# Indigenous Eye Health

# e-Health and Technology Roundtable

# 11 June 2013

## REPORT

Indigenous Eye Health Unit
Melbourne School of Population and Global Health
The University of Melbourne

# 1. Background

There is much work around the development of information technology (IT) systems to support improved eye care and outcomes for Indigenous Australians. This includes the development of electronic health records, clinical tools and templates for patient management, systems for information sharing and messaging, data monitoring, continuous quality improvement and telehealth.

Much of this work is happening under the auspices of different companies and organisations and there appears overall a lack of shared purpose. There is often confusion and duplication and there is difficulty coordinating the various different interests of the different groups involved.

The aim of the 'Indigenous Eye Health in e-Health and Technology' roundtable was to bring together interested stakeholders (software companies, government departments, Aboriginal health and eye health professionals and non government organisations) to discuss and workshop key parameters for eye health that need to be reviewed or developed in clinical software and other clinical and health systems tools. Additionally, we wanted to explore how eye health service integration outcomes can be supported through the use of these IT systems and software programs.

## 1.1. Roadmap Recommendations

The Roadmap to Close the Gap for Vision Report (Roadmap) contains 42 interlocking recommendations to government and was published by The University of Melbourne in 2012. A checklist of the Roadmap recommendation relevant to e-health and technology is attached to this report in Appendix 3. The checklist highlights that of the 42 Roadmap recommendations, 26 are linked to software and technology.

Key recommendations as outlined in the Roadmap and of primary relevance to e-health, clinical software and IT systems are listed below.

- Primary Eye Care as Part of Comprehensive Primary Health Care – To improve identification and referral for eye care needs from primary health care

- Indigenous Access to Eye Health Services – To enhance access to Aboriginal and mainstream eye services

- Co-ordination and Case Management – To improve co-ordination of eye care services and the successful navigation of referral pathways

- Monitoring and Evaluation - To capture and report information about progress and improvement of services and outcomes in Indigenous eye health

- Governance – To ensure that there is national delivery of 'Close the Gap for Vision'

Recommendations that are of secondary relevance to the roundtable include the following:

- Eye Health Workforce – to increase availability and improve distribution of the eye health workforce

- Elimination of Trachoma – to eliminate blinding trachoma from Australia

- Health Promotion and Awareness – to improve awareness and knowledge of health in communities to support self- empowerment

- Health Financing – to ensure adequate funding is allocated to 'Close the Gap for Vision'

Although these recommendations are critical for the full implementation of the Roadmap recommendations, the actions required to implement these recommendations are not directly linked to the use of software or e-health tools.

## 1.2. Roundtable Objective and Goals

The main objective of the meeting was to bring together people and organisations interested in Indigenous eye Health, e-health and other technologies to discuss and agree upon a few key parameters and processes to be considered and included in software, e-health and reporting and monitoring systems to support and improve Indigenous eye health across Australia.

The Roadmap identifies a number of gaps in the health system that contribute to the inequity of Indigenous eye health in Australia.   The following goals are specifically derived from the Roadmap recommendations:

- appropriate prompts (flags) for eye health are developed and included in existing clinical software;

- tools are utilised by practitioners to facilitate better eye care outcomes

- systems are able to report and monitor eye care indicators

## 1.3. Participants

Advice was sought from the Department of Health and Ageing (OATSIH), National Aboriginal Community Controlled Health Organisation (NACCHO) and the Medical Software Industry Association (MSIA) to seek a list of potential organisations that would be suitable to invite to the Roundtable.  Invitations were sent to 25 organisations.

Participants included those working in the areas of medical software development and IT systems that are currently used, or being developed for use in Aboriginal community controlled health organisations (ACCHO); primary health care services; eye health care; clinical quality and management; e-health; and telehealth.

In total 33 participants from 21 organisations attended the meeting.   Participants incorporated a broad range of knowledge and professional experience from a range of fields including health care providers, health care managers, policy makers, program managers, researchers and software developers.   The mix of perspectives provided for enthusiastic interaction and shared learning through the Roundtable.

# 2. Priorities

The goals above set out three clear priority areas  in which developments in  medical software, IT and e-health systems will assist to implement the recommendations  and contribute to close the gap for vision.  These are primary health care, coordination of eye care, and indicators for eye health.

 A fourth priority telehealth has also been identified as an emergent field in which work is being done to support improved access to eye care.

## 2.1. Primary Health Care

The Roadmap clearly identifies primary health care as the initiator or starting point for eye care patient journey for most Aboriginal and Torres Strait Islander people.   It is necessary to ensure that primary health care is appropriately supported by technology to identify eye care needs, treat basic eye conditions and initiate referral for specialist eye care when required.

### Key Questions – Primary Health Care

1) **What are the appropriate prompts (flags) for eye care required in clinical software for primary health care?**

2) **What are the possible technology solutions to include these prompts?**

3) **What are the barriers to include the prompts and solutions to these barriers?**

   **How do we ensure that the minimum complement of prompts is consistent in all Aboriginal primary care systems?**

### Summary of discussion - Primary Health Care

*Clinical prompts*

The Roundtable broadly agreed that a set of simple clinical prompts were required to be built into clinical software for practitioners to facilitate primary care services with basic eye examinations. This should include prompts for assessment of distance and near vision, retinal examination every 12 months for people identified with diabetes and assessment for trichiasis (where appropriate).

In addition to the clinical prompts mentioned above, recall and messaging capability for eye care services need to be linked to or used to communicate with primary care and hospital services.

These functions will facilitate the co-ordination, follow up and shared care arrangements for patients with eye care needs.

### Guidelines

The eye care prompts need to be developed to facilitate compliance with the Medicare Benefits Schedule (MBS) requirements for Aboriginal and Torres Strait Islander health assessments as well as existing guidelines for best practise including (but not limited to) the RACGP-NACCHO preventative health guide, Central Australian Rural Practitioner's Association (CARPA) Standard Treatment Manual, Clinical Procedures Manual for remote and rural practice (CRANA plus) manual and NHMRC guidelines.

It was recognised that work may need to be done to modify these existing guidelines to include or update best practise for vision and eye examinations.  A suggestion was also made to include linked instructional support within clinical record software.  Standardisation of the eye care requirements within each of these guides was also required.

### Software

There are a vast number of software products and IT solutions around clinical prompts and other tools for primary health care.  Currently none of the templates used in primary health care plans include a suite of vision or eye health items or prompts, although this is being worked on by a number of groups.

Further considerations include the number of software products available, where each has flexibility to tailor to particular needs and share information across different systems.

Eye care health providers, who work across different primary care settings, largely use their own information systems that are different to the information systems used in primary care services.

### Links to existing systems

Recognising there are many clinical tools, prompts and electronic alert and reminders currently used in clinical practice, efforts to link into existing systems should avoid duplication in development and user alert fatigue.

In order for these clinical prompts to be broadly adopted across primary care service, strategies to encourage or facilitate uptake and implementation are needed.   The development of prompts and clinical software tools need to be largely clinician led to ensure that what is developed is practical and used.

There is potential benefit in considering how recalls can be linked to the personally controlled electronic health record (PCEHR) and other national systems.  Linking the prompts and software components to practice accreditation or quality improvement processes could address this issue.

Another suggestions raised, was to link payment of clinicians to services delivered or patient outcomes.

The medical software industry recognises that it is difficult to evaluate the use of many medical software programs and applications available.   There is a need to ensure that any new software

tools developed to improve eye care can work for clinicians across primary care, specialist health and hospital systems.

## 2.2. Co-ordination

The co-ordination of eye care is identified in the Roadmap as a key shortfall of the existing service system. Co-ordination is critical to achieving successful outcomes when referral from primary care to specialist services and hospital services are required.

Treatment for eye and vision problems often involves multiple steps, with different practitioners at different locations. A patient may be referred from the primary health service to an optometrist, then an ophthalmologist and then may also require hospital-based care. Services are managed separately and appointments have to be scheduled independently. Existing referral systems are disconnected and it is a difficult struggle to efficiently transfer information along the pathway of care and back to the referring practitioners.

Often patients requiring treatment for eye or vision conditions will require support for travel and to attend appointments.

The Roundtable workshopped and discussed the potential technology solutions to support co-ordination of the patient journey and improve outcomes.

## Key Questions – Co-ordination

1) **How can technology be used to ensure patient referrals from primary health care are completed?**

2) **Can technology be used to better support patients along this pathway of care?**

3) **How can we better monitor coordination of care?**

4) **What are the strengths and limitations to implementation of these suggestions?**

## Summary of discussion – Co-ordination

### *Electronic messaging and recalls*

The use of electronic recall and messaging systems to facilitate patient recall and follow-up care can improve the patient care pathway. Electronic messaging systems to prompt patient recalls are available and can be tailored by primary care practitioners to include messaging functions to communicate with other practitioners. Although, the majority of software systems in use by optometry and ophthalmology services already comply with national standards for transmitting and receiving messages (HL7.2), most optometry and ophthalmology services do not use these functions to link or share information with the systems that are widely used in primary health care services.

### *Referral processes*

Sector-wide agreement on a set of standards for eye care referral would assist to establish consistent referral processes for eye care across the health system. These processes could then be supported by information and communication tools, such as electronic messaging and referral systems to connect primary care to specialist services including optometry, ophthalmology and hospital-based services. This would help health services to actively follow up referrals.

Currently practise for referrals in many locations, rely on individual phone calls and faxes. These forms of communication are difficult to track or monitor. Additionally, the responsibility for following up referrals is dependent on the individual patient managing and attending their referred appointments.

### Shared care plans and information systems

Electronic forms or templates for referral or shared cared templates provide potential solutions for coordinating care without the impediments associated with paper files. An electronic shared care plan can be easily accessed by all of the people involved in the provision of care for an individual, including their carers and the individual patient. The software for such shared care plans is available from several suppliers.

The potential benefits of using shared platforms such as servers or clouds to provide a central repository for shared data and patient information to improve co-ordination and manage referral processes should be explored.

### Limitations

There are technologies available to assist the monitoring and coordination of patient care. However, uptake and use of the software is variable. Some of the limitations include:

- Practitioners only able to view the information on site
- Clinicians and health care workers not trained in use of systems
- Duplication of work when information is required to be entered into multiple systems
- Workflow systems are not in place
- Practises and procedures underlying the requirements for use of the tools and rules around privacy are not clear

Currently there are few links between primary care and specialist eye services to ensure that treatment is completed following referral. Additionally, there is often much detail relevant to each patient consultation and the existing tools used in primary care service do not easily captured this information , this creates complexity around sharing information relevant to coordinating patient care. The technology can only go as far as recording the referral – technology cannot force a patient to comply with clinical guidelines.

Currently hospital systems are not very flexible; it is difficult to clearly identify feedback from hospitals within primary health care systems. There is potential for Medicare Locals to play a key role in facilitating and coordinating regional health information to link primary care systems with specialist and other services including hospitals.

### 2.3. Reporting and Monitoring Indicators for Eye Care

The need for performance data to ensure services are being appropriately delivered at national, jurisdictional, regional and local levels has been identified as priority to close the gap for vision. Reporting and monitoring of indicators for eye health will inform service planning, and assist in monitoring national performance in eye health.

In addition, the Australian government has international reporting responsibilities to the World Health Organisation (WHO) for eye care under Vision 2020, through the National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss. There are responsibilities under the Australian national eye care framework to report to the Committee of Australian Governments (COAG) and the Australian Health Ministers Advisory Council (AHMAC).

The Roundtable discussed ideas on how the monitoring of indicators for eye health could be effectively supported by technology solutions to improve national oversight for eye health and improve accountability processes for reporting.

## Key Questions - Reporting and Monitoring Indicators for eye care

1. **What are successful examples of national monitoring and reporting in Indigenous health care?**

2. **What are the technology solutions to aggregate local data to support regional and national reporting of eye care?**

3. **What are the technology solutions to aggregate local data to support regional and national reporting of eye care?**

4. **What are the technology solutions to aggregate local data to support regional and national reporting of eye care?**

## Summary of Discussion - Reporting and Monitoring Indicators for Eye Care

Agreement from the eye care sector and government departments on appropriate indicators for eye health and systems to collect, aggregate and report eye health data are needed to monitor progress on closing the gap for vision.

Processes for this sort of information flow were not well set up across jurisdictions or across the health system. Where possible any newly developed information and reporting systems should be designed to assist reporting with the least impost on local health services and practitioners and they should not require duplicate data entry.

A number of successful systems for reporting and monitoring within the health system were identified. These included cervical screening (Pap smear programs), the national diabetes register, and communicable disease reporting and notification systems. These programs were considered successful based on good local data collection, which was then collated and reported at a jurisdictional or national level. Lessons can be drawn from successful reporting processes that have

been implemented in other areas of health, including laboratory testing, infectious disease control, and screening and immunisation programs.

IT solutions or software that can be linked across different operating systems to collect aggregate and report eye health information are required.   This information should be reported up from the local level to regional or jurisdictional levels to then be aggregated and disseminated nationally through an appropriate organisation such as the Australian Institute of Health and Welfare (AIHW). A database that could be accessed through a Web service to collate information would provide a solution for collating and reporting eye health information.   The technology required and the infrastructure to set up such a system is currently available.   However, this type of system would require someone to own the database and publish the information.

Data on the long-term outcomes or management of patients is not necessarily captured within state and national data systems.  Although there are some systems in place to support monthly reporting of primary care indicators in ACCHO services, such as the OCHRE streams project and One-21-Seventy clinical audit system, currently these systems do not regularly monitor or include a suite of eye health indicators.

Almost half of Indigenous adults access services through mainstream providers.   The indicators and reporting systems need to be consistent across Aboriginal health service and mainstream services, to get an accurate national picture on how eye health is progressing.   Consideration should also be given to appropriate governance structures for oversight of the monitoring and reporting of eye health.

It was noted that the success of Indigenous patient identification within mainstream services was variable and better processes for identification should be promoted to address this issue and ensure more accurate reporting.


## 2.4. Telehealth

### An emergent technology

There is significant interest in government in telehealth and we can identify interest from the eye care sector.  At least four identified projects in WA, QLD, NSW and NT are currently underway. Another two projects are currently seeking funding.   Each of these trials is being developed to investigate the use of telehealth technologies for diabetic retinopathy screening.

There are many reasons to consider telehealth as an option to increase access to eye care. Benefits of telehealth include reduction of patient travel costs, the ability for clinicians to provide and receive timely feedback and improved communication between primary health care and specialist services.

Development of camera technology can potentially affect the cost of diabetic retinal screening programs. The issues around constantly having to update cameras and software as technology improves are a potential disadvantage.

Telehealth can contribute to better eye health outcomes in the future, and the existing trials will shed light on the challenges and benefits associated with this technology.   Telehealth will provide a useful tool and link to improve access to consultations but may not necessarily improve patient

outcomes. The development of telehealth technology needs to occur alongside improvements in service delivery and co-ordination of eye care. .

## 3. Principles

The following principles were broadly agreed through discussion by the Roundtable participants and underlie each of the Roundtable outcomes:

1. Sectors should work to minimize duplication of effort;
2. Sectors should work to ensure sharing of information and lessons;
3. The workload impost of eye care on eye care practitioners and health service administrators within software, IT and e-health systems should be minimized;
4. Work in this area should be consistent with best quality, best practice approaches;
5. Development of any technology-based solutions should be clinician led.

## 4. Actions

We identify the next steps to progress activity and address specific issues for each of the four priority areas.

### 4.1. Actions for Primary Health Care

i. Work with the OAA, RANZCO, NACCHO and RACGP to develop sector agreement on standardisation of clinical flags or prompts for eye health including:
   - near and distance vision
   - diabetic eye examinations and
   - trichiasis.

ii. Once the requirements for these prompts have been agreed, work with the medical software industry to ensure that appropriate prompts are developed and incorporated into existing medical software packages.

iii. Once software is available, promote use of prompts and practitioner implementation through the inclusion of vision and eye health care in primary health care quality and accreditation processes.

### 4.2. Actions for Coordination

i. Work with primary health care services, optometry, ophthalmology, and hospitals to develop agreement on the scope and extent of information that is required to be regularly collected, reviewed, and shared between practitioners

to provide appropriate feedback in the referral process and to facilitate coordination of treatment for eye and vision issues.

ii. Work with primary health care services, hospitals and the medical software industry to extend the scope of existing recall and messaging systems to include functionality for secure messaging between primary care services, hospitals and optometry and ophthalmology services when required.

iii. Encourage the use of automated referrals and electronic discharge summaries for eye and vision care, by primary care services, specialist services and hospital based services where possible.

## 4.3. Actions for Monitoring and Reporting Indicators for Eye Care

i. Work with relevant government departments, the eye care sector and medical software industry association to incorporate the sector agreed indicators for eye care into existing data monitoring streams, including but not limited to OCHRE streams, and Pen CAT (Pen Clinical Audit Tool).

ii. Continue advocacy for separate Medicare item numbers for laser treatment of the ocular complications of diabetes.

iii. Identify regions and services where primary health care, eye care and hospital–based services organisations can aggregate local eye health data into a regional dataset to be used for regional eye health planning.

## 4.4. Actions for Telemedicine

i. Promote opportunities to share information on developments in regional and national eye telehealth projects to reduce unnecessary duplication. This could include the use of central repositories such as the Australian Indigenous Health InfoNet, improved circulation of online newsletters and the Closing the Gap Clearing House.

ii. Continue to review current processes and systems for the management and treatment of patients with diabetes. Ensure that maximum use of existing, low cost technologies and systems for the management of diabetic retinopathy are strengthened along with development of new technologies. These systems support the whole patient journey and will support the sustainability of future telehealth initiatives to improve diabetic retinopathy screening.

## 4.5. Other Actions

The informal national oversight body established under the guidance of the Roadmap that includes NACCHO, OAA, RANZCO, and Vision 2020 Australia, will seek input from RACGP, to develop technical

advice for the medical software industry to ensure that tools to facilitate eye care are developed and integrated with sector support and in alignment with best practise.   This will include definition of standardised terminology and indicators.

# 5. Issues for the Commonwealth arising from the Indigenous Eye Health in e-health and Technology Roundtable

## 5.1. Issues for Primary Health Care

i.   The key next step arising from the roundtable was for the eye care sector to establish agreement on a set of eye care items that can be included in medical and clinical decision support software and health care information and communication systems.  Once agreed, work with the medical software industry is required to ensure these prompts and items can be included in existing systems.

ii.   Eye health indicators need to be built into and included in primary health care quality, monitoring and accreditation processes. The indicators could also be included in standards and guidelines for primary health care and brief training for primary health care practitioners.  The eye health indicators have been indentified and included in the National Framework mentioned below.

iii.   The Commonwealth could support the development of web-based modules or brief training on the inclusion of eye care primary health care and e-health systems.

## 5.2. Issues for Coordination

i.   The need to share information between eye care, primary care, visiting and hospital services was identified as a key issue for improving eye health.  Visiting service providers need to be familiar with and use the existing health information, communication and technology systems that are used by local health services and appropriate eye health checks need to be included in recall systems.

ii.   Visiting eye care services that are supported by the Commonwealth including the Visiting Optometry Scheme (VOS),  Medical Specialists Outreach Assistance Program (MSOAP) Urban Specialists Outreach Assistance Program (USOAP) and Rural Health Outreach Fund (RHOF) are an important care provider in the mix of eye care services.  These visiting services need to be integrated into existing communication and information sharing systems to improve coordination of eye care.

iii.   The Commonwealth could consider how best to support the linkages between primary care and specialists care services and hospitals, in particular to improve referral systems and

provide feedback on outcome of referral. Medicare Locals could play a key role in supporting the coordination of regional eye care services. Hospital systems were identified as being particularly problematic for electronic systems communication in and out of the hospital.

iv. Additional support is required at the regional level to identify or establish an information sharing and communication hub. The roundtable identified that this hub should be web-based to enable primary health care, eye care, visiting and hospital–based services to share data and information.

## 5.3. Issues for Monitoring and Reporting Indicators for Eye Care

i. A web-based hub could enable local eye health data to be aggregated into a regional dataset to be used for regional eye health planning and could also be used for jurisdictional and national monitoring of eye health.

ii. The proposed National Framework for the Prevention of Avoidable Blindness Implementation Plan includes Aboriginal and Torres Strait Islander eye health as a priority. This framework includes a set of sector agreed indicators to monitor national eye health performance. These indicators need to be included in the national data monitoring systems, including but not limited to OCHRE streams and the National Health Performance Authority (NHPA).

iii. The roundtable also identified the need for a separate Medicare item number for laser treatment of the ocular complications of diabetes to enable the effective monitoring of this component of eye care.

## 5.4. Issues for Telemedicine/ Telehealth

i. Multiple eye care telehealth projects are investigating the use of telehealth for diabetic retinopathy screening. The Commonwealth could promote opportunities to share information on developments related to these innovative telehealth projects. This could reduce unnecessary duplication and share lessons from each of the projects. The use of central repositories such as the Australian Indigenous Health InfoNet, improved circulation of online newsletters and the Closing the Gap Clearing House are appropriate platforms for this level of information sharing and dissemination.

ii. The solutions to improve care for patients with diabetes will not come from technology alone. Solutions that encourage the use of low cost technologies and improving best practise for the management of diabetic retinopathy, such as the use of diabetic care plans and retinal photography should be strengthened. Developing the systems that support the whole patient journey will also support the sustainability of future initiatives to improve diabetic retinopathy screening such as telehealth.

## 5.5. National oversight

i.    Stakeholders at the roundtable identified that there is currently no existing structures to oversee national monitoring and governance and set national guidelines and benchmarks for Indigenous eye health including those matters that are relevant to e-Health, software and new technologies.

Stakeholders agreed that further consultation with the Department of Health and Ageing was required to identify the appropriate commonwealth body (or bodies) with oversight of e-Health, health monitoring systems and health information communication technology systems, for which Indigenous eye health issues can be raised and prioritised.

## APPENDIX 1 - List of Roundtable Participants and Organisations

| | | |
|---|---|---|
| Jaki | Adams- Barton | Fred Hollows Foundation |
| David | Andrews | Royal Australia and New Zealand College of Ophthalmologists |
| Mitchell | Anjou | Indigenous Eye Health Unit |
| Luke | Arkapaw | Brien Holden Vision Institute |
| Tricia | Boetta | Royal Australian College of General Practitioners |
| Andrea | Boudville | Indigenous Eye Health Unit |
| Laima | Brazionis | Telehealth Eye and Associated Medical Services Network (TEAMSnet) |
| Anthea | Burnett | Brien Holden Vision Institute |
| Sven-Erik | Bursell | Telehealth Eye and Associated Medical Services Network (TEAMSnet) |
| Judy | Carrigan | Indigenous Eye Health Unit |
| Wills | Cindy | MKM Health |
| Lesley | Bainbridge | Commonwealth Department of Health and Ageing |
| Brian | Dunstan | Database Consultants Australia |
| Julian | Flint | Improvement Foundation |
| Michael | Georgeff | Precedence Health |
| Derek | Gower | Houston Medical |
| Vanessa | Harris | Lowitja Institute |
| Paul | Harvey | Ellex |
| Alex | Hope | Aboriginal Medical Services Alliance Northern Territory |
| Jon | Hughes | Smart Health Solutions |
| Peter | Kiriazis | Ellex |
| Vince | McCauley | Medical Software Industry Association |
| Susan | Mizrahi | Vision 2020 Australia |
| Roy | Monaghan | National Aboriginal Community Controlled Health Organisation |
| Aislin | Martin | Royal Australian College of General Practitioners |
| David | Murtagh | Aboriginal Medical Services Alliance Northern Territory |
| Lyndon | Ormond-Parker | The University of Melbourne |
| Lesley | Podesta | Fred Hollows Foundation |
| Georgia | Savage | Fred Hollows Foundation |
| Jared | Slater | Optometrists Association of Australia |
| Hugh | Taylor | Indigenous Eye Health Unit |
| Dee | Tumino | Vision 2020 Australia |
| Mary | Warner | Commonwealth Department of Health and Ageing |

## Apologies

| | | |
|---|---|---|
| Ross | Nable | Australian Medicare Local Alliance |
| Angus | Turner | Lion's Eye Institute |
| Tim | Henderson | Alice Springs Hospital |
| Brad | Murphy | Royal Australian College of General Practitioners |
| Ross | Bailie | Menzies Research Institute |
| Matthew | Corkhill | Commonwealth Department of Health and Ageing (eHealth) |

**APPENDIX 2 - Agenda**

**Indigenous Eye Health**

**in e-Health and Technology Roundtable**

VENUE       Graduate House 220 Leicester Street, Carlton, Victoria, 3053

AGENDA

| | |
|---|---|
| 9.30 am | Coffee and tea available at Graduate House |

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|---|---|---|
| 10.00 AM | Welcome and introductions | |
| | Hugh Taylor | IEHU UoM |
| | Lyndon Ormond-Parker | UoM |

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|---|---|---|
| 10.30 am | Session 1 **Primary health care** | |
| | Tricia Boetta | RACGP |
| | Vince McCauley | MSIA |
| | Group discussions | |
| | Feedback and discussion | |

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|---|---|
| 11.40 am | Break |

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| 11.55 am | Session 2 **Coordination of eye care** | |
| | Roy Monaghan | NACCHO |
| | Luke Arkapaw | BHVI |
| | Group discussions | |
| | Feedback and discussion | |

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| 12.55 pm | Lunch |

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| 1.30 pm | Session 3 **Telehealth** | |
| | Lesley Podesta | FHF |
| | Sven-Erik Bursell | TEAMSnet |
| | Anthea Burnett | Vision CRC |
| | Discussion | |

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| 2.10 pm | Break |

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| 2.25 pm | Session 4 **Eye care indicators** | |
| | Susan Mizrahi | Vision 2020 Australia |
| | Julian Flint | IF |
| | Group discussions | |
| | Feedback and discussion | |

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| 3.35 pm | Wrap up and conclusion |
| | Lyndon Ormond-Parker |
| | Hugh Taylor |

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|---|---|
| 4.00 pm | Drinks and nibbles |

## APPENDIX 3.  Roadmap and e-Health and Technology Checklist

## The Roadmap to Close the Gap for Vision Recommendations

| 1 | | PRIMARY CARE AS PART OF COMPREHENSIVE PRIMARY HEALTH CARE | e-health and technology |
|---|---|---|---|
| | 1.1 | Enhancing eye health capacity in primary health services | ✔ |
| | 1.2 | Health assessment items include eye health | ✔ |
| | 1.3 | Diabetic retinopathy detection | ✔ |
| | 1.4 | Eye health inclusion in clinical software | ✔ |
| **2** | | **INDIGENOUS ACCESS TO EYE HEALTH SERVICES** | |
| | 2.1 | Aboriginal Health Services and eye health | |
| | 2.2 | Cultural safety in mainstream services | |
| | 2.3 | Low cost spectacles | ✔ |
| | 2.4 | Hospital surgery prioritization | ✔ |
| **3** | | **CO-ORDINATION AND CASE MANAGEMENT** | |
| | 3.1 | Local eye care co-ordination | ✔ |
| | 3.2 | Clear pathways of care | ✔ |
| | 3.3 | Workforce identification and roles | |
| | 3.4 | Eye care support workforce | |
| | 3.5 | Case co-ordination | ✔ |
| | 3.6 | Partnerships and agreements | ✔ |
| **4** | | **EYE HEALTH WORKFORCE** | |
| | 4.1 | Provide eye health workforce to meet population needs | |
| | 4.2 | Improve contracting and management of visiting services | ✔ |
| | 4.3 | Appropriate resources for eye care in rural and remote areas | ✔ |
| | 4.4 | Increase utilisation of services in urban areas | ✔ |
| | 4.5 | Billing for visiting MSOAP supported services | ✔ |
| | 4.6 | Rural education and training of eye health workforce | |
| **5** | | **ELIMINATION OF TRACHOMA** | |
| | 5.1 | Definition of areas of risk | |
| | 5.2 | Effective interventions | |
| | 5.3 | Surveillance and evaluation | ✔ |
| | 5.4 | Certification of elimination | ✔ |
| **6** | | **MONITORING AND EVALUATION** | |
| | 6.1 | Managing local eye service performance | ✔ |
| | 6.2 | State and National performance | ✔ |
| | 6.3 | Collating existing eye data sources | ✔ |
| | 6.4 | National benchmarks | ✔ |
| | 6.5 | Quality assurance | ✔ |
| | 6.6 | Primary health service self-audit in eye health | ✔ |
| | 6.7 | Program evaluation | ✔ |
| **7** | | **GOVERNANCE** | |
| | 7.1 | Community engagement | |
| | 7.2 | Local Hospital Networks and Medicare Locals | ✔ |
| | 7.3 | State/territory management | ✔ |
| | 7.4 | National oversight | ✔ |
| | 7.5 | Program interdependence | |
| **8** | | **HEALTH PROMOTION AND AWARENESS** | |
| | 8.1 | Eye health promotion | |
| | 8.2 | Social marketing eye care services | |
| **9** | | **HEALTH FINANCING** | |
| | 9.1 | Current spending on Indigenous eye health (non trachoma) | |
| | 9.2 | Current spending on trachoma | |
| | 9.3 | Full additional annual capped funding required | |
| | 9.4 | Cost to 'Close the Gap for Vision' funded for 5 years | |