

Non-clinical support in Aboriginal and Torres Strait Islander eye care

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Brien Holden Vision Institute



The **Fred Hollows**
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EXECUTIVE SUMMARY

This report serves as a review of non-clinical support in eye care for Aboriginal and Torres Strait Islander (herein Aboriginal) Australians. We categorise non-clinical support as ‘roles’ (jobs or responsibilities related to non-clinical support), and ‘functions’ (aspects of a person’s role that deliver non-clinical support) that assist patients to attend eye care services and complete clinical pathways. The people who provide non-clinical support are both health system based (clinicians, coordinators, administrators), and community based (Elders, family, school staff). Staff who are designated to perform non-clinical support functions, such as eye health coordinators, cultural advisors, and interpreters, often job-share, or are in part-time or casual positions. This model has resulted in an absence of these roles (clinical and non-clinical), while Aboriginal Health Workers (AHWs), Primary Health Care (PHC) clinicians, administrators, transport drivers, family, and Elders fulfil many aspects of these roles on an informal basis. While full-time roles to provide non-clinical support may not be cost-effective or necessary, the current model has left significant gaps in the capacity of staff to provide these important services. Evidence suggests that a lack of non-clinical support impacts patient experiences negatively, and subsequently creates complexities and barriers to attendance that could otherwise be avoided.

To further understand who provides non-clinical support, and how it is provided in the context of eye care, this report presents the findings from an analysis of three data sources. First, an exploratory review of literature in Aboriginal health generally, to understand how non-clinical support is provided outside of eye health. Secondly, a systematic review of peer-reviewed literature specific to Aboriginal eye health, to synthesise published evidence of the way non-clinical support operates within eye health systems. Thirdly, a review of selected policy documents, to understand how non-clinical roles related to eye health are acknowledged, defined and resourced within national and state policy environments. Data from all sources were analysed qualitatively and coded inductively to identify references to non-clinical roles and functions. Originally, a set of focus groups were undertaken with key eye health stakeholders in the Northern Territory (NT) and New South Wales (NSW), to triangulate evidence found in the literature and policy reviews. However, as ethics approval was not obtained for these stakeholder interviews, references to these interviews have not been included in this report.

The results from the systematic review and policy review were collated and summarised, whereby six key non-clinical support functions in eye health emerged. These comprise: coordination of eye care (patient liaison/case management, travel and transport, integrating linking services), cultural literacy and brokerage, interpreting and translation, health promotion and patient education, community engagement and trust-building, and social and emotional support. Results from the exploratory literature review, were used to provide evidence of how non-clinical support is successfully provided in other areas of Aboriginal health. The findings provide evidence of challenges in each area. Eye care coordination, a complex and multifaceted role, is largely performed by eye care coordinators working in either regional, tertiary, or primary care contexts. Depending on resources and need, eye care coordination including patient liaison, administration, arranging travel, providing transport, and facilitating linkages between services providers is often split across multiple roles of which AHWs are key. Access to funding for eye care coordination is complex and varying, and relevant policies do not adequately recognise the importance of Regional Eye Health Coordinators (REHCs).

While acknowledged in the policy environment as important and necessary; cultural literacy (equipping non-Aboriginal health staff with Aboriginal cultural knowledge), cultural brokerage (assisting Aboriginal patients in interactions with non-Aboriginal health staff), and cultural support (provision of cultural advice and assistance to patients by Elders or other community members in cultural knowledge authoritative positions), remains secondary in the context of clinical systems/processes and limited resources. As the role of AHWs have shifted away from 'two-way medicine' and cultural brokerage, and towards acquiring clinical skills and responsibilities, cultural brokerage and support for patients can be minimal or absent altogether. In some communities, cultural liaison officers, cultural advisors, transport drivers, and Elders, perform these functions. However, these are often provided on an ad-hoc basis, and in some cases not remunerated. This is linked to a lack of specific funding and programs that support community-based roles in providing these support services to patients. In tertiary contexts, Aboriginal Liaison Officers (ALOs) are key providers of cultural support to patients, yet a lack of these positions means access to these services are not always available.

A central aspect of culturally safe care is the availability of and access to Aboriginal language interpreters. In Aboriginal language speaking communities, interpreting is a crucial non-clinical function that bridges communication between Aboriginal patients and non-Aboriginal clinicians. However, the evidence presented in this report shows that due to poor accessibility of Aboriginal language interpreters, family and community members, and in some instances other patients, act as interpreters in their absence. State-based policies do not recommend the use of carers, family, and friends as interpreters, despite acknowledging the lack of trained and registered Aboriginal interpreters.

Health promotion strategies are integral to eye health programs, of which success involves a whole of community approach. A key focus in this area is trachoma control and prevention, whereby family and community members, and staff in community workplace settings (schools, lands councils, youth services, women's groups, Elders groups), are crucial to program success. Non-clinical support functions include sharing local knowledge with program coordinators, campaigning for improvements in housing and infrastructure, spreading information about hygiene practices, and delivering practical activities to communities. While policies suggest that Indigenous Outreach Workers and eye health 'ambassadors' should raise awareness and promote eye health, this is not supported by specific programs or funding.

Historical experiences still impact patient decision-making in eye care today. This highlights the ongoing need for eye care services to engage and build trust with the Aboriginal communities they work in. AHWs and REHCs are seen as vital by eye care practitioners, and often act as a bridge to communities by prompting and facilitating attendance to clinics. Elders groups were also identified as an avenue whereby community trust can be built upon. Linked to historical experiences, is the importance of social and emotional support as a key non-clinical function. The provision of social and emotional support can help patients feel more comfortable when accessing eye care, particularly in hospital settings, or health services that are outside their communities. Having family members, carers or escorts present for specialist care supports patient attendance, and improves communication with health staff. AHWs and ALOs were noted as having a better understanding of socioeconomic stressors, and as a result able to provide care that considers social determinants such as income, housing, and availability of family support. In the policy environment, ALOs are acknowledged as the key providers of social and emotional support in hospital contexts. Travel schemes in the NT, South Australia, Western Australia, and Queensland do not support escorts for

social, emotional or cultural support (as do schemes in NSW and Victoria), which remains a key barrier.

The report concludes that the non-clinical support functions outlined are key to leveraging attendance and accessibility of preventive, primary and tertiary eye care services. Yet, a lack of adequate acknowledgement around the importance of some functions, clarity around the roles that perform them, and sustainable policies, funding and resources to support them remain key challenges. Part of the issue, is linked to difficulties estimating and discerning exactly how current funding is distributed in different regions and interdisciplinary health areas (such as chronic or integrated team care). This report provides various examples of the way non-clinical support is provided in other areas of Aboriginal health, in which eye health systems and services may adapt. However, improving access to support functions related to cultural literacy and brokerage, interpreting, and social and emotional support applies to all areas of Aboriginal health and reflects barriers in the health system at large. Furthermore, evidence from the data compiled in this report points to a disjuncture between an acknowledgement of the important role that family members provide in supporting Aboriginal patients to access care, and the provision of specific resources and programs to enable this.

Based on the evidence collated in this report, the following recommendations are proposed.

- Further research to provide:
 - Evidence of successful non-clinical support models in Aboriginal eye care.
 - A regional analysis to determine costing and current access to funds that support the delivery of non-clinical support in Aboriginal eye care.
 - A review of access to and funding of Aboriginal language interpreter services in communities that primarily speak Aboriginal languages.
- Specific funding to support the work that community-based roles such as liaison officers, cultural advisors, and Elders do in providing cultural support to patients, and cultural advice to health staff.
- Changes to state based travel schemes in the NT, South Australia, Western Australia, and Queensland to support escorts for the reason of social, emotional, or cultural support.

ABBREVIATIONS

ACCHS	Aboriginal Community Controlled Health Service
AHP	Aboriginal Health Practitioner
AHW	Aboriginal Health Worker
ALO	Aboriginal Liaison Officer
COAG	Council of Australian Governments
FGD	Focus Group Discussion
ITC	Integrated Team Care
ICDP	Indigenous Chronic Disease Program
IPTAAS	Isolated Patient Travel and Accommodation Assistance Scheme (NSW)
MSOAP	Medical Specialist Outreach Assistance Program
MOICDP	Medical Outreach Indigenous Chronic Disease Program
NAATI	National Accreditation Authority for Translators and Interpreters
NACCHO	National Aboriginal Community Controlled Health Organisation
NATSIHP	National Aboriginal and Torres Strait Islander Health Plan
NFAPEH	National Framework for Action to Promote Eye Health
NSW	New South Wales
NT	Northern Territory
OATSIH	Office of Aboriginal and Torres Strait Islander Health
QLD	Queensland
REHC	Regional Eye Health Coordinator
SA	South Australia
SOS	Specialist Outreach Service
VOS	Visiting Optometrist Scheme
VPTAS	Victorian Patient Transport Assistance Scheme
WA	Western Australia

1 INTRODUCTION

This report serves as an exploratory review of non-clinical support roles and functions in eye care for Aboriginal and Torres Strait Islander (herein Aboriginal) Australians. Non-clinical roles may involve coordination, interpreting, cultural brokerage or emotional support. Yet these facets may be a part of a person's clinical role, particularly in the case of Aboriginal Health Workers (AHWs) or Aboriginal Health Practitioners (AHPs), who are expected to both perform and mediate between biomedical practice and their holistic implementation in Aboriginal contexts.¹ Non-clinical support "functions" are defined as any facet of a clinical or non-clinical person's role that provides support to an Aboriginal patient in relation to their health care. Non-clinical support functions in Aboriginal health have been demonstrated to reduce anxiety around new diagnoses,² assist in interpreting biomedical information, help patients feel safe around non-Aboriginal clinicians,^{3,4} and help non-Aboriginal clinicians understand how wellbeing/illness is socially and culturally understood and placed. Similarly, the role of the family and community includes key non-clinical support functions that enhance accessibility. Some examples include, facilitating and motivating attendance to appointments such as dialysis,⁵ accompanying patients to mainstream services to help alleviate fear⁶ or fear of discrimination,² sharing the responsibilities associated with patient care outside the clinic/hospital environment,⁷ and enhancing the effectiveness of preventive health promotion activities such as nutrition education.⁸

In examining factors that facilitate culturally responsive care⁹ the Patient Experience in Eye Care (PEEC) study¹⁰ provided evidence for the importance and need for non-clinical support functions/roles in eye care at the community level, particularly in the context of sociocultural determinants, such as linguistic ability, poverty, historical trauma, and racism that make access to eye health care challenging for Aboriginal patients. Based on patient and Aboriginal Community Controlled Health Service (ACCHS) clinician perspectives in the NT and NSW, linguistic, administrative and emotional support; and liaison with families including communication of biomedical information and consent to treatment, is needed.¹⁰ In the context of eye health, coordination of services has been identified as a key factor in the successful delivery of eye care services to Aboriginal patients.¹¹⁻¹⁴ Evidence from The Fred Hollows Foundation suggests that when Aboriginal eye care support staff are employed, services experience higher ophthalmic attendance rates along with improved patient experiences.¹⁵ However a lack of recognition for the importance of these roles, and an associated lack of funding means they are either limited or in some places non-existent. The 2017 update on the implementation of the Roadmap to Close the Gap for Vision¹⁶ reported that, since the publishing of the initial recommendations based on data collected from the National Indigenous Eye Health Survey in 2009¹⁷ no action has been taken to define patient support staff roles, identify support staff needs, or allocate such roles within eye health systems. In order to understand how non-clinical support functions/roles contribute to outcomes in Aboriginal eye health, including if or how they impact accessibility, a review of the literature and policy context is required.

2 AIMS & METHODS

The aim of the project was to review current knowledge pertaining to non-clinical support in Aboriginal eye care through three key activities: a literature review which included exploratory and systematic components, a review of policy documents relevant to Aboriginal eye health, and a review of eye care stakeholder perspectives. As ethics approval was not gained for the stakeholder interviews, reference to these interviews have not been included in this report.

2.1 LITERATURE REVIEW METHODS

2.1.1 SYSTEMATIC REVIEW

The aim of the systematic review was to identify and review evidence pertaining to non-clinical support, specifically in the field of Aboriginal eye health in Australia. The following databases were searched for studies published between January 2000 and July 2018: Medline/EMBASE, Web of Science, Informit, EBSCO (CINAHL & Anthropology Plus), and ProQuest Central. Table 1 shows the search terms used for each area of interest combined with the 'AND' Boolean operator. The database search results were imported into a single library in EndNote (Clarivate Analytics, USA) to remove duplicate articles. The combined library was imported into Abstrackr (Brown University, USA) for title and abstract screening.

Table 1: Search terms used for systematic review

#1 Health (health or well* or ill* or disease* or "health care" or patient* or hospital* or treatment* or medic* or pain* or chronic) **AND #2 Australian context** (Australi* or "New South Wales" or Queensland or "Northern Territory" or "WA" or "SA" or Tasmania or "ACT" or "NSW") **AND #3 Indigenous context** (Indigen* or Aborigin* or Koori or Murri or "Torres Strait" or "Oceanic Ancestry Group") **AND #4 Eye care** (eye care or blindness or ocular or optom* or ophthal* or refractive error or myop* or visual acuit* or vision screening* or visual impairment or vision impairment or eye-care or vision care or visually impair* or amblyop* or cataract* or spectacle* or eyeglass* or glasses or vision or trahcoma or trichiasis)

Any studies investigating the topic of Aboriginal eye health in Australia were eligible for inclusion. Two reviewers independently assessed the titles and abstracts of all articles retrieved from the literature search using the inclusion and exclusion criteria outlined in Table 2. Where it was unclear whether the selection criteria were met, studies were included for full-text review. Two reviewers independently assessed the eligibility of the full-text articles according to the inclusion and exclusion criteria. Disagreements were resolved through discussion, and adjudicated by a third reviewer.

Table 2: Systematic review inclusion/exclusion criteria

Inclusion criteria	Exclusion criteria
• Empirical research studies • Publication type: peer reviewed journal articles • Includes data related to non-clinical support functions in Aboriginal and Torres Strait Islander eye health in Australia	• Publication type: Reviews, study protocols, commentaries, editorials • Location not Australia • Does not include data on Aboriginal and Torres Strait Islander health in Australia

Articles identified for inclusion in the review were synthesised to identify evidence of non-clinical support roles and functions in the field of Aboriginal eye health. NVivo qualitative data analysis Software (QSR International Pty Ltd. Version 12, 2018) was used to conduct the synthesis, which involved a combination of qualitative methods including inductive thematic analysis and meta-narrative¹⁸ techniques.

2.1.2 EXPLORATORY REVIEW

To complement the results of the systematic review, an exploratory literature review was conducted to identify articles in the broader field of Aboriginal health that provide evidence of the effectiveness of non-clinical roles, including the outcomes they produce, and how this relates to accessibility of health services for Aboriginal patients. Searches were conducted in well-established databases for health literature including Medline, EMBASE, Web of Science, CINAHL and Informit. A number of relevant grey literature reports were also included. Thematic synthesis as outlined in 2.1.1 was also conducted on articles identified in the exploratory review.

2.2 POLICY REVIEW METHODS

The aim of the policy review was to identify and review key policy documents pertaining to Aboriginal eye care, in order to understand current recommendations regarding non-clinical support. Policy documents were identified by personnel from the Fred Hollows Foundation who hold expertise in the Aboriginal eye health policy environment. A total of 65 documents were provided for analysis (see 7.3 for full document list). Each document was reviewed in full, and any references to non-clinical roles either specifically or broadly related to eye health were coded using Nvivo 12. Each policy document was classified using the variables outlined in Table 3.

Table 3: Policy review document classification variables.

Classification	Variables
Document type	Policy document; Implementation plan; Program guideline; Progress report; Policy framework; Healthcare standards
Theme	Aboriginal health (general); Chronic disease; Cultural safety; Eye care service delivery; Funding health activities; Health workforce; Language & interpreting; Patient travel
Geographic location	National; NT; NSW; VIC; WA; SA; QLD; TAS
Eye health specific document	Yes; No
Document references non-clinical roles in general	Yes; No
Document references non-clinical roles in eye health specifically	Yes; No

3 DESCRIPTIVE RESULTS

3.1 SYSTEMATIC REVIEW

Figure 1 shows the number of articles at each stage of the review process. A total of 27 articles were included in the final qualitative synthesis (see 7 for full article list). Detailed thematic results are discussed in section 4.

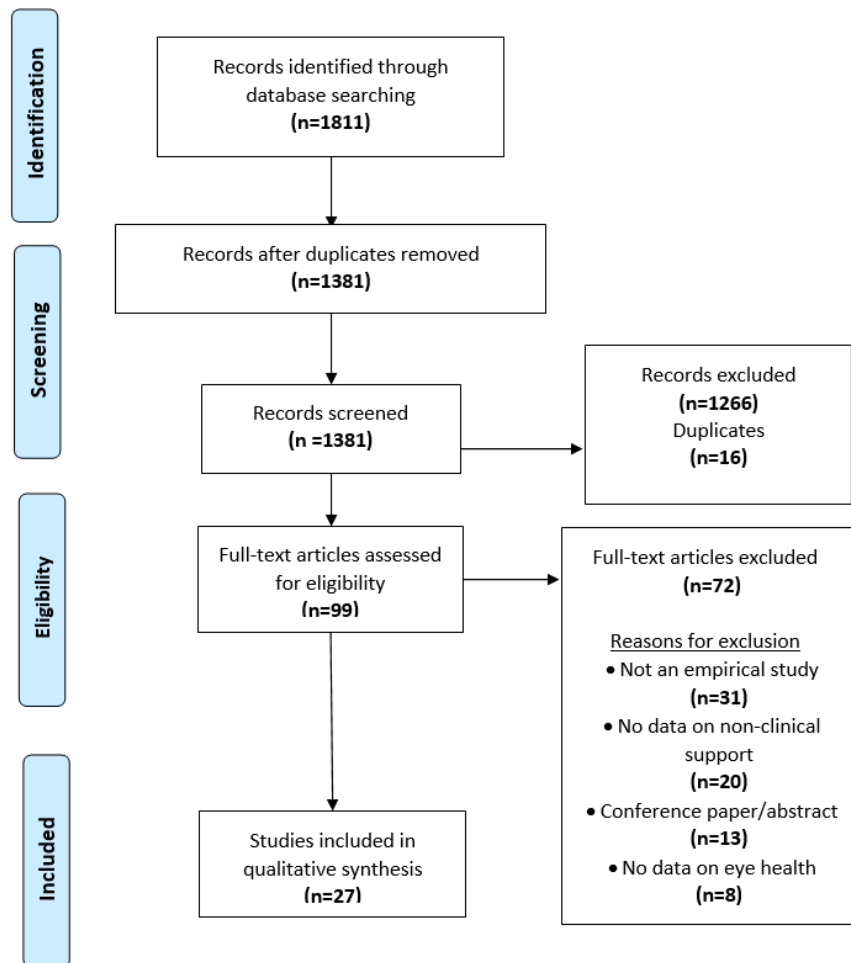


Figure 1: PRISMA Flow diagram of systematic review process and article sampling.

Figure 2 portrays key roles in Aboriginal eye care and the non-clinical support functions they perform. Figure 2 does not solely represent the level of ‘importance’ or ‘presence’ of a role or function; it also points to discussion around the need for, or absence of, certain roles. Eye health coordinators and AHWs (in some cases this is a dual role) are often responsible for the different aspects of coordination, a considerable part of which is liaising and engaging directly with patients, and organising access to travel schemes, transport and accommodation when attending eye care outside of their communities. ACCHS staff, and other (non-eye health specific) coordinators, including chronic care coordinators also contribute to support functions related to coordinating eye care. School staff, play a key role in trachoma control programs and the health promotion initiatives that surround them. While other community-based roles such as family members, cultural advisors/liaisons and Elders were noted in the literature as providing a range of functions including interpreting (in the absence of accredited interpreters), cultural brokerage, social and emotional support, and provision of transport. Interestingly the position of ALO (hospital) is not reported on widely within the eye health literature. This finding differentiated from the exploratory and policy reviews, whereby the importance of ALOs in Aboriginal health are referenced frequently. This finding may point to a bias or dearth in the eye health literature. These results are further explored in section 4.

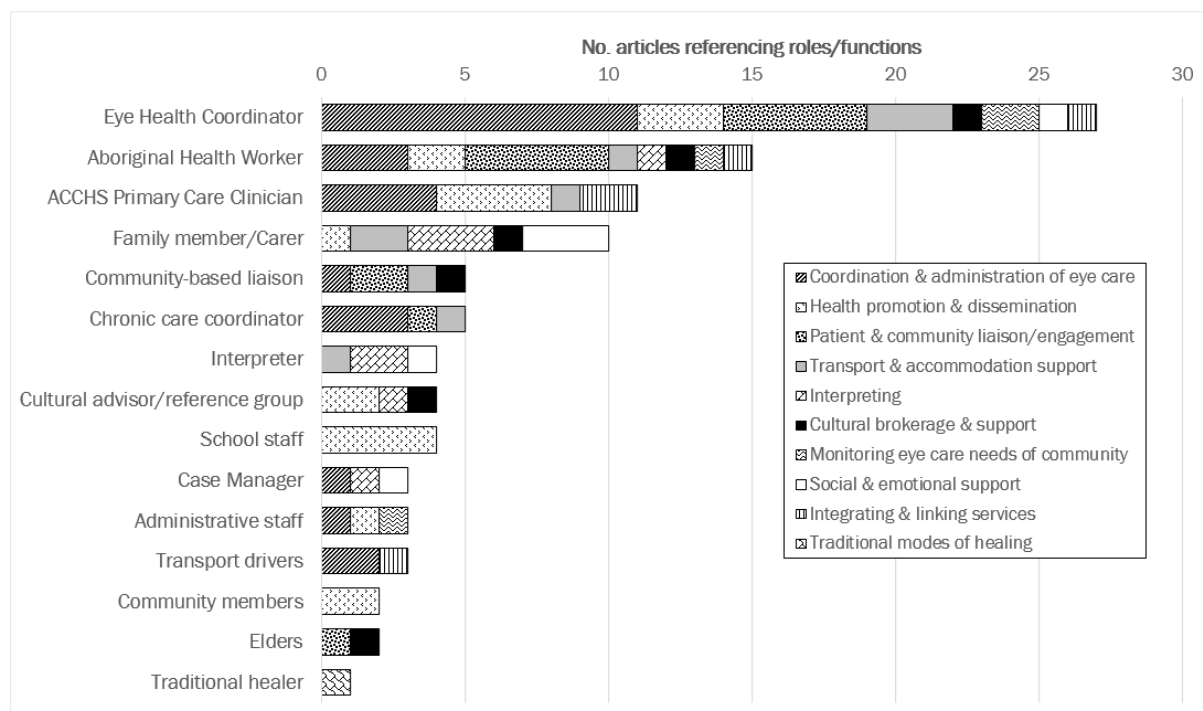


Figure 2: Roles that perform non-clinical support functions in Aboriginal eye care.

3.2 EXPLORATORY REVIEW

A total of 65 articles (peer-reviewed and grey literature) were included in the exploratory review (see 7.2 for full article list) of non-clinical support in Aboriginal health broadly. Figure 3 shows exploratory review articles disaggregated by health topic. Figure 4 shows both health system and community affiliated roles identified as fulfilling non-clinical support functions, arranged by the number of articles within which they were mentioned. Figure 5 shows key non-clinical support functions identified within the articles. Family and community members were identified in the literature as integral to social and emotional support, transmitting health information to the wider community and interpreting for patients. AHWs and ALOs fulfilled similar roles in addition to providing cultural brokerage to non-Aboriginal clinicians and cultural support to patients. Elders were also important in providing cultural brokerage and support, in addition to acting as a central link between service providers and communities. Moreover health networks and community groups were also identified as integral to providing additional social and emotional support, and enabling spaces where health information could be created, discussed and shared.

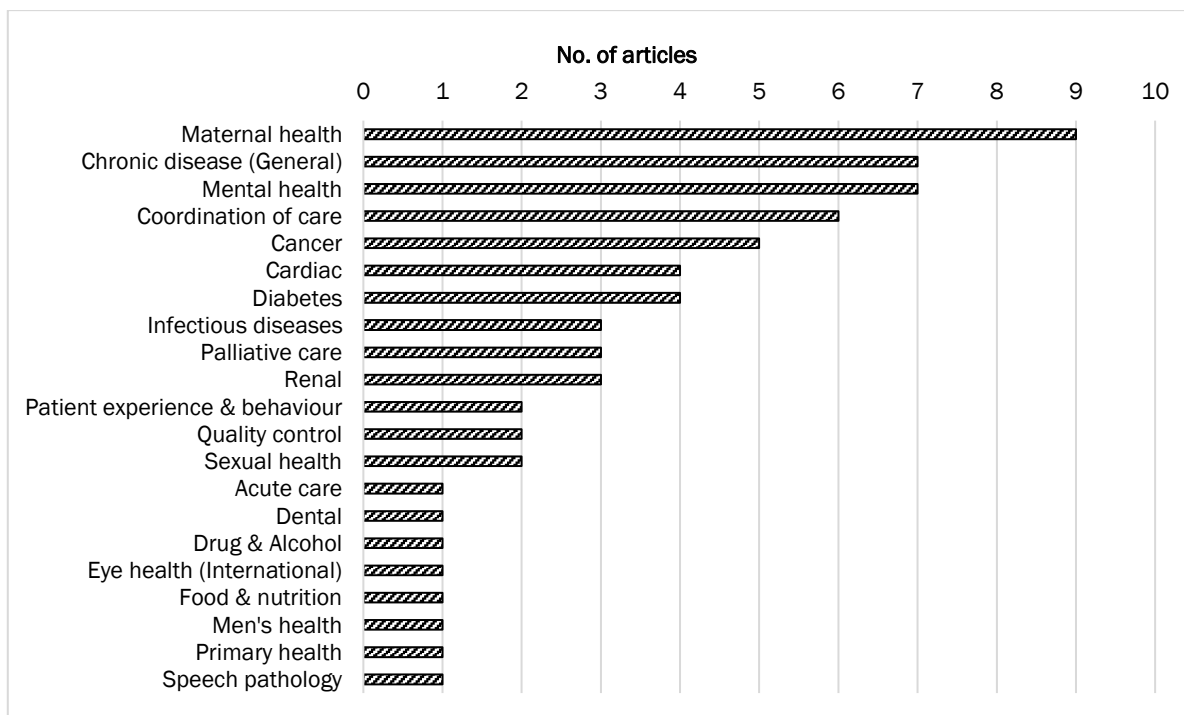


Figure 3: Articles included in the exploratory review by health topic (total n=65).

Key health areas where evidence of non-clinical support roles has resulted in enhanced access and uptake of clinical services include maternal health, mental health, and some areas of chronic disease (diabetes, renal, cancer). These are discussed in further detail in section 4, to highlight how the eye health sector can better enable access to non-clinical support.

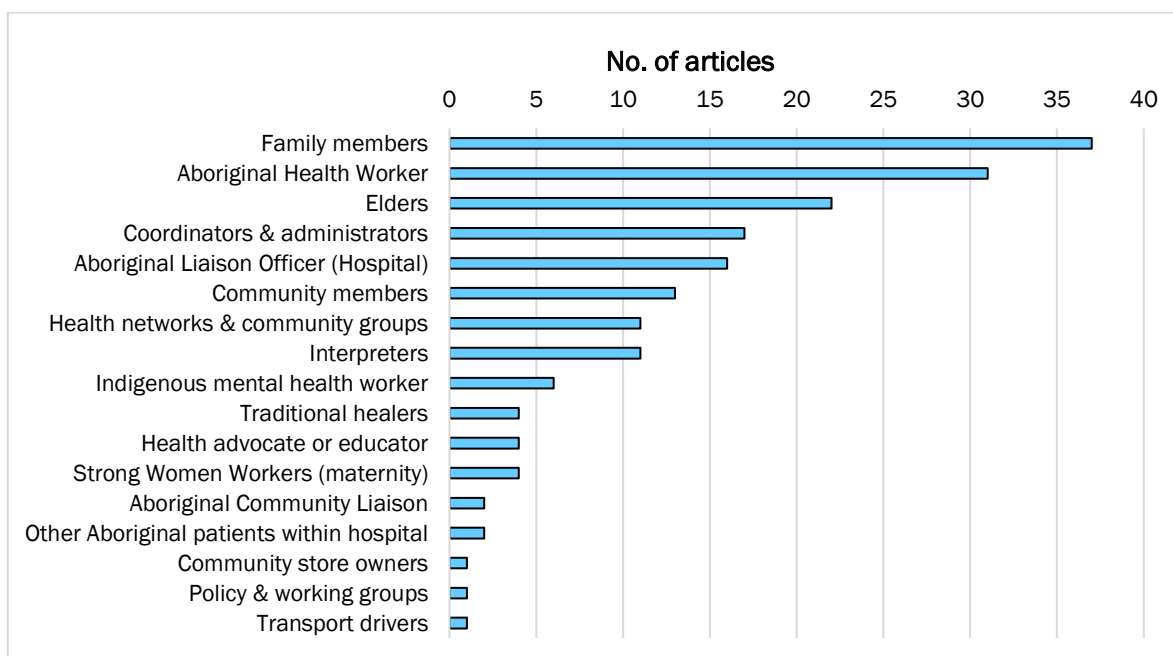


Figure 4: Roles associated with performing non-clinical support functions identified in the exploratory review articles (total n=65).

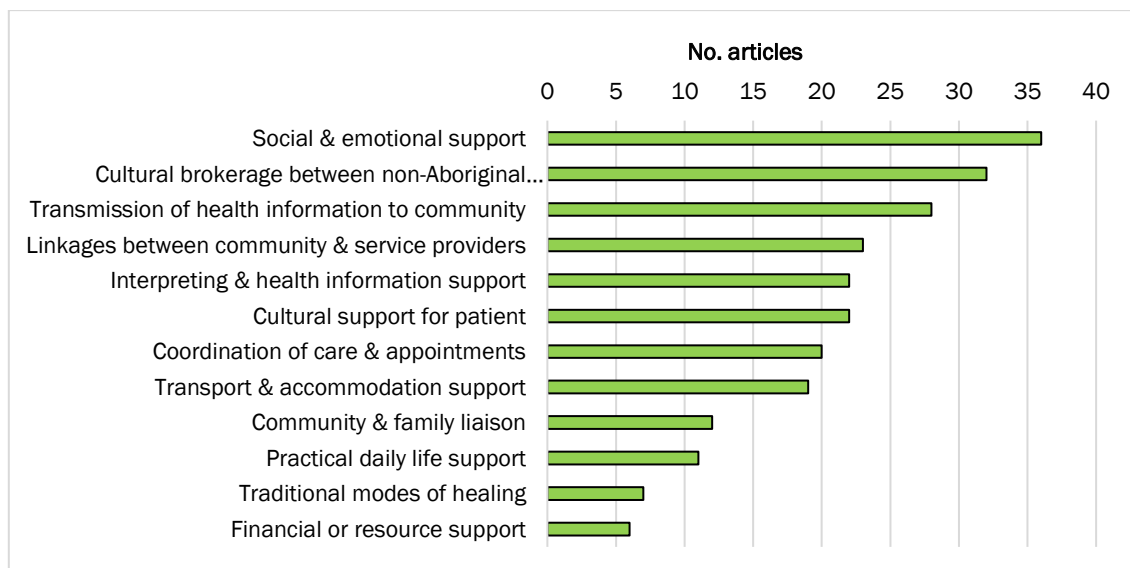


Figure 5: Key non-clinical support functions identified in exploratory review articles (total n=65).

3.3 POLICY REVIEW

Table 4 shows the total number of documents (n=65) included in the policy review, and their associated classifications (see Table 3 for policy document classifications).

We found that there were five non-eye health specific documents included in the policy review which made no reference to non-clinical support roles. These include:

- **Aboriginal Health (general)**
 - QLD Making Tracks Towards Closing the Gap in Health Outcomes¹⁹
 - QLD Statement of action in health outcomes²⁰
 - SA Policy Guideline: Checklist of Best Practice Program²¹
 - SA Policy Directive: Aboriginal Health Impact Statement²²
- **Health workforce**
 - QLD Aboriginal & Torres Strait Islander Workforce Framework²³

Furthermore, we found two eye health specific documents included in the policy review that do not reference non-clinical roles. These include:

- **Progress Report**
 - Second Progress report under the National Framework for Action to Promote Eye Health
- **Program Guideline**
 - Victorian Eye Service Manual: September 2016

Table 4: Number of documents included in the policy review disaggregated by document type, theme, and state. See Table 3 for a full list of classification variables.

	Healthcare Standards	Implementation plan	Policy Document	Policy Framework	Program Guideline	Progress Report	Total
Aboriginal Health (general)	1	3	12		2	2	20
National	1	1	2		1	2	7
NSW			1				1
NT			1				1
QLD		1	2				3
SA			3		1		4
VIC		1	2				3
WA			1				1
Chronic Disease					3		3
National					3		3
Cultural Safety			7				7
National			1				1
NSW			1				1
NT			2				2
QLD			1				1
SA			1				1
WA			1				1
Eye care service delivery			1	3	4	4	12
National				3	3	4	10
VIC			1		1		2
Eye health promotion		1	1				2
National		1	1				2
Funding health activities					2		2
National					2		2
Health workforce			5				5
NSW			1				1
QLD			1				1
SA			1				1
VIC			1				1
WA			1				1
Language & interpreting services					8		8
NSW					1		1
QLD					2		2
SA					1		1
TAS					1		1
VIC					1		1
WA					2		2
Patient Travel					6		6
NSW					1		1
NT					1		1
QLD					1		1
SA					1		1
VIC					1		1
WA					1		1
Total	1	4	26	3	25	6	65

However the majority of eye health specific documents (12/14) included in the policy review do reference non-clinical roles:

- **Policy Document**
 - National Framework Action to Promote Eye Health
 - Victorian Advisory Council: Koori Health Eye Health Strategy 2013-2014
- **Implementation Plan**
 - Implementation Plan: National Framework for Action to Promote Eye Health
- **Progress Report**
 - The Roadmap to Close the Gap for Vision Annual Update 2017
 - First progress report under the National Framework for Action to Promote Eye Health
 - Third Progress report under the National Framework for Action to Promote Eye Health
- **Policy Framework**
 - NACCHO Eye Health Report 2016
 - The Roadmap to Close the Gap for Vision (Full report)
 - The Roadmap to Close the Gap for Vision Summary Report 2015-2017
- **Program Guideline**
 - Evaluation of Medical Specialist Outreach Assistance Program & Visiting Optometrist Scheme
 - Visiting Optometrist Scheme Guidelines
 - Visiting Optometrist Scheme Service Delivery Standards

4 THEMATIC RESULTS

Thematic results draw upon each of the two data sets, the literature and policy reviews (2.1, 2.2). Key non-clinical functions in Aboriginal eye care are presented to draw a more cohesive understanding of each; including the roles that perform them and how these are recognised and supported in the policy environment. Examples from the exploratory review (2.1.2) are drawn upon to provide evidence of how non-clinical support is successfully provided in other areas of Aboriginal health.

4.1 COORDINATION OF CARE

In chronic disease care, introducing specific care goals and designated staff members with specified time allocated to chronic care coordination enhanced patient outcomes.²⁴ Creating a patient navigator position within primary care settings for Aboriginal cancer patients – a recognised and credentialed role in the United States²⁵ – assisted patients in overcoming sociocultural barriers.²⁶ Similar roles are described in dental studies, whereby “health advocates” were a factor in successful completion of dental pathways among Aboriginal patients.²⁷ Patient journey modelling and educational partnership activities have resulted in enhanced coordination and transition of care in the complex area of maternal diabetes; whereby introducing community-based care coordinators helped address issues of frequent staff turnover.²⁸

Coordination of eye care at the primary level involves several key areas; coordination of optometry clinics within ACCHSs,²⁹ integration of primary eye care into chronic disease coordination,³⁰ and coordination of screening and prevention programs; including school screening for refractive error,²⁹ or community screening, health promotion, and mass drug administration for trachoma.³¹ Coordination of tertiary eye care involves coordinating patient attendance to ophthalmology clinics including surgery, and ensuring appropriate follow up care. Coordination of eye care involves a multitude of non-clinical functions, particularly for rural and remote Aboriginal patients, who require

support accessing care outside of their communities. Unsurprisingly eye care coordinators perform a large role in the coordination of primary and tertiary eye care for Aboriginal patients. The role of 'eye care coordinator' differs depending on its location, responsibilities, and the individual person performing it; and is seen as a multifaceted role that is central to patients accessing and completing eye care. Some eye care coordinators are clinic-based, working in primary care, others are tertiary based, working in hospitals, and others fulfil a regional role working between both primary and tertiary eye care (Regional Eye Health Coordinators or REHCS). In some locations REHCs are engaged in service provision and coordination, while others may perform either one or the other.

Policy documents referencing non-clinical support roles in the general area of eye care coordination are shown in Table 5, including the type of document it was referenced in. Federal funding for eye care coordination is available from varying sources including Medical Specialist Outreach Assistance Program (MSOAP), Indigenous Chronic Disease Package (ICDP), and Medical Outreach Indigenous Chronic Disease Program (MOICDP). Access to these funds however, are complex and varying, and current policies do not adequately recognise the importance of REHCs. Progress reports noted in Table 5 outline additional funding sources for the delivery of eye care coordination across the states and territory; whereby some locations (VIC, SA) have funded state wide eye care coordinators, and others (NT, QLD) have funded regional coordination initiatives.

Table 5: Policy documents referencing non-clinical roles related to coordination of eye care.	
National	<u>Policy document</u> • Council of Australian Governments (COAG) National Indigenous Reform Agreement (2008) states an increase in the number and quality of training of the Indigenous health workforce as an output.³² • National Aboriginal & Torres Strait Islander Health Plan (NATSIHP) 2013-2023 advises funding for Eye Health Coordinators should be accessed via MSOAP and Indigenous Chronic Disease Package.³³ <u>Program Guideline</u> • The evaluation of the MSOAP and VOS (2012) states funding for eye care coordination is available via MSOAP and the Indigenous Chronic Disease Program (ICDP).³⁴ • The MOICDP service delivery standards (2016) states fund-holders are expected to access identified local coordination personnel available to enable visiting services to be as effective as possible.³⁵ <u>Policy Framework</u> • The Roadmap to Close the Gap for Vision (2012) recommends local areas identify personnel, positions and training required for the proper coordination, organisation and delivery of eye care; clear and ongoing funding and support needed for Regional Eye Health Coordinator (REHC) role; and case coordination for diabetic patients should be provided by chronic disease coordinators.³⁶ <u>Progress Report</u> • The Integrated Team Care (ITC) program implementation guidelines (2018) provides funding for care coordinators, Indigenous health project officers and outreach workers.³⁷
NSW	<u>Progress Report</u> • The third progress report under the National Framework for Action to Promote Eye Health (NFAPEH) (2015) states that coordinators were funded for: vision screening of pre-schoolers through the State-wide Eyesight Pre-schooler Screening program; and age-related macular degeneration at Sydney eye hospital. Moreover, an eye health nurse coordinator and an initiative to encourage diabetes educators to refer patients to optometry were implemented in the Far West NSW local health district.³⁸

NT	<u>Progress Report</u> - The first progress report under the NFAPEH (2008) states that Commonwealth funding was received for trachoma coordinators in the NT from 2006-2008; ophthalmology services were linked with OATSIH eye coordinators in remote NT regions; and OATSIH funded the Fred Hollows Foundation to employ eye health program managers to reduce cataract surgery waiting lists.³⁹ - The third progress report under the NFAPEH (2015) states that the NT Department of Health and Rural Health Outreach Fund provided joint funding for eye care coordinator and Indigenous eye care liaison officer, which supported referral to ophthalmologists.³⁸
VIC	<u>Policy Document</u> - The Koolin Balit Aboriginal health plan (2012) and the VACKH Aboriginal eye health strategy (2013) acknowledges the need for a state wide eye health coordinator; and notes the creation of the Patient Pathways Coordinator position created at the Royal Victorian Eye and Ear Hospital.^{40,41} <u>Progress Report</u> - The third progress report under the NFAPEH (2015) notes the role of a state wide eye health coordinator based at VACCHO for implementation of Koolin Balit Aboriginal Health Plan.³⁸ - The NACCHO report on Eye Health Service Delivery (2016) reports that funding for the Patient Pathway Coordinator was continued from 2013-2017.⁴²
SA	<u>Policy Document</u> The SA Aboriginal Health Care Plan (2010) reported that funding had been allocated to appoint a state coordinator and project support personal who prioritise eye and ear health; and a large number of Aboriginal patient pathway officer roles were being developed.⁴³
WA	<u>Progress Report</u> The NACCHO report on Eye Health Service Delivery (2016) reports that the Lions Outback Vision van linked with ACCHSs to share and synchronise referrals and patient records to ensure continuity of care.⁴²
QLD	<u>Progress Report</u> The NACCHO report on Eye Health Service Delivery (2016) reports that the Institute for Urban Indigenous Health will continue to provide eye care coordination services to communities in south-east QLD.⁴²

No related references identified in reviewed documents for Tasmania.

4.1.1 PATIENT LIAISON, CASE MANAGEMENT & ADMINISTRATION

Patient and community liaison was identified as a key function in the exploratory review with ALOs being central in encouraging cardiac patients to attend hospital care,⁴⁴ and minimising self-discharge rates.⁴⁵ The exploratory review provided examples in the areas of maternal and mental health, which drew on specific roles that supported patient liaison in the community, such as Strong Women Workers (community-based maternal health workers)^{28,46,47} and Indigenous Mental health Workers.⁴⁸⁻⁵⁰ These areas of health push for a more holistic approach to care, which draws on a whole of life approach rather than a focus on single disease areas or body parts. In the area of sexual health, regular face to face visits to patients and community members helps create accountability.⁵¹ Whereas examples in cancer²⁶ and renal care^{5,52} show the importance of liaising with the patient's family network to enhance and support complex care coordination.

Patient liaison and case management is a key function in coordinating eye care services, particularly in the context of patient distrust of health services and fear of cataract surgery.⁵³ Penrose *et al*⁵⁴ reported significant gains in patient engagement, and community relationship building when regional cataract surgery coordinators were in place. In the NT community liaison roles have a positive impact on turn up rates for cataract surgery.⁵⁵ Additional types of support related to patient liaison such as ensuring meals are supplied to patients attending services, or aides to reduce barriers commonly cited as reasons for non-attendance.⁵³ In Western NSW, ACCHS based REHCs provide case coordination in partnership with the ophthalmology department through

the Outback Eye Service, which is the only mainstream service in the region that seeks to provide culturally competent tertiary eye care for Aboriginal patients.⁵⁶

Moreover, administrative duties are a large component of primary and tertiary eye care coordination. These include organisation of optometry/ophthalmology clinic dates, supporting visiting eye care practitioners to complete paperwork during outreach clinics in communities, and organising logistics surrounding patient attendance.²⁹ REHCs and AHWs are recognised as integral in the success of cataract surgery under the 'Intensive Eye Surgery Week' model, providing a high level of case management and patient assistance.⁵³

Policy documents referencing non-clinical support roles in the area of patient liaison, case management and administration are shown in Table 6, including the type of document it was referenced in. Federal funding for "Indigenous Outreach Workers" whose role may perform the function of patient liaison and case management, may be accessed through the ICDP. However the role performed by Indigenous Outreach Workers and whether or not it involves eye health activities is determined by fund holders. The Visiting Optometrist Scheme (VOS) offers funding for administrative support to visiting optometrists; while MSOAP offers the same to visiting specialists more broadly.

Table 6: Policy documents referencing non-clinical roles related to patient liaison, case management & administration.	
National	<u>Program Guideline</u> - The VOS service delivery standards (2015) supports funding for administrative staff to support visiting optometrists.⁵⁷ - The RHOF service delivery standards (2012) and the MOICDP service delivery standards addendum (2016) support funding to cover the cost of administrative support for up to the same working hours (consultations/treatment time) as those hours undertaken by the visiting specialist; but not for visiting health professionals providing upskilling or preparation of upskilling materials.^{35,58} - The ITC Program implementation guidelines (2018) state that ICDP funded outreach worker duties include community liaison, administration and support.³⁷ <u>Policy Framework</u> - The Roadmap to Close the Gap for Vision (2012) recommends funding for "outreach workers" through the ICDP; and the provision of eye care education to teachers so they can identify students with potential eye problems.³⁶
NT	<u>Progress Report</u> The NACCHO report on Eye Health Service Delivery (2016) noted the position of Ophthalmology Indigenous Liaison Officer in Central Australia region created through the Central Australia and Barkly Integrated Eye Health Strategy group.⁴²

No related references identified in reviewed documents for NSW, VIC, SA, WA, QLD, and Tasmania.

4.1.2 TRAVEL, TRANSPORT AND ACCOMMODATION

Evidence from the exploratory literature, shows health staff often have to either 'work the system', or work outside of the system to organise transport for patients. This process is inefficient and often unrecorded and unrecognised.⁵⁹ A QLD study provides evidence of specific roles that were developed to coordinate local transport to support home visits in chronic disease care.⁶⁰ Other aspects such as the arrangement of spousal accommodation when patients are admitted to hospital, as evident in cardiac care⁴⁴, should also be considered for patients with cataract. To

create integrated care structures, Aboriginal mental health services have been designed to enable transport and accommodation to be integrated across disciplines and organisations to lower barriers to access.⁴⁹ A recommendation from a focus group to improve care-coordination in pregnant patients with diabetes was made to create the role of “traffic controller”, to improve referral, treatment and transport for patients along the whole patient pathway.²⁸

Due to barriers related to patient rurality, geographic distance of eye care services, and complex socioeconomic determinants linked to poverty and cultural marginalisation,¹⁰ Aboriginal Australians require additional support to travel outside of their communities to attend eye care. A 2018 study,⁵⁴ found the introduction of “regional cataract surgery coordinators” at the primary care level increased rates of cataract surgery completion among Aboriginal patients from 16% to 45%. This increase was achieved by introducing additional non-clinical support functions such as facilitating access to transport and accommodation.⁵⁴ A 2017 study analysing the factors influencing attendance to specialist appointments identified transport drivers as the cornerstone in enabling patient attendance due to their familiarity of the local population.⁶¹ Chronic care coordinators have also been noted to support patients by organising travel assistance.³⁰

Policy documents referencing non-clinical support roles in the area of travel, transport and accommodation are shown in Table 7, including the type of document it was referenced in. Travel schemes are available to cover the cost of transport, accommodation, and one escort in all states, however the criteria and administration involved in claiming subsidies is burdensome. Funding is available through the ITC program specifically for care coordinators or outreach workers to arrange travel. The Roadmap to Close the Gap for Vision³⁶ (policy framework) outlined in 2012 that transport drivers were underfunded. Evidence from the eye health literature outline the importance of transport drivers,⁶² however currently there is no clear or direct funding for these roles within the policy environment, resulting in the role being split amongst other health service staff on an ad-hoc basis. In NSW, the Isolated Patient Travel and Accommodation Assistance Scheme (IPTAAS), works on a reimbursement basis, creating barriers for low-income patients who do not have the money to pay for travel costs upfront.

Table 7: Policy documents referencing non-clinical roles related to travel, transport & accommodation.	
National	<u>Program Guidelines</u>
	The ITC Program implementation guidelines (2018) states that where transport, specialist/allied health or an urgent service is required the Supplementary Services Funding Pool is available to ITC Care Coordinators or Outreach Workers.³⁷
	<u>Progress Report</u>
	The NACCHO report on Eye Health Service Delivery (2016) highlighted that travel is daunting to Aboriginal patients – sometimes patients are allowed one support person to accompany them.⁴²
	<u>Policy Framework</u>
	The Roadmap to Close the Gap for Vision (2012) states that employing transport drivers for eye health activities is underfunded.³⁶

NSW	<u>Program Guideline</u> The NSW IPTAAS Guidelines for Assessment (2015) states: - Financial assistance towards travel and accommodation costs is provided for one escort/carer where the referring medical practitioner or treating specialist certifies that it is medically necessary for an escort/carer to accompany the patient during their journey and/or to remain with them during the period of treatment. Escorts must be over 18 years of age.⁶³ - Travel assistance is based on a system where costs are paid upfront and the patient/escort applies for a reimbursement afterwards. The system provides a subsidy and is not designed to provide a full reimbursement.⁶³
NT	<u>Program Guideline</u> The NT Patient Assistance Travel Scheme guidelines (2017) states: - One escort is approved per patient, and consideration is given to the ability, experience and relationship to the patient before approval. Escorts must be 18 years of age.⁶⁴ - Escorts can only claim public transport tickets when they accompany a patient to a maximum value of \$50 per return journey for ground transport.⁶⁴ - Escorts are also responsible for costs associated with their travel if there is a gap between the subsidy and actual cost.⁶⁴ - If a replacement is required, or an escort must leave prior to the original expected departure, return travel will be for either, but not both.⁶⁴ - Automatic approval of an escort is only given when a patient is traveling interstate for surgery or intensive treatment.⁶⁴
VIC	<u>Program Guideline</u> The Victorian Patient Transport Assistance Scheme (VPTAS) (2015) guidelines state: - VPTAS patient travel claim forms can be signed by an authorised officer including: resident medical officer, intern, nursing unit manager, social worker, ward clerk, or administration staff. The referring GP is not an authorised officer.⁶⁵ - Travel assistance available for a maximum of one eligible escort (unless patient in under 18 years of age).⁶⁵ - Commercial air travel is covered for an escort of treatment location exceeds 350km one way.⁶⁵ - An escort who does travel, but does not stay can claim two return journeys. Approval must be granted by an approved medical specialist and state the necessity and nature of the accommodation assistance.⁶⁵
SA	<u>Program Guideline</u> The SA Patient Assistance Transport Scheme (2016) guidelines state: - In some circumstances, an applicant may be able to access a subsidy for an escort to support them in their travel and treatment needs. An escort is responsible for the client's travel and accommodation needs during treatment.⁶⁶ - Patient is entitled to one escort who must be 18 years of age.⁶⁶ - Travel and accommodation subsidies for people on the Anangu Pitjantjara Yankunytjatjara (APY) Lands requiring medical specialist services is the responsibility of the Nganampa Health Council.⁶⁶
WA	<u>Program Guideline</u> The Patient Assisted Travel Scheme Policy for the WA Country Health Service (2015) states: An escort needs to be considered medically necessary by their doctor/specialist, such as a patient needing somebody to deliver physical requirements. They must be over 18 years of age and able to care for the patient. They are responsible for transport and accommodation during treatment, and attend all appointments.⁶⁷
QLD	<u>Program Guideline</u> The QLD Patient Travel Subsidy Scheme guidelines (2016) state: - An escort is defined as a person who accompanies a patient when they travel to access a specialist medical service. This can be to assist them in their treatment, in an active care role or if the patient is impaired. The escort must be 18 years or older.⁶⁸ - Escort is automatically approved if the patient has a visual impairment.⁶⁸

No related references identified in reviewed documents for Tasmania

4.1.3 INTEGRATING & LINKING DIFFERENT SERVICES

In the area of mental health, Indigenous Mental Health Workers seek to create linkages between health services and other services such as housing, financial support⁵⁰ and local community organisations such as Aboriginal Lands Councils⁶⁹ to achieve better holistic outcomes for patients.⁴⁹ A similar approach is noted among “maternal infant care workers”, who also assisted pregnant women and mothers in accessing housing services.⁷⁰ Health networks are also an integral mechanism whereby patients can be linked to different services associated with their health needs, various examples were found in cancer⁷¹ and chronic disease care (Men’s Sheds).⁷²

Eye care pathways are long and complicated for Aboriginal patients, and include a multitude of different services (ACCHS and mainstream), clinicians, and support staff.³⁶ Due to the complexity of the pathway, integrating and linking different services (primary, tertiary, and support services) was identified as a key non-clinical function. Eye health coordinators are central in the integration of primary eye care into tertiary services,¹² and diabetic eye care programs,⁷³ with one study stating that in locations where this role is not present, a higher burden is placed on specialist and tertiary services which are resource restrictive.⁷⁴ Due to high rates of diabetes among the Aboriginal Australian population (38% > 55 years),⁷⁵ and the associated risk of diabetic retinopathy, integration of primary eye care into chronic disease care is a central task whereby chronic care coordinators are fundamental.^{30,54} A 2007 study³⁰ noted the involvement of an Aboriginal Elders committee as a strategy to improve integrated chronic disease services. However a shift from REHC role specific funding to pooled funding for chronic disease management, has been perceived as detrimental to eye health.¹²

Policy documents referencing non-clinical support roles in the area of integrating & linking different services are shown in Table 8, including the type of document it was referenced in. Eye health coordinators and ITC coordinators are acknowledged in the policy environment as key to integrating and linking services. In Victoria the state wide eye health coordinator is responsible for facilitating relationships between ACCHSs and mainstream services. In NT and QLD education programs have been provided to diabetes educators to build understanding around the role of optometry and create opportunity for referrals.

Table 8: Policy documents referencing non-clinical roles related to integrating & linking different services.	
National	<u>Program Guideline</u> • The VOS Service Delivery Standards (2015) supports eye health coordinators to improve integration of eye health services.⁵⁷ • The ITC Program implementation guidelines (2018) states that ITC coordinators must liaise with ACCHSs to discern what types of care can be provided within the practice and what needs to be outsourced.³⁷
NSW	<u>Policy document</u> • The policy directive for the NSW Aboriginal Health Plan (2013) states that the Local Health District aims to strengthen the operation and establishment of Aboriginal health partnerships and build these partnerships into governance and accountability structures.⁷⁶
NT	<u>Progress Report</u> • The third progress report under the NFAPEH (2015) states that The Ipswich Diabetes Service partnered with the QLD and NT Optometry Association to provide education programs to diabetes educators on the role of the optometry in care of diabetes patients. However a lack of diabetes educators is noted as an ongoing challenge.³⁸

VIC	<u>Policy document</u> The Koolin Balit Aboriginal Health Plan (2012) acknowledged the VACCHO state-wide coordinator for Aboriginal eye health as the facilitator of relationships between mainstream eye care providers and ACCHSs.⁴¹
QLD	<u>Progress Report</u> - The third progress report under the NFAPEH (2015) states that The Ipswich Diabetes Service partnered with the Queensland and Northern Territory Optometry Association to provide education programs to diabetes educators on the role of the optometry in care of diabetes patients.³⁸ - The NACCHO report on Eye Health Service Delivery (2016) reported that the Indigenous Diabetes, Eyes and Screening (IDEAS) van received \$5 million in funding in 2014 from AMS services and the RFDS in QLD and works in 41 communities. The IDEAS van links with the ACCHS to share and synchronise referrals and patient records to ensure continuity of care.⁴²

No related references identified in reviewed documents for SA, WA and Tasmania.

4.2 CULTURAL LITERACY, BROKERAGE & SUPPORT

Due to an increasing focus on clinical responsibilities of AHWs, cultural brokerage is supported less by the health system. A chronic disease study found that gearing AHW roles towards education and cultural mentorship was positive, but not sufficient in creating significant change in the context of health services that focus on acute care.⁶⁰ Acknowledging the importance of adhering to gender roles and norms structured by Aboriginal cultures (where practiced), including having specific male and female health worker roles, has been shown to support culturally safe chronic care in Yolngu communities (NT).⁷⁷ In the area of mental health in QLD, “Indigenous Worker” roles seek to provide a real voice and advocate on behalf of their communities, this model involves a team of two workers (one Aboriginal and one non-Aboriginal) who focus on prevention, health promotion, early intervention and community work.⁴⁹ Similar approaches have been taken in metropolitan Victoria, whereby an ALO and cardiac nurse worked together to enhance cultural safety within cardiac rehabilitation.⁷⁸ Examples from cancer,⁷⁹ renal,⁵ and sexual health⁸⁰ services, show how placing Elders and Aboriginal health service staff in cultural knowledge authoritative positions created new ways of being, knowing and doing among non-Aboriginal staff. In particular, leveraging Elders into positions that enhance cultural support for patients and cultural knowledge exchange for health practitioners is recommended in several studies.^{50,69,81,82} A Canadian study describes a community level tele-ophthalmology clinic designed to provide services for Aboriginal Canadians (Cree peoples) with diabetes.⁸³ To overcome linguistic and cultural barriers, nurses fluent in Cree were hired, and cultural artefacts were included in clinic screening protocols.⁸³ A teepee (traditional Cree shelter) was set up outside the teleophthalmology clinic whereby an Elder would conduct a smoking ceremony, and patients would engage in cultural activities, and discussions around holistic health and goals for healthy living.⁸³ Before the program was introduced the tele-ophthalmology clinic attendance rate was 20%; this increased to 50% in the first year and 85% in the second year.⁸³

Providers of cultural support include AHWs,^{31,84-86} community-based liaison officers,^{31,85,87,88} eye health coordinators,⁵⁶ family members,^{84,89,90} Elders,⁸⁵ and Indigenous reference group members.⁹¹ Several studies noted how different types of cultural brokerage prompted and facilitated attendance at eye care clinics,^{56,62,74,86-88,92} as well as positively impacting patients’ understanding of medical processes.⁸⁴ Cultural assistance received from Elder groups and interpreters in chronic disease care⁸⁵ and from community liaison in trachoma control,³¹ were also reported.

A 2011 study looking at coordination of outreach eye care services highlighted the importance of community based liaison officers and AHWs in acting as brokers between health services and patients; whereby eye care practitioners voiced that these roles are vital to patient attendance.¹² An evaluation of the Specialist Outreach Service (SOS),⁸⁴ stated AHWs are well positioned to act as cultural brokers, in that they positively impact a patients' understanding of medical processes. However, it is important to note, that while the role of the AHW originally focused on two-way medicine and cultural brokerage; over time this role has shifted away from these aspects and towards increasing biomedical skills and responsibilities.^{93,94}

Local staff and community members serve as an important source of information in ensuring health promotion programs and materials are culturally appropriate, relevant and understandable. A South Australian study⁹⁵ consulted an REHC to ensure health promotion materials targeting visual impairment were culturally appropriate. Trachoma control programs have noted that the involvement of members from an Aboriginal consultative group in program planning, allowed cultural and linguistic appropriateness and relevance of health promotion resources.⁹⁶ Additionally, an NT study³¹ reported that support from community members, such as providing cultural and contextual knowledge, was crucial in planning trachoma control programs, yet noted that this kind of support often goes unpaid.

Policy documents referencing non-clinical support roles in the area of cultural literacy, brokerage & support are shown in Table 9, including the type of document it was referenced in. While there is apt acknowledgement for the need to support cultural brokerage in the health system within the national policy environment, this is only supported in some states with specific funding and programs. ALOs are broadly recognised as key to providing cultural brokerage in mainstream spaces, despite stakeholders noting a lack of these roles on the ground. Moreover, there is poor recognition and funding of the work that community-based roles such as liaison officers, cultural advisors, and Elders do in providing cultural support to patients and cultural advice to health staff (also identified in the stakeholder analysis). Funding for cultural awareness training for outreach optometrists is provided under VOS.

Table 9: Policy documents referencing non-clinical roles related to cultural literacy, brokerage & support.

National	<u>Policy Document</u> - The NFAPEH (2005) defined the facilitation of ALOs to reduce barriers to access ophthalmology services in mainstream hospitals as a key action item addressing cultural accessibility.⁹⁷ - The National Cultural Respect Framework (2016-2026) endorses the identification and remuneration of cultural professionals (cultural brokers, traditional healers) to assist in understanding health beliefs and practices of Aboriginal people as a key focus area.⁹⁸ <u>Implementation Plan</u> - The NFAPEH implementation plan (2014) acknowledges the need to continue implementing the Mainstream Primary Care Programme which provides Indigenous Health Project Officers who work to improve capacity of primary care providers including eye professionals to deliver culturally sensitive care.⁹⁹ <u>Policy Framework</u> - The Roadmap to Close the Gap for Vision (2012) recommends outreach service providers undergo cultural awareness training.³⁶ <u>Program Guideline</u> - The VOS Service Delivery Standards (2015) states VOS funding is available for cultural awareness training for outreach optometrists.⁵⁷ - Outreach service providers undergo cultural awareness training.¹⁰⁰ - The ITC Program implementation guidelines (2018) states that the role of Care Coordinators is to provide culturally appropriate care, and advocate on behalf of Aboriginal clients.³⁷
NSW	<u>Policy Document</u> - The Aboriginal Cultural Training Framework for NSW Health policy directive (2011) states that administrative and support staff should be offered Aboriginal cultural training courses.¹⁰¹ - The Aboriginal Workforce Strategic Framework 2016-2020 policy directive instructs organisations to take specific action to improve the representation of Aboriginal people across all roles and levels; as part of an ongoing commitment to culturally safe workplaces for Aboriginal people.¹⁰²
NT	<u>Policy Document</u> - The NT Health Aboriginal Cultural Security Framework (2016-2026) endorses the ongoing need for existing initiatives dedicated Aboriginal positions including roles for Liaison Officers, Health Workers, Health Practitioners and Community Workers. It also states the importance of including Aboriginal leaders and Elders in the design, delivery and evaluation of services to ensure culturally safe practice.¹⁰³ - The NT Aboriginal Health Plan (2015-2018) states that communication will be further strengthened through improved health literacy and accessible written materials.¹⁰⁴ <u>Progress Report</u> - The NACCHO report on Eye Health Service Delivery (2016) states that Central Australia and Barkly Integrated Eye Health Strategy group created the role of Ophthalmology Indigenous Liaison Officer which aims to ensure cultural safety along the patient journey.⁴²
VIC	<u>Policy Document</u> - The Victorian government Aboriginal health, wellbeing and safety strategic plan (2017-2027) and the Aboriginal Health Workforce plan (2014-2017) endorses the development of career pathways for Aboriginal people working in non-clinical roles to ensure culturally safe health care.^{105,106} - One of the Victorian government's Koolin Balit state-wide action plan's supplementary aims is to enhance ALO training and identify training needs with VACCHO.¹⁰⁷ - The Aboriginal Health Workforce plan (2014-2017) states that Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) program supports ALO programs, and requires services to report on cultural responsiveness to the department.¹⁰⁶ <u>Progress Report</u> - The third progress report under the NFAPEH (2015) states that Victorian Eye Service supported ALOs to work alongside optometrists to support culturally appropriate services.³⁸

SA	<u>Policy Document</u> - The SA Aboriginal Health Workforce Framework (2017-2022) states its commitment to enforcing and developing non-clinical roles in Aboriginal health including: AHWs, ALOs, and cultural consultant roles.¹⁰⁸ - The SA Aboriginal Health Care Plan (2010–2016) states that the establishment of Aboriginal cultural advisor positions and cultural advocates as a key strategy to quality service provision. In addition it is acknowledged that the utilisation of ALOs are attributed to lower rates of self-discharge.⁴³ <u>Progress Report</u> - The third progress report under the NFAPEH (2015) states that there is an ALO program supported in Adelaide hospital.³⁸
WA	<u>Policy Document</u> - A key strategy of the WA Aboriginal health and wellbeing framework (2015-2030) and the WA Aboriginal Workforce Strategy (2014-2024) is to develop a strong, skilled and growing Aboriginal health workforce across all levels.^{109,110} - The WA Health Aboriginal Cultural Learning Framework (2012) endorses the use of policies, programs and practices designed to attract, upskill and retain Aboriginal staff and to upskill all staff to respond to Aboriginal health issues.¹¹¹
QLD	<u>Policy Document</u> - The QLD Aboriginal and Torres Strait Islander Cultural Capability Framework (2010-2033) identifies the appointment of Aboriginal and Torres Strait Islander Cultural Advisors as a way to develop leadership and partnerships. Moreover it acknowledges that inclusive recruitment and retention involves the clarification, recognition and enhancement of AHW and ALOs.¹¹² - The QLD Making Tracks Investment Strategy identifies ALOs as key to providing cultural support to patients and cultural mentorship to clinicians treating Aboriginal patients.¹⁹

No related references identified in reviewed documents for Tasmania.

4.3 INTERPRETING & TRANSLATION

Several studies from the exploratory literature note the difficulty in obtaining Aboriginal language interpreters, and the ad-hoc use of family members as interpreters in their absence.¹¹³⁻¹¹⁵ Despite larger Aboriginal language groups, such as the Yolngu peoples, having a higher number of interpreters; positive changes in health practice occur slowly.¹¹⁵ An NT study outlined the importance of involving female Elders in the translation of clinical information regarding foetal anomaly screening; whereby researchers found that the concept of ‘risk’, which is often used to explain the need for preventive measures in health, is not translatable in Yolngu Maatha (language of the Yolngu peoples).¹¹⁶ Having community-based AHWs present in consultations has been reported to enhance understanding and communication between patients and clinicians in hospital settings in the NT,^{4,117} and primary care settings in QLD.¹¹⁸ Chronic disease programs have also involved AHWs in passing on and translating health information, which minimises anxiety and confusion.^{2,119} ALOs working in cardiac care helped minimise stress among patients, by passing on information.⁴⁴ However using AHWs or ALOs as interpreters and translators, can also create overwhelming expectations if they are not sufficiently equipped.¹¹⁷

The normalisation of biomedical terminology and assumption of scientific literacy among Aboriginal patients in health spaces, continues to impact accessibility and uptake of eye care services.¹⁰ In Aboriginal language speaking communities, interpreting and translating are crucial non-clinical functions that bridge communication between Aboriginal patients and non-Aboriginal clinicians. Previous studies have noted utilising Aboriginal interpreters as part of integrated chronic disease care delivery,³⁰ and to translate trachoma control surveys administered in schools.¹²⁰ A 2016 study reported involving AHWs to provide interpreting assistance during the development of a health promotion video targeting diabetic retinopathy.¹²¹ However, issues surrounding the availability of

Aboriginal interpreters^{84,113} often results in this important function being undertaken by other roles including community liaison,¹¹ clinic staff, and family members.¹²²

Policy documents referencing non-clinical support roles in the area of interpreting and translation are shown in Table 10, including the type of document it was referenced in. State-based language policies acknowledge the link between the availability of interpreters and culturally safe care. The NT, WA and QLD language policies (key states where Aboriginal languages are still spoken), specifically note the need for Aboriginal language interpreters; yet in the latter two states it is acknowledged that availability of such interpreters are scarce. All states require interpreters to be accredited by the National Accreditation Authority for Translators and Interpreters (NAATI). However in WA it is noted that Aboriginal Interpreters can instead be registered with the Kimberley Interpreting Service. State-based policies do not recommend the use of carers, family, and friends as interpreters, despite the lack of trained and registered Aboriginal interpreters. Training clinical staff on how and when to engage interpreters is recommended nationally.

Table 10: Policy documents referencing non-clinical roles related to interpreting.	
National	<u>Policy Framework</u> The Roadmap to Close the Gap for Vision (2012) states that language support for patients in WA, NT and SA is important and not prioritised. It identifies community liaison roles as a vital link between individuals, their families and the clinic and its services, including interpretation and translation support.³⁶
NSW	<u>Program Guideline</u> The NSW government policy directive for Standard Procedures for Working with Health Care Interpreters (2017) states: - In theory health practitioners are responsible for booking interpreters, yet in practice this is delegated to administrative staff.¹²³ - Interpreters are engaged to facilitate communication between two parties who do not speak the same language. Interpreters support patients/carers/families to make informed decisions and avoid risk of harm.¹²³ - A health care interpreter must be certified or accredited by NAATI. Only in exceptional circumstances should a person interpret if they are not accredited or certified by NAATI.¹²³
NT	<u>Policy Document</u> - The NT Aboriginal Health Plan (2015-2018) and NT Aboriginal Cultural Security Framework (2016-2026) state that access to interpreters is key to culturally safe health care, and it should be ensured that Aboriginal patients have access to accredited interpreters.^{103,104} - The NT Aboriginal Cultural Security Framework (2016-2026) states the broad area of “communication” as one of its priority domains, whereby provision of training to clinical staff on how to engage interpreters for Aboriginal patients; and tracking progress by looking at the number of consumers who requested an interpreter and who received one, are defined as key strategies.¹⁰³
VIC	<u>Program Guideline</u> The Victorian Government Language Services Policy (2017) states: - NAATI interpreters are to be used where possible, and offered to all patients who have limited or no English language skills, and at no cost to the patient. Clients should be aware of their right and the pathways to access an interpreter service.¹²⁴ - Family members should not interpret for an individual; every reasonable effort must be made to use an accredited interpreter before a family member/friend may assist.¹²⁴ - The language policy framework is underpinned by recognition that carer participation enhances culturally responsive health care delivery.¹²⁴ - Culture and language should be considered in the design and delivery of language/interpreter services.¹²⁴

SA	<u>Policy Document</u> - The SA Aboriginal Health Care Plan (2010-2016) endorses the utilisation of interpreters wherever necessary.⁴³ <u>Program Guideline</u> - The SA Aboriginal Languages Interpreters and Translators Guide (2013) states that where communication in English is a barrier to an individual/group communicating with the government, an interpreter should be used. Where consent is required, and in instances where an action/decision will have a critical impact, the use of these services is imperative.¹²⁵ - The SA Health Guide for Engaging with Aboriginal People (2013) recognises ALOs as knowledgeable in communication and engagement with Aboriginal patients.¹²⁶ <u>Progress Report</u> - The third progress report under the NFAPEH (2015) states that Adelaide hospital offers an Aboriginal interpreter service.³⁸
WA	<u>Policy Document</u> - The WA Health System Language Services Policy (2017) acknowledges that while Vocational Education & Training or NAATI accreditation of interpreters is preferred, this may not be available for Aboriginal language speakers. Alternatively Aboriginal interpreters can/should be registered with the Kimberley Interpreting Service. It is also recognised that carers of clients may also require language services.¹²⁷ <u>Program Guideline</u> The WA Health System Language Services Policy Guidelines (2017) states: - It is not appropriate to tell a patient or carer to “bring an interpreter”.¹²⁸ - The interpreter service must be advised of the client’s name/and skin group, so that cultural rules may be adhered to (e.g poison skins).¹²⁸ - Patients have the right to have a carer present and the role that carers play in an interpreting context should be made clear.¹²⁸ - Friends and family are not qualified interpreters, however where an interpreter is not available reasonable attempts should be made to understand patient concerns using a family member.¹²⁸ - The WA Patient Assisted Travel Scheme Policy WA Country Health Service (2015) states that escorts are approved when a patient requires a translator.⁶⁷
QLD	<u>Policy Document</u> - The QLD Aboriginal and Torres Strait Islander Cultural Capability Framework (2010-2033) communication framework specifies that interpreter services should be sought when necessary; however it is acknowledged that a shortage of interpreters is a repeated difficulty.¹¹² - The QLD Language Services Policy (2016) aims to enhance access to qualified interpreters and develop a plan to ensure services can still be delivered in the absence of one; train staff in how to work with interpreters, including their obligation to provide efficient and inclusive services for people that are not proficient in English; and implement appropriate arrangements for funded non-government organisations to engage interpreter services.¹²⁹ <u>Program Guidelines</u> The QLD government Language Services Guidelines (2016) acknowledges that there are very few accredited interpreters in QLD Aboriginal and Torres Strait Islander languages; NAATI may be able to provide assistance in sourcing them. Furthermore, the guidelines state the importance of making sure staff are aware that the refusal to provide an interpreter is potentially discriminatory and important in obtaining consent; however friends and relatives should not be used as interpreters. The guidelines also note that some QLD government agencies employ cultural liaison workers to support communication between Aboriginal language speakers and service providers.¹³⁰
TAS	<u>Program guidelines</u> The Services Guidelines for Tasmanian Government Agencies (2016) aims to enhance access to interpreters and translation services to enable equitable access. The guidelines promote the use of credentialed interpreters, and do not endorse the use of friends and family members as interpreters due to bias or lack of competence.¹³¹

4.4 HEALTH PROMOTION & PATIENT EDUCATION

Understanding cultural governance and kin structures,^{72,132} and involving Elders in the design and delivery of health promotion and education ensures information is passed to the community appropriately and organically.^{2,27,81,116} The importance of AHWs and community-based liaison workers in spreading information verbally within the community are outlined in studies in the area of tuberculosis¹³³ and mental health¹¹⁹. In chronic disease care AHWs have successfully used storytelling as a way of promoting better dietary knowledge and practices.⁶⁰ AHWs have also used theatre to help educate community members about the importance of cervical screening tests.³ Distributing health information through family members and extended family networks, has been reported to increase successful referrals,¹³⁴ and assist in chronic illness management.² A QLD study investigating chronic disease health promotion techniques, noted peer-to-peer information sharing, in existing informal networks such as “The Murri Grapevine”, as the most successful form of communication and influence.⁷² In the NT, involving community grocery store staff in food labelling, and explanation of dietary information, contributed positively to diabetes awareness.²⁴ Group-based approaches to discussing health information, and creating spaces in which health topics may be discussed was also outlined as an effective strategy to increase foetal anomaly screening.¹¹⁶

Health promotion strategies are a crucial part of eye health programs, of which success involves a whole of community approach.⁸⁹ A 2016 study noted that involving community members in the design of a health promotion video targeting diabetic retinopathy was fundamental to its effectiveness.¹²¹ AHWs have been central in assisting with trachoma elimination, however previous studies have identified that low levels of trachoma control knowledge among AHWs, and a lack of clarity around the role of AHWs in schools present barriers.³¹ School staff play a key role in delivering and maintaining hygiene information targeted at trachoma elimination.^{31,135} For example a 2014 study¹²⁰ noted that 33% of school staff believed that young children presenting with eye and nose secretions every day was normal, posing a major barrier to trachoma elimination. It is suggested that fostering school staff (principals, teachers) as trachoma educators can increase awareness, engagement and knowledge in Aboriginal communities.^{89,120}

Community members and staff in community workplace settings (lands council, youth services, women’s groups, Elders groups), while often not remunerated, are also key to successful trachoma control programs, including sharing local knowledge with program coordinators, campaigning for improvements in housing and infrastructure,³¹ spreading information about hygiene practices,¹²⁰ and delivering practical activities to community members.⁸⁹ Community-based roles can also be utilised to support mass drug administration to treat active trachoma.³¹

Policy documents referencing non-clinical support roles in the area of health promotion & patient education are shown in Table 11, including the type of document it was referenced in. The national policy environment acknowledges the need to improve the role of families, communities, and school staff in the delivery of eye health promotion strategies, including (where relevant) trachoma control. The need to support Outreach Workers and eye health ‘ambassadors’ to raise awareness and promote eye health is acknowledged in the National Framework for Action to Promote Eye Health. The ICDP supports the provision of education to Aboriginal community members to address risk factors associated with chronic disease (including diabetic retinopathy).

Table 11: Policy documents referencing non-clinical roles related to health promotion & patient education.

National	<u>Policy Document</u> - The NFAPEH endorses the role of: families and community members in trachoma control promotion; and parents and school staff in referring children with potential eye problems. Furthermore, Outreach Workers are acknowledged as key to raising awareness of eye health needs and supporting patient access to eye care.⁹⁷ <u>Policy Framework</u> - The Roadmap to Close the Gap for Vision (2012) recommends the involvement of families and community members in trachoma control and diabetes health promotion; and the support of community-based eye health ambassadors for peer education, and sharing positive patient experiences.³⁶ <u>Healthcare Standards</u> - The National Guide to a Preventative Health Assessment (2012) states that involving families/community members in trachoma control, and ensuring safe and functional washing facilities are available at home, in childcare and at school is recommended to support behavioural change.¹³⁶ <u>Program Guideline</u> - The MOICDP Service Delivery Standards Addendum (2017) recommends engagement with, and provision of education in, Aboriginal communities to address chronic disease risk factors.¹³⁷
NSW	<u>Policy Document</u> The NSW policy directive for interpreters (2017) states that in group health education sessions, materials and a briefing should be given to interpreters prior to the session. Debriefing between a health practitioner and health care interpreter must be conducted to raise any feedback points, including cultural issues.¹²³
NT	<u>Progress Report</u> The third progress report under the NFAPEH (2015) reported that between 2011-2014 visits were undertaken to remote NT communities to provide planned eye health education and information, including supporting community member participation in trachoma promotional campaigns. In the same period a range of activities targeted at diabetic eye health were provided, including improving the capacity of carers and families to promote eye health.³⁸
SA	<u>Progress Report</u> The third progress report under the NFAPEH (2015) reported that eye health educators were employed in SA under the 'My eye health program' to deliver education days.³⁸
WA	<u>Policy Document</u> WA Aboriginal Health and Wellbeing Framework (2015–2030) identifies strengthening the role of peer education models to address poor health outcome risk factors as one of its priority areas.¹⁰⁹

No related references identified in reviewed documents for VIC, QLD and Tasmania.

4.5 COMMUNITY ENGAGEMENT & TRUST-BUILDING

Aboriginal patients' distrust of, and non-engagement with, health services is rooted in a long history of colonisation, racism and dispossession, including the health system's role in supporting policies that produced the Stolen Generations.^{5,138,139} Actively seeking the engagement of Elders to build trust and engage the wider community has been successfully used in projects focusing on food security,¹⁴⁰ and sexual health.^{80,141} Elders are seen as examples to the wider community, therefore the use of services can encourage others to do the same.¹⁴² However, the way Elders are treated within the health system, will also have an impact on uptake and attendance of services among the wider community.²

An NT study reported that AHWs who undertook community activities and home visits improves chronic disease management of patients, yet it was noted that much of this work is not recorded and may be unrecognised or undervalued.²⁴ In the area of mental health, similar approaches outlined strategies undertaken by community-based mental health workers including engaging community members at football matches. Community health networks are also noted in the area of cancer care as key to community engagement; examples include providing a starting point for referrals to allied health services and counselling, demystifying screening processes, addressing fears and barriers, and allowing community members to build relationships with others who may have similar health concerns.⁷¹

Historical experiences still impact patient decision-making in eye care today.¹⁰ This highlights the ongoing need for eye care services to engage and build trust with the Aboriginal communities they work in. AHWs and REHCs are seen as vital by eye care practitioners,^{12,143} and often act as a bridge to communities by prompting and facilitating attendance to clinics.⁶¹ Staff from community-based health services and hospitals stated AHWs were ideal in providing liaison between eye care services and the community.¹⁴⁴ In the context of diabetes, community development roles assist with networking in the community, and focus on prevention, increased access, and improved services in remote NT communities.³⁰

Policy documents referencing non-clinical support roles in the area of community engagement & trust-building are shown in Table 12, including the type of document it was referenced in. National policies and some state-based policies (NSW, NT, VIC, and WA) acknowledge the need to engage community members in the design and delivery of health care services. In Victoria, the state-wide eye care coordinator is specifically responsible for building eye health awareness among community members. In WA there is emphasis placed on the role of community members and networks in strengthening care; however it is unclear how this is to be funded or achieved.

Table 12: Policy documents referencing non-clinical roles related to community engagement & trust-building.

National	<u>Policy Document</u> - The COAG National Indigenous Reform Agreement (2008) defines engagement with Aboriginal community members and leaders as central to the design of programs and services.³² <u>Policy Framework</u> - The Roadmap to Close the Gap for Vision (2012) acknowledges that community liaison provides a vital link between individual community members, their families and the clinic and its services.³⁶
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National	<u>Program Guideline</u> - Grant Programme Guidelines for the Indigenous Australians' Programme (2015) states that engagement with Aboriginal community members and leaders should be central to design of programs and services.¹⁴⁵ - The Indigenous Australians' Health Programme Guidelines (2018) states that health services are expected to have knowledge of community needs and linkages to community groups.¹⁰⁰ - The ITC Program implementation guidelines (2018) states that ITC funded Outreach Workers don't require a formal qualification but do require strong links to the community where they work. Furthermore, Primary Health Networks should base service delivery and commissioning arrangements through the inclusion of consumer input through Community Advisory Committees.³⁷ <u>Progress Report</u> - The Closing the Gap Prime Minister's Report (2018), defines engagement with Aboriginal community members and leaders as central to the design of programs and services.¹⁴⁶ - The ten-year review of the Closing the Gap Strategy (2018) recommends community consultations as key to the Closing the Gap strategy.¹⁴⁷
NSW	<u>Policy Document</u> The NSW Aboriginal cultural training framework policy directive (2011) states that consultation, collaboration and partnerships with community groups is essential.¹⁰¹
NT	<u>Policy Document</u> The NT Aboriginal Health Plan (2015-2018) aimed to increase involvement of Aboriginal communities in the governance, design, planning, development, delivery and evaluation of service planning and delivery.¹⁰⁴
VIC	<u>Policy Document</u> The Koolin Balit Victorian Government strategic directions for Aboriginal health (2012–2022) states that VACCHO's Aboriginal eye health coordinator role is responsible for improving community awareness.⁴¹
WA	<u>Policy Document</u> - The WA Health Aboriginal Cultural Learning Framework (2012) recognises service delivery is improved through increased Aboriginal community involvement.¹¹¹ - WA Aboriginal Health and Wellbeing Framework (2015-2030) states that services need to be easily accessible with a focus on returning care to the home by supporting and strengthening the community roles and networks in health care. There is a role for the health system to utilise community capacity and create community-led responsibility for health management. Priority areas include: increasing capacity for communities to take back care, control and responsibility for health and wellbeing, including the creation of systems that support communities to make informed choices in planning and service delivery.¹⁰⁹

No related references identified in reviewed documents for SA, QLD, and Tasmania.

4.6 SOCIAL & EMOTIONAL SUPPORT

In the exploratory literature, family members are noted as the key providers of social and emotional support. Knowledge of cultural roles played by family members is central in facilitating shared care with clinicians; for example, understanding the role of the matriarch incorporated in childbirth, childcare and rearing.^{72,141,148} Family support networks enhance chronic care management,² enable kidney transplants,^{5,52} and are crucial in palliative care relocation.¹⁴⁹ In general, family members help motivate a patient to be healthy and well.¹³⁴ Two studies noted the importance and commitment of Elders in providing social and emotional support by way of teaching cultural ways and traditional activities.^{81,150} Holistic approaches in cardiovascular care note AHWs placing a greater emphasis on the linkages between socioeconomic stressors and heart health, enquiring whether patients have adequate housing, money and family support in order to provide socioeconomically appropriate care.¹⁵¹ Yarning circles held at Men's Sheds have provided a safe environment for Aboriginal men to seek support in addressing issues related to mental health and

stress.¹⁵² A study looking at the role of AHWs in palliative care, noted that increasing the clinical responsibilities of community-based health workers has had a negative impact on patient care, as it has taken away from important social liaison and support aspects.⁴ Creating community networks or group activities (sport, art-making), has assisted patients in supporting each other in the areas of cancer care, mental health, and self-management of chronic diseases.^{71,81,153} An evaluation of a NSW midwifery program, provides an example of holistic antenatal care whereby a key function was social support and trust-building. This allowed vulnerable patients to access other support such as domestic violence services.¹⁵⁴ In the Central Australian context, Ngangkari (traditional healers) are often sought out to provide treatment for spiritual illnesses; thus having Ngangkari present in clinical spaces may assist patients in feeling emotionally supported.¹⁵⁵

The provision of social and emotional support can help patients feel more comfortable when accessing eye care, particularly in hospital settings, or health services that are outside their communities. Having family members or carers present for specialist care supports patient attendance, and improves communication with health staff.¹²² A 2018 study reported 31% of patients attending cataract surgery required a carer, likely due to reduced visual acuity.⁵⁴ As part of a regional cataract surgery program in QLD, a home support team provided meals and social support for patients and carers.⁵⁴

Policy documents referencing non-clinical support roles in the area of social and emotional support are shown in Table 13, including the type of document it was referenced in. Dedicated provision of funding to support escorts to accompany patients to attend ophthalmic surgery is available across all states. However only state-based travel schemes in NSW and Victoria allow escorts for the sole reason of social, emotional or cultural support. Additional assistance is provided to family members through the Victorian Patient Transport Assistance Scheme (VPTAS) where approved by a medical specialist. Despite a broader acknowledgement of the need for family-centered care, travel schemes in NT, SA, WA and QLD do not support escorts for social, emotional or cultural support.

Table 13: Policy documents referencing non-clinical roles related to social & emotional support.	
National	<u>Policy Document</u> The COAG National Indigenous Reform Agreement (2008) endorsed funding for counselling services, but not social and emotional wellbeing counsellors.³²
NSW	<u>Program Guideline</u> The NSW IPTAAS guidelines for assessment (2015) criteria approves escorts for cultural support reasons such as in the case of Aboriginal and Torres Strait Islander patients.⁶³
NT	<u>Program Guideline</u> The NT government PATS guidelines (2017) does not allow patient escorts for the sole reason of social/emotional support.⁶⁴
VIC	<u>Policy Document</u> - Koolin Balit Victorian Government strategic directions for Aboriginal health (2012–2022) endorses ALOs to assist patients in a hospital setting by assisting with social/emotional and cultural support.⁴¹ <u>Program Guideline</u> - VPTAS guidelines (2015) state that Family members may be eligible for VPTAS family support assistance if approved by a medical specialist.⁶⁵ - The Victorian government Language Services Policy (2017) states that family members should not interpret, however their role as emotional support should be emphasised.¹²⁴

SA	<u>Program Guideline</u> The SA PATS guidelines states that patients travel assistance does not allow patient escorts for the sole reason of social/emotional support.⁶⁶
WA	<u>Policy Document</u> - There is a role for the health system to utilise family capability. Priority areas include increasing capacity for families to take back care, control and responsibility for health and wellbeing. Aboriginal family systems of care need to be recognised and supported in policy.¹⁰⁹ <u>Program Guideline</u> - The WA Patient Assisted Travel Scheme Policy guidelines (2015) does not allow patient escorts for the sole reason of social/emotional/cultural support.⁶⁷
QLD	<u>Program Guideline</u> The QLD Patient Travel Subsidy Scheme guideline (2016) states that escorts are not approved solely for emotional support or to keep a patient company.⁶⁸

No related references identified in reviewed documents for Tasmania.

5 CONCLUSION

Non-clinical support functions are key to leveraging attendance and accessibility of preventive, primary and tertiary eye care services. Yet, a lack of adequate acknowledgement around the importance of some functions, clarity around the roles that perform them, sustainable policies, and funding and resources to support them remain key challenges. Part of the issue, is linked to difficulties estimating and discerning exactly how current funding is distributed in different regions and interdisciplinary health areas (such as chronic or integrated team care). This report provides various examples of the way non-clinical support is provided in other areas of Aboriginal health, in which eye health systems and services may adopt. However, improving access to support functions related to cultural literacy and brokerage, interpreting, and social and emotional support applies to all areas of Aboriginal health and reflects barriers in the health system at large. Furthermore, evidence from the data compiled in this report points to a disjuncture between an acknowledgement of the important role that family members provide in supporting Aboriginal patients to access care, and the provision of specific resources and programs to bolster this. Based on the evidence collated in this report, the following recommendations are proposed.

- Further research to provide:
 - Evidence of a model that measures the impact of non-clinical support roles in Aboriginal eye care.
 - A regional analysis to determine costing and current access to funds that support the delivery of non-clinical support in Aboriginal eye care.
 - A review of access to and funding of Aboriginal language interpreter services in communities that largely speak Aboriginal languages.
- Specific funding to support the work that community-based roles such as liaison officers, cultural advisors, and Elders do in providing cultural support to patients, and cultural advice to health staff.
- Changes to state based travel schemes in the NT, South Australia, Western Australia, and Queensland to support escorts for the reason of social, emotional, or cultural support.

This report has several limitations. First, reviewed policy documents were sampled purposively (rather than systematically) and therefore some documents of relevance may have been overlooked. Secondly, grey literature was not included in the systematic review, and as a result some relevant data may have been missed.

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7 APPENDIX

7.1 SYSTEMATIC REVIEW: INCLUDED ARTICLES

First Author	Title	Year
Anjou, M. D.	Correcting Indigenous Australians' refractive error and presbyopia	2013
Anjou, M. D.	Local co-ordination and case management can enhance Indigenous eye care - a qualitative study	2013
Anjou, M.D.	We can see the gap regional eye health coordination for indigenous Australians	2012
Baillie, R.	Improving organisational systems for diabetes care in Australian Indigenous communities	2007
Baunach, E.	The development of culturally safe and relevant health promotion resources for effective trachoma elimination in remote Aboriginal communities	2012
Boudville, A. I.	Eye health promotion to improve awareness and prevent vision loss among Indigenous Australians	2013
Boudville, A. I.	Improving eye care for Indigenous Australians in primary health care settings	2013
Boudville, A. I.	Indigenous access to cataract surgery: an assessment of the barriers and solutions within the Australian health system	2013
Copeland, S.	Understanding Indigenous patient attendance: A qualitative study	2017
Gruen, R. L.	Improving access to specialist care for remote Aboriginal communities: evaluation of a specialist outreach service	2001
Gruen, R. L.	Specialist outreach to isolated and disadvantaged communities: a population-based study	2006
Harch, S.	Management of type 2 diabetes - a community partnership approach	2012
Hsueh, Y. S.	Close the gap for vision: The key is to invest on coordination	2013
King, M.	Co-operative inquiry: the development of a visual impairment prevention program initiative for two Aboriginal communities in South Australia	2003
Lange, F. D.	Trachoma elimination in remote Indigenous Northern Territory communities: baseline health-promotion study	2014
Lange, F. D.	The impact of health promotion on trachoma knowledge, attitudes and practice of staff in three work settings in remote Indigenous communities in the Northern Territory	2017
Maher, L.	Eye health services for Aboriginal people in the western region of NSW, 2010	2012
Mak, D. B.	Prevalence and control of trachoma in Australia, 1997-2004	2006
McDermott, R. A.	Improving diabetes care in the primary healthcare setting: a randomised cluster trial in remote Indigenous communities	2001
Meyer, J.	Evaluating a health video on diabetic retinopathy	2016
Moynihan, V.	Coordination of diabetic retinopathy screening in the Kimberley region of Western Australia	2017
Penrose, L.	Process redesign of a surgical pathway improves access to cataract surgery for Aboriginal and Torres Strait Islander people in South East Queensland	2018
Smith, A. R.	Epidemiology of open- and closed-globe trauma presenting to Cairns Base Hospital, Queensland	2006
Tapp, R. J.	The roadmap to close the gap for vision–diabetes-related eye care in the Indigenous Australian population	2013
Turner, A. W.	Coordination of outreach eye services in remote Australia	2011
Turner, A. W.	Eye health service access and utilization in the National Indigenous Eye Health Survey	2011
Wright, H. R.	Barriers to the implementation of the SAFE strategy to combat hyperendemic trachoma in Australia	2010

7.2 EXPLORATORY REVIEW: INCLUDED ARTICLES

First Author	Title	Year
Arora, S.	Dismantling sociocultural barriers to eye care with tele-ophthalmology: lessons from an Alberta Cree community	2013
Aspin, C.	Strategic approaches to enhanced health service delivery for Aboriginal and Torres Strait Islander people with chronic illness: a qualitative study	2012
Baillie, J.	Improving preventive health care in Aboriginal and Torres Strait Islander primary care settings	2017
Barnett, L.	Culturally appropriate methods for enhancing the participation of Aboriginal Australians in health-promoting programs	2011
Brimblecombe, J.	From targets to ripples: tracing the process of developing a community capacity building appraisal tool with remote Australian Indigenous communities to tackle food security	2014
Campbell, S.	Paths to improving care of Australian Aboriginal and Torres Strait Islander women following gestational diabetes	2017
Cass, A.	Sharing the true stories: improving communication between Aboriginal patients and healthcare workers	2002
Chamberlain-Salaun, J.	Sharing success - understanding barriers and enablers to secondary prophylaxis delivery for rheumatic fever and rheumatic heart disease	2016
Conway, J.	The barriers and facilitators that indigenous health workers experience in their workplace and communities in providing self-management support: a multiple case study	2017
Cuesta-Briand, B.	'Connecting tracks': exploring the roles of an Aboriginal women's cancer support network	2016
Davies, J.	"Only your blood can tell the story"- a qualitative research study using semi-structured interviews to explore the hepatitis B related knowledge, perceptions and experiences of remote dwelling Indigenous Australians and their health care providers in north	2014
Daws, K.	Implementing a working together model for Aboriginal patients with acute coronary syndrome: an Aboriginal Hospital Liaison Officer and a specialist cardiac nurse working together to improve hospital care	2014
Deshmukh, T.	'It's got to be another approach': an Aboriginal Health Worker perspective on cardiovascular risk screening and education	2014
Devitt, J.	Difficult conversations: Australian Indigenous patients' views on kidney transplantation	2017
Einsiedel, L. J.	Self-discharge by adult Aboriginal patients at Alice Springs Hospital, Central Australia: insights from a prospective cohort study	2013
Emden, C.	Better medication management for Indigenous Australians: Findings from the field	2005
Gibson-Helm, M.E.	Identifying evidence-practice gaps and strategies for improvement in Aboriginal and Torres Strait Islander maternal health care	2018
Grace, J.	A rapid anthropological assessment of tuberculosis in a remote aboriginal community in northern Australia	2006
Harris, A.	The Aboriginal Mental Health Worker Program: The challenge of supporting Aboriginal involvement in mental health care in the remote community context	2007
Heil, D.	Shifting expectations of treatment: from 'patient as individual' to 'patient as social person'	2006
Hengel, B.	Perspectives of primary health care staff on the implementation of a sexual health quality improvement program: a qualitative study in remote aboriginal communities in Australia	2018
Henwood, M.	Men's health and communities of practice in Australia	2017
Hersh, D.	Speech-language pathology practices with Indigenous Australians with acquired communication disorders	2015
Hinton, R.	Developing a best practice pathway to support improvements in Indigenous Australians' mental health and well-being: a qualitative study	2015
Isaacs, A.N.	Mental health services for aboriginal men: mismatches and solutions	2012
Jan, S.	An holistic economic evaluation of an Aboriginal community-controlled midwifery programme in Western Sydney	2004
Jones, K.	Factors Relating to Access to Dental Care for Indigenous South Australians	2016
Katzenellenbogen, J.M.	Strategic information for hospital service planning: a linked data study to inform an urban Aboriginal Health Liaison Officer program in Western Australia	2015
Kelly, J.	Yaitya tirkka madlanna warratinna: exploring what sexual health nurses need to know and do in order to meet the sexual health needs of young Aboriginal women in Adelaide	2007

Kelly, J.	Travelling to the city for hospital care: access factors in country Aboriginal patient journeys	2014
Kildea, S.	Birthing on Country (in Our Community): a case study of engaging stakeholders and developing a best-practice Indigenous maternity service in an urban setting	2018
Kirkham, R.	Health service changes to address diabetes in pregnancy in a complex setting: perspectives of health professionals	2017
Kirkham, R.	Emotional labour and aboriginal maternal infant care workers: The invisible load	2018
Lowell, A.	Supporting aboriginal knowledge and practice in health care: lessons from a qualitative evaluation of the strong women, strong babies, strong culture program	2015
McGrath, P. D.	The case for Aboriginal Health Workers in palliative care	2007
McGrath, P.	'I don't want to be in that big city; this is my country here': Research findings on Aboriginal peoples' preference to die at home	2007
McGrath, P.	Insights, on Aboriginal Grief Practices from the Northern Territory, Australia	2008
McKenna, B.	"Cultural brokerage" and beyond: piloting the role of an urban Aboriginal Mental Health Liaison Officer	2015
Newham, J.	'There's only one enabler; come up, help us': staff perspectives of barriers and enablers to continuous quality improvement in Aboriginal primary health-care settings in South Australia	2016
Panzer, A.J.	Regional health workforce planning through action research: lessons for commissioning health services from a case study in Far North Queensland	2016
Peiris, D.	Building better systems of care for Aboriginal and Torres Strait Islander people: findings from the Kanyini health systems assessment	2012
Ralph, A.P.	Low uptake of Aboriginal interpreters in healthcare: exploration of current use in Australia's Northern Territory	2017
Read, C.M	Working with an Aboriginal community liaison worker	2006
Reibel, T.	Young Aboriginal women's voices on pregnancy care: factors encouraging antenatal engagement	2015
Reilly, R.E.	Identifying psychosocial mediators of health amongst Indigenous Australians for the Heart Health Project	2008
Rix, E. F.	The perspectives of Aboriginal patients and their health care providers on improving the quality of hemodialysis services: a qualitative study	2015
Russell, F.M	A pilot study of the quality of informed consent materials for Aboriginal participants in clinical trials	2005
Saethre, E.J.	Conflicting traditions, concurrent treatment: medical pluralism in remote aboriginal Australia	2007
Santhanam, R.	Care, Community Capacity: Rethinking Mental Health Services in Remote Indigenous Settings	2006
Sayers, J.M.	The Role of the Mental Health Worker in a Housing and Accommodation Support Initiative for Indigenous Australians	2017
Sayers, J.M.	Brokering Community Engagement: Proactive Strategies for Supporting Indigenous Australians with Mental Health Problems	2016
Schmidt, B.	Community health workers as chronic care coordinators: evaluation of an Australian Indigenous primary health care program	2016
Schoen, D.	Health promotion resources for Aboriginal people: lessons learned from consultation and evaluation of diabetes foot care resources	2010
Shahid, S.	Factors contributing to delayed diagnosis of cancer among Aboriginal people in Australia: a qualitative study	2016
Si, D.	Describing and analysing primary health care system support for chronic illness care in Indigenous communities in Australia's Northern Territory - use of the Chronic Care Model	2008
Stamp, G.	'They get a bit funny about going'--transfer issues for rural and remote Australian Aboriginal people	2006
Sushames, A.	Perceived barriers and enablers to participation in a community-tailored physical activity program with Indigenous Australians in a regional and rural setting: a qualitative study	2017
Swain, L. S.	Exploration of Aboriginal and Torres Strait Islander perspectives of Home Medicines Review	2015
Valery, P.C.	Unmet supportive care needs of Australian Aboriginal and Torres Strait Islanders with cancer: a prospective, longitudinal study	2017
Waterworth, P.	Factors Influencing the Health Behaviour of Indigenous Australians: Perspectives from Support People	2015
Watson, J.	Developing strategies to gather information about the maternity experiences of indigenous women in an acute care setting	2002

Wild, K.	'Give us the full story': overcoming the challenges to achieving informed choice about fetal anomaly screening in Australian Aboriginal communities	2013
Willis, E.M	Indigenous women's expectations of clinical care during treatment for a gynaecological cancer: rural and remote differences in expectations	2011
Worrall-Carter, L.	Exploring Aboriginal patients' experiences of cardiac care at a major metropolitan hospital in Melbourne	2016
Zubrzycki, J.	Knowing, Being, and Doing: Aboriginal and Non-Aboriginal Collaboration in Cancer Services	2017

7.3 POLICY REVIEW: INCLUDED POLICY DOCUMENTS

Author	Title	Year
Australian Government	Closing the Gap Prime Minister's Report 2018	2018
Australian Government	Evaluation of the Medical Specialist Outreach Assistance Program and the Visiting Optometrists Scheme	2012
Australian Government	First Progress Report on the Implementation of the National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss	2008
Australian Government	Grant Programme Guidelines Indigenous Australians' Programme - Primary Health Care Activity	2015
Australian Government	Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023	2015
Australian Government	Implementation Plan under the National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss	2014
Australian Government	Indigenous Australians' Health Programme: Programme Guidelines	2018
Australian Government	Integrated team care: Program implementation guidelines	2018
Australian Government	Medical Outreach - Indigenous Chronic Disease Program: Service Delivery Standards Addendum 2016	2016
Australian Government	Medical Outreach - Indigenous Chronic Disease Program: Service Delivery Standards Addendum 2017	2017
Australian Government	National Aboriginal & Torres Strait Islander Health Plan 2013–2023	2013
Australian Government	Rural Health Outreach Fund Service Delivery Standards	2012
Australian Government	Second Progress Report on the Implementation of the National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss	2012
Australian Government	Third Progress Report on the Implementation of the National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss	2015
Australian Government	Visiting Optometrists Scheme: Grant Programme Guidelines	2015
Australian Government	Visiting Optometrists Scheme: Service Delivery Standards	2015
Australian Health Ministers' Advisory Council	Cultural Respect Framework 2016-2026	2016
Australian Government	National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss	2005
Council of Australian Governments	National Indigenous Reform Agreement (Closing the Gap)	2008
The Close the Gap Campaign Steering Committee	A ten-year review: the Closing the Gap Strategy and Recommendations for Reset	2018
Government of SA	Aboriginal Health Care Plan 2010 – 2016	2010
Government of SA	Patient Assistance Transport Scheme (PATs)	2016
Government of SA	Policy Directive: Aboriginal Cultural Respect Framework	2007
Government of SA	Policy Directive: Aboriginal Health Impact Statement Policy Directive	2014
Government of SA	Policy Guideline: Checklist of Best Practice Program Development for Aboriginal Health Policy Guideline	2014
Government of SA	SA Health Aboriginal Workforce Framework 2017-2022	2017
Government of SA	SA Health Guide for Engaging with Aboriginal People	2013
Government of SA	South Australian Aboriginal Languages Interpreters and Translators Guide	2013
Government of WA	Patient Assisted Travel Scheme Policy WA Country Health Service	2015

Government of WA	WA Aboriginal Health and Wellbeing Framework 2015–2030	2015
Government of WA	WA Health Aboriginal Cultural Learning Framework	2012
Government of WA	WA Health Aboriginal Workforce Strategy 2014–2024	2014
Government of WA	WA Health System Language Services Policy	2017
Government of WA	WA Health System Language Services Policy Guidelines	2017
Taylor, H. R. et al	Annual Update on the Implementation of the Roadmap to Close the Gap for Vision	2017
National Aboriginal Community Controlled Health Organisation	National ACCHO Sector Report on Eye Health Service Delivery for Aboriginal and Torres Strait Islander people	2016
NT Government	Northern Territory Aboriginal Health Plan 2015 - 2018	2015
NT Government	Northern Territory Health Aboriginal Cultural Security Framework 2016 - 2026	2016
NT Government	Northern Territory Health Aboriginal Cultural Security Policy	2016
NT Government	Patient Assistance Travel Scheme guidelines	2017
NSW Government	Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS): Guidelines for Assessment	2015
NSW Government	Policy Directive: Interpreters – Standard Procedures for Working with Health Care Interpreters	2017
NSW Government	Policy Directive: NSW Aboriginal Health Plan 2013-2023	2013
NSW Government	Policy Directive: NSW Health Good Health - Great Jobs: Aboriginal Workforce Strategic Framework 2016 - 2020	2016
NSW Government	Policy Directive: Respecting the Difference: An Aboriginal Cultural Training Framework for NSW Health	2011
QLD Government	Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033	2010
QLD Government	Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2026	2016
QLD Government	Making Tracks Policy and Accountability Framework toward closing the gap in health outcomes for Indigenous Queenslanders by 2033	2012
QLD Government	Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033 Investment Strategy 2015–2018	2015
QLD Government	Multicultural Affairs Queensland: Language services guidelines	2016
QLD Government	Patient Travel Subsidy Scheme (PTSS) guideline (part A)	2016
QLD Government	Queensland Language Services Policy	2016
QLD Government	Statement of Action towards Closing the Gap in health outcomes	2018
Tasmanian Government	Multicultural Language : Services Guidelines For Tasmanian Government Agencies	2016
Taylor, H. R. et al	The Roadmap to Close the Gap for Vision (Full Report)	2012
Taylor, H. R. et al	The Roadmap to Close the Gap for Vision (Summary Report 2015-2017)	2015
The Royal Australian College of General Practitioners	National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people: Third Edition	2018
The Victorian Eyecare Service	Manual of procedures and conditions for rural service providers	2016
Victorian Government	Koolin Balit Aboriginal health workforce plan 2014–17	2014
Victorian Government	Koolin Balit Statewide action plan: 2013 to 2015	2013
Victorian Government	Koolin Balit Victorian Government strategic directions for Aboriginal health 2012–2022	2012

Victorian Government	Korin Korin Balit-Djak Aboriginal health, wellbeing and safety strategic plan 2017–2027	2017
Victorian Government	Language services policy Department of Health and Human Services	2017
Victorian Government	Victorian Patient Transport Assistance Scheme (VPTAS)	2015
Victorian Advisory Council on Koori Health	Aboriginal Eye Health Strategy 2013-2014	2013