



Regional Implementation Roundtable Report April 2014

The Roadmap to Close the Gap for Vision

Indigenous Eye Health Unit

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1. Summary

On 13 March 2014, the Indigenous Eye Health Unit hosted a Roundtable that brought together 63 stakeholders from seven jurisdictions and a range of organisations across Australia, to share experiences and gauge lessons learned from regional efforts to close the gap for vision. A pre-Roundtable survey was conducted to profile the current status of regional implementation across the country.

A regional approach to close the gap is currently identified in nine geographic areas of Australia, each of which is at a different stage of implementation. Despite local contextual differences, a number of common issues were identified across the regions. These included:

- difficulties with obtaining, analysing and sharing local data to conduct gap analyses
- data access and quality concerns
- issues with establishing functional regional collaborative networks
- human and financial resource constraints.

A number of suggestions for the ways forward were consistently identified, including:

- that there needs to be an agreed and shared understanding of what data are required and what they will be used for
- that specifically assigning an appropriately skilled individual or organisation within a region the task of data compilation and analysis is necessary
- that fostering regional collaborations and building trust is integral
- that service directories should be prepared for regions and integrated with existing resources and existing communication pathways wherever possible
- that local, jurisdictional and national commitment and support are required, with clear communication regarding information and purposes
- that there is an imperative to engage with community and need to develop and support Indigenous leadership capacity.

Following consideration of the issues raised at the Roundtable, a number of specific recommendations for action are proposed. These include:

- that the existing suite of regional implementation tools are expanded and refined and that further resources are developed, including a list of data elements required to calculate regional gaps; a services gap calculator; and a regional implementation 'how to' guide
- that the data elements for collection and sharing at a regional level need to be agreed on and be consistent across the country, to enable local, jurisdictional and national aggregation
- that when the required data elements are agreed, there is a need to continue work with the medical software industry to ensure that these data elements can be readily collected and extracted
- that discussions are held with national agencies and relevant data custodians regarding data access protocols, for example Medicare data
- that regions consider appointing a designated project officer, tasked with establishing collaborative networks and co-ordinating the regional implementation approach
- that a service directory and referral protocol template is developed
- that the Indigenous Eye Health Unit offer to conduct ongoing regional implementation meetings

- that opportunities for development of Indigenous leadership are sought and supported
- that the national oversight policy paper, which seeks establishment of a national governance and accountability mechanism for the Roadmap, is further developed and endorsed by the sector.

Overall, participants reported that the Roundtable was a most successful event, with the presentations, opportunities for networking and discussions that allowed sharing of experiences noted as highly useful activities. Participants generally indicated that following participation in the Roundtable, they felt better equipped to varying extents to advance a regional approach to Indigenous eye care.

This Roundtable forum has highlighted both the shared experiences and the importance of local contextual considerations in advancing the regional implementation approach. Further, the goodwill, achievements and hard work of those engaged in regional implementation are evident. The way forward is clear. Together, with concerted effort, commitment, communication and a strong shared vision for an equitable eye health system, we can close the gap and eliminate Indigenous disparities in eye health.

2. Background

The *Roadmap to Close the Gap for Vision* (2012) identifies a set of 42 interlocking recommendations that collectively seek to identify and address systemic barriers to accessing and utilising eye care services by Indigenous Australians, improve awareness of eye health and preventive measures among both patients and providers, improve health system and case co-ordination, reorient health services to meet the cultural and linguistic needs of Indigenous Australians, and establish regional, jurisdictional and national oversight of these processes. Regional implementation of these multi-pronged recommendations requires a collaborative, multidisciplinary and whole-of-system approach, which may be facilitated at a regional level by the adoption of seven key steps:

1. Define region and population and identify regional hub
2. Gap and needs analysis for service requirements
3. Establish regional collaboration network
4. Develop regional service directory and referral protocols
5. Identify co-ordination and case management staff roles
6. Establish regional data collection and monitoring system
7. Ensure regional accountability and oversight

Regional activity consistent with this Roadmap approach has been identified in nine geographic regions of Australia that span 5 jurisdictions and together encompass over 27% of Australia's Indigenous population. Each of these regions is at a different stage of implementation, and although there are shared experiences and challenges, each region's local context also generates a number of unique considerations.

To share experiences, glean lessons learned, and further inform the rollout of regional implementation elsewhere across the country, representatives from a range of organisations and stakeholder groups active in each of the nine regions were invited to participate in a

Roundtable forum hosted by the Indigenous Eye Health Unit. Representatives of national agencies and peak organisations were also invited. Prior to the Roundtable, all invitees (or their organisational delegates) were asked to complete a questionnaire which was intended to provide background information about how far advanced each region is in regional implementation, identify key issues and inform the Roundtable discussion. This was also an avenue to allow those who could not attend on the day to provide input and insights.

This report presents a brief summary of key issues from the pre-Roundtable survey and the Roundtable, lessons learned from regional implementation across the country, action areas identified and visions for the way forward.

3. Roundtable objectives and goals

- To share experiences in regional implementation of the Roadmap in the nine regions and glean lessons learned
- To prompt consideration of how to overcome the commonly encountered barriers in regional implementation
- To identify priority areas for future action
- To facilitate networking between stakeholders within and between regions
- To inspire participants with a renewed sense of enthusiasm and showcase their regional engagement in a nationwide initiative
- To empower participants with knowledge and networks required to adopt and advance a regional approach.

4. Participants

4.1 Pre-roundtable survey respondents

In total, 50 responses were received from the approximately 101 individuals that were invited to participate in the survey or to assign an organisational delegate to participate in lieu. Respondents represented a range of organisations spanning clinical, government and non-government sectors (Fig 1). Affiliations of the five respondents who identified as representing 'Other' organisations comprised two peak bodies, a state affiliate, a university and a national organisation.

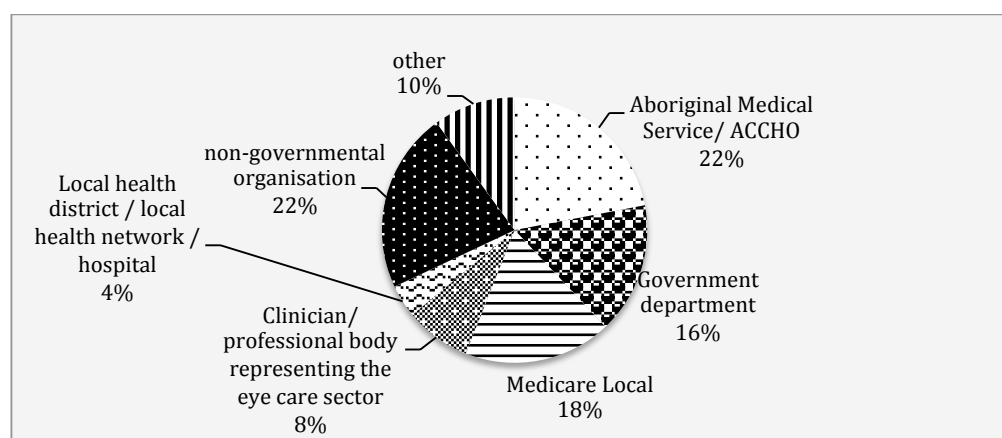


Fig. 1: Organisational affiliation of questionnaire respondents

Responses were received from representatives of all jurisdictions in which regional implementation is occurring and from stakeholders working at the national level (Fig. 2).

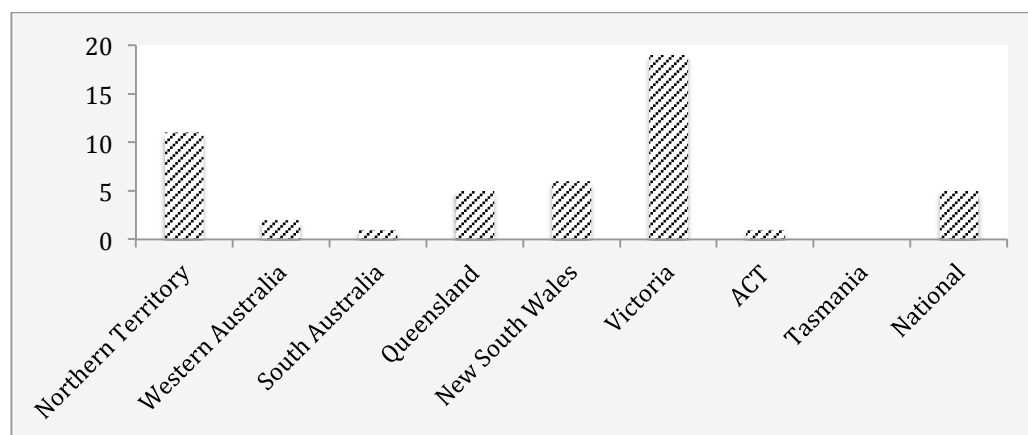


Fig. 2: Jurisdictions in which respondents primarily work

4.2 Roundtable participants

In total, 63 participants representing 32 organisations and seven jurisdictions participated in the Roundtable forum. A full list of participants is attached as Appendix 1.

5. Profile of the current status of regional implementation across the country

This section presents information gleaned from the pre-Roundtable survey regarding the current status of regional implementation.

5.1 Progress in regional implementation

Information regarding the regional implementation steps that currently exist or are being adopted regionally was provided by 34 respondents (Fig. 3). Overall, Step 1 (*define region and population and identify regional hub*) was the most commonly identified regional implementation activity (82%, n=27). The least cited implementation step was '*identify co-ordination and case management staff roles*' (41%, n=13).

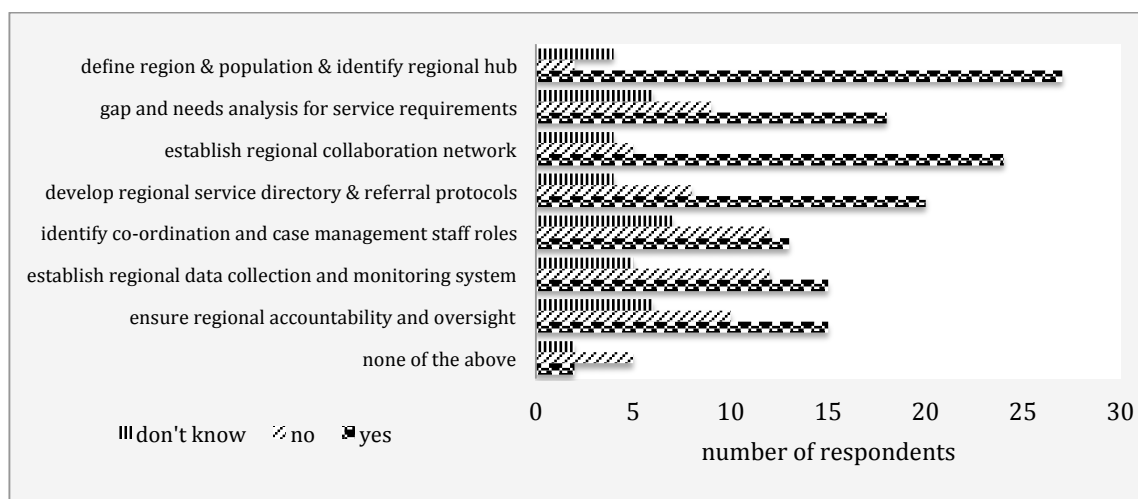


Fig. 3: Responses to the question 'In your geographic area, do you think that any of the following steps for regional implementation currently exist or are being adopted?'

Four respondents (representing three jurisdictions and the government and non-government sectors) indicated that all seven steps of regional implementation existed or were being adopted in their region, although some advised that several steps were only partially implemented.

A small number of respondents indicated that they did not believe any of the seven steps were in place in their region. Existing practice was described as fragmented due to the public/private split and lack of communication both between providers and between elements of the health system. Elsewhere, existing services were described as being Indigenous-specific services delivered through a health service and outreach visits; it was also reported that Indigenous utilisation of mainstream services could not be accurately ascertained as Indigenous identification in mainstream services was not clear.

Acknowledging that jurisdictions may comprise several different regions that may well be at different stages, it is of note that perceptions of progress and steps achieved within the same jurisdiction varied markedly in some instances. Variation in implementation across jurisdictions was also noted by representatives of national organisations.

5.2 Status of regional collaborative networks

Approximately two-thirds of respondents who answered the question about collaborative networks indicated that these exist in their area (62%, n=23). A range of existing organisations/structures/fora can be identified as regional collaborative networks. The networks may differ within and between jurisdictions both in structure and function. Additionally, some have eye health identified as a priority and others do not.

A range of stakeholders were identified as being involved in these collaborative networks (Fig 4). Additional stakeholders that were identified included:

- low vision agency
- private practice
- spectacle suppliers (e.g. subsidised scheme & low cost spectacle scheme)
- medical workforce agency

- state health department Indigenous health units
- community health organisations
- welfare organisations
- nursing agency
- mental health

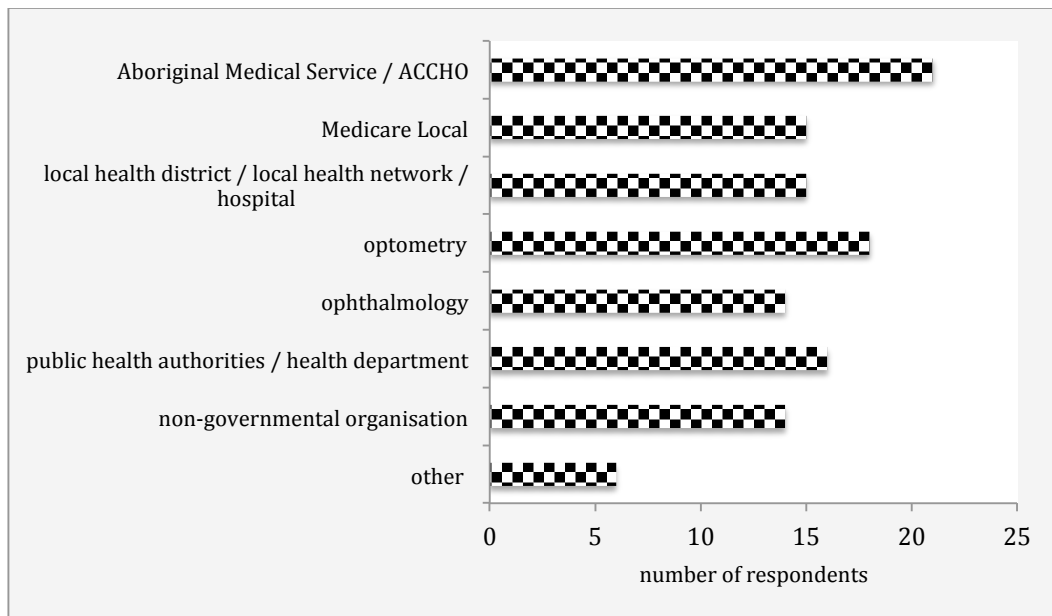


Fig. 4: Stakeholders identified as being involved in regional collaborative networks

26 respondents identified other existing fora/committees/partnerships or other existing structures as potential avenues to facilitate Indigenous eye care planning. These included:

- Closing the Gap partnerships
- universities
- regional or jurisdictional eye health advisory groups (e.g. Central Australia Barkly Eye Health Operational Group (CABEHOG), Northern Territory; Koolin Balit Aboriginal Eye Health Advisory Group, Victoria)
- non-governmental organisations and co-ordinating bodies such as Lions Outback Vision and the Indigenous and Remote Eye Health Service (IRIS)
- primary care partnerships
- Aboriginal and Torres Strait Islander health forums and committees
- regional co-ordination meetings between Aboriginal Community Controlled Health Organisations and Aboriginal partnership network
- Medicare Locals
- regional and state co-ordinators liaising with commercial and non-commercial service providers
- other partnership mechanisms such as The Queen Elizabeth Diamond Jubilee Trust Partnerships

Concern was expressed regarding existing service structures being threatened by new arrangements, especially where program ownership was not shared by stakeholders.

5.3 Regional data sharing

Several examples of effective data sharing between stakeholders were provided, with many respondents noting that further work was still required or in progress to upgrade and/or further formalise processes. In one region it was noted that data sharing did not occur passively but rather required a person to co-ordinate the process.

5.4 Regional service directories

The majority of respondents indicated that a regional directory would be useful (Fig. 5).

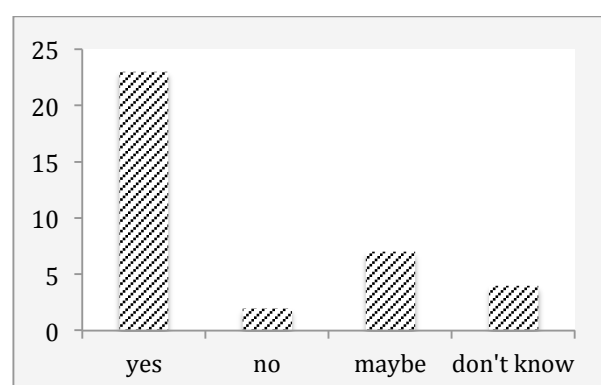


Fig. 5: Responses to the question ‘Do you think that the development of a regional service directory would be of value to you?’

5.5. Suggestions for ways in which the Indigenous Eye Health Unit can facilitate regional efforts to close the gap

Numerous suggestions were received regarding ways in which the Indigenous Eye Health Unit could assist regions to close the gap for vision. Key activity areas included:

- advocacy for funding
- dissemination of information to the community and regions
- dissemination of information to the eye care sector
- provision of technical input
- collaboration on research and service development projects
- assistance with establishing networks and encouraging consultation/ collaboration
- supporting governance mechanisms and supporting a national body tasked with overseeing that required processes are put in place

6. Regional implementation: key lessons learned

This section summarises key insights from the pre-Roundtable survey and the Roundtable presentations and discussions. The Roundtable agenda is provided as Appendix 2 and copies of the presentations as Appendix 3.

6.1 Gaps and needs analysis

The Katherine region of the Northern Territory was presented as a sample area where the gap and needs analysis step has been conducted and this information has been subsequently used as a basis for planning and advocating for additional support and services.

Population needs data can be readily estimated using the IEHU calculator. Comparison with existing service delivery data is required to define service gaps and estimate needs.

Key discussion insights

Much current service data are available, although accessibility varies within and between jurisdictions. Data identified as being available included:

- Visiting Optometrists Scheme (VOS) and Rural Health Outreach Fund (RHOF) services
- spectacle schemes
- hospital data
- number of Indigenous patients with diabetes attending a General Practice clinic
- national key performance indicators

Data from Medicare and private practitioners were identified as being more difficult to access. While some data are available at an aggregated level, granular (including regional) data are difficult to access. Service delivery data exist at a local level – other potential data sources include regional authorities such as local hospital districts and Medicare Locals, and jurisdictional health departments.

The personally controlled electronic health record was noted as a potentially useful resource but limited uptake at this stage limits utility for population-level monitoring.

Some health facilities / organisations have only just started looking into eye health and as such the nature and scope of available data have not yet been established. Even in settings where data sharing was occurring, the patchy nature of available eye health data was noted. Additionally, in some circumstances there was discrepancy between data reported and local experience (e.g. waiting times).

Barriers to undertaking gap and needs analysis include:

- data quality
 - lack of Indigenous identification in data sources
 - inconsistent data coding
 - inconsistent recording and reporting of eye services provided by different service providers
- data access
 - difficulties with interrogating eye health data from information systems, both electronic systems and in settings where paper-based records are used
 - different electronic systems i.e. databases and patient management software in use
- regional data management
 - engagement with the various data custodians and issues of data sharing

- data use and data analysis
- fragmentation of data, issues with data co-ordination; linkage of existing data sources to understand complete cycle of care
- lack of leadership to co-ordinate this process and issues of responsibility for undertaking this process
- difficulties with estimating workforce requirements

Suggested actions that may make obtaining the required data easier:

- highlight the benefits of data sharing and facilitate an understanding of why these data are required
- foster partnerships, which requires that issues of trust and relationship-building are addressed
- consider incentives to set up the necessary systems
- identify solutions to data integration issues
- resolve data management issues associated with transient and highly mobile staff such as missing data due to data not being entered into local repositories, or double counting
- presence of Indigenous identifiers on Medicare cards
- address issues around Indigenous identification and reasons underlying under-identification, create outwardly safe environments – staff need to have cultural skills to understand why the data are being collected
- secure funding to upgrade data systems/technology
- establish protocols for data sharing, confidentiality and high level agreements
- need to listen to community need about required data

Consideration needs to be given to the human resource requirements to undertake gap and needs analyses, and in particular identifying who will do the work, who will lead this process, what kind of background and qualifications are required and how these personnel may be supported to do this work. It was suggested that medical students and other trainees undertaking research could be usefully engaged in this process. A key factor is the need to identify someone charged with the task of assembling the information available.

Recommendations/actions:

- Existing resources to facilitate gap and needs analyses are to be further refined and additional tools developed. These include
 - an explicit list of data elements that each region needs to collect in order to undertake gap and needs analysis
 - list of possible data sources for each region to consider accessing
 - the online calculator to be further developed to comprise a step-by-step function that enables calculation of all required elements for the gap and needs analysis
- IEHU to consider offering to hold meetings to facilitate gap and needs analyses in regions/jurisdictions, to help guide regions through this process
- IEHU to provide information around successful regional data collection and effective models

6.2 Regional collaboration networks

Two different models of collaborative networks were presented. The Victorian model demonstrated the value of a state committee, which exists as an additional structure overarching the regional collaboration networks. The Central Australia Barkly model demonstrated the importance of identifying a driver within a region to assemble the collaboration network, and presented the important lesson that establishing the network was a first step but this does not necessarily assure an efficient implementation approach.

A Medicare Local perspective highlighted the importance of trust in establishing collaborative networks, and the need for the development of shared goals.

Key discussion insights

Several good examples of effective regional collaborative networks in eye health and in the broader health arena were identified. These included the Institute for Urban Indigenous Health in South East Queensland, the Central Australia Barkly regional network and other collaborations throughout the Northern Territory, the Campaspe Aboriginal-led initiative in the Loddon Mallee, efforts surrounding trachoma, and an initiative for co-ordination of oral health services in Far West NSW.

Recommendations/actions:

- Ongoing work is required at the jurisdiction level to support establishment of state/territory-wide groups for Indigenous eye health
- Opportunities to work with NACCHO to develop Indigenous involvement and leadership in eye health are to be sought and supported
- Regional meetings to facilitate establishment of local networks to be arranged
- IEHU to engage with NACCHO to undertake an environmental scan to identify any case studies of successful Indigenous-led collaborations

6.3 Regional data collection

A presentation from the Queensland perspective highlighted the importance of regional data mapping exercises to identify data sources and utilise these data to profile the eye health status and service gaps in a region. Such an exercise is necessary to guide health service planning and allow monitoring of progress over time.

Key discussion insights

Factors that may facilitate regional data **collection**:

- agreement and communication about what data are important; what each data element will be used for; how these data will feed in to a process to improve patient outcomes
- scoping of what data are available

- development of nationally agreed data elements and data standards, to facilitate cross-regional communication and national aggregation. It was suggested that a nationally consistent data system that can be integrated locally is required
- consideration of utility of identifiable vs. de-identified data – patients who access multiple services may be counted twice so having identifiable data would enable de-duplication of a data set.

Factors that may facilitate regional data **sharing**:

- regional and jurisdictional health department support, commitment, trust and goodwill. Consultation with stakeholders. Need to resolve issues of sensitivities regarding data and the concerns about potential for data to be used in an adverse way
- formal agreements: formal data access and data sharing protocols and memorandums of understanding
- resolving issues of data access (e.g. to Medicare data) and issues surrounding data linkage and privacy
- improved data integration and interoperability between IT systems and between public and private practitioners
- resolving issues of patient file integration e.g. for when patients move between jurisdictions or regions
- co-ordination: it was suggested that there is a need for a lead agency to co-ordinate the data and act as a support agency
- a concerted push from the sector to access specific Medicare data may be useful. This may also prevent multiple requests from various stakeholders being submitted to the same data custodian
- consider and resolve the issues of human resources and capacity to collect and analyse data, which is a particular challenge in the busy service provision setting
- suggestion that it would be useful to set up a state or Commonwealth database which is fed to a national register and accessible to all stakeholders to enable identification of regional needs.

The proposed data elements are outlined in Appendix 4. These are all quantitative and it was suggested that additional data elements are required as the existing proposed suite of measures do not capture information on patients who drop out of the system and workforce required to support service delivery. Qualitative data and data on follow up (e.g. post-op reviews, number of spectacles collected [cf number of spectacles prescribed]) are also required. There is also no measure of co-ordination or health promotion activities. Obtaining data from the new national health survey that currently may not include eye health would be useful.

There was a perception that data sharing is also limited by different software systems and by the fact that different data elements are being collected (information silos). It should be noted that data sharing does not require data linkage, individual patient identification or the same information technology systems to be in use across settings or for the systems to communicate with one another. Rather, it requires that each stakeholder group be aware of the required data elements and their intended use, collect the data elements, extract the data elements and come to the table with a summary report to share with the regional collaborative network. Each stakeholder group within a region will contribute different data to the regional data collection. For example, the data elements from primary care will differ from those collected by hospital services. Combined, these data from the various regional

stakeholders can be used to profile the eye health burden, service needs and gaps in a region.

Key practical point: It is likely that there are some limitations in existing data in most regions. These need to be acknowledged but should not preclude activity in this space. As the data improve, the profile of regional activity can be further refined.

Recommendations/actions:

- There is a need to engage with national agencies, including Medicare data custodians, to explore options for data collection and analysis, and to consider issues of data release protocols
- IEHU to lead a data mapping exercise to identify what data are available and where these data sources are held
- Need to agree on required data elements
- When agreed data elements are established, local software structures to be refined to enable extraction of these data elements
- Given the identified lack of capacity to analyse data, engagement with local universities within regions may be of use
- IEHU to develop a simple monitoring tool template to aggregate/ present serial data to gauge regional progress over time

6.4 Service directories

Service directories are proposed as resources that will contain details of eye care services and visiting and resident eye care providers in a given region. Referral protocols are the agreed allocation of roles and responsibilities across the full pathway of eye care, incorporating patient support and identification of eye problems, monitoring, treatment and follow up of patients.

A presentation from NSW provided details on a service directory that currently exists in draft for a part of NSW. It currently includes details about roles, definitions of responsibilities, contact details and communities being serviced. It is not restricted to bulk-billed services, nor can it be assumed that all providers/ centres listed in the directory will bulk bill.

The Australian College of Optometry perspective emphasised the central role of good referral pathways and protocols in improving clinic attendance rates and reducing avoidable vision loss. Challenges in establishing referral protocols were discussed and the components of a good referral protocol system outlined.

Key discussion insights

- It is important to integrate with existing resources and health pathways/communication avenues when developing local directories.
- Structures to establish service directories are already in place in some areas but are not being utilised.
- In some rural/remote areas where follow up of patients is potentially problematic due to distance, it is useful to have a list of people in the community who can provide patient follow up.
- Costs associated with establishing a directory and funds available to do so need to be considered.
- The need to seek input of the end-users of a directory was flagged, with regard to local utility of such a resource and where it might best sit. Using directories to clarify referral pathways was considered a potential useful application of a directory.
- Keeping a directory up to date was noted as an issue and particularly pertinent in settings where there is a transient workforce – this turnover not only renders a directory quickly out of date but also means that many people might not be aware of, let alone use, a directory.

Recommendations / actions:

- NSW draft directory to be circulated to participants as an example
- An agency to be identified to develop a service directory and referral protocol template. This will serve as a guide for regions to develop their own service directories in due course.

6.5 Co-ordination and case management

A presentation from the Australian Medicare Local Alliance (AMLA) highlighted some of the Commonwealth funded initiatives available to support regional service co-ordination and case management approaches.

Key discussion insights

Potential resources to support co-ordination and case management include community liaison officers, primary health clinic co-ordinators and use of telehealth. Co-ordination is often restricted by different funding models and by limited funding. There are considerable issues of capacity. For example, many Aboriginal Medical Services do not have the necessary funding but do need to prioritise the management of eye health and require a dedicated person to take on this role. It was suggested that an ideal scenario for effective co-ordination would be to have a model with a state/territory co-ordinator and co-ordinators also based in each region.

Effective co-ordination may be defined by integrated service delivery data and by mapping of patient journeys/pathways.

In general it was noted that there was some confusion about the difference between co-ordination, which is intended to refer to the systems level co-ordination, and case management, which occurs at the individual patient level. Definitions of these and other terms commonly used to describe the regional implementation approach can be found in the Roadmap to Close the Gap for Vision glossary, attached as Appendix 5.

Recommendations/actions:

- Change terminology to clarify that this step of regional implementation refers to *system* co-ordination and *patient* case management
- IEHU to provide information to regions around opportunities to develop and utilise existing and available resources and support

6.6 National oversight

The national oversight policy paper was presented for consideration by participants. There was discussion that national oversight also needs to be developed from the grassroots and concern that the term 'oversight' implies a top-down approach. The accountability mechanisms inherent in the document were discussed and the direction of accountability explored.

The majority of participants supported the need for national oversight.

Recommendations/actions:

- IEHU to circulate the national oversight policy paper to Roundtable participants for input. Feedback to be submitted to the IEHU within a two-week period and document to be revised thereafter.
- The definition of accountability in the document to be revised

The revised national oversight paper is attached as Appendix 6.

7. Post session evaluation highlights

Overall, 26 Roundtable participants completed the post-session evaluation. All indicated that they felt to some extent that they could apply the information discussed at the Roundtable to their work and that they felt more able to advance a regional approach to Indigenous eye care. The formal presentations, group discussions, opportunities to network and learn about others experiences were all identified as useful.

Respondents indicated that they would consider participating in a similar Roundtable in future, to share experiences and be updated on progress in other regions.

8. Overarching recommendations

- It is recommended that establishing regional collaborative networks needs to occur as the next step in regional implementation once a region has been defined. The steps of regional implementation are to be re-ordered, such that '*establish a regional collaborative network*' is step 2. This is because establishing a regional collaborative network is necessary before data sharing and gap and needs analyses can be comprehensively undertaken.
- The steps for regional implementation are to be further refined and additional step-by-step details required to be undertaken to achieve each step provided (i.e. development of a 'how to' guide using the existing checklist as the basis for this document).
- Regional implementation meetings, hosted by IEHU, to be conducted in regions to provide additional guidance and technical support in the form of a how-to, step by step seminar.
- Regions to consider appointing a person as a designated project officer to support and progress regional implementation.
- Consider engaging local university departments of rural or public health to participate in the gap and needs analysis and in subsequent evaluations.
- The Roadmap glossary to be further developed to assist with communication and ensure a common language and consistency in use of terms.
- IEHU to develop mechanisms to enable tracking of progress in regions
- Sector to consider the process of document development and in particular the mechanisms for obtaining sector endorsement.

9. Acknowledgements

We wish to thank all those who participated in the Roundtable and the pre-Roundtable survey for their time and for sharing their experiences. The time and efforts of the volunteer scribes and Indigenous Eye Health Unit staff are gratefully acknowledged. We thank Professor Kerry Arabena for facilitating the day.

The Indigenous Eye Health Unit acknowledges funding support from the Australian Government Department of Health.

10. Appendices

- 1 List of Roundtable participants
- 2 Roundtable agenda
- 3 Roundtable presentations
- 4 List of proposed data elements
- 5 Roadmap to Close the Gap for Vision Glossary
- 6 National oversight policy paper v2
- 7 Sample service directory and referral pathway document

Appendix 1: List of Roundtable Participants

SURNAME	FIRST NAME	ORGANISATION
Abouzeid	Marian	Indigenous Eye Health Unit, The University of Melbourne
Ah Tong	Brandon	Vision 2020 Australia
Andrews	David	Royal Australian and New Zealand College of Ophthalmologists
Anjou	Mitchell	Indigenous Eye Health Unit, The University of Melbourne
Arabena	Kerry	The University of Melbourne
Atkinson	Daria	Loddon Mallee Murray Medicare Local
Atkinson	Josie	Indigenous Eye Health Unit, The University of Melbourne
Bacot-Kilpatrick	Jane	Australian Medicare Local Alliance
Barney	Kulan	Victorian Aboriginal Community Controlled Health Organisation
Barton	Joanna	Outback Eye Service
Boag	Melissa	Aboriginal Health Branch, Victorian Department of Health
Boudville	Andrea	Indigenous Eye Health Unit, The University of Melbourne
Briggs	Lisa	National Aboriginal Community Controlled Health Organisation
Browne	Samantha	Indigenous and Rural Health Division, Australian Department of Health
Cappuccio	Skye	Optometrists Association Australia
Cerie	Gary	Bullcreek Optometry
Crosbie	Christine	South Eastern Melbourne Medicare Local
Culpin	Desley	Aboriginal Health Council of South Australia
de Paoli	Heidi	Rural Workforce Agency, Victoria
Dunn	Elaine	Australian Medicare Local Alliance
Ellis	Rose	NSW Rural Doctors Network
Ferguson	Rachael	Indigenous Eye Health Unit, The University of Melbourne
Gersbeck	Jennifer	Vision 2020 Australia
Glenie	Kate	Loddon Mallee Region, Victorian Department of Health
Gray	Gemma	Barwon South Western Region, Victorian Department of Health
Gray	Michelle	Mallee District Aboriginal Services
Jackson	Jonathan	Australian College of Optometry
Jackson	Rod	Rural Workforce Agency, Victoria
Jones	Matt	Loddon Mallee Murray Medicare Local
Lange	Fiona	Indigenous Eye Health Unit, The University of Melbourne
Lim	Nicole	Fred Hollows Foundation
Lyons	Louise	Victorian Aboriginal Community Controlled Health Organisation
Martin	Aislinn	Royal Australian College of General Practitioners
Mills	Kay	Barwon South Western Region, Victorian Department of Health
Morse	Anna	Brien Holden Vision Institute
Napper	Genevieve	Australian College of Optometry
Noa	Rahera	Fred Hollows Foundation
O'Connor	Barbara	ATSICHC Brisbane
O'Donohue	Kelley	Institute of Urban Indigenous Health
O'Keefe	Maureen	Australian College of Optometry
Owen	Renee	Wathaurong Aboriginal Cooperative Health Service

Palmer	Samantha	Indigenous and Rural Health Division, Australian Department of Health
Penrose	Lisa	Institute of Urban Indigenous Health
Piccles	John	Bila Muuji Aboriginal Health Service
Quilty	Genevieve	Optometrists Association Australia
Ravesi	Michelle	Community Services, Monash Health
Santamaria	Linda	Ophthalmology Department, Monash Health
Shipp	Maurice	Indigenous Eye Health Unit, The University of Melbourne
Stanford	Emma	Indigenous Eye Health Unit, The University of Melbourne
Stewart	Allison	Northern Territory Medicare Local
Stracey	Mark	Aboriginal Health Branch, Victorian Department of Health
Suggit	Daniel	National Aboriginal Community Controlled Health Organisation
Taylor	Hugh	Indigenous Eye Health Unit, The University of Melbourne
Taylor	Meredeth	Indigenous and Rural Health Division, Australian Department of Health
Thornton	Angus	Fred Hollows Foundation
Waddell	Colina	Brien Holden Vision Institute
Wilkinson	Penny	Loddon Mallee Murray Medicare Local
Wilson	Heather	Central Australian Aboriginal Congress
Wright	Catherine	National Aboriginal Community Controlled Health Organisation
Wright	Helen	Lions Outback Vision
Young	Greg	South Eastern Melbourne Medicare Local

Appendix 2: Regional Implementation Roundtable agenda

Indigenous Eye Health Regional Implementation Roundtable

Thursday 13 March, 9.00 am – 4.45 pm

Melbourne Museum, Treetops, 11 Nicholson Street, Carlton



Agenda

8.30	Registration and pre Roundtable refreshments	
9.00	Welcome Acknowledgement of Country Introduction of attendees	Professor Kerry Arabena, The University of Melbourne
<u>Session 1</u>		
9.15	Roadmap - progress, regions, survey NACCHO perspective Commonwealth perspective	Professor Hugh Taylor, The University of Melbourne Lisa Briggs, National Aboriginal Community Controlled Health Organisation Samantha Palmer, Australian Department of Health
10.15	Morning Tea	
<u>Session 2</u>		
10.30	Gaps and needs analysis Discussion in table groups; feedback from tables	Nicole Lim, Fred Hollows Foundation
<u>Session 3</u>		
11.30	Regional collaboration network Panel presentations; whole group discussion	Mark Stracey, Department of Health, Victoria Matt Jones, Loddon Mallee Murray Medicare Local Angus Thornton, Fred Hollows Foundation
12.30	Lunch	
<u>Session 4</u>		
1.20	Regional data collection Discussion in table groups; feedback from tables	Kelley O'Donohue, Institute of Urban Indigenous Health
<u>Session 5</u>		
2.10	Service directory/referral protocols Panel presentations; whole group discussion	Colina Waddell, Brien Holden Vision Institute Dr Genevieve Napper, Australian College of Optometry
3.00	Afternoon Tea	
<u>Session 6</u>		
3.15	Coordination and case management Discussion in table groups; feedback from tables Monitoring, accountability and oversight Presentation; whole group discussion	Elaine Dunn, Australian Medicare Local Alliance Mitchell Anjou, The University of Melbourne
<u>Session 7</u>		
4.10	What do I plan to do now? Evaluation of Roundtable Summary of the day Closing remarks	Professor Kerry Arabena Professor Hugh Taylor
4.45	Post Roundtable refreshments	
6.00	Dinner (venue to be advised)	

IEHU contacts: Maurice Shipp 0419 134 018; Mitchell Anjou 0433 673 452

Appendix 3: Presentations



Roundtable Overview of
Discussion Questions

Thursday 13th March 2013
Melbourne Museum, Treetops

Twitter

#CTG4Vision



Session 2: Gaps and needs analysis

- The first of 7 steps for regional implementation
- Information is required for:
 - cataract operations
 - diabetes retinal exams
 - provision of spectacles
 - optometry days
 - ophthalmology days

Session 2: Gaps and needs analysis

Discussion Questions

1. What information is 'obtainable' in your region?
2. What information is harder to get and are there some ideas/solutions about getting the more difficult to get information?
3. What support could be provided to make getting the information easier?



Session 2: Gaps and needs analysis

Discussion Questions

1. What information is 'obtainable' in your region?
2. What information is harder to get and are there some ideas/solutions about getting the more difficult to get information?
3. What support could be provided to make getting the information easier?

Session 2: Gaps and needs analysis

Discussion Questions

1. What information is 'obtainable' in your region?
2. What information is harder to get and are there some ideas/solutions about getting the more difficult to get information?
3. What support could be provided to make getting the information easier?



Survey Results: Existing regional structures identified

Existing structures to facilitate Indigenous eye care service planning in your regions	Closing the Gap partnerships
	Universities
	Regional or jurisdictional eye health advisory groups
	NGOs and co-ordinating bodies
	Primary care partnerships
	Aboriginal and Torres Strait Islander health forums & committees
	Regional co-ordination meetings
	Medicare Locals
	Commercial and non-commercial service providers
	Other partnership mechanisms

Session 3: Regional Collaborative Networks

Discussion Questions

1. Are there regional examples of effective collaborative networks in other areas of health and or specifically for eye health?
2. Are there existing regional networks and how do we get eye care prioritised?
3. Who should be involved in a jurisdictional network?

Session 4: Regional Data Collection

Many issues and challenges identified with regional data collection



Session 4: Regional Data Collection

Discussion Questions:

1. What existing systems could be used to support regional eye care data collection?
2. Are the proposed required data elements appropriate?
3. What is required to support sharing of information within a region?
4. How can we get this work done in a region?

Session 5: Service Directories and Referral Protocols

Regional service directory

- These are proposed as resources that will contain details of eye care services and visiting and resident eye care providers in a given region.

Referral protocol

- The agreed allocation of roles and responsibilities across the full pathway of eye care. Incorporating patient support and identification of eye problems, monitoring, treatment and follow up of patients.

Survey Results: Regional Service Directories

Do you think that the development of a regional service directory would be of value to you?



Total of 36 responses to this item received

Session 5: Service Directories and Referral Protocols

Discussion Questions

1. What is a useful regional service directory?
2. How would a directory be maintained and where would it live?
3. What systems are currently used in regions to support referrals for eye care?
4. What information is required to better link between primary/secondary/hospital services?
5. What would a regionally agreed referral protocol look like?

Session 6A: Coordination and Case Management

- **Co-ordination** -the organising of services at a systems level, for instance co-ordinating visiting optometry services to visit an area prior to a scheduled ophthalmology visit. Distinct from case management, which describes co-ordination of care at the individual patient level.



Session 6A: Coordination and Case Management

- **Case management** - the process by which the pathway of an individual patient through the eye care system is co-ordinated and managed.
- E.g. patient, has complex eye care needs (e.g. due to diabetes, cataract)
 - assigned a co-ordinator / case manager to
 - helps navigate the eye care system
 - making appointments and ensuring attendance, arranging transportation etc.

Session 6A: Coordination and Case Management

Discussion Questions

- Where are the potential resources to support coordination and case management?
- How can effective coordination be defined and measured?



Session 6B: Monitoring, Accountability and Oversight

Discussion Questions

1. Does the group endorse the need for national oversight?
2. How can we modify/improve the proposal for national oversight?
3. How do we progress the advocacy for national oversight?

Session 7: Summary and Evaluation

Reminder:

Please complete Roundtable Evaluation Questionnaire



Contacts

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Roundtable

Regional Implementation Lessons Learnt

13th March 2014

Hugh R Taylor AC
Harold Mitchell Chair of Indigenous Eye Health
Melbourne School of Population and Global Health



Established in 2008
Now has 11 staff

Ultimate Aim;
To Close the Gap for Vision

1. Define to scope of the problem
2. Characterise current service models
3. Develop recommendations for sustainable, cost-effective eye care services

...but also Fast Track Trachoma



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Vision Loss in Children

One fifth as common as in mainstream

Vision Loss in Adults

Blindness is 6 times more common
Low Vision is nearly 3 times more common

Causes of Blindness in Adults

32% Cataract
14% Refractive Error, and Optic Atrophy
9% Trachoma and Diabetic Eye Disease

Overall 94% of Vision Impairment is avoidable
...and 35% have never had an eye exam

Roadmap Summary

Roadmap is a comprehensive set of 42 interlocked recommendations

Efficiency increases tremendously with increased funding
cataract x7, diabetes x5, glasses x2.5

This will Close the Gap for Vision and provide a template for other specialist services

The Challenge now is to have the Roadmap implemented

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We know what we need to do...

Trachoma		Implement the SAFE Strategy
Cataract		- If VA is <6/12 or impaired function refer for assessment - Ensure provision of surgery
Diabetes		- Retinal assessment for those with diabetes (every 12 months) - Ensure provision of laser treatment
Refractive Error		- Screening for VA (near and distance vision) refer to optometrist - Ensure provision of spectacles

Number of Blind and Visually Impaired Indigenous Australians

2010

15,000

- No coherent plans

- Incomplete programs

- Status quo

2030

30,000

2,000

- Commitment and leadership

- Roadmap fully implemented

- Coherent, sustainable

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The Patient Journey is like a Leaky Pipe



Vision loss is not less in urban and regional areas...

Crude Prevalence rates of Vision Loss in Indigenous Australians

State	Children		Adults		Regions	Children		Adults	
	Low Vision	Blindness	Low Vision	Blindness		Low Vision	Blindness	Low Vision	Blindness
NSW	3.3%	0.4%	5.7%	7.4%	Major City	4.5%	0.8%	7.7%	7.6
NT	0.8%	0%	9.1%	3%	Inner Regional	2.9%	0%	7.8%	2.4
QLD	0.9%	0.3%	11.6%	0.4%	Outer Regional	1.5%	0%	6.6%	0.6
SA	0%	0%	9.3%	1.6%	Proximal	0.9%	0%	10.2%	3.8
TAS	0%	0%	4.7%	0%	Very Remote Coastal	1.1%	0.3%	9.3%	1.1
VIC	0%	0%	8.9%	6.9%	Very Remote Inland	0.3%	0.3%	12.7%	3.8
WA	1.9%	0.2%	12%	1.8%	TOTAL	1.5%	0.2%	9.4%	1.9

...even though services are readily available

Victorian Advisory Council for Koori Health (VACKH) Eye Health Subcommittee Aboriginal Eye Health Strategy 2013-2014



1. Linked to State DH Aboriginal Health Plan 2012-2022 'Koolin Balit'
2. Endorsed by Minister for Health
3. Maintain existing VACCHO officer, RVEEI ALO, spec scheme
4. Implement in 3 health regions in 2013
5. Progressively implementation in other 3 regions 2014 - 2015

2nd Annual Update November 2013

Eye Conditions Map

to include the condition, prevalence, and status of the condition and whether it is a priority for the region.

Condition	Prevalence	Status
1. Cataract	1.2%	High
2. Diabetic retinopathy	0.5%	High
3. Glaucoma	0.1%	High
4. Macular degeneration	0.1%	High
5. Refractive error	1.5%	High
6. Trachoma	0.1%	High
7. Other eye conditions	0.1%	High

42 Roadmap recommendation

Cataract – 35/42 recommendation

Diabetic retinopathy – 35/42

Refractive error – 34/42

Trachoma – 37/42

Steps for Regional Implementation

- 1 Define region and population and identify regional hub
- 2 Gap and needs analysis for service requirements
- 3 Establish regional collaboration network
- 4 Develop regional directory and referral protocols
- 5 Identify co-ordination and case management staff roles
- 6 Establish regional data collection and monitoring system
- 7 Ensure regional accountability and oversight

Regional Implementation of the Roadmap

NSW	West and Far West NSW
NT	Central Australia/Barkly, Katherine Region, Greater Darwin/East Arnhem,
QLD	South East – IUIH
VIC	Loddon Mallee, Barwon South West, Southern Metropolitan
WA	Kimberley and Pilbara

Lessons Learned

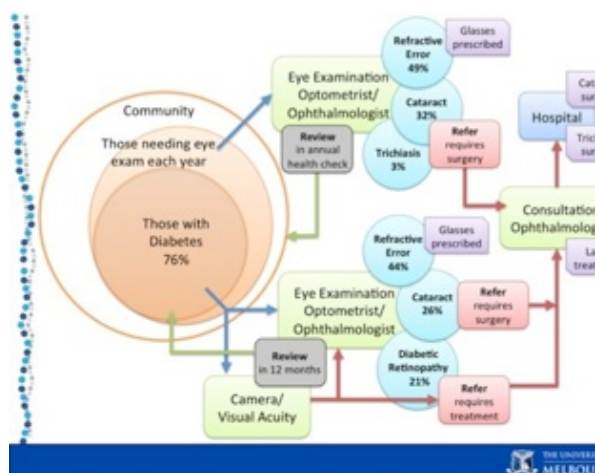
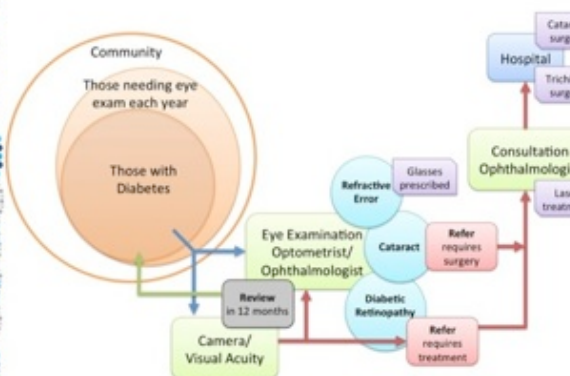
From work in 9 regions

• Specific issues include;

- Importance of jurisdictional support;
- Leadership;
- Data sharing and ongoing monitoring;
- Challenge of creating change;
- Support and funding.



Next steps, this Roundtable



Best Practice for Indigenous Eye Health

- NHMRC guidelines recommend annual retinal examination for those with diabetes
"no Indigenous person with diabetes should be allowed to go for more than 12 months without an eye exam"
- Eye checks mandatory in MBS 715 adult health assessments
- But reminders are overlooked in management plans;
 Patient Incentive Program (PIP)
 Team care arrangements and
 GP management plans
- Need to co-ordinate eye care and support patient access

Medicare and Eye Examinations

MBS Health Assessment items for Children, Adults and Older people

From 1 May 2013, MBS 715 item includes vision checks and eye exams

DESCRIPTION	COMPLETED DATES	ACTION

INTERVIEWERS AS REQUIRED

Interviewing ☐ NOT DONE Review Interviewing ☐ NOT DONE Update ☐ NOT DONE Plan Interview ☐ NOT DONE Plan ☐ NOT DONE Micrographs ☐ NOT DONE Comments ☒ NOT DONE Other ☐ NOT DONE	Interviewing ☐ NOT DONE Review Interviewing ☐ NOT DONE Update ☐ NOT DONE Plan Interview ☐ NOT DONE Plan ☐ NOT DONE Micrographs ☐ NOT DONE Comments ☐ NOT DONE Other ☐ NOT DONE
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National Guide to a Preventative Health Assessment for
Aboriginal and Torres Strait Islander People



Chapter 6: Eye Health



Software Round Table, June 2013

- 48 representatives of industry, stakeholders
- Focus on prompts, reminders
- Incorporation of referrals and reports
- Simple clinical audit and tallies
- Ongoing work with industry on this



Supports in GP Software

Adult health assessments	MBS item 715 billing	Track referral and follow up of patients with eye care needs	Recall patients who require follow up	
Chronic Disease	Include eye care components in chronic disease management plans	Include eye care practitioners in Team Care Arrangements (TCAs)	Links to Indigenous Chronic disease practice incentive program (PIP)	Link to coordination and case management Care Coordinators and Supplementary Services (CCSS)
Indicators for reporting and monitoring	links to national reporting and monitoring systems for Indigenous health data	Aggregate local data into regional and jurisdictional datasets	Track performance	Share information

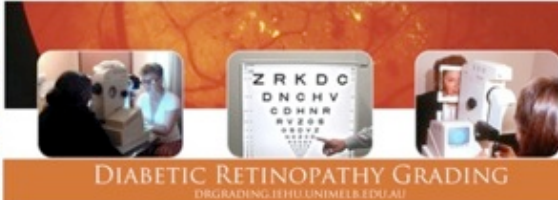
On-line Retinopathy Grading Course

Now available online at no cost

Direct link: droding.leh.unimelb.edu.au

Via website: tehu.unimelb.edu.au

Certificate of competency provided after successful completion



Retinal Photography Medicare Application

- 1994 - request to RACO Anomalies Committee to submit an application
- 1998 - request supported by Health Minister rejected by Cabinet
- 2000 - full MSAC application rejected, lacked optometric support
- Nov 2008 first draft circulated for input
- Mar 2009 informal submission
- May 2009 request pre-lodgement meeting
- Sep 2009 start rewriting - new process
- Oct 2010 draft for comment
- Nov 2010 pre-lodgement teleconference
- Jun 2011 submitted
- Sep 2011 letter of rejection - new process

Retinal Photography Medicare Application

- Dec 2011 meeting with MSAC - new process
- Aug 2012 high level meetings with DoHA
- Sep 2012 MBD start to assist
- Dec 2012 application sections A and B submitted and approved
- Jan 2013 application sections C and D submitted
- Mar 2013 PASC review
- Jun 2013 revision requested
- Oct 2013 approved and open for public consultation
- Jan 2014 prepare contracted economic evaluation
- May 2014 draft submission
- Aug 2014 final submission
- Oct 2014 review by ESC
- Nov 2014 MSAC review and approval?
- Review and approval by Cabinet

Be part of the effort to improve indigenous health

Get involved
rahc.com.au
1300 897 242

Introduction

This module provides an overview of trachoma, an entirely preventable disease affecting people living in environments with poor personal and community hygiene. This document will be addressed regarding its management, the Trachoma Control Program (TCP) Strategy and Management, as well as clinically relevant information for its diagnosis, assessment, treatment and screening. Drawing on information and guidelines from the World Health Organization, government research and clinical practice guidelines, this module is aimed at helping the health professional become better equipped with and more aware of trachoma. This is a disease that is preventable and treatable. It is with this information that health professionals are encouraged to identify areas for clinical application as well as areas for future learning.

Please note there are multiple links and resources provided within this module, intended for internet reading around the time allotted to work through the module material. You may wish to consult these resources to enhance your learning and ongoing development. Furthermore, all your work will be saved as you move through the module. This means you can return to the module multiple times and complete it as time allows.

The graphics in the logo for the trachoma program and the Trachoma Story film, created by Lyle McMillan, is a used with permission from the Centre for Eye Research Australia. The graphics is copyright reserved to either Australian Indigenous art Australian Aboriginal people traditionally have hunted for graphics by looking at nature in the world. For our learning modules, the graphics have been created using.

Further Information

- **Trachoma: A Public Health Challenge** - This publication provides a brief overview of the current status of trachoma as well as information regarding prevention, management, prevention in clinical, research and community, community consultation and equity in funding.
- **Trachoma: A Public Health Challenge** - This publication provides a brief overview of the current status of trachoma as well as information regarding prevention, management, prevention in clinical, research and community, community consultation and equity in funding.

What are the risk factors for diabetic retinopathy?

These modifiable risk factors have consistently been identified in the development of diabetic retinopathy: glycaemic control, systolic blood pressure and serum lipids and one non-modifiable risk factor: duration of diabetes. The RAHC guidelines for the management of diabetic retinopathy recommend a multidisciplinary approach to achieve optimal glycaemic control and to adequately manage blood pressure and serum lipids. Key targets for management of these risk factors are shown in table 1.

Stages of diabetic retinopathy

Diabetic retinopathy progresses through stages, from normal (no detectable diabetic retinopathy) to normal non-proliferative diabetic retinopathy, moderate non-proliferative diabetic retinopathy, severe non-proliferative diabetic retinopathy and proliferative diabetic retinopathy (Table 2). Diabetic retinopathy also includes assessment of diabetic macular oedema, vitreous haemorrhage and vitreous traction. Diabetic retinopathy is sometimes divided up into mild and moderate non-proliferative diabetic retinopathy.

Pre-Quiz

Please complete the following Pre-Quiz. This quiz is intended to help you reflect on your own personal knowledge prior to this topic. It is not a test and is provided as a baseline for your learning.

Question 1
What is diabetic retinopathy?

a. A complication of diabetes
b. A leading cause of visual loss
c. A preventable cause of blindness
d. All of the above

Stages of diabetic retinopathy

Diabetic retinopathy progresses through stages, from normal (no detectable diabetic retinopathy) to normal non-proliferative diabetic retinopathy, moderate non-proliferative diabetic retinopathy, severe non-proliferative diabetic retinopathy and proliferative diabetic retinopathy (Table 2). Diabetic retinopathy also includes assessment of diabetic macular oedema, vitreous haemorrhage and vitreous traction. Diabetic retinopathy is sometimes divided up into mild and moderate non-proliferative diabetic retinopathy.



IDF World Atlas 2013

6.3 Clinical guidelines and Position Statements

Guidelines are essential for ensuring consistency in the management of patients with diabetes. The IDF World Atlas 2013 provides a comprehensive overview of the current state of diabetes management across different regions and countries. It includes clinical guidelines, position statements, and practical advice for healthcare professionals.

Clinical Guidelines

The IDF World Atlas 2013 provides a comprehensive overview of the current state of diabetes management across different regions and countries. It includes clinical guidelines, position statements, and practical advice for healthcare professionals.

Practical Advice for Healthcare Professionals

The IDF World Atlas 2013 provides a comprehensive overview of the current state of diabetes management across different regions and countries. It includes clinical guidelines, position statements, and practical advice for healthcare professionals.

Regional Planning Tool Kit; www.iehu.unimelb.edu.au

Roadmap Implementation Resources

Please find below links to the Roadmap to Close the Gap for Vision publications, information, resources and tools to support regional implementation.

The Roadmap to Close the Gap for Vision: Full Report

- The Roadmap to Close the Gap for Vision Full Report - January 2012
- The Roadmap to Close the Gap for Vision Summary Report April 2013
- Supplement A: Ethics Documents
- Roadmap Annual Progress Update 2013

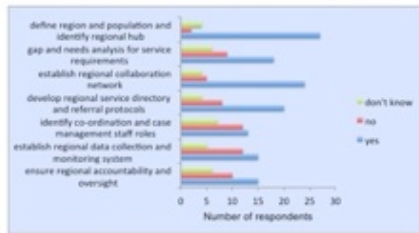
Regional Implementation Tools and Resources (A-Z)

- AMLA Medicare Local Collaborative Framework 2013
- Diabetic Retinopathy Grading Course Information
- Eye Checker Proposed Guide for Aboriginal and Torres Strait Islander Health Assessments (draft)
- Online Eye Care Services Calculator
- Regional Implementation Checklist (draft)
- Regional Implementation Data Sheet (draft)
- Sample Minimum Eye Health Data Set for Regions (draft)
- Software Supports for Eye Care Presentation
- VADKH Aboriginal Eye Health Strategy 2013-2014
- VADKH Aboriginal Eye Health Strategy Regional Implementation Information Sheet

Pre-Roundtable Survey

There is good progress in regional implementation across the country....

In your geographic area, do you think that any of the following steps for regional implementation currently exist or are being adopted?



.... but there is still much work to be done.

Pre-Roundtable Survey

Suggested activities that IEHU might assist with:

- Advocacy for funding
- Informing the community
- Disseminating information to the sector
- Technical advice and support
- Facilitating networks & collaboration
- Supporting national governance

Let us know of anything else we might assist you with to help close the gap for vision!

Summary

- We are making some real progress in implementing the Roadmap
- A lot of people are doing a lot of good work
- We want to reflect on the **Lessons Learnt** to help us all to Close the Gap for Vision

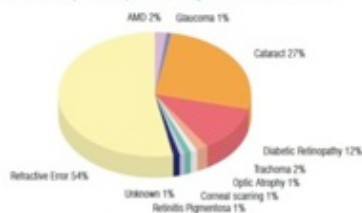
Developing Local Solutions

- Improve screening rates for diabetic retinopathy;
- Integrate eye care in primary health care and diabetes management plans;
- Develop local referral pathways, service directories and plans for eye care;
- Improve the monitoring and evaluation of regional eye health outcomes;
- Improve awareness and knowledge of eye conditions affecting people with diabetes

Why Eye Care is Important for those with Diabetes

- 37% percent of Indigenous adults have diabetes
- 13% have already lost vision
- 98% of blindness is preventable
- Only 20% have had the annual eye exam
- Only 37% received needed laser treatment

Low Vision (<6/12) in Indigenous Adults



Learnings from Regional Implementation - 1

Importance of jurisdictional governance/support

State level governance/support –

- NACCHO affiliate
- state health department
- commonwealth state office
- hospital/hospital district perspective for state
- state level agencies/NGOs
- professional bodies, OAA and RANZCO

Allows alignment with government policy

Regions develop solutions within an agreed state plans

Successes in Victoria and Queensland

Learnings from Regional Implementation - 2

Leadership

Who is in charge?

- Local ACCHO
- Local Hospital District/State health region
- Medicare Local
- NGO

Other stakeholders are local practitioners – optometrists and ophthalmologists, medical clinics

- Bring together all stakeholders
- Regional ownership - sharing a common goal and plan

Learnings from Regional Implementation - 3

Data and monitoring

Gap analysis – what is going on?

no-one really knows what is going on overall
determining what is needed to achieve the shared goal
if change is to be effected we need to monitor

Important to understand current services and service provision

Importance of sharing data among services providers/stakeholders

- Trust, confidentiality and a shared goal

If things aren't counted, they aren't done

Learnings from Regional Implementation - 4

Challenges of creating change

Need to think about doing things differently, better and more efficiently

- GP refer to optometrist
- include eye health screening in adult health checks
- using regional hub for services – not capital city
- sequenced visits to communities

- Encouraging a broader perspective – consulting with community, population needs

When things are done properly, they work

Learnings from Regional Implementation - 5

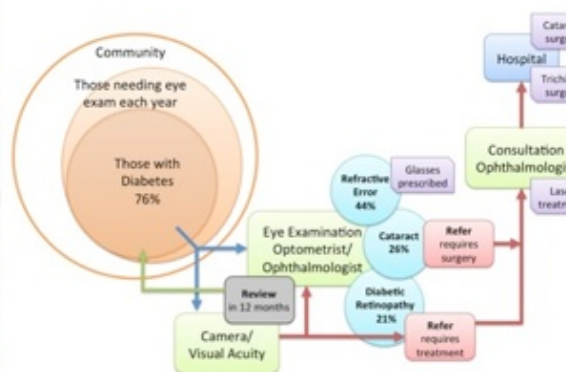
Support and funding

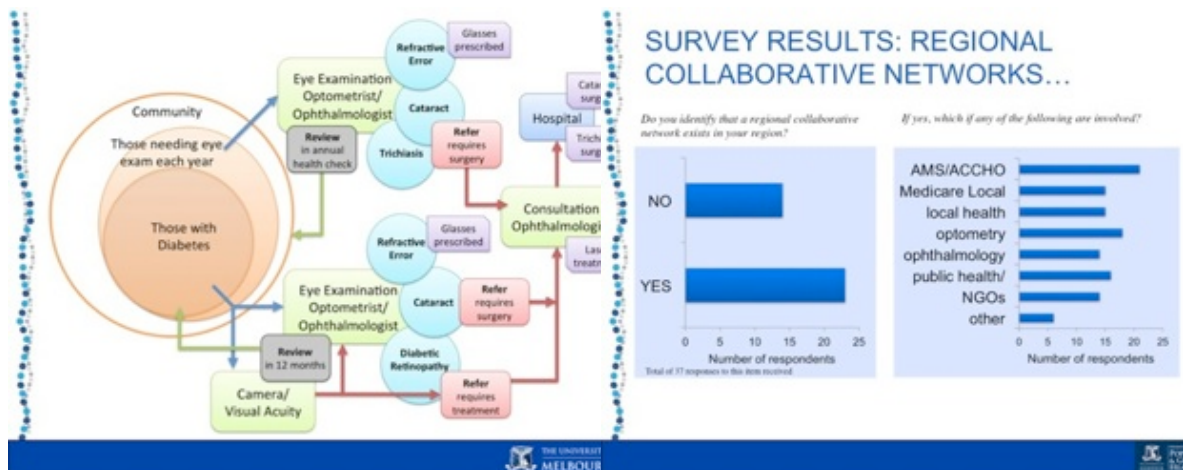
- There are opportunities for support and funding

- Medicare Locals; CCSS
- General practice; ICDP, PIP, and GP and team care plans
- Diabetes care coordinators
- Jurisdictional Closing the Gap initiatives
- Specialist support RHOF, MOICDP, VOS



ICO Guidelines for Diabetic Eye Care





Australian Government – Eye Health Policy and Programmes Handout

Indigenous Eye Health Unit - Roundtable 13 March 2014

The Australian Government recognises that poor eye health has a significant impact on Aboriginal and Torres Strait Islander people's lives, education and employment opportunities.

- *The Closing the Gap—Improving Eye and Ear Health Services for Indigenous Australians* measure provides \$66 million over four years, from 2013–14.
- The Eye Health component aims to:
 - reduce the prevalence of trachoma, a preventable eye disease that can cause blindness;
 - provide trachoma surveillance and reporting across Australia;
 - provide access to expert advice on Indigenous eye health issues;
 - increase access to eye care services; and
 - ultimately improve Indigenous children's school attendance and employment opportunities.

Government Review of Expenditure

- The Government is considering grant programmes in line with its priorities and to ensure that Indigenous programmes achieve real, positive change to the lives of Aboriginal people.
- Funding beyond 2013–14 for a range of programmes, including eye health, is part of the review.

Trachoma

- Australia is on track to eliminate trachoma by 2020, with prevalence rates in 5-9 year olds in screened communities falling from 14% in 2009 to 4% in 2012.
- There are hotspots that require continued effort and the Commonwealth is providing ongoing funding for trachoma control activities in NSW, NT, SA and WA through the multilateral Project Agreement on Improving Trachoma Control Services for Indigenous Australians. This agreement was signed on 5 February 2014.
- New National Guidelines for the Management of Trachoma are available at:
[http://www.health.gov.au/internet/main/publishing.nsf/Content/D02F0C1C2AB90509CA257C66001C089C/\\$File/trachoma-SoNG-Jan2014.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/D02F0C1C2AB90509CA257C66001C089C/$File/trachoma-SoNG-Jan2014.pdf)
- The National Trachoma Surveillance and Reporting Unit (NTSRU) is currently hosted at the Kirby Institute at the University of New South Wales. The NTSRU collects and collates trachoma surveillance and monitoring data from jurisdictions with trachoma and produces an annual Australian Trachoma Surveillance Report. The report using 2013 data will be published mid-2014.

Australian Government – Eye Health Policy and Programmes Handout

Indigenous Eye Health Unit - Roundtable 13 March 2014

Indigenous Eye Health Unit, University of Melbourne

- Has contributed expert advice to the knowledge base for improving the eye health of Indigenous Australians.
- 2013-14 partnership with the Australian Government and Department of Health to provide:
 - expert advice on Indigenous eye health policy issues;
 - Development of Indigenous eye care resources;
 - Technical support on trachoma control activities;
 - Stakeholder engagement; and
 - Coordination of Indigenous eye care programmes and services.

Cataract Surgery

- Fred Hollows Foundation (FHF) conducted cataract surgery intensives in Darwin, Katherine and Dubbo in 2013-14, following previous Australian Government investment in cataract surgery in Central Australia and the Barkly regions of the NT.
- FHF leads the Central Australia and Barkly Integrated Eye Health Strategy (CABIEHS), as a partnership of service providers so that people in those regions have better access to eye care services.
- Cataract surgery blitzes have reduced surgery waiting lists in Central Australia and the Barkly.

Visiting Optometrists Scheme (VOS)

- Improves access to optometry services in rural and remote communities.
- 2009-10: VOS expansion for Indigenous Australians to provide additional services to people in Indigenous communities, for whom there is an increased prevalence of eye disease.
- The new arrangements for the VOS program are subject to the Government's consideration. Decisions around the timing of any announcement are a matter for the Government.
- The location of VOS services is available on the Rural and Regional Health Australia (RRHA) website:
<http://www.ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/aboutUs>

Australian Government – Eye Health Policy and Programmes Handout Indigenous Eye Health Unit - Roundtable 13 March 2014

Medical Outreach Indigenous Chronic Disease Package (MOICDP)

- Funding for medical specialists, general practice and allied health outreach services to Indigenous people living in urban, rural, regional and remote Australia.
- Priority areas: diabetes; cardiovascular disease; chronic respiratory disease; chronic kidney disease and cancer.
- Eye health services can be provided for patients suffering from conditions related to diabetes.

Rural Health Outreach Fund (RHOF)

- Improves access to medical specialists, GPs, allied and other health providers in rural, regional and remote areas.
- Four health priorities: eye health; maternity and paediatric health; mental health; and chronic disease management.
- Funds may be provided for the cost of travel, accommodation, meals and incidentals, facility fees, administrative support at the outreach location, cultural training, lease of equipment, absence from practice allowance and workforce support.

Medicare Locals

- The Australian Government is currently considering the outcomes of the Review of Medicare Locals to ensure funding is being spent as effectively and efficiently as possible. The Review has three components: a review of the functioning of Medicare Locals; an independent financial audit of all Medicare Locals; and stakeholder feedback on the role and functioning of Medicare Locals.

Practice Incentive Programme (PIP)

- PIP Guidelines released in August 2013 include a section on eye health, recommending assessment and referral if required.
- In January 2014, diabetic retinopathy was included in the PIP Guidelines to give a more complete picture of eye health.

Medical Benefits Scheme (MBS)

- MBS Item 715 - adult health assessment now includes taking a history of the patient's eye health and conducting an eye examination.

Australian Government – Eye Health Policy and Programmes Handout Indigenous Eye Health Unit - Roundtable 13 March 2014

Future Directions

Partnership Approach

- The Department of Health recognises that improving the eye health of Indigenous Australians requires a partnership by key stakeholders.
- This partnership approach is critical to:
 - Developing policy responses that are tailored to individual community and regional needs;
 - Developing strategies to encourage eye care programmes to complement each other and reflect the patient journey through the health system;
 - Using available data to identify community need for eye care services;
 - Building capacity in service systems to deliver sustainable eye care services over time; and
 - Exploring and utilising emerging technologies.
- The Department is keen to hear your ideas on other partnership opportunities.

Gaps and Needs Analysis

Katherine Region (Northern Territory)

Indigenous Eye Health Unit - Regional Implementation
Roundtable - March 13, 2014



Collaboration - Katherine Region

- Katherine Regional Integrated Eye Health Program (KRIEHP)
- Brien Holden Vision Institute: outreach optometry and education programs
- Vision CRC Research Project – 'Models of Vision Care Delivery for Aboriginal and Torres Strait Islander Communities'

Gaps & Needs Analysis – Approach

- Ongoing process with regular stakeholder engagement
- Focused on identifying ways in which we can improve currently delivery and coordination of services

Gaps & Needs Analysis – Multiple Processes

- Qualitative data or stakeholder feedback
- Quantitative 'data' obtained through programs/projects
- IEHU projected eye health needs vs current level of services

Qualitative 'data'

- Valuable but often forgotten source of 'data'
- Importance of respecting local knowledge
- Obtained through informal and more formal conversations, qualitative research studies
- Participation/involvement in service delivery is beneficial

Quantitative Data

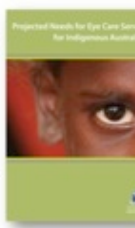
- Baseline data from the 3 'levels' of eye care:
 - primary
 - secondary
 - tertiary



Data collection must have a **purpose** and be focused on **improving patient care**

IEHU Projected Need for Eye Care Services

- Compares current level of services in Katherine region with population-based projected needs
- Eye condition prevalence data for the Indigenous Australian population based on the 2008 National Indigenous Eye Health Survey
- Has supported advocacy efforts for increase in services



Successes

- ✓ Regional eye care discussions
- ✓ CQI process at PHC level: a form of needs analysis
- ✓ Securing of additional eye care services

These would not have been possible without **relationship building** and ongoing stakeholder consultation

Despite these 'wins' there are still ongoing challenges in the form of workforce, sustainability etc.

Challenges

- Many competing health priorities – can be challenging to maintain momentum
- Can only work with the data available to us
- Need to be flexible – gaps and needs can be perceived differently

Key Learnings

- Gaps/needs analysis and data collection must always **serve a purpose** and focus on ensuring **patient care**
- **Relationship building** is extremely important
- **Respect 'local knowledge'** and support stakeholders to address gaps/needs that they have identified



Department of Health

health

Koolin Balit means healthy people

Aboriginal eye health in Victoria

Mark Stracey – Director of Aboriginal Health

- 10 year whole of government strategic directions for Aboriginal health
- \$61.7 million over four years to support implementation
- A significant portion of this funding (\$33.5 million) to implement regional activity
- \$1.5 million to support the implementation of an Aboriginal Eye Health Plan and projects to close the gap for vision



Koolin Balit Aboriginal Eye Health Advisory Group

health

The Koolin Balit Aboriginal Eye Health Plan

Brings together key stakeholders in Victorian Aboriginal eye health with the aim of closing the gap for vision. The group will:

- work together to implement agreed priorities
- share successes and address challenges in the implementation of programs and projects
- support the coordination of statewide activity
- provide advice and refer issues for discussion by other the appropriate groups or committees



Priorities

- Improving access to high-quality eye health services for Aboriginal Victorians.
- promoting eye health and improving early intervention to reduce the impact of preventable eye health conditions and the delayed treatment of conditions resulting in blindness and vision loss among Aboriginal Victorians.
- strengthening and developing partnerships to provide innovative, culturally responsive pathways to eye care.



What we will do

health

Reflections on Closing the Health Gap

- Bring key stakeholders together
- Work in partnership with the regional offices to implement a regional approach to improving patient pathways and addressing barriers to access
- Continue the Victorian Aboriginal Spectacle Subsidy Scheme
- Continue VACCHO Statewide Eye Health Coordinator
- Improve data and evidence



- partnerships breed success
- strong relationships with community build trust
- local issues need local solutions
- providing the capacity to innovate at the local level works
- there are some areas that need statewide coordination
- commitments can and must turn into action

- Aboriginal health workers can't do it all – it needs a whole of system approach
- senior level commitment, engagement and communication leads to success
- we need to keep improving our data and evidence
- flexibility of our model allowed us to meet the complex health needs of Aboriginal Victorians
- there is still a long way to go

Working together 



Trust equation

Credibility + Reliability + Integrity

Self Interest

= TRUST

Questions?

The CABIEHS regional collaborative network

Indigenous Eye Health Regional Implementation Roundtable

March 13, 2014



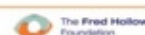
The regions

- CABIEHS covers the Central Australia and the Barkly regions of the NT
- Total population is approximately 43,000
- Approximately 40% of the population are Aboriginal and Torres Strait Islander people, with a 73% ratio outside of Alice Springs
- Each region has unique challenges and is covered by its own Regional Eye Coordinator, but both are serviced by the same sole ophthalmologist
- The Central Australia Hospital Network comprises both regions with hospitals in Tennant Creek and Alice Springs



CABIEHS overview

- CABIEHS stands for the Central Australia & Barkly Integrated Eye Health Strategy
- The collaborative network was established in 2007
- The aims and governance of the network have changed over time
- All key stakeholders are involved in the governance body (CABEHOG) at operational and strategic levels
- Australian government has funded coordination/ secretariat functions, and well as some programs (e.g. intensive eye surgery weeks) since inception



Participants

CABEHOG comprises a wide range of key eye health practitioners and organisations:

- Alice Springs Hospital Ophthalmologist
- Central Australia and Barkly Regional Eye Health Coordinators
- Local optometrists
- Central Australia Hospital Network
- Central Australian Aboriginal Congress Aboriginal Corporation
- Anyinginyi Health Aboriginal Corporation
- Australian Department of Health
- AMSANT
- Brien Holden Vision Institute
- Centre for Disease Control
- Australian Department of Health
- Central Australia Remote Health
- Guide Dogs SA/NT
- Northern Territory Medicare Local
- Indigenous Eye Health Unit
- The Fred Hollows Foundation



How CABEHOG works

- CABEHOG focuses on operational issues to engage participants and maintain momentum
- Executive level representatives are encouraged to attend to provide strategic input and decision making clout
- CABEHOG develops and implements a work plan containing a small number of high priority actions which are reviewed regularly
- Meetings are held every two months
- The Fred Hollows Foundation carries out the secretariat function, which was formerly a more intensive coordination role



Some key learnings

- It is vital to have a shared understanding of the reasons for a collaborative network, and allow these to change over time if necessary
- One major issue provided a focus for the network in the early stages, however momentum and engagement were reduced when CABIEHS was formalised as a comprehensive eye health strategy with a wide range of aims and objectives
- A coordination role can be beneficial, particularly in the early stages of collaboration, but too much "driving" can be counterproductive
- It can be difficult to effectively engage both executive and operational people in the same forum. CABIEHS governance has been continually evolving to get the right people around the table on a regular basis
- One of the most important outcomes has been significantly improved relationships between the stakeholders, resulting in better communication, collaboration and coordination





Regional Data Collection South East QLD

Kelley O'Donohue

Regional Eye Health Project Officer

kelly.odonohue@iuih.org.au



About the Institute for Urban Indigenous Health

- Institute for Urban Indigenous Health (IUIH) was formed in 2009 to improve Health Outcomes for the Aboriginal & Torres Strait Islander community of South East Qld.
- The IUIH is the regional body for South East Qld. The 5 member services that make up this regional body are: ATSIChS (Greater Brisbane), Kambu (Ipswich), Kalwun (Gold Coast), Yuku-Burri-Ba (Brisbane Bayside & North Stradbroke Island) & Morten ATSIChS
- There are 13 AMS's in South East Qld with 4 new clinics planned to open 2014
- IUIH Departments are: Regional Tobacco & Healthy Lifestyle, Clinical Services, Care Coordination, USOAP, Spear Heads, Community Engagement, Work it Out, Workforce and Development, Drug and Alcohol, Data, Close the Gap teams, Mums & Bubs.



Mapping objectives: to present the 'big picture' of current eye health data and services for Aboriginal and Torres Strait Islander peoples in SEQ to inform a regional approach to eye health services planning and implementation. The outcomes included:

- Identification of all possible sources of data on eye health and eye health services reaching Aboriginal and Torres Strait Islander people in urban SEQ
- Collation and synthesis of existing data to help inform the planning process
- Mapping of eye health prevention, screening and care services provided at the primary care level in Aboriginal Medical Services within the IUIH model.



Regional data collection in SEQ - Methodology

- A review of the 2009 *Guide to Australian eye health data* which provides a summary of national and regional data sources;
- Data requests sent to:
 - Aboriginal and Torres Strait Islander Health Unit, QLD Department of Health;
 - Health Statistics Unit, QLD Department of Health
 - Medicare (Data request using eye service item numbers + Aboriginal and Torres Strait Islander breakdown)
 - Inpatient and outpatient data for eye procedures
- Review of Australian Bureau of Statistics website; and
- MASS Spectacle Supply Scheme which provides a comprehensive range of free basic spectacles (prescriptions glasses) for eligible Queenslanders.
- Health Service Data (7 Mmex & 6 Medical Director)





What we have been able to find?

National prevalence data – AIHW / ABS / NIEHS

MASS Spectacle scheme

- No of Urban clients accessing glasses - QLD

Health service data via MMex (7 services)

- No active clients per service
- No active diabetic clients per service
- 715 Eye health checks - including eye health screening data

What has been difficult to find?

- Service provision data (Medicare)
- QLD prevalence data
- QLD hospital admissions / outpatient / waiting list data
- Health service data via Medical Director (6 services)

What we would like to know but can't find?

- All of the above



Service Directories



Colina Waddell

Why a "Service Directory"

- Capture multiple service providers
 - Primary, Secondary and Tertiary
- Turnover in staff and service providers
- Joining the dots – making the linkages

Brien Holden Vision Institute



Brien Holden Vision Institute



How?

- Existing Service Directories
- Drafted an outline
- Circulated to Vision CRC partners
- Feedback received and modified

Brien Holden Vision Institute



Brien Holden Vision Institute



Working with ACCHSs

- Working with Aboriginal Community Controlled Health Services
- Getting feedback – Practice Managers & Aboriginal Health Workers
- Workshop at Eye Care Forum (June 2014)
- Adjust and refine directory

Ultimate Outcome

- Develop a generic template for use in regional and health service settings
- Build into existing health care planning and scheduling infrastructure
- A valuable and important tool developed by and for services on the ground to use

Brien Holden Vision Institute



Brien Holden Vision Institute

Example Service Directory

- Primary Care Linkages
- Eye Care Services
- Organising Clinics & Hospitals
- Public Health Programs
- Regional Networks
- NGOS



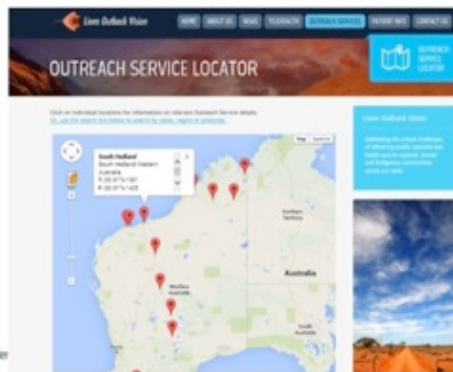
Coordination of eye care resources and personnel in [region]

List of eye health coordination personnel -

Role	Definition/Responsibilities	Contact Name & Contact Details	Communication covered by service
Primary Care Linkages Optician, Ocular Health Manager, Ocular Health Coordinator	Ensure that all patients with diabetes have an annual retinal eye exam. Collaborate with primary care teams to ensure patient links for ongoing eye care arrangements and ongoing. Monitor progression of diabetic patients getting annual eye exams.		
Primary Health Care Team (GP, Nurse, A&E)	Coordinate eye care and vision checking as part of Adult Health Checks and refer for eye examinations as required per documented guidelines. Manage acute/emergency eye care cases as per standard treatment protocols. Ensure follow up along the patient pathway.		
Regional networking Regional network (public and private) existing eye care services.	Regional community, regional eye care services and private existing eye care services.		
Eye Health team working programs	Coordinate eye and vision screenings for diabetic refer to eye care practitioners as required and ensure follow up (patient - routine appropriate services).		

Lions Outback Vision: Service Locator

<http://outbackvision.com.au/outreach-eye-services/>



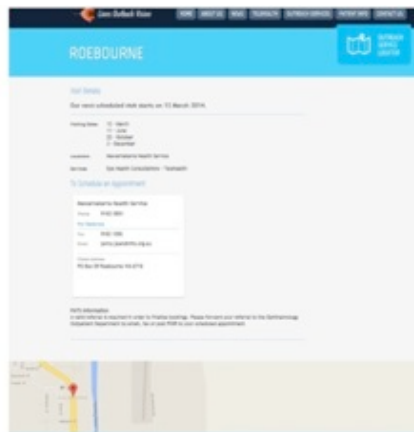
Brien Holden

Lions Outback Vision: Outreach Visits Schedule

<http://outbackvision.com.au/outreach-eye-services/>



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vision
for everyone...everywhere
brienholdenvision.org

Brien Holden Vision Institute

Referral Protocols

Genevieve Napper

Australian College of Optometry

Indigenous Eye Health Regional Implementation Roundtable 13 March 2014



ACO service locations in Victoria – 19 Aboriginal Health services



Visiting Optometrists Scheme

- Supports services to 16 ACCHOs in regional areas
- Metro services
- 3 ACCHOs

Optometrists employed by ACO and all consultations bulk billed to Medicare; workforce of 17 regular optometrists

- Victorian Aboriginal Spectacle Subsidy Scheme (VASSS) makes glasses available for all members of Victorian Aboriginal communities for \$10 (once every two years). Includes an expanded range of frames endorsed by Aboriginal community elders – Department of Health Victoria
- 4198 pairs of glasses prescribed under the subsidy 2010 – 2013
- available through ACO services (urban and rural) and 28 participating practices in rural areas



Eye care services – referral pathways and protocols

Referral protocols are required for primary care (first point of contact at health service) to optometry; optometry to ophthalmology; and ophthalmology to hospital to ensure good care outcomes

Most optometry services are visiting services eg. weekly, quarterly, yearly; with limited optometrist availability for support between visits in many cases

Effective referral pathways

- aim to reduce or eliminate avoidable vision loss and blindness
- strengthen service sustainability (improve attendance rates)



The leaky pipe is an example of a system without good referral protocols



Eye care services – referral pathways and protocols

Aboriginal Health Worker (AHW), GP, other primary health care worker → optometrist in Aboriginal Health Service (AHS)

Optometrist (AHS) → AHW, GP, primary health care worker (eg. diabetes educator)

Optometrists (AHS) → mainstream optometrist (eg. for more specialist testing)

Optometrist → ophthalmologist (eg. cataract surgery, laser treatment for diabetic eye disease)

Ophthalmologist → surgery (hospital) or laser

→ = in person attendance or communication/report; two way

How do these referrals occur and who is responsible?



Referral pathways and protocols - Current Challenges

How do these referrals occur and who is responsible?

Eg. from optometrist to ophthalmologist/eye hospital

- Determine reason for referral; and discuss with patient / AHW
- Identify most appropriate destination for referral (service directory)
- Identify any out of pocket costs to patient
- Identify wait time and determine if appropriate for clinical condition
- Discuss options with patient / support person
- Initiate referral via letter/phonecall/electronically
- Provide appropriate clinical and other information
- Discuss appointment type with patient (eg. letter, phonecall, immediate)
- Discuss costs, transport, reminders with AHS

Follow up – who will do this?

Reminder, transport, attendance support, explanation of outcome

Assistance with costs, follow through to outcome



What would a good system look like? – referral protocols

Public or private service – what is available, when and costs clear
Support for costs is clear (eg. Medicare Local CCSS program and how this is activated)

Geographical accessibility – transport

Cultural appropriateness of service

Clinical pathways – explanations of laser, surgery

Need to know that the outcome has been achieved (feedback loop)

Regional referral protocols

- What would they look like?
- Formal written agreements of roles and responsibilities?
- Assurance of cost certainty
- or informal agreements?
- Eye health co-ordinator; specialist referrals co-ordinator
- What is the responsibility of the optometrist during a busy clinic day





AML Alliance - role

- Funded to provide leadership, support, advice and information to Medicare Locals and the national *Closing the Gap* workforce employed through both the Improving Indigenous Access to Mainstream Primary Care and the CCSS Programs.
- provides a conduit for communication and engagement between Indigenous peak bodies, jurisdictional bodies and other stakeholders who are interested and/or have a key role in Aboriginal and Torres Strait Islander health

Care Coordination & Supplementary Services program

- CCSS target chronic diseases:** cancer, diabetes, respiratory, renal, cardiovascular
 - Two components:
 - Care coordination** is provided by qualified health workers to assist patients accessing services consistent with their GP care plan.
 - Supplementary Services** is a flexible funding pool to access the specialist, allied health and other support services in line with their care plan and specified medical aids they need to manage their condition effectively.
 - Patient Eligibility:** Care plan in place, referred for care coordination by GP, any age, have 1 or more of the CCSS CDs
 - Workforce available:** 61 MLs funding approx 160 care coordinators; employed by MLs, general practice, ACCHO sector
 - In 2013
 - 156,644 episodes of care coordination
 - 58,843 direct clinical services
 - 32,3354 appts including 1172 Ophthalmologist & 327 Optometrist
 - For more info:**
<http://amlalliance.com.au/medicare-local-support/Aboriginal-and-Torres-Strait-Islander-health/ccss>

Coordinated Veterans' Care program

- CVC Program** is a Department of Veterans' Affairs program to better manage and coordinate primary and community care for Gold Card holders who are **most at risk** of being admitted or readmitted to hospital.
 - Gold Card** holders can include veterans, war widows, war widowers and dependants.
 - primarily focused on Gold Card holders with the following chronic conditions:
 - congestive heart failure
 - Coronary artery disease
 - Pneumonia
 - Chronic obstructive pulmonary disease
 - Diabetes
 - GPs are paid to enrol Gold Card holders in the CVC Program and to provide ongoing, comprehensive and coordinated care with the assistance of the practice nurse or a community nurse from a DVA contracted community nursing provider
 - 15 contracted Medicare Locals are involved
- For more info:**
<http://amlalliance.com.au/medicare-local-support/coordinated-veterans-care>

Australian Primary Care Collaboratives

- Aims to find better ways to provide primary health care services to patients through shared learning, peer support, training, education and support methods
 - By 2015 around 1500 practices and **Aboriginal Medical Services** will have participated in the APCC program by working with Medicare Locals contracted in the APCC program
 - Key benefits** include:
 - Opportunity to exchange of ideas and experiences with peers;
 - Learning skills to move from reactive to proactive patient care;
 - Increase business efficiency
 - Learning how to measure improvements in patient care; and
 - Improving health outcomes, particularly for people with, or at risk of, chronic conditions
- For more info:**
<http://amlalliance.com.au/medicare-local-support/australian-primary-care-collaboratives>

Clinical Engagement and Cross Sector Collaboration

- Working towards the primary healthcare sector, through Medicare Locals and the hospital sector, **work together and ensure the clinical needs of both areas integrate effectively and efficiently**
 - CECSC program been developed to provide resources and opportunities for MLs
 - needs analysis undertaken in 2013 which identified a number of ways AML Alliance, the lead agency for MLs, could support the ML network
 - A number of activities happening within the program
 - ML Collaborative Framework** - practical guide to MLs wishing to engage with other healthcare organisations, such as Local Hospital Networks (LHNs) and Aboriginal Community Controlled Health Organisations
- For more info:**
<http://www.amlalliance.com.au/medicare-local-support/clinical-engagement-and-cross-sector-collaboration>



Indigenous Eye Health Regional Implementation Roundtable



Monitoring, accountability and oversight

Mitchell Anjou
13 March 2014
Melbourne

Steps for Regional Implementation

- 1 Define region and population and identify regional hub
- 2 Gap and needs analysis for service requirements
- 3 Establish regional collaboration network
- 4 Develop regional directory and referral protocols
- 5 Identify co-ordination and case management staff roles
- 6 Establish regional data collection and **monitoring** system
- 7 Ensure regional **accountability** and **oversight**



Monitoring

Capturing and reporting progress, improvement and outcomes

Accountability

Answerability, acknowledgement of responsibility

Oversight

Review and overview; supports coverage, consistency and continuity

Review covers Indigenous eye care policy 1976-2010

- 11 Health Ministers
- 9 Heads of Department
- 7 Department name changes
- 7 formal reviews of eye health
- Need for close community input and involvement
"Solutions" cannot be imposed
- **Need for national oversight and monitoring**
Peaks and troughs, often led by a "champion"
- Need to integrate basic eye care into primary care
Stand alone services are not appropriate, but PHC must do primary eye care
- Need mechanisms to overcome jurisdictional issues
Implementation often delayed
- Need commitment of appropriate priority and resources
Many recommendations not implemented



Currently there is no national oversight or national accountability for Aboriginal and Torres Strait Islander eye health

- No group accountable for national oversight
- No group that collects and collates information or data
- No group with sector authority to determine guideline and benchmarks

But there is no need or desire to set up a separate, stand-alone, vertical program – use existing committee structures

What could be achieved with national oversight

- Overseeing national strategy implementation
- Developing national policy and funding initiatives
- Provide expert technical and policy advice and recommendations to Australian government and jurisdictions
- Developing guidelines for consistency
- Report performance and progress and identify areas of concern
- Report to Australian government, jurisdictions and other stakeholders



Appendix 4: List of proposed data elements

DESCRIPTION	LOCATION								DATA ELEMENT	
	Aboriginal Health Service		Community		Private		Hospital		Aboriginal and Torres Strait Islander Patients	
	Local	Visiting	Local	Visiting	Local	Visiting	Local	Visiting	Annual	Monthly
Primary Care -GP -Nurse -Aboriginal Health Worker										Number of Patients screened for Vision Problems
										Number of patients referred with vision problems
										Number of patients with diabetes
										Number of patients with diabetes referred for retinal examination
										Number of patients with retinal examination provided/retinal photograph taken in clinic
										Number of MBS Item 715 (Adult and Older Persons) billed
Secondary Care -Optometry										Number of days of service
										Number of patients examined
										Number of spectacles prescribed and/or provided
										Number of patients examined with diabetes
										Number of referrals to ophthalmology
										? consider cataract/diabetes/other categorisation
-Ophthalmology Clinic (Including Hospital Outpatients)										Number of days of service
										Number of patients examined
										Number of patients examined with diabetes
										Number of patients with diabetes requiring laser treatment
										Number of retinal laser treatments given
										Number of referrals for surgery
Tertiary Care -Ophthalmology Surgery										? consider cataract/other
										Number of days of service
										Number of surgical procedures cataract
										Number of surgical procedures other ocular
										Number of people on waiting list for cataract surgery
										Number of people on waiting list for cataract surgery >90 days

Appendix 5: Roadmap to Close the Gap for Vision - Glossary

The purpose of this glossary is to provide some clarity and consistency around terms commonly used to describe the regional implementation approach recommended in the Roadmap to Close the Gap for Vision.

Data sharing

The process by which various stakeholders within a region collaborate to share eye health data *at a systems level* from across a range of sources. These data may be combined/ aggregated to provide a regional or population profile of eye health. [This does not require data linkage or the same information technology systems to be in use. Rather, it requires that each stakeholder group be aware of the required data elements, collect the data elements, extract the data elements and come to the table with a summary spreadsheet to share with the regional collaborative network].

This concept is distinct from the sharing of information *about an individual patient* that occurs as part of clinical care (e.g. communication of information about an individual patient as part of a referral process).

Gap and needs analysis

Aims to quantify the expected prevalence of eye disease and the associated predicted need for eye care services in a region and to calculate the 'gap' by comparing the *expected* needs with the *existing* level of service provision in a region.

Steps:

- identify the expected burden of the following eye conditions among the local Indigenous population, based on disease prevalence data (which are available from the National Indigenous Eye Health Survey) and the size of the local Indigenous population (which is available from the Australian Bureau of Statistics):
 - o cataract
 - o diabetic retinopathy
 - o refractive error and need for glasses
- based on this information and the average caseload of a visiting or resident clinician, calculate the expected number of optometry and ophthalmology service days required
- identify current service provision/ uptake by Indigenous Australians
- expected need for eye care less current service provision/ uptake = the gap

The Indigenous Eye Health Unit has developed an online calculator to facilitate these steps, which is available online at: <http://dr-grading.iehu.unimelb.edu.au/ecwc/>

National oversight

A proposed governance structure which would oversee the implementation of the various components of the Roadmap and initiatives to close the gap for vision, at a national level. National oversight and accountability are required to support sustained service delivery and improve eye health outcomes.

Patient case management

Describes the process by which the pathway of an individual patient through the eye care system is co-ordinated and managed.

An individual patient, when identified as having complex eye care needs (e.g. due to diabetes, cataract) is assigned a co-ordinator / case manager to help them navigate their way through the eye care system, for instance by assisting with making appointments and ensuring attendance, arranging transportation etc.

Referral protocol

The agreed allocation of roles and responsibilities across the full pathway of eye care. Can incorporate patient support and identification of eye problems, monitoring, treatment and follow up of patients.

Regional collaboration network

Describes the mechanism by which the various stakeholders in a regional healthcare system communicate and work together in a collaborative way.

Regional data collection

Describes the data that includes information about eye health status and eye health care within a region, and contains information from a range of relevant sources. The desired outcome of effective data sharing within a region. These data can be used to assess performance and monitor progress. These data may also be reported to jurisdictions, for jurisdictional monitoring.

Regional implementation

The Roadmap to Close the Gap for Vision identifies 42 interlocked recommendations which together comprise a comprehensive framework to remove barriers to eyecare service access and utilisation by Indigenous Australians, increase awareness of eye health issues among both patients and providers, reorient health services to meet the cultural and linguistic needs of Indigenous Australians and establish regional, jurisdictional and national governance and oversight mechanisms.

Regional implementation of these multi-pronged recommendations requires a collaborative, multidisciplinary and whole-of-system approach, which may be facilitated by the adoption of seven key steps:

1. Define region and population and identify regional hub
2. Establish regional collaboration network
3. Gap and needs analysis for service requirements
4. Develop regional service directory and referral protocols
5. Identify co-ordination and case management staff roles
6. Establish regional data collection and monitoring system
7. Ensure regional accountability and oversight

Regional service directory

These are proposed as resources that will contain details of eye care services and visiting and resident eye care providers in a given region.

Required data elements (also referred to as 'minimum data set')

The minimum set of data elements required to accurately profile eye health status and eye health services in a given setting. These data can then provide the basis for aggregation to allow regional, jurisdictional, national and international reporting.

Systems co-ordination

Refers to the co-ordination of services at a systems level, for instance co-ordinating visiting optometry services to visit an area prior to a scheduled ophthalmology visit. Distinct from case management, which describes co-ordination of care at the individual patient level.

The Roadmap to Close the Gap for Vision – the need for National Oversight

This discussion paper has been prepared by the Indigenous Eye Health Unit
April 2014

The Roadmap to Close the Gap for Vision (2012) proposes 42 recommendations to close the gap for vision and eliminate the inequities in Aboriginal and Torres Strait Islander eye health and vision in Australia. National oversight is recommended (Recommendation 7.4) to provide continuity, oversight and accountability by monitoring national progress for Indigenous eye health. It is proposed that this function needs to be established by government to develop national policy, oversee implementation of national strategies and to report to Australian government and State/Territory governments. National oversight will ensure the maintenance of national coverage, oversight and accountability and provide timely report of performance to government and all service providers and stakeholders.

Oversight and accountability are identified as two absolutely key ingredients that are required to support sustained service delivery and care outcomes. The failure to institute such governance structures is considered a significant factor for the failure of previous programs, particularly the failure of recommendations arising from reviews about Indigenous eye health. Oversight and two-way accountability is required at each administrative level in the service system – local, regional, jurisdictional and national.

Currently there is no clear national oversight or national accountability for Aboriginal and Torres Strait Islander eye health. Although a number of groups are involved in national programs, there is

- no government or sector agreed group with this remit or that is accountable for this function
- no group that collects and collates information or data that would suggest or support national oversight responsibilities
- no group with sector authority to endorse evidence-based guidelines and benchmarks for Indigenous eye health.

In establishing an effective review or governance function, it would be highly desirable to utilize an existing committee structure, experience and expertise wherever possible. There is no need nor is there desire to set up a separate, stand-alone, vertical program.

It is suggested that a governance body with accountability to COAG, AHMC or AHMAC take on this oversight function and that it would appropriately focus effort in Indigenous eye care. This is deemed essential if the goal of closing the gap for vision is to be achieved.

History informs

The past failures of policy implementation and proper funding for eye health programs have resulted from a lack of consistent focus on Indigenous eye health. A Critical History of Indigenous Eye Health Policy Making (2011) covers the period 1976 to 2010. Seven formal reviews of eye health have been conducted in that time and a number of consistent findings are identified. There is a need for close community input and involvement, national oversight and monitoring, integration of basic eye care into primary care, mechanisms to overcome jurisdictional issues and a commitment to appropriate priority and resources. The historical review demonstrates that solutions cannot be imposed, that there have been many peaks and troughs in Indigenous eye

health activity, stand alone services are not appropriate and eye health must be part of the broader health care, and that implementation of recommendations has often been delayed or just not carried out. However, the overriding essential is national oversight.

Data and monitoring

The availability of data to inform policy and service planning at a national level is poor and spasmodic. There is a lack of aggregated data at jurisdictional and national levels and there is limited oversight monitoring or accountability. Even data about national schemes for visiting services and low cost spectacle support are not readily available or shared. National systems management cannot be undertaken without performance data to inform planning and this information needs to be accessible to stakeholders. National monitoring can showcase best-practice models and will provide enhanced local and regional service planning and improved accountability to Aboriginal and Torres Strait Islander communities.

National guidelines

Development of the following national guidelines will support activities to close the gap for vision and the rollout of the Roadmap:

- Definition of targets
 - Clinical pathway standards for timeliness, quality and availability of services
- Collection of data
 - Data elements for reporting at local, regional and jurisdictional levels
- Reporting performance
 - National eye health KPI and target reporting – regional, jurisdictional and national
- Strategic workforce education and training requirements
- Health promotion framework for Indigenous eye health

Stakeholder endorsement and involvement

The Roadmap to Close the Gap for Vision includes a firm recommendation on the need for national oversight of Indigenous eye health and vision care issues and has been endorsed by:

National Aboriginal Community Controlled Health Organisation (NACCHO)
Optometrists Association Australia (OAA)
Royal Australian and New Zealand College of Ophthalmologists (RANZCO) and
Vision 2020 Australia.

Representatives of these four stakeholders are well placed to provide expert, technical and policy advice and recommendations to federal and jurisdictional government departments and authorities responsible for Aboriginal and Torres Strait Islander eye health and support national oversight functions.

The Australian government has initiated and provided important support for Indigenous eye health and the recommendation for national oversight is to build and consolidate from these efforts.

The functions of national oversight

The aims and functions of national oversight would include:

1. Overseeing the national implementation of strategies that address Aboriginal and Torres Strait Islander eye health and vision care issues, consistent with the recommendations of The Roadmap to Close the Gap for Vision
2. Developing the national policy and funding initiatives identified to close the gap for vision
3. Providing expert, technical and policy advice and recommendations to federal government departments and authorities responsible for Aboriginal and Torres Strait Islander eye health
4. Providing expert, technical and policy advice and recommendations to support jurisdictional committees responsible for Aboriginal and Torres Strait Islander eye health
5. Developing guidelines and benchmarks to support nationally consistent Aboriginal and Torres Strait Islander eye health
6. Developing a reporting framework to allow national oversight for Aboriginal and Torres Strait Islander eye health
7. Reporting to federal and state/territory governments and other stakeholders, including local and regional communities, regarding monitoring data and activity tracking, progress on 'closing the gap for vision' and identifying areas of concern
8. Reporting progress made to appropriate Australian government authority (eg. AHMAC).

References

Taylor HR, Anjou MD, Boudville AI, McNeil RJ. **The Roadmap to Close the Gap for Vision: Full Report**. Melbourne: Indigenous Eye Health Unit, Melbourne School of Population Health, The University of Melbourne, ISBN 978-0-7340-4756-4; 2012. 137 p.

Jones JN, Henderson G, Poroch N, Anderson I, Taylor H. **A Critical History of Indigenous Eye Health Policy-Making. Towards Effective System Reform**. Melbourne: Indigenous Eye Health Unit, Melbourne School of Population Health, The University of Melbourne, ISBN 978-0-7340-4209-5; 2011. 180 p.

Appendix 7: Sample service directory and referral pathway document

EYE CARE DIRECTORY
Resources & Personnel
[insert region name]
[insert ACCHO – if relevant]

Last updated: [insert date]

Contents:

1. Preamble
2. List of eye health coordination personnel
3. Define the referral pathway and referral process (where do you send referrals to?)
4. Regional VISITING EYE CARE SCHEDULE
5. Useful resources

1. Preamble

This directory is to enable health care workers in the multidisciplinary team to identify whom they can refer eye care clients to within the [insert region name] Region of [insert State/Territory name].

It provides a list of associated personnel and other useful contacts, resources and links. The communities serviced by eye care practitioners within the [insert region name] Region are listed. It is the responsibility of each region to keep this up to date and review regularly to ensure all contacts are up-to-date.

2. List of eye health coordination personnel

Coordination of eye care resources and personnel in [region]			
Role	Definition/Responsibilities	Contact Name & Contact Details	Communities covered by service
Primary Care Linkages			
Chronic Disease Case Managers/ Diabetic Care Coordinators	Ensure that ALL patients with diabetes have an annual retinal eye exam. Collaborate with primary care teams to ensure patient lists for visiting eye care practitioners are prepared. Monitor proportion of diabetic patients getting annual eye exam.		
Primary Health Care Team (GP, Nurse, AHP)	Conduct routine eye and vision checks (e.g. as part of Adult Health Check) and refer for eye examinations as required (as per recommended guidelines). Manage acute/emergency eye care cases as per standard treatment protocol. Ensure follow up along the patient pathway.		
Aboriginal Community Based Workers (where relevant)	Recognise community members not attending clinics and promote visiting eye care services.		
Kids/School health screening programs	Conduct eye and vision screenings for children refer to eye care practitioners as required and ensure follow up (patient receives appropriate services).		
Eye Care Services			
Optometrist	Provide comprehensive eye health examinations including refraction, detection of eye and vision disorders and management or referral to ophthalmology as appropriate. Provide majority of eye care services including annual diabetic retinal examinations.		
Ophthalmologist	Medical specialist who diagnoses and treats eye or vision disorders, by medical, surgical or laser therapies. Responsible for specialized eye care as per cases referred by optometrists or GPs (i.e. not routine diabetic eye examinations)		
Emergency Eye care	On-call ophthalmology for emergency cases.		
Orthoptist	Allied Health Eye Care practitioners who investigate and manage vision defects and abnormalities of eye movement. Typically work alongside Ophthalmology services, conducting a range of tests to		

	contribute to patients' diagnosis and management.		
Low Vision Services	Assess functional vision of patients who are visually impaired and provide services to assist with vision/magnifying aids or rehabilitation/orientations and mobility, daily living support.		
Spectacles	Sources and options for spectacle supply (subsidised spectacle schemes, low cost spectacle schemes, private prescriptions, readymade spectacles)		
Organising Eye Clinics			
Regional Eye Health Coordinators	Coordinate and facilitate visiting eye care services to remote community health services/ACCHSs. Liaise with clinics regarding scheduling and ensuring patient lists are prepared, transportation arranged etc.		
Aboriginal Eye Health Practitioners/Workers (where relevant)	Facilitate visiting eye care services within their primary health care clinic, where relevant work in partnership with RECH regarding trip scheduling etc.		
Transport Services	Ensuring patients arrive in timely manner for appointments.		
Organising Hospital			
Patient Liaison	Where relevant, contact patient/ACCHSs prior to scheduled hospital appointment to confirm date and answer any queries. Act as first point of contact for patient at hospital and assist with patient pathway of care.		
Scheduling Appointments (Ophthalmology)	Inform clinics/patients of scheduled ophthalmology appointments with adequate notice to arrange patient transport. Interact with Patient Liaison officers to maximize patient attendance. Notify ACCHSs of DNAs for future follow up.		
Transport Services	Transport services from Community to Hospital and back, utilizing PATS where relevant.		
Public Health Programs			
Trachoma Surveillance and Screening services	Coordinate/conduct trachoma prevalence surveys and oversee community wide treatment programs as required by prevalence data. Monitor trends in trachoma and report both locally and national surveillance programs.		
Regional Networks			
Regional eye care group			
Regional ACCHSs network			

Medicare Local			
Local Hospital Network			
NGOs			
Brien Holden Vision Institute			
Fred Hollows Foundation			
Indigenous Eye Health Unit			

Facilitating Eye care services within your clinic

- Generating recall lists
- Eye care practitioners using electronic records
- etc

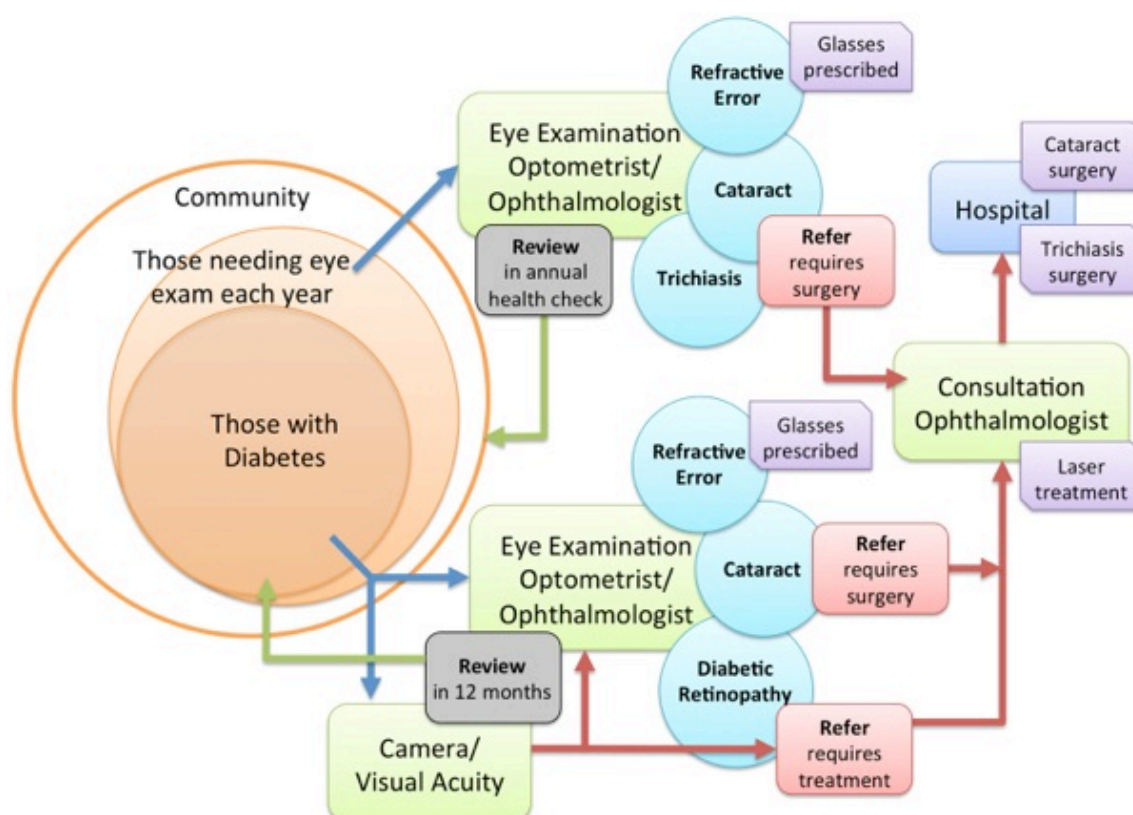
Regional Eye Care referral pathways

Eye care is primarily provided by eye care practitioners: optometrists and ophthalmologists. The majority of eye care in Australia is provided by optometrists, who then refer appropriately to ophthalmologists for treatment or management of eye pathology using medicines, laser or surgery. In the context of eye care provided in/through primary health care settings (such as ACCHOs), the three tiers (primary, secondary, tertiary) of eye care is defined as:

- Primary At the primary health care level (e.g. vision screening for the AHC)
- Secondary By an eye practitioner (e.g. visiting optometrist or ophthalmologist)
- Tertiary Hospital-based care/treatment (e.g. cataract surgery)

Define the referral pathway and referral processes (where do you send referrals to).

This picture 'The Pathways for Eye care' represents the eye care referral pathway as shown by IEHU Roadmap to Close the Gap for Vision, January 2013 page 24: Taylor, H.R., et al., The Roadmap to Close the Gap for Vision (Full Report). 2012, Melbourne School of Population Health, University of Melbourne: Melbourne.



4. Regional Visiting eye Care Schedule

(Regional schedule and local schedule where available)

5. Useful resources

Indigenous EyeInfoNet

The HealthInfoNet is a 'one-stop' internet resource that aims to inform practice and policy in Indigenous health by making research and other knowledge readily accessible. In this way, the HealthInfoNet aims to contribute to 'closing the gap' in health between Indigenous and other Australians.

Australian Indigenous HealthInfoNet

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Telephone: 08 9370 6336

Facsimile: 08 93706022

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