Fundholder Forum for Indigenous Eye Health

Report

Indigenous Eye Health

4 October 2016

THE UNIVERSITY OF MELBOURNE

Minum Barreng
Indigenous Eye Health
Melbourne School of Population and Global Health

TABLE OF CONTENTS

Appendices

Acknowledgements

Indigenous Eye Health at The University of Melbourne would like to thank all who contributed to and participated in the forum. We would particularly like to thank all speakers who presented on the day and Michael Kitts (from PwC, PricewaterhouseCoopers) for facilitating the meeting.

Funding support from the Australian Government Department of Health is acknowledged and appreciated.

The report can be accessed at IEH website: www.iehu.unimelb.edu.au

Acronyms

AMS	Aboriginal Medical Services
EESSSP	Ear and Eye Surgical Support Services Program
IEH	Indigenous Eye Health, The University of Melbourne
MOICDP	Medical Outreach Indigenous Chronic Disease Program
PHN	Primary Health Network
RHOF	Rural Health Outreach Fund
VOS	Visiting Optometrists Scheme

Executive Summary

On 4 October 2016, Indigenous Eye Health at The University of Melbourne hosted a 'Fundholder Forum in Indigenous Eye Health.' Stakeholders from seven states and territories and representatives from the Australian Government Department of Health attended to share experiences, approaches and outcomes from eye surgery programs and Indigenous eye care coordination initiatives and to explore the opportunities available to enhance current outreach programs.

Each jurisdiction has a number of outreach programs coordinated through the fundholder organisations. These programs assist Indigenous communities in urban, remote and regional settings to access health services and include:

- Visiting Optometrists Scheme (VOS)
- Rural Health Outreach Fund (RHOF)
- Medical Outreach Indigenous Chronic Disease Programme (MOICDP)

In recent times this has also included the Ear and Eye Surgical Support Services Program (EESSSP), or similar, that supports eye (and ear) surgery for Indigenous patients. Fundholders are also undertaking new activities in 2016-2017 to enhance Indigenous eye care coordination.

Jurisdictions described their experience, outcomes and learnings of the eye surgery programs, including the EESSSP, which have allowed a number of Indigenous patients to receive much needed cataract and other eye care surgical support. Although NSW and NT did not receive specific EESSSP funding, they were also able to access support funds through other means to ensure that a number of additional Indigenous patients received eye surgery. Stakeholders identified a number of barriers common to different jurisdictions to ensure patients received eye surgery through these schemes including:

- Challenges in locating up-to-date waiting lists for assessment and surgery
- Working with hospitals (private and public) in a timely manner
- Working within the short-term timeframe of the funding; and
- Challenge of how to build sustainability into the system.

A draft needs assessment framework was presented to the meeting to guide discussion about this important function of fundholders. Fundholders agreed that establishing a nationally consistent and best practice approach would be advantageous and that the needs assessment relevant to Indigenous eye health should include coordination between VOS, RHOF and MOICDP programs. It was also noted that a needs assessment is a living document that should be periodically reviewed and responsive to changing health patterns and priorities.

The Indigenous eye care coordination programs being undertaken by fundholders are still in the early stages of development in each jurisdiction. The plans and activities outlined for coordination varied between fundholders and were generally only short term in nature due to the length of the current funding agreements (12 months), despite fundholders generally applying longer-term thinking to the coordination issues.

Fundholders also identified a number of ways in which funding and delivery of Indigenous eye health outreach services could be improved. Common thoughts included:

- Increasing the length of funding agreements
- Support greater flexibility and fundholder discretion within the programs
- Improving knowledge management and exchange, by systematic sharing of approaches, outcomes and leading practice
- Developing a national performance framework for Indigenous eye health outreach fundholding with key outcomes-based, performance indicators.

Overall, feedback from the participants suggested that the Forum was well received and provided fundholders with opportunities to network, and share experiences and information with others working across the country. Bringing fundholders together in this way allowed interaction and problem-solving of shared issues to further support their role in Indigenous eye health and work towards closing the gap for vision.

Introduction

The Roadmap to Close the Gap for Vision (2012) is a sector-endorsed, whole-of-system policy framework (with 42 recommendations) that seeks to close the inequity in eye health between Indigenous and non-Indigenous Australians. The Roadmap identifies the importance of an eye care workforce to meet population needs, management of visiting services, coordination of patient care coordination of eye care systems, accessibility of surgical services and establishment of clear patient pathways of care.

In recent years there has been a number of changes to planning, funding and policy of Indigenous eye care services. Stakeholders at the March 2016 roundtable 'Planning sustainable and coordinated Indigenous eye health services' (held by IEH at The University of Melbourne) discussed these changes. It was noted by the participants that effective coordination is required across outreach services to improve the delivery of health services for Indigenous Australians. A consultative, evidence-based approach to planning was called for to support Medical Outreach Indigenous Chronic Disease Program (MOICDP), Rural Health Outreach Fund (RHOF) and Visiting Optometrists Scheme (VOS).

Most jurisdictions received funding for the Ear and Eye Surgical Support Services (EESSSP), which commenced in 2015-2016 and was refunded in 2016-2017. The goal of the program is to improve access to surgical services for Indigenous people living in remote and rural areas.

A second Commonwealth support program for Indigenous eye care coordination was funded in 2016-2017 to work in partnership with eye health care stakeholders to ensure integration of services from initial consultations, to treatment, referral and continuity of care. Activities suggested included:

- establishing an Indigenous eye health advisory group for eye care outreach programmes (RHOF, VOS, MOICDP);
- assessing need for improved coordination of Indigenous eye health activities;
- undertaking needs assessment and planning in consultation with relevant stakeholders;
- maximising alignment of services provided through the VOS, RHOF and MOICDP;
- identifying and implementing strategies to address barriers, gaps and inefficiencies; and
- working with/leverage off local organisations to maximise support for coordination of outreach eye health services at delivery

Both the EESSSP and the Indigenous eye care coordination programs are relatively new and are currently funded for 12-month periods.

In October 2016, IEH at the University of Melbourne held this forum with fundholders to follow-up from the March roundtable and discuss the outcomes and challenges of the EESSSP, the needs assessment process and planning for the coordination funding. Potential improvements to the outreach programs to support the goal to close the gap for vision were also discussed.

Forum objectives and goals
The forum brought together fundholders from each jurisdiction to discuss Indigenous eye health. The goals of the forum were to:

- Share learnings, experiences and outcomes from the eye surgery program
- Discuss needs assessment for Indigenous eye care
- Share approaches, learnings and progress on Indigenous eye care coordination activities
- Identify ideas and opportunities to improve current and future eye care outreach and support programs

Participants
Twenty-four (24) participants from eleven organisations and seven jurisdictions participated in the forum. A full list of attendees and organisations represented is attached at Appendix 1.

Eye Surgery Programs

Presentations were made by representatives from six jurisdictions (NSW, NT, QLD, SA, TAS and WA). The objectives of the session were to hear about each jurisdictions eye surgery program and the successes and positive outcomes achieved and then to identify the barriers and other lessons learned from the eye surgery programs.

The EESSSP aims to increase access for Indigenous Australians residing in remote and rural areas to receive surgery for ear and eye conditions. This forum focused on the eye (not ear) surgery program.

NSW and NT did not receive specific EESSSP funds for the eye surgery program but all other states received funding.

An overview of the presentations and discussion is presented below.

AMS supporting local coordination: Building good relationships with AMS greatly facilitates the progression and underpins the success of the program, however many jurisdictions noted that this takes time. The clinic staff know their patients well; who has received surgery and who is in need of it. Some funding has been provided to AMS to support coordination and involve clinic staff. Coordinating cataract surgery is much better when good working relationships are also established between the hospitals and the AMS. This results in a real and positive change.

Public versus private hospitals: A number of fundholders reported difficulty in engaging public hospitals and to advocate for additional theatre time. In most situations public hospitals were engaged first but some were not able to accommodate the request for extra surgical time within the recommended timeframe of the funding program. In such cases private hospitals provided an alternative solution, offering greater flexibility with time (including weekends) and more surgeries conducted during a given theatre session (greater throughput).

Patient travel: Although funds cover the accommodation and transport of the patients, some patients are not willing to travel to places that are unfamiliar to them. Such situations can bring about anxiety for some. The use of funds to allow a carer to travel with them has greatly assisted attendance for assessment and surgery, but still has not completely solved the non-attendance rates.

Waiting lists: Locating an accurate, up-to-date waiting list can be challenging and time consuming for fundholders. Some jurisdictions reported that it took time to understand the referral pathways and the variety of patient journeys. As the funding is designated for a specific time period, these delays impacted on the delivery of surgical services.

Staff continuity: Success of the eye surgery program relies heavily on staff knowledge, awareness and continuity. In some areas, there are constant changes and high turnover of staff that make it difficult for programs to progress. Time is needed to bring the staff up-to-date, to maintain knowledge of the work and how to arrange services and staff turn-over impacts negatively on patient care.

Length of funding: The majority of the 12-month period was spent on locating waiting lists, determining those patients requiring surgery and building the right relationships before being able to arrange care. Consequently, the period of time remaining for the delivery of the surgical services was quite limited and impacted on the outcomes.

Pathways and coordination:
One fundholder reported that some patients referred for surgery by one provider were not deemed to need surgery when referred to and examined by another provider. Again, this slows surgery response time as a result.

Tele-health: Patients may be required to make multiple trips to a distant location for pre-op, post-op or follow-up surgical sessions. To avoid cost wastage and alleviate the anxiety of the patient, tele-health may provide an alternative but this is still to be determined. Collating leading practice in tele-health for eye care was of interest to participants.

Needs Assessment

The objective of the session was to provide some thoughts and approaches for needs assessments in Indigenous eye care. A copy of the presentation is at Appendix 3.

A consistent, systematic, whole of eye care system, best practice approach was proposed for needs assessment in Indigenous eye care that can also complement the broader needs assessment requirements of fundholders.

A five-step process was suggested as a way to gather the necessary information for Indigenous eye care needs assessment.

Step 1 - Regional Profiles: A consistent, region-by-region approach is recommended. Fundholders will be able to ensure that funds are being properly distributed and this approach empowers regional agencies and structures.

There are a number of ways regions can be identified:

- Use existing regional Indigenous eye health regional structures or boundaries used for planning by the fundholder
- Jurisdictional health regional structures
- Local government areas
- PHN boundaries
- Local health/hospital districts

Step 2 - Population Needs: The IEH calculator can assist in determining Indigenous eye care needs in a region by providing estimates of the yearly requirements for coordination and delivery of eye services, for a given population of Aboriginal and Torres Strait Islander people. Estimates provided include:

- Annual comprehensive eye examinations
- Optometry and ophthalmology days
- Cataract surgery and diabetic retinopathy treatment
- Coordination workforce required

The IEH calculator can be found at www.iehu.unimelb.edu.au

Step 3 - Existing Service Levels: The analysis of data from current outreach services reports, AIHW and MBS workforce service allows fundholders to develop a picture of existing service levels for a region. The collection of local data, where possible, will provide additional information to support estimates of existing service levels.

Step 4 - Gap Analysis: The information collected from the previous three steps is used to identify the gap between population-based needs for Indigenous eye care and the currently available services. This provides a measure of the service gap – the additional services that need to be provided in order to meet population-based needs.

Step 5 - Program Priorities: Reflecting on the inputs from Steps 1-4 will assist with the planning process of MOICDP, RHOF and VOS and provide information for the appropriate resources required for the additional programs (like EESSS).

Outreach fundholders have demonstrated experience in conducting needs assessments that are needs based, reflect consumer perspectives and provide basis to address the unique needs of local communities. The template presented at the forum was broadly consistent with current fundholder approaches. Fundholders noted that they have also recently completed needs assessments for the VOS. The attendees agreed that a needs assessment framework for Indigenous eye care would be worthwhile and of value. Fundholders welcomed the opportunity to have input into the development of a needs assessment framework that would act as a guide for national consistency and best practice and to set some baseline data from which to measure outcomes. It was noted that a needs assessment is a living document that should be maintained to be reflective of changing health patterns and priorities. It was considered that Primary Health Networks (PHN) could assist

with this process. Although this would reduce duplication, it was generally agreed that at this stage the PHN process is too broad to inform outreach decision-making.

IEH was asked to prepare and circulate a draft needs assessment framework to the fundholders for comment.

Indigenous Eye Care Coordination

Fundholder presentations were made by representatives for each jurisdiction (NSW, NT, QLD, SA, TAS, VIC and WA) to share approaches, learnings and progress on Indigenous eye care coordination activities.

Fundholders are planning to use the coordination funds in a number of ways.

Establishing jurisdictional committees: Most jurisdictions have established or are in the process of creating state/territory wide committees to support Indigenous eye care coordination. The committees generally comprise a number of stakeholders and will provide advice and support for fundholders against the objectives of the coordination plans and broader Indigenous eye care issues and needs.

Regional structures to coordinate eye care: Given the significant geographic areas of jurisdictions, regional structures are being established to support efficient coordination. Regions provide more manageable areas to consider coordination needs and regional stakeholder groups can provide the local information and engagement required to support coordination. These regional groups will also be responsible for communicating other regional learnings and ideas from the jurisdictional committee to their region. The regional groups can further assist with determining what the true need is in the community. This information can be fed back to the jurisdictional committee to help with the development of a population based needs analysis. The importance of working closely with local stakeholders in each region was emphasised.

Engagement with PHNs: One jurisdiction described PHNs and regional coordinators working together to create clinical pathways. Fundholders identified that engagement and information exchange with PHNs is important but noted that the PHNs are still all at different stages of planning. PHNs provide in some jurisdictions potential alignment with regional groups but in other jurisdictions may be too large for local regional coordination considerations. It was also identified that PHN needs assessments are likely to be broader than the requirements of needs assessment for fundholders.

Appointment of staff with jurisdictional responsibilities: Several fundholders are appointing, or already have appointed, a jurisdictional Indigenous eye health coordinator. Most felt that this role was appropriate and required to manage the tasks and implement the necessary changes for improved coordination.

Distributing funds to a provider: One jurisdiction supported the main outreach Indigenous eye health provider with the coordination funds with the goal of improving coordination through supporting service provider needs.

Patient pathways: There was general agreement that the approach taken when improving coordination should be patient centered. Establishing improved patient pathways should consider and be designed around the patient (not the providers). It was considered important to work with the key personnel involved (i.e. optometrist, ophthalmologist, hospitals) to ensure that patients are provided with a smooth and efficient journey.

Improving Outreach for Indigenous Eye Health

This open session discussed ideas and opportunities for improving and enhancing existing and future eye care outreach and support programs.

Flexibility in guidelines: Most fundholders agreed that there needs to be some flexibility with the guidelines. More flexibility would assist fundholders capacity to react and respond to change in a timely manner. Fundholders felt that there was a need for more delegation to make decisions relating to eye health outreach programs based on changing local needs and priorities. For example, when unforseen events occur that impact timelines of which services are administered, fundholders would like to be able to respond, within the funding guidelines, instead of waiting for approval.

Bulk billing: Fundholders also stated that delegation should include the ability, depending on the service proposal, to prioritise provider selection to be able to support those practitioners who agree to bulk bill Indigenous eye care patients.

Increased length of funding: A 12-month funding period is too short to implement real changes in outreach services and coordination, as the majority of time is spent determining the tasks and ways funding will be used. Significant and sustainable change may require more complex negotiation and systems building which is difficult to achieve in the short term. Arrangements with providers are also compromised by short one-year funding agreements. Even though fundholders were only in the early phases of coordination improvement, a long-term thinking approach was identified as needed for coordination planning.

Developing a performance framework with key indicators: Fundholders identified the potential value and need for a performance framework to drive Indigenous eye health jurisdictionally but also to support a national approach to planning and information sharing. Key indicators for fundholders would form part of this framework. IEH offered to prepare and circulate a draft framework.

Forum Evaluation

At the Forum close, participants were asked to complete an evaluation to provide feedback on their experience of the meeting. A total of 11 surveys were completed (from 13 distributed, 85% response rate).

Overall, the feedback received was very positive with opportunities to share learnings and experiences with people from other jurisdictions being a primary outcome for all participants (average response 4.73, where 5 is the maximum score). Qualitative feedback reinforced this assessment: '*Good to hear about different approaches - reflects the need for diversity/flexibility in the different geographical areas'; 'Listening to other approaches to coordination funding was valuable*'. The majority of participants (91%) also indicated that the information discussed was of value and interest to their work (average response 4.55, where 5 is the maximum score). Similarly, a high proportion of participants (91%) indicated that the Forum had met their expectations, which was also reflected with most participants (82%) indicating that they felt more able to advance a jurisdictional approach to Indigenous eye care after participating in the Forum (average response 3.75, where 5 is the maximum score).

Some participants also indicated that the networking and opportunities to share information that arose from bringing the group of fundholders together allowed interaction and problem-solving of shared issues, *'Presentations from other states - issues they experience - how they overcome them'*. Many participants provided feedback on ways that IEH could help support their eye health planning and coordination needs. Consistent feedback identified IEH's valued role providing technical advice and support. Others also indicated a role to support fundholders to improve policy through informal advocacy.

In summary, the evaluation highlighted that the Forum was very well received by participants and provided an excellent opportunity to share experiences with others working in the same field, as described by one participant: *'Good opportunity for questions - group input to solutions'.*

Conclusion

The Fundholder Forum in Indigenous Eye Health brought together fundholders from across Australia to discuss shared learnings, barriers and positive outcomes of the EESSSP and Indigenous eye care coordination programs. A draft needs assessment was presented to gather thoughts for discussion around the development of best practice approaches to needs assessment for Indigenous eye health.

Fundholders agreed that a nationally consistent approach would be advantageous and supported the development a needs assessment framework and performance framework with key indicators. Fundholders shared thoughts to improve current outreach programs. This report was generated to capture the main findings from the day.

Appendices

Appendix 1 Forum Participants

List of forum participants

Surname	First	Organisation
Anjou	Mitchell	Indigenous Eye Health, The University of Melbourne
Bagnulo	Sharif	NSW Rural Doctors Network
Beaumont	Eveline	Rural Workforce Agency Victoria (RWAV)
Copeland	Rosemary	Top End Health Service
Duggin	Vivienne	Rural Health West WA
Ellis	Rose	NSW Rural Doctors Network
Gilden	Rosamond	Indigenous Eye Health, The University of Melbourne
Hale-Robertson	Karen	CheckUP, Queensland
Hawgood	Jacqui	CheckUP, Queensland
Holden	Carol	Indigenous Eye Health, The University of Melbourne
Jatkar	Uma	Indigenous Eye Health, The University of Melbourne
Kitts	Michael	PricewaterhouseCoopers (PwC)
McCulloch	Mandy	Rural Doctors Workforce Agency (RDWA)
O'Connor	Barbara	Queensland Aboriginal & Islander Health Council (QAIHC)
O'Neill	Claire	NSW Rural Doctors Network
Perkins	Kerin	TAZREACH
Pollard	Michelle	Brien Holden Vision Institute (BHVI), Northern Territory
Roberts	Philip	Indigenous Eye Health, The University of Melbourne
Rye	Liz	Queensland Aboriginal & Islander Health Council (QAIHC)
Schubert	Nick	Indigenous Eye Health, The University of Melbourne
Scinta	Gretchen	Rural Doctors Workforce Agency (RDWA)
Stanford	Emma	Indigenous Eye Health, The University of Melbourne
Stilling	Rhonda	Department of Health, Australian Government
Taylor	Julie	Department of Health, Australian Government
Taylor	Hugh	Indigenous Eye Health, The University of Melbourne

Appendix 2 Agenda for Forum

Fundholder Forum in Indigenous Eye Health

Tuesday 4 October 2016, 10.00 am – 4.00 pm
Graduate House, The University of Melbourne,
220 Leicester St, Carlton, Victoria

Agenda

9:45 am	Registration and morning tea	
10:00 am	Welcome and introductions	Michael Kitts

Session 1 Eye Surgery Programs

10:15 am	Fundholder presentations on eye surgery programs	Fundholders
11:25 am	Group discussion	Michael Kitts

Session 2 Needs Assessment

11:45 pm	Some Indigenous Eye Health thoughts regarding needs assessment	Mitchell Anjou

12:10 pm Lunch

Session 3 Indigenous Eye Care Coordination

12:55 pm	Fundholder presentations on eye care coordination activities	Fundholders
2:05pm	Group discussion	Michael Kitts

2:25pm Afternoon Tea

Session 4 Improving Outreach for Indigenous Eye Health

2:45 pm	Table discussion developing Ideas and opportunities to improve current and future eye care outreach programs	Fundholders
3:20 pm	Group discussion	Michael Kitts
3:50 pm	Summary of the day and closing remarks	Hugh Taylor
4:00pm	End of Forum	

Appendix 3 Needs Assessment Presentation

Fundholder Forum in Indigenous Eye Health
4 October 2016

Needs Assessment

Some Indigenous Eye Health thoughts regarding needs assessment

'thoughts from the Ivory Tower'

Mitchell Anjou

Minum Barreng
Indigenous Eye Health
Melbourne School of Population and Global Health

THE UNIVERSITY OF MELBOURNE

Needs assessment

- Systematic method to
- identify unmet health and health care needs
- at a population level, and
- making change to meet unmet needs.

Using epidemiological and qualitative approaches to determine priorities…
Incorporating clinical and cost effectiveness and patients' perspectives…
Balancing clinical, ethical, and economic considerations of need…

➢Determining what should be done, what can be done and what can be afforded

from Wright et al 1998 BMJ

THE UNIVERSITY OF MELBOURNE

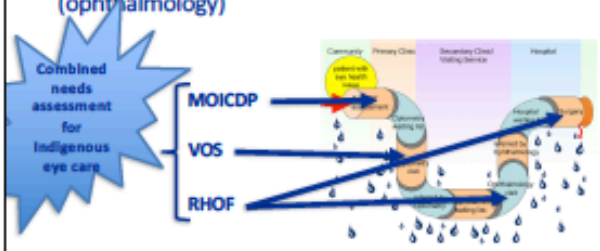
IEH interest in 'nationally consistent, best practice' fundholder needs assessment

- Needs assessment is necessary to close the gap for vision (identifying unmet need and making change to meet this)
- IEH regional work has provided opportunity to undertake regional needs assessment with local stakeholders
- IEH observes a range of approaches to needs assessment adopted by different fundholders
- IEH considers **population needs** must be used as a basis for needs assessment…and should be used for planning, prioritisation and government reporting

THE UNIVERSITY OF MELBOURNE

Needs assessment in Indigenous eye health

- Consider whole of eye care system primary care (AMS), secondary assessment (optometry, ophthalmology), hospital intervention (ophthalmology)



THE UNIVERSITY OF MELBOURNE

Needs assessment in Indigenous eye health

- We consider there is value in **national consistency** and **best practice** approaches in Indigenous eye health needs assessment
- We understand needs assessment processes for fundholders is broader than Indigenous eye health
- We understand timelines and resources provided for fundholder needs assessment consistently involve compromise

➢ A simple logic pathway/framework is being developed that complements the broader needs assessment requirements – your input would be appreciated

Indigenous Eye Health Needs Assessment

Step 1: Regional Profiles

- Adopt a regional approach to the needs assessment
- Assess:
  - Population health data
  - Current regional services
  - Distribution of the workforce
- Goal/Benefits:
  - Certainty for fundholders that funds are being distributed appropriately
  - Empowers regional agencies and structures

Step 1: Regional Profiles

Suggestions for identifying regions

- Existing regional Indigenous eye health structures
- Existing regional boundaries used for planning by the fundholder for outreach and/or eye health programs
- Jurisdictional health regional structures
- Local Government Areas
- Primary Health Network (PHN) boundaries
- Local Health/ Hospital Districts

Step 1: Regional Profiles

The profiling of regions should document:

- Communities, towns and cities (by rural area classification)
- Aboriginal and Torres Strait Islander population
- AMS location
- Optometry, ophthalmology, community health and/or hospital services
- Available population health data

Step 2: Population Needs

Indigenous Eye Health eye care services calculator

- Estimates annual requirements for delivery and coordination of eye care services for a given Indigenous population
- Based on prevalence rates from the NIEHS (2009) and The Roadmap to Close the Gap for Vision (2012)
- www.iehu.unimelb.edu.au

Estimates

- Comprehensive eye examinations required annually
- Cataract surgery and diabetic retinopathy treatment need
- Optometry and ophthalmology days required
- Coordination and support workforce required

Step 3: Existing Service Levels

Data sources can include:

- Existing outreach services reports
- Qualitative data from consultations
- Jurisdictional health data
- Regional committee data and information
- AIHW and MBS workforce and service
- Eye health stakeholder committees

Step 3: Existing Service Levels

Use data to determine:

- Existing services for optometry and ophthalmology within regions
- Local vs Visiting Services
- Use of subsidized spectacle scheme
- Waiting times to surgery / Equity of surgery (CSR90)
- Cataract surgery rates (CSR)
- Estimates of utilisation rates of these services by Indigenous people

Step 4: Gap Analysis

Steps 1-3: Regional analysis of service need to be matched to existing service levels

↓

Aggregate gap in existing services – region by region

Step 5: Program Priorities

Inputs to consider from steps 1-4 all contribute to service prioritisation and service planning

Region X Example (Step 1)

Region	Communities and Towns and Cities by RA	Indigenous Population	AMS	Local Optom Services	Hospital Services	Access to bulk-billing [Optoms]	Access to bulk-billing [Ophthal outreach]	Waiting time to Cataract Surgery	Existing Eye Health Outreach Support	Other Comments
Region X	Community A (RA IV) Town B (RA) Town C (RA) City D (RA)	280 80 80 XXX Total 9680	5 AMS	6 in Towns B and C. City D has many options	1 Hospitals with eye surgery 1 in Town C and 2 in City D	VOA Optoms bulk-billing 2 local Optoms in Town B and C bulk-bill	Only bulk-billing Ophthal in City D (2 hospitals).	18 months in Town C. Up to 2 years in City D (2 hospitals).	77 day VOA Service across Community A, Town A and Town B (2x Optoms). 1 Ophthal under RACP in Town C (40 Days)	Region X is characterised by high diabetes hospitalisation rates (XX/1000 compared to X/1000 non-Aboriginal).

Step 1 Regional Profiles

Region X Example (Step 2)

Region: Region X
Population: 9680

OPTOMETRY CONSULTATIONS	NUMBER OF PATIENTS
Comprehensive eye examinations required each year	1812
People over 40 requiring glasses each year	606
People over 40 with diabetes requiring annual retinal examination	912
OPHTHALMOLOGY CONSULTATIONS	
People requiring cataract referral consultations	98
People requiring trichiasis referral consultations	35
People requiring diabetic retinopathy referral consultations	106
Total people requiring ophthalmology consultations	239
HOSPITAL SURGERY	
People requiring cataract surgery	98
People requiring trichiasis lid surgery	35
Total people requiring hospital surgery	126
WORKFORCE	**WORKFORCE REQUIREMENTS**
Optometry days required	201
Optometry workforce required (EFT)	1.0
Ophthalmology days required (consultation and surgery)	75
Ophthalmology workforce required (EFT)	0.3
Coordination workforce required total (EFT)	1.3

Step 2 Population Needs

Region X Example (Step 3)

Region	Estimated eye examinations	SSS Script No./ Estimated people over 40 needing glasses	SSS Script No./Estimated no. of people over 40 receiving glasses	Optom Days- VOS	Est Optom Days- local	Ophthal Days (RHOF)
X	1,112	606	432 Private local Optom- 211 (49%) VOS- 221 (51%)	77	74 49:51 = x days: 77 days.	40

Step 3 Existing Service Levels

Region X Example (Step 4)

Region	Aboriginal Pop	Est Eye exams gap	Optom Days gap %	Ophthal Days Gap %	Cataract Surgery Gap %	DR referral gap %	0/40 Glasses Need	SSS 15-16
X	9480	31%	25%	43%	69%	62%	606	432

Step 4 Gap Analysis

Region X Example (Step 5)

- Inputs from steps 1-4 contributes to service prioritisation for VOS, MOICDP, RHOF and Eye (and the EESSSP).
- In this example, whilst the gap in VOS wasn't as large, consultations showed low visit numbers for Community A. Also in this example, the Ophthalmologist agreed to bulk-bill Aboriginal clients as a result of the findings of the NA.

Region	Optometry needs	Ophthalmology needs	Action
X	More VOS needed in Community A Better links between	Review RHOF Ophthalmology in Town C	Increase VOS to Community A by 4 days. Maintain other VOS levels. Review in 12 months. Jurisdictional Eye Health Coordinator to work with regional forum on the link between VOS and diabetes programs. RHOF Ophthalmologist has agreed to provide bulk-billed consults to Aboriginal clients. Maintain existing Ophthalmology service levels and review outcomes in 12 months. Jurisdictional Coordinator to work with regional forum on approach to reduce cataract surgery waiting times.

Step 5 Program Priorities

Needs assessment in Indigenous eye health

- We encourage efforts to adopt nationally consistent and best practice approaches in Indigenous eye health needs assessment
- We suggest that population-based needs assessment should be used to establish community needs

...it is now time to close the gap for vision

...and fundholders are integral to this outcome

Minum Barreng