versus current evidence-based approach

	Historical Dogma	**Current Perspective**
The mainstay of amblyopia treatment	Patching	Optimal refractive correction
Timing of refractive correction and occlusion (patching or atropine)	Simultaneous	Occlusion prescribed subsequent to gains from optical treatment effect
Patching dosage for moderate amblyopia	Generally, the more the better; usually ≥ 5–6 hours	Start with 2 hours; can increase dosage if needed
Patching dosage for severe amblyopia	Full-time or most waking hours	Start with 6 hours; 2 hours is effective in some cases
Atropine penalization use	Patching failures only	First-line treatment as alternative to patching or for patching failures
Atropine penalization guidelines		
Amblyopia severity	Only for moderate amblyopia	Both moderate & severe cases
Age of child	Only in young children	Younger and older children
Age after which amblyopia can no longer be treated	Approximately 6–9 years of age	Upper age limit not established; albeit generally greater VA gains if <7 years of age
Recurrence of amblyopia after treatment cessation in 9 to <13-year-old children	High likelihood of regression	Vast majority (>90%) do not regress

7-9 / OTHER MATTERS

7. List of Acronyms

8. Dates of Upcoming Council Meetings:
   a. Friday, December 10, 2021
   b. Friday, January 21, 2022
   c. Friday, March 25, 2022
   d. Friday, June 24, 2022
   e. Friday, September 16, 2022
   f. Friday, December 9, 2022

9. Adjournment

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
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)
CJO	Canadian Journal of Optometry	Journal published by CAO whose mandate is to help optometrists build and manage a successful practice

List of Acronyms Used by the College of Optometrists of Ontario

Acronym	Name	Description
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
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*
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

List of Acronyms Used by the College of Optometrists of Ontario

Acronym	Name	Description
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	Comprises of the 26 health regulatory colleges in 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
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
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

List of Acronyms Used by the College of Optometrists of Ontario

Acronym	Name	Description
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
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 the interests of medical practitioners

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Acronym	Name	Description
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
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

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Acronym	Name	Description
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

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