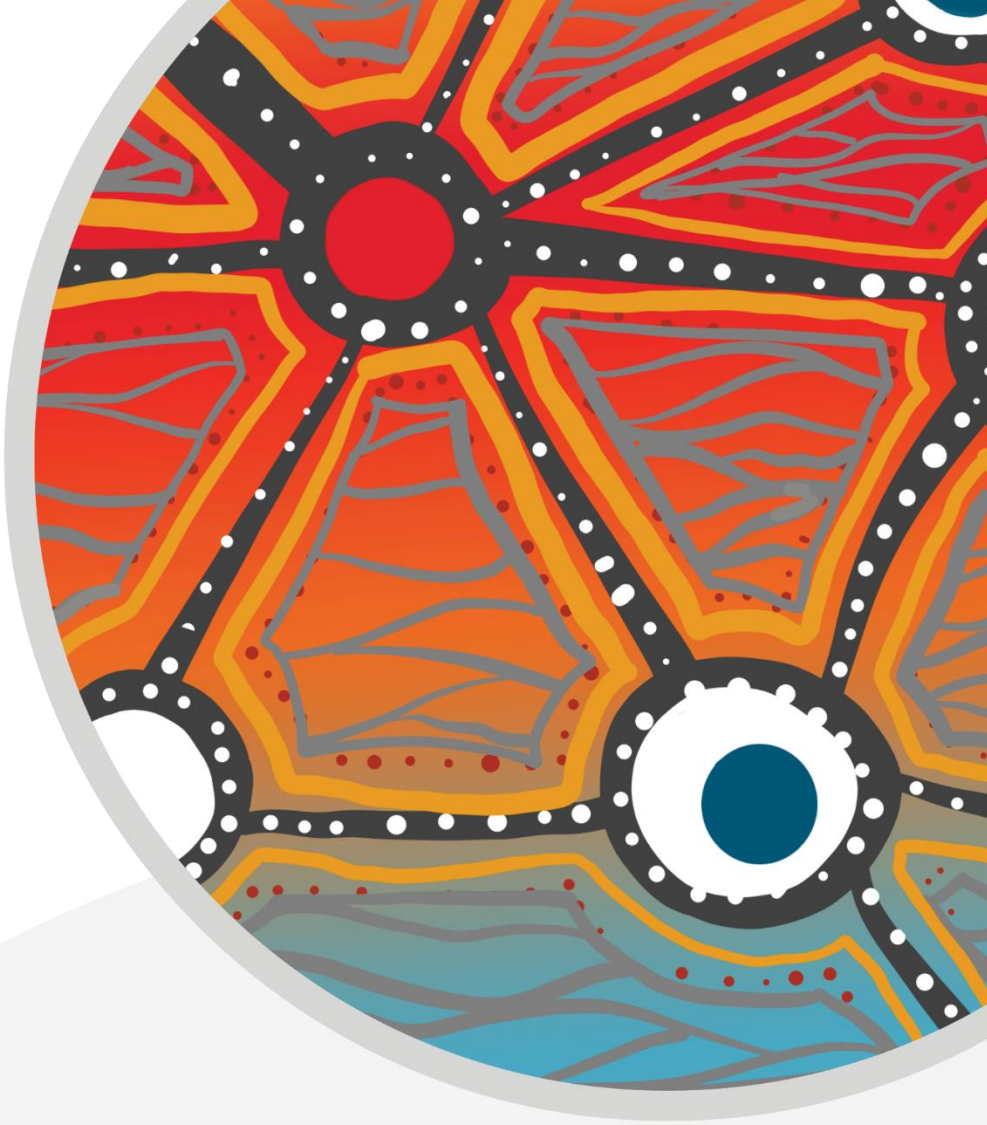

EVALUATION OF REGIONAL IMPLEMENTATION OF THE ROADMAP TO CLOSE THE GAP FOR VISION

INDIGENOUS EYE HEALTH, THE UNIVERSITY OF MELBOURNE

FINAL REPORT

JULY 2021

www.artd.com.au

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This work was completed with the assistance of the Indigenous Eye Health Unit at the University of Melbourne. We would especially like to acknowledge Tessa Saunders, Academic Specialist in Indigenous eye health policy and practice and Mitchell D Anjou, Associate Professor and Deputy Director of Indigenous Eye Health.

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ARTD Consultancy team

We also acknowledge the talent and artistry of Emma Walke, who designed the artwork for our report cover page. The design shows a story of connection to country and people, representing the breadth of work we do with Aboriginal and Torres Strait Islander communities across Australia. The colours represent the land, and the lines in between represent the water that connects us all.

ABBREVIATIONS AND ACRONYMS

ACCHO	Aboriginal Community Controlled Health Organisation
ACO	Australian College of Optometry
AHLO	Aboriginal Health Liaison Officers
AIHW Indigenous Eye Health Measures	Australian Institute of Health and Welfare Indigenous Eye Health Measures reports
AMS	Aboriginal Medical Services
ATSIRG	Aboriginal and Torres Strait Islander Reference Group
IEH	Indigenous Eye Health
IEHU	Indigenous Eye Health Unit
PICC	Palm Island Community Company
REHCs	Regional Eye Health Coordinators
Roadmap	Roadmap to Close the Gap for Vision
RVEEH	Royal Victorian Eye and Ear Hospital
RWAV	Rural Workforce Agency Victoria
VAHS	Victorian Aboriginal Health Services
VOS	Visiting Optometrists Scheme

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EXECUTIVE SUMMARY

This report presents the results of an independent evaluation of the progress and effectiveness of regional implementation of the *Roadmap to Close the Gap for Vision* (the Roadmap).

Project context

In 2012, the Indigenous Eye Health Unit (IEHU) at the University of Melbourne launched the Roadmap. A key element of the Roadmap included a recommendation to establish regional collaborative networks to facilitate implementation of Roadmap priorities and activities.

About the evaluation

This evaluation is one of three separate, but complementary pieces of research commissioned by IEHU to understand the regional approach to implementation of the Roadmap. The focus of this evaluation, conducted by ARTD Consultants, is to understand how regional activities have been implemented, key enablers and barriers, changes that have occurred across the eye care pathway and learnings for the future.

The evaluation has been informed by a co-design process with key stakeholders from across the national eye health sector and overall guidance provided by an Aboriginal and Torres Strait Islander Reference Group and a project advisory committee. A concurrent mixed-method design was used to inform data collection and address the key evaluation questions:

1. How is regional activity to improve eye care services for Indigenous Australians being implemented across Australia?
2. What are the enablers and barriers to implementing regional eye health activity?
3. What changes are happening as a result of this activity?
4. What role has IEH played in supporting regional activities?
5. What else is needed to improve eye care systems and eye health outcomes for Indigenous Australians?
6. Are there learnings that are transferrable beyond Indigenous eye care?

Data sources and methods

Key findings

Implementation

Regional implementation data provided by IEHU shows that of the 64 identified regions covering the whole of Australia, 63 of these are currently considered by IEHU as 'active' collaborations[1]. This constitutes a 98.7 per cent reach in terms of the Australian Indigenous population. Of the 182 Aboriginal Community Controlled Organisations (ACCHOs) and other Aboriginal Medical Services, 99 per cent of these are covered by Roadmap regions and 89 per cent are actively engaged in Roadmap regions.

Stakeholders identified factors supporting regional implementation of the Roadmap including:

- having Aboriginal and Torres Strait Islander representation and leadership in regional groups to ensure group priorities are reflecting those of the communities being served;
- having ongoing dialogue and connections across communities and sectors to determine solutions that work for individual regions, including supporting health system planning and development;
- dedicated funded coordinator for regional groups to support progress of regional groups and provide a mechanism for accountability;
- Close the Gap for Vision IEHU conferences/roundtables and annual Roadmap reports and updates.

Barriers affecting implementation included:

- a lack of reported cultural safety within some regional groups;
- competing health priorities for community and health professionals as health disparities have increased in other areas of care;
- funding challenges experienced by many in the health sector including short-term funding, the impact of which is higher staff turnover and transitions, with many staff covering multiple roles which creates additional burden on regional group members.

Effectiveness

Survey respondents agreed (63 per cent) that there have been positive changes to Indigenous eye care since 2013, particularly in relation to **improved access to eye health services and treatment** for Aboriginal and Torres Strait Islander people, however, there is still further work to be done. Factors improving access have included having greater numbers of Aboriginal and Torres Strait Islander healthworkers, improvements in referral pathways and increased availability of culturally safe services.

Service providers have improved provision of eye care programs and services for Aboriginal and Torres Strait Islander people (60 per cent agree, 29 per cent tend to agree) including **communication and coordination of eye care** across providers. Stakeholders also noted that through regional groups they have developed a **better understanding of the data** gaps and challenges in monitoring and data collection of Aboriginal and Torres Strait

[1] IEH Unit (2021, May). *Regional implementation data overview.* Melbourne: IEH.

Islander patients across services and it will be important to continue to build this evidence base in future.

Stakeholders identified a **strong increase in awareness of Aboriginal and Torres Strait Islander eye health** as a result of regional implementation at all levels of the system with IEHU having a significant role raising the profile and increasing awareness at a national level. At a service provider level, awareness has been increased through eye health education in communities and targeted funding for Aboriginal and Torres Strait Islander eye health care.

Stakeholders reported regional groups have **improved use of local resources** by facilitating opportunities for local key eye health partners to map access and referral pathways for patients through the eye health system and identify areas of duplication, gaps and look for opportunities to create efficiencies. To support this it will be important to ensure regional partnerships and networks can be sustained, although the sector is still facing challenges in relation to funding and adequate regional eye care workforce.

Future

The regional approach of working collaboratively through local networks and partnerships to strengthen Indigenous eye care services is potentially applicable across a range of health conditions that affect Aboriginal and Torres Strait Islander people. Principles of a regional approach that could be applicable to other contexts included community ownership and empowerment, capacity building, cultural safety and appropriateness and improvements to coordination of services at a system level.

Looking forward

The evaluation has identified four key lessons to respond to challenges and build on achievements and further embed regional approaches.

1. INTRODUCTION

1.1 BACKGROUND AND POLICY CONTEXT

In 2008, the National Indigenous Eye Health Survey found that Aboriginal and Torres Strait Islander adults experience higher rates of vision loss and blindness than other Australians. It also found that vision loss accounted for 11 percent of the Indigenous health gap and that 94 percent of vision loss was preventable or treatable.

In 2012, the Indigenous Eye Health Unit (IEHU) at the University of Melbourne launched the *Roadmap to Close the Gap for Vision* (the Roadmap), building on the 2008 survey by documenting the findings of extensive national consultations. The Roadmap outlines 42 policy and practice recommendations to close the gap for vision, providing an evidence-based, whole-of-system framework for action at the local, state and national levels in order to achieve eye health equity.

To date, 24 of the 42 recommendations have been fully implemented and 84 per cent of activities completed, with the remaining in progress[2]. Significant progress towards closing the gap for vision has been made, with rates of blindness among Aboriginal and Torres Strait Islander people reducing from six to three times that of non-Indigenous people from 2008 to 2016.

The achievements and learnings of the implementation of the Roadmap has informed a subsequent national five-year plan for Aboriginal and Torres Strait Islander eye health and vision, *Strong eyes, Strong communities 2019–2024*. This plan complements existing work of the Roadmap, with an increased focus on community leadership and control, expanded mainstream services and an ongoing commitment to flexible, regionalised delivery with national oversight.

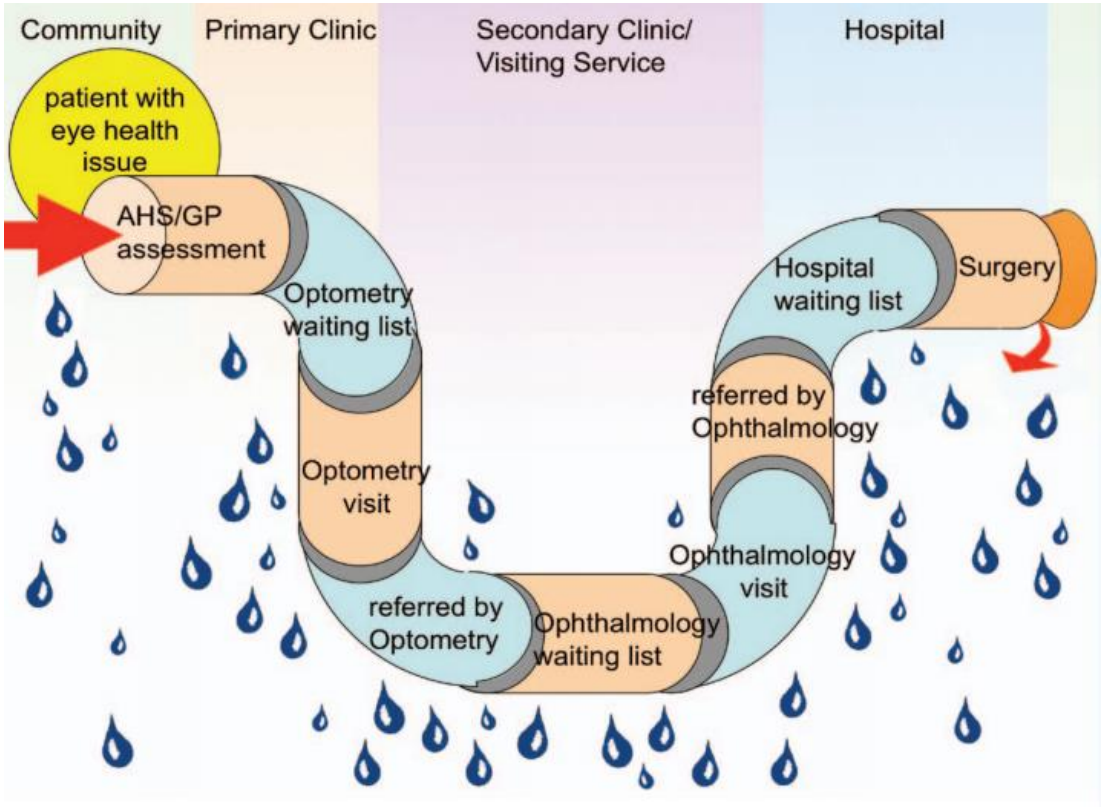
1.2 REGIONAL IMPLEMENTATION OF THE ROADMAP

A key recommendation of the Roadmap is the establishment of regional collaborative networks to facilitate implementation of the Roadmap. These networks include stakeholders from across the eye health care pathway. The regional model is seen as a way to ensure locally determined and relevant approaches to improving eye health systems.

The Roadmap recognises that access to good quality and culturally-safe eye care services is fundamental to improving the health of Aboriginal and Torres Strait Islander Australians but there are a number of system gaps, barriers and inefficiencies that prevent this. This is commonly depicted through the image of a 'leaky pipe' (Figure 1), which represents the challenges within the patient pathway for eye care.

[2] Indigenous Eye Health Unit (2020). Annual Update on the Implementation of the Roadmap to Close the Gap for Vision. University of Melbourne: Author. Retrieved from https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0008/3543713/2020-AnnualUpdate.pdf

FIGURE 1. THE 'LEAKY PIPE' IN THE PATIENT PATHWAY FOR EYE CARE



Source: The Roadmap to Close the Gap for Vision. (2012). Indigenous Eye Health Unit, Melbourne School of Population Health, The University of Melbourne.

The 'leaky pipe' illustrates the need for a coordinated, whole-of-system approach to improving service delivery and outcomes. Key to achieving this is the establishment of 'regional collaborative networks'. These networks include stakeholders from across the eye care pathway, including Aboriginal Medical Services (AMS), Primary Health Networks, Local Hospital District/ Networks, regional health authorities/ departments, local and visiting eye care practitioners and local health services. IEHU operates as an intermediary coordinating body, providing support and advocacy across the regional networks and broader advocacy and health promotion.

Since 2013, 63 regional networks have been established across Australia, covering over 98.7 per cent percent of the Indigenous population. The way the Roadmap is implemented differs across networks, reflecting the diversity of communities, systems and structures, the different needs across geographical settings, and varied stages of implementation.

The regional model is as a key strategy to ensure flexibility and appropriateness for different needs within regions, and ownership by those living and working within the local area. Indigenous participation and leadership through Aboriginal Community Controlled Health Organisations (ACCHO) and other AMS is central to regional implementation.

1.3 DEFINING A REGIONAL APPROACH[3]

A definition of what is meant by a 'regional approach' is required in order to evaluate this way of working and to assess its effectiveness. The IEHU advice on what constitutes regional approaches has been adapted over time, in order to be responsive to regional need and changing context.

Prior to the launch of the Roadmap, previous Australian Government Department of Health-funded programs had supported implementation of Regional Eye Health Coordinators (REHCs) in around 30 regions across Australia, commencing in the 1990s. However, subsequent policy changes to the REHC program in 2003 resulted in funds previously allocated for eye care activity being incorporated into Aboriginal Health Service program funding, of which eye care was one of many activities that could be funded based on the priorities of the health service.

The consultations for the Barriers project (along with analysis of past reviews of programs) found that, although there had been significant contribution made by REHCs with regard to delivery of eye care services, and that REHCs had played a key role in eye care service organisation and arrangement, this varied across the 34 original regions for the program and in some regions REHCs had not been employed or there were current vacancies[4].

It also found that REHCs did not function well when working in isolation and when their roles worked only at a service delivery level. Consultations found that better progress was made where REHCs functioned as facilitators of local eye health systems, working with others to improve coordination across the eye care pathway and encouraging integration of primary health care with local 'specialist' eye care services (including visiting optometric and ophthalmic services).

Reliance on a single role or person assisting individual clients was found to be a barrier to system change. In addition, the definitions of the roles of REHCs were not clear and were found to be inconsistent across different regions, with many roles vacant at the time of consultation.

The need for 'local' or 'regional' approaches, supported by and feeding into jurisdictional and national structures was also identified in the consultations. Local knowledge, ownership and participation was identified as crucial - including local hospitals, local eye care service providers, local ACCHOs and local community members[5].

[3] This section draws heavily on a desktop review conducted by the IEHU. We would like to acknowledge Tessa Saunders, Guy Gillor, Guy-Robert Lahens and Mitchell Anjou for allowing us to include the definition of a regional approach and summary of key steps involved in regional implementation of eye care services for Aboriginal and Torres Strait Islander Australians.
[4] Anjou, M. D., Boudvile, A. I., & Taylor, H. R. (2012). We can see the gap regional eye health coordination for indigenous Australians. *Aboriginal and Islander Health Worker Journal, 36*(2), 12-16.
[5] Taylor, H.R., et al. (2012). *The Roadmap to Close the Gap for Vision: Full Report*. The University of Melbourne.

Therefore, the regional approach proposed by the Roadmap and IEHU has focused on population-based and system-level coordination at a localised level, involving key stakeholders in the eyecare pathway.

Population-based approaches to improving eyecare are central to Roadmap recommendations – as opposed to individual clinics that focus only on their patient cohort, or jurisdictional or national level approaches that would not account for local needs and context. This population-based approach is discussed throughout the Roadmap and became a key element of the later regional implementation approach advocated for by IEHU.

When consolidated, the key regional implementation steps include:

1. Define region, including population and surgical hub
2. Undertake gap analysis (based on population) to determine regional needs, service needs, and existing services
3. Establish regional collaborative network
4. Identify co-ordination and case management staff and allocate roles
5. Establish regional data collection and monitoring system
6. Develop regional service directory and referral protocols
7. Ensure regional accountability and oversight
8. Undertake local planning and action through regional collaborative network
9. Introduce regional health promotion and awareness

1.4 READING THIS REPORT

Section 2 provides details on the evaluation purpose, methods and data sources, including analysis procedures and strengths and limitations. The findings are presented across two sections.

Section 3 presenting findings from a national survey of the Indigenous eye health sector that captures views regarding implementation supports, the effectiveness of regional groups and changes to Indigenous eye care.

Section 4 presents detailed insights on how regional implementation has occurred in practice, including barriers and enablers to establishment and delivery, outcomes achieved, the role of IEHU and aspirations for the future, including lessons on transferability of the regional approach.

Section 5 identifies key lessons to consider for future development of the regional approach to strengthening Indigenous eye health.

2. ABOUT THE EVALUATION

This chapter describes the approach and methods that have been used to evaluate regional implementation of the Roadmap. It includes details on the evaluation scope, questions, data sources and analysis procedures. Limitations of the evaluation are also identified. Details relating to specific aspects of data collection are elaborated in relevant sections of the report.

2.1 SCOPE AND FOCUS

The evaluation is one of three separate, but complementary pieces of research commissioned by IEHU to understand the regional approach to implementation of the Roadmap:

- a desktop review of all publicly-available information on regional eye health activity (delivered by IEHU)
- an evaluation of the specific role of IEHU in implementing a regional approach to the Roadmap (delivered by Clear Horizon)
- an evaluation of the regional approach to implementation of the Roadmap (this evaluation).

The focus of this evaluation is to understand how regional activities have been implemented, key enablers and barriers to implementation, changes that have occurred across the eye care pathway as a result of regional implementation, and identifying ongoing system gaps and learnings for the future.

The IEHU, Clear Horizon and ARTD have worked collaboratively to minimise the burden of data collection on stakeholders and with the consent of participants, to share data and insights where there is overlap in focus.

2.1.1 ETHICS AND IMPACT OF COVID-19

Multiple ethics approvals were obtained for the evaluation project, from The University of Melbourne, the Australian Institute of Aboriginal and Torres Strait Islander Studies, the Aboriginal Health Research Ethics Committee of South Australia, the Aboriginal Health and Research Committee of NSW, the Western Australian Aboriginal Human Ethics Committee, the Northern Territory Human Research Ethics Committee, the Central Australia Human Research Ethics Committee, and the Townsville Health and Hospital Service Human Research Ethics Committee. In addition, Research Governance Office (RGO) approvals were provided from multiple RGOs.

Due to the implications of the COVID-19 pandemic, changes to the methodology for the project were required and ethics amendments accepted for these. This included extending the time-frame for data collection and the project; changing the majority of interviews and focus groups to video-based (using Zoom) rather than face-to-face; and removing the hard-copy option for the national survey. These changes, as well as the additional burden on organisations and individuals due to COVID-19, are likely to have impacted on individual's capacity to participate in the evaluation.

2.2 CO-DESIGNED

The evaluation has been informed by a co-design process with key stakeholders from across the national eye health sector and overall guidance provided by an Aboriginal and Torres Strait Islander Reference Group and a project advisory committee. This has helped to ensure the evaluation addresses the needs and priorities of those impacted by the Roadmap and increases stakeholder ownership and use of the findings.

The evaluation has incorporated three co-design workshops, to date—the first to confirm the evaluation aims and methods, the second to share and reflect on the preliminary findings and make necessary refinements to the methods, and the third to share all findings and get input on the draft report. These workshops were facilitated by independent Aboriginal facilitator, Kate Kelleher.[6]

2.3 KEY QUESTIONS

Table 1 shows alignment between the focus of the evaluation, evaluation questions and relevant sections of the report.

TABLE 1. KEY EVALUATION QUESTIONS

Evaluation focus	Question		Report section
Implementation	1.	How is regional activity to improve eye care services for Indigenous Australians being implemented across Australia?	3.2, 4.1 and 4.2
	2.	What are the enablers and barriers to implementing regional eye health activity?	3.2 and 4.3
Effectiveness	3.	What changes are happening as a result of this activity?	3.4 and 4.4
	4.	What role has IEHU played in supporting regional activities?	4.5
Future	5.	What else is needed to improve eye care systems and eye health outcomes for Indigenous Australians?	4.6
	6.	Are there learnings that are transferrable beyond Indigenous eye care?	4.6

[6] http://www.katekelleherconsulting.com/

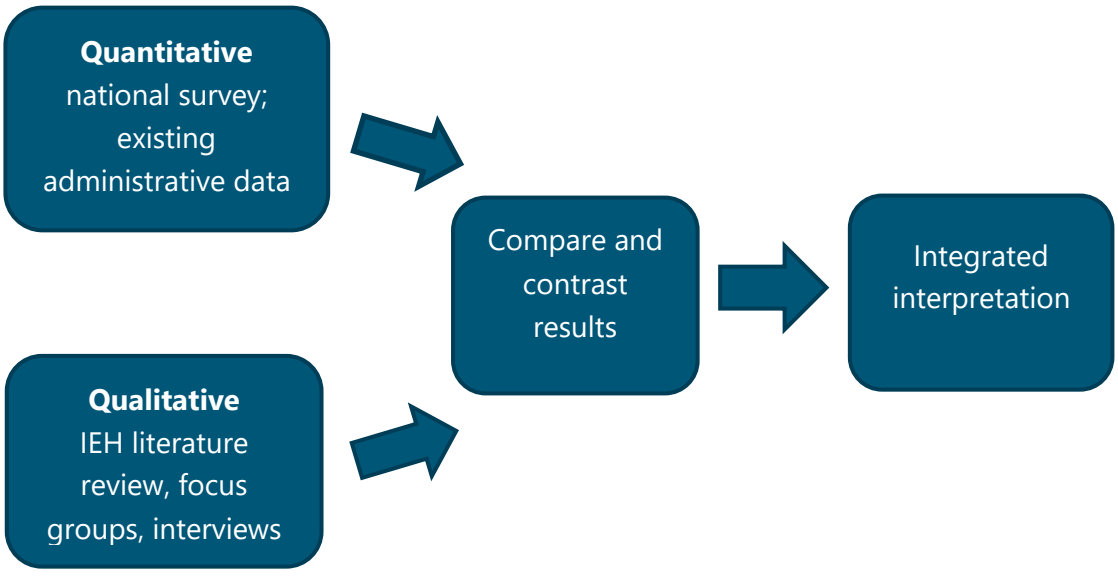
2.4 METHODOLOGY

We used a concurrent mixed-method design to inform data collection. This enabled a holistic view of regional implementation progress and outcomes to answer the key evaluation questions using the following methods and data sources (see Figure 2):

- available existing data collected and collated by IEHU, including metrics on regional groups and a literature review;
- scoping interviews with the IEHU to understand their perspectives on implementation progress and effectiveness;
- a survey of stakeholders involved in the eye health sector across all regional networks including members of regional network groups;
- focus groups and interviews with key stakeholders in eight selected regions;
- workshops and consultations with representatives from across the Indigenous eye health sector;
- interview data provided by Clear Horizon as part of their evaluation of the intermediary role of IEHU.

A mixed-method design is particularly useful when evaluating community-driven change initiatives because it can capture diverse stakeholder perspectives and triangulate and synthesise evidence from multiple sources to arrive at robust evaluative conclusions.

FIGURE 2. MIXED METHOD DESIGN TO ADDRESS KEY EVALUATION QUESTIONS



2.4.1 METHODS AND DATA SOURCES

Descriptions for each of the methods and data sources used in the evaluation, including participant sample size and timing of data collection activities is detailed in Table 2 below.

TABLE 2. DESCRIPTION OF DATA SOURCES, SAMPLE AND TIMING

Data source	Description	Sample	Timing
Existing documents and data	Policy documents, desktop review by the IEHU on publicly-available information on regional eye health activity and regional implementation data provided by IEHU.	Literature review included 56 papers, high-level metrics on 63 regional groups, various policy documents.	Ongoing
National survey	National online survey distributed to stakeholders working across the Aboriginal and Torres Strait Islander eye health sector. The 20-minute survey asked questions about experience working in the sector, activities, tools and resources that support their work, perceptions of changes that have occurred over time, and what more is needed to improve eye care and eye health outcomes for Aboriginal and Torres Strait Islander people.	n=98	April 2021
Co-design workshops	Three workshops held across the duration of the evaluation to inform the design, share emerging findings and discuss and reflect on the final evaluation results.	Three workshops, workshop 1: 38 participants (face to face), workshop 2: 36 participants (online), workshop 3: 30 participants (online)	October 2019; December 2020 and May 2021
Scoping interviews	Semi-structured one-hour individual and interviews with IEHU staff.	n=5	December 2020

Focus groups	One to two hour focus groups, including seven online and one face-to-face, with a selection of regional groups who responded to an expression of interest to participate in the evaluation. The purpose was to understand how regional groups were established and how they function, enablers and barriers, views on changes that are linked to regional group activities and suggestions for future policy and practice. Each focus group was accompanied by a 30 minute to an hour long pre-meeting between IEHU staff and the group facilitators so facilitators could be briefed on the region by IEHU.	8 groups, 44 participants	October 2020 to May 2021
Supplementary interviews	Semi-structured, 30 minute interviews were conducted with individuals connected with each of the regional groups who were not able to attend the focus group.	n=9 participants	Nov 2020 to May 2021
Data from Clear Horizon	Interviews with Indigenous eye care stakeholders.	n=28	Dec 2020 to May 2021

2.4.2 ANALYSIS

All information collected was analysed and reported in a manner that placed priority on retaining the integrity of participant responses. Analysis of qualitative data has been ongoing during data collection, with regular feedback and discussion meetings between members of the evaluation team. Interviews were analysed through a framework matrix, which summarised qualitative data to enable both cross-case and thematic analysis against participant experiences.

Quotations (without attribution to specific individuals) have been used to add depth, richness and authenticity to the analysis contained in the report. A variety of techniques to enhance rigour in qualitative research were incorporated including: method, theory and researcher triangulation, assessment of rival explanations and divergent patterns and peer debriefing.[7] Further information on qualitative data and analysis is provided in Section 4 of the report.

The survey data was analysed using descriptive statistics (i.e. frequencies, means and measures of central tendency and variation). We used Excel and SPSS to visualise and present the data and cross-tabulations by variables of interest to explore differences in respondent sub-groups.

2.5 STRENGTHS AND LIMITATIONS

The strengths and limitations of the data sources used in this evaluation are outlined in the Table 3. As noted above in Section 2.1.1, evaluation activities during 2020 were paused for a period of approximately six months due to the impact of COVID-19 which led to the evaluation adopting a primarily online approach to stakeholder engagement and data collection.

The evaluation also experienced some delays while awaiting national ethics clearance to release the survey, which was original planned for late 2020, but was not possible to distribute until April 2021. These disruptions impacted stakeholder engagement and required qualitative data collection activities that were originally planned as face-to-face to switch to online modes.

[7] Patton, M. Q. (2002). *Qualitative research and evaluation methods.* Thousand Oaks, CA: Sage.

TABLE 3. STRENGTHS AND LIMITATIONS OF DATA SOURCES

Data source	Strengths	Limitations
Existing documents and data	Provided an overview of available information on the implementation and impact of regional groups, identifying factors that fostered or hindered implementation.	Limited research and evidence base available on regional approaches to Indigenous eye care. Metrics on regional activities do not provide detailed information on group activities.
National survey	Provided a breadth of perspectives from across Australia on what has worked well to support regional implementation, challenges and changes over time.	Limited responses to the survey and possibility of self-selection and non-response bias. IEHU staff were included as anonymous respondents to allow them to share their personal views and experiences as participants or observers in the regional approach and regional groups. The survey was the main way that IEHU staff were included in the evaluation to share their views and experiences. Timing impacted by COVID-19 pandemic and affected by delays in receiving jurisdictional ethics approvals.
Co-design workshops	Provided an opportunity to have input from a wide range of eye health stakeholders across the country and key stages of the evaluation. Facilitated by an independent consultant. Allowed for sharing of lessons across the three evaluation projects.	Shift to online delivery due to COVID-19 may have affected engagement and attendance rates

Scoping interviews and pre-focus group meetings	Provided important background and contextual information on the history of the Roadmap and observations on the establishment and progress of regional groups.	N/A
Focus groups	Provided local insight at the regional level around the process, enablers and barriers and outcomes of regional group activities.	Mainly delivered online and low attendance rates across some of the groups.
Supplementary interviews	Provided an opportunity to follow up with participants who did not attend the focus group or who had specific insight on a particular aspect of regional group implementation.	Low uptake
Data from Clear Horizon	Provided complementary information, especially on the role of IEHU to enable elaboration and triangulation of evaluation findings.	Secondary data that was not explicitly collected for the purpose of addressing questions covered in this evaluation.

3. NATIONAL SURVEY OF INDIGENOUS EYE HEALTH SECTOR

This section summarises responses from a national online survey distributed to stakeholders working across the Aboriginal and Torres Strait Islander eye health sector.

The survey asked questions about experience working in the sector, activities, tools and resources that support their work, perceptions of changes that have occurred over time, and what more is needed to improve eye care and eye health outcomes for Aboriginal and Torres Strait Islander people.[8]

3.1 RESPONDENT CHARACTERISTICS

In total, 127 survey responses were received of which 98 were sufficiently complete to include in the analysis. This constitutes an overall completion rate of 77 per cent. As distribution of the survey used a variety of communication channels to promote the survey through email lists, newsletters and other methods, a precise response rate could not be established[9].

Respondents had been working in Aboriginal and Torres Strait Islander eye health for varying lengths of time, though almost all respondents (95 per cent) had at least a year of experience in the sector.

Respondents had extensive experience working in the sector, with around one-quarter identifying as Aboriginal or Torres Strait Islander.

More than a third of respondents (38 per cent) had experience of more than seven years in the sector, while 29 per cent of respondents had one to three years experience and 28 per cent had four to seven years experience.

Nearly a quarter of respondents identified as Aboriginal (24 per cent) including 2 per cent identifying as both Aboriginal and Torres Strait Islander. Almost three-quarters of respondents (73 per cent) identified as neither Aboriginal nor Torres Strait Islander and the remining 2 per cent preferred not to say.

When asked in which states and/or territories they mostly worked, respondents were able to tick as many options as applied to them. The most common state or territory worked in was Victoria, selected by 31 per cent of respondents. The Northern Territory was the second most common, selected by 14 per cent of respondents, see Table 4.

[8] The national survey included a number of open text fields that elicited an unexpectedly high volume of rich qualitative data that has been used to inform Section 3, with representative quotes from survey respondents supporting interview and focus group data.

[9] We have estimated a response rate of 34 percent, based on the following assumptions. Total sample of 370, comprising 64 regional groups, averaging five members per group, plus 50 representatives from peak bodies and policy staff at national and jurisdictional levels.

TABLE 4. WHERE RESPONDENTS WORK

	n	%
Victoria	37	31%
NT	17	14%
QLD	16	13%
NSW	13	11%
SA	11	9%
National role/ multi-state/territory role	11	9%
WA	7	6%
Tasmania	7	6%
ACT	1	0%
Total responses (from 98 respondents)	**120**	

Source: National survey of the Aboriginal and Torres Strait Islander Eye Health Sector (2021). Note: As multiple responses were allowed, percentages do not sum to 100 per cent and the total count exceeds the number of respondents.

When respondents were asked in which types of geographical area/s they mostly worked, they were again able to tick all options that applied to them. Among the respondents there was an even spread across 'Remote/ Very remote' areas (32 per cent), 'Regional (inner or outer)' areas (35 per cent) and 'Urban/ Major City' areas (33 per cent).[10]

Respondents worked across a range of organisation types, see Table 5. Respondents most commonly selected that they worked for an Aboriginal community-controlled health organisation/ Aboriginal medical or health service (16 per cent), a non-government organisation/ hospital (12 per cent) or a not-for-profit/ charity (11 per cent).

A significant number of respondents (13 per cent) also selected the 'Other' option, with almost all of these respondents (n=17) indicating that they worked for a university, or more specifically, the University of Melbourne or the IEHU.

Given that around one in ten respondents to the national survey are potential representatives of IEHU with responsibility for leading the development of the Roadmap regional implementation approach, this should be noted as a possible source of positive bias to the survey results.

[10] Source: National survey of the Aboriginal and Torres Strait Islander Eye Health Sector (2021). Note: As multiple responses were allowed, percentages do not sum to 100 per cent. There were 98 unique respondents for this question.

TABLE 5. REPONDENTS BY ORGANISATION TYPE

	n	%
Aboriginal Community Controlled Health Organisation / Aboriginal Medical or Health Service	22	16%
Other (please specify)	17	13%
Hospital	16	12%
Non-Government Organisation/ Not-for-profit/ Charity	15	11%
Fund-holder organisation	12	9%
Optometry (Not-for-profit or Government funded)	10	7%
Optometry (Private)	9	7%
Government department	7	5%
Ophthalmology clinic (Not-for-Profit or Government funded)	7	5%
Peak body	6	4%
Ophthalmology (Private)	5	4%
Primary Health Network	4	3%
Primary Care Partnership (PCP)	3	2%
Primary care clinic/ service (non-AMS)	2	1%
Total responses (from 98 respondents)	**135**	

Source: National survey of the Aboriginal and Torres Strait Islander Eye Health Sector (2021). Note: As multiple responses were allowed, percentages do not sum to 100 per cent and the total count exceeds the number of respondents.

Respondents also worked across a range of roles in the sector, see Table 6. Many respondents worked in a program/ policy/ other management/ administrative role (31 per cent) and 14 per cent of respondents were optometrists.

Again, a number of respondents (15 per cent) selected the 'Other' option and among these respondents, some indicated that they were researchers or academics (n=4), while others included a range of policy, project and management positions, as well as health workers.

TABLE 6. RESPONDENT ROLES

	n	%
Program/ policy/ other management/ administrative role	36	31%
Optometrist	16	14%
Aboriginal Health Worker/ Practitioner	9	8%
Nurse	8	7%
Eye Care coordinator	9	8%
Ophthalmologist	8	7%
Care Coordinator	6	5%
Practice Manager	4	3%
Indigenous Outreach Worker	3	3%
General Practitioner	1	1%
Orthoptist	0	0%
Other (please specify)	17	15%
Total responses (from 98 respondents)	**117**	

Source: National survey of the Aboriginal and Torres Strait Islander Eye Health Sector (2021). Note: As multiple responses were allowed, percentages do not sum to 100 per cent and the total count exceeds the number of respondents.

Most respondents (71 per cent) were, or had been, part of a regional Aboriginal and Torres Strait Islander eye health stakeholder group/ network. 41 per cent were, or had been, part of one regional group/ network and 31 per cent were, or had been, part of more than one regional group/ network.

3.2 IMPLEMENTATION SUPPORTS

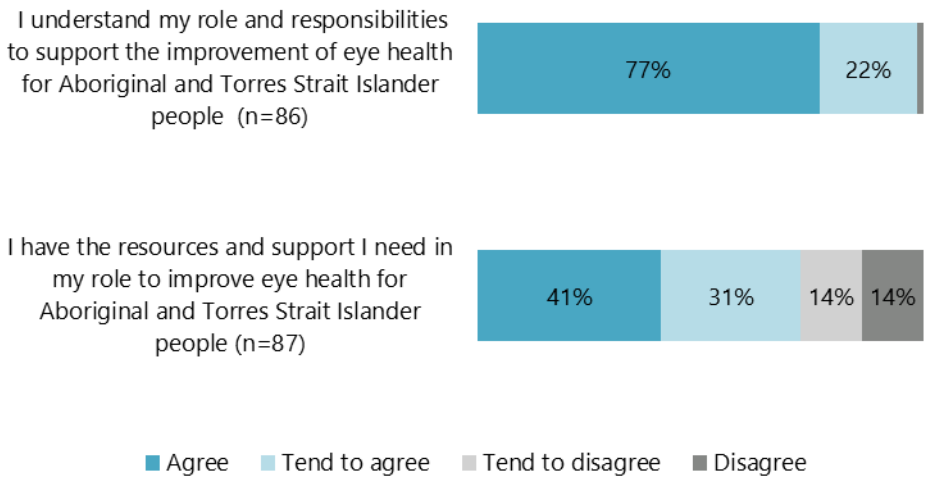
Respondents were presented with a series of statements regarding the supports they have in working in Aboriginal and Torres Strait Islander eye health and were asked to rate the extent to which they agreed or disagreed with these statements on a 4-point scale. The survey first presented two broad statements before examining specific key supports, tools and resources for people in their roles.

Almost all respondents (99 per cent) answered that they understand their role and responsibilities to support the improvement of eye health for Aboriginal and Torres Strait Islander people (see Figure 3). Moreover, most respondents (77 per cent) selected the highest level of agreement on the 4-point scale.

Indigenous eye health sector workers know what to do, but are less certain they have the resources and support needed to carry out their work

Most respondents (72 per cent) agreed or tended to agree that they have the resources and support needed for their role (see Figure 3). The level of agreement with this statement, however, was lower, as 41 per cent of respondents selected the highest level of agreement on the 4-point scale and 28 per cent selected a level of disagreement.

FIGURE 3. UNDERSTANDING OF ROLE AND AVAILABLE SUPPORTS AND RESOURCES

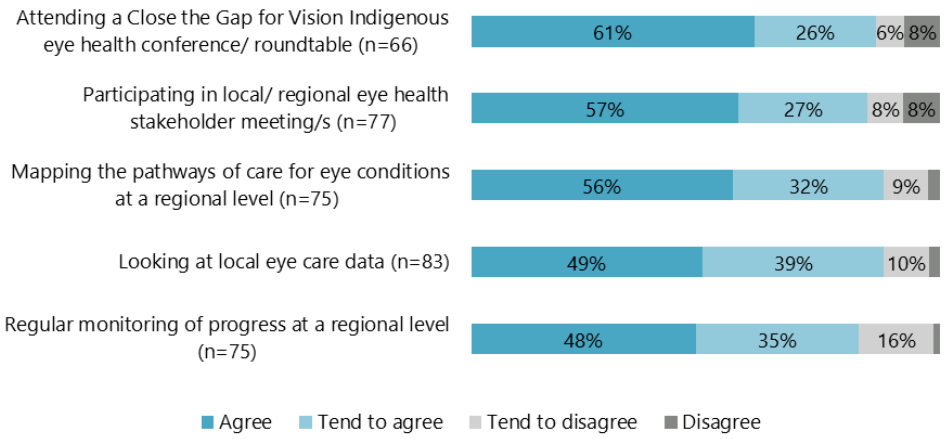


Source: National survey of the Aboriginal and Torres Strait Islander Eye Health Sector (2021). Note: "Don't know" responses were excluded as missing values and percentages below 5 per cent are not shown.

3.2.1 WHAT ACTIVITIES HAVE SUPPORTED INDIGENOUS EYE HEALTH SECTOR WORKERS?

The surveyed stakeholders responded positively to all of the activities listed when asked if these activities had been key supports in their role (see Figure 4). Respondents most strongly agreed that attending a Close the Gap for Vision Indigenous eye health conference/ roundtable had been a key support - 61 per cent selected the highest level of agreement on the 4-point scale.

FIGURE 4. ACTIVITIES THAT SUPPORT INDIGENOUS EYE HEALTH SECTOR WORKERS



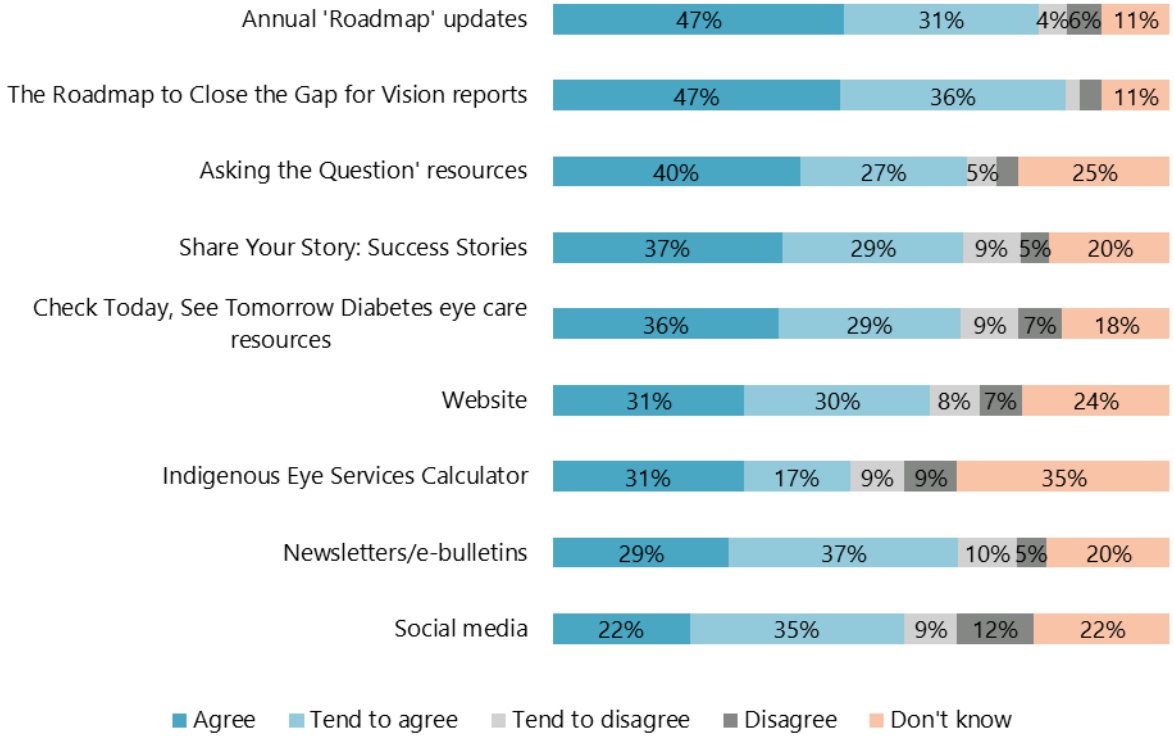
Source: National survey of the Aboriginal and Torres Strait Islander Eye Health Sector (2021). Note: "Don't know" responses were excluded as missing values and percentages below 5 per cent are not shown.

3.2.2 WHAT TOOLS AND RESOURCES HAVE SUPPORTED INDIGENOUS EYE HEALTH WORKERS?

When asked about tools and resources provided by IEHU and whether they had been key supports in their role, the most positive responses were to the Roadmap to Close the Gap for Vision reports (47 per cent agree, 36 per cent tend to agree) and Annual Roadmap updates (47 per cent agree, 31 per cent tend to agree) (see Figure 5). While responses to the tools and resources were positive across the board with low levels of disagreement, respondents were less likely to agree that the Indigenous Eye Services Calculator, website, newsletters/ e-bulletins and social media were key supports.

There were also significant proportions of people who selected 'Don't know' for many of the tools and resources, indicating that there was a lack of awareness among some regarding IEHU tools and resources.

FIGURE 5. INDIGENOUS EYE HEALTH UNIT TOOLS AND RESOURCES

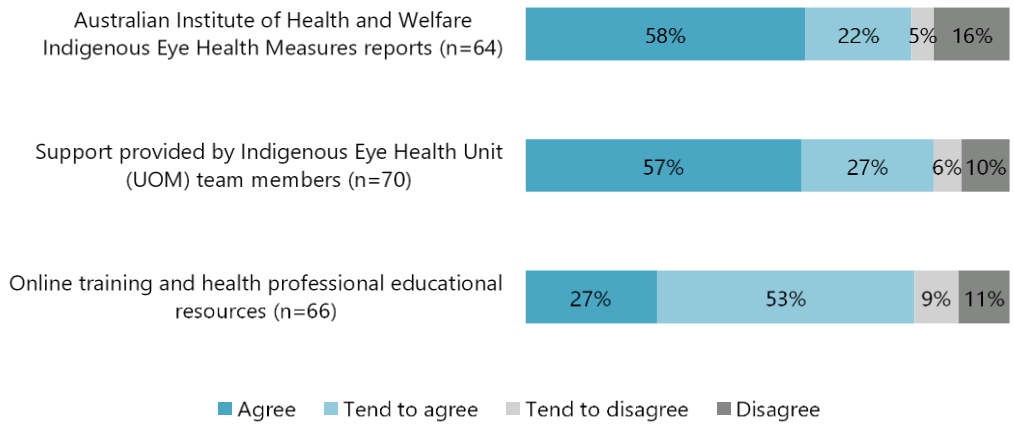


Source: National survey of the Aboriginal and Torres Strait Islander Eye Health Sector (2021). Note: percentages below 5 per cent are not shown.

Respondents were also asked about other tools and resources in the sector (see Figure 6). There were particularly high levels of agreement that AIHW Indigenous Eye Health Measures reports and IEHU team members were key supports, with more than 50 per cent selecting the highest level of agreement on the 4-point scale for both.

While respondents also agreed that online training and health professional educational resources had been helpful, most respondents (53 per cent) selected 'tend to agree' on the 4-point scale.

FIGURE 6. OTHER TOOLS AND RESOURCES



Source: National survey of the Aboriginal and Torres Strait Islander Eye Health Sector (2021). Note: As not all respondents answered this question, the number of responses does not equal the number of survey respondents.

3.3 EFFECTIVENESS OF REGIONAL GROUPS

Respondents were presented with a series of statements regarding regional approaches to improving eye care for Aboriginal and Torres Strait Islander people and asked to rate the extent to which they agreed or disagreed on a 4-point scale. These statements varied slightly depending on level of involvement in regional groups.

Accordingly, responses were analysed based on the following respondent groups:

- Respondent who had participated in *one* regional group/ network (n=40)
- Respondent who had participated in *multiple* regional groups/ networks (n=30)
- Respondent who had *not* participated in a regional group/ network (n=28)

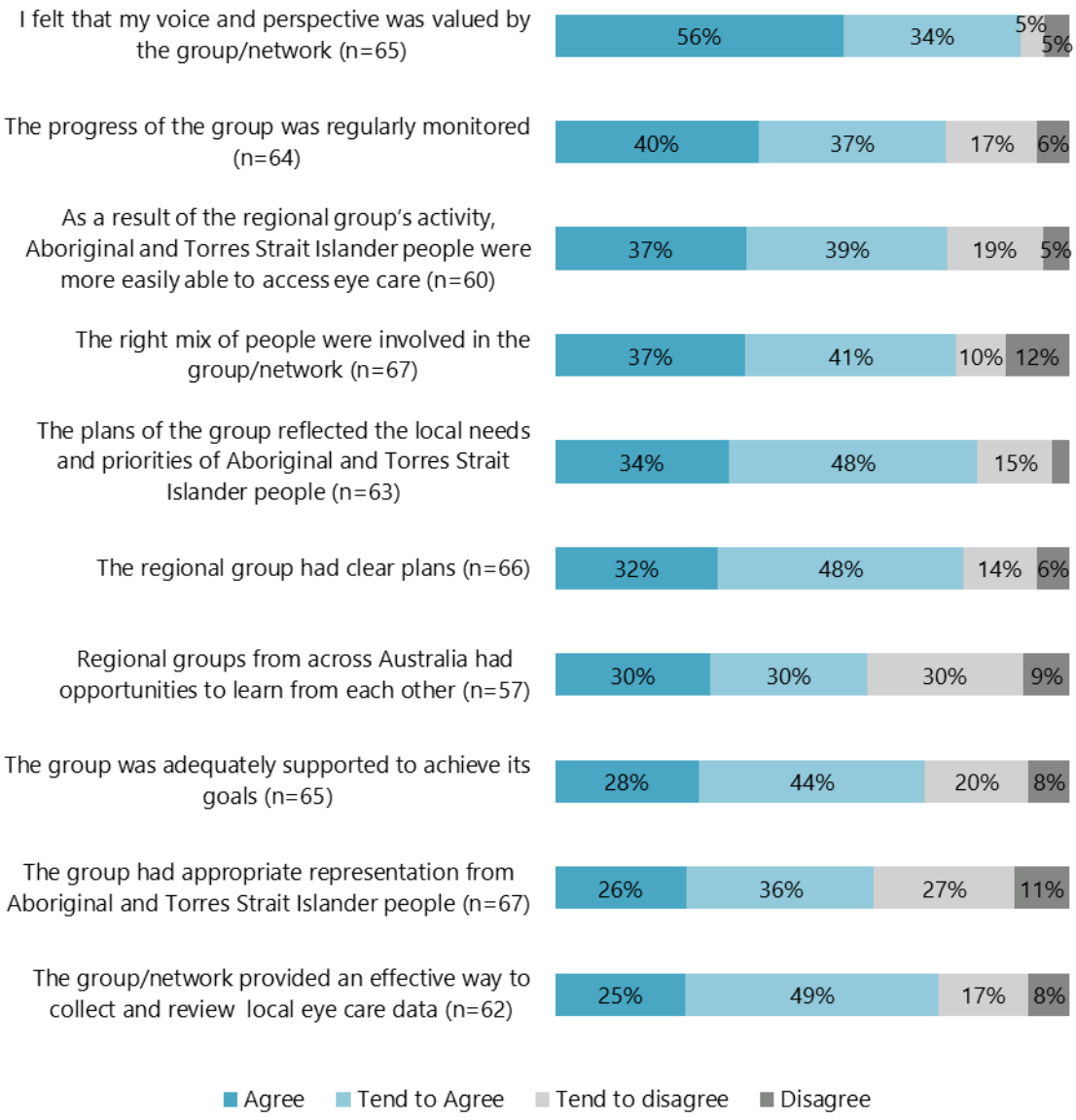
To avoid repetition, in the analyses presented below we have combined respondents who reported being involved in one or multiple regional groups/networks as the results did not vary significantly between these groups.

3.3.1 RESPONSES FROM THOSE WHO HAD PARTICIPATED IN ONE OR MORE REGIONAL GROUPS/ NETWORKS

Among respondents who had participated in one or more regional groups there were high levels of agreement with most of the statements regarding group effectiveness (see Figure 7). These respondents agreed most strongly (56 per cent agree, 34 per cent tend to agree) with the statement that they felt their voice and perspective was valued by the group.

The statements with the lowest levels of agreement were whether the groups had opportunities to learn from each other (60 percent overall agreement, 39 percent disagreement) and whether the groups had appropriate representation from Aboriginal and Torres Strait Islander people (62% overall agreement, 38 percent disagreement).

FIGURE 7. VIEWS ABOUT EFFECTIVENESS FROM THOSE WHO HAVE PARTICIPATED IN ONE OR MORE REGIONAL GROUP



Source: National survey of the Aboriginal and Torres Strait Islander Eye Health Sector (2021). Note: percentages below 5 per cent are not shown.

3.3.2 RESPONSES FROM THOSE WHO HAD NOT PARTICIPATED IN A REGIONAL GROUP/ NETWORK

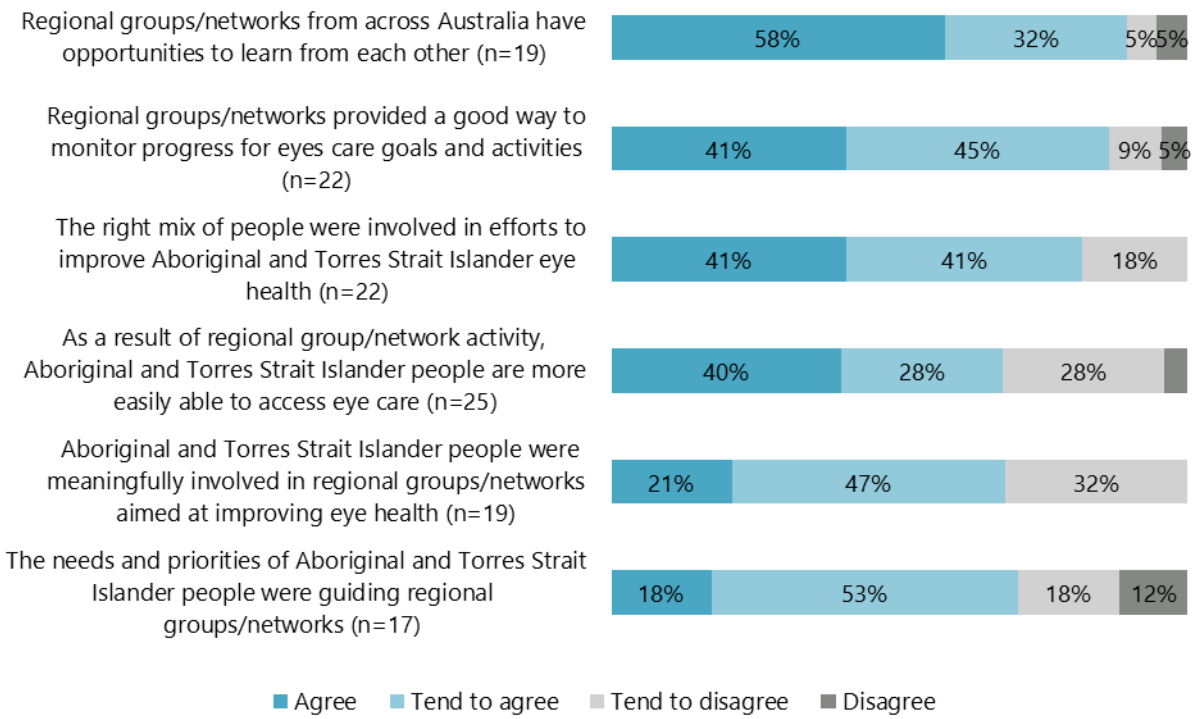
When asked about regional approaches to improving eye care for Aboriginal and Torres Strait Islander people prior to the COVID-19 pandemic, respondents who had not participated in a regional group were generally positive, with the majority indicating they agreed or tended to agree with all the statements in Figure 8.

Almost all of these respondents (90 per cent) agreed or tended to agree that that regional groups from across Australia have opportunities to learn from each other. There were more mixed responses to the statements regarding: (1) meaningfully involving Aboriginal and

Torres Strait Islander people in regional groups/networks; and (2) whether their needs and priorities were guiding these groups/networks.

These two statements had the lowest percentages of respondents indicating the highest level of agreement on the 4-point scale at 21 per cent for the former and 18 per cent for the latter. This could be because those who had not participated in the regional groups were less aware of how groups were formed and their membership.

FIGURE 8. VIEWS ABOUT EFFECTIVENESS FROM THOSE WHO HAVE NOT PARTICIPATED IN A REGIONAL GROUP



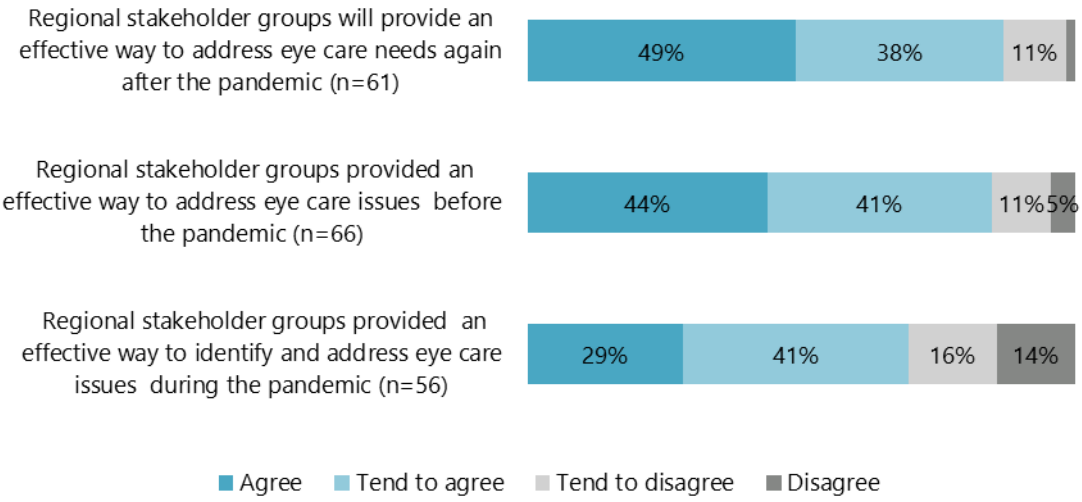
Source: National survey of the Aboriginal and Torres Strait Islander Eye Health Sector (2021). Note: percentages below 5 per cent are not shown.

3.3.3 IMPACT OF COVID-19

When asked about the impact of the COVID-19 pandemic on regional groups, respondents who had participated in one or more groups were optimistic about the role of these groups in the future for addressing eye care needs *after* the pandemic (49 per cent agree, 38 per cent tend to agree) (see Figure 9).

There were slightly lower levels of agreement (29 per cent agree, 41 per cent tend to agree) with the statement regarding the role and impact of regional groups *during* the COVID-19 pandemic. This indicates a recognition of the COVID-19 pandemic affecting the work of regional groups.

FIGURE 9. EXPERIENCE OF REGIONAL GROUPS IN THE CONTEXT OF COVID-19



Source: National survey of the Aboriginal and Torres Strait Islander Eye Health Sector (2021). Note: Percentages below 5 per cent are not shown.

3.4 CHANGES TO INDIGENOUS EYE CARE

Respondents were shown a series of statements regarding changes to eye care for Aboriginal and Torres Strait Islander people since 2013 and were asked to rate the extent to which they agreed or disagreed with these statements on a 4-point scale (See Figure 10).

Across the statements, most respondents agreed or tended to agree that there had been positive changes in Indigenous eye health since 2013. Notably, there were particularly high levels of agreement with the statements that access to eye care has improved for Aboriginal and Torres Strait Islander people (63 per cent agree, 26 per cent tend to agree) and that service providers have increased awareness of Aboriginal and Torres Strait Islander eye health (53 per cent agree, 40 per cent tend to agree).

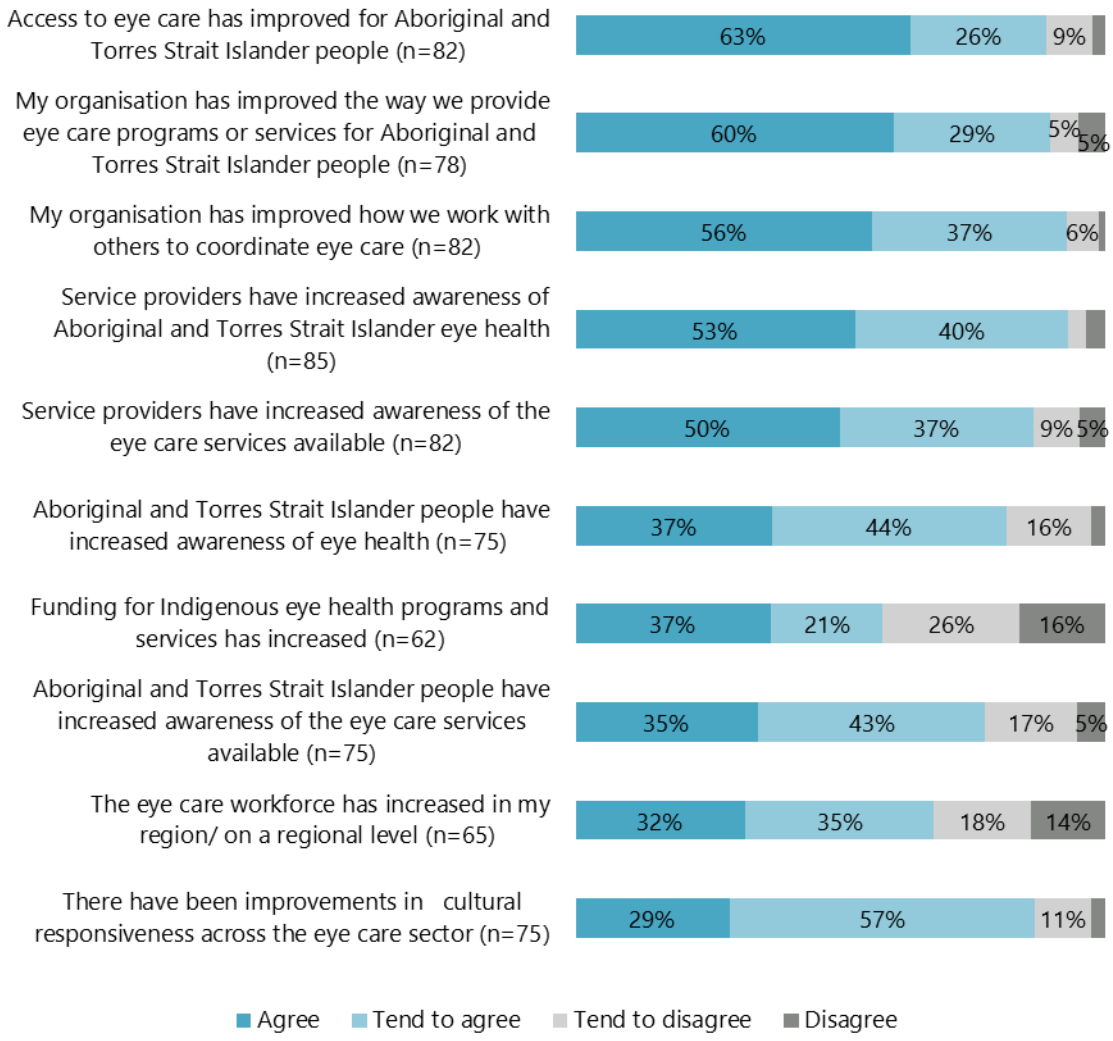
90 per cent of respondents agreed or tended to agree that access to eye care has improved for Aboriginal and Torres Strait Islander people, but were less positive about changes in funding and rural workforce levels

Respondents also felt that their organisations had improved the way they worked, indicating strong levels of agreement with the statement that their organisations had improved the way they provide eye care programs and services for Aboriginal and Torres Strait Islander people (60 per cent agree, 29 per cent tend to agree) and the statement that their organisation had improved how they work with others to coordinate eye care (56 per cent agree, 37 per cent tend to agree).

The sentiment among respondents was more mixed when it came to the statements that funding had increased for Indigenous eye health programs and services (26 per cent tend to disagree, 16 per cent disagree) and that the workforce had increased at a regional level (18 per cent tend to disagree, 14 per cent disagree).

Finally, while responses were almost all positive when it came to the statement that there have been improvements in cultural responsiveness in the eye care sector, positive respondents did not select the highest level of agreement on the 4-point scale and most (57 per cent) selected that they tended to agree with the statement.

FIGURE 10. CHANGES IN THE INDIGENOUS EYE HEALTH SECTOR



Source: National survey of the Aboriginal and Torres Strait Islander Eye Health Sector (2021). Note: percentages below 5 per cent are not shown. Respondents did not answer all questions, so the number of responses does not equal the number of respondents.

3.5 COMPARISON OF DIFFERENT STAKEHOLDER RESPONSES

We investigated whether there were differences in stakeholder responses based on the following variables:

- whether a respondent identified as Aboriginal/ Torres Strait Islander or not
- whether a respondent was involved in a regional group/ network or not
- experience in the sector

- State/territory they mostly worked in
- organisation type
- role, and
- geography (remote/very remote, regional, urban/ major city).

Given the small sample size it was not possible to conduct non-parametric tests for statistical significance. Instead, we visually inspected cross-tabulations to compare responses. We found no discernible differences in views about implementation supports, effectiveness of regional groups, or perceived changes over time to Indigenous eye care.

4. LOCAL EXPERIENCES OF REGIONAL IMPLEMENTATION

This section begins with an overview of regional implementation progress. We then present details on how a selection of regional groups have worked together. The remainder of the section identifies enablers and barriers to implementation, changes that have occurred, the role of IEHU in supporting regional groups and lessons for the future.

4.1 REGIONAL IMPLEMENTATION OVERVIEW

Regional implementation data provided by the IEH Unit show that of the 64 identified regions covering the whole of Australia, 63 of these are currently considered by IEH as 'active' collaborations[11]. This constitutes a 98.7 per cent reach in terms of the Australian Indigenous population. Of the 182 Aboriginal Community Controlled Organisations and other Aboriginal Medical Services, 99 per cent of these are covered by Roadmap regions and 89 per cent are actively engaged in Roadmap regions.

IEH report that they have direct involvement in almost two-thirds of regional groups across Australia (40/64 = 63%). In terms of engagement by stakeholder type, ACCO/AMS are involved in all regions (and 89% of all ACCO/AMS are involved in a regional group), Primary Health Networks are involved in 65 per cent of regional groups, optometry 59 per cent, ophthalmology 48 per cent and hospitals 76 per cent.

4.2 HOW ARE PEOPLE WORKING TOGETHER?

Regional groups were invited to submit expressions of interest to participate as case studies for this evaluation. Eight regional groups were selected including: Tasmania (covering three Roadmap regions) (Tas), Geelong (VIC), North and West Metropolitan Melbourne (VIC), Western New South Wales (NSW), Southeast Queensland (QLD), Townsville and Palm Island (QLD), Upper Hume (VIC) and Central Australia and Barkly (covering two Roadmap regions) (NT).

Each regional group has a different story of inception with the groups being formed in a range of different ways and over different time periods. Some were formed through established partnerships to which additional key members were identified and invited to join, others were approached as a key organisation by IEHU and were supported to form the group. The period of time in which groups have been running ranges from several years to more than 13 years during which time group membership, objectives and activities have changed and evolved as needed in response to funding changes, organisation changes and emerging priorities in the eye health sector.

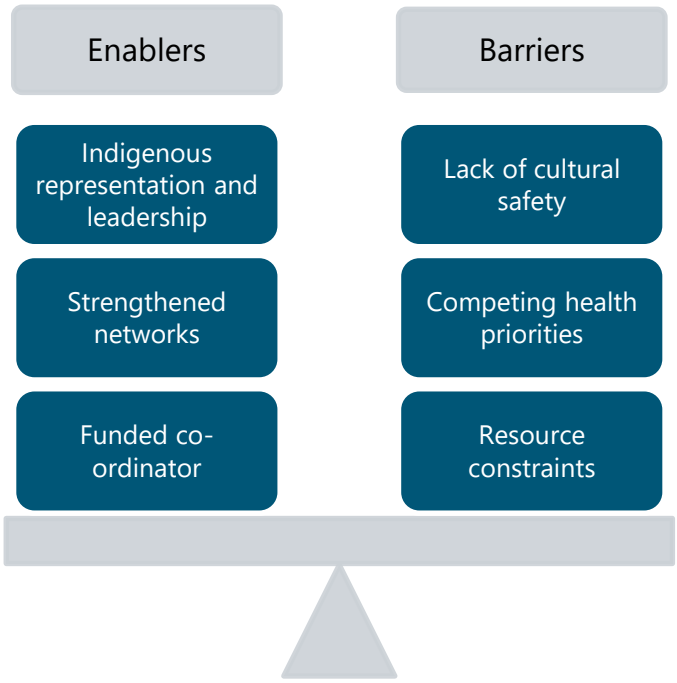
Appendix 4 includes an overview of the context in which groups came together and includes details of group members and key activities conducted by each group.

[11] IEH Unit (2021, May). *Regional implementation data overview.* Melbourne: IEH.

4.3 WHAT ARE THE ENABLERS AND BARRIERS?

Figure 11 provides a high-level summary of factors that enabled and hindered regional implementation of the Roadmap drawing on cross-case comparison of the eight regional groups as well as supplementary information provided in open-text fields of the national survey. These factors are elaborated in the sections below.

FIGURE 11. IMPLEMENTATION BARRIERS AND ENABLERS



4.3.1 IMPLEMENTATION ENABLERS

ABORIGINAL AND TORRES STRAIT ISLANDER REPRESENTATION AND LEADERSHIP IN REGIONAL GROUPS

Stakeholders identified strong Aboriginal and Torres Strait Islander representation and leadership in regional groups is a key enabler supporting successful implementation. Increased representation helps in ensuring group priorities reflect those of the communities being served. Having endorsement from community was noted as incredibly important in supporting community ownership in the regional group and that community priorities, needs and challenges are being heard and addressed.

Having Aboriginal and Torres Strait Islanders in leadership positions in the group could help to ensure that the information expressed by Indigenous group members flows through to the leadership decisions that are made by the group.

> *Creating safe places and appropriate meeting approaches for Aboriginal and Torres Strait Islander people should be goal for all regional groups. Encouraging*

> *Aboriginal organisations and individuals to take the lead in meetings would be helpful and supporting capacity development to do so might be important. Exploring how each group should approach Aboriginal participation and engagement might be worthwhile as a standing item. (Survey participant)*

Many stakeholders recognised that Aboriginal and Torres Strait Islander representation in regional groups could be strengthened. Some of the factors that appear to have affected levels of involvement are explored further in the next section, which examines views regarding implementation barriers.

ONGOING DIALOGUE AND CONNECTIONS ACROSS COMMUNITIES AND SECTORS

The regional groups have brought stakeholders together in regions to tackle local eye health issues and determine solutions that will work for their region, including health system planning and development.

They have provided networking opportunities that bring together stakeholders from different regions across Australia to share lessons/learnings/challenges of what has worked and what has not worked. Stakeholders highlighted that the groups provided a regular opportunity to have an ongoing dialogue about eye health needs in communities and determine how these could best be met.

> *My observations include regional groups being effective for sharing information and breaking down silos of operation...this included reduced duplication of effort and some rationalisation and efficiencies. Regional groups helped to create new relationships between sector players and strengthen existing relationships. (Survey participant)*

DEDICATED FUNDED COORDINATOR FOR REGIONAL GROUPS

Stakeholders reported that a funded coordinator role with a dedicated focus on regional implementation has been a critical enabler to support progress of regional groups and provide a mechanism for accountability. Stakeholders identified a number of functions integral to the success of this role including providing secretariat support, proactively engaging members to attend meetings, facilitating the development of objectives to guide fund-seeking and overseeing group data collection and management practices.

> *While the regional groups were effective, they were entirely reliant on a dedicated funded organisation / individual to drive progress and accountability. They were incredibly useful in establishing the issues, networking, sharing information and ideas however ongoing commitment and coordination will not occur without that driving organisation / individuals. (Survey participant)*

4.3.2 IMPLEMENTATION BARRIERS

LACK OF CULTURAL SAFETY

A key barrier identified by stakeholders through the survey and focus groups was a lack of reported cultural safety within some regional groups. Additionally it was reported there were low numbers of Aboriginal and Torres Strait Islander peoples regularly engaging as members of regional groups.

Stakeholders identified a number of actions to increase the cultural safety of groups including creating safer meeting spaces for regional groups, working closely with local elders to get support for the group, regular engagement with ACCHOs to get up to date information on community needs, and investing in cultural safety training and capacity development.

Critically, the most important action identified was to create safer spaces with some suggestions including:

- Highlighting Aboriginal and Torres Strait Islander people's program successes in social and other media.
- Listening and taking action when Aboriginal and Torres Strait Islander people make suggestions for change.

> *The group dynamics play such an important role in the effectiveness of the groups and in setting/pursuing their priorities. The groups I have been involved in often failed to have strong Aboriginal and Torres Strait Islander representation in terms of attendance and participation. This could be because they weren't engaged (asked, allowed/supported to attend) or that they didn't feel safe to do so (bad experience, feeling culturally unsafe and/or powerless). (Survey participant)*

COMPETING HEALTH PRIORITIES

Stakeholders reported that competing health priorities for community and health professionals has been one of the key barriers to regional implementation. Many of those involved in regional groups noted that in a lot of regions, eye care is being pushed down the list of priorities as health disparities have increased in other areas of care. Stakeholders noted that eye health in communities is often not viewed as critical in terms of the effect it has on quality of life and therefore it can be difficult to get community engagement and buy-in.

A contributor to this is a broader discussion that the current model of care for Indigenous eye health is westernised and many Aboriginal and Torres Strait Islander stakeholders have strongly advocated for a more holistic approach, addressing the social determinants of health rather than targeting eye care separately.

> *Listening to local people about their wider needs in relation to improved health/eye health. The social determinants of health of poverty and limited and overcrowded housing are critical factors that lead to loss of vision. However other social determinants such as connectedness to family, culture, identity and country*

> *are values that have to come to the fore to present a positive approach instead of coming from a deficit approach. (Survey participant)*

RESOURCES

Another key barrier identified by stakeholders was the funding challenges that many of the groups faced. The funding model experienced by many in the health sector tends to be affected by short-term funding, the impact of which is higher staff turnover and transitions, with many staff covering multiple roles which creates additional burden on regional group members.

This is where groups with no dedicated group coordinator (either through lack of time or lack of funding) were particularly affected. The effect of this model on regional implementation is that it tends to affect group membership, including reducing continuity of membership and similarly increasing turnover among staff in member organisations which necessitates the continual re-establishment of new connections and relationships.

4.4 WHAT CHANGES HAVE OCCURRED?

Through the survey, focus groups and interviews, stakeholders highlighted a number of areas in which a regional approach to Indigenous eye health has contributed to positive changes in regions.

INCREASED AWARENESS OF ABORIGINAL AND TORRES STRAIT ISLANDER EYE HEALTH ISSUES

Stakeholders identified a strong increase in awareness of Aboriginal and Torres Strait Islander eye health as a result of regional implementation. Increased awareness was identified both at the service provider level and in communities with anecdotal reports of increased numbers of patients accessing eye care services. Respondents felt this was related to education in the community about eye health, as well as targeted funding of eye care in Aboriginal and Torres Strait Islander communities including the deployment of retinal cameras.

Stakeholders noted the importance of ensuring there is vertical integration of awareness of Aboriginal and Torres Strait Islander eye health issues with regional level conversations being able to affect change at a national level. IEH has had a significant role in supporting that process, raising the profile and awareness of Indigenous eye health at policy level committees.

> *So, now we're seeing, more and more, I guess, awareness and appreciation of these local models and the success of them, and we're at the very least having a conversation around how can we redistribute the resources to Aboriginal organisations and their communities, so that eye care services can be delivered BY community instead of TO community. So that's been my biggest observation over the last decade and a half. (Interview participant)*

INCREASED COORDINATION, DATA SHARING AND COMMUNICATION BETWEEN PROVIDERS

Coordination, data sharing and communication between eye health providers has increased as a result of the regional groups. Stakeholders reported that regional groups have provided an opportunity for eye health stakeholders to come together periodically to collaborate and share information to improve coordination of services.

More localised and more accurate data which is partially due to issues regarding identification of Aboriginal and Torres Strait Islander peoples in the eye care system

Stakeholders also noted through the groups they have developed a better understanding of the data gaps and challenges in monitoring and data collection of Aboriginal and Torres Strait Islander patients across services. Some groups have started proactively gathering their own data to support future funding efforts. Stakeholders identified the need to improve data collected around identification in particular and address barriers relate to data access and linkage across services.

Case Vignette: North and West Metropolitan Melbourne

Analysing data from IEHU, the North and West Metropolitan Melbourne regional group found that lower than expected numbers of Aboriginal people were engaging with diabetic treatments and eye surgery in the area. In particular, engagement from Aboriginal people in western metropolitan Melbourne was noted as a challenge for the group and attributed to a lack of culturally safe services for the community.

Regional group partners include the Victorian Aboriginal Health Services (VAHS), Australian College of Optometry (ACO), Royal Victorian Eye and Ear Hospital (RVEEH) and Rural Workforce Agency Victoria (RWAV). VAHS has hosted an ACO optometry service at VAHS since 1997. Partnerships were strengthened through the shared work of the regional group and the following activities were implemented to increase community access to culturally safe services:

- VAHS worked with RVEEH to set up an ophthalmology service at VAHS with funding from RWAV so that Aboriginal patients could receive some ophthalmological care at VAHS and those who needed surgery at RVEEH could be fast-tracked to the hospital
- VAHS has established fortnightly triage meetings between the RVEEH Aboriginal Hospital Liaison Officer to pick up referrals and support patient engagement

ACO operates a mobile community eye service which provides eye examinations and increases the rates of referrals into VAHS and through to RVEEH.

IMPROVED ACCESS TO EYE HEALTH SERVICES AND TREATMENT

Access to eye health services and treatment for Aboriginal and Torres Strait Islanders has improved although it was noted there is still significant work to be done.

> *There has been more opportunity and awareness for health workers and for community. Commonwealth funding granted for trachoma resources and health promotion has enabled free resources and delivery throughout Australia.*

Key factors that have supported improved access include:

- Increased numbers of Aboriginal and Torres Strait Islander health workers involved in engagement in the community;
- Increased availability of culturally safe cataract surgery and access to optometry services; and
- Improvements in referral pathways for Aboriginal and Torres Strait Islander communities.

Case Vignette: Townsville and Palm Island

Between 2017-2018, the jurisdictional outreach fundholder in Queensland, CheckUP, identified that there was a need to address disjointed coordination and funding in the public and private eye care health systems and streamline the referral pathway to the public eye services at the regional hospital. There were a large number of different providers delivering eye care services and community members were becoming confused and overwhelmed seeing multiple services for the same or similar eye related services.

> *'People were suffering from the disorganisation of the whole system'*

CheckUP arranged a meeting between regional stakeholders to determine the key services needed in the region and to start reforming the pathway of care. Out of this meeting, agreement was reached that allowed redirection of funding and a clearer referral pathway for the community on Palm Island. By withdrawing funding from some service providers in the region, duplication and confusions were reduced and this allowed for improved pathways to accessing public eye health care.

Now, patients start with the Palm Island Community Company (PICC) as a central access point and an Optometrist visit once a month. Any patients requiring follow up by an Opthalmologist are referred to Townsville hospital. The hospital also hired two Indigenous liaison officers, who are community members themselves, to coordinate visits and transport from the Island to Townsville.

> *'It's great to see that we've come out the other end, with a much more streamlined system where we never lose anybody in the system anymore.'*

The group also started to monitor their performance through sharing patient service data. Ophthalmology and optometry patient numbers are shared and reported quarterly to the group and the Commonwealth. This new refined pathway now ensures that patients can't get lost between systems and services. If non-attendance does occur, patients aren't removed from the list but followed up by the liaison officers and rebooked for an appointment.

IMPROVED USE OF LOCAL RESOURCES

Stakeholders reported regional implementation has improved access to local eye health resources including additional local equipment. The regional groups facilitated an opportunity for local key eye health partners to map access and referral pathways of patients through the eye health system and identify areas of duplication, gaps and look for opportunities to create efficiencies.

Case Vignette: Tasmania

In 2017, the Tasmanian Aboriginal Health Reference Group (TAHRG), representing five Aboriginal community controlled health organisations, came together to discuss barriers to eye care in their communities. A major challenge included providing regular eye screening for patients with diabetes. Screening could be provided through visiting eye care services, like optometry, and with retinal cameras used within the community clinics. In 2019, a retinal camera was provided under a national program and was to be shared across the five organisations but this proved difficult to manage across all the sites.

The one camera needed to be moved to the next clinic every two months and some patients were required to come in for multiple appointments to access the camera or the visiting optometrist.

> *We started off with one camera shared between five organisations. It would spend two months with...one, two months [with another]. We would slowly rotate it around and we quickly learned that whilst it worked well in theory, the practical side of that was that people weren't able to maintain their skills. People were getting trained, and then it would be 10 months before they got to use the camera.*

The national consortium, funded by the Australian government, was able to provide an extra two cameras meaning three of the five sites would have their own cameras. The cameras have improved screening and access to treatment of diabetic retinopathy for Aboriginal patients in Tasmania. Having a camera onsite has also meant staff using cameras could maintain their skills and strengthen their own capacity to manage cases without supervision. The removal of this barrier was credited to the communication between stakeholders in the regional group.

We now have three cameras through the TAHRG members. We have one at Karadi Aboriginal Corporation, there's one at Circular Head Aboriginal Corporation, and one at Flinders Island Aboriginal Association Inc.

4.5 ROLE OF IEH IN SUPPORTING REGIONAL IMPLEMENTATION

Interviews conducted by Clear Horizon were analysed to understand the role of IEHU in supporting regional implementation. Interviewees included eye care stakeholders from the ACCHO sector, key peak national eye health bodies, funders, Government, non-government organisations, and staff from IEHU for a total of 28 interviewees. Four key impacts were identified as a result of IEHs role in supporting a regional approach to Indigenous eye care.

- IEHU has created a range of technical products that contribute to an improved evidence-base around Indigenous eye health and have contributed to the establishment of a sector that has a shared vision and plan for improving Indigenous eye health.
- IEHU has supported regional networks to assess the status of eye health for Indigenous peoples in the region, understand the gaps in their eye health pathways, and identify solutions to identified gaps. Where regional implementation has been successful, this has led to improved collaboration among health providers and improved pathways to eye care for Indigenous peoples.
- IEHU has supported the formal and informal sharing of information and evidence across national, state, and regional levels and has been an effective facilitator of stakeholder groups spanning sector, discipline, and place. Because of this, the IEHU has contributed to the creation of networks and collaborations that focus on improving access to Indigenous eye health services. This improved collaboration has occurred vertically (from national to regional) and horizontally (within and between regions).
- IEHU has directly contributed to the facilitation of policy changes and increased funding at the Federal level, which has in turn contributed to improvements in the way eye health services are delivered to Indigenous peoples and has increased the number of eye health services provided to Indigenous peoples.

4.6 LOOKING AHEAD

Stakeholders discussed ways in which eye health outcomes for Aboriginal and Torres Strait Islander people could be further improved at a regional level:

- **Providing community with opportunities to feedback** about implementation of the Roadmap and the broader objectives of the Roadmap. This would help to support vertical system integration, ensuring that community and regional level decisions are heard at the national level.
- **Increasing the Aboriginal and Torres Strait Islander health workforce** including supporting school transition career pathways into health positions; ensuring there are more identified Aboriginal and Torres Strait Islander eye health roles in clinics - this is particularly crucial for ensuring better engagement from community; and increasing cultural safety in the existing eye health workforce.
- **Increasing education and funding** support for ACCHOs to produce their own eye care resources for communities. This could involve posters, brochures, good news stories, interpreters and cultural safety training for other providers. The objective of this would be to increase cultural safety for staff and community, reduce language and cultural barriers to access and increasing awareness of eye health in communities.
- **Increasing Aboriginal and Torres Strait Islander representation** in regional groups, stakeholders suggested inviting elders, ACCHOs and potentially guest speakers such as consumers who have utilised the pathways. Critically work on improving the cultural safety of regional groups needs to precede this.

- **Providing secretariat support** for regional groups, as discussed previously this was identified as a key enabler to successful implementation of a regional approach. This is something we mentioned in the key enablers for implementation. There was strong agreement that this needs to be a paid position rather than relying on volunteers and/or organisational champions.
- **Exploring further options for networking** including bringing regional groups together at regular time points to facilitate communication across regions.

TRANSFERABILITY TO OTHER CONTEXTS

The regional approach of working collaboratively through local networks and partnerships to strengthen Indigenous eye care services is potentially applicable across a range of health conditions that affect Aboriginal and Torres Strait Islander people.

As discussed in Section 1.3, the regional approach adopted by IEHU, as advocated by the Roadmap, focuses on population-based and system-level coordination at a localised level, involving key stakeholders across the care pathway continuum. This is distinct from a siloed approach that involves individual agencies and clinics that tend to focus only on their patient cohort, or jurisdictional and national approaches that often do not account for local needs and context.

When thinking about the potential transferability of a regional approach beyond Indigenous eye care it is important to consider carefully:

- **The type of health condition**: specific issues relating to the type of health condition
- **The nature of regional groups**: who will be involved in establishing and implementing regional groups, including key steps, processes, elements and timeframes
- **The resources**: resources (e.g. time, staff, money, equipment, technology, space, infrastructure etc) that will be required to make regional groups work
- **The people**: characteristics of the key actors in regional groups with respect to their levels of expertise, knowledge, experience, commitment and so on
- **Institutional factors**: the role of factors such as organisational culture, inter-agency arrangements, and other policy initiatives
- **Outcomes**: what are the key outcomes, for whom, and how will they be produced.

The experience of implementing regional groups also suggests that while learning from others is often helpful for generating ideas and insights, it is more important to base local health planning efforts on underlying principles. This is because principles are more amenable to replication than specific programs or initiatives.

It was common, for instance, to hear that regional groups had found it valuable to draw upon principles such as community ownership and empowerment, capacity building, cultural safety and appropriateness, and a focus on connecting services and supports so that pathways to treatment and care are well co-ordinated across the different parts of the system.

Rather than replicating what happened in the regional approach to Indigenous eye care to related Aboriginal health initiatives, future regionally-based initiatives should be encouraged

to consider the underlying principle for particular actions and to work through how these principles can be enacted in their own location.

5. KEY LESSONS AND NEXT STEPS

The regional approach to supporting implementation of the Roadmap has played an important role in raising awareness and catalysing efforts to address Indigenous eye health inequity and close the gap for vision.

The evaluation has identified four key lessons to further embed regional approaches. The lessons outlined below are designed to support the IEHU and Indigenous eye care stakeholders to build on the work achieved to date through the Roadmap and plan for the future.

Lesson 1: Strengthen Indigenous leadership and ownership

As noted in Section 3, during the early phase of evaluation planning an Aboriginal and Torres Strait Islander Reference Group (ATSIRG) was established to provide input and guidance. The ATSIRG has been actively involved in shaping co-design workshops, designing data collection instruments, and providing feedback on evaluation findings.

The ATSIRG and IEHU are exploring opportunities to expand the group's role beyond the evaluation to serve as a resource for the wider eye health and vision care sector. The results from our evaluation and Clear Horizon's review of the role of IEH support these and other activities to enhance self-determination and engagement with Aboriginal and Torres Strait Islander people and organisations.

In particular, the evaluation found strong endorsement from stakeholders that continued efforts to embed eye health services in ACCHOs and other Aboriginal primary care services are needed. We found examples of effective ACCHO led eye care models that demonstrate what can be achieved when regional capacity to respond to eye health and vision concerns is improved through workforce development and access to equipment such as retinal cameras (see for example, Tasmanian case vignette, p. 33).

Lesson 2: Sustain regional partnerships and networks

Of the 64 identified regions covering the whole of Australia, 63 are currently considered by the IEHU as 'active' collaborations. While regional partnerships and networks have been developed, levels of engagement and capacity to collaborate on projects responding to locally identified need varies significantly.

Most regional groups do not receive direct funding to support co-ordination and delivery of activities such as undertaking population gap analysis, service mapping, sharing data collection and analysis for planning and monitoring, developing eye care pathways and developing solutions to identified service gaps. This means that maintaining regional group activities relies largely on the passion and commitment of individual members/champions and organisations.

There is strong support for additional funding to be made available through Jurisdictional Fundholders for co-ordinators across Australia to build on and further embed a regionally based approach. Results from the national survey of the Aboriginal and Torres Strait Islander eye health sector workers in this evaluation found that almost half of respondents reported problems with funding for Indigenous eye health programs and services.

Furthermore, a key recommendation for improving future policy and practice that arose from stakeholder interviews, focus groups and co-design workshops was the need for more flexible funding options to support solutions to local eye care needs that have been identified through needs assessment and local mapping of service gaps. While access to some resources is available through Jurisdictional Fundholders, there was a desire to increase the range of outreach funding beyond what is currently available to meet service demand in areas of need and stimulate innovation.

Finally, a key success of regional groups has been the opportunities they afford for local and interjurisdictional exchange of ideas and promising practices. In particular, regular regional-level meetings of local stakeholders from across different parts of the eye care sector and the annual Close the Gap for Vision conference were noted as important forums for discussing challenges and sharing success stories.

Lesson 3: Enhance cultural competence of eye health workforce

The results of the evaluation demonstrate a need to improve cultural appropriateness of eye services to ensure that mainstream organisations in particular adopt culturally safe practices. Indeed, a key focus of many regional groups has been on promoting cultural awareness through the provision of professional education activities and resources, as well as advocating for employment and capacity building of Aboriginal and Torres Strait Islander people in the eye health sector to support workforce development.

While many regional groups are actively working to increase cultural competency, there remains a concern regarding under-representation of Aboriginal and Torres Strait Islander on regional committees. Strengthening connections between regional groups, ACCHOs and other Aboriginal health services across all regional groups is a priority action to empower communities to lead and participatein eye health system redesign. This in turn will help ensure that every point of contact across the eye care pathway is culturally safe and tailored to local contexts.

Lesson 4: Continue to build the evidence base

Monitoring data across the pathway of care allows stakeholders to assess the effectiveness of activities they are putting in place, as well as identify gaps or issues in access or utilisation of services. However, establishing systems for ongoing data collection to informing planning

and evaluation of impacts has been challenging for many regional groups due to gaps in information sharing, data collection limitations and reporting practices.

While existing resources such as the AIHW eye health measures report and annual IEHU Roadmap updates were considered highly valuable by stakeholders, there remains an ongoing need to improve local data collection to monitor and evaluate the impact of regional group activities on the eye health of Aboriginal and Torres Strait Islander people. Local data collection has a number of key advantages including that the data directly reflects the region and is timely and contemporaneous.

Stakeholders also noted the importance of supplementing local information from regional groups and Jurisdictional Fundholders with evidence from the National Eye Health Survey. A need was identified to support further rounds of data collection to measure progress in reducing the prevalence and addressing the causes of vision impairment in the Aboriginal and Torres Trait Islander population across Australia.

Findings from the IEHU desktop review also highlights the dearth of available evidence on regional approaches to improving eye care for Indigenous Australians. The review found there is limited literature about regional approaches nationally, and the majority of sources are grey literature, especially conference papers.

APPENDIX 1 SITE SUMMARIES

	Background	Group members (#; Types)	Key Activities
Tasmania	• Initial Tasmanian stakeholder meeting held in 2017 • Current stakeholders built off the pre-existing Tasmanian Aboriginal Health Reference Group (TAHRG), with Tasmanian Aboriginal Centre (TAC) plus eye care sector and government • Group members received funding support to attend national Indigenous Eye Health conferences in Melbourne and Alice Springs through jurisdictional fundholder (Tazreach)	19; managerial and clinical staff at optometry and ophthalmology practices, care coordinators, managers and nurses at ACCOs and other Aboriginal community organisations, and leadership staff in public health entities and reference groups	• Eye care services funded and provided from all ACCOs • Funding cultural awareness training for eye healthcare workforce • Tools to support identification of Aboriginal clients at eye healthcare intakes developed and implemented • Eye care pathways mapped • Bulkbilling for ophthalmology services identified as a barrier • Acquiring and providing training for retinal cameras (acquired by three ACCOs)
Geelong	• IEH and Barwon Health facilitated group creation in 2016 with Wathaurong Aboriginal Cooperative	26; primary health networks, regional health services, community health organisations, integrated health services, academic partners, peak bodies in areas of optometry and Aboriginal health and wellbeing, Aboriginal co-operatives, optometry and ophthalmology services	• Identifying Aboriginality in eyecare services and referrals • Hospital preferential pathway established • Bulk billing for specialist ophthalmology services and diabetic injections • Wathaurong staff support on use of retinal camera provided with support from ACO"
North and West Metropolitan Melbourne	• Group established in 2014 through Department of Health and with Victorian Aboriginal Health Service (VAHS) and Victorian Aboriginal Community Controlled Health Organisation (VACCHO) when there were only pockets of eye care services activity in the north and west areas of Melbourne	24; not-for-profit community health organisations, peak bodies in areas of optometry and for ACCHOs in Victoria, Aboriginal health services, public health networks, specialist hospitals, government health departments, individual professionals in optometry and ophthalmology	• Optometry service at VAHS and through ACO expanded through outreach to north and west • Eyecare pathways established to support patients to optometry and hospital (RVEEH) • Fast-tracking Aboriginal patients in need of surgery at hospital

			• Created an ophthalmology clinic inside an Aboriginal Health Service, run by a specialist hospital (state funded) and also funded through jurisdictional outreach fundholder (Australian government funded). Equipment purchased through state government support
Western New South Wales	• Fred Hollows Foundation (FHF) investigation of eye health services in the region in 2012 revealed poor communication between eye health services, a lack of public ophthalmology and a need for improved cross-system coordination • FHF funded a secretariat through the jurisdictional fundholder (NSW RDN) to support a regional stakeholder group which first came together in 2014 • The New South Wales Eye Health Partnership was created and is now a strongly-functioning governance body, based on a similar steering committee in Central Australia	22; primarily composed of ACCHOs, including the peak body for the region, also includes the local health district, primary health network, organisations that manage eye health services, and NGOs	• Collect data on VOS services, public ophthalmology services, Aboriginal patient access, cataract surgery and waiting lists, trends in national indicators to do with primary care, and then look for emerging gaps and problems. This is used to come up with new projects, new services, and/or changes in services. Data collection is done every six months with primary care data collected annually • Put together an Eye Health Service Plan for the region using data collected • Supported improved communication between service providers and consequently improved coordination of services • Supporting public ophthalmology services and coordinating public transport for such services • Supporting clinics through funding, equipment, setting up bulk billing and/or helping with staffing to support Aboriginal patients • Annual training for primary care workers in basic vision screening, referrals and eye conditions • Work with Commonwealth programs to have Aboriginal-specific cataract surgery lists in some areas • Increasing eligibility for Aboriginal patients to the NSW Spectacle Scheme: now every Aboriginal patient in NSW has access to the Scheme • Trained Aboriginal health workers and nurses to triage retinal photos

Southeast Queensland	• Regional group members previously worked together on other Aboriginal and Torres Strait Islander health issues • Collective approach of ACCOs within the region has allowed more equitable and effective use of funding for all players • Eye health services established and directly managed in ACCOs since 2013 • Partnership and regional approach has created an eye health focused development organisation	9; Community Controlled Health Service, development organisation, private hospital	• Extensive eye care service network provided through ACCOs • Direct employment of optometrists by ACCOs • 2 x regional (visiting) ophthalmologists per month to IUIH clinics (one general ophthalmologist and 1 retinal injection clinic per month) • A cataract surgery pathway - this service is funded by the state government and is provided in partnership with a cataract surgeon and the Mater hospital (cataract surgery is done on Saturdays. • Improved and more streamlined pathways to care, understood by ACCOs and providers • Working with university and foundation partners to provide final year optometry traineeships • Workforce development crew for high school-aged students
Townsville & Palm Island	• The jurisdictional outreach fundholder coordinated bringing all the stakeholders in Palm Island and Townsville together in 2017 to consider potentials to check in on the effectiveness of existing activities and consider options for improve eye care • Regional stakeholder group established as a result to provide ongoing work for implementation and monitoring of reforms	6; not-for-profit organisations, Queensland Health, individual professionals (optometrist)	• Established public pathways to care thereby removing private sector service barriers • Streamlined pathways to eye health care resulting in increased access to care and community outcomes • Hospital hired two Indigenous liaison officers and these roles were filled by community members to coordinate visits and transport from the island to Townsville • Integrated data collection and regional multiparty consideration allowed better monitoring of care. Service data is collected quarterly on ophthalmology and optometry patient numbers that is also reported to the Commonwealth for outcomes monitoring)
Upper Hume	• Approached by IEHU to form a regional group and supported by Primary Care Partnership • Started in 2018	7: Aboriginal health service, ACCO, hospital, community health centre, primary care partnership, optometrist	• Clarifying and understating the eye care pathways including refractive error, diabetic retinopathy and cataract surgery • Monitoring access and data

			• Focus on retinal photography
Northern Territory, Alice Springs	• Oldest identified regional eyecare group with origins back to 2007-8 • Originally started with 5 partners • Covers two NT health regions – Central Australia and Barkly • Group continues to meet quarterly and a similar group was established in Top End NT in 2017	20; representing about 16 organisations, including ACCOs, hospitals, PHN, local and visiting optometry services, NACCHO affiliate	• Conduct strategic planning exercise every few years • Have working groups around particular priority areas including data and information; advocacy; workforce and infrastructure • Supported systems improvements in service coordination and delivery, information sharing and joint advocacy • Works with Top End group for territory wide engagement and advocacy • Fred Hollows Foundation funds the group secretariat position through AMSANT (territory NACCHO affiliate) • Launched a regular quarterly workforce survey • Have established a portal to collect data and other related information • Established strong and continuing identity in region around eye care and network that externally shares information, approaches and experiences

APPENDIX 2 SURVEY INSTRUMENT

Survey: Evaluating regional implementation of the Roadmap to Close the Gap for Vision

The Roadmap to Close the Gap for Vision (Roadmap) was published by the Indigenous Eye Health Unit (IEHU) at the University of Melbourne in 2012, following extensive national consultation. A key recommendation was to develop "regional" approaches to organising and improving access to eye care services for Indigenous Australians and, since 2012, IEHU has supported and advocated for regional approaches across Australia.

We would like to hear your perspective on how effective this regional approach has been, including the sorts of changes that have occurred and are occurring at a local and regional level, what has supported these changes, and what successes and challenges people working in the area have experienced. We want to hear from people working across the Aboriginal and Torres Strait Islander eye health sector, even if you don't directly participate in a regional group or network.

We are keen to learn about what was happening in regional implementation before the COVID-19 (Coronavirus) pandemic and also to consider if regional approaches will be a helpful way of working during and after the pandemic.

The information gathered will help with planning future activities and allow learning to be shared about what works to improve eye care for Aboriginal and Torres Strait Islander people.

The survey will take about **15-20 minutes** to complete. You can exit the survey at any time and continue later from the same device.

The survey is being managed by independent evaluators from ARTD Consultants. Your response will be anonymous and will be analysed together with all other responses to the survey.

On completion of the survey you can enter a competition to win one of **20 'Check Today, See Tomorrow' T-Shirts or a pair of Deadly Eyewear sunglasses, to the value of $50.**

If you would like to participate in this survey, **please first read the downloadable** Participant Information Sheet **and indicate your consent below.** All ethics approvals for this project are listed in the Participant Information Sheet. Please ensure you have approval from your organisation to participate, if needed.

If you have any questions or concerns about this survey please contact Rachel Aston from ARTD Consultants via email.

Consent Form – Declaration by participant

I (the participant) have read and understood the Participant Information Statement and

Consent Form, and any questions have been answered to my satisfaction.

If you decide to take part in the study, you are telling us that you:

- are aged 18 years or older
- have appropriate approval from your organisation to complete the survey
- agree to participate in the survey
- know you can refuse to take part in the research or exit the survey at any time
- consent for your survey responses to be used in the evaluation
- consent that your survey response may be included in conference presentations and published in journal articles or other reports on the condition that you cannot be identified.

About you

The survey has five sections ('about you', 'regional approaches', 'supporting people working in Aboriginal and Torres Strait Islander eye health', 'changes' and 'final comments'). You can select 'not applicable' for answers that are not relevant to you.

This survey is designed to evaluate the progress and impact of regional approaches to improving eye care for Aboriginal and Torres Strait Islander people. Participants in the survey are expected from all over Australia and from people working in many different roles in the eye care system.

We want to hear about what was happening in regional implementation *before* the COVID-19 pandemic and also to consider if regional approaches will be a helpful way of working emerging from and after the pandemic.

Do you identify as Aboriginal and/or Torres Strait Islander?

- Aboriginal (1)
- Torres Strait Islander (2)
- Both Aboriginal and Torres Strait Islander (3)
- Neither (4)
- Prefer not to say (5)

Which states or territories do you *mostly* work in? (Tick all that apply)

- ACT (1)
- NSW (2)
- NT (3)
- QLD (4)
- SA (5)

- Tasmania (6)
- Victoria (7)
- WA (8)
- National role/ multi-state/territory role (9)

How would you classify the geographical area/s you mostly work in? (Tick all that apply)

- Remote/ Very Remote (1)
- Regional (inner or outer) (2)
- Urban/ Major City (3)

What type of organisation/s do you work for? (Tick all that apply)

- Aboriginal Community Controlled Health Organisation / Aboriginal Medical or Health Service (1)
- Fund-holder organisation (3)
- Government department (4)
- Hospital (5)
- Non-Government Organisation/ Not-for-profit/ Charity (6)
- Optometry (Private) (7)
- Optometry (Not-for-profit or Government funded) (8)
- Ophthalmology (Private) (9)
- Ophthalmology clinic (Not-for-Profit or Government funded) (10)
- Peak body (11)
- Primary care clinic/ service (non-AMS) (12)
- Primary Care Partnership (PCP) (13)
- Primary Health Network (14)
- Other (please specify) (15) _____

What best describes your role?

- Aboriginal Health Worker/ Practitioner (1)
- Care Coordinator (2)
- Eye Care coordinator (3)
- General Practitioner (4)
- Indigenous Outreach Worker (5)
- Nurse (6)
- Ophthalmologist (7)
- Optometrist (8)
- Orthoptist (9)
- Practice Manager (10)
- Program/ policy/ other management/ administrative role (11)
- Other (please specify) (12) _____

Approximately how long have you been working in Aboriginal and Torres Strait Islander eye health? (Tick one only)

- Less than a year (1)
- 1-3 years (2)
- 4-7 years (3)
- More than 7 years (4)

5.1 HOW PEOPLE ARE WORKING TOGETHER

Are you, or have you been, part of a 1regional Aboriginal and Torres Strait Islander eye health stakeholder group/ network?

- Yes, one regional group/ network (1)
- Yes, more than one regional group/ network (2)
- No, I have not participated in a regional group or network or I am not sure (3)

2c Regional approaches to improving eye care

Display This Question:

If Q7. Are you, or have you been, part of a 1regional Aboriginal and Torres Strait Islander eye heal... = No, I have not participated in a regional group or network or I am not sure

Thinking about regional approaches to improving eye care for Indigenous Australian that *you know about,* to what extent do you agree or disagree with the following statements?

Prior to the COVID-19 (Coronavirus) pandemic:

	Agree (2)	*Tend to agree (3)*	*Tend to disagree (4)*	*Disagree (5)*	*Don't know (6)*	*Not Applicable (7)*
The right mix of people were involved in efforts to improve Aboriginal and Torres Strait Islander eye health (2)	○	○	○	○	○	○
Aboriginal and Torres Strait Islander people were meaningfully involved in regional groups/networks aimed at improving eye health (3)	○	○	○	○	○	○
The needs and priorities of Aboriginal and Torres Strait Islander people were guiding regional groups/networks (4)	○	○	○	○	○	○
Regional groups/networks from across Australia have opportunities to learn from each other (5)	○	○	○	○	○	○
Regional groups/networks provided a good way to monitor progress for eyes care goals and activities (7)	○	○	○	○	○	
As a result of regional group/network activity, Aboriginal and Torres Strait Islander people are more easily able to access eye care (8)	○	○	○	○	○	

Thinking about before, during and what might happen after the COVID-19 pandemic, to what extent to do you agree/disagree with the following:

	Agree (1)	*Tend to agree (2)*	*Tend to disagree (3)*	*Disagree (4)*	*Don't know (5)*	*Not Applicable (7)*
Regional stakeholder groups provided an effective way to address eye care issues *before* the pandemic (5)	○	○	○	○	○	○
Regional stakeholder groups provided an effective way to identify and address eye care issues *during* the pandemic (1)	○	○	○	○	○	○
Regional stakeholder groups will provide an effective way to identify and address eye care needs *after* the pandemic (2)	○	○	○	○	○	○

Please provide any additional comments about how people are working together on a regional level if you would like to:

What could help the regional groups you are aware of to work more effectively in the future?

2b Regional approaches to improving eye care

Display This Question:

If Q7. Are you, or have you been, part of a 1regional Aboriginal and Torres Strait Islander eye heal... = Yes, more than one regional group/ network

Thinking about the **regional groups/networks** that you have been part of, to what extent do you agree or disagree with the following statements? (Only answer this question if you are part of **more than one** group)

Prior to the COVID-19 (Coronavirus) pandemic:

	Agree (1)	*Tend to agree (2)*	*Tend to disagree (3)*	*Disagree (4)*	*Don't know (5)*	*Not applicable (6)*
Most of the regional groups had the right mix of people involved (8)	○	○	○	○	○	○
Most of the regional groups had appropriate representation from Aboriginal and Torres Strait Islander people (2)	○	○	○	○	○	○
Most of the regional groups had clear plans (21)	○	○	○	○	○	○
Most of the regional groups had plans that reflect the local needs and priorities of Aboriginal and Torres Strait Islander people (1)	○	○	○	○	○	○
I felt that my voice and perspective was valued in **most** of the groups I participated in (12)	○	○	○	○	○	○
Most of the regional groups were adequately supported to achieve their goals (3)	○	○	○	○	○	○
In most of the regional groups I am part of, the goals and activities of the group were regularly **monitored** (16)	○	○	○	○	○	○
Regional groups/networks provided an effective way to collect and review **local eye care data (23)**	○	○	○	○	○	○
Regional groups from across Australia had opportunities to learn from each other (5)	○	○	○	○	○	○
As a result of regional group/ network activity, Aboriginal and Torres Strait Islander people were more easily able to access eye care (13)	○	○	○	○	○	○

Thinking about <u>before, during</u> and <u>what might happen after</u> the COVID-19 pandemic, to what extent to do you agree/disagree with the following:

	Agree (1)	*Tend to agree (2)*	*Tend to disagree (3)*	*Disagree (4)*	*Don't know (5)*	*Not Applicable (6)*
Regional stakeholder groups provided an effective way to address eye care issues *before* the pandemic (4)	○	○	○	○	○	
Regional stakeholder groups provided an effective way to identify and address eye care issues *during* the pandemic (1)	○	○	○	○	○	
Regional stakeholder groups will provide an effective way to address eye care needs again *after* the pandemic (2)	○	○	○	○	○	

Please provide any additional comments about how people are working together on a regional level, if you would like to:

What could help the regional groups you are part of to work more effectively in the future?

2a Regional approaches to improving eye care

Display This Question:

If Q7. Are you, or have you been, part of a 1regional Aboriginal and Torres Strait Islander eye heal... = Yes, one regional group/ network

Thinking about the regional group/network that you participate/d in, to what extent do you agree or disagree with the following statements? (Answer this question if you are part of one group only)

Prior to the COVID-19 (Coronavirus) pandemic:

	Agree (1)	*Tend to Agree (2)*	*Tend to disagree (3)*	*Disagree (4)*	*Don't know (6)*	*Not Applicable (7)*
The right mix of people were involved in the group/network (1)	○	○	○	○	○	○
The group had appropriate representation from Aboriginal and Torres Strait Islander people (13)	○	○	○	○	○	○
The regional group had clear plans (12)	○	○	○	○	○	○
The plans of the group reflected the local needs and priorities of Aboriginal and Torres Strait Islander people (3)	○	○	○	○	○	○
I felt that my voice and perspective was valued by the group/network (5)	○	○	○	○	○	○
The group was adequately supported to achieve its goals (6)	○	○	○	○	○	○
The progress of the group was regularly **monitored (10)**	○	○	○	○	○	○
The group/network provided an effective way to collect and review **local eye care data (9)**	○	○	○	○	○	○
Regional groups from across Australia had opportunities to learn from each other (11)	○	○	○	○	○	○
As a result of the regional group's activity, Aboriginal and Torres Strait Islander people were more easily able to access eye care (8)	○	○	○	○	○	○

Thinking about before, during and what might happen after the COVID-19 pandemic, to what extend do you agree/ disagree with the following:

	Agree (1)	*Tend to agree (2)*	*Tend to disagree (3)*	*Disagree (4)*	*Don't know (5)*	*Not Applicable (6)*
The regional stakeholder group provided an effective way to address eye care issues *before* the pandemic (4)	○	○	○	○	○	○
The regional stakeholder group provided an effective way to identify and address eye care issues *during* the pandemic (1)	○	○	○	○	○	○
The regional stakeholder group will provide an effective way to address eye care needs again *after* the pandemic (2)	○	○	○	○	○	○

Please provide any additional comments about how people are working together on a regional level, if you would like to:

What could help the regional group you are part of to work more effectively in the future?

In what ways could Aboriginal and Torres Strait Islander people be more effectively engaged in improving the eye health system at a regional level?

5.2 SUPPORTING PEOPLE WORKING IN ABORIGINAL AND TORRES STRAIT ISLANDER EYE HEALTH

To what extend do you agree or disagree with the following statements?

	Agree (1)	*Tend to agree (2)*	*Tend to disagree (3)*	*Disagree (6)*	*Don't know (4)*	*Not applicable (5)*
I understand my role and responsibilities to support the improvement of eye health for Aboriginal and Torres Strait Islander people (1)	○	○	○	○	○	○
I have the resources and support I need in my role to improve eye health for Aboriginal and Torres Strait Islander people (2)	○	○	○	○	○	○

To what extent do you agree or disagree that the following activities have been key supports for you in your role?

	Agree (1)	*Tend to agree (2)*	*Tend to disagree (3)*	*Disagree (6)*	*Don't know (4)*	*Not applicable (5)*
Participating in local/ regional eye health stakeholder meeting/s (1)	○	○	○	○	○	○
Mapping the pathways of care for eye conditions at a regional level (2)	○	○	○	○	○	○
Regular monitoring of progress at a regional level (5)	○	○	○	○	○	○
Looking at **local eye care data (23)**	○	○	○	○	○	○
Attending a Close the Gap for Vision Indigenous eye health conference/ roundtable (4)	○	○	○	○	○	○

To what extent do you agree or disagree that the following Indigenous Eye Health Unit (University of Melbourne) tools and resources have been key supports for you in your role?

	Agree (1)	*Tend to agree (2)*	*Tend to disagree (3)*	*Disagree (6)*	*Don't know (4)*	*Not applicable (5)*
Indigenous Eye Services Calculator (16)	○	○	○	○	○	○
Check Today, See Tomorrow Diabetes eye care resources (18)	○	○	○	○	○	○
'Asking the Question' resources (19)	○	○	○	○	○	○
The Roadmap to Close the Gap for Vision reports (9)	○	○	○	○	○	○
Annual 'Roadmap' updates (12)	○	○	○	○	○	○
Share Your Story: Success Stories (11)	○	○	○	○	○	○
Newsletters/e-bulletins (13)	○	○	○	○	○	○
Website (14)	○	○	○	○	○	○
Social media (15)	○	○	○	○	○	○

To what extent do you agree or disagree that the following other tools and resources have been key supports for you in your role?

	Agree (1)	*Tend to agree (2)*	*Tend to disagree (3)*	*Disagree (4)*	*Don't know (5)*	*Not Applicable (6)*
Australian Institute of Health and Welfare Indigenous Eye Health Measures reports (1)	○	○	○	○	○	○
Online training and health professional educational resources (2)	○	○	○	○	○	○
Support provided by Indigenous Eye Health Unit (UOM) team members (5)	○	○	○	○	○	○

Are there any other things that have supported you in your role?

Are there any ways that existing tools, resources and other supports could be improved?

What additional tools, supports or resources would be useful in improving eye health for Aboriginal and Torres Strait Islander people at a regional level in the future?

5.3 CHANGES

Thinking about changes to eye care *for Aboriginal and Torres Strait Islander people* since 2013 (or since you started working in the Indigenous eye health area), to what extent do you agree or disagree with the following statements?

	Agree (1)	*Tend to agree (2)*	*Tend to disagree (3)*	*Disagree (4)*	*Don't know (5)*	*Not applicable (6)*
Access to eye care has improved for Aboriginal and Torres Strait Islander people (1)	○	○	○	○	○	○
Service providers have increased awareness of Aboriginal and Torres Strait Islander eye health (2)	○	○	○	○	○	○
Service providers have increased awareness of the eye care services available (11)	○	○	○	○	○	○
Aboriginal and Torres Strait Islander people have increased awareness of eye health (3)	○	○	○	○	○	○
Aboriginal and Torres Strait Islander people have increased awareness of the eye care services available (12)	○	○	○	○	○	○
My organisation has improved the way we provide eye care programs or services for Aboriginal and Torres Strait Islander people (4)	○	○	○	○	○	○
My organisation has improved how we work with others to coordinate eye care (5)	○	○	○	○	○	○
There have been improvements in **cultural responsiveness** across the eye care sector (13)	○	○	○	○	○	○
The eye care workforce has increased in my region/ on a regional level (14)	○	○	○	○	○	○
Funding for Indigenous eye health programs and services has increased (15)	○	○	○	○	○	○

What have been the *most* significant changes you have seen in the Aboriginal and Torres Strait Islander eye health system since 2013 (or since you started working in the space if it was after 2013)?

What are the main things that contribute to improving Aboriginal and Torres Strait Islander eye health?

What are the main challenges or barriers for improving Aboriginal and Torres Strait Islander eye health?

Do you have any other comments about how to improve eye health outcomes for Aboriginal and Torres Strait Islander people in the future?

Thank you for participating in this survey

If you would like to go into the draw for a **chance to win a 'Check Today, See Tomorrow' T-Shirt or a pair of Deadly Eyewear sunglasses to the value of $50** please send an e-mail to Holly Kovac. We will only use this email to contact you if you win a prize and it will not be used to identify your answers to the survey.

If you would like to receive a copy of the final report from the evaluation, please email Holly Kovac. Your email address will be stored separately to your survey responses and will not be used to identify you.

APPENDIX 3 FOCUS GROUP SCHEDULE

In 2010 the Indigenous Eye Health Unit at the University of Melbourne consulted with Aboriginal health service staff, specialist eye health personnel and service users across Australia as part of the ''Barriers to the provision and utilisation of eye health services for Indigenous Australians'. As a result of that project and with sector support and endorsement, IEH published 'The Roadmap to Close the Gap for Vision' in 2012.

One of the recommendations of The Roadmap was that solutions for organising and improving eye care for Aboriginal and Torres Strait Islander people should be organised at the local level. A key element of this local level organisation was a regional approach where multiple stakeholders work in a collaborative way to identify and address the eye care needs of Aboriginal and Torres Strait Islander people within the area.

Since 2013, regional implementation has been occurring across Australia, with over 50 regions now established across all states and territories. Approaches and activities differ across different regions, reflecting the diversity of communities, systems and structures, and different needs across regional, remote and urban settings - as well as stages of implementation.

IEHU is now evaluating if taking a regional approach, where stakeholders work together to identify and address the eye care needs for the local population, is an effective way of improving eye care services and outcomes for Aboriginal and Torres Strait Islander people.

Your group/network has been selected as one of the 'case study' sites to explore what these regional approaches look like, how effective they have been, and both the challenges and enablers experienced by stakeholders working in this way. There are different opportunities to feed information forward to the evaluation if you don't feel comfortable in the focus group environment. I.e. questions could be sent out in written form, opportunity to provide written feedback via email.

Domain	Questions	Prompts
Context	**To start off with a bit of context, can you tell us how the regional group came together?**	• When? Who are the group members and what are their roles? • Prior to this regional group, what processes were in place for collaborative approaches to eye care services for Aboriginal and Torres Strait islander people? • How have you worked to identify areas of focus (in eye health) to work on?
Regional implementation relationships	**Thinking about organising service provision:** • **Have you seen any changes to the way eye care solutions are being driven and implemented by those living and working within the local area?** • **Have pathways of care become clearer and easier to navigate?** • **Has coming together as a regional group supported improvement in communication between stakeholders?** • **How could this group be strengthened by more Indigenous participation and leadership within this group?**	• Are there key people that need to be engaged?
Regional implementation barriers	**What key barriers have hindered regional implementation?**	• Workforce; priorities (i.e. non-eye-care); governance; funding; lack of evidence, local stakeholders

Regional implementation enablers	**What key enablers have supported regional implementation?**	• Workforce, priorities, funding, governance, local stakeholders
Impact	**What outcomes have you seen as a result of taking a regional approach?**	• What improvements of eye health services exist across the system now that didn't before?
	Have you seen improvements in cultural safety across the eye care system?	• Is the eye care system considered culturally safe?
	Can you tell me about a positive consumer/patient eye care experience?	
Sustainability	**In terms of sustainability what supports are needed to improve eye care for Indigenous Australians?**	• How can the system of eye care become or continue to be locally coordinated? • How does the region collect, share and monitor performance data? • What consideration has the group given to succession planning?
Future key learnings	**What are the key learnings from this experience that you think are important to feed forward?**	• What would you include, change, amend in a future regional model?
Other	**Is there anything else you would like to comment on?**	

APPENDIX 4 FOCUS GROUP PARTICIPANTS

TABLE A1. FOCUS GROUP PARTICIPANTS

Site	Total no. of participants
Central Australia and Barkly (NT)	7
Upper Hume (VIC)	4
Tasmania (TAS)	4
Geelong (VIC)	6
Southeast Queensland (QLD)	6
Western NSW (NSW)	7
Townsville and Palm Island (QLD)	7
North and West Metropolitan Melbourne (VIC)	3

TABLE A2. INDIVIDUAL INTERVIEWS

Site	Organisation present (no. of participants if more than one)
Upper Hume	Community Health
Tasmania	Optometrist
Tasmania	ACCO
Geelong	University
Geelong	Ophthalmologist
Geelong	University
Geelong	Workforce Agency (2)
North and West Metro Melbourne	ACCHO