Acknowledgements

CheckUP and QAIHC gratefully acknowledge the input and contribution made by the many stakeholders and providers who are committed to delivering eye health outreach services to Queensland communities. CheckUP and QAIHC also acknowledge the funding provided by the Australian Government Department of Health which makes these services possible.

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Disclaimer

This publication includes general statements based on information collected from key informants in the context of the consultation process, however the reader is advised that the accuracy of the information cannot be guaranteed.
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Regions

Far North

North West

Central

South West

South East

State-Level Key Themes and Priority Actions

Recommendations

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Appendix B: Position Description: Regional Coordinator
Appendix C: Needs Assessment Methodology – VOS
Appendix D: VOS Location Visit Report
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### Abbreviations

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<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>AICCHS</td>
<td>Aboriginal and Islander Community Controlled Health Services</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>EESS</td>
<td>Eyes and Ears Surgical Services</td>
</tr>
<tr>
<td>EHC</td>
<td>Eye Health Coordinator</td>
</tr>
<tr>
<td>HHS</td>
<td>Hospital and Health Service</td>
</tr>
<tr>
<td>IDEAS Van</td>
<td>Indigenous Diabetes Eyes and Screening Van</td>
</tr>
<tr>
<td>IEHU</td>
<td>Indigenous Eye Health Unit (IEHU) Melbourne School of Population and Global Health</td>
</tr>
<tr>
<td>IUIH</td>
<td>Institute for Urban Indigenous Health</td>
</tr>
<tr>
<td>LVR</td>
<td>Location Visit Report</td>
</tr>
<tr>
<td>MASS</td>
<td>Medical Aids Subsidy Scheme</td>
</tr>
<tr>
<td>MOICDP</td>
<td>Medical Outreach Indigenous Chronic Disease Program</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
</tr>
<tr>
<td>OMS</td>
<td>Outreach Management System</td>
</tr>
<tr>
<td>PHN</td>
<td>Primary Health Network</td>
</tr>
<tr>
<td>QAIHC</td>
<td>Queensland Aboriginal and Islander Health Council</td>
</tr>
<tr>
<td>QATSIHP</td>
<td>Queensland Aboriginal and Torres Strait Islander Health Partnership</td>
</tr>
<tr>
<td>RAICCHO</td>
<td>Regional Aboriginal and Islander Community Controlled Health Organisation</td>
</tr>
<tr>
<td>RC</td>
<td>Regional Coordinator</td>
</tr>
<tr>
<td>RPCC</td>
<td>Regional Planning and Coordination Committee</td>
</tr>
<tr>
<td>RHOF</td>
<td>Rural Health Outreach Fund</td>
</tr>
<tr>
<td>SAF</td>
<td>State Advisory Forum</td>
</tr>
<tr>
<td>VOS</td>
<td>Visiting Optometrists Scheme</td>
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</table>
Definitions

For the purposes of this consultation, the following definitions have been used to describe the service provider type:

<table>
<thead>
<tr>
<th>Service Provider Type</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Optometrist</strong></td>
<td>A practitioner who provides primary eye and vision care, performs eye examinations to detect vision problems, and prescribes corrective lenses to correct those problems. Some optometrists also make and fit eyeglasses or may use the services of an optician. When an optometrist detects eye disease, the patient may be referred to an ophthalmologist, a medical specialist who evaluates and treats diseases of the eye.</td>
</tr>
<tr>
<td><strong>Ophthalmologist</strong></td>
<td>A medical specialist who specialises in the assessment, medical and surgical care of the eyes and visual system and in the prevention and treatment of eye disease and injury.</td>
</tr>
<tr>
<td><strong>Optometry Assistant</strong></td>
<td>An assistant who works with optometrists, eye and vision care clinics.</td>
</tr>
<tr>
<td><strong>Medical Aids Subsidy Scheme (MASS)</strong></td>
<td>Assists eligible Queensland residents to access a range of free basic spectacles.</td>
</tr>
<tr>
<td><strong>Dispensing Optician/Agent</strong></td>
<td>A technician trained to design, verify and fit eyeglass lenses and frames, contact lenses, and other devices to correct eyesight using prescriptions supplied by an ophthalmologists or optometrist or optician.</td>
</tr>
</tbody>
</table>

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Executive Summary

CheckUP is an experienced fund holder, having worked with a suite of Commonwealth funded outreach services programs for 15 years. The Queensland Aboriginal and Torres Strait Islander Health Council (QAIHC) is the peak body representing Aboriginal and Islander Community Controlled Health Services (AICCHS) in Queensland.

The Visiting Optometrists Scheme (VOS) was established in 1975 to provide funding to optometrists to deliver outreach eye care services to people living in regional, rural and remote locations across Australia, who do not have ready access to primary eye care services.

In 2009 - 2010, the VOS was expanded to provide increased optometry services to Aboriginal and Torres Strait Islander people, and plays a significant role in detecting eye disease and ensuring appropriate referral for treatment and ongoing management.

The Evaluation of the Medical Specialist Outreach Assistance Program and the Visiting Optometrists Scheme, published in September 2011, contained a number of recommendations to enhance the program, including the introduction of a single fund holder arrangement in each jurisdiction.

To ensure services are aligned to community needs, the Commonwealth Department of Health requested that CheckUP, as the newly appointed fund holder in Queensland, conduct a Needs Assessment to be completed by 31 October 2015.

In response to this request, CheckUP, in collaboration with QAIHC, has lead a comprehensive stakeholder consultation process which includes a focus on the eye health needs of Aboriginal and Torres Strait Islander communities, at both the regional and local level.

The findings, contained within this report, have assisted CheckUP and QAIHC to identify and prioritise service needs and target locations across the state to inform the ongoing implementation of the VOS for the remainder of 2015 - 2016, and into the future.

Program Objectives

The objective of the VOS is to improve the eye health of people residing in regional, rural and remote locations, including Aboriginal and Torres Strait Islander communities, by:

- Increasing optometry services in areas of identified need.
- Improving the coordination and integration of eye health services and the quality of ongoing patient care.
- Enhancing communication between visiting optometrists, local health providers and other visiting health professionals.

To achieve this, funding is provided to address a range of financial disincentives incurred by optometrists participating in the program, including:

- Travel, accommodation and meals
- Facility fees and administrative support at the outreach location
- Lost business opportunity due to time spent travelling to outreach locations
- Locum support at the home practice
- Lease and transport of equipment
Program Integration

The VOS is funded as a discrete program. To support the improved coordination of eye health services in Queensland, CheckUP and QAIHC have adopted an integrated approach to the planning and delivery of the these services, ensuring they are complementary to, and align with, those delivered under other Commonwealth funded outreach programs managed by CheckUP (see Table 1 & 2 below). This shared focus provides a framework to efficiently and effectively co-plan and deliver medical specialist, allied health and support services across every program to minimise duplication, improve communication between providers and be responsive to community need.

CheckUP uses a well tested and consistent approach to identify need, plan services, contract providers and monitor service performance, which is applied to every program they manage. Working closely with QAIHC, close attention is paid to ensuring services are delivered in a culturally safe and supportive environment that is inclusive of both service recipients and the Aboriginal and Torres Strait Islander workforce. The existing provider support and retention strategy has been expanded to include the VOS providers and will serve to maintain the current workforce while building capacity to respond to future demand.

<table>
<thead>
<tr>
<th>Program</th>
<th>Objective</th>
<th>Eye Health Providers</th>
<th>Links/Alignment</th>
<th>Eye Health Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visiting Optometrists Scheme (VOS)</td>
<td>Increase optometry services in areas of identified need.</td>
<td>Optometrist</td>
<td>Supports referral pathways to and from ophthalmology medical specialists for consultation, ongoing review and access to surgical follow up as required.</td>
<td>Provides for screening, prevention, review and post-surgery follow up. Services will be informed by the VOS Need Assessment conducted in 2015 to ensure service provision is aligned to identified need.</td>
</tr>
<tr>
<td></td>
<td>Improve the coordination and integration of eye health services and the quality of ongoing patient care.</td>
<td>Optometry Assistant</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enhance communication between visiting optometrists, local health providers and other visiting health professionals.</td>
<td>Optometry Student</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The regional structure used by CheckUP and QAIHC includes Regional Coordinators placed across the state to facilitate local service planning, delivery, integration and coordination of VOS services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The Eye Health Coordinator (EHC) supports the delivery of eye health services, data monitoring and the implementation of referral and care pathways to increase</td>
<td></td>
</tr>
</tbody>
</table>

Table 1: CheckUP Outreach Service Programs - Eye Health Services
| Medical Outreach Indigenous Chronic Disease Program (MOICDP) | Increase access to multidisciplinary care in primary health care settings. Increase the range of services offered by visiting health professionals to prevent, detect and manage chronic disease more effectively. Includes expanded primary health for Aboriginal and Torres Strait Islander people in the treatment and management of chronic disease. | Ophthalmologist Optometrist Optometry Assistant | Supports referral pathways to and from ophthalmology medical specialists for consultation, review, access to surgery and community based follow up. The regional structure used by CheckUP and QAIHC includes Regional Coordinators placed across the state to facilitate local service planning, delivery, integration and coordination of MOICDP services. The EHC supports the delivery of eye health services, data monitoring and the implementation of referral and care pathways to increase access to appropriate services. CheckUP’s marketing and communication strategy facilitates communication between all outreach providers, stakeholders and facilities. Supports the management of a range of complex and chronic conditions related to eye health including diabetes. |
| Rural Health Outreach Fund (RHOF) | To improve health outcomes for people living in regional, rural and remote locations by supporting outreach health activities. Provide both public and private outreach health services Broaden the range and choice of health | Ophthalmologist Optometrist Optometry Assistant | Supports referral pathways to and from ophthalmology medical specialists for consultation, review, access to surgery and community based follow up. The regional structure used by CheckUP and QAIHC includes Regional Coordinators placed across the state to |

Eye health is a focus area. Supports the management of a range of complex and chronic conditions related to eye health including diabetes.
<table>
<thead>
<tr>
<th>services and options available in regional, rural and remote locations. Remove financial disincentives that create barriers to service provision.</th>
<th>facilitate local service planning, delivery, integration and coordination of RHOF services. The EHC supports the delivery of eye health services, data monitoring and the implementation of referral and care pathways to increase access to appropriate services. CheckUP’s marketing and communication strategy facilitates communication between all outreach providers, stakeholders and facilities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes and Ears Surgical Services (EESS)</td>
<td>Increase access to surgical interventions for Indigenous Australians with diagnosed eye and ear conditions who have been placed on a surgical waiting list.</td>
</tr>
<tr>
<td>Eye Health Coordination (EHC - RHOF)</td>
<td>To support the appointment of an Eye Health Coordinator (EHC) to ensure the planning and delivery of services is coordinated, including liaison between members of the multidisciplinary team. The implementation of the VOS and other linked programs will draw on the support and knowledge of the RC network and</td>
</tr>
</tbody>
</table>
RPCCs, supported by the EHC.

 providers, stakeholders and facilities.

Table 2: CheckUP Outreach Services - Program Objectives and Alignment

<table>
<thead>
<tr>
<th>Program</th>
<th>Multidisciplinary</th>
<th>Rural and Remote Areas</th>
<th>Aboriginal and Torres Strait Islander Focused</th>
<th>Improve Coordination and Integration</th>
<th>Improve Liaison between Providers</th>
<th>Improve Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>VOS</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>MOICDP</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>RHOF</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>EESS</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>EHC</td>
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<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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Regional Structure

A regional focus has been applied to all aspects of the governance, planning and delivery of outreach services managed by CheckUP, and now includes the VOS. As partners, CheckUP and QAIHC have established a regional structure comprising of:

- Five regions aligned with Primary Health Network (PHN) and Hospital and Health Service (HHS) boundaries to facilitate a local approach to planning and service delivery (see Figure 1).
- The boundaries also encompass the Regional Aboriginal and Islander Community Controlled Health Organisations where they are established (see Appendix A).
- Regional Planning and Coordination Committees (RPCCs) convened in in each region.
- A network of Regional Coordinators (RCs) placed across Queensland including:
  
  North Region - two RCs with one based in Townsville and one based in Cairns
  North West Region - one RC based in Mt Isa
  Central Region (incorporating Wide Bay and Sunshine Coast) one RC based in Gladstone
  South East Region - one RC working remotely in Brisbane
  South West Region - one RC based in Brisbane who travels to the region
  A Statewide Auxiliary Regional Coordinator based in Brisbane
Coordination Roles

Regional Coordinators

Working across sectors, the primary purpose of the Regional Coordinator position is to manage and support the integration and coordination of outreach services in their allocated region by:

- Working with local stakeholders to drive and support the use of a population health and needs-based approach for service planning and delivery.
- Leading the development of regional service delivery plans that align with identified population health and community needs.
- Monitoring the implementation of outreach services to ensure they are culturally appropriate, efficient and effective.
- Supporting CheckUP and QAIHC with the overall management and implementation of the outreach service programs at the state level.

A copy of the Regional Coordinator Position Description is contained in Appendix B.

The RCs have been actively engaged in the VOS Needs Assessment, working with the relevant stakeholders and providers in their region/s to facilitate the consultation process. In a number of regions, the scheduled RPCC coincided with the timing of the work and provided an additional opportunity for local input.
Membership of the RPCCs includes representatives from the AICCHS, HHSs, General Practitioners, Service Organisations (eg RFDS), Primary Health Networks, and service providers including medical specialists and allied health practitioners. This direct engagement allows CheckUP to gather local "on the ground" service data and information in a coordinated and efficient way.

**Eye Health Coordinator**

Following the appointment of the CheckUP **Eye Health Coordinator** in July 2015, the RCs now receive targeted support to improve the overall coordination of eye health services across the regions. The additional capacity and resourcing will also drive the prioritisation of eye health across the suite of outreach programs.

**Key responsibilities associated with this role include:**

- The scheduling and delivery of VOS services which are integrated with specialised services provided in identified locations, including ophthalmology and surgical services.
- Monitoring and enhancing effective eye care screening, review mechanisms and referral pathways across the private, public and community controlled health sectors.
- Driving the collection of regional eye care data delivered under the RHOF, MOICDP, EESS and VOS in Queensland.
- Identify opportunities for data sharing with other key providers and organisations to measure service performance and establish benchmarking.
- Working in partnership with QAIHC to ensure that eye health services provided by CheckUP are culturally appropriate for Aboriginal and Torres Strait Islander communities.

**Methodology**

The Needs Assessment methodology used a phased approach to focus specifically on eye health, as illustrated in Figure 2 below. A description of each phase is provided in Sections 1-5 and Appendix C.
Section 1: Evidence Review

A Snapshot

A range of data sources were reviewed to provide an evidence platform from which to analyse, identify and align the need for optometry services in the broader context of eye and vision health (refer Table 4 Section end). A snapshot of the key issues of concern is presented below.

What do we know?

Blindness rates in Aboriginal and Torres Strait Islander adults are 6.2 times the rate in Australians as a whole, with the major causes of blindness being cataract (32%), uncorrected refractive error (14%), optic atrophy (14%), diabetic eye disease (9%) and trachoma (9%). Rates of low vision are 2.8 times the rate compared to mainstream Australian society with the primary causes being uncorrected refractive error (54%), cataract (27%) and diabetic retinopathy (12%) (Reference: Clinical and Experimental Optometry p.422-423 (2013)).

In the 2008 National Indigenous Eye Health Survey, 1.5% of Aboriginal and Torres Strait Islander children had low vision and 0.2% reported blindness, based on a sample of 2,883 Indigenous Australians with 62% living in remote areas. This survey was based on actual eye examinations and minimised the problem of under-reporting due to undiagnosed conditions. It is estimated that 94% of vision loss in the Indigenous population is preventable or treatable but 35% of Indigenous adults have never had an eye exam.

The most recent self-reported data on eye health comes from the 2012 - 2013 Health Survey based on a representative sample of 9,300 Indigenous Australians.

Key findings are highlighted below.

Eye and Vision Problems

- One-third (33%) of Indigenous Australians reported eye or sight problems.
- After adjusting for differences in the age structure of the two populations, Indigenous Australians reported higher rates of partial/complete blindness (7 times) and cataract (1.4 times) than non-Indigenous Australians.
- Long-sightedness (19%) and short-sightedness (13%) were the most common problems reported followed by partial/complete blindness (3%) and cataract (1%).
- Nine percent (9%) of Indigenous children aged 0–14 years had eye or sight problems.
- Long-sightedness (19%) and short-sightedness (13%) were the most common problems reported followed by partial/complete blindness (3%) and cataract (1%).
- The leading causes of blindness for Indigenous adults found in this study were cataract, optic atrophy, refractive error, diabetic retinopathy and trachoma.
- Indigenous Australians reported higher rates of partial/complete blindness (7 times) and cataract (1.4 times) than non-Indigenous Australians.
- A higher proportion of Indigenous females (38%) reported eye problems compared with Indigenous males (29%). In 2012 - 13, 9% of Indigenous children aged 0 - 4 years had eye or sight problems. Eye problems increased with age.
Diabetes

- Those with diabetes were twice as likely to report eye problems (82%) as those without diabetes (43%).
- 29% of Indigenous Australians with diabetes reported they had sight problems due to diabetes and 49% had consulted an eye specialist within the last 12 months.
- Diabetic retinopathy often has no early symptoms, early diagnosis and treatment can prevent up to 98% of vision loss.
- Of those who had diabetes, 20% reported having had an eye examination within the last year and 13% had visual impairment.

Cataracts

- Approximately 65% of Indigenous Australians who needed cataract surgery had been operated on, and a further 35% still required treatment.

Trachoma

- The National Trachoma Surveillance and Reporting - none of the children screened in Queensland had active trachoma.

What is the impact of poor eye health?

The partial or full loss of vision is the loss of a critical sensory function that potentially impacts all dimensions of life. Vision loss and/or eye disease can lead to linguistic, social, behavioural and learning difficulties during the schooling years with poor education outcomes and employment prospects. Visual impairment can also affect health related quality of life and independent living.

Cataract is a degenerative condition in which the lens of the eye clouds over, obstructing the passage of light. Blindness from cataract is now rare due to a highly effective surgical procedure but remains a major cause of vision loss among Aboriginal and Torres Strait Islander peoples (Taylor et al. 2014). Diabetic retinopathy is damage to the blood vessels in the retina caused by complications of diabetes. Without treatment, diabetic retinopathy can progress to blindness. Although diabetic retinopathy often has no early symptoms, early diagnosis and treatment can prevent up to 98% of vision loss (Taylor et al. 2014). The NHMRC recommends that Indigenous Australians with diabetes should have an eye examination every year (NHMRC 2008).

Trachoma is an eye infection that can result in scarring, in-turned eyelashes (trichiasis) and blindness. Trachoma in Australia is found almost exclusively in remote and very remote Indigenous populations and is associated with living in an arid dusty environment; poor waste disposal and high number of flies; lack of hand and face washing; overcrowding and low socio-economic status (NTSRU 2012).

Measuring Performance

The National Aboriginal and Torres Strait Islander Health Performance Framework does not include any specific indicators around eye health. While eye health is included in MBS health assessments, no statistics for participation in eye health examinations are reported. The unmet needs in eye health are similar for those living in urban, urban and regional areas as in remote areas.

Our response

Eye health can be affected by diseases such as diabetes, as well as environmental factors linked to higher rates of infection and crossinfection, geographic isolation, economic disadvantage and barriers to health care, which can limit the opportunities for detection and treatment.
The Australian Government will provide $22 million over four years from 2013 - 14 to improve the eye health of Indigenous Australians. $16.5 million dollars of this has been allocated to continue national efforts to eliminate trachoma by 2020.

In addition, approximately $25.4 million is being provided from 2013 - 14 to 2016 - 17 to support the Visiting Optometrists Scheme (VOS), which improves access to optometry services for people living in rural and remote locations. In 2013 - 14, around 19,000 Indigenous patients (out of 39,000 total) were seen through the VOS nationally. As the VOS fund holder in Queensland, CheckUP has the expereince and capacity to implement these important eye health programs in an integrated, consultative and efficient manner.

What should we be doing?

The Roadmap to Close the Gap for Vision (2015), developed by Professor Hugh Taylor at the Indigenous Eye Health Unit (IEHU) Melbourne School of Population and Global Health, identifies a set of forty-two (42) recommendations that collectively seek to reduce sytemic barriers to accessing and utilising eye care services by Indigenous Australians.

The IEHU ‘Developing Linkages for Indigenous Eye Health’ and ‘Indigenous Eye Health Indicators’ spotlight the mechanisms for achieving the level of coordination required to improve eye health, including a whole of system approach, and the interplay between regional, state and national levels. Elements which are essential to improve regional eye care services include establishing a collaborative network, undertaking a gap and needs analysis for service requirements, developing referral protocols, establishing a regional service directory, system coordination and patient case management, local planning and action through a regional collaborative network, an established regional data collection and monitoring system and mechanisms to ensure regional accountaiblity and oversight.

The linkages and recommendations advocated by IEHU, including local coordination of eye health services, providing an appropriate workforce and engaging with Indigneous communities to identify need, already exist in Queensland, and are made possible by the CheckUP and QAIHC Regional Structure, the Regional Coordinator (RC) network and the application of established data, reporting and service delivery sytems, as illustrated in Table 3 below. In 2015 - 2016 the delivery of VOS will be further enhanced by the work of the new Eye Health Coordinator (EHC) who is supporting the identification of real-time health needs in local communities.

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<thead>
<tr>
<th>Table 3: CheckUP and QAIHC Regional Structure and IEHU Essential Regional Elements Alignment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Regional Structure</strong></td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
</tbody>
</table>
The Role of Optometrists

Overall, 94% of visual loss in Indigenous Australians is preventable or treatable and 35% of Indigenous adults have never had an eye examination. Optometrists play a key role as part of the eye-care team in early detection, ongoing management and treatment of this visual loss. A set of guidelines developed by Optometry Australia (2015) to support the delivery of optometry services for Indigenous communities have been used by CheckUP as a reference point and include:

1. Eye health services should be delivered in a culturally appropriate manner regardless of the clinical setting where they are delivered.

2. Optometrists providing or intending to provide services to Aboriginal and Torres Strait Islander communities should link with any existing optometrists and organisations already providing eye care in these communities, to avoid wasteful overlap of services and to share knowledge and experience.

3. Eye care services should be delivered with the assistance and co-operation of the local health infrastructure already in place. This might include the local Aboriginal Medical Service (AMS) or Community Controlled Health Service (CCHS) or a state-owned clinic or hospital. Where possible, services should be co-ordinated by Eye Health Coordinators and other eye-health workers within these kinds of organisations.

4. Ideally, optometric services should be delivered with continuity, where an optometrist regularly visits a community over a period of years.

5. Spectacles required should be affordable, payment methods appropriate and the spectacles delivered through sustainable methods, such as through the Eye Health Coordinator.

6. Optometrists must develop sustainable and effective referral methods to additional healthcare services such as ophthalmologists and general medical practitioners, where other medical problems are observed. Services co-ordinated with visiting ophthalmological services provide optimal patient care.

7. When providing optometric services through AMS/AICCHS or state-owned clinics or hospitals and there is time, the provision of continuing education to the local eye health workforce is recommended to maximise the impact of visiting optometric services.
<table>
<thead>
<tr>
<th>TITLE</th>
<th>CONTENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008 National Indigenous Eye Health Survey - University of Melbourne</td>
<td>Defines the extent, causes and impact of vision loss in Aboriginal and Torres Strait Islander peoples.</td>
</tr>
<tr>
<td>Australian Aboriginal and Torres Strait Islander Health Survey 2012-13</td>
<td>Collects information from the Aboriginal and Torres Strait Islander population in non-remote areas and remote areas, including discrete communities. Combines the existing ABS National Aboriginal and Torres Strait Islander Health Survey (NATSIH) together with two new elements - a National Aboriginal and Torres Strait Islander Nutrition and Physical Activity Survey (NATSINPAS) and a National Aboriginal and Torres Strait Islander Health Measures Survey (NATSIHMS).</td>
</tr>
<tr>
<td>Vision 2020 - Aboriginal and Torres Strait Islander Health Funding Priorities (2015)</td>
<td>Overview of priorities and evidence on the urban, regional and remote under service to support Aboriginal and Torres Strait Islander eye health and vision care.</td>
</tr>
<tr>
<td>Vision 2020, National Disability Services and the Australian Blindness Forum (2013) - A Snapshot of Blindness and Low Vision Services in Australia (2015)</td>
<td>National perspective on the blindness, low vision and rehabilitation sector, including access to services by Aboriginal and Torres Strait Islanders.</td>
</tr>
<tr>
<td>Vision 2020 Australia - Eye health, vision care and the Sustainable Development Goals (2015)</td>
<td>Links to targets and indicators identified by Vision 2020 to advocate on behalf of the eye health and vision care sector.</td>
</tr>
<tr>
<td>Vision 2020 Australia - Regional Eye Health Coordinators Workshop Final Report 2011</td>
<td>Details issues raised by the National Regional Eye Health Coordinators and strategies to improve eye health service coordination and integration.</td>
</tr>
<tr>
<td>University of Melbourne Indigenous Eye Health Unit - The value of Indigenous Sight: An economic analysis (Final Report prepared by PricewaterhouseCoopers 2015)</td>
<td>Provides an estimate of the economic impact of eliminating unnecessary vision loss for Indigenous Australians. Companion of current eye care services and programs to economic impacts generated by the implementation of the Roadmap to Close the Gap for Vision and the need for further investment in the coordination of eye services.</td>
</tr>
<tr>
<td>Regional Implementation Roundtable Report April 2014 - IEHU</td>
<td>Details shared experiences and lessons learned from regional efforts to Close the Gap for Vision.</td>
</tr>
<tr>
<td>Australian Health Ministers’ Advisory Council, 2015, Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report, AHMAC, Canberra</td>
<td>Provides an overview of current evidence and prevalence rates for eye health conditions experienced by Aboriginal and Torres Strait Islanders and communities.</td>
</tr>
<tr>
<td>Reference</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Australian Institute of Health and Welfare, Eye health in Aboriginal and Torres Strait Islander people, Canberra (May 2011)</td>
<td>Details self-reported eye health concerns and treatment seeking behaviour in the Indigenous community based on perceived severity.</td>
</tr>
<tr>
<td>Guidelines on the provision of sustainable eye care for Aboriginal and Torres Strait Islander Australians. (2013) 96 Clinical and Experimental Optometry 4 422-423</td>
<td>Details guidelines for the optometric profession who play a key role as part of the eye-care team in early detection, ongoing management and treatment of this visual loss.</td>
</tr>
<tr>
<td>B. Ah Tong, G. Duff, G. Mullen and M. O’Neill, August 2015, A Snapshot of Blindness and Low Vision Services in Australia, Vision 2020 Australia, National Disability Services, Australian Blindness Forum, Sydney.</td>
<td>Providers engaged with this research report that current major policy reforms in disability and aged care including the National Disability Insurance Scheme (NDIS), the Home Care Packages Program and the Commonwealth Home Support Program in particular, may not adequately account for the functional needs of people who are blind or vision impaired.</td>
</tr>
<tr>
<td>Northern Territory Special Reconnaissance Unit Report Commonwealth Department of Health (2012)</td>
<td>Describes the trachoma surveillance program, national trachoma data collection processes and outcomes.</td>
</tr>
<tr>
<td>CheckUP Telehealth - Provider and Stakeholder Consultation Report (2014)</td>
<td>Details mechanisms for outreach providers in Queensland to increase their uptake and service delivery through telehealth.</td>
</tr>
<tr>
<td>Summary of Eye Health Service Delivery through SEQ ATSICCHS August 2015 - IUIH and Fred Hollows Foundation (in draft not yet published)</td>
<td>An overview of eye health services currently provided across SEQ and future service demand.</td>
</tr>
<tr>
<td>IUIH - Eye Health Regional Report (May 2014)</td>
<td>Includes a needs analysis and recommendations for service development across SEQ.</td>
</tr>
<tr>
<td>Medicare Local Comprehensive Needs Assessment for Far North Queensland Medicare Local (FNQML), North and West Medicare Local (NWQML), Central Queensland Medicare Local (CQML), Sunshine Coast Medicare Local (SCML), Metro North Brisbane Medicare Local (MNBL), Greater Metro South Brisbane Medicare Local (GNSBL), Gold Cost Medicare Local (GCML), West Moreton Oxley Medicare Local (WOMOL) Darling Downs and South West Medicare Local (DDSWML).</td>
<td>Provides an overview of identified health needs and priorities within Medicare Local catchment areas, including eye health and complex and chronic conditions.</td>
</tr>
</tbody>
</table>
Section 2: Consultation

Our Approach
CheckUP and QAIHC are committed to forming enduring and sustainable partnerships with key stakeholders and organisations to inform the ongoing planning and implementation of VOS services in Queensland.

Key principles which underpinned the Needs Assessment process were:

Communication - open communication with key stakeholders/organisations involved in the planning and delivery of VOS services.

Consistency - working together with key stakeholders/organisations to ensure a consistent approach to VOS service planning and implementation.

Coordination - outcomes for VOS service recipients and communities can be improved through better alignment of planning, implementation and service delivery within regions across the state.

Collaboration - collaboration with key stakeholders/organisations to support the effective and efficient delivery of VOS services.

Multi-Level Consultation

The VOS consultation process was conducted on two levels. Firstly, at the national and statewide level, key stakeholder organisations from the health, community and university/research sectors were actively engaged to provide input from an evidence, health planning and research perspective. Secondly, at the regional/local level key stakeholders, organisations and outreach service providers, representative of the planning regions used by CheckUP and QAIHC, were invited to contribute to the process to inform the mapping of existing eye health services, the identification of unmet need or service gaps and options for future service delivery. Improved coordination, integration and communication was highlighted through the identification of links in the planning and service delivery process undertaken by CheckUP, QAIHC and other key organisations at the jurisdictional and local level. This approach will ensure the planning, implementation and delivery of VOS services is maximised.

Online Survey

An online Needs Assessment Survey was designed to identify the level and type of eye health service need identified in each planning region, against key priorities outlined in the VOS guidelines. A description of the survey questions is presented in Section 3: Collection, Collation and Analysis.

CheckUP Data

Findings from the previous work undertaken by the Outreach Services team to inform the delivery of services under the MOCIDP and RHOF were also reviewed to extract any information relevant to eye health priorities. This included the Outreach Services Needs Assessment (2015), the Provider and Facility Review (2015), Health in Focus (2014) and outcomes from the RPCCs and forums conducted during 2014 - 2015.

Participants

A collection of national, state level and regional/local key stakeholders and providers were invited to participate in the Needs Assessment. The list was generated to include those who offered valuable insight and expertise into issues associated with eye health and/or those who provide eye health services. In the case of face to face interviews and/or teleconferences, a number were grouped for ease of contact, or when contacted, advised of another stakeholder or colleague who could also add value to the process.

Overall, more than 110 organisational representatives and providers contributed to the consultation,
including Hospital and Health Services, Queensland Health, Aboriginal and Islander Health Islander Community Controlled Health Services (AICCHS), QAIHC, policy and research bodies, private and public health care providers including ophthalmologists, optometrists and general practitioners, Medical and Clinical Directors, Regional Coordinators and RPCC members from each of the planning regions.

Table 5 details the list of participants and their engagement in a range of activities including face to face (F2F) interviews, teleconferences, the completion of an online survey and the sharing of data from specific eye health focused projects and services.

In summary:
- 15 F2F interviews were conducted
- 36 surveys were completed - representing > 100 providers, services and organisations
- 8 organisations shared data and/or information focused on eye health needs in Queensland

<table>
<thead>
<tr>
<th>Table 5: Key Stakeholder Consultation List - Organisations and Providers</th>
<th>Interview</th>
<th>Survey</th>
<th>Shared Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apunipima Cape York Health Council</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Child Development Service - Cairns Hospital and Health Service</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Cairns Eye and Laser Clinic - Cairns Hospital Eye Specialist</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Cunnamulla Corporation for Health</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Gidgee Healing - Mt Isa Aboriginal Community Controlled Health Service</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Nhulundu Wooribah Indigenous Health Organisation Inc.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Aboriginal &amp; Torres Strait Islander Community Health Service - South West &amp; South East (South Burnett, Gympie, North Coast, Gold Coast)</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Wuchopperen Health Service</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Torres and Cape Hospital and Health service - Thursday Island</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Rowan Churchill - Optometrist</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Luxottica/OneSight - Northwest and Far North Regions</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>McKinlay Shire Multi-Purpose Health Service</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Michael Young Optometrists - VOS</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>North West Hospital and Health Service</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Mount Isa Medical Centre</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Jundah Primary Health Care - Central West Hospital and Health Service</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Muttaburra Primary Health Care</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Institute for Urban Indigenous Health (represents 37 multiple services/providers)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Hodgson Optical - VOS</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Mulungu Aboriginal Corporation - Medical Service</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Windorah Primary Health Centre</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optometry - QLD/NT</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fitzpatrick Family Optometrists</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North and West Remote Health</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queensland University of Technology (QUT) School of Optometry</td>
<td>✔</td>
<td></td>
<td></td>
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<tr>
<td>Birdsville Clinic Queensland Health</td>
<td>✔</td>
<td></td>
<td></td>
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<tr>
<td>The Optical Superstore</td>
<td>✔</td>
<td></td>
<td></td>
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<tr>
<td>Eyecare Plus Mt Isa Optical</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Fred Hollows Foundation - Far North Queensland and South East Queensland</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cairns and Hinterland Hospital and Health Service (Divisions x 3)</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes on Edward</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diamond Jubilee Partnerships - IDEAS Van (Project + Providers)</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSIRO e-health Research Unit - Indigenous Tele-Eye Care Project (Torres Strait Islands)</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigenous Eye Health Unit (IEHU) Melbourne School of Population and Global Health (Professor Hugh Taylor)</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vanguard Health - IRIS Project</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regional Coordinator’s (CheckUP and QAIHC) - Statewide/Regions</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QAIHC Statewide Outreach Coordinator</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CheckUP Statewide Outreach Coordinator</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 3: Data Collection, Collation and Analysis

Design
CheckUP worked with QAIHC and a number of key stakeholders and organisations, including the Institute for Urban Indigenous Health (IUIH), Optometry QLD/NT, Fred Hollows and OneSight, to design the VOS Needs Assessment Survey and matched interview questions. The questions and format are complementary to the annual survey administered by CheckUP to inform the planning and delivery of services under the RHOF and MOICDP. This approach enabled enrichment of the data set collected by CheckUP previously and a comprehensive understanding of how best to address eye health needs under the VOS, EESS and the EHC role.

Purpose
The purpose of the Needs Assessment was to collect quantitative and qualitative data about eye health needs, service level and demand as compared to services currently provided under the VOS.

The data has been collated, and analysed to:

A. Develop an in-depth understanding of the perceived level of need for current, expanded or new eye health services under the VOS.
B. Identify current/potential barriers and enablers to support improved integration and coordination of VOS services with other programs.
C. Identify opportunities and strategies for the EHC to facilitate better integration, coordination and access to eye health services provided under the VOS, MOICDP, RHOF and EESS.
D. Provide an evidence set to inform the redesign of the current VOS Services Schedule to meet identified need, for implementation from January 2016.
E. Develop a set of recommendations to inform the ongoing implementation VOS services during VOS during 2015 - 2016 including strategies to maximise the efficiency and effectiveness.

Survey Format
The online survey contained twenty-seven (27) questions administered through Survey Monkey. A hard copy was available on request. Table 6 provides a summary of the data collected from each question and how it links to the purpose of Needs Assessment, A - E inclusive:

<table>
<thead>
<tr>
<th>Question</th>
<th>Focus/Data Collected</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A: Qs 1 to 7 - General Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 - 6</td>
<td>Organisation Type, Location, Representative/s and Contact Details</td>
<td>A - E</td>
</tr>
<tr>
<td>7</td>
<td>Your Region (based on CheckUP/QAIHC Regional Structure)</td>
<td></td>
</tr>
<tr>
<td>Part B: Need Identification - Qs 8 &amp; 9 - participants were asked to provide input to identify met/unmet need.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Need Identification - participants were asked to describe the overall need for eye health services, particularly optometry, in the region/s.</td>
<td>A, E</td>
</tr>
<tr>
<td>Q</td>
<td>Question</td>
<td>Scenario</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>9</td>
<td>Level of Need - participants were asked to indicate the overall level of need that exists for eye health priorities in the region/s.</td>
<td>A,E</td>
</tr>
<tr>
<td>10</td>
<td>Service Type/s - participants were asked to what extent does the overall level of eye health service/s available meet the demand in the region/s.</td>
<td>A,D,E</td>
</tr>
<tr>
<td>11</td>
<td>Other Health Needs - participants were asked to indicate any other health or service need which has the potential to impact on eye health, for example, complex and chronic conditions, and associated comorbidities.</td>
<td>A,C,D,E</td>
</tr>
<tr>
<td>12</td>
<td>Provider Type - participants were asked to indicate the type of provider and level of demand required to meet the need in the region/s.</td>
<td>A,C,D,E</td>
</tr>
<tr>
<td>13</td>
<td>Locations Identified - participants were asked to provide a rationale for any specific locations identified in Q12.</td>
<td>A,C,D,E</td>
</tr>
<tr>
<td>14</td>
<td>Activity - participants were asked to indicate the type and level of activity required to meet this need per location/region identified.</td>
<td>A,C,D</td>
</tr>
<tr>
<td>15</td>
<td>Access Barriers such as availability, distance, travel, type of service, cultural safety</td>
<td>A,B,C,D</td>
</tr>
<tr>
<td>16</td>
<td>Referral/Review/Follow Up Care (includes spectacles and surgery)</td>
<td>A,B,C,D,E</td>
</tr>
<tr>
<td>17</td>
<td>Visit Frequency to Support Best Practice (Optometry Services)</td>
<td>A,B,C,D</td>
</tr>
<tr>
<td>18</td>
<td>Coordination with Local/Regional Services (VOS) (includes administration and support)</td>
<td>A,B,C,D,E</td>
</tr>
<tr>
<td>19</td>
<td>Duplication of Services (VOS and other services)</td>
<td>A,B,C,D</td>
</tr>
<tr>
<td>20</td>
<td>Communication (between VOS and other providers/services)</td>
<td>A,B,C,D</td>
</tr>
<tr>
<td>21</td>
<td>Available Workforce/Providers to Deliver Services (all types/levels)</td>
<td>B,D</td>
</tr>
<tr>
<td>22</td>
<td>Access to Culturally Appropriate Services and Providers (VOS)</td>
<td>A,B,C,D</td>
</tr>
<tr>
<td>23</td>
<td>Physical Infrastructure in Service Locations/Facilities (VOS)</td>
<td>B,D</td>
</tr>
<tr>
<td>24</td>
<td>Service Promotion (VOS and MASS)</td>
<td>B,C</td>
</tr>
<tr>
<td>25</td>
<td>Participants were asked to comment on the equipment considered essential to deliver services under VOS, if it’s fixed or transportable and any specific location/s.</td>
<td>B,D</td>
</tr>
<tr>
<td>26</td>
<td>Participants were asked to indicate specific locations where equipment access is an issue.</td>
<td>B,D</td>
</tr>
<tr>
<td>27</td>
<td>Participants were asked to provide a rationale for any equipment indicated is essential, but may not be currently available to provide a comprehensive VOS service.</td>
<td>B,D</td>
</tr>
</tbody>
</table>
**Response Time**

The survey was initially open for the a two week period from 14 September to 30 September 2015, with a further extension until 7 October 2015, to accommodate a number of RPCCs convened at the same time. The CheckUP Outreach Services e-blast was used to provide information about the process, key dates and reminders to complete. Interviews and teleconferences were conducted concurrently.

**Analysis**

The data has been analysed using the following methods:

1. **Survey Data** - Survey Monkey was used to generate statistical responses.
2. **Interview/Teleconferences** - thematic analysis was used to generate key themes which emerged from the qualitative data.
3. **Data Validation** - key themes/issues which emerged from the data were validated with selected participants.
4. **Data Comparison** - where eye health data has been shared, a comparison has been undertaken with other available data sets.

A summary of the collated responses and key themes is contained in **Section 5: Findings and Recommendations.**
Section 4: Service Mapping and Delivery

Existing systems and processes used by CheckUP to manage the RHOF and MOICDP now incorporate the VOS program. These systems support the ongoing collection of dynamic program and service data as detailed below.

Service Data

An online reporting system, the Outreach Management System (OMS), is used by CheckUP to capture service data and information for every outreach program. Providers and/or organisations who receive funding to deliver services, including the VOS, are required to submit an online Location Visit Report (LVR) after each visit. The LVR contains a set of standard questions aligned to the priorities of the program and its completion triggers payment to the provider (see Appendix D). In conjunction with the Needs Assessment, this data has been analysed to determine the current level of services being provided under VOS since July 2015, including patient numbers, type of service provided, number of clinical sessions, percentage of Aboriginal and Torres Strait Islander people attending, referral sources and follow up care required.

*Given the timing of the VOS Needs Assessment process, there was limited service data available in the OMS, as a number of providers haven't yet delivered a service for this year.*

Service Monitoring

All providers, including those contracted under the VOS, are required to "self-monitor" their delivery to ensure they have the capacity to provide the agreed number and type of service to identified locations as outlined in the Service Schedule. This also includes reporting any proposed changes to services based on need, which is also captured by CheckUP as part of the larger cross-program Needs Assessment and Provider and Facility Review process. This data is used to track and measure service performance and will inform future VOS service planning during 2015 - 2016.

Verification

The ongoing verification of VOS service delivery is managed by CheckUP via:

- **Fortnightly budget analysis** to identify the potential for fund reallocation. If surplus funds are identified then additional visits or approved reserve proposals can be funded.
- **Monthly Review of Location Visit Reports (LVRs) and Services Schedules** to determine service delivery compliance as per the agreed services schedules, program data collection and identify early trends or issues to be addressed.
- **Fortnightly teleconferences with Regional Coordinators** to provide an opportunity to support the effectiveness of the regional coordination model, identify issues related to integration and coordination with other local/regional health services and service improvement.
- **Quarterly Regional Coordinator Reports** which focus on regional/local issues and facilitate the ongoing review of services delivered under VOS to determine the extent to which regional needs are being met.
- **Regional Planning and Coordination Committees** which provide a forum to exchange information, identify health trends, monitor progress, table issues for discussion and provide input into regional service plans.
- **Monthly compliance** to contract deliverables including services provided and funding utilisation.
- **Tracking and monitoring** of service data at the regional and state-wide level via the OMS.
• **Active follow-up by Regional Coordinators** who are responsible for working with providers/organisations to address any shortfall in services and/or issues which may be impacting on the level of service provided.
• **RCs provide commentary** around the local context for performance issues and implement tailored strategies with providers to address these issues. Issues are "red flagged" in bi-monthly reports.
• **Monitoring and review** of eye health service delivery by the **Eye Health Coordinator** to support the the regional coordination and integration of services.

**Current Services**

Current VOS services delivered since July 2015, have been reviewed against the outcome of the Needs Assessment consultation, survey responses, OMS service data and provider feedback. It is important to note that management of the VOS by CheckUP has resulted in a number of new systems and processes being introduced to existing VOS providers, including contracting, the use of the OMS, invoicing and standardised formula based service costing.

*This represents a significant change management process, and considerable effort has been made by the CheckUP team, RCs and the EHC to ensure providers are well informed and supported during this period.*

**Service Principles**

A set of eight Service Principles, developed by CheckUP and QAIHC, are used to support and inform the consultation, decision making and prioritisation processes which occur at both the state and regional level (refer to **Table 7**). The principles provide a framework for the review of current/existing services and the consideration of new/expanded services, including the VOS. They also align with the prioritisation and service planning considerations detailed in the VOS Service Delivery Standards (1 July 2015), provided in **Appendix E**.

<table>
<thead>
<tr>
<th>Table 7: Outreach Service Principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identified Need - health priority, service type, location/area/region, emerging trends</td>
</tr>
<tr>
<td>2. Workforce - type, skills, capacity, availability, development</td>
</tr>
<tr>
<td>3. Infrastructure - existing, future, suitability, equipment</td>
</tr>
<tr>
<td>4. Links to other Program/Services - referrals, care coordination, provider communication, integration, other funding sources, minimise duplication</td>
</tr>
<tr>
<td>5. Provider - local/regional, private, public, discipline, primary health care</td>
</tr>
<tr>
<td>6. Capacity - local services, community, workforce, technology</td>
</tr>
<tr>
<td>7. Value for Money - efficiency, effectiveness, maximise MBS</td>
</tr>
<tr>
<td>8. Culturally Appropriate - knowledge, understanding, insight, acceptance, experience</td>
</tr>
</tbody>
</table>

**Decision Making**

To ensure a robust decision making, CheckUP has developed a 4 step process, illustrated in **Figure 3**, which is applied to every program they deliver:

1. **Identify Need** - identify ways in which the VOS can support and respond to identified eye health needs
2. **Plan** - use a systematic decision making process to determine how the VOS funding is best distributed to meet identified health needs and priorities.
3. **How/What/Who** - determine the required service type, service model, service links and appropriate service provider.

![Figure 3: VOS Decision Making Framework](image)

**Informed by the outcomes of the VOS Needs Assessment, this process will be used to determine and finalise the services to be delivered from January 2016.**

**Service Prioritisation**

As a fundholder, CheckUP is required to prioritise and cost the VOS services based on identified need. To guide this process, the following factors are considered:

- specialist led vs allied health services
- hospital based vs primary health care services
- MBS uptake and utilisation vs fee for service or gap payments charged
- demand to continue existing services - historical vs future
- high demand for new services to meet need - short term vs long term
- “one off” services to meet specialised unmet need - surgical services, treatment for diabetic retinopathy
- current funding allocation - stable vs increase expected
- planned number of visits per annum vs realistic expectations, capacity and environmental factors eg. weather
- workforce capacity - local provider vs visiting provider
- workforce support payment - short term vs long term expectation when a services is established

**Workforce Prioritisation**

Service prioritisation also requires a process of workforce prioritisation in relation to provider type and capacity measures used by CheckUP to monitor service performance, illustrated in Table 8 & 9 below.
### Table 8: Workforce Prioritisation

<table>
<thead>
<tr>
<th>Level</th>
<th>Provider Type</th>
<th>Links to Other Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Optometrist</td>
<td>Ophthalmologist - to provide an integrated service with the optometrist who supports screening, reviews, referral pathways for specialist care and follow up including post-surgery.</td>
</tr>
<tr>
<td>Medium</td>
<td>Optometry Assistant</td>
<td>Optometrist - a team approach includes the role of the Optometry Assistant to support the clinic services and the dispensing of glasses as required.</td>
</tr>
<tr>
<td>Low</td>
<td>Optometry Student</td>
<td>Optometrist - there is a requirement to provide support and supervision for the optometry student enabling participation in clinics and service provision within the scope of practice.</td>
</tr>
</tbody>
</table>

### Table 9: Performance Monitoring

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Capacity Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optometrist</td>
<td><strong>Increase frequency of service</strong>&lt;br&gt;  o Number of face to face visits delivered&lt;br&gt;  o Number of telehealth sessions delivered&lt;br&gt;  o Frequency of visits&lt;br&gt;  o Number of clinical sessions delivered&lt;br&gt;  o&lt;br&gt;<strong>Increasing access</strong>&lt;br&gt;  o Number of patients seen per visit&lt;br&gt;  o Number of aboriginal and Torres Strait Islander patients seen&lt;br&gt;  o Number of patients who did not attend&lt;br&gt;  o Number of patients on the waiting list&lt;br&gt;<strong>Services provided</strong>&lt;br&gt;  o Referrals to follow up treatment (e.g. surgery)&lt;br&gt;  o Types of follow up treatment required&lt;br&gt;  o Number of referrals&lt;br&gt;  o Types of eye disease identified&lt;br&gt;<strong>Identified barriers/enablers in providing the service</strong>&lt;br&gt;<strong>Utilising other program links</strong>&lt;br&gt;<strong>Upskilling</strong>&lt;br&gt;  o Upskilling provided&lt;br&gt;  o Type of upskilling provided&lt;br&gt;  o Number of providers who attended the upskilling session&lt;br&gt;  o Type of providers who attended the upskilling session&lt;br&gt;<strong>Facility and Patient Feedback</strong></td>
</tr>
</tbody>
</table>
Section 5: Findings and Recommendations

This section presents the key findings from the VOS Needs Assessment Survey, interviews and teleconferences from both the state-wide and regional perspective. Priority actions arising from the findings are presented from both the state-level and regional perspective.

Who were the participants?

Interviews and Teleconferences

Fifteen (15) face to face interviews or teleconferences were conducted with key stakeholder organisations and providers from across the health, community, university and community controlled health sector including HHSs, AICCHS, IEHU, Optometry Qld/NT, OneSight, Michael Young Optometrists, IUIH, QUT, the Fred Hollows Foundation, CSIRO, Eyes on Edward, Diamond Jubilee Partnerships, Vanguard and QAHC. Key issues and themes which emerged during the interviews have been incorporated into findings for both the state-wide and regional sections.

Surveys

Thirty six (36) surveys were completed by organisations at the state-wide and regional level, collectively representing input from approximately 112 services and providers (Figure 4).

Of the 36 surveys completed:

- 24% were completed by AICCHS
- 21% were completed by HHSs (clinical)
- 17% were completed by private optometrists
- 12% were completed by service provider organisations
- 12% identified as ‘other’
- 5% were private ophthalmologists
- 5% were general practices
- 2% were PHNs
- 2% were universities
- 2% were HHSs (non-clinical)
Data Sharing

Eight (8) organisations shared data and/or information focused on eye health needs in the regions of Far North, North West, South West and South East Queensland including the Fred Hollows Foundation, OneSight, CSIRO, IUH, the IDEAS Van, IEHU, QAIHC and QUT. The data sets included service reviews, activity data from clinic teams, recent research and project reports detailing the use of innovative technology and service models.
Statewide Level
Survey Results

At the state-wide level, the four key indicators of overall need, service level and demand, availability and required activity have been summarised in relation to addressing identified eye health priorities across regions.

1: Level of Need for Eye Health Priorities

![Graph showing the overall level of need for eye health priorities.]

Summary

The level of need indicated by respondents in Queensland was most critical in relation to Diabetic Retinopathy, Diabetic Eye Care, and Cataracts. As these issues have a strong correlation with lifestyle factors, this reinforces that the services delivered under VOS must be well coordinated with other providers and the community. These results are consistent with the regional perspective also.
2. Level of Service to Meet Demand

When asked to what extent the overall level of available eye health services meet the demand, an identifiable trend is limited access to specialist Ophthalmology services, both general and surgical, which require a significant increase. However, the finding does not discount the value of other services and programs which are provided. This feedback reinforces the role of CheckUP in monitoring services to ensure appropriate links and cross program referrals are made where possible.

Summary

When asked to what extent the overall level of available eye health services meets the demand, an identifiable trend is limited access to specialist Ophthalmology services, both general and surgical, which require a significant increase. However, the finding does not discount the value of other services and programs which are provided. This feedback reinforces the role of CheckUP in monitoring services to ensure appropriate links and cross program referrals are made where possible.
3. Provider Type and Level of Demand

Summary

Respondents were asked to indicate the type of provider and level of demand required to meet the need in the region/s. As expected, these results are consistent with those around level of service and ability to meet demand, reinforcing the demand for specialist ophthalmology services. The scale of demand for optometrist services is at a moderate level, reinforcing the role of the optometrist is an important one in providing eye health care.
4. Activity Type and Level

The type and level of activity required to meet this need

Summary

These results suggest an increase in the level of activity is needed across most areas to meet the identified need. Consultation/assessment and eye health promotion emerged as areas where the current level of activity was insufficient, recording the highest levels of substantial increase needed, followed by post-surgical follow up care and surgical intervention.

Notation: A review of the Outreach Services Needs Assessment 2015 - 2016 results revealed the need for eye health services under the RHOF and MOICDP was consistent with VOS. More than 50% of respondents reported that medical specialist/ophthalmology services were required to meet the identified need.
Comments

A range of key issues and concerns were reported by the state level respondents including:

Access to services

- There is a need for Optometry cover in regional country towns where the population is not large enough to support a permanent practice.
- Optometry service to these areas allows access to glasses and ocular health screening for people for whom the cost of travel to Optometry services is prohibitive.
- Ongoing regular access, providing consistency of care, recalls, and principles of early intervention and prevention of avoidable blindness are critical.
- We know that community members, from other communities in other regions, travel to utilise our service.
- Economic and financial independence, cost of visiting the mainland for basic eye health is a barrier.
- Overall need is around a collaborative approach and referral pathways.
- Access to free pharmaceuticals for Indigenous communities is important.

The value of optometry services

- These services improve productivity, health and quality of life for these people and reduce the huge costs associated with the complications of poor vision.

Service model and visits

- This should be based on community size, transience of community and be in line with the recognised Indigenous Eye Health Unit productivity calculations regarding number of patients per annum requiring an eye test.
- The accepted ratio is 1 full time Optometrist per 10,000 people. Towns with a population of 500 people more than a 1 hour drive from a permanent practice, would therefore require an Optometrist to visit 1 day a month. Such towns with lesser coverage, or no coverage are under serviced.

Barriers to services

- Unfortunately these services are less profitable than traditional optometry practice - a fact not reflected in current levels of absence from practice allowance.
- There has not been any restrictions or delays on the delivery of service and the Health Service is very supportive and the preparation of the clients list is excellent.
- Cultural needs and distance are barriers.

Target population

- Prevention is achieved through screening school children which has not previously been provided in these communities.
Other health conditions

- Better diabetic control improves eye health outcomes.
- We need to manage diabetes better.
- Social, economic and lifestyle choices are a common factor, and we do get clients with health issues which are referred to Optometry within the health check process, and to reassure the patient. Some behaviour problems with children could be related to certain eye conditions.
- Diabetes, Vascular Disease, Chronic Heart Disease, Kidney Disease, Secondary Tumour Metastasis.

Demand for services

- Clinic days for 3-4 Optometrists are fully booked. Mornington Island, Doomadgee, Mount Isa (Gidgee), Palm Island.
- Need to provide assistance to the Optometrist to expedite the visit process by acquiring the retinal scanning prior to consultation, for Optometrist review, in addition to processing all patient paperwork. Mornington Island, Doomadgee, Mount Isa (Gidgee), Palm Island.
- An Ophthalmology service is provided however it is inadequate for the need. Mornington Island, Doomadgee, Mount Isa (Gidgee), Palm Island.
- Dispensing Opticians are included on the team for all clinics. Local community members are trained to fit and repair spectacles, with repair kits provided in all communities. Mornington Island, Doomadgee, Mount Isa (Gidgee), Palm Island.
- North Burnett (Central) North West need optometry service providers.
- The current level is sufficient - most of the organizing is done by myself or the optometrist directly with the centre we are visiting (North West).
- The current level is sufficient - this service through QUT School of Optometry, QUT Health Clinics are very supportive and are fully equipped to fulfil clinics and follow up. The portable equipment is valuable and the pathway are invaluable (South West, South East and Central).
- Ophthalmology 3-4 times a year for laser 6-9 times a year if injections are being delivered. This can be achieved in a HHS but more difficult in remote parts where smaller numbers of patients are better to be transported to the larger hub.

Referrals

- Once the visiting van service is running well, the referral and follow up this can help meet demand.
- Referrals are discussed with the Health Centre team after each Clinic with case managers.
- Cherbourg has a large cataract waiting list for which a pathway is lacking at present. Inala to PAH is needed in 2016.
- Pre and Post op visits can potentially be managed by the visiting service.
- There has been no difficulties with this process at all the AICCHS clinics (South West, South East, Central).

Technology

- When visiting teams are not available or when teams can use telehealth eg endocrine - then this can be discussed.
- Store and forward for screening photos is important and needs funding to support it.
Workforce and Training

- Training in photo screening for diabetic retinopathy is important.
- There is a new range of Diabetes education material from University of Melbourne being released for Indigenous patients in October 2015.
- Registrars and students need exposure to the realities of geographic isolation and the challenges in delivering first world services.
- Indigenous medical care with cultural awareness training is also vital in Australia.

Administration and Support

- Most of the organising for clinics is done by the optometrist directly with the centre we are visiting.
- All our clinics are planned and if the need is higher, this is coordinated by the Optometrist with the clinic and myself.
Regional Level

Results are presented for each of the five planning regions used by CheckUP and QAIHC. VOS priority actions are presented at the end of the section. Any reference to a particular “provider” whether an individual practitioner and/or service organisation has been removed from the free text comments to maintain confidentiality and prevent respondent identification. This information will be made available to the Department of Health as needed.

A copy of the current 2015 - 2016 Service Schedules for the RHOF, MOICDP and VOS programs is located on the CheckUP web site: http://www.checkup.org.au/page/Initiatives/Outreach_Services/

FAR NORTH REGION

NEED IDENTIFICATION

Overall Need (Question 8)

When asked to describe the overall need for eye health service in the region/s, respondents told us:

Local provider and AICCHS:

- **Principal work is in paediatric health.**
- **A small number of children that come through the Child Development Service in Cape York have visual problems.**
- **Opportunities for treatment are limited. Particularly for some conditions such as strabismus, which is one of the more frequently occurring problems I see, are poor and infrequent.**
- **Support for continuation of Aboriginal and Islander diabetic screening for retinopathy in communities and funding for co-ordinators.**
- **The eye health needs in remote Cape York remain high, with a significant lack of any type of community based optometry, access to visual technical services or prescription glasses, and only FIFO specialist ophthalmology services at various times. Typical eye health issues include the T2D retinopathy in communities with generally poorly controlled diabetes (prev T2D from 15-30%).**
- **Evidenced care requires at least annual ophthalmology review and often laser treatment. Cataract continues to be an issue requiring surgery. Age related macular degeneration is a typical issue requiring optometry services which can only be accessed via this program.**
- **Visual acuity deficits are very common, as are diabetic eye disease (rates of 20% NIDDM in over 15yr populations in Cape communities) and cataracts (roughly 10% in over 55yrs).**
- **Forsayth has a predominantly older population most of whom therefore require vision checks, eye care and glasses. The closest Optometrist is in Atherton which is 4.5 hours’ drive distant. There is a visiting service that visits Georgetown twice annually. Georgetown is approximately forty minutes’ drive distant from Forsayth. It would be beneficial for an Optometrist to visit Forsayth regularly.**
- **High need for optometry in the Remote Cape York region that I cover with an optometrist.**
- **Our team services 13 towns/communities in the far north and at times we also cover three towns west of Cairns, screening diabetics, refractive errors, cataracts, pterygium and other related eye conditions. If we didn’t provide this service, many patients would eventually have**
worse vision than they have now due to the remoteness & the cost of travelling to a town/city where there is an established optometry service (AICCHS).

- Ophthalmology services are needed locally including laser and cataract surgery particularly to support chronic disease referrals.
- There is no local facility for eye surgery even for eye procedures under local anaesthetic. Clients have to travel from Mareeba to Cairns [approx 1hr by car 1.5hrs by bus] to attend the Ophthalmology service.
- Clients without independent transport are severely impacted by this.
- Patient Transport Scheme only assists clients with the bus fare and low income clients cannot afford the taxi fares associated with these specialist appointments.
- Often clients need a support person for ophthalmological assessments and procedures so these barriers apply for the support person also.
- Day surgery for cataract surgery in Cairns means the client has to pay for accommodation in Cairns as they are recommended not to travel up the range and also expected to return for review appointment with the Ophthalmologist early the next day.
- High prevalence of Type 2 Diabetes in Mareeba area. Limited bulk billing Optometry services and not all Optometrists able to process MASS spectacles so clients bounce between services getting assessed and getting glasses.
- Need a collaborative approach, screening school children is necessary, referral pathways are essential.

Level of Need (Question 9)

Summary

These results indicate the highest overall level of need is for Diabetic Eye Care, followed by Diabetic Retinopathy and the management of Cataracts. This is consistent with the current literature around eye health conditions nationally, particularly for Indigenous communities.
Service Type (Question 10)

Summary
The very high demand for specialist ophthalmology services, both general and surgical, is outstanding with a similar level for complementary/linked optometry services.

Additional comments provided by respondents included:

Local AICCHS staff:
- Public hospital ophthalmology services are rare in regional locations.
- Excessive waiting lists in all regions.
- Such a long wait for children with strabismus in Cape York communities (Aurukun, Lockhart River, Kowanyama).
- MASS is not utilised - as a not-for-profit organisation, glasses are fully funded.
- Initial increase in service is needed to clear the backlog, with more regular service provision following this to ensure effective pathways.
- Regularity of service is key to community awareness and continuity of care.
- Larger communities - Hopevale Aurukun Kowanyama Napranum need an increase.
- Would be great to get glasses assessment and provision better organised.
- Assessment, ordering and delivery services to remote communities challenging, if dispensing not possible.
- Some Health Services work better than others, some patients are more compliant and look after their health better, current level is sufficient.
Local provider:

- We can only manage a low increase, as our surgical team operate on an average of 80 eye patients each year at the Weipa Hospital. The team can only operate on so many patients in five days each year as we only have one surgical theatre. Patients are flown in each morning for their surgery, so making sure patients whom are coming in from their communities are on time to catch their charters and transporting them to the hospital all takes time. Our eye team (Optometrist & Coordinator) do the dispensing at the health clinic in each community/-town.

- MASS glasses are a way of getting patients in to see the optometrist (a big help) as glasses get lost, stolen or broken and need replacing.

Visiting provider:

- I feel that we are meeting demand in the communities that we still visit, especially in the larger towns where other providers now attend (VOS).

- It is noted that other providers now go more often than we do and this serves to squeeze our patient base smaller in these communities. I believe we supply a more cost-effective and better connected service that also includes ophthalmology but miss out on these more lucrative locations as we concentrate more on servicing the entire region rather than 'cherry-picking' based on profitability.

- Any increased demand due to a change of circumstances can be readily met as I do not operate a permanent practice in an urban location that requires locum support.

- There are a few places that we could expand to quickly (Chillagoe, Croydon, Georgetown) to fill any unmet need as identified by this process.

- We need to re-establish the visiting Ophthalm to Gulf communities as per the previous 17 years.

- We have a magnificent team of Ophthalmals for both outreach and surgery in Cape York but could really benefit with increased support.

- We need Health Workers.

- Palm Island has reasonable optometry cover, but desperately needs coordinators.

- Townsville Hospital services are woefully inadequate to provide for indigenous patients.

- A strict policy of dumping patients who don’t show up for appointments coupled with the lack of eye health workers means than few indigenous patients who need public eye care services make it to treatment.

- A local ophthalmologist bulk-bills Palm Island patients twice a year and at his rooms, but suffers financially from the no-show rate of up to 80%.

- Public hospital surgery does happen - we just need help getting patients that far without losing them to follow-up.

- Palm Island now has facilities for MASS dispensing - so even when the optometrist isn’t there eligible patients can get glasses.
Other Health Needs (Question 11)
Respondents highlighted the following health and service needs which have the potential to impact on eye health, for example, complex and chronic conditions, and associated comorbidities:

- **Support for optometric diabetic eye screening in communities is the greatest health need, both the service provider (optometrist) the support staff required.**
- **CVD disease and smoking both very common (15% and rates of smoking between 50 - 70%).**
- **The predominantly older population of Forsayth has an expected higher percentage of chronic conditions than the general population.**
- **Usually if a patient see another service and are having problems with their eye they are usually referred to us on our next visit or referred onto Cairns depending on how urgent it is.**

Provider Type (Question 12)

![Graph showing provider type and demand level](image)

**Summary**

Optometry providers rate most highly in meeting the demand for services, followed by the specialist ophthalmology services, both general and surgical. The valued and necessary support of an Optometry Assistant is also a feature.

Additional comments provided by respondents included:

**Local and visiting provider:**

- **Demand would be higher if people realised how poor their eyesight was due to refractive error, ie correctable!! Large communities in particular - perhaps Weipa and Cooktown visits and arrange for community clusters to visit.**
- **If there wasn’t an optometry service providing a service to these remote Far North areas then it would be chaos as patients would have to be flown down to a regional city/town. Costs would be blown out due to patients needing flights, accommodation and carers to
accompany them, nonattendance at their appointments would also be an issue due to the patient not having been out of their communities and the money for taxi fares, food etc.

- I have worked in the Far North and filling in for the coordinator in the North West area, the optometrist has to do the consult, dispense glasses, and enter data so this means that they will see less patients at each visit.
- Our ophthalmologist travels with our team, this works well with a coordinator - without them there would be no surgical treatment.
- Optometry is the cornerstone of eye care in the remote regions and without the presence of them the results would be disastrous. Otherwise they are back to photography and referral into a regional hub much too late....and refractive error is untreated.
- Hugely important to get the full potential out of running this sort of outreach program. This was provided with tremendous results for 10 years and all communities have suffered since the support was removed. Only Cape York was largely maintained through the generosity of the Wuchopperen, but that finishes in a matter of weeks (Coordinator).
- Demand can be ably met between the optometry and assistant in my opinion.
- Services needed for Palm Island.
- Other locations that were once served by the AICCHS include Ingham, Abergowrie, Collinsville, Bowen.
- I would accompany the optometrist to the above locations (Ophthalmologist).
- Other locations can refer to the ophthalmologist in Townsville.
- May need help from health worker to ensure patients attend appointments.
- Patients from North Qld to be referred to Townsville Hospital.
- This function is normally filled by the optometrist / assistant combination.
- Local community members are trained to fit and repair spectacles, with repair kits provided in all communities.

Locations Identified (Question 13)

Specific locations which respondents identified as benefiting from increased or better coordinated services were:

Palm Island, Cape York communities, Ingham, Abergowrie, Collinsville, Bowen, Weipa, Cooktown, Chillagoe, Croydon, Georgetown.
Activity (Question 14)

Respondents selected consultation/assessment, upskilling/workforce development and pre-surgical assessment as the top three types of activity required to meet the identified need. This is consistent with the most prevalent eye health needs reported for the region, and the importance of upskilling and developing local providers and health workers to build sustainable services and increase efficiency.

Additional comments provided by respondents included:

Local AICCHS staff:
- More training of Health Service staff and promotions to get more patients into the service.
- We do not do it, patients are referred to Cairns from the Far North.
- Can only do as many as you can in a day.
- Post-surgical clinics are held about 4 weeks after surgery, optometrist and coordinator attend these clinics.
- Need staff at each Health Service to help out, this does not happen at times, makes the clinic harder, so less patients are seen on the day.
- Needs to be more health promotions, who, where and when - it’s hard to do when you have patients waiting and a very busy clinic.
- Would probably be a good thing for the student optometrist to do some work in the remote areas.
• We need to implement tele-ophthalmology. However, until there is a billable item number where the service (TCHHS) and the ophthalmologist are able to claim this will not be viable. The other issue is equipment. We need an anterior segment camera and portable retinal camera to undertake this.

Local service coordinator:
• Part of my role is working with the health promotion team as well as Maternal and Child Health and Chronic Disease. Eye health promotion could be a full time position.
• I have never seen any in the six years I have been here.
• With better co-ordination we can lift to satisfy needs...we currently attend but patients are not always there to be seen.
• Better notification and health promotion is required.

Private provider:
• This is a contentious topic as allegations of over-servicing and inappropriate servicing/billing to Medicare are rife in some areas. In discussion with Ophthals as to whether we need to get this equipment (cameras) as part of our regime the response has been lukewarm...so we haven’t.
• Done well in the Cape.... but needs improved agreements and protocols elsewhere to reduce patient travel and costs for post-op care that can be done by visiting Optoms.
• Huge potential for upskilling local staff to help with clinics. This would serve to make AHW’s feel more included in the running of the clinics and position them to be a local eye support worker to help clients between our visits.
• This was done successfully in the past and doesn’t take much to establish but the results can be remarkable when the correct people are engaged to join in.
• Technology is available but never used in my experience. This is done informally between optometrists visiting a community and Ophthals back at their practice using smart phones etc.
• A Co-ordinator and local support is the key to getting the most effective results.

A visiting provider:
• Optometry, as a primary health service provider in the regions we work has adequate cover and service. We do however require additional ophthalmology days with particular reference to cataract assessment and surgery and management of diabetic retinopathy.
• Long waiting lists for pre surgical assessment and surgery procedures.
• Ophthalmology specific procedures have waiting lists due to insufficient resourcing.
• We adhere to the Roadmap to Indigenous Eye Health and the recommendation of no more than a 90 day waiting period for surgical procedures.
• In reality we have waiting lists in excess of a year or more, so ophthalmology and surgical procedures is a huge area of opportunity or improvement.
• Reporting and data sharing in accordance with privacy laws could be improved.
• A relatively high need for therapeutics exists, based on eye health conditions as described previously.
• High need for spectacle supply - particularly in adults. Also noted that glasses are often lost, borrowed or damaged in a short time frame.
• We rely on the employees of other organisations, however the time available from them is short.
• In Palm Island our local full-time employee is training, however the investment (both time and financial) has been significant with little external support.
• Telehealth is valuable in speeding up diagnosis and treatment but must be followed up with regularity of service with patient outcomes as a result.
• Technology and networking are barriers on occasion.
• We have developed eye health posters specific to Indigenous communities to educate on refractive error (individual posters for both adults and children), cataract, macular degeneration, healthy eating and diabetes, trachoma and cleanliness.
• Although we travel great distances and spend so much effort to get to the locations...there is a trend to reducing the hours we can actually work when we get there that reduces the profitability of the job.
• If we travel so far and spend a day getting to a location, seeing 10 patients when 25 want to be seen is counter-productive for all involved and a waste of the resources.
• Better co-ordination required and agreement with Q Health to work extended hours as required.
• There is a feeling of 'visiting team overload' where some teams visit fortnightly and only see a few patients...we visit every 4 months on average and are busy and this is not always met with a collaborative response.
• The better locations jump on board and do 'opportunistic' testing as the Eye visits are generally well attended.
• Eye health professionals need easily accessible funding that compensates for all costs & time taken to provide outreach services.
• This is increasingly important now that Medicare optometry funding has been cut by 5% and frozen until 2018.
• Ophthalmologists sacrifice potentially lucrative surgical sessions to do outreach for little financial reward - possibly even a significant loss considering high staff costs at their practices and the possibility of quiet clinic days with significant no-shows.
Respondents were asked to identify issues associated with access, coordination, workforce demand and cultural appropriateness in their region/s as presented below:

### Access Barriers - Availability, Distance, Travel, Type of Service, Cultural Safety (Question 15)
- Usual ones of poor co-ordination of services, distance
- Distance, unmade road, wet season
- Distance travelled, heavy portable equipment to be transported
- Availability of rooms
- Always improved with co-ordination....need to re-engage locals to fit and adjust spectacles as they arrive after we leave...

### Referral/Review/Follow Up Care - includes Spectacles and Surgery (Question 16)
- Spectacle provision.
- We need staff to fit glasses at each Health service when they arrive - usually glasses are just handed out by reception staff.
- Optometrists should provide spectacles as part of the service.
- MASS payments to optometrists should be realistic.
- Ophthalmologists risk significant no-shows on surgical lists from outreach patients.
- We need health workers to ensure attendance. Hospital management should take this into account.

### Visit Frequency to Support Best Practice - Optometry Services (Question 17)
- Optometry increases would be good.
- Palm Island - ideal - monthly.
- Palm Island clinic is held quarterly, between 2-5 days based on patient needs.
- With transient communities, regularity of service is important to ensure that follow ups are performed on a relatively timely basis.

### Coordination with Local/Regional Services (VOS) - includes Administration and Support (Question 18)
- Local coordination is critical, we need support to do this.
- Can be done, need to meet with DONs from each service to see what they need and what help they can give the team.

### Duplication of Services - VOS and other services (Question 19)
Nil comments

### Communication between VOS and other providers (Question 20)
Nil comments
Available Workforce/Providers to Deliver Services - all Types/Levels (Question 21)

- Always hard to fill support positions. But this job is done by others so I have never been involved in the recruitment of staff.
- I have trained at least a dozen different people to assist in the day-to-day tasks.
- Limited availability of workforce.

Access to Culturally Appropriate Services and Providers - VOS (Question 22)

- Services work best when backed by a local indigenous health practice/organisation.
- Not currently accessed due to the amount of time we have been running the program, we know the communities.

Physical Infrastructure in Service Locations/Facilities (VOS) (Question 23)

- Space in clinics can be limited.
- Availability of rooms can be a problem at times.
- OK...but often rooms not available due to the recent increase in visiting teams.
- Paying a facility fee should see this change.
- Variable - needs work.

Service Promotion (VOS and MASS) (Question 24)

- Needs to be improved. How and when, who pays?
- Needs much improvement through co-ordination.
- Good - QLD health staff have always been very helpful.
EQUIPMENT

Essential Equipment (Question 25)
Respondents rated how essential access to fixed or portable optometric equipment including a Slit Lamp, Ophthalmoscope, Retinoscope, Eye/Test Chart, Tonometer, Retinal Camera and Optical Coherence Tomography (OCT) to deliver a comprehensive VOS service.
Specific Locations (Question 26)

Respondents did not identify any specific locations where equipment access is an issue.

Rationale (Question 27)

Respondents were asked to provide a rationale for any essential equipment:

- We need to implement tele-ophthalmology. However, until there is a billable item number where the service (TCHHS) and the ophthalmologist are able to claim this will not be viable. The other issue is equipment. We need an anterior segment camera and portable retinal camera to undertake this.
- OCT is becoming essential, but is not financially viable in most outreach locations.
- A mobile OCT might be worth looking at (Torres Strait).
- Lasers are needed for Ophthalmology visits.
- Slit lamp table at each community (Slit lamp is in a road case and travels with team).
- Mobile fields analysis can be undertaken - the full list of equipment is available upon request (Ishihara, stereo fly, phoria card, tools, BIO, trail frame and lenses, mirrors, auto refractor/keratometer).
- OCT essential for high levels of diabetic eye disease.
- Allow cataract and diabetic eye disease assessment.
- Just normal required optometry equipment.
Based on the results and key themes identified, the VOS priority actions for CheckUP and QAIHC in the Far North region are:

**VOS PRIORITIES - FAR NORTH REGION**

1. Scope the following locations where it has been indicated benefit would come from access to new and/or increased or specialised services/capacity:
   - Cape York communities (Hopevale, Napranum, Arakun, Lockhart River, Kowanyama)
   - Chillagoe, Croydon, Georgetown
   - Forsayth
   - Ingham, Abergowrie, Collinsville, Bowen
   - Palm Island
2. Explore ways to improve local coordination and links between services, particularly Cape York, Palm Island, Cooktown, Weipa and Palm Island.
3. Make connections and improve referral pathways between specialised ophthalmological services and optometry services across the region.
4. Look at alternative providers and available options to provide service choice, this includes services not funded by VOS, for example charitable organisations/other NGOs.
5. Where there are multiple providers going into one location, initiate discussions to confirm who is providing what and validate requests for additional or expanded services e.g. Palm Island and Torres Strait.
6. Investigate the use of telehealth to complement existing or new specialised eye health and screening services where the technology is already in place, including Townsville and Cape York.
7. Expand teams to include Health Workers/students where funding and capacity allows.
NORTH WEST REGION

Overall Need (Question 8)

When asked to describe the overall need for eye health service in the region/s, respondents told us:

**Local and visiting provider:**

- Based on evidence from previous clinics (statistics provided separately), there is a high need for eye health and optometry services in the regions of North West and Far North (charitable provider).
- Services are essential for the early detection of eye disease (especially diabetic retinopathy) and for providing a treatment pathway appropriate to the needs of each community. It has also been proven to be a very cost-effective approach to publicly funded eye services.
- We are fortunate to have excellent relations with ophthalmology by having them travel with us and the reliable referral pathway must be maintained.
- The greatest 'need' with regard to eye services is with co-ordination which has drastically reduced over the last 8 years and much of which is shouldered by myself now.
- There is a significant need for optometry and ophthalmology services in rural and remote areas, particularly for indigenous patients.
- Indigenous diabetic patients in these areas are at serious risk of developing undetected sight-threatening eye disease.
- One team visits up to 28 remote and rural communities across Northern and Western Qld none of which have full time optometric services.
- Of these 28, only Cloncurry, Normanton, Karumba, Mornington Island and Doomadgee are visited by other Optometrists. The other 20 communities are smaller and less commercially viable to visit. So don’t as readily attract other competing services.
- I am now the only optometrist who visits Blackall and Barcaldine.
- The team is the only one in these regions to include an ophthalmologist for one of the circuits each year.
- Suitable equipment (portable lasers) makes ophthalmology clinics particularly effective and reduces unnecessary patient travel.
- The overall need for eye services in these communities is currently being met, but is constantly being monitored.

**A local provider:**

- Access to services is limited beyond the scope of the clinic environment.
- At the moment we have 2 Private Optometry Practices in the Town (Mt Isa) and a volunteer Optometrist that comes every 6 weeks who is based at the Community Controlled Aboriginal Medical Service to see mainly Indigenous patients. They also provide free glasses to them.
- A mobile van comes with an Ophthalmologist and Optometrist to provide eye screening and treatment to Indigenous patients every month.
- Jundah is a small community of approx. 90 people with a significant aged population in a low to mid-range socio economic group. There is no public transport.
- Longreach is approx. 230km to the north. There is a visiting ophthalmologist - 4 - 5 times a year, with a long waiting list. A private Optometrist visits Longreach 6 times a year.
• Normanton, Doomadgee and Mornington Island are extremely remote with high community population suffering from chronic disease like Diabetes, Heart Disease etc. These areas have a high Indigenous population.
• The cost and fear of leaving their families to have to travel a minimum of 500km is unaffordable and scary.
• If a small team can come to the community at one time, with the support of other stakeholders, you have a much better opportunity for these people seeking or accepting help or assistance.

Challenging locations:
• Windorah is located in the south west Queensland in the channel country.
• Windorah PHC (Primary Health Centre) covers an approximate area of 62,000 square kilometres with an approximate population of 60-80 within the town and approximately 60 on the outlaying properties.
• Windorah township has an aging population with approximately 10 persons over the age of 70 (4 who are indigenous); 10 aged between 60 and 70 (2 who are indigenous); 8 indigenous children under the age of 15 years; total of 25 indigenous within the township.
• There is no access to public transport. REX airlines flies into Windorah enroute to Brisbane to Mt Isa and returns twice weekly.
• The closest optometry and other eye health services in the region are provided by a visiting provider, some 320km (Longreach) away.
• As there is no public transport between Windorah and Longreach, eye health for those most in need is inaccessible.

A visiting provider:
• In Mt Isa, 30% of our patients are Aboriginal or Torres Strait Islander. Mount Isa Hospital has a visiting Ophthalmologist from Townsville once a month and the waitlist can be up to a year or more.
• We are the optometry team visiting the Laura Johnson Home of the Aged in Mt Isa and also services Cloncurry on a regular monthly basis.
• Since the closure of one Optometrist in Mt Isa we are now the only private optometrist that supplies spectacles via MASS, our monthly visit service is usually fully booked.
• Mt Isa is well served for optometric services at this point through 2 permanently based optometrists and visiting optometrists.
• While one optometrist does not do MASS work I believe everyone else does and I would expect each optometrist would not be fully booked i.e. there is spare capacity at present.
• More ophthalmological services would be great but realistically having a visiting ophthalmologist once a month for a week is better than a lot of places.
• We are working with North West Hospital and Health Service to determine a more effective patient outcome.
Level of Need (Question 9)

Summary

These results indicate the highest overall level of need is for Diabetic Eye Care, followed by Cataracts and then Diabetic Retinopathy. This is consistent with the current literature around eye health conditions nationally, particularly for Indigenous communities.
Summary

The very high demand for specialist ophthalmology services, both general and surgical, is closely
followed by the need for complementary/linked optometry services. This is also consistent with
other regions.

Additional comments provided by respondents included:

Local and visiting provider:

- McKinlay Shire requires an increase in service level.
- Mt Isa - an Ophthalmologist visits once a month from Townsville.
- Very few surgeries are performed locally, insufficient to meet demand.
- Jundah – there is a long waiting list in Longreach.
- Some areas have had no optometry cover for some time eg: Indigenous populations in
  Hughenden and Richmond.
- Health workers are needed…and Indigenous patients lack the transport to get them to the
  hospitals.
- MASS specs will be provided on visits to Hughenden and Richmond.
- Eye health to most in need is inaccessible in Windorah. Approximately 25 persons (Adult and
  children) within the township, would be eligible for this scheme (MASS).
- Monthly visits from the Mt Isa optometrist have been triaged. The catchment area is the
  whole North West region so the wait time for cataracts can be over 12 months.
- There is only one MASS supplier in Mt Isa. One visiting provider goes to Cloncurry 2-3 times
  a year...another goes monthly.
Established regional provider:

- As a provider I feel that we are meeting demand in the communities that we still visit. Especially in the larger towns where other providers now attend. It is noted that the other providers now go more often than we do and this serves to squeeze our patient base in these communities.
- I believe we supply a more cost-effective and better connected service that also includes ophthalmology but miss out on these more lucrative locations as we concentrate more on servicing the entire region rather than ‘cherry-picking’ based on profitability.
- Any increased demand due to a change of circumstances can be readily met as I do not operate a permanent practice in an urban location that requires locum support.
- We need to re-establish the visiting ophthalmologist to Gulf communities.
- We would like to establish a smaller 'blitz' approach to surgery for Gulf patients at Mount Isa. Along the same lines as Cape York....general ophthalmology is done in Mount Isa by the ophthalmologist for one week each month...it is hoped that another ophthalmologist can establish a surgical blitz in Mount Isa for 3 days subsequent to a visiting circuit to the Gulf communities accompanying the Optom.
- We don't currently have a specific dispenser. This is done by the Optom in the Gulf and shared with the co-ordinator in Cape York.
- It is an essential part of the treatment of the patient and when better resourced enables a faster and more efficient through-put of patients. When the cost of travel to the communities is so high, it is important that as many patients can be attended to as possible when the clinic is running to maximise the cost/benefit.
- MASS underpins my service and we would be lost without it. The vast majority of my patients obtain their glasses via MASS...we are happy with it.

Another provider/view:

- We have tailored and modified the clinic schedules and team sizes to meet the local demand. Teams include 3-4 Optometrists, Dispensers, Optical assistants and administration/screening staff, per community needs.
- Regularity of service is key to community awareness and continuity of care.
- We have the resources, skills and expertise to expand to other regions which may require additional Optometry services.
- Consistent monitoring and evaluation of community needs are taken into consideration.
- Excessive waiting lists exist in all regions.
- The clinic model includes 2-3 experienced Dispensers on each team, glasses are delivered back to community 3-4 weeks after the clinic.
- MASS is not utilised for this program.
Other Health Needs (Question 11)

Respondents highlighted the following health and service needs which have the potential to impact on eye health, for example, complex and chronic conditions, and associated comorbidities:

- Diabetes, Hypertension, Dyslipidaemia, Trachoma
- Diabetic education
- Availability of General Practitioners for diabetes in Mt Isa.
- Chronic diseases impact significantly on workload.

Provider Type (Question 12)

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Summary

Ophthalmologists, both general and surgical, rate most highly in relation to meeting the demand for services, followed by optometry. This is consistent with other regions, where these three provider types feature prominently.

Additional comments provided by respondents include:

- Local provider:
  - In Doomadgee and Mornington Island one provider has been offering eye care services ‘free of charge’ for the last 2 years.
  - Volunteers have no prior experience in remote communities and undertake their work unpaid. Glasses are generously provide free of charge to the patients. The unintended result of this has been an increase in “glasses sharing” that then reduces the attendance at check-ups by some patients.
  - The standard of referral has greatly reduced as well due to the lack of experience of the practitioner and may result in patients not being booked directly for procedures with the Mt
Isa ophthalmologist, causing extra travel costs and inconvenience to the patient and the public purse.

- I could see more patients on the day if an assistant was funded...there are usually five left over on the waiting list at Blackall, Barcaldine and Winton, following each trip recently.

**Visiting provider:**

- *Clinic days for 3-4 Optometrists are fully booked.* Mornington Island, Doomadgee, Mount Isa (Gidgee)
- Optometry assistants provide assistance to the Optometrist to expedite the processes by acquiring the retinal scanning prior to consultation, for Optometrist review, in addition to processing all patient paperwork. Ophthalmology service is provided, however it is inadequate for the need and long waiting lists result. Local community members are trained to fit and repair spectacles, with repair kits provided in all communities.

**Locations Identified (Question 13)**

Specific locations which respondents identified as benefiting from increased or better coordinated services were:

- **Jundah** - centre of the Barcoo Shire; clients from local rural area, Stonehenge and Windorah would use a service.
- **Mt Isa** has two full time optometrists and a visiting optometrist to service the community which equates to one optometrist to about 8,900 people. Levels around 1 optometrist to 7,500 to 10,000 people has been standard.
- **Cloncurry**
Activity (Question 14)

Overwhelmingly respondents selected the category of “other” which referred to Health Workers/Indigenous Eye Health Workers and Eye Health Coordinators, followed by a similar level of activity for upskilling/workforce development and pre-surgical assessment. This is consistent with the most prevalent eye health needs reported for the region.

Additional comments provided by respondents included:

Local providers:
- Long waiting list in Longreach.
- RFDS provide a good service with clinics.
- PHC staff provide services in consultation with RFDS.
- Local nursing staff are always looking for assistance with health promotion advice.
- Ratio of optometrists to population is within norms and there is spare capacity for appointments at present - I am full time and not booked out.
- Both permanently based optometrists have the capacity for visual field testing and ocular coherence tomography (OCT)
- Pre-surgical assessment in outreach clinics cuts out a visit to metropolitan centres and readies patients for a single for surgery.
• We see little glaucoma / other pathology requiring computerised fields. Travel to Townsville or Charters Towers is not too onerous for the small numbers of patients involved.
• On-site medical treatment and intravitreal injections are simple for an ophthalmologist to do & save patient travel and risk of dropout.
• Surgery doesn’t happen. We need to increase the efficiency of the patient journey to surgery.
• Health workers needed to monitor attendance.
• Will naturally increase if visiting services increase to meet demand.
• Trained and dedicated eye health workers desperately needed to facilitate and coordinate services.
• Could definitely be useful - especially as mobile technology and Medicare cover becomes available to assist.
• There is a well-documented need for refractive correction, cataract surgery and diabetic retinopathy.
• We need trained indigenous eye health workers. Years of experience and Melbourne University tell us we need a team of a dozen in NQ - we have none.

SERVICE PROVISION

Respondents were asked to identify issues associated with access, coordination, workforce demand and cultural appropriateness in their region/s as presented below:

Access Barriers - Availability, Distance, Travel, Type of Service, Cultural Safety (Question 15)

• Distance - we are 900km from Townsville, 1800km from Brisbane.
• There is no access public transport in Windorah.
• Windorah - distance, available transport, finance, time, accommodation, loss of income.
• Barriers are: distance, available transport, finance, time, accommodation, loss of income.
• I do still see people from other communities in Mt Isa courtesy of the fact that they know there is a full time service here. This may be because they have a need for a service more urgently than is available in their community, or they were coming to Mt Isa anyway and added this to their list of things to do or they have access to transport to get to Mt Isa.
• Distance, available transport, finance, time, accommodation, loss of income.
• Many in the community don’t have health insurance and pensioners
• High % of clients don’t have adequate in house support when they have eye problems - widowed or both partners have chronic disease.
• Travelling great distances, reduces service time with patients.
• Although we travel great distances and spend so much effort to get to the locations...there is a trend to reducing the hours we can actually work when we get there that reduces the profitability of the job. If we travel so far and spend a day getting to a location, seeing 10 patients when 25 want to be seen is counter-productive for all involved and a waste of the resources.
Visiting provider:
- A number of access barriers exist, including availability of flights, particularly with the change of provider in the Gulf region. These flights are expensive and heavily booked - bookings must be made at least 2 months in advance to secure seating for the whole team.
- Large distances between communities combined with availability of flights means less flexibility in terms of days/times spent in community.
- Challenges exist in communicating with community members regarding their follow up care. We are working with NWHHS in the Gulf to determine a more collaborative approach which will provide more assistance to advise and recall patients prior to clinics.
- In the past we have worked with community members (particularly Elders) to physically drive around and find our patients.
- Regarding spectacle delivery, we work with the below organisations to dispense glasses in Doomadgee - Gidgee Healing in Mt Isa - Mornington Island - PICC Children and Family Centre in Palm Island.
- Employees of each organisation have been trained to do basic fitting adjustments for glasses. We dispense single vision and bi-focal only (no multi-focal) to avoid issues upon receipt and fitting of glasses.

Referral/Review/Follow Up Care - includes Spectacles and Surgery (Question 16)
- Cost - many in the community don’t have health insurance and are pensioners, high % of clients don’t have adequate in house support when they have eye problems - widowed or both partners have chronic disease

Local AICCHS staff:
- Supply of spectacles post optometrist visit is very slow, sometime months.
- Patients should receive their prescription glasses in a much more timely fashion.
- Always improved with co-ordination....need to re-engage locals to fit and adjust spectacles as they arrive after we leave.

Visit Frequency to Support Best Practice - Optometry Services (Question 17)
- Yearly for a new service and monitor the uptake (Jundah)
- Two services per year needed (Windorah)
- Richmond and Hughenden - quarterly to monthly.
- Mt Isa is well served with a visiting ophthalmologist and two permanently based optometrists.
- Jundah visit yearly and see take up..
- Windorah – 3 services per year
- Monthly service Mt Isa
- Can be adjusted as required, but feel we have the mix about right.
- Better health promotion may lead to an increased demand but this can easily be met by negotiation.
- We visit Doomadgee and Mornington Island 3 times per year, ensuring Diabetics are monitored regularly if on 6 month recall. Mt Isa (Gidgee Healing) clinic is held every 5-6 weeks.
Coordination with Local/Regional Services (VOS) - includes Administration and Support (Question 18)

- Travelling for provision of services is difficult, especially trying to organise related appointments
- Better co-ordination required and agreement with Q Health to work extended hours as required. There is a feeling of 'visiting team overload' where some teams visit fortnightly and only see a few patients...we visit every 4 months on average and are busy and this is not always met with a collaborative response.
- The better locations jump on board and do 'opportunistic' testing as the Eye visits are generally well attended.

Duplication of Services - VOS and other services (Question 19)

Nil comments

Communication between VOS and other providers (Question 20)

Nil comments

Available Workforce/Providers to Deliver Services - all Types/Levels (Question 21)

- Clinical nurse needed locally (Windorah)

Access to Culturally Appropriate Services and Providers - VOS (Question 22)

- Sufficient understanding of local community on the part of providers.

Physical Infrastructure in Service Locations/Facilities (VOS) (Question 23)

- Use a building with ramp access.

Service Promotion (VOS and MASS) (Question 24)

- Not really required as services are generally fully subscribed without the need for regional promotion.
- Community newsletter monthly.
Essential Equipment (Question 25)
Respondents rated how essential access to fixed or portable optometric equipment including a Slit Lamp, Ophthalmoscope, Retinoscope, Eye/Test Chart, Tonometer, Retinal Camera and Optical Coherence Tomography (OCT) to deliver a comprehensive VOS service.
Specific Locations (Question 26)
The following locations were identified as having equipment issues and/or using mobile equipment to provide services:

- *Local equipment is old (Jundah)*
- *We have an ophthalmoscope and eye/test chart and the Retinal Camera visits annually from Longreach Community Health (Windorah)*

Rationale (Question 27)
Respondents were asked to provide a rationale for any essential equipment:

- *Local equipment is old (Jundah)*
Based on the results and key themes identified, the VOS priority actions for CheckUP and QAIHC in the North West region are:

**VOS PRIORITIES - NORTH WEST REGION**

1. Scope the following locations where it has been indicated benefit would come from access to new and/or increased or specialised services/capacity:
   - Richmond
   - Hughenden
   - Jundah
   - Stonehenge
   - Windorah
   - Cloncurry
   - Mornington Island
   - Doomadgee
   - Normanton
   - Mount Isa (Gidgee)
   - Blackall
   - Barcaldine

2. Explore ways to improve local coordination and links between services, particularly the Gulf region, Mt Isa (Gidgee), the NWQHHS and western corridor communities.
3. Make connections and improve referral pathways between specialised ophthalmological services and optometry services across the region.
4. Look at alternative providers and available options to provide service choice, this includes services not funded by VOS, for example charitable organisations/other NGOs.
5. Where there are multiple providers going into one location, initiate discussions to confirm who is providing what and validate requests for additional or expanded services, particularly Mt Isa.
6. Promote awareness of, and access to, providers who dispense under MASS, which is reported as a high need.
CENTRAL REGION

NEED IDENTIFICATION

Overall Need (Question 8)

When asked to describe the overall need for eye health service in the region/s, respondents told us:

Visiting provider:

- I visit Taroom and Wandoan four times per year.
- Another optometrist also visits these two towns and we co-ordinate or trips so as not to overlap.
- These locations are quite remote with aging populations and my services are fully utilized in most instances.
- I co-ordinate my visits with the visiting ophthalmologists [who visit three times per year]...and fill the gap screening for eye disease between those visits.
- I visit nursing homes and provide MASS and VA spectacles to those eligible in those locations.
- I also see quite a few children and some private patients.
- The need for optometry services in the rural Indigenous centres is very apparent.
- The university has been very efficient with the clients and we have a good pathway with recall, referral and follow-up processes.
- The optometry van comes into my region and we access that pathway.
- Working with the Optometrist and Ophthalmologist we hope to have a pathway with the HHS and local AICCHS.
- We have a time frame of 6-8 weeks and then send them back to the Health Centre so we do not have lost glasses.
- Glasses processing through the university is working and most glasses are return within time frame and this system is permanent so the processing is made easier.
Level of Need (Question 9)

These results indicate the highest overall level of need is for Cataracts, Diabetic Eye Care and Diabetic Retinopathy with a similar result for Adult Refractive Error. This is consistent with the current literature around eye health conditions nationally, particularly for Indigenous communities.

Summary

These results indicate the highest overall level of need is for Cataracts, Diabetic Eye Care and Diabetic Retinopathy with a similar result for Adult Refractive Error. This is consistent with the current literature around eye health conditions nationally, particularly for Indigenous communities.
**Service Type (Question 10)**

The very high demand for optometry and specialist ophthalmology services, both general and surgical, is outstanding and aligns with the result for other regions.

**Other Health Needs (Question 11)**

Respondents highlighted the following health and service needs which have the potential to impact on eye health, for example, complex and chronic conditions, and associated comorbidities:

*Nil responses*
Provider Type (Question 12)

Please indicate the type of provider and level of demand required to meet the need in your region/s:

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Summary

Optometry providers rate most highly in meeting the demand for services, followed by the Optometry Assistant and then specialist ophthalmology services, both general and surgical. This result reinforces the importance of the Optometry Assistant role in delivery efficient and effective clinics.

Additional comments provided by respondents included:

- I try to tailor the visits to meet the demand: Biggenden, Gayndah, Mundubbera, Eidsvold, Monto, Springsure, Rolleston, Moura, Theodore, Taroom, Wandoan, Hervey Bay.
- Hervey Bay has a high demand for optometrists providing MASS glasses.
- There are visiting services to Mundubbera only.
- There are also visiting services to near towns: Biloela, Emerald.
- I understand that visits to Mundubbera are VERY expensive if a charter flight is used... what's wrong with driving the distance - it’s only 2 hrs.
Locations Identified (Question 13)
Specific locations which respondents identified as benefiting from increased or better coordinated services were:

Activity (Question 14)

![Bar chart showing the type and level of activity required to meet this need]

Summary
Respondents selected Consultation/Assessment, Pre-Surgical Assessment, Medical/Eye Procedures General, Surgical Intervention and Student Placements as the top five types of activity required to meet the identified need. This result highlights the “value add” of including a student in the optometry team.

Additional comments provided by respondents included:

SERVICE PROVISION
Respondents were asked to identify issues associated with access, coordination, workforce demand and cultural appropriateness in their region/s as presented below:

Access Barriers - Availability, Distance, Travel, Type of Service, Cultural Safety (Question 15)
- Access to cataract surgery a problem.

Referral/Review/Follow Up Care - includes Spectacles and Surgery (Question 16)
Nil comments
Visit Frequency to Support Best Practice - Optometry Services (Question 17)
Nil comments

Coordination with Local/Regional Services (VOS) - includes Administration and Support (Question 18)
Nil comments

Duplication of Services - VOS and other services (Question 19)
Nil comments

Communication between VOS and other providers (Question 20)
Nil comments

Available Workforce/Providers to Deliver Services - all Types/Levels (Question 21)
Nil comments

Access to Culturally Appropriate Services and Providers - VOS (Question 22)
Nil comments

Physical Infrastructure in Service Locations/Facilities (VOS) (Question 23)
Nil comments

Service Promotion (VOS and MASS) (Question 24)
Nil comments
Respondents rated how essential access to fixed or portable optometric equipment including a Slit Lamp, Ophthalmoscope, Retinoscope, Eye/Test Chart, Tonometer, Retinal Camera and Optical Coherence Tomography (OCT) to deliver a comprehensive VOS service.

Essential Equipment (Question 25)
Visiting Optometrists Scheme Needs Assessment 2015 - 2016

Ophthalmoscope

- Essential
- Not Essential
- Fixed
- Mobile

Eye/Test Chart

- Essential
- Not Essential
- Fixed
- Mobile
Specific Locations (Question 26)
Respondents did not identify any specific locations where equipment access is an issue.

Rationale (Question 27)
Respondents were asked to provide a rationale for any essential equipment:
- computerised visual field screener...mobile...always
- nil equipment needed, I bring my own except for slit-lamp
- just normal required optometry equipment

Based on the results and key themes identified, the VOS priority actions for CheckUP and QAIHC in the Central region are:

VOS PRIORITIES - CENTRAL REGION

1. Scope the following locations where it has been indicated benefit would come from access to new and/or increased or specialised services/capacity:
   - Hervey Bay

2. Make connections and improve referral pathways between specialised ophthalmological services and optometry services across the region, particularly cataract surgery.

3. Promote awareness of, and access to, providers who dispense under MASS, which is reported as a high need, particularly in Hervey Bay.
SOUTH WEST REGION

NEED IDENTIFICATION

Overall Need (Question 8)

When asked to describe the overall need for eye health service in the region/s, respondents told us:

- The need for optometry services in the rural Indigenous centres is very apparent.
- Charleville and Cunnamulla have a visiting optometrist about 9 times a year to various towns in the region over a week long period.
- The van comes 4 times a year - 3 times to Charleville and once to Cunnamulla. This service has 3 members - ophthalmologist, optometrist and ophthalmic assistant.
- The visiting specialists will only do minor surgery on their visits. There are full surgery facilities in Roma.

Level of Need (Question 9)

Summary

These results indicate the highest overall level of need is for Cataracts, then Diabetic Eye Care, followed by Diabetic Retinopathy. Whilst the order varies slightly according to the highest rated priority, the result is consistent with the current literature around eye health conditions nationally, particularly for Indigenous communities, and other Queensland regions.
Service Type (Question 10)

Summary
The very high demand for specialist ophthalmology services, both general and surgical, is consistent with other regions, followed by a matched result for optometry, dispensing and spectacle supply.

Additional comments provided by respondents included:

**Visiting/AICCHS provider:**

- The current service requires a moderate increase and is needed due to a waiting list.
- An extra day monthly would suffice in Cunnamulla.
- More ophthalmology services are required for the Cunnamulla and surrounding communities as the nearest surgical service is either Toowoomba or Brisbane.
- As the local AICCHS can no longer funded for travel, this has a huge impact on clients and their families requiring ophthalmology services.
- The PTSS is very limited with reimbursement and most of the clients cannot afford the upfront costs to travel and accommodate themselves when these services are required.
- Only available in Toowoomba and Brisbane. A private optometrist dispenses the glasses.
- This is an adequate service for the community and is provided through the visiting optometrist.
- I have honed my visits to meet the need - this applies to all of the towns I visit.
- All towns need an increase.
- I realise that surgery requires a theatre etc - however there are no services in most towns.
- The university has been very efficient with the clients and we have a good pathway with recall, referral and follow-up processes.
- Another visiting Optometrist comes into my region and we access that pathway.
AICCHS/ visiting provider/local provider:
- Ophthalmologist with procedural capabilities is needed in 2016 (Roma).
- Roma has increased capacity for 2016.
- In the long term, cataract surgery in Charleville could be considered.
- The only other optometrist/sunglass seller who visited Longreach on an irregular basis has apparently just gone bankrupt.
- More trips could easily be completed for Cherbourg.
- Patients are generally referred to Brisbane for laser/general ophthalmology (offered appointments within the month).
- Currently no surgery is performed at Cherbourg.

Other Health Needs (Question 11)
Respondents highlighted the following health and service needs which have the potential to impact on eye health, for example, complex and chronic conditions, and associated comorbidities:
- Cunnamulla is plagued with Chronic Disease, predominately, Type 2 Diabetes (T2D). There are many clients with comorbidities associated with T2D. This certainly has the potential to impact on eye health in the future.
- There is generally a poor understanding of healthy lifestyle choices - there is a much higher rate of smoking, drinking and poor diet.
- Regarding diet, often the only food available for an evening meal is a bowl of fat and cholesterol from the local servo that's been roasting there all day.
- If people learned to grow their own gardens, there would be far less disease in general.
Provider Type (Question 12)

Summary

General Ophthalmology rates most highly, followed by Surgical Ophthalmology and a very similar result for Optometry, with support from the Optometry Assistant.

Additional comments provided by respondents included:

- Optometry services are being provided for a day on a monthly basis, but an extra day is required for the Cunnamulla community.
- Currently no optometry assistant services Cunnamulla.
- A general ophthalmologist service is certainly required as URGENT for this community to provide surgery at the Charleville Hospital which is 2 hours away by car. This service needs to be bulk billed as well.
- The visiting specialists will only do minor surgery on their visits. There are full surgery facilities in Roma.
- Cunnamulla community requires a generalist ophthalmology service ASAP as well as the surgical provision of service at the Charleville Hospital to reduce expensive travel to urban centres. This has a huge impact on our local community clients and is not conducive in providing a sustainable service.
- Roma visits, the ophthal can fly commercially QantasLink.
- Cherbourg needs a cataract pathway through QHealth into the HHS at Inala.
- Charleville and Cunnamulla need patient transport to Roma for surgery.
Locations Identified (Question 13)
Specific locations which respondents identified as benefiting from increased or better coordinated services were:

*Cherbourg, Cunnamulla, Roma*

Activity (Question 14)

**Summary**

Respondents selected Pre-Surgical and Consultation/Assessment as the top two types of activity required to meet the identified need. This is consistent with the most prevalent eye health needs reported for the region and the requirement for increased access to screening and surgical services.

**Additional comments provided by respondents included:**

- Immediate local ophthalmology consultation and assessment is required for the Cunnamulla Community.
- Pre-Surgical assessment is required for procedures that could be delivered at the Charleville Hospital.
- To be delivered at the Charleville Hospital which is 2 hours travel and not in Toowoomba or Brisbane.
- Telehealth follow up consultations could be made available for all Cunnamulla clients with visiting ophthalmologist conducting the surgical intervention.
- This is looked after by the locum GP service here in Cunnamulla.
- Up skilling the immediate workforce here in Cunnamulla would be beneficial for the community requiring eye health services.
- We have a DRS machine but no current staff are trained in the use of same.
• *Our service has the capacity to support any telehealth consultations and case discussions that are required.*

• *The service needs to include eye health in the yearly Health Promotion Program calendar.*

• *We would support student placements.*

• *Referrals - this is done in conjunction with the local GP - they can liaise with the PA Hospital if necessary.*

• *I do MASS - It’s a long way to travel for such little remuneration. It would not be unreasonable for the MASS rebate paid to visiting optometrists to be substantially higher to compensate.*

**SERVICE PROVISION**

Respondents were asked to identify issues associated with access, coordination, workforce demand and cultural appropriateness in their region/s as presented below:

**Access Barriers - Availability, Distance, Travel, Type of Service, Cultural Safety (Question 15)**

• *Access to cataract surgery a problem.*

• *This can be a problem for people living on properties - some have to travel over 2 hrs to see me.*

• *Can they get travel funding for this??*

**Referral/Review/Follow Up Care - includes Spectacles and Surgery (Question 16)**

• *Currently is managed very well in Cunnamulla.*

**Visit Frequency to Support Best Practice - Optometry Services (Question 17)**

• *One day /month is the current service provision.*

• *Cunnamulla requires an extra day per month.*

• *An extra day per month would suffice and sustain the waiting list.*

**Coordination with Local/Regional Services (VOS) - includes Administration and Support (Question 18)**

• *Currently is managed very well in Cunnamulla.*

**Duplication of Services - VOS and other services (Question 19)**

*Nil comments*

**Communication between VOS and other providers (Question 20)**

*Nil comments*

**Available Workforce/Providers to Deliver Services - all Types/Levels (Question 21)**

• *Indigenous health worker from the community needs to accompany patients and stay with them over night when surgery requires this. Relatives are less helpful and sometimes distracting.*

• *It’s easier to do student placements in a full-time practice.*
Access to Culturally Appropriate Services and Providers - VOS (Question 22)

- The visiting optometrist provides a great service to the Cunnamulla community and is culturally safe with all the clients.

Physical Infrastructure in Service Locations/Facilities (VOS) (Question 23)

- Our service has a designated consultation room for the visiting optometrist to deliver his services.

Service Promotion (VOS and MASS) (Question 24)

- We send a visiting service provider calendar around to the local service providers and community.

EQUIPMENT

Essential Equipment (Question 25)

Respondents rated how essential access to fixed or portable optometric equipment including a Slit Lamp, Ophthalmoscope, Retinoscope, Eye/Test Chart, Tonometer, Retinal Camera and Optical Coherence Tomography (OCT) to deliver a comprehensive VOS service.
Specific Locations (Question 26)
Respondents did not identify any specific locations where equipment access is an issue.

Rationale (Question 27)
- Respondents were asked to provide a rationale for any essential equipment:
- slit lamp, ophthalmoscope, retinoscope, eye/test charts, tonometer and retinal camera – this equipment is brought by the VOS provider (Cunnamulla)
- No real issues with equipment access for the optometry service.
- Adequate equipment is supplied by Michael Young.
Based on the results and key themes identified, the VOS priority actions for CheckUP and QAIHC in the South West region are:

**VOS PRIORITIES - SOUTH WEST REGION**

1. Scope the following locations where it has been indicated benefit would come from access to new and/or increased or specialised services/capacity:
   - Cunnamulla (CACH)
   - Cherbourg
   - Charleville (longer term)
2. Support improvements in local service coordination between Roma and other communities/towns in the SW region.
3. Make connections and improve referral pathways between specialised ophthalmological services and optometry services across the region, particularly cataract surgery (Roma Hospital).
4. Support development of referral pathways from SW to Metro South HHS for access to ophthalmology surgery.
5. Explore the utilisation of Roma Hospital in 2016. For eye surgery with increased procedural capacity.
6. Explore providing optometry assistant services to increase the capacity of existing provider/s.
SOUTH EAST REGION

NEED IDENTIFICATION

Overall Need (Question 8)
When asked to describe the overall need for eye health service in the region/s, respondents told us:

- North Coast trips are not funded by VOS at all.
- The need for optometry services in the rural Indigenous centres is very apparent.

Level of Need (Question 9)

Summary
These results indicate the highest overall level of need is for Amblyopia (lazy eye), followed by Cataracts and Diabetic Eye Care. This result may be related to the number of children with reported attendance at urban AICCHS clinics across South East Queensland.
Summary

The very high demand for specialist ophthalmology services, both general and surgical, aligns with the findings for other regions. The ratings for optometry services, dispensing and spectacle supply are similar.

**Additional comments made by provided by respondents included:**

- **We have long waitlists in many clinics (esp Logan area) and could easily increase clinics by 30-40%.**
- **Pathways in the Gold Coast region are yet to be fully integrated. Elsewhere, we are finding as our Optometry demand increases, so too does our Ophthalmology. We will be commencing telehealth over the next 1-2 months.**
- **We are MASS dispensing agents, and for private prescriptions we facilitate referral to an outside supplier.**
- **We dispense MASS at all our locations.**
- **Frame choice and fittings should be increased in consultation with MASS dispensing agents.**
- **Patients are generally referred to Brisbane for laser/general ophthalmology (offered appointments within the month).**
Other Health Needs (Question 11)

Respondents highlighted the following health and service needs which have the potential to impact on eye health, for example, complex and chronic conditions, and associated comorbidities:

- Integration of health services for chronic disease management is imperative to maximise positive outcomes.
- Our Optometrists take part in case conferencing and multidisciplinary care of chronic, complex patients.

Provider Type (Question 12)

Summary

Surgical Ophthalmologists, followed by General Ophthalmologists rate most highly, followed by the Optometrist, supported by the Optometry Assistant.

Additional comments provided by respondents included:

- We wish to train indigenous community member Optical assistants.

Locations Identified (Question 13)

Specific locations which respondents identified as benefiting from increased or better coordinated services were:
Activity (Question 14)

Respondents selected Pre-Surgical Assessment as the highest ranked activity type, followed by Surgical Intervention and Consultation/Assessment. This result suggests that access to cataract and other surgical interventions is limited and in high demand.

Additional comments provided by respondents included:

- We provide VF testing at all clinics, and do see significant numbers of glaucoma patients.
- We wish to upskill ACCHO staff in optometry assisting, screening. We also wish to recruit Indigenous Optometrists and Optical Assistants.
- We will commence this thanks to the new Medicare item number over the next 1-2 months.
- Not enough community knowledge as to preventative eye care. Diabetics seem more aware of foot care than eye care.
- Wish to increase these with an appropriate model (currents receive students from the University of NSW Optometry).
**SERVICE PROVISION**

Respondents were asked to identify issues associated with access, coordination, workforce demand and cultural appropriateness in their region/s as presented below:

### Access Barriers - Availability, Distance, Travel, Type of Service, Cultural Safety (Question 15)

- Cost (perceived) and cultural safety is a big barrier in urban areas to Indigenous people accessing mainstream services.
- Also, when eye health is within the ACCHO, other healthcare providers (GP’s, Podiatrists etc) can assist in ensuring patients attend for eye health care.
- Access to cataract surgery.
- Our patients can be transient and experience transport problems to attend public hospitals without a high level of coordination.

### Referral/Review/Follow Up Care - includes Spectacles and Surgery (Question 16)

- Referrals to Access to cataract surgery. Our patients can be transient and experience transport problems to attend public hospitals without a high level of coordination.
- Access to cataract surgery a problem.

### Visit Frequency to Support Best Practice - Optometry Services (Question 17)

- Yearly diabetic eye exams are best achieved through eye health within the ACCHO, so the primary health team can monitor **frequency** and assess levels of diabetic retinopathy etc.

### Coordination with Local/Regional Services (VOS) - includes Administration and Support (Question 18)

- Yearly diabetic eye exams are best **coordinated** through eye health within the ACCHO, so the primary health team can monitor frequency and assess levels of diabetic retinopathy etc.

### Duplication of Services - VOS and other services (Question 19)

*Nil comments*

### Communication between VOS and other providers (Question 20)

*Nil comments*

### Available Workforce/Providers to Deliver Services - all Types/Levels (Question 21)

- We wish to train optometry assistants and students.

### Access to Culturally Appropriate Services and Providers - VOS (Question 22)

- Many Indigenous patients choose to access all healthcare at their local ACCHO for any number of reasons including cultural safety.
**Physical Infrastructure in Service Locations/Facilities (VOS) (Question 23)**

*Nil comments*

**Service Promotion (VOS and MASS) (Question 24)**

*Nil comments*

### EQUIPMENT

**Essential Equipment (Question 25)**

Respondents rated how essential access to fixed or portable optometric equipment including a Slit Lamp, Ophthalmoscope, Retinoscope, Eye/Test Chart, Tonometer, Retinal Camera and Optical Coherence Tomography (OCT) to deliver a comprehensive VOS service.

![Slit Lamp Pie Chart]

- **Essential**
- **Not Essential**
- **Fixed**
- **Mobile**
Visiting Optometrists Scheme Needs Assessment 2015 - 2016

**Ophthalmoscope**

- Essential
- Not Essential
- Fixed
- Mobile

**Retinoscope**

- Essential
- Not Essential
- Fixed
- Mobile
Visiting Optometrists Scheme Needs Assessment 2015 - 2016

Eye/Test Chart

- Essential
- Not Essential
- Fixed
- Mobile

Tonometer

- Essential
- Not Essential
- Fixed
- Mobile
Specific Locations (Question 26)
Respondents did not identify any specific locations where equipment access is an issue.

Rationale (Question 27)
Respondents were asked to provide a rationale for any essential equipment:

- We need more equipment!

*Based on the results and key themes identified, the VOS priority actions for CheckUP and QAIHC in the South East region are:*

### VOS PRIORITIES - SOUTH EAST REGION

<table>
<thead>
<tr>
<th>1.</th>
<th>Scope the following locations where it has been indicated benefit would come from access to new and/or increased or specialised services/capacity:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Logan</td>
</tr>
<tr>
<td></td>
<td>- Multiple AICCHS services</td>
</tr>
<tr>
<td>2.</td>
<td>Support improvements in local service coordination between Roma and other communities/towns in the SW region.</td>
</tr>
<tr>
<td>3.</td>
<td>Make connections and improve referral pathways between specialised ophthalmological services and optometry services across the region, particularly cataract surgery.</td>
</tr>
<tr>
<td>4.</td>
<td>Support the development of referral pathways for increased access to cataract surgery.</td>
</tr>
<tr>
<td>5.</td>
<td>Support the uptake and utilisation of telehealth using existing technology.</td>
</tr>
<tr>
<td>6.</td>
<td>Scope the provision of additional screening for children attending AICCHS clinics across SEQ.</td>
</tr>
<tr>
<td>7.</td>
<td>Explore providing optometry assistant services and or funding for students to increase the capacity of existing provider/s.</td>
</tr>
</tbody>
</table>

State-Level

**Key Themes and Priority Actions**

The Needs Assessment process has reinforced the importance of the role of the Optometrist in providing primary eye care services.

A team approach, which includes services provided by Optometry Assistants is the preferred workforce combination. This allows for clinic support and in some cases, dispensing of glasses via MASS.

The demand for specialist ophthalmology services is overwhelming, in particular general and specialist eye and cataract surgery.

The ophthalmology registrar training program will cease in Queensland in 2016, and will no doubt increase the level of demand over time.
Access to the MASS is in high demand and for some clients and communities is the only mechanism available for dispensing of glasses.

**CheckUP will explore promoting uptake to the scheme by preferentially contracting VOS providers who work with MASS.**

The challenges of providing services in rural and remote communities is evident. This is not new, but continues to be a barrier for some, in particular limited or no access to services in their home town and the necessity to travel, which incurs a personal cost and may prevent them from receiving a service at all.

From the perspective of the VOS providers, the cost of traveling to rural and remote communities, within a reasonable timeframe, is high on their agenda. This presents a challenge with limited funding and the necessity to rationalise travel costs in some cases.

**CheckUP intends to revisit the current costing arrangements for travel during 2015 - 2016, in collaboration with the VOS providers, to see where efficiencies and/or improvements can be made.**

The coordination of services across regions and locations continues to arise as a key issue which needs to be addressed. While a lot of effort is made by some providers to do this, the ongoing challenge with service fragmentation and multiple providers, both local and visiting, make it very complex.

**More support is needed at the regional level, as detailed by the Roadmap to Close the Gap for Vision. For CheckUP and QAIHC the regional structure and the role of the RPCCs, RCs and EHC are perfectly positioned to support this approach.**

Funding support and financial viability are ongoing issues for VOS providers who go to rural and remote communities.

Competition between local or resident providers and visiting VOS providers and/or other organisations such as charities and other NGOs who also provide eye health services is a contentious issue.

**Loss of income is forefront in many VOS providers’ minds, and this issue requires further work on the part of CheckUP to determine the best way to address it going forward.**

Concern around the demand for services, versus services that are provided but have low levels of activity is also very evident. It is challenging to accurately predict the uptake that a clinic or visiting service will have, as it can be impacted by so many factors, but, from an efficiency and funding perspective performance measures are necessary to ensure a return on investment. Some providers struggle with this concept and feel it does not account for the local context or personal barriers or sacrifices they have overcome to work with the VOS.

**More work is required to monitor and review the uptake and performance of the current and future VOS providers, using data collected by CheckUP, to establish benchmarks for future comparison.**
Recommendations

Based on the outcomes of the Needs Assessment process, a set of recommendations has been developed to inform the ongoing implementation and efficient delivery of VOS services in the current financial year (refer Table 10). For ease of reference the recommendations are categorised under four domains accompanied by a proposed timeframe for action during 2015 - 2016:

1. Partnerships and Key Relationships
2. Service Improvement, Data Capture and Sharing
3. Service Models and Innovation
4. Service Delivery

It is acknowledged that CheckUP and QAIHC are already actively engaged in addressing actions under a number of domains, building on existing relationships, structures and systems, with new opportunities to come.

<table>
<thead>
<tr>
<th>Table 10: RECOMMENDATIONS</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Partnerships and Key Relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish and/or expand existing formal partnerships with key organisations to support the delivery of cross sectoral eye health service delivery in Queensland.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Establish and/or expand existing data sharing agreements with key organisations to support outcome measurement including OneSight, CSIRO, IEHU Melbourne University, IUIH, Hospital and Health Services, Primary Health Networks, Fred Hollows, QAIHC/AICCHS and the IDEAS Van.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Identify and harness existing and future forums for key stakeholders and working partner organisations to share best practice methodologies and outcomes for eye health including the CheckUP Outreach Symposium.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Work collaboratively with other key services and providers to raise awareness of VOS and other eye health services which are provided across Queensland.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Expand the membership of CheckUP and QAIHC Outreach Governance and Regional Structures to actively engage with key stakeholders/organisations focused on eye health.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Domain 2: Service Improvement, Data Capture and Sharing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Redesign the Location Visit Report to include additional questions which are specifically aligned to the VOS program and its funding criteria for implementation from January 2016.</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Identify and establish opportunities for data sharing and best practice benchmarking at both the state and national level with other jurisdictional VOS fund holders.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Work collaboratively with other key services, organisations and researchers who are focused on improving eye health to align the CheckUP VOS data collection processes to theirs for future benchmarking, including Optometry Qld/NT, OneSight, Fred Hollows, the IDEAS Van, CSIRO, IUIH and the IEHU at Melbourne University.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Explore the opportunity to work with the IEHU at Melbourne University to formally evaluate the impact of the CheckUP and QAIHC regional planning structure and Eye Health Coordinator role in Queensland, to drive well connected, effective and efficient service delivery.</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Explore the feasibility of “hot mapping” CheckUP eye health service and location data with Optometry Qld/NT.</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>
Domain 3: Service Models and Innovation

<table>
<thead>
<tr>
<th>Requirement</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilise links to existing RPCC forums to identify opportunities for new and innovative service models to delivery outreach eye health services.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Review the current annual Provider and Facility Review process and survey to incorporate and/or address issues raised by VOS providers.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Include additional items or questions around communication and liaison with local providers and communities, cross program referral pathways and the coordination of services in the CheckUP Health in Focus Survey 2015.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Under the CheckUP Clinical Governance Framework establish an Eye Health Clinical Governance Sub Committee to benchmark service data informed by best practice guidelines.</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Investigate alternative and innovative service modes and technology including telemedicine to support screening and diagnosis of diabetic eye conditions for rural and remote communities.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Monitor and track the delivery and performance of existing services funded under VOS and those recommended for inclusion from January 2016 via the Outreach Management System.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Share and benchmark de-identified VOS data with other key stakeholders and organisations to build a robust evidence base.</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

Domain 4: Service Delivery

<table>
<thead>
<tr>
<th>Requirement</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actively promote VOS and medical specialist eye health service availability and links to MASS for dispensing services.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Engage and work with other providers such as OneSight and the IDEAS Van to address eye health service need in locations/communities which are not able to be supported under the VOS due to funding limitations.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Ensure eye health is addressed in all consultation, service mapping and planning processes undertaken by the Regional Coordinators and Regional Planning and Coordination Committees.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Review the existing membership of the Regional Planning and Coordination Committees to engage with key stakeholders/organisations focused on eye health.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Reiterate the requirement for visiting VOS optometrists to provide evidence of having engaged with a local/resident service provider in a community/local before proposing the delivery of a services under VOS.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Provide VOS services which focus on preventive screening for children and adults.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Identify future opportunities for VOS services to be delivered in school settings to provide screening and follow up for children.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Link VOS with other organisations and provider/s to access follow up care, including surgical services.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Link VOS with services delivered under EESS to provide local optometry screening, referral and follow up.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Identify and promote local/regional services able to dispense glasses at a subsidised rate for patients who do not a concession card and are ineligible under the MASS.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Ensure all VOS providers have completed cultural safety and awareness training provided by CheckUP, QAIHC and local communities.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Provide a range of service options for patients to choose from in communities with unmet health needs and/or significant access and cultural barriers.</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
### Next Steps

Based on the findings and recommendations arising from the VOS Needs Assessment, the existing VOS services are currently being reviewed and reshaped for implementation from January 2016. CheckUP will continue to liaise with the Department of Health throughout this process to ensure proposed changes and/or contractual arrangements are supported, open and transparent.

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CheckUP and QAIHC would like to acknowledge the gracious contribution made by key stakeholders and providers who are committed to improving eye health care in Queensland communities.
APPENDICES

Appendix A: CheckUP and QAIHC Regional Structure
Appendix B: Position Description - Regional Coordinator
Appendix C: Needs Assessment Methodology - VOS
Appendix D: VOS Location Visit Report
Appendix E: VOS Service Delivery Standards