Established and Effective Models of Eye Healthcare Delivery for Aboriginal and Torres Strait Islander Peoples and their Implementation

A focused resource for ophthalmologists, other healthcare workers and organisations involved in the eye health sector

Preamble

RANZCO's Reconciliation Action Plan (RAP) commits the College to activities that seek to achieve equity in access and health outcomes for Aboriginal and Torres Strait Islander Peoples; continue to build collaborative partnerships with Aboriginal and Torres Strait Islander peoples and the health sector; build on our existing commitment to increasing the number of Aboriginal and Torres Strait Islander ophthalmologists in Australia; and will improve and enhance our organization's cultural safety practices.

The Established and Effective Models of Eye Healthcare Delivery for Aboriginal and Torres Strait Islander Peoples and their Implementation resource is part of the College's reconciliation journey and our commitment to improving health outcomes for Aboriginal and Torres Strait Islander Peoples.

Introduction

RANZCO acknowledges the progress to date achieved through the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023, the National Agreement on Closing the Gap, and the Roadmap to Close the Gap for Vision.

The College welcomes the National Aboriginal and Torres Strait Islander Health Plan 2021-2031 committing the Government to a true partnership with Aboriginal and Torres Strait Islander people, communities and organisations. The vision of the new Health Plan is for the Australian health system to be free of racism and inequality and for all Aboriginal and Torres Strait Islander Peoples to have access to timely, effective, high quality, appropriate and affordable health services.

Despite progress made, Aboriginal and Torres Strait Islander peoples still experience blindness and vision loss at three times the rate of other Australians and wait significantly longer for common sight-saving treatments. There remains much to be done to Close the Gap.

Over the years, many ophthalmologists have developed practical ways to provide services to Aboriginal and Torres Strait Islander peoples - in their practices, through collaboration with local Aboriginal Medical Services (AMSs), in public hospitals and by undertaking outreach services. RANZCO commends their commitment to and efforts to Close the Gap.

This resource aims to further the vision of the Health Plan by making available effective models of care for Aboriginal and Torres Strait Islander peoples currently utilised by RANZCO Fellows and by putting other interested Fellows in touch with those that are currently using these models. In this way, we hope that ophthalmologists and others interested in providing and/or developing these essential services will be supported to meet the goals of Close the Gap for Vision.

Interested ophthalmologists, should consider the most suitable model based on their circumstances and practice and how they can adapt the model to best meet local needs. Please ask RANZCO staff to put you in contact with any service lead you believe may be useful as a mentor.

We Value your Opinion

If you have any feedback on the service delivery models outlined in this document or any suggestion on how to improve access to eye care or health outcomes for Aboriginal and Torres Strait Islander Peoples, please email RANZCO staff.

Principles underpinning models of care

1. Cultural safety

All staff involved in healthcare delivery to Aboriginal and Torres Strait Islander peoples should have undertaken cultural safety training

Cultural safety is a critical component of patient safety, and cultural safety must be defined by Aboriginal and Torres Strait Islander Peoples.

Cultural safety enables patient's trust in the health service to provide care and improve well-being and is therefore beneficial to health outcomes

The *National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025* aims to make cultural safety the norm for Aboriginal and Torres Strait Islander patients. It sets a clear direction and course of action for AHPRA, National Boards and Accreditation Authorities, who together regulate Australia's 740,000 registered health practitioners.

All healthcare practices, organisations and providers involved in the delivery of inpatient or outpatient care to Aboriginal and Torres Strait Islander peoples should ensure workplaces and healthcare service delivery environments are culturally safe and support continuous quality and practice improvement in this regard (1).

The RANZCO Cultural Safety training modules[1] are available to Fellows to enable them in delivering culturally safe and respectful ophthalmology services to Aboriginal and Torres Strait Islander peoples. In completing the Cultural Safety training modules Fellows will have their cultural safety learnings recognised via CPD points.

2. Patient-centred care

It is widely acknowledged that patient-centred care results in safer, higher quality healthcare. A patient-centred approach treats each person respectfully as an individual, involves their family, other carers, and community members and is concerned about the patient's comfort and surroundings as well as their beliefs and values.

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[1] The material in the RANZCO Cultural Safety Module has been reviewed by Aboriginal and Torres Strait Islander people.

It is a requirement for all Australian trainees to complete the RANZCO Cultural Safety Module and the AIDA course, which was developed and is delivered by Aboriginal and Torres Strait Islander people. ABSTARR Consultancy has developed a cultural safety resource to support the RANZCO Cultural Safety Module. ABSTARR was established by Professor Gregory Phillips from the Waanyi and Jaru Aboriginal Australian peoples and comes from Cloncurry and Mount Isa. Professor Phillips is Professor of First People's Health in the School of Medicine at Griffith University and CEO of ABSTARR.

It is not currently a requirement for Australian Fellows to complete the RANZCO Cultural Safety Module and the AIDA course however this may change over time.

The material in the RANZCO Cultural Safety Module is not specific to areas where Fellows and Trainees may work. In addition to the module, it will be beneficial for doctors to engage with local cultural mentors to learn about cultural safety issues specific to their practice locations.

This is especially important in delivering care to disadvantaged or vulnerable populations and is likely to support greater involvement and engagement with healthcare services and therefore achieve better health outcomes [2].

The models of care outlined in this resource take a patient-centred care approach to the healthcare they deliver. For example, cultural safety is embedded in each model and comprehensive services in one place are offered where possible.

Aboriginal and Torres Strait Islander peoples should be active partners and have a leadership role in the delivery of services.

In line with the National Safety and Quality Health Service Partnering with Consumers Standard (2), health outcomes are improved by partnering with consumers in the planning, design, delivery, measurement and evaluation of systems and services. This requires clear and ongoing engagement with community stakeholders e.g., local Aboriginal-controlled health organisations and consumers in the design, implementation, and feedback mechanisms.

Aboriginal and Torres Strait Islander health workers

Aboriginal and Torres Strait Islander health workers and liaison officers play an essential role in supporting Aboriginal and Torres Strait Islander patients in navigating the healthcare system. They work collaboratively with other healthcare professionals to achieve better health outcomes for Aboriginal and Torres Strait Islander peoples and communities and play a key role in facilitating relationships and clinical care between Aboriginal and Torres Strait Islander patients and other health professionals.

Drawing on their community and cultural knowledge, Aboriginal and Torres Strait Islander health workers advocate for the needs of Aboriginal and Torres Strait Islander patients and support other health professionals in ensuring the delivery of healthcare is culturally safe.

3. No out-of-pocket costs

The essential requirement of all models presented is that services are available at no cost to the patient. Out-of-pocket expenses present an absolute barrier for many Aboriginal and Torres Strait Islander patients in accessing their healthcare needs (3).

4. Excellent, comprehensive, accessible, and reliable outpatient services

The standard of care, the facility and the equipment should be excellent

Clinical care should be high calibre with access to standard-of-care equipment in good condition. Aboriginal and Torres Strait Islander peoples commonly have complex eye care problems and many co-existing illnesses. Highly trained medical and ancillary staff with an understanding of these complex healthcare needs are essential.

Services should offer comprehensive outpatient care where possible

Outpatient services which offer comprehensive diagnostic services and include the delivery of outpatient procedures such as eye injections and laser at the one site, provide patients with the most efficient, patient-centred service and reduce the opportunity for the patient to be lost to follow up.

Outpatient services that offer incomplete outpatient services, requiring patients to attend follow up appointments at another location, contribute to low consumer satisfaction and engagement.

Services must be consistent, sustainable, and accessible

It is recommended that clinics are regularly scheduled where possible, so future bookings are always available. This provides consumers with the certainty to engage with the service.

The frequency of visits and the number of appointments available should reflect clinical needs and local demand for services.

Eye care services should actively monitor the attendance of patients who require ongoing treatment, post-op care, and/or monitoring.

Where patients stop attending appointments, the eye care service should actively reach out to the patient, the referring optometrist or GP, or the supporting ACCHO/ AMS for support.

The use of Aboriginal and Torres Strait Islander status as a clinical modifier

The use of Aboriginal and Torres Strait Islander status, to expedite care in public hospital eye services, received the backing of the Australian Government Chief Health Officer in 2013 (4). Queensland Health, for example, acknowledges Aboriginal and Torres Strait Islander status as a clinical modifier for referral purposes which serves to prioritise access to public hospital clinics.

Prescribing practitioners should understand any prescribing information specific to Aboriginal and Torres Strait Islander peoples

https://www.pbs.gov.au/publication/factsheets/closing-the-gap/Factsheet-FOR-PRESCRIBERS-ABORIGINAL-HEALTH-PRACTITIONERS-THEIR-PEAK-BODIES.PDF

Regional coordination

To help support improved eye care outcomes, collaborative stakeholder groups are now operating across Australia. These groups ensure that the pathways of eye care in each geographic region are understood and working well and that the different parts of the patient pathway (primary, optometry, ophthalmology) can be navigated by patients.

Ophthalmologists' engagement with the regional stakeholder groups helps establish better pathways for care and helps ophthalmologists and practice managers better understand the patient's journey through their local eye care pathways.

The College can help you get in touch with your local collaborative Indigenous eye care group.

Data and monitoring performance and progress

It is important to ensure that population needs are being met in service delivery (sufficient services are provided) and that performance and progress are monitored such that additional improvements in care can be made

5. Expedited access to surgical inpatient services

Successful comprehensive care models have developed robust, expedited access pathways to publicly funded or no gap surgery for those patients where surgery is indicated. This access is tailored to the local situation.

Waitlisting for surgery

In some cases, Aboriginal and Torres Strait Islander patients can be directly waitlisted onto the public hospital inpatient waitlist from the private rooms or AMS clinics foregoing the need for a public hospital outpatient appointment.

Where patients cannot be directly added to the inpatient waitlist, the local public hospital may agree to provide fast-track appointments for identified Aboriginal and Torres Strait Islander patients who are referred from private rooms or the AMS for surgery, bypassing the usual long wait for an appointment at the public hospital clinic.

Prioritisation when waitlisting for surgery

The recommendation for non-urgent surgery for Aboriginal and Torres Strait Islander patients is for the first surgery to occur within 90 days. To achieve this, Aboriginal and Torres Strait Islander patients are prioritised on the public wait list for surgery. Aboriginal and Torres Strait Islander status is used as a comorbidity to increase the urgency of the surgery by one category – Category 3 becomes Category 2 for example.

Booking patients for surgery

In many jurisdictions, Category 2 patients awaiting public surgery face long waits. Some models manage this problem by putting in processes to ensure Aboriginal and Torres Strait Islander patients on the surgical waitlist have their surgery within 3 months.

In some areas, the ophthalmologist has access to the public operating waiting list, which enables them to have some control over booking dates and waiting times for patients. This is especially useful where many patients are over-boundary on the inpatient waitlist.

Models of care:

Model 1: Comprehensive eye health services in private practices

Model 2: Fast-tracked ophthalmology outpatient services in public hospital outpatient clinics

Model 3: Comprehensive AMS Eye Health Clinics

Model 4: Outreach ophthalmology services to rural and regional areas

1. Comprehensive eye health services in private practices

Key features

- All services provided to patients who are identified as Aboriginal and Torres Strait Islander on the referral and/or who self-identify are bulk billed and it is ensured that there are no other incidental costs in accessing the service (no out of pocket costs)
- Aboriginal and Torres Strait Islander patients are booked in the same manner as other patients and are seen in the same clinics
- Services are patient-centred in that private ophthalmology practices offer comprehensive outpatient consultation and diagnostic services and minor procedure services such as intravitreal injections and laser treatments
- Patients are commonly referred from local AMS clinics as well as from GP and optometry practices
- Access to publicly funded or no gap surgery is expedited. This access is tailored to the local situation
- Clinic staff have access to cultural safety training and participation and ongoing upskilling becomes part of the mandatory staff training expectations

Key requirements to make private practice services work

- A commitment from yourself and your private practice to ensure there are no out of pocket expenses for Aboriginal and Torres Strait Islander patients and to provide a respectful and culturally safe space
    - Access cultural safety training for your staff
    - Understand how to provide a welcoming and culturally safe environment for the care of Aboriginal and Torres Strait Islander patients and work with your practice manager to do so
    - Consider if your practice wishes to display the 'We bulk bill Aboriginal and Torres Strait Islander peoples to help close the gap' resource developed by RANZCO for participating practices
    - Ensure community organisations and GPs and optometrists in the community are aware you offer bulk billing for Aboriginal and Torres Strait Islander patients

we bulk bill A4.pdf we bulk bill A3.pdf

- Practice processes that generate and maintain a referral base to make your service effective
    - Ensure awareness of the service in the local community among patients and referrers

    - Identification of Aboriginal and Torres Strait Islander status on the referral is essential for some private practice services whilst other services will bilk bill any patient that self-identifies as Aboriginal and Torres Strait Islander
    - Work with your practice manager to educate your staff to 'Ask the Question'. Australian Institute of Health and Welfare training resources are available (5). Indigenous Eye Health, University of Melbourne has also developed Ask the Question practice resources (6).
    - Develop a good relationship and maintain ongoing engagement with local AMSs and other healthcare providers for Aboriginal and Torres Strait Islander peoples. Consider, visiting their practices and establishing ongoing contact to provide teaching and support and touch base with referring practitioners from time to time to ensure the service is meeting the patients' and practitioners' needs
    - Join or make yourself known to regional stakeholder groups in Indigenous eye health
    - Familiarise yourself with local Aboriginal communities and their history and organisations
- Engagement with the Head of the Ophthalmology Department at your local public hospital to arrange for Aboriginal and Torres Strait Islander patients you refer for surgery to receive fast-tracked surgical access. In some cases, a formalised agreement between private practices and a public hospital may be drawn up.
- Engagement with local AMS and public hospital Aboriginal and Torres Strait Islander health workers to put in place supports such as Aboriginal Liaison Officers (ALOs) or other staff members from the AMS to accompany patients for surgery and public hospital appointments, patient transport arrangements, access to the subsidised spectacle scheme, etc.

Examples of this model in current use

- Service for Aboriginal and Torres Strait Islander patients – Lions Eye Institute Broome and Midland, WA
- Service for Aboriginal and Torres Strait Islander patients - Hobart
- Ophthalmologists in Geelong and Southwest Victoria, in collaboration with University Hospital Geelong

2. Fast-tracked eye health services in public hospital outpatient clinics

Key features

- The public hospital outpatient service uses Aboriginal and Torres Strait Islander status to expedite the waitlisting and booking of Aboriginal and Torres Strait Islander peoples within the clinic
- Referrers include Aboriginal and Torres Strait Islander status when they refer patients to the service
- Staff have undertaken cultural competency training
- The outpatient service provides a welcoming and culturally safe environment for the care of Aboriginal and Torres Strait Islander patients
- Aboriginal and Torres Strait Islander patients being waitlisted for surgery are prioritised to category 2 or higher and are booked for surgery within 3 months

Key requirements

- A commitment to Close the Gap by public hospital Ophthalmology Department team members with the backing of the local health service. This can be advocated for within the team and the organisation by any consultant ophthalmologist or training registrar within the unit as well as by other team members.
- Engagement with referrers such as AMSs, GPs, and optometrists, so there is awareness of the need to include Aboriginal and Torres Strait Islander status when patients are referred to the service and an understanding that the care of these patients will be prioritised.
- Engagement with the public hospital Aboriginal Liaison Service to arrange for cultural competency training for all staff and to ensure the clinic is welcoming for Aboriginal and Torres Strait Islander patients. Clinic staff are trained to 'ask the question' (5, 6).
- Triage processes that embed Aboriginal and Torres Strait Islander status as a clinical modifier to increase the urgency of the categorisation, for example, from category 3 to 2 for non-urgent patients.
- After triaging, Aboriginal and Torres Strait Islander patients are booked for their outpatient service rather than being waitlisted. This is essential considering the long delays across Australia in public outpatient services for category 2 patients.
- When establishing this model Aboriginal and Torres Strait Islander peoples on the outpatient and inpatient waitlists are identified and booked for the services they are waitlisted for.
- Development of collaborative clinical care pathways from the community into the hospital clinic. For example, at the RHHEC patients are seen in the local AMSs by optometrists who can access fast-tracked referrals to the public eye clinic when specialist care is needed.

Examples of fast-tracked eye health services in public hospital clinics

- Inala Community Health Centre, Southern Queensland
- The Royal Hobart Hospital Eye Clinic (RHHEC)
- The Royal Victorian Eye and Ear Hospital
- Monash Health

3. Collaborative and Comprehensive Eye Health Clinics in AMSs

Key features

- The eye clinic is physically located in an AMS
    - There is community control of the service with care being provided in a culturally safe setting with Aboriginal and Torres Strait Islander peoples controlling the space and the way that care is delivered
    - Ensures the complete health needs of patients can be attended to, including GP care, diabetic education, case management, and mental health, and that accessing regular eye healthcare becomes accepted as an important and necessary component of overall health and well being
    - Optometrists working at the AMS can easily discuss and refer patients to ophthalmologists also working at the AMS enabling the development of shared care models (including telehealth)
- Staffing and case management
    - Requires an ophthalmologist with or without an ophthalmology registrar. It is recommended that a consultant ophthalmologist is present wherever possible to provide direct oversight to training registrars in the care of this group of patients who frequently have complex eye health issues and other coexisting illnesses so that decisions can be made, thus avoiding unnecessary return appointments.
    - Enhanced with an Aboriginal Liaison Officer assigned to the clinic, who supports the team on the day of clinic, co-ordinates care and accompanies patients if they need surgery at the hospital
    - AMS staff contact patients to work out the timing of appointments to suit the patients, and then the day before the appointment to attend to transport needs, etc
- Frequency
    - It is recommended that clinics are regularly scheduled where possible, so future bookings are always available
    - The frequency of visits should reflect local service demands and an agreement between the AMS and the involved ophthalmologists
- Equipment
    - Ideally, all clinically important ophthalmic ancillary testing is available so patients can receive a comprehensive and complete outpatient service and don’t require referral to another outpatient service.
    - It is challenging to provide comprehensive services during the visits when there is a lack of some equipment such as an OCT and A-scan. Whilst ophthalmology clinics in AMSs can and do take place without essential ancillary testing equipment it can limit consumer engagement, as consumers become aware that it is not a complete service and further assessment elsewhere may be needed.
    - Recommended minimum equipment for a diagnostic clinic can be found in Appendix 1

- Treatments at the AMS Eye Health Clinic
    - The best models of care are when most standard outpatient treatments can be undertaken at the AMS clinic, such as laser services and eye injections. This allows patients to access these treatments, which may be needed regularly, in the culturally safe space of the AMS
    - A list of recommended minimum equipment for a treatment clinic can be found in Appendix 2
- Bookings for inpatient services such as cataract surgery
    - Patients requiring surgery are booked directly onto a public hospital inpatient waitlist. All surgeries are booked as category 2 or higher (90 days max wait).

Key requirements to make an AMS eye health clinic work

- An AMS which has the space and an interest in providing ophthalmology services to their patients
- Visiting ophthalmologists who have the goodwill to commit to a regular clinic at the AMS and are either salaried or agree to bulk bill all the services they provide there
- A formalised agreement with the AMS and ongoing engagement with AMS staff to ensure the services continue to meet the needs of the AMS and their patients – services should be patient-focused
- Available funding for staff, infrastructure, and equipment - which may require advocacy to secure
- Building local capacity by up-skilling and training local Aboriginal and Torres Strait Islander health workers
- An established relationship with referrers and other healthcare providers
- Established and expedited onward referral pathways for surgery and any outpatients' services that cannot be provided at the AMS Eye Health Clinic
- Medical Outreach Indigenous Chronic Disease Program (MOICDP) may provide a 'workforce' payment and some administrative support if Medicare billing is not sustainable.

Examples of comprehensive AMS eye health clinics

- Victorian Aboriginal Health Service (VAHS) Eye Clinic, Fitzroy, Melbourne
- Derbarl Yerrigan Health Service, East Perth.
- Maringga Turtpandi Aboriginal Health Service, Hillcrest, Adelaide

4. Outreach services in rural and regional areas

Key features

- Ophthalmologists travel to regional, rural, remote, and very remote communities to provide general ophthalmology services
- Having services come to the area patients live in helps them to feel safe in accessing the services and minimises the time, travel costs and disruption to patients compared to accessing the nearest alternative service
- Services are provided in a variety of settings such as AMSs, public hospital clinics, mobile vans, and other medical clinic spaces
- Services, particularly in areas with no resident ophthalmologist, typically see both Aboriginal and Torres Strait Islander and other patients during the same visit
- Services are free of charge thus removing the economic hurdles that rural and Aboriginal and Torres Strait Islander patients often face
- Funding for health workers to travel to deliver the service is mostly supported by Rural Health Outreach Fund (RHOF) and MOICDP
- Services are delivered in partnership with AMSs, jurisdictional local health services, hospitals, non-government organisations (NGOs), and Primary Health Networks (PHNs)
- The frequency of visits varies pending local service demands and agreement between key stakeholders such as AMSs, local health services, PHNs, NGOs, and involved ophthalmologists

- Staffing
    - Ophthalmologist +/- service registrar
    - Specialist eye nurse and/or an orthoptist
    - Local coordinator to help establish a potential patients list
    - Program coordinator for larger outreach services
- Equipment
    - Local equipment may include a slit lamp and OCT. Portable laser units and other equipment may be brought to the site for each visit.
    - Other equipment is brought to the site such as minor procedure equipment for ocular injections, lasers, a portable retinal camera, etc
    - Consumables such as eye drops and intravitreal injections are brought to the site or can be negotiated to be provided locally.
- Treatment
    - Surgical procedures can be performed in the regional hospital or medical centre where outreach services are provided.

Key requirements for successful outreach services

- The goodwill of individuals for the regular provision of services
- The goodwill of individuals for the coordination of the service for smaller outreach services. Larger services require service coordinator funding
- The funding of sufficient rural and Aboriginal and Torres Strait Islander healthcare workers to build, support and maintain the service
- The building of local capacity by up-skilling and training local health workers
- Harnessing a strong partnership between the community, corporate bodies, and government to meet the increasing demand for eye health services
- More outreach service information, including recommended outreach equipment requirements, are available on the RANZCO Outreach Portal

Examples of Outreach Services

- Lions Outback Vision WA
- Outback Eye Service NSW
- Central Australian Regional Eye Service NT
- St John Eye Van Queensland (previously known as the IDEAs Van)

References

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3. Aboriginal and Torres Strait Islander Health Performance Framework 2020 summary report 2020 [Available from: https://www.indigenoushpf.gov.au/.
4. Baggoley C. Email correspondence from the CMO of Australia to the CMO in each jurisdiction to support using Indigeneity as a comorbidity to increase the prioritisation category for Indigenous patients. 2013.
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6. Improving Eye Care Service Delivery with Appropriate Identification of Aboriginal and Torres Strait Islander Status: Melbourne School of Population and Global Health, Indigenous Eye Health; [Available from: https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/roadmap/asking-the-question.

Appendix 1: Equipment recommended for an AMS eye health clinic to provide basic eye health assessments (some may be portable and transported to the clinic)

- Vision chart – preferably illuminated (for recording vision)
- Occluder and pinhole (to help with recording vision)
- Trial frame and a basic set of trial lenses (for checking the need for glasses)
- Slit-lamp (for examining the patient)
- Tonometer (for measuring eye pressure)
- Basic disposable items and eye medication needed for examination (discuss with visiting practitioners)

Appendix 2: Additional equipment is recommended for an AMS eye health clinic to provide comprehensive diagnostic services. Some may be portable and transported to and from the clinic - discuss with visiting practitioners.

- A-scan (for measuring the intraocular lens for cataract surgery)
- B scan (to check the back of the eye where cataracts are dense)
- OCT and Fundus Camera (to check for glaucoma and retinal swelling from diabetes and ageing changes)
- Field analyser (to look for field loss from glaucoma and other causes)
- Optional: lensometer (for measuring glasses) and autorefractor (for measuring patients' refraction)

Appendix 3: Additional equipment recommended for an AMS eye health clinic to provide useful clinic-based procedures

- YAG laser
- Retinal laser
- Intravitreal injection gear, consumables, drugs, etc are best supplied by the local pharmacy (organised by the AMS), as part of the partnership but may be brought to the clinic in a travelling tool kit