Indigenous Australia Program

DEVELOPMENT EFFECTIVENESS

OUTREACH OPTOMETRY PROGRAM 2006 – 2012

The Indigenous Australia Program (IAP) supported optometrists to visit rural and remote Top End Northern Territory communities to screen, treat and refer patients with eye health conditions between 2006 and 2012. The Outreach Optometry Program (OOP) was designed to improve people's access to primary eye health care in remote Top End communities.

Key results

- From 2006 to 2012, the IAP was one of the largest service providers of visiting optometrists in the NT and made a strong contribution to eye health in participating communities.
- 39 optometrists contracted by OOP reached 37 communities and performed over 2,262 patient examinations and referred patients with eye conditions for specialist treatment.
- From 2010 to 2012, an average of 75% of the examinations conducted were for Aboriginal and Torres Strait Islander patients.
- Between 2009 and 2012, 58% of all examinations were for female patients.
- The highest number of patient examinations and communities visited was in 2010.
- Between May 2006 and 2012, over 4,000 pairs of spectacles were dispensed to people living in remote communities by all NT organisations involved with the Low Cost Spectacle Scheme (LCSS). (Refer to Bulletin #9 May 2014 for more information)

In a submission to the VOS evaluation, The Foundation stated that without the support of these cultural brokers, it is

"MOST UNLIKELY THAT INDIVIDUAL OPTOMETRISTS COULD ENSURE APPROPRIATE CULTURAL SAFETY..."

Background

The IAP received federal government funding from the Australian Government Department of Health and Aging under the Visiting Optometry Scheme (VOS). The IAP provided coordination, administrative support and funding. The IAP collaborated with optometrists, health specialists, community health centres, Aboriginal Community Controlled Health Organisations, Regional Eye Health Coordinators, Centrelink, the Northern Territory Government Department of Health and the private optometry providers.

The Fred Hollows Foundation
Indigenous Australia Program
08 8920 1400 | reception@hollows.org | www.hollows.org

Culturally appropriate service delivery

- Optometrists were provided with a short written cultural guide for working in remote communities. The guide covered communication, privacy, caring for country, cultural heritage, intellectual property, culturally appropriate greetings, dress code, interpreters, food, accommodation and sorry business.
- When required optometrists used culturally appropriate materials, such as turtle and other animal symbols instead of words for eye testing.
- Cultural brokers that were able to help to ensure that service delivery was appropriate in each community context. Either the OOP Coordinator, the Regional Eye Health Coordinator or an Aboriginal and /or Torres Strait Islander IAP project officer would act as a cultural broker for the optometrists and patients. Cultural brokers can help to ensure patients are treated in a safe and culturally appropriate environment so that patient attendance is maximised. The role of the OOP Coordinator as a cultural broker was affirmed in the 2007 external review of the spectacle scheme. The review found that the Coordinator had developed strong relationships with both the communities and Aboriginal Eye Health Coordinators and had provided support in a respectful manner. Despite the critical nature of this role, these cultural broker roles were not funded by the VOS.
- An accurate and agreed list of community names, with both English and Indigenous language names included was developed after assumptions were made about a client's place of residence and Aboriginal and / or Torres Strait Islander and English language place names were being used interchangeably.

Challenges

Patient data was collected during outreach visits but not systematically entered into a centralised database. As a result, aspects such as reach to Aboriginal and Torres Strait Islander populations, gender equity and geographical access were not routinely monitored.

There was no monitoring and evaluation plan or risk management plan for the OOP, nor was there systematic monitoring of the Program's systems, capacity and efficiency. Issues such as increasing wait times for spectacles, errors in spectacle orders and significant losses borne by IAP for the supply of spectacles may have been able to be identified and managed much earlier had these M&E and risk systems been in place. Longer-term outcomes and the process of transition of the LCSS were not documented.

A paper outlining the experiences of the National Trachoma and Eye Health Program that Fred Hollows initiated in the 1970s noted the importance of Aboriginal workers and that the complexity of the role of a cultural broker is not to be underestimated:

"NOT ONLY WERE THESE [ABORIGINAL] WORKERS FAMILIAR WITH HEALTH AND EYE PROBLEMS, BUT THEY WERE INTERPRETERS, NEGOTIATORS, PEACEMAKERS, TRAVEL OFFICERS, CULTURAL AWARENESS OFFICERS AND, IMPORTANTLY, ROLE MODELS IN REPRESENTING ABORIGINAL PEOPLE."

Jones J, Buzzacott T, Briscoe G, Murray R, Murray R, Beyond Sandy Blight: Five Aboriginal experiences as staff on the National Trachoma and Eye Health Program, Australian Institute of Aboriginal and Torres Strait Islander Studies, 2008.

NT communities visited by OOP 2006–2012

The communities visited were concentrated in the Greater Darwin and Katherine regions of the NT and the proportion of the population serviced by the OOP varied significantly between communities. From 2006 to 2012, the OOP was one of the largest VOS service providers in the NT.

Lessons Learned: Outreach

Optometrists: Involvement of local service providers in outreach work is the optimal model as it increases the opportunity for continuity of care and strong relationships between the provider and patients and their communities. Barriers to the involvement of optometrists need to be identified and addressed, such as making funds available to backfill during an optometrist's participation in an outreach visit.

Cultural brokers: Anecdotal evidence in the literature, and feedback in IAP reports, repeatedly note that such roles are critical for ensuring culturally appropriate service delivery in communities.

- Further research is needed to build a robust evidence base about the benefits and value of the contribution of cultural brokers to service delivery.
- Funding for remote and very remote outreach work needs to include sufficient funds for coordination of the work as well as for cultural brokers to support optometrists and patients.

Coordination: It is cost effective to invest in coordination of optometry and ophthalmology outreach services. Such coordination leads to increased efficiency – through increased clinical activity and decreased wait times for patients.

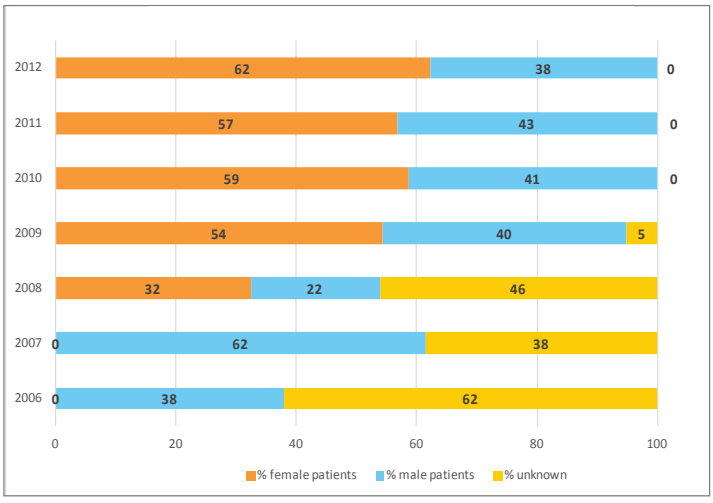
- Further cost effectiveness research on such coordination roles is needed.

Human resource management: The demanding nature of outreach work needs to be taken into account by ensuring schedules are realistic and/or staff participating in the visits are rotated. Debriefing after visits and monitoring staff/contractor well-being should be carried out systematically.

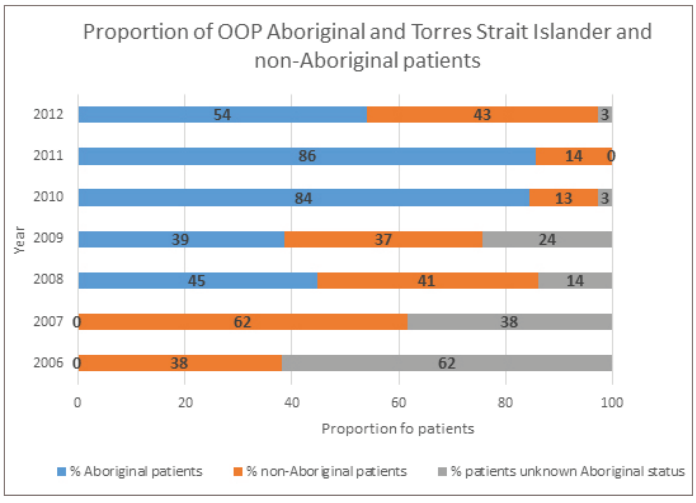
Cultural brokerage is needed otherwise personnel coming from mainstream services may

"LACK SUFFICIENT FLEXIBILITY, UNDERSTANDING AND/OR CAPACITY TO CATER FOR AN HOLISTIC VIEW OF HEALTH AND WELLBEING,"

which can, in turn, result in negative experiences for patients.



Proportion of OOP examinations by gender and year



Proportion of OOP Aboriginal and Torres Strait Islanders to non-Aboriginal patients

Lessons Learned: Program management

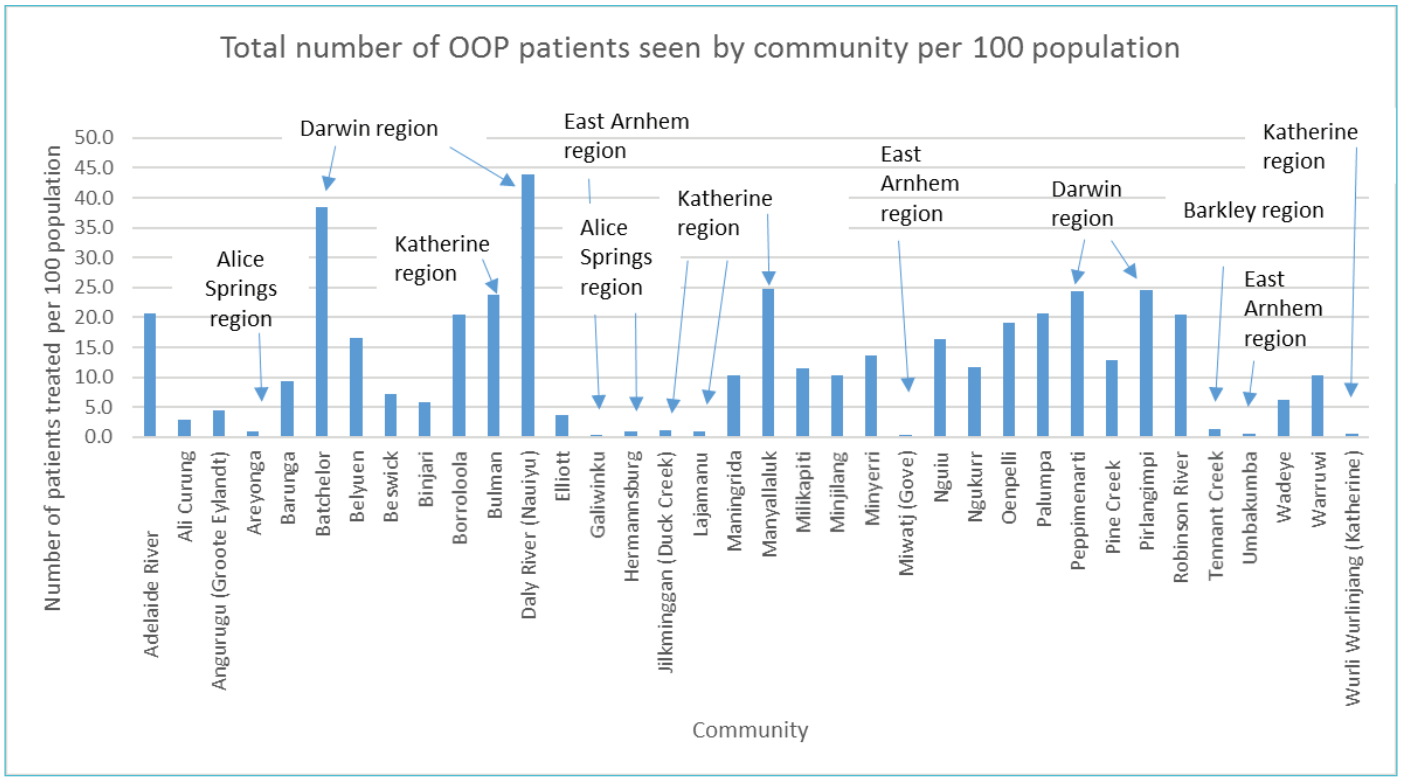
Advisory groups: Such groups for programs should be established prior to, or at the beginning of programs and should have clear terms of reference or operating guidelines.

Partnership arrangements: Prior to the commencement of a program the IAP needs to ensure that: it has the capacity to support its role in the partnership; the partnership represents the best value for money; the partner and IAP have transparent and established quality control systems; and regular communication is planned for, and maintained, throughout the partnership. Programs need to put in place an upfront risk management plan to plan for, and mitigate against, potential risks including financial risks

Data sharing: There needs to be systematic and consistent collection and entry of patient data into information systems, and sharing of this data between health service providers, to be able to ensure effective patient referrals, continuity of care and coordination.

Program data: Such data needs to be systematically collected and entered into a central patient information system to be used for program monitoring and also for accountability purposes. Analysis and interpretation of this data needs to be documented and used to inform continuous quality improvement of programs and for future program design. Clear protocols for data management need to be established and followed for each program and for the IAP as a whole.

M&E design: During program design, programs need to carefully consider the data they need to collect for monitoring, accountability and quality control purposes and then design an M&E plan for the program. The plan should include data collection tools, reporting templates, IT and data management systems supporting data collection and analysis methods to be used. Long-term impact of some projects should be measured. The transition of programs, as well as any reflection that occurs during the process, should be well documented by IAP and shared in order to inform future programming.



Number of OOP patient examinations per 100 population in each community 2006–2012