Australian Government

Department of Health and Aged Care

Evaluation of Outreach Programs

Evaluation Report

Volume 1: Main report

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Contents

Acronyms and glossary of key terms 1
Executive summary 1
Outreach programs evaluated 1
Key evaluation questions 1
Evaluation methods 2
Evaluation findings 3
Recommended actions 6
1. Policy context for outreach programs 12
2. Evaluation scope and objectives 15
3. Evaluation methods 18
Evaluation data sources 18
Impact of COVID–19 on evaluation methods 26
Reporting on the evaluation 27
4. Overview of the programs 28
Process for commissioning services 28
Outreach programs in scope of the evaluation 29
Overview of the fundholders 30
Overview of each outreach program 31
Service delivery standards 42
Monitoring performance of outreach services 45
5. Literature scan 46
Key messages and their relevance to the evaluation 46
6. Evaluation findings 49
1. How well are each of the outreach programs being delivered? 49
Local capacity building 94
2. How effective are each of the outreach programs in achieving their intended outcomes? 98
Other models of care 119
3. How efficient and cost-effective are each of the outreach programs? 125
4. To what extent are the outreach activities coordinated across the outreach programs? 138
7. Areas for improvement 144
Building on a strong foundation 144
Priorities for strengthening outreach 145
8. Implications for Closing the Gap 154
Priority reform 1 – Formal partnerships and shared decision making 156
Priority reform 2 – Building the community-controlled sector 157
Priority reform 3 – Transforming government organisations 158
Priority reform 4 – Shared access to data and information at a regional level 159
Appendix 1A: Literature scan 161
Approach 161
Summary of findings by literature source 162
Appendix 1B: Information provided to stakeholders 178
Appendix 1C: Stakeholders consulted 180
Appendix 1D: Interview topic guides 184
Interview topic guide – Fundholders 184
Appendix 1E: Fundholder documents provided 190
Appendix 1F: Review of fundholder documentation 195
Appendix 1G: Key observations from case studies 200
Common themes 201
Case study summaries 202
Queensland: True Women's Health 202
Appendix 1H: Analysis of program service delivery standards 210

Appendix 1I: Related reviews and evaluations 218
Appendix 1J: Data specifications 223
Appendix 1K: Workforce groups 226
1. Allied Health 226
2. General Practitioners 226
3. Nursing and Aboriginal Health Workers 226
4. Medical Specialists 227
4. Medical Specialists (continued) 228
References 229

Acronyms and glossary of key terms

ACCHO	Aboriginal Community Controlled Health Organisation
ACRRM	Australian College of Rural and Remote Medicine
AMS	Aboriginal Medical Service
CIEH	Co-ordination of Indigenous Eye Health Program
EESS	Eye and Ear Surgical Support Program
Fundholder	refers to each state and territory jurisdictional organisation currently receiving Commonwealth funding to manage and coordinate the delivery of one or more of the Outreach programs.
HEBHBL	Healthy Ears – Better Hearing, Better Listening
HoA	Heart of Australia
Host providers	Health organisations that host visiting outreach service providers in target communities
IAHP	Indigenous Australians' Health Programme
LHN/LHD/HHS/THO	Local Hospital Networks. These are legal entities established by each Australian state/territory charged with operational management of public hospitals and local service delivery. Jurisdictions have their own local names: New South Wales – Local Health Districts, Queensland – Hospital and Health Services, South Australia – Local Health Networks, and Tasmania – Tasmanian Health Organisations.
MM	Modified Monash category. A measure of remoteness and population size classified into 7 categories, from MM1 (major city) to MM7 (very remote).
MBS	Medicare Benefits Schedule
MOICDP	Medical Outreach Indigenous Chronic Diseases Program
MSOAP	Medical Specialist Outreach Assistance Program
NGO	Non-government organisation
NSW RDN	New South Wales Rural Doctors Network
NT Health	Northern Territory Department of Health
PHN	Primary Health Network
RDWA SA	Rural Doctors Workforce Agency (SA)
RFDS	Royal Flying Doctors Service

RHW	Rural Health West
RHT	Rural Health Tasmania
RHOF	Rural Health Outreach Fund
RHOF PMS	Rural Health Outreach Fund – Pain Management Services
RWAV	Rural Workforce Agency Victoria
TAZREACH	Is an office tasked with managing outreach programs on behalf of Tasmanian Department of Health.
Visiting outreach providers	Health professionals funded to provide outreach health services
VOS	Visiting Optometrists Scheme

Executive summary

Access to health care is a hallmark of Medicare, irrespective of where a person lives. Ensuring access to care in rural and remote areas of Australia and smaller communities remains a policy priority and ongoing challenge for governments. Outreach is one of the key strategies used to provide access to these communities.

Various levels of government invest in outreach. The Commonwealth government administers a range of outreach programs aimed at boosting primary health care and specialist care through fundholder arrangements. State and territory governments invest in outreach to ensure the safe operation of small country hospitals in addition to filling gaps in service provision. The disability and aged care sectors are also providing outreach services that often call on similar workforce groups as the health sector.

This report sets out the objectives, methods and findings from an evaluation of selected Commonwealth government outreach programs and puts forward recommendations for program improvement, along a range of observations for possible broader system change.

Outreach programs evaluated

The evaluation sought to assess the impact of the select outreach programs between 2017-18 and 2020-21. The programs evaluated were:

- Eye and Ear Surgery Support (EESS)
  Supports for more timely access to surgical interventions for Aboriginal and Torres Strait Islanders who need eye surgery and/or ear surgery for conditions arising from Otitis Media.
- Healthy Ears, Better Hearing, Better Learning (HEBHBL)
  Aims to increase access to ear and hearing services for Aboriginal and Torres Strait Islander children and youth aged 0-21 in rural and remote areas.
- Heart of Australia (HoA)
  Provides specialist medical services, including cardiology and respiratory medicine, to 31 regional, rural and remote communities in Queensland.
- Medical Outreach Indigenous Chronic Disease Program (MOICDP)
  Supports increased access to healthcare for Aboriginal and Torres Strait Islander people with chronic disease. The scope of this program includes all Indigenous people with chronic disease regardless of geographical location.
- Rural Health Outreach Fund (RHOF)
  Aims to improve access to healthcare services for all residents in rural and remote communities. The program has 4 areas of focus: mental health, eye health, chronic disease and paediatric health.
- Visiting Optometrist Scheme (VOS)
  Supports optometry services for Australians in regional, rural and remote areas. The program has Indigenous (40%) and non-Indigenous (60%) funding components.

Key evaluation questions

The overall aims of the evaluation were to inform the Commonwealth government on the appropriateness, effectiveness and efficiency of the programs and how it could potentially be improved in the future. Four high-level evaluation questions were considered:

1. How well are each of the outreach programs being delivered?
2. How effective are each of the outreach programs in achieving their intended outcomes?
3. How efficient and cost-effective are each of the outreach programs?
4. To what extent are the outreach activities coordinated across the outreach programs?

While targeted observations were made where appropriate, the evaluation sought to address these questions by taking a high level approach and consider themes, findings and recommendations that apply across the selected outreach programs more broadly rather than in-depth exploration of each specific program. To this end the evaluation focussed on considering the extent activities across the programs are coordinated to enable care to be integrated and promote care continuity.

Evaluation methods and timing

The evaluation team used a mixed methods approach which drew upon a variety of qualitative and quantitative sources of data and information to address the evaluation questions:

- Interviews with a wide range of stakeholders, including national peak bodies, jurisdictional agencies, fundholders and outreach and host providers. A full list of stakeholder organisations interviewed as part of the evaluation along with the interview topic guides for each stakeholder group are presented in Appendix 1C: Stakeholders consulted.

- Surveys of national workforce peak bodies, outreach and host providers.
  The response rates for the host and outreach provider surveys were lower than anticipated (21% and 16%, respectively) [1] and were clearly impacted by competing priorities, such as pressures associated with COVID–19. Refer to Chapter 3 below for more information on the survey response rates by fundholder and jurisdiction. More information on the individual survey questions and responses by stakeholder group is provided in Appendix 3A, Volume 3.

- Case studies involving an in-depth consideration of outreach services provided in selected regions or a focus on specific selected services provided in a jurisdiction. The detailed findings and observations from the case studies are presented in Volume 2, with an overview and summary of key messages from the case studies provided in this report in Appendix 1G: Key observations from case studies.

- Data and information routinely generated by the fundholders through administration of the programs and Medicare data for selected MBS items. For more information on the program information, refer to Chapter 3 below.

The evaluation started in August 2021 and was completed in September 2022. It was conducted in 3 stages:

- Planning, including preparation of the project and evaluation plans and development of the evaluation tools and stakeholder engagement processes.

- Delivery, including conducting the surveys, interviews, case studies and data collections and subsequent synthesis and analysis of the data and information

- Reporting, including the preparation of a draft report in July 2022 and then, reflecting Department and other stakeholder feedback, the final report was prepared and provided to the Department in September 2022.

[1] The total response rate for the host and outreach provider surveys does not reflect total submissions as the figure from one fundholder was not reported.

Evaluation findings

Building on a strong foundation

The evaluation focussed on identifying opportunities for improvement in the outreach programs.

It is important to acknowledge the existing value of the outreach programs to the many Australians living in rural and remote communities and the strong foundation they provide for improving access to health care for these communities. Along with government investment in building local workforce and service capacity and providing support for patient transport that facilitate regional service access, outreach provides an essential way of enabling patients to access services without travelling far from their local community.

The Commonwealth government provided $89.1m in funding support for the 6 outreach programs in 2020–21, excluding any related MBS expenditure (see Table 1).

Table 1*:* Program funding and activity 2017-18 to 2020–21

Program	2017-18	2018-19	2019-20	2020-21
MOICDP	$33,750,000	$32,710,000	$36,350,000	$36,967,950
Healthy Ears	$7,255,027	$7,350,000	$7,350,000	$7,350,000
VOS	$6,552,831	$6,916,379	$7,006,292	$8,709,241
RHOF	$27,404,300	$26,980,245	$27,363,586	$27,814,559
RHOF PM	$0	$0	$2,030,000	$2,062,000
EESS	$2,801,000	$2,000,000	$1,660,000	$2,244,000
Heart of Australia	$0	$0	$4,000,000	$4,000,000
Total	$77,763,158	$75,956,624	$85,759,877	$89,147,750

Source: Unpublished data provided by the Department of Health.

It is estimated that the mean service delivery expenditure provided under the MOICDP, HEBHBL, VOS and RHOF over the four years from 2017-18 to 2020-21 was $57.1m and this supported an estimated 56,000 visits by outreach providers to local communities across rural and remote areas of Australia, and an estimated 536,000 occasions of service to local patients.

Stakeholders consulted consistently commented on the critical nature of the outreach programs and the essential role they play in increasing access to health services in underserved communities. The fundholders and other local services anecdotally provided various examples of how the outreach programs have provided the community access to a range of health services where they otherwise would not have been available. Through the bi-annual reporting process, fundholders highlight good news stories that occurred within the relevant reporting period. These stories provide a rich qualitative evidence base that showcase the importance of the outreach programs and their impact on the communities in which they service. Stakeholders in the outreach space discussed the strong relationships they have forged and fostered with local and regional stakeholders which has allowed them to work together to plan, coordinate and deliver these much needed services to underserved communities across Australia.

Whilst noting some variation across jurisdictions, many host providers and visiting health professionals survey respondents also noted the critical importance of the outreach programs and rated various processes related to the delivery of the outreach programs highly. Over 70% of host providers who responded to the survey rated the integration and coordination of outreach services and collaboration with visiting providers as very/quite strong (72%; 81%; 89%, respectively). All host provider survey respondents assessed outreach services as important (97% very important; 3% quite important) and 85% described these services as very or quite accessible to people in the local community. Over 70% of visiting health professionals

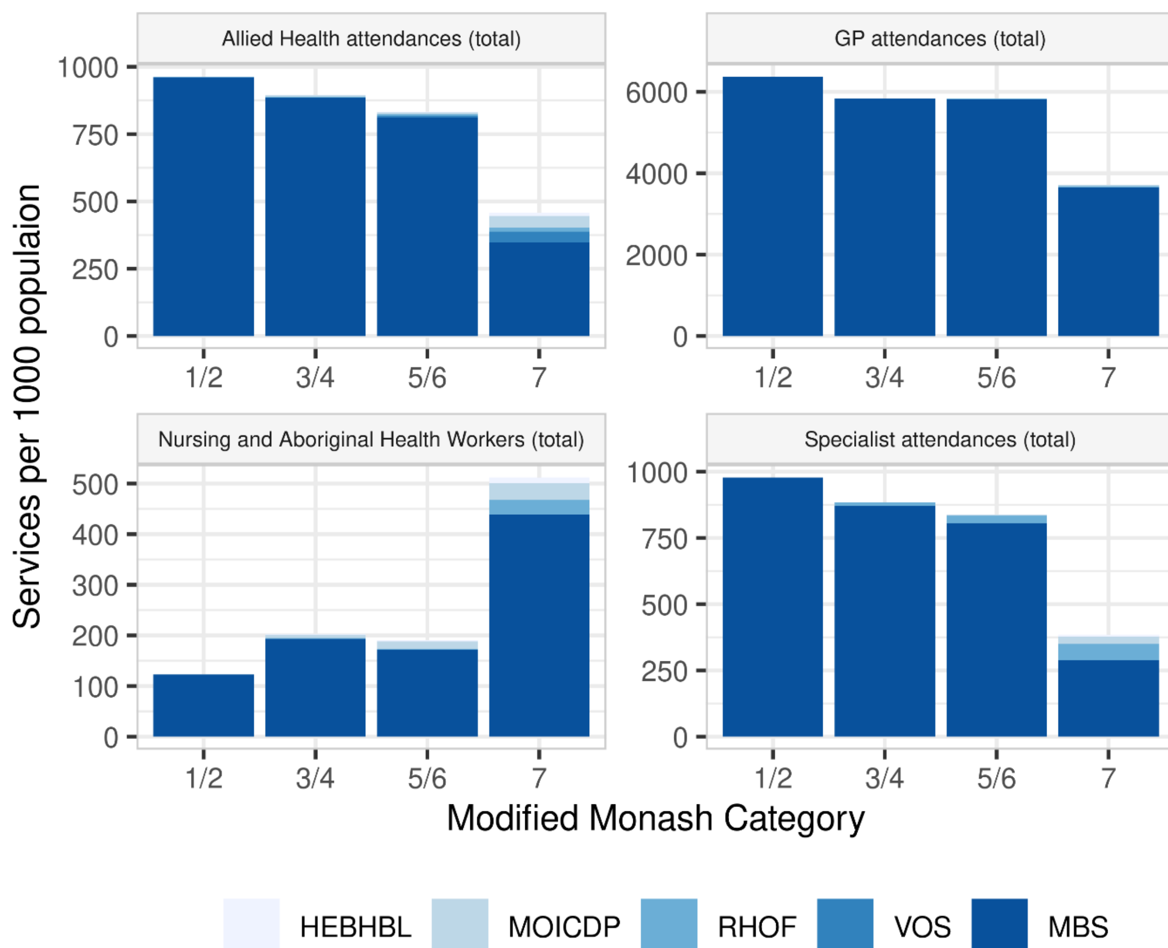
who responded to the survey rated the coordination of outreach services and collaboration with host provider staff as very or quite strong (71% and 78%, respectively).

Impact on access to services

Together, it is estimated that the MOICDP, HEBHBL, VOS and RHOF contribute over 25% of allied health (27.3%) and medical speciality services (28.7%) and over 15% of nursing and Aboriginal health worker services (15.4%) across small remote community in Australia that are categorised as MM 7. Just less than 2% of GP services (1.8%) are provided by outreach in these communities.

Figure 1 presents the underlying population service utilisation rate for each workforce grouping and MM category for the period 2017-18 to 2020-21. The figure demonstrates the extent to which outreach programs have contributed to improving the relative access to health care in rural and remote communities, particularly for allied health and medical specialist services. For example, we estimate the programs have reduced the difference in services access between MMM 1-2 and MMM 7 by 16.4% for allied health and 13.1% for medical specialists over the four years 2017-18 and 2020-21.

Figure 1: Estimated impact of outreach programs on underlying relative service utilisation in each Modified Monash category by workforce grouping, 2017-18 to 2020-21.



Source: Unpublished outreach program data and MBS data publicly available through the AIHW. Note outreach program data reflects the assumption that 50% of outreach activity is MBS billed.

This provides evidence that the objectives of the programs, in improving population access and reducing the gap between geographical regions and population groups, are being met.

Areas for improvement

Notwithstanding the significant benefit of the outreach programs, the data and information collected during the evaluation pointed to specific areas where improvements to the administration of the programs may be possible in the future through targeted action, including:

- **Improving efficiency**
  Outreach services aim to respond to the priority needs of local communities and be tailored to fill service gaps and integrate into the local services. Stakeholders consistently reported that the outreach programs were too complicated and prescriptive, offering little scope without a lengthy approval process to use the funds more flexibly within and across programs to meet health priorities.

- **Build stronger community engagement**
  Local communities value outreach services but often stressed that they have little involvement in service planning and configuration of the services. They are also concerned that once services are provided, many outreach providers do not spend sufficient time in the community building understanding and trust and assisting local staff in building capacity for shared care and developing priority skills and competencies. There were indications of robust engagement and partnership in the regional models reviewed during the evaluation.

- **Further support local services**
  Universally, stakeholders pointed to the importance of local service support as the pivotal factor for outreach service effectiveness. But all too often local services reported being overstretched and not adequately resourced to provide adequate support for outreach services, including availability of staff to coordinate clinics and telehealth consults and capital infrastructure to accommodate providers and enable telehealth. Recognising this reflects a broader issue of resourcing local health services, there may still be scope to further support local capacity through outreach funding.

- **Encourage further innovation**
  There are several innovations in outreach services, including greater use of telehealth during COVID–19, regional ACCHO-led services, mobile clinics and integrated eye services, but these innovations tended to be isolated and rely on the efforts of champions rather than be encouraged more broadly through stronger program incentives. Such incentives could help promote broader system adoption of appropriate local innovations.

- **Improve sharing and learning**
  Effective communication between outreach and host providers is important and further facilitation and encouragement of stable and trusted partnership in this regard would be valuable. Fundholders broadly supported a more active role by the Department in creating opportunities for sharing and learning across the system and providing feedback to them on performance and futures directions of the programs.

- **Enhance transparency**
  NACCHO and other stakeholders support greater consistency in how fundholders carry out need assessments and service planning. Nationally consistent and accessible data on program outputs is required. Fundholders would appreciate greater transparency over program funding and other program policy decisions. Stakeholders more broadly expressed the need for greater access to program information and more timely information.

- **Strengthen governance and funding stability**
  There was broad agreement that the 'shotgun' approach to fundholder arrangements was not optimal, but given the time and effort taken to establish productive relationships between agencies there is broad support across stakeholders for maintaining stability in the system. Fundholders and providers strongly support longer term funding assurances, to build trust in the system, enable attraction and retention of clinicians and ensure sustainability.

Recommendations in each of the priority areas for improvement were developed to address the issues highlighted in these areas. The recommendations categorised by each area of improvement can be found in Box 29 of this report. These recommendations have been reordered here to separately identify recommendations for initial action (see Box 1) and future-thinking (see Box 2) actions.

Recommended actions

The mixed methods approach allowed the evaluation team to draw upon a range qualitative and quantitative data sources outlined in the evaluation methods section above. The qualitative and quantitative information collected during the execution phase of the evaluation was subsequently synthesised and triangulated. The key areas for improvement and the associated 39 recommendations were developed as an output of this process.

The key areas for improvement outlined above highlight issues consistently raised by stakeholders across programs and jurisdictions in consultations, surveys and other key program documentation. Through the analysis of the quantitative data sources, such as AIHW data and program financial and activity documents, the team sought to assess the potential impact of the outreach programs and explore the themes discerned from the qualitative data sources.

The recommendations set forth below are actions that seek to alleviate reported and observed challenges within and across programs. The aim of the suggested actions is to reduce reported barriers and enhance the effectiveness and efficiency of the outreach programs in meeting their outlined policy objectives.

Box 1 lays out 18 recommendations for initial action and Box 2 sets out 21 further recommendations for future-thinking action. Additionally, a range of broader health system issues have been identified in Box 3.

In formulating the recommended actions, consideration was given to the implications for Aboriginal and Torres Strait Islander people and the alignment with supporting the priority reform objectives of the Closing the Gap Agreement:

- Priority Reform 1 – Formal partnerships and shared decision making
- Priority Reform 2 – Building the community-controlled sector
- Priority Reform 3 – Transforming government organisations
- Priority Reform 4 – Shared access to data and information at a regional level

Chapter 7 and 8 of the report provide further details on relevant actions and broader system issues and their alignment with the Closing the Gap Agreement.

Box 1: 18 Recommendations for initial action

1. **Recommendation 1:** The Department to review the governance and funding arrangements for HoA with a view to strengthen the overall coordination and integration of regional and local outreach service planning and delivery across Queensland.

2. **Recommendation 2:** Remove variation in the annual service plan approval process and establish a consistent approach across all programs by enabling the advisory forum in each jurisdiction to approve annual service plans for the RHOF.
3. **Recommendation 3:** Existing fundholders should be retained across all jurisdictions, while supporting the establishment or continued support of regional governance models that enable decisions regarding service planning, funding and delivery to be progressively devolved. This will build the capacity for regionally-responsive models that provide outreach to surrounding local communities.
4. **Recommendation 4:** Encourage fundholders to maintain a single advisory forum that oversees the needs and service planning functions for all outreach programs. Where multiple outreach fundholders exist in a jurisdiction, the fundholders could be encouraged to establish a shared Advisory Forum and coordinate needs assessment and service planning processes to avoid duplication and streamline reporting to the Department. These arrangements could be extended to include other organisations involved in improving access to health services (for example, PHNs), where appropriate.
5. **Recommendation 5:** To strengthen the role of the Aboriginal and Torres Strait Islander health sector in the governance of outreach programs, require fundholders to invite the National Aboriginal Community Controlled Health Organisation affiliate organisations (or their nominee) to co-chair the advisory forum.
6. **Recommendation 6**: Require fundholders to provide the Department and the National Aboriginal Community Controlled Health Organisation with their planned needs assessment and service planning processes for each period, including how and when they will engage with local communities and other key stakeholders and to what extent the process will be coordinated with other fundholders to avoid duplication and streamline reporting to the Department.
7. **Recommendation 7:** Fundholders to make the following publicly available:
    - The planned needs assessment and service planning process before for each planning period, including the nature and timing of opportunities for local communities and other key stakeholders to provide input into the process and key contacts for feedback.
    - The outcomes of the needs assessment and the service plan before the commencement of each the service period, including details of the services and communities to receive the services.
8. **Recommendation 11:** The Department to engage with fundholders, and NACCHO and its affiliates, directly and more actively in creating opportunities for it to share and learn from each other and provide information and feedback on their performance and the future directions for the programs, including annual plenary planning forums, online communities of practice, regular performance feedback and national events to 'showcase' service innovations.
9. **Recommendation 12:** To improve transparency and support the objectives in the Closing the Gap Agreement, the Department to consult with the National Aboriginal Community Controlled Health Organisation and its affiliates prior to finalising funding allocations for Aboriginal and Torres Strait Islander Australians under the MOICDP, VOS, HEBHBL, EESS outreach programs.
10. **Recommendation 15:** Establish harmonised service delivery standards for the RHOF and the MOICDP to enable more flexible use of funding and better support local community health priorities. The service delivery standards should remove any inconsistencies by providing for the same level of coverage of the:
    - MM categories
    - Age of patients
    - Range of medical, allied health and nursing providers
    - Range of health conditions that can be addressed in meeting local priorities.
11. **Recommendation 17:** Ensure the service delivery standards for HEBHBL program, the provision under the VOS and EESS program are harmonised with those for the RHOF and the MOICDP to ensure consistent coverage of patient age groups and MM categories. While noting the variation in program objectives, alignment of age and location of patients may facilitate integration of services in supporting the broader eye and health needs of individuals in local communities

12. **Recommendation 19:** Review the current indexation of outreach programs with a view to applying a consistent approach across all programs with consideration given to existing approaches (for example MBS indexation, or the way the Independent Hospital Pricing Authority determines the hospital efficient price).
13. **Recommendation 20:** Review the range of planned service arrangements that require fundholders to seek approval from the Department (including alternative services arrangements where an underspend is anticipated) with a view to allow greater fundholder decision making capacity while strengthening reliance on fundholder accountability to ensure appropriated service provision and value for money.
14. **Recommendation 23:** Simplify and harmonise guidance in the service delivery standards across all programs on the remuneration arrangements available for each workforce group and how they interact with funding support for transport, accommodation and food, including clarification of appropriate use of the Medicare Benefits Schedule and Workforce Support Payments to provide coverage of time:
    - travelling while away from usual practice
    - providing direct patient care
    - building local workforce capacity
    - engaging with local communities.
15. **Recommendation 25:** Extend the provision of funding for administration of the programs from 15% to 20%, with the requirement that 10% of the funding to be provided to extend financial support to host providers to coordinate and participate in face-to-face outreach visits, telehealth shared care arrangements, upskilling and education of their staff and enable community-led orientation and cultural awareness training.
16. **Recommendation 26:** Specify the requirement in the service delivery standards that a framework be applied to help guide the development of agreed local host and outreach provider arrangements in each community, including the number and nature of local staff involved, clinical equipment and facilities required, clinical referral protocols for ongoing treatment, risk management protocols and clinical governance arrangements.
17. **Recommendation 31:** Building on the momentum achieved through the COVID-19 pandemic, develop and monitor the implementation of a national program of shared care arrangements including local support for use of telehealth to broaden access and reliability of services, upskill the local workforce and support cost-effective continuity of care.
18. **Recommendation 37:** Allow fundholders to provide a consolidated:
    - needs assessment
    - annual service plan
    - narrative report.

    These documents would cover all the outreach programs. The single narrative report should include an explanation of factors contributing to any significant activity and/or budget variances within specific programs and identify planned mitigation strategies to bring the programs back on track.

Box 2: 21 Future-thinking actions

1. **Recommendation 8:** The Department to review existing fundholder data information and reporting and design and establish a new standardised single national minimum data set, along with a streamlined data collection and reporting process, that:
    a. covers all programs
    b. reduces data burden on fundholders.
    c. provides a sound basis for performance monitoring and feedback
    d. enables consolidation of the data at the jurisdiction and national levels.
2. **Recommendation 9:** As part of the new standardised national minimum data set, the Department to establish and collect a small suite of key consumer facing key performance indicators (including outreach provider continuity, patient experiences, clinic utilisation, visit duration and unit costs)

with data elements specified in the Australian institute of Health and Welfare metadata store to improve consistency and facilitate cross-jurisdictional comparisons.

3. **Recommendation 10:** To improve transparency and establish more robust data sharing arrangements that align with the National Agreement on Closing the Gap, the Department to provide key stakeholders groups, such as the National Aboriginal Community Controlled Health Organisation, its affiliates and the fundholders with regular and timely access to the national minimum dataset for the outreach programs.
4. **Recommendation 13:** Fundholders to work with the NACCHO affiliates to identify further opportunities to progressively devolve outreach program funding for MOICDP, VOS, HEBHBL, EESS to regional Aboriginal Community Controlled Health Organisations, where robust governance and service capacity are in place.
5. **Recommendation 14:** The Department to explore ways to further integrate the VOS with funding support under the RHOF and the MOICDP for ophthalmologists and other eye health providers to enable more flexible use of eye health funding and better support local community eye health priorities, including review of existing enabling legislation for the Visiting Optometrists Scheme.
6. **Recommendation 16:** Extend the scope and coverage of the service delivery standards of the RHOF and the MOICDP to explicitly include dental health and to confirm coverage of eye and ear health services to clarify the scope for integration with services funded under other relevant outreach programs.
7. **Recommendation 18:** Review the current approaches to allocating funding to jurisdictions for the programs and explore alternative methods, including those that are responsive to both changes in demographics and the capacity of local service provision. For example, variations in Medicare Benefits Schedule utilisation across rural and remote areas in each jurisdiction could provide a signal of local service capacity and align with the Workforce Incentives Program and other initiatives aimed at building the local workforce.
8. **Recommendation 21:** Encourage fundholders to extend existing collaborative arrangements with other fundholders to foster regional approaches to conducting needs assessment and service planning and establishing a shared 'regional master plan' that incorporates outreach, regional and local services.
9. **Recommendation 22:** Establish a greater focus on planning, monitoring and funding time spent by outreach providers in undertaking community engagement and relationship building and host provider teaching and training. These activities could be supported by incorporating specific plans guided by consultation with communities and budget allocations under the overall service plans.
10. **Recommendation 24:** Review the Medical Benefits Schedule and existing workforce support payment arrangements to create a simpler, more consistent and sustainable way to reimburse outreach providers. This may include exploring the feasibility of moving to blended payments.
11. **Recommendation 27:** Fundholders to establish online portals with information about all outreach services planned across jurisdictions, including interactive maps that highlight service location, clinic type, visit dates and contact details of host and outreach providers. There may be opportunities for these portals to evolve and enable consumers and referring health professionals to book appointments at the clinics and receive reminders in the future.
12. **Recommendation 28:** The Department to commission the development of, and the National Aboriginal Community Controlled Health Organisation to oversee the administration of, national host provider and patient experiences surveys (and/or other culturally appropriate activities) after each planning cycle. The National Aboriginal Community Controlled Health Organisation to report back on the key findings to the fundholders and the Department before the next planning cycle.
13. **Recommendation 29:** Require fundholders to work collaboratively with rural health workforce agencies, local host providers and other relevant agencies to actively plan for the withdrawal of outreach services in response to opportunities to build local workforce capacity, thereby actively working to reduce the risk of unnecessary ongoing reliance on the provision of services by outreach providers.
14. **Recommendation 30:** The Department to consult with the Australian Commission on Safety and Quality in Health Care on their progress in developing culturally safe PREMs suitable for use with

Aboriginal and Torres Strait Islander patients, including exploration of opportunities for outreach services to pilot the tool during development.

15. **Recommendation 32:** The Department to review existing and anticipated future Medicare Benefits Schedule items for telehealth to assess the viability to support the expansion of telehealth enabled shared care arrangements for both medical and non-medical outreach providers.
16. **Recommendation 33:** The Department to commission a review of the cost of providing HoA mobile services to assess value for money and consider the sustainability of the services in light of planned local and regional service developments and alternative outreach services. The evaluation should include consideration of both total capital and recurrent costs.
17. **Recommendation 34:** Commission assessments of alternative service models that services are exploring in outreach to assess their value-for-money and potential in increasing access to underserved communities.
18. **Recommendation 35:** Review the funding provision for program administration in 3 to 5 years in light of the impact of implementing recommended efficiency measures, particularly where there are existing systems and the fundholder administers multiple programs. Rather than a percentage, consider the feasibility of capping the amount of funding allocated for administration.
19. **Recommendation 36:** The Department to establish unit costing methods using the routine national outreach data collection to facilitate sharing and learning across fundholders and service provider organisations and allow greater understanding of the key cost drivers facing fundholders for particular services, regions and communities.
20. **Recommendation 38:** The Department to work with state and territory departments to explore alternative arrangements for the Ear and Eye Surgical Support Services program that may better support access to elective ear and eye surgery for Indigenous Australians in public and private hospitals, including options that build on existing national and regional systems and processes.
21. **Recommendation 39:** To enhance communication across providers and patient access to care records, require outreach providers to upload an event summary onto My Health Record for every patient attendance at an outreach clinic, giving due consideration to arrangements for patients without My Health Record accounts.

Box 3: Broader health system observations

Broader system observation 1: To strengthen consideration of health outreach as an enduring and responsive mechanism to improving service access in rural and remote communities, the Department could consult with officers from relevant portfolio areas to ensure further integration of the health outreach programs is achieved through future strategy development under the Stronger Rural Health Strategy and the National Agreement on Closing the Gap.

Broader system observation 2: Department could explore feasibility of revising funding arrangements to better support the sustainability of outreach providers and services by establishing processes for more predictable and reliable funding.

Broader system observation 3: The Department could consult with universities and health agencies responsibilities for medical, nursing and allied health student clinical placement programs to explore scope to further integrate students into outreach services, including arrangements to financially support students.

Broader system observation 4: The Department could encourage fundholders to engage with public and private health service agencies to identify and explore the potential to expand strategies to promote a workplace culture whereby participation in outreach is actively supported by the agency.

Broad system observation 5: The Department could encourage host services to further explore new workforce models and training pathways, such as the Certificate III in Allied Health Assistance, which seek to bolster and develop local capacity to better support the outreach programs.

Broader system observation 6: The Department to consider the feasibility of commissioning the assessment of service models to build an evidence base for innovations that represent value for money, with a view to provide support for the capital infrastructure required for such innovations through the establishment of an open and contestable national funding pool.

Broad system observation 7: The Department could commission a study on the long term recurrent costs of transport for one day visits versus the provision of capital infrastructure that provides accommodation and support for longer stays by outreach providers, particularly in smaller and very remote communities. This may contribute to broader economic consideration of the financing of capital infrastructure in rural and remote communities.

Broader system observation 8: The Department may seek to investigate possible ways to further encourage fundholders to explore potentially cost-effective service innovations, recognising that existing arrangements allow fundholders to roll over unspent funds that may result from efficiencies generated from service innovations and invest them back into service expansion.

1

Policy context for outreach programs

Access to health care is a hallmark of Medicare, irrespective of where a person lives. Ensuring access to care in rural and remote areas of Australia and smaller communities remains a policy priority and ongoing challenge for governments. Outreach is one of the key strategies used to provide access to these communities.

Various levels of government invest in outreach. The Commonwealth government administers a range of outreach programs aimed at boosting primary health care and specialist care through fundholder arrangements with rural workforce agencies and Primary Health Networks (PHNs). State and territory governments invest in outreach to ensure the safe operation of small country hospitals in addition to filling gaps in service provision. The disability and aged care sectors are also providing outreach services that often call on similar workforce groups as the health sector.

Outreach can be provided through hub-and-spoke models, where collaborative arrangements between regional services and local services enable clinicians to visit small communities rather than fly-in-fly-out services from metropolitan centres. Where access to care is required from clinicians from metropolitan centres, face-to-face visits can be supplemented with telehealth services, sharing care with local staff and thus providing continuity of care for patients. Outreach is also being expanded to more specialised care requiring dedicated facilities, equipment and expertise through mobile clinics. Rather than transport patients to the service to enable economies in the use of high-cost capital infrastructure, the mobile clinics bring the services to the communities.

Box 4 provides an overview of the national policy landscape.

Box 4: Overview of national policy landscape

Australia's Long Term National Health Plan[2]

Australia's Long Term National Health Plan outlines reform plans for guaranteeing Medicare and stronger primary care, including stronger rural health, supporting public and private hospitals, and prioritising mental health and preventative health.

The plan refers to the government's investment in the **Stronger Rural Health Strategy,** which sets out initiatives aimed at delivering 3,000 additional doctors and 3,000 additional nurses to rural and remote regions over 10 years, including new clinical training schools to enable doctors to train and work in rural and remote areas, and opportunities for nurses and allied health professionals to have a stronger role in multidisciplinary care.

The plan recognises that the National Rural Generalist Pathway will strengthen primary care through training and recognition for rural GPs and highlights that the Royal Flying Doctor Service and the Rural Health Outreach Fund are already strengthening access to needed healthcare services.

[2] Australian Department of Health. (2019). *Australia's Long Term National Health Plan.* https://www.health.gov.au/sites/default/files/australia-s-long-term-national-health-plan_0.pdf

National Agreement on Closing the Gap[3,4]

The objective of the National Agreement on Closing the Gap is to enable Aboriginal and Torres Strait Islander people and governments to work together to overcome the inequality experienced by Aboriginal and Torres Strait Islander people. At the centre of the agreement are 4 priority reforms that focus on changing the way governments work with Aboriginal and Torres Strait Islander people:

1. Strengthen and establish formal partnerships and shared decision-making
2. Build the Aboriginal and Torres Strait Islander community-controlled sector
3. Transform government organisations so they work better for Indigenous Australians
4. Improve and share data and information to enable Indigenous communities make informed decisions.

The Productivity Commission has established a dashboard to monitor the agreement and in terms of the reform priorities indicators include, the number of partnerships, number of government contracts awarded to Aboriginal Community Controlled Health Organisations (ACCHOs), number of Indigenous Australians employed in mainstream government organisations and number of comprehensive regional profiles created.

National Medical Workforce Strategy[5]

The National Medical Workforce Strategy 2021–2031 acknowledges the maldistribution of the medical workforce across rural and remote area as a priority for reform and recommends action that aligns with the national health plan to:

- Build on innovative funding and incentive models for GPs in rural and remote areas in collaboration with regional networks and the National Rural Health Commissioner and the Primary Health Care 10 Year Plan.
- Monitor the use of locums in providing outreach services and direct doctors entering Australia from overseas to practice in areas of most need, noting general concerns of an over reliance on both locums and international medical graduates.
- Reshape training to increase pathways and posts available in rural and remote areas, including models that create connections between metropolitan and regional services so that trainees can be based in rural areas and college selection processes that target rural origin students.
- Promote generalism as an attractive career path and work collaboratively to reduce the stigma around generalist careers, including continued implementation of the National Rural Generalist Pathway and leverage of innovations that can be adapted to other medical specialties.

National Nursing Strategy[6]

The Chief Nursing and Midwifery Officer is leading work to develop the first National Nursing Strategy. The strategy will look at: workforce sustainability, diversity of the profession and the challenges of regional, rural and remote nursing.

National Rural Health Commissioner report on Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia[7]

The recommendations of this report are designed to promote better use of existing resources and infrastructure to address current gaps in allied health workforce distribution and service provision in rural and remote populations including:

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[3] Closing the Gap. (n.d.). *Priority Reforms*. https://www.closingthegap.gov.au/national-agreement/priority-reforms

[4] Coalition of Peaks. (2020). *National Agreement on Closing the Gap*.

[5] Australian Department of Health. (2021b). *National Medical Workforce Strategy 2021-2031*. https://www.health.gov.au/sites/default/files/australia-s-long-term-national-health-plan_0.pdf

[6] Australian Department of Health and Aged Care. (2021). *What we're doing for nurses and midwives*. https://www.health.gov.au/health-topics/nurses-and-midwives/what-we-do

[7] National Rural Health Commissioner. (2020). *Report on Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia*. https://www.health.gov.au/sites/default/files/documents/2021/04/final-report-improvement-of-access-quality-and-distribution-of-allied-health-services-in-regional-rural-and-remote-australia.pdf

- Improved access by trialling Service and Learning Consortia that integrate rural and remote 'grow your own' health training systems with networked rural and remote health service systems.
- Increase the participation of Indigenous people in the allied health workforce by expanding the National Aboriginal and Torres Strait Islander Health Academy model and creating a Leaders in Indigenous Allied Health Training and Education Network.

National Rural Health Commissioner

The National Rural Health Commissioner works to improve rural health policies and keep a strong focus on the needs of rural communities with current focus on regional funding support for the development of localised innovative models of care and recognition and implementation of the national rural generalist pathway.

Australia's Primary Health Care 10 Year Plan[8]

The focus of Australia's Primary Health Care 10 Year Plan is on the integration of primary health care with hospitals and other parts of the health system, aged care, disability care and social care systems. The plan sets out actions over the short, medium and longer term to progress reform across 3 themes: future focused, person centred and integrated care including:

- Voluntary patient registration to support continuity of GP care establish a basis for continuation of Medicare Benefits Schedule (MBS) telehealth.
- Implement regional collaborative commissioning approaches in rural health to drive sustainable 'one health system' models.
- Trial rural area community controlled health organisations to support comprehensive primary health care teams in areas of market failure.
- Moves over time from PHN commissioning of Indigenous services to direct funding of ACCHOs and trialling Indigenous community-led commissioning models.

The aim being to systematically implement joint jurisdiction-wide planning of primary health care services in each jurisdiction, consistent with the National Health Reform Agreement, with Commonwealth, State/Territory, PHNs, local health networks (LHNs) and other stakeholders at the table. Over time, PHNs and LHNs should be required to develop joint regional plans and collaborative commissioning approaches.

The plan notes that Chief Nursing and Midwifery Officer is leading work to develop the first National Nursing Strategy. The strategy will look at: workforce sustainability, diversity of the profession and the challenges of regional, rural and remote nursing.

National Health Reform Agreement Long Term Health Reforms Roadmap[9]

The National Health Reform Agreement Long Term Health Reforms Roadmap identifies actions, deliverables and timeframes for key areas of reform:

- nationally cohesive health technology assessment
- paying for value and outcomes
- joint planning and funding at a local level
- empowering people through health literacy
- prevention and wellbeing
- enhanced health data centre
- interfaces between health, disability and aged care systems.

The aim of efforts to reform planning and intersectoral collaboration is for integrated planning and funding of health services at a local level to support providers to plan, resource, work together, and coordinate care for patients. Better coordination between the hospital, primary care, aged care and disability systems will better ensure people can access the services they need.

[8] Australian Department of Health. (2022). *Australia's Primary Health Care 10 Year Plan 2022-2032*. https://www.health.gov.au/sites/default/files/documents/2022/03/australia-s-primary-health-care-10-year-plan-2022-2032-future-focused-primary-health-care-australia-s-primary-health-care-10-year-plan-2022-2032.pdf

[9] Australian Health Ministers. (2021). National Health Reform Agreement Long Term Health Reforms Roadmap. https://www.health.gov.au/sites/default/files/documents/2021/10/national-health-reform-agreement-nhra-long-term-health-reforms-roadmap_0.pdf

2

Evaluation scope and objectives

The Department of Health and Aged Care (the Department) engaged Health Policy Analysis (HPA) to evaluate its outreach programs in July 2021. The evaluation of the outreach programs was conducted between July 2021 to September 2022 and sought to assess the impact of the programs between 2017-18 and 2020-21. Table 2 lists the programs that fall within scope of the evaluation and provides a brief description of the populations and areas of focus of each program.[10,11]

Table 2: Description of outreach programs in scope of the evaluation

Program	MM category coverage	Program description
Eye and Ear Surgery Support (EESS)	3–7	Supports for more timely access to surgical interventions for Aboriginal and Torres Strait Islanders who need eye surgery and/or ear surgery for conditions arising from Otitis Media.
Healthy Ears, Better Hearing, Better Learning (HEBHBL)	2–7[1]	Aims to increase access to ear and hearing services for Aboriginal and Torres Strait Islander children and youth aged 0-21 in rural and remote areas.
Heart of Australia (HoA)[12]	2–7 Currently Qld only	Provides specialist medical services, including cardiology and respiratory medicine, to 31 regional, rural and remote communities in Queensland.
Medical Outreach Indigenous Chronic Disease Program (MOICDP)	1–7	Supports increased access to healthcare for Aboriginal and Torres Strait Islander people with chronic disease. The scope of this program includes all Indigenous people with chronic disease regardless of geographical location
Rural Health Outreach Fund (RHOF)	3–7	Aims to improve access to healthcare services for all residents in rural and remote communities. The program has 4 areas of focus: mental health, eye health, chronic disease and paediatric health. The evaluation also encompasses the Rural Health Outreach Fund Pain Management (RHOF-PM) and Tele-Derm which are both funded under the RHOF. RHOF-PM supported the extension of specialist pain management services (2019 to 2021). Tele-Derm is a service that provides rural and remote doctors access to dermatological advice and education.

[10] Australian Department of Health. (2020a). *Outreach Programs Service Delivery Standards*. https://www.health.gov.au/sites/default/files/documents/2021/12/outreach-programs-service-delivery-standards.pdf
[11] Australian Department of Health. (2020b). *Rural Health Outreach Fund: Service Delivery Standards*. https://www1.health.gov.au/internet/main/publishing.nsf/Content/651B62BEE7DE74CFCA257BF0001C95A3/$File/RHOF-Service-Delivery-Standards-From-1-July-2020.pdf
[12] Heart of Australia. (2022). *About Heart of Australia*. https://www.heartofaustralia.com/about_us/

Program	MM category coverage	Program description
Visiting Optometrist Scheme (VOS)	2–7	Supports optometry services for Australians in regional, rural and remote areas. The program has Indigenous (40%) and non-Indigenous (60%) funding components.

[1]*Note: Aboriginal and Torres Strait Islanders residing in MM1 locations may receive support may receive HEBHBL services on approval*

The overall aim of the evaluation was to help inform future policy decisions and examine ways in which health access in regional, rural and remote locations can be strengthened through improved outreach programs. The evaluation set out to answer these questions by taking a high level approach and delving into themes, findings and recommendations discerned across Commonwealth outreach programs more broadly rather than an in-depth exploration into themes and issues of specific programs.

Many of the outreach programs have a particular focus and impact on Aboriginal and Torres Strait Islander people and individuals residing in regional, rural and remote areas, noting MOICDP does not have any geographic location limits, as the programs aim to improve access to health services and outcomes for these populations; therefore, Aboriginal and Torres Strait Islander people are of central importance in this evaluation.

The evaluation sought to identify barriers and enablers to implementing initiatives and assess the efficiency, effectiveness and appropriateness of these programs. Table 3 presents the high level questions and sub-questions the evaluation aimed to address.

Table 3: Key evaluation questions and sub questions and data sources

Evaluation questions
1 How well are each of the outreach programs being delivered?
1.1 How well are the programs being governed? Funding allocations. Fundholder arrangements. Jurisdictional advisory fora. Performance monitoring and assessment.
1.2 How well are community needs identified and addressed through service planning? Needs assessment and service planning. Local community engagement. Allocation to areas of priority need.
1.3 How well are outreach providers recruited and placed according to the service plan? Awareness of programs. Evaluation of service proposals. Provider participation and retention.
1.4 How well are the services operating within the local communities? Local service coordination. Upskilling of local service providers. Integration of outreach and local services. Cultural competence of outreach providers.
2 How effective are each of the outreach programs in achieving their intended outcomes?

Evaluation questions	
	2.1 How effective is each program in increasing access by the relevant service populations? Service provision and utilisation. Multidisciplinary approach to care. Service range (prevent, detect, manage). Fit for purpose service delivery models. Financial factors.
	2.2 How effective is each program in contributing to improved health outcomes for the relevant populations? Existing measurement and monitoring. Experience of local services and providers.
	2.3 What impact is telehealth having on delivery of each of the programs? Local capacity to provide. Existing utilisation trends (e.g. Tele-Derm). Integration into outreach service models.
3	**How efficient and cost-effective are each of the outreach programs?**
	3.1 What are the key cost drivers in managing the outreach programs? Administration costs. Outreach service delivery costs. Host service provider costs. Location-specific challenges.
	3.2 Are the outreach programs a cost-effective method of achieving desired outcomes? Existing program unit costs. Alternative service models.
4	**To what extent are the outreach activities coordinated across the outreach programs?**
	4.1 To what extent has program administration been coordinated across programs? Coordination of outreach programs across Fundholders. Location-specific challenges.
	4.2 To what extent have the programs provided integrated services and continuity of care? Integration of services across outreach programs. Integration of outreach programs with local services.

3

Evaluation methods

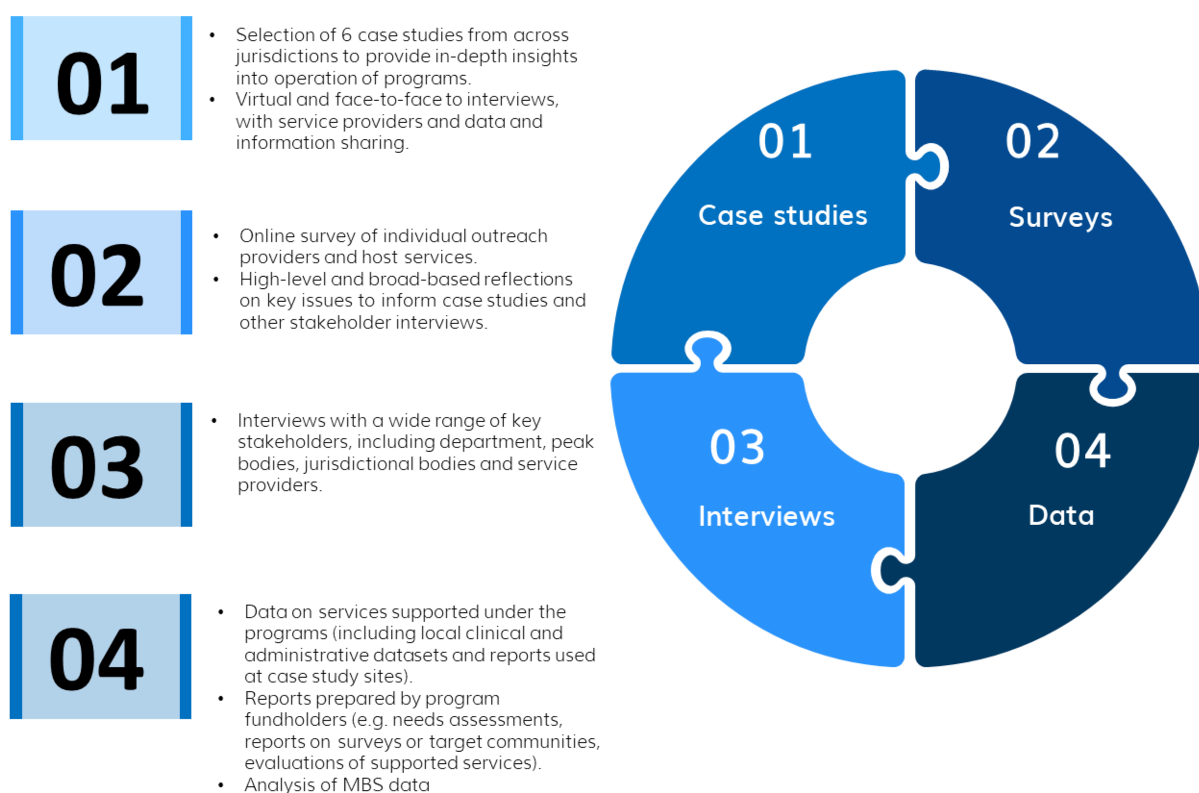
The following section outlines the project methodology to conduct the evaluation of the outreach programs.

The evaluation methods outlined reflect the evaluation plan approved by the Department in November 2021. Key evaluation questions and sub-questions were developed and data sources to answer the evaluation questions were specified in the plan.

Evaluation data sources

The evaluation team used a mixed methods approach to evaluating the programs, which drew on a variety of qualitative and quantitative sources. Figure 2 outlines the evaluation data sources. These are then described in turn.

Figure 2: Evaluation data sources



1. Case studies

Six case studies were conducted across 5 jurisdictions. Volume 2 describes the case study sites and services.

Figure 3: Case study descriptions

Case study	Jurisdiction	Description
Heart of Australia	Queensland	Geographically-based case study, covering the Heart of Australia program providing services in the town in Theodore.
True Relationships & Reproductive Health	Queensland	Serviced-based case study, covering the RHOF and focussed on a sexual health outreach program provided by True Relationships & Reproductive Health based in Brisbane.
South Coast	New South Wales	Geographically-based, covering all programs in the SE NSW region, and, in particular, outreach service delivery in the communities of Nowra and Batemans Bay.
Central Australia Aboriginal Congress	Northern Territory	Geographically-based, focussing on the MOICDP and covering the central Australia region of the NT
North West Tasmania	Tasmania	Located in the North West of the island and focussed on all outreach services provided in communities such as Burnie, Wynyard and Smithton, including the primary health care services provided by Rural Health Tasmania and the coordination of the EESS program for the jurisdiction.
Kimberley region	Western Australia	Geographically-based, covering all programs in the Kimberly region with The Lions Eye Vision Northwest Eye Hub highlighted as an example of regional innovation.

The case studies were conducted virtually or face-to-face from January through to late April 2022. While the original aim was to conduct all case study visits engaging with stakeholders face-to-face, COVID–19 impacted on the method in which the visits were conducted (see section 'Impact of COVID–19' below).

The detailed findings and observations from the case studies are presented in Volume 2, with an overview and summary of key messages from the case studies provided in this report in Appendix 1G: Key observations from case studies.

2. Surveys

Three surveys were developed and distributed for the purposes of the evaluation:

- Workforce peak bodies. Brief survey of key workforce peak bodies identified in the stakeholder engagement plan, with an invitation for follow up with a semi-structured interview.
- Outreach providers. Survey of the clinicians who provided the outreach services to people in the communities visited, as distinct from the organisations contracted by fundholders to coordinate the services of the clinicians.
- Host providers. Survey of representatives of the local community services that host the outreach clinicians, whether this be a local GP clinic, community health service, local hospital or Aboriginal Medical Service.

Box 5 highlights the topics collected through each of the surveys.

Box 5: Information collected through outreach surveys

Workforce surveys

- Importance of outreach services
- Effectiveness of outreach services
- Barriers and enablers
- Recommendations to strengthen outreach programs

Outreach and host provider surveys

- Recruitment and retention of outreach providers
- Aspects of delivering outreach services including:
  - importance of outreach services
  - coordination of outreach services
  - community involvement and collaboration
  - upskilling and capacity building
  - cultural competency
  - patient safety and clinical quality
  - integration and continuity of care.
- Telehealth in outreach service delivery
- Barriers and enablers
- Recommendations and further comments

Workforce peak bodies survey

The workforce peak bodies survey asked respondents to comment on the importance of outreach services, the effectiveness of specific outreach programs within scope of the evaluation and barriers and enablers to the effectiveness of these programs.

Survey invitations were distributed to 12 workforce peak bodies in December 2021. The workforce bodies survey was subsequently sent to 19 contacts within these organisations, with 4 responses received back, resulting in a 21% response rate. Respondents included representatives of the following organisations:

- Optometry Australia
- Australian College of Rural and Remote Medicine
- Australian Society of Ophthalmologists
- Australian Medical Association.

Stakeholders that did not submit a response indicated that while they are aware of the outreach programs, they could not contribute insights.

Outreach and host provider surveys

A total of 9 out of the 10 jurisdictional fundholders distributed surveys to their individual outreach and host providers. Rural Health Tasmania was the only fundholder that did not distribute surveys to their host and outreach providers as the organisation only recently became the fundholder for the EESS and did not begin actively overseeing service operations until mid–2022.

The timeframes in which the outreach and host provider surveys were active in the field were dependent on fundholder priorities and reporting requirements, but generally the surveys were distributed between December 2021 and late April 2022

Table 4 and Table 5 show the response rates for the outreach and host provider surveys across jurisdictions. The response rates for both the outreach and host provider surveys reflect the submissions that were considered usable for analysis (excluding responses that had less than 10% of the survey questions completed).

Table 4: Outreach provider response rates

Fundholder	Jurisdiction	Response rate (%)
HoA	Qld	16% (5/32)
CheckUP	Qld	18% (48/264)
TAZREACH	Tas	23% (24/105)
RWAV	Vic	32% (18/57)
RHW	WA	50% (19/38)
NSW RDN	NSW	11% (129/1149)
RDWA SA	SA	17% (21/123)
NT PHN	NT	45% (22/49)
NT Health	NT	Unknown (9 responses included)
Total		**16% (295/1817*)**

Notes: Values rounded to the nearest tenth. The denominator in the total response rate does not reflect total submissions from the NT Health as this figure was not reported.

Table 5: Host provider response rates

Fundholder	Jurisdiction	Response rate
HoA	Qld	4% (2/55)
CheckUP	Qld	7% (8/124)
TAZREACH	Tas	9% (5/57)
RWAV	Vic	54% (7/13)
RHW	WA	48% (10/21)
NSW RDN	NSW	45% (25/56)
RDWA SA	SA	20% (11/54)
NT PHN	NT	23% (9/40)
NT Health	NT	Unknown (includes 10 responses)
Total		**21% (87/420*)**

Notes: Values rounded to the nearest tenth. The denominator in the total response rate does not reflect total submissions from the NT Health as this figure was not reported.

The response rates for the host and outreach provider surveys were lower than anticipated and were clearly impacted by competing priorities (including separate surveys conducted by the fundholders) and pressures associated with COVID–19. The HPA team, assisted by the fundholders, followed up with survey recipients prior to the survey closing dates. On multiple occasions, the team received feedback from respondents across jurisdictions that many recipients did not have capacity to complete the survey.

Information on the key themes from the survey responses is woven throughout Chapter 6. More information on the survey questions and responses by stakeholder group is provided in Appendix 3A, Volume 3.

3. Interviews

The scope of stakeholder interviews was guided by the stakeholder engagement plan developed as part of the project plan, with a total of 77 stakeholders within scope and invited for an interview.

The timing of communication from the Department and/or HPA regarding the evaluation varied by stakeholder group. For example, HPA made initial contact with the fundholders in August and September 2021 in the evaluation planning stage to conduct initial interviews, begin the process of gathering fundholder documents and data and select case study sites. HPA then made initial contact with national stakeholder groups, such as NACCHO and the National Rural Health Commissioner, to inform them of the evaluation and invite them to participate in an interview. Following on from initial interviews conducted in the planning stage, HPA worked with the Department and the fundholders to select the case study sites and contact relevant jurisdictional stakeholders in both case study and non-case study sites between November 2021 to April 2022. The evaluation information sheet provided to stakeholders is in this volume

in Appendix 1B: Information provided to stakeholders, and examples of interview topic guides by stakeholder group are in Appendix 1D: Interview topic guides.

Out of 77 stakeholders that were invited to participate, HPA conducted a total of 69 interviews with stakeholder organisations. All stakeholders considered in scope of the evaluation received email correspondence from the evaluation team and those that did not respond to the initial invitation subsequently received a follow up email inviting them to participate in an interview.

In addition to speaking with 10 national stakeholders, the evaluation team conducted interviews with a total of 59 jurisdictional stakeholder organisations, which included fundholders, advisory fora members, jurisdictional health department officers, PHNs, NACCHO and NACCHO affiliate organisations, local services and individual providers. Many of these interviews were conducted in conjunction with the selected case studies in New South Wales, Northern Territory, Queensland, Tasmania and Western Australia (45 interviews), and separate interviews were conducted with other relevant stakeholders in the non-case study jurisdictions, which included Victoria and South Australia (14 interviews). All stakeholder interviews were completed by early May 2022.

A full list of stakeholder organisations contacted and interviewed as part of the evaluation along with the interview topic guides for each stakeholder group are presented in Appendix 1C: Stakeholders consulted.

4. Program data

The evaluation sought access to 3 main sources of program data and information:

- Fundholder documents (financial, activity and narrative reports) prepared by fundholders and provided to the Department as a requirement under their funding agreements.
- Fundholder routine administrative data collected by fundholders to administer the outreach programs and monitor performance.
- MBS data held by the Department.

Fundholder documents

Financial and performance reports were received from all 10 fundholders. As required by the service delivery standards, the financial performance reports received from the fundholders are reported to the Department biannually. The performance reports contain narrative and data components. The data component outlines service activity for the reporting period including number of visits by program, health category and location, actual expenditure and number of patients. The narrative reports include operational status, service activity, a brief overview of program expenditure, details of underspend, upskilling activities and good news stories. The narrative reports also include key barriers and enablers faced during the reporting period and strategies to navigate barriers.

The financial documents are also provided to the Department biannually. These cover total costs and expenses during the reporting period and a break down expenditure by selected service-related activities relevant to the service delivery standards, such as travel, meals, accommodation, absence from practice allowance, service administration, backfilling and locum support, upskilling and workforce support payments.

A full list of program documents provided by the fundholders is listed in Appendix 1E: Fundholder documents provided. The key themes discerned from the documents are presented in Appendix 1F: Review of fundholder documentation.

Fundholder routine administrative data

HPA requested directly from all fundholders routine administrative data that each fundholder collects in relation to outreach service delivery.

HPA first requested activity reports from the Department in August 2021 and was advised these were best obtained directly from the fundholders. Activity reports were requested from fundholders and intermittently received from August 2021, along with the other documents mentioned above, such as the financial documents and performance reports. On examination of the activity reports, significant variability was noted in the type of documents received, quantity and consistency. In addition, HPA felt there was merit in collecting data in greater detail to better analyse variability in service utilisation and costs across communities.

HPA elected to develop separate data specifications for the EESS and the other outreach programs. In developing and finalising the data specifications, HPA conducted multiple rounds of consultation by videoconference with all the fundholders to gain an understanding of the common data elements that may be feasible to collect. Responses from fundholders suggested data collection varies between jurisdictions, and not all variables of interest are commonly collected. Further, fundholders indicated that some variables would be difficult to obtain from their existing information systems.

After consultation with the fundholders, HPA developed data specifications for both the EESS and remaining outreach programs that were deemed reasonable and feasible, with the expectation that there would be some variability in the level of data obtained from each fundholder. The data requests for the outreach programs and the EESS program are provided in Appendix 1J: Data specifications.

The data specifications were sent to the relevant fundholders in December 2021 requesting that data from 2017–18 to the most current period be provided to HPA by the end of January 2022. The fundholders not sent data specifications were RHT (as its contract with the Department is new and service delivery did not commence until early 2022) and HoA (as it does not report data in the same way as other fundholders). All fundholders that received data requests applied for extensions to the deadline provided in early 2022 with feedback that COVID–19 was significantly stretching fundholder resources. HPA was conscious of not imposing on the frontline health care efforts of fundholders and granted extensions accordingly – with multiple extensions granted in some cases. All populated datasets were received by April 2022, except for the RHOF and EESS in Northern Territory, where the program managers indicated they did not have the capacity to collate the required data during their pandemic response.

Data was requested at 3 levels:

- Service level – relating to the service plans for the year, including nature of service, provider details and number of visits by community in the period.
- Visit level – data providing detail on the duration, number of occasions of service and costs per visit, which may involve multiple clinics/communities.
- Session level – data providing detail of the services and providers involved in the clinics at each community during a visit.

The datasets received from fundholders had significant gaps in the variables and years of data provided, most notably the visit level breakdown of costs and session level data. Feedback received from fundholders was that they commission contracts with providers, but not individual clinicians, so it was difficult for them to obtain data on services provided by individual clinicians, occasions of service and costs at visit and service levels. As such, much of the data at this level could not be examined. Some variables could still be obtained by proxy, such as the type of professional, which could be taken from the service name at the service level and then linked between the dataset levels.

To sense check the data within the fundholder datasets, HPA reconciled the total costs during each service period in the fundholder data sets against the cost totals in the financial documents and activity reports. In most instances, total costs did not correlate between the different document types and their corresponding service periods, leading to uncertainty in the

reliability of the data. To further check this, financial documents were then reconciled against the aggregate costs and expenses listed in the fundholder activity reports. The analysis again showed significant and widespread variation between the activity reports and financial documents.

As such, a decision was made that fundholder datasets and activity reports could not be relied upon confidently, so the financial documents provided by fundholders were instead used. While the financial documents did not offer the level of detail requested in the fundholder data specifications, helpful data on aggregate costs could still be obtained (see Table 6). Definitions of these can be seen at Appendix 1H: Analysis of program service delivery standards. Analysis of these financial data can be seen in Chapter 6.

Table 6: Cost items of interest obtained from fundholder financial documents

Data items	
Cultural training, orientation and familiarisation	Workforce support
Travel, meals, accommodation and incidentals	Professional support
Absence from practice/ travel time allowance	Equipment lease
Administrative support	Telemedicine and eHealth
Backfilling and locum support	Host facility fees
Upskilling	

Additionally, not all financial documents could be obtained from all fundholders, leading to some missing data for analysis. Many of the financial documents were also obtained in PDF form, so code had to be written in the R Studio software to be able to read in and analyse the documents.

In cases where financial documents were not received, HPA made efforts in following up with both the fundholders and funding agreement managers, but not all documents could be obtained. The financial documents that could not be received are shown in Table 41 in Appendix 1E: Fundholder documents provided.

MBS data

HPA submitted a formal request for MBS data at the end of November 2021 through the Department's Data Assessment Request Assessment Panel via a written Data Request Form. Justification and clarification of various data items were subsequently requested, along with specification of the table shell for the data in late January 2022. Due to technical issues (explained further below), HPA was not able to gain access to the MBS data within an adequate timeframe, so an alternative approach was taken.

Intended approach to using MBS data

The MBS data detailed below were requested to enable both a longitudinal and cross-sectional picture of general practice, specialist medical and allied health service billing and utilisation by place of service and place of patient residence. It was noted that not all allied health professionals have access to MBS billing and those who do have, in many instances, limited access (for example, chronic conditions). Further, data were requested in recognition that MBS billing collection may not be feasible for all medical practitioners in all communities given the need to minimise financial barriers to care and the inability to top up MBS with workforce support payments by fundholders. These factors limited the validity of the requested data in measuring the true utilisation of services in rural and remote communities.

The data requested consisted of MBS data in csv format from 2011–12 to 2020–21, which included data at an SA2 level of the beneficiary and SA3 level of the provider. The variables requested are shown in Table 7. The summary measurements requested (within the sub-groups defined by the cross-classification of the requested variables) included:

- number of services
- number of patients

- benefit paid ($)
- schedule fee ($)
- fee charged ($)
- proportion of services that are bulk billed.

The services excluded from the data request were:

- services where the hospital indicator identifies the service was provided in hospital
- services where the broad type of service category was one of:
  - anaesthetics (code 400)
  - pathology (codes 501 and 502)
  - diagnostic imaging (code 600)
  - operations (code 700)
  - assistance in operations (code 800)
  - radiotherapy and therapeutic nuclear medicine (code 1000).

The following analysis of MBS data was intended:

- Analysis of trends in the age standardised rate of MBS services per population across SA2s over a 10-year period, grouped into provider type (that is, general practitioner, type of medical specialist and selected allied health categories). For the initial set of analyses, a time series approach was to be used to test whether support of new or expanded outreach services has increased access for patients across the relevant SA2s.

- Estimating the proportion of MBS activity supported through outreach arrangements by year and type of service. This would have enabled quantification of the potential impact of the outreach services on access for Aboriginal and Torres Strait Islander people, and rural and remote populations.

- Using more detailed information on when outreach services occur. This was to be used to estimate differences in the activity rates between periods in which outreach services were supported and periods where there was no outreach activity supported. In this analysis, differences between SA2s were to be estimated by comparing the rate of activity in SA2s with outreach services with similar SA2s where there are no outreach services.

Data were to be analysed by the SA2 region of the patients' residence because this is level was required for aligning the causal effect of providing the outreach service and observing an increase in MBS activity. In addition, for the analysis outlined above, a comparator group of similar SA2s was to be created where similarity is defined by the SA2s having a similar level of the SEIFA and MM category. Both these metrics were to be calculated at the level of SA1 and, when aggregated to SA3s, would become less specific (or less homogenous) because SA3s often cover regions with different levels of these indices. This would be particularly true for SEIFA when aggregated at the level of SA3s.

Table 7: MBS data requested from the Department of Health

Variable	Detail
Year and month of service	Dates for calculating these periods relate to the date of the Medicare service
Statistical Area Level 2 (SA2) of beneficiary	n/a
Broad type of service (BTOS) category	n/a

Variable	Detail
Telemedicine items	Items - 99, 112, 113, 114, 149, 288, 353, 355, 356, 357, 358, 359, 361, 371, 372, 384, 389, 812, 827, 829, 867, 868, 869, 873, 876, 881, 885, 891, 892, 894, 896, 898, 899, 901, 905, 906, 2095, 2100, 2121, 2122, 2125, 2126, 2137, 2138, 2143, 2144, 2147, 2150, 2179, 2180, 2193, 2195, 2196, 2199, 2220, 2729, 2731, 2799, 2820, 3003, 3015, 6004, 6016, 6025, 6026, 6059, 6060, 10945, 10946, 10947, 0948, 13210, 16399, 17609, 10983, 80001, 80011, 80021, 80101, 80111, 80121, 80126, 80136, 80146, 80151, 80161, 80171, 82150, 82151, 82152, 82220, 82221, 82222
Age group	0 to <18 years, 18+
Derived Major Specialty of the provider	Separate medical groups for general practitioners, paediatric medicine, paediatric surgery, cardiology, endocrinology, psychiatry, nephrology, pulmonologists (respiratory and sleep Medicine), obstetrics, obstetrics and gynecology, ophthalmology, otolaryngologists (ENT), medical oncology
	Separate allied health groups for podiatrist, physiotherapist, dietician, optometrist, audiologist, psychologist – clinical, psychologist – non-clinical, others grouped together (chiropractor, diabetes educator, exercise physiologist, osteopath, social worker)
	Aboriginal Health Worker
	Aggregated nurse group (nurse practitioner plus midwife)
	Separate groups for non-referred attendances, GP trainee, dentistry registered
SA3 of the provider	n/a

The Department approved HPA's request to access the MBS data, as per Table 7, in May 2022, however, significant technical issues were faced in accessing data via the server on the Department's remote desktop in which the data were to be accessed from. Technical issues preventing access to the MBS data persisted until July 2022 until a decision was made that the time left on the project would not allow analysis of MBS data. As such, an alternate approach was taken to try and achieve some of the analyses described above using data from publicly available AIHW datasets.

Impact of COVID–19 on evaluation methods

The COVID–19 pandemic created limitations on the movement of people across jurisdictional boundaries and between communities and organisations. It also generated enormous pressures on frontline health staff and supporting health agencies.

The pandemic impacted the evaluation team in the following ways:

- Ability to travel. While HPA planned for and was able to conduct face-to-face case study visits in Queensland, New South Wales and Tasmania, the ongoing uncertainties and pressures associated with COVID–19 prevented the HPA team from visiting respective communities at the remaining case study sites within the evaluation timeframes. Therefore, virtual case studies were conducted in Western Australia and the Northern Territory.

- Engage with stakeholders. Some jurisdictions and Indigenous Australian agencies were affected more than others, with engagement and availability of stakeholders limited at various points in the evaluation.

- Delayed responses. Delay in the completion of surveys and data requests by fundholders.

Reporting on the evaluation

This evaluation report is presented in 3 volumes:

- Volume 1 (this document) is the main evaluation report. It provides a background on the outreach programs in scope of the evaluation and outlines the methods and approaches for conducting the evaluation. It highlights findings drawn from the main sources of qualitative and quantitative data and presents recommendations on the key issues the evaluation sought to address. This volume contains the following appendices which further describe the evaluation methods and the key themes discerned from individual data sources:
  - Appendix 1A: Literature scan
  - Appendix 1B: Information provided to stakeholders
  - Appendix 1C: Stakeholders consulted
  - Appendix 1D: Interview topic guides
  - Appendix 1E: Fundholder documents provided
  - Appendix 1F: Review of fundholder documentation
  - Appendix 1G: Key observations from case studies
  - Appendix 1H: Analysis of program service delivery standards
  - Appendix 1I: Related reviews and evaluations
  - Appendix 1J: Data specifications
- Volume 2 presents the details of 6 case studies that were conducted for the evaluation. The key issues and themes findings from Volume 2 are summarised in the main report (Volume 1).
- Volume 3 provides more detail and information on the survey methods and presents summary data from the surveys completed by the national workforce bodies, host provider and outreach providers.

4

Overview of the programs

This section describes the history and objectives of each of the outreach programs within scope of the review and provides information on the funding distributions, service levels, operations and workforce of the individual programs.

Process for commissioning services

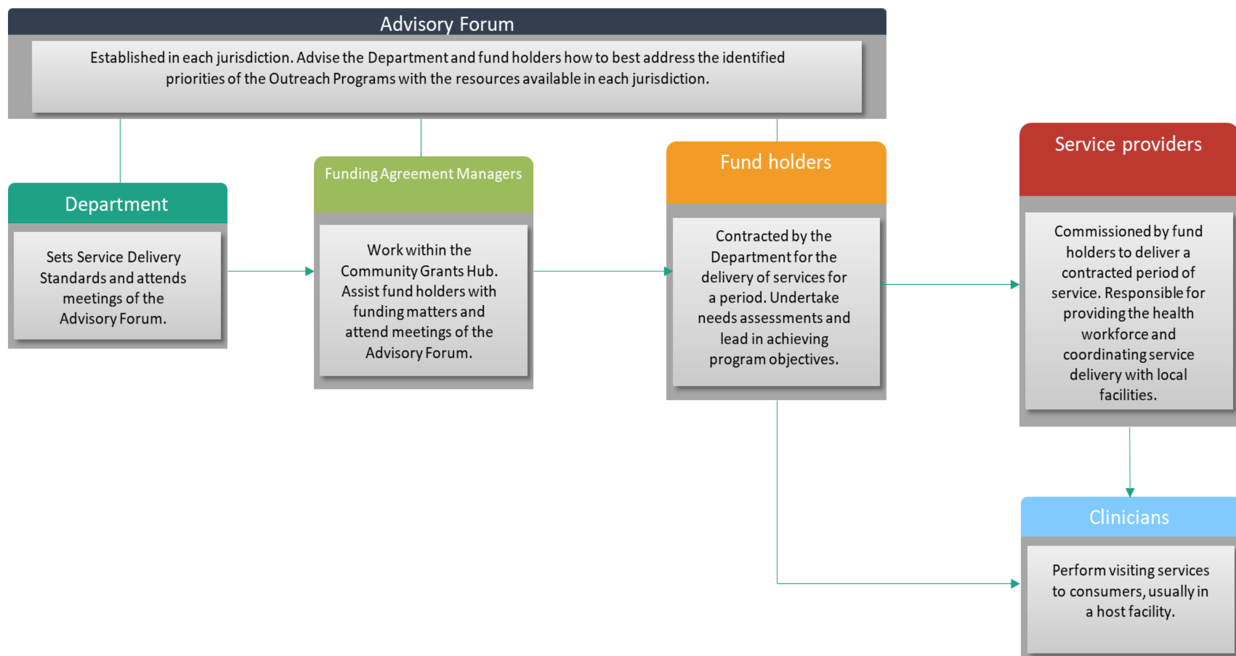
To administer the outreach programs, the Department distributes funds to funding recipients known as '**fundholders.**' Fundholder organisations have been appointed within each jurisdiction to manage these programs, which operate independently from each other. Except for the Northern Territory and Tasmania (Rural Health Tasmania), where there are 2 jurisdictional fundholders, in the other jurisdictions, a single fundholder manages all 5 outreach programs (excluding HoA, which is a private organisation). As such, the evaluation of these 6 programs spans across 10 fundholders operating in all 7 jurisdictions. More information on the individual fundholders across jurisdictions is provided in the "Overview of the fundholders" section. As per the outreach program service delivery standards, the high-level responsibilities of the fundholder include:[10]

- Meeting the requirements and delivering services as outlined in their standard grant agreements and the service delivery standards for each of the outreach programs within their purview.
- Including Aboriginal and Torres Strait Islander peoples in the planning and administration of outreach programs to ensure services are culturally safe and consider Aboriginal and Torres Strait Islander peoples' population needs.
- Collaborating with local communities to ensure sufficient coordination and delivery of outreach services.
- Performing needs assessments and service planning.
- Conducting administrative tasks, which include appropriate record keeping and data collection, that align with the outlined reporting requirements for each outreach program.

The Department also creates a set of service delivery standards which the fundholders must commit to meeting to receive funding for the delivery of the relevant outreach programs. The Community Grants Hub within the Department of Social Services executes and manages the Department's contracts, including those for the outreach programs, through its Funding Arrangement Managers. It is the responsibility of fundholders to meet the service delivery standards and report to the funding arrangement managers. As part of the service delivery process, the fundholders are also required to undertake needs assessment for the communities they are contracted to service in consultation with other jurisdictional stakeholders, such as PHNs, LHNs and ACCHOs. Fundholders contracted to deliver the outreach programs in each jurisdiction range from PHNs to health workforce bodies.

To deliver services, fundholders may hire clinicians and staff directly, or commission outreach provider organisations, which then contract the clinicians to provide the services. In most cases, fundholders commission provider organisations, which results in less visibility over the individual clinicians that visit communities and details on the occasions of service they provide. Figure 4 outlines the stakeholders involved in commissioning and delivering outreach services.

Figure 4: Stakeholders involved in commissioning and outreach service



The fundholders consult with an **advisory forum** based in each jurisdiction to assist in identifying areas of need and the best ways to address these needs. Advisory forums are comprised of several members with knowledge and expertise in the delivery of services in the communities the fundholders are contracted to serve. These members include:[10]

- state/territory health authorities
- rural workforce agencies
- medical colleges or other relevant groups of health practitioners
- PHNs
- consumer representative
- Aboriginal and Torres Strait Islander health organisations
- local hospitals, community-based services and local communities.

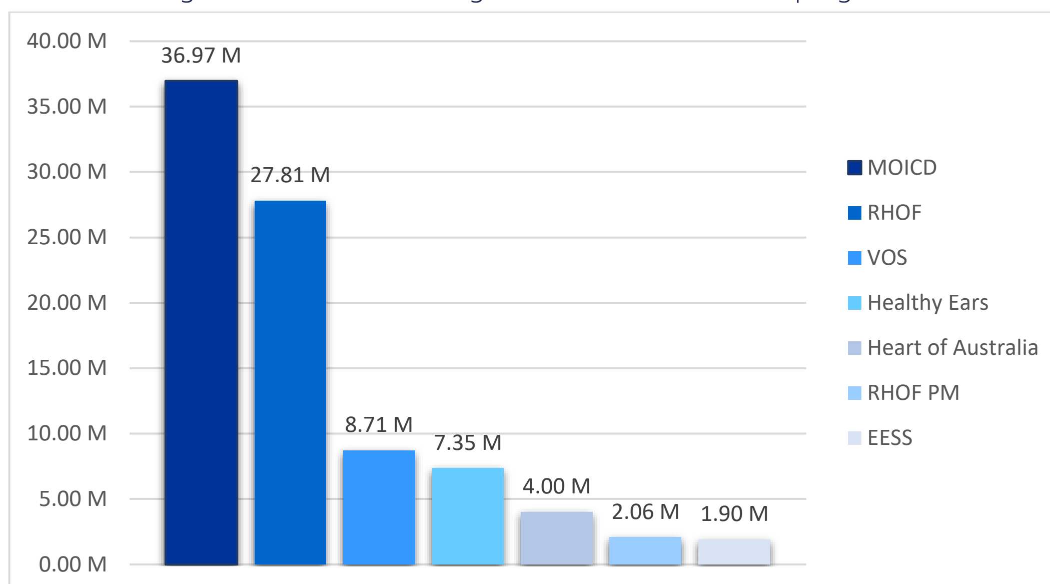
Outreach programs in scope of the evaluation

Table 2 lists the outreach programs in scope of the evaluation. The MOICDP, HEBHBL and EESS are funded through the Indigenous Australians' Health Programme (IAHP). The Medicare Services Special Appropriation, Outcome 4.1 funds the VOS.[10] HoA receives funding via Government grants and private sponsorship, while the RHOF receives separate funding from the Department of Health.[13]

Figure 5 shows the funding allocated across outreach programs in the scope of this review.[14]

[13] Australian Department of Health. (2020b). *Rural Health Outreach Fund: Service Delivery Standards*. https://www1.health.gov.au/internet/main/publishing.nsf/Content/651B62BEE7DE74CFCA257BF0001C95A3/$File/RHOF-Service-Delivery-Standards-From-1-July-2020.pdf
[14] Department of Health. (2021b). *Contact and funding information for HPA*.

Figure 5: 2020–21 funding distribution of outreach programs



Source: The Department provided a document outlining outreach funding allocations by programs within scope of the evaluation and fundholder from 2017–18 to 2023–24 (length of existing fund agreements vary by program).

Overview of the fundholders

The following fundholders are responsible for delivering the outreach programs:

- New South Wales Rural Doctor's Network (NSW RDN), which is a non-government organisation (NGO) headquartered in Hamilton, New South Wales, that supports the multidisciplinary health workforce in regional, rural and remote New South Wales and Australian Capital Territory. The organisation currently provides outreach in over 170 locations.[15]
- Rural Health Workforce Agency Victoria (RWAV), which is a government-funded health workforce agency that aims to improve healthcare services in regional, rural, remote, and Aboriginal and Torres Strait Islander communities in Victoria. RWAV delivers services, including outreach, throughout approximately 425 primary care facilities across Victoria.[16]
- CheckUP, which is an NGO that partners with providers to improve primary healthcare services in urban, regional, rural and remote areas of Queensland, including Aboriginal and Torres Strait Islander communities. It aims to increase access to medical specialists, GPs and allied health professionals through its delivery of the outreach programs.[17]
- HoA, which is a private organisation operating several mobile clinics via trucks across specific loops in Queensland.[12]
- Rural Health West (RHW), which is a health workforce agency in Western Australia funded by the Australian Government. RHW supports over 1,000 outreach services

[15] NSW Rural Doctors Network. (2022a). *Outreach*. NSW Rural Doctors Network. https://www.nswrdn.com.au/site/index.cfm?display=221635
[16] Rural Workforce Agency Victoria. (2022). *Our Vision and Mission*. Rural Workforce Agency Victoria. https://www.rwav.com.au/our-vision-and-mission/
[17] CheckUP. (2016). *Outreach Services*. CheckUP. https://www.checkup.org.au/page/Initiatives/Outreach_Services/

through rural and remote Western Australia, including Aboriginal and Torres Strait Islander communities.[18]

- **Rural Doctors Workforce Agency (RDWA)**, which is a rural workforce agency headquartered in Mile End, South Australia. The agency supports over 150 providers across 33 different specialist categories to 68 different locations across South Australia.[19]
- **TAZREACH services (an office within the Tasmanian Department of Health)** is headquartered in Launceston, and holds funding for all outreach programs, with the exception of the EESS.
- **Rural Health Tasmania (RHT)**, which describes itself as a health and well-being organisation that offers free health services to the North West, Central Coast and West of Tasmania.[20] RHT commenced administering the EESS only at the start of 2021–22 and is in its infancy supporting surgery under the program.
- **NT Department of Health (NT Health)**, which is the jurisdictional health service in the Northern Territory, headquartered in Darwin and Alice Springs, and administers all outreach programs, except for the MOICDP.
- **Northern Territory Primary Health Network (NT PHN)**, which is the sole PHN in the Northern Territory, with offices distributed throughout the Territory. The PHN administers the MOICDP.[21]

Overview of each outreach program

Medical Outreach – Indigenous Chronic Disease Program (MOICDP) objectives

The MOICDP supports outreach services to increase access to health services for Aboriginal and Torres Strait Islander people with chronic disease with the aim of better prevention, detection and management of chronic disease. The program has evolved from previous iterations of chronic disease funding programs and the Department has committed to funding the program through to 30 June 2024.

While program eligibility is not confined to services operating in specific geographic locations, the need for certain service types across different geographic areas is considered. Services covered by the MOICDP include:[10]

- primary care
- allied health
- nursing care
- specialist care
- training (including cultural awareness and safety training)
- care navigation and coordination
- GP outreach.

In 2011–12, the Aboriginal and Torres Strait Islander Chronic Disease Fund in the Department replaced the Indigenous Chronic Disease Package. The fund initially committed $833.27 million

[18] Rural Health West. (2022). *Outreach*. https://www.ruralhealthwest.com.au/outreach
[19] Rural Doctors Workforce Agency. (n.d.). *Outreach Services*. Rural Doctors Workforce Agency. https://www.ruraldoc.com.au/outreach-services
[20] Rural Health Tasmania. (2020). *Our Services: What We Do*. Rural Health Tasmania. http://www.ruralhealthtas.com.au/
[21] Northern Territory Primary Health Network. (2021). *Outreach Health*. https://www.ntphn.org.au/programs/outreach-health/

over 4 years from 1 July 2011 to 30 June 2015. The IAHP was established in 2014 and has continued to provide funding to the MOICDP through the IAHP since 2015.[22,23]

Table 8 lists the current the jurisdictional fundholders for the MOICDP and their funding allocations by financial year since 2017–18.

Table 8: MOICDP fundholder organisations by jurisdiction and funding by financial year

Jurisdiction	Fundholder	17–18 $ (mil)	18–19 $ (mil)	19–20 $ (mil)	20–21 $ (mil)	21–22 $ (mil)	22–23 $ (mil)	23–24 $ (mil)
NSW	NSW RDN	10.5	10.5	11.3	11.5	11.7	11.9	12.2
Vic	RWAV	1.5	1.4	1.6	1.6	1.7	1.7	1.7
Qld	CheckUP	8.4	8.2	9.0	9.2	9.3	9.5	9.7
WA	RHW	4.6	4.4	5.0	5.1	5.2	5.3	5.4
SA	RDWA SA	2.0	1.8	2.1	2.2	2.2	2.2	2.3
Tas	TAZREACH	1.1	1.0	1.2	1.2	1.2	1.2	1.2
NT	NT PHN	5.7	5.4	6.1	6.2	6.3	6.4	6.5
Total		**33.8**	**32.7**	**36.3**	**37.0**	**37.7**	**38.2**	**39.0**

Source: The Department provided a document outlining outreach funding allocations by programs within scope of the evaluation and fundholder including funding allocations for MOICDP from 2017–18 to 2023–24.

Healthy Ears – Better Hearing, Better Listening (HEBHBL)

The HEBHBL program commenced in 2013 with $24 million allocated to the program for 2013–14 to 2016–17.

In 2017, the Department commissioned a review of Australian Indigenous Ear and Hearing Health initiatives, which found that the Department's investment was sufficient in supporting a wide range of services to improve ear and hearing health. As a result, the Department addressed several recommendations, including committing additional funding to create a hearing assessment program for Aboriginal and Torres Strait Islander children of preschool age and establishing a national performance indicator for ear and hearing health to address gaps in data collection.[24]

Funding by the Department was subsequently extended for another 12 months over 2017–18 followed by an additional funding commitment of $95 million for 2018–19 to 2021–22 to support and promote ear health services for Aboriginal and Torres Strait Islander people, which included funding for the HEBHBL program.[25]

While Tasmania initially did not participate in the initiative from 2013–14 to 2016–17 and used state resources to support hearing and ear service outreach for Aboriginal and Torres Strait Islander youths, funding for the HEBHBL program in Tasmania was established on 1 July 2017 with TAZREACH as the fundholder.

Table 9 lists the current jurisdictional fundholders for the HEBHBL program and their funding allocations by financial year since 2017–18.

[22] Bulletpoint. (2021). *Aboriginal and Torres Strait Islander Chronic Disease Fund*. https://www.bulletpoint.com.au/aboriginal-and-torres-strait-islander-chronic-disease-fund/
[23] Australian Department of Health. (2021a). *Indigenous Australians' Health Programme*. https://www.health.gov.au/initiatives-and-programs/indigenous-australians-health-programme
[24] Siggins Miller. (2017). *Ear and Hearing Examination Final Report*.
[25] Australian Department of Health and Ageing. (2013). *Healthy Ears - Better Hearing, Better Listening Service Delivery Standards*. https://ruralhealthwest01.blob.core.windows.net/www-production/docs/default-source/outreach/standards/hebhbl-service-delivery-standards.pdf?sfvrsn=4

Table 9: HEBHBL fundholder organisations by jurisdiction and funding by financial year

Jurisdiction	Fundholder organisation	17–18 $ (mil)	18–19 $ (mil)	19–20 $ (mil)	20–21 $ (mil)	21–22 $ (mil)
NSW	NSW RDN	1.2	1.2	1.2	1.2	1.2
Vic	RWAV	0.3	0.3	0.3	0.3	0.3
Qld	CheckUP	2.1	2.1	2.1	2.1	2.1
WA	RHW	1.7	1.7	1.7	1.7	1.7
SA	RDWA SA	.6	.7	.7	.7	.7
Tas	TAZREACH	.03	.03	.03	.03	.03
NT	NT Health	1.4	1.4	1.4	1.4	1.4
Total		7.3	7.4	7.4	7.4	7.4

Source: The Department provided a document outlining the outreach funding allocations by program within scope of the evaluation and fundholder including funding the fund allocations for HEBHBL from 2017–18 to 2021–22.

Eye and Ear Surgical Support program (EESS)

The EESS program aims to increase access to eye surgery and ear surgery associated with otitis media for Aboriginal and Torres Strait Islander people living in rural and remote communities and covers people in MM 3–7 areas.

While State and Territory Governments have primary responsibility for eye and ear surgery, the EESS program expedites access to surgery for those who have been waiting for surgery for lengthy periods.

As opposed to the other outreach services where the clinician travels to the local community of the patient, the EESS arranges transport for the patient to travel to the closest and/ or most appropriate centre for ear or eye surgery and recovery following the surgery.

The following items can be paid to provider by fundholders under the EESS:[10]

- Orientation to the outreach location.
- Health provider travel, meals and accommodation.
- Transport of a patient and one carer from MM 3–7 locations into regional or metropolitan centres.
- Equipment lease and purchase.
- Facility fees: the Department suggests up to $200 per day but can allow up to $400 per day after assessment on a case-by-case basis.
- Administrative and other costs associated with providing the outreach service.

Eye surgical interventions are provided irrespective of age, while ear surgery is only provided to those requiring surgery as a result of acute or chronic otitis media, and those aged zero to 21 years. Aboriginal and Torres Strait Islander people already on a surgery waiting list are eligible under the EESS.

The Surgical Support Program within the EESS received approximately $1.9 million in funding from 2015–16 to 2016–17. Funding has been renewed since 2016–17 and has been extended until 30 June 2022. After 30 June 2022, the decision to continue EESS funding will be determined by need. The EESS is currently one of the 3 programs funded under the IAHP.

Table 10 lists the current the jurisdictional fundholders for the EESS program and their funding allocations by financial year since 2017–18.

Table 10: EESS fundholder organisations by jurisdiction and funding by financial year

Jurisdiction	Fundholder organisation	17–18 $	18–19 $	19–20 $	20–21 $	21–22 $
NSW	NSW RDN	466,000	300,000	300,000	345,000	300,000
Vic	RWAV	175,000	100,000	100,000	0	279,500
Qld	CheckUP	712,000	500,000	500,000	609,000	700,000
WA	RHW	677,000	480,000	480,000	700,000	768,578
SA	RDWA SA	286,000	180,000	180,000	250,000	300,000
Tas	TAZREACH	145,000	100,000	100,000	-	-
NT*	NT Health	340,000	340,000	340,000	N/A	N/A
Total		2.8M	2.0M	2.0M	1.9M	2.4M

*Source: The Department provided a document outlining the outreach funding allocations by program within scope of the evaluation and fundholder including funding the fund allocations for EESS from 2017–18 to 2021–22. *Note: From 20-21 onwards, the eye component of the EESS program does not have NT Health as the fund holder. Vanguard Health is currently contracted under a separate process to provide eye surgeries in the Northern Territory.*

Visiting Optometrist Scheme (VOS)

The VOS supports optometrists providing outreach services to individuals living in regional, rural and remote areas (MM 2–7). The VOS is currently funded under the Medicare Services Special Appropriation, Outcome 4.1 and includes a non-Indigenous and Indigenous component, which represent 60% and 40% of annual funding respectively.

The was VOS set up by the Department in 1975 under the Health Insurance Act 1973 and has continued to operate under various funding pools since then.

A review of the VOS was conducted in 2005–06 and resulted in various funding and administrative changes. Key changes included simplifying billing processes for participating optometrists and changing the definition of what is considered an 'isolated area' to align with the Accessibility and Remoteness Index of Australia remoteness classification system (this changed in 2009 to reflect the Australian Statistical Geographical Classification remoteness area). Any services considered outside of scope due to the program changes were offered a 2-year agreement to ease the transition.[26]

In 2009–10, the program was expanded through the VOS Expansion for Indigenous Australians. This was funded under the 'Improving Eye and Ear Health Services for Indigenous Australians for Better Education and Employment Outcomes' measure and allocated a component of the funding (40%) to increase optometry services for Aboriginal and Torres Strait Islander people, particularly those living rural and remote areas.[27]

In 2012, the Department engaged HPA to evaluate the Medical Specialist Outreach Assistance Program (MSOAP) and the VOS. In response to the evaluation recommendations, the Department established jurisdictional fundholder arrangements which came into effect on 1 July 2015. The role of the jurisdictional fundholders is to manage program activities in relation to the coordination and delivery of outreach services. This includes recruiting optometrists to provide outreach eye health services in identified areas of need.[32]

In 2018, Optometry Australia undertook a survey of VOS providers to assess whether the existing guidelines and governance arrangements were effective in facilitating optometrists to provide outreach optometry services and a subsequent review of, and change to, the VOS (and

[26] Department of Health and Ageing. (2005). *Meta-evaluation of Regional Health Strategy*
[27] Australian Department of Health. (2015). *Visiting Optometrists Scheme (VOS)-Service Delivery Standards*. https://www1.health.gov.au/internet/main/publishing.nsf/Content/ruralhealth-vos-service-delivery-std

MOICDP, HEBHBL and EESS programs). In 2020, the Department revised and consolidated the outreach program service delivery standards.[28]

Any optometrist who participates in Medicare is eligible to provide optometric outreach services and receive funding under the VOS. Support is provided for MM 2–5 areas but focuses on MM 3–5 locations. In circumstances where an optometric service is delivered in an ACCHO or other AMS, the VOS may extend to MM 1 locations. Optometric services in MM 1 locations may also be integrated with the MOICDP in cases where the person has a chronic disease eligible under the program.[27]

Table 11 lists the current the jurisdictional fundholders for the VOS program and their funding allocations by financial year since 2017–18.

Table 11: VOS fundholder organisations

Jurisdiction	Fundholder organisation	17–18 $ (mil)	18–19 $ (mi)	19–20 $ (mil)	20–21 $ (mil)	21–22 $ (mil)	22–23 $ (mil)	23–24 $ (mil)
NSW	NSW RDN	1.1	1.1	1.2	1.4	1.5	1.5	1.5
Vic	RWAV	.5	.5	.5	.7	.7	.7	.7
Qld	CheckUP	1.4	1.5	1.5	1.8	1.9	1.9	2.0
WA	RHW	1.1	1.4	1.4	1.7	1.8	1.8	1.8
SA	RDWA SA	.7	.7	.7.	.9	.9	1.0	1.0
Tas	TAZREACH	.3	.3	.3	.4	.4	.4	.4
NT	NT Health	1.4	1.4	1.4	1.8	1.8	1.8	1.9
Total		6.5	6.9	7.0	8.7	8.9	9.0	9.3

Source: The Department provided a document outlining the outreach funding allocations by program within scope of the evaluation and fundholder including funding the fund allocations for VOS from 2017–18 to 2023–24.

Rural Health Outreach Fund (RHOF)

The RHOF provides funding to support outreach programs to increase access to health services in regional, rural and remote areas. The program was established in 2011–12 and first committed a 4 year investment commencing 1 July 2011. The fund officially came into effect on 1 July 2013 and consolidated the following programs:

- MSOAP
- MSOAP – Ophthalmology expansion
- MSOAP – Maternity services expansion
- Rural Women's GP Service
- National Rural and Remote Health – Kimberley Paediatric Outreach Program.

The RHOF supports a wide range of health providers, such as specialists, general practitioners, nurses, allied health professionals, to deliver services in regional, rural and remote areas. Geographic locations in MM 3–7 are considered eligible for RHOF support. While the fund supports a broad range of health services, there are specific areas of focus that have been identified based on need. These include:

- chronic disease management
- eye health
- maternity health

[28] Optometry Australia. (2020). *Optometry Australia members delivering services under the Visiting Optometrists Scheme are invited to give feedback.* https://www.optometry.org.au/advocacy_government/optometry-australia-members-delivering-services-under-the-visiting-optometrists-scheme-are-invited-to-give-feedback/

- mental health
- paediatric care.

Funding for the RHOF has been aligned with the MOICDP so both programs can be delivered together synergistically to achieve value for money. In line with the MOIDCP, the RHOF allows services to employ a wide range of flexible service delivery models, such as cluster, telehealth or hub-and-spoke models, to meet program objectives. The following services are eligible for funding:

- specialist medical services
- allied health services
- midwife and nursing services
- combinations of eligible services (that is, multidisciplinary teams)
- outreach GP services
- administration and coordination of these services.

The program covers MM 3–7 areas, however, MM 4–7 areas are the primary focus. In some instances, MM 1 & 2 areas may also be eligible, depending on the level of access to medical services.[11]

The Department initially committed $124.1 million over 4 years to the RHOF (2011–12 to 2014–15) and has most recently allocated an additional $115.11 million over 4 years (2020–21 to 2023–24) to fundholders.[29]

Table 12 lists the current the jurisdictional fundholders for the RHOF program and their funding allocations by financial year since 2017–18. This includes funding for pain management outreach services (ceased 30 June 2021) and Tele-Derm, which are both funded under the RHOF.

Table 12: RHOF fundholder organisations by jurisdiction

Jurisdiction	Fundholder	Component	17–18 $ (mil)	18–19 $ (mil)	19–20 $ (mil)	20–21 $ (mil)	21–22 $ (mil)	22–23 $ (mil)	23–24 $ (mil)
NSW	NSW RDN	RHOF	4.9	4.8	4.9	5.0	5.0	5.2	5.2
		PMS	-	-	.4	.4	-	-	-
VIC	RWAV	RHOF	2.8	2.7	2.8	2.8	2.8	2.9	2.9
		PMS	-	-	.2	.2	-	-	-
Qld	CheckUP	RHOF	8.0	7.8	7.9	8.0	8.2	8.3	8.4
		PMS	-	-	.6	.6	-	-	-
WA	RHW	RHOF	4.9	4.8	4.9	5.0	5.0	5.1	5.2
		PMS	-	-	.4	.4	-	-	-
SA	RDWA-SA	RHOF	2.5	2.5	2.5	2.5	2.5	2.6	2.7
		PMS	-	-	.2	.2	-	-	-
TAS	TAZREACH	RHOF	1.4	1.4	1.4	1.4	1.4	1.4	1.5
		PMS	-	-	.1	.1	-	-	-
NT	NT PHN	RHOF	3.0	3.0	3.0	3.1	3.1	3.2	3.2
		PMS	-	-	.2	.2	-	-	-
National	ACRRM	Tele-Derm	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[29] Australian Department of Health. (2014). *Flexible Fund Guidelines Rural Health Outreach Fund*. https://www.rwav.com.au/wp-content/uploads/Rural-Health-Delivery-Standards.pdf

Jurisdiction	Fundholder	Comp-onent	17–18 $ (mil)	18–19 $ (mil)	19–20 $ (mil)	20–21 $ (mil)	21–22 $ (mil)	22–23 $ (mil)	23–24 $ (mil)
Total			27.5	27.0	29.4	29.9	28.0	28.7	29.1

Source: The Department provided a document outlining the outreach funding allocations by program within scope of the evaluation and fundholder including funding the fund allocations for RHOF from 2017–18 to 2023–24

In addition to the main funding of the RHOF, additional auxiliary programs are funded by the Department to support the RHOF.

Pain management

The RHOF-PMS was established to support the delivery and increase access to pain management services in regional, rural and remote areas across Australia. In addition to increasing access to multidisciplinary pain management services in these areas, the program seeks to build local capacity by supporting upskilling and training opportunities. This includes educating local health professionals on appropriate and safe pain management treatments to reduce patients' chronic pain while reducing overprescribing and overuse of prescription opioids. The program supports a wide range of services including specialist, nursing, allied health and multidisciplinary team care.

Tele-Derm

Tele-Derm is an online resource funded through the RHOF and run by the Australian College of Rural and Remote Medicine (ACRRM). Tele-Derm provides health professionals with guidance and advice on the diagnoses and management of dermatological conditions. The digital health platform was established to support health professionals operating in rural and remote regions and increase specialist access to these areas. Tele-Derm allows health professionals operating in RHOF-funded areas to submit de-identified, digital images of patients' skin conditions along with any relevant health history. This information is subsequently reviewed by a dermatologist within 48 hours who provides suggestions and aids in the diagnosis and treatment of these cases. The portal also provides educational and training resources to improve and support the delivery of dermatology care in these areas.

Heart of Australia (HoA)

While HoA provides outreach services, its model differs to other fundholders in that it operates as a private company and is funded by commercial sponsors and through grants from the Department of Health and Queensland Health. HoA currently has 5 trucks, with its fifth truck rolled out at the beginning of 2022. This new truck has new features and equipment, such as an audiology diagnostic device and a CT machine.

After commencing operations in 2014, HoA has expanded service operations to 32 rural and remote communities across Queensland (as of September 2021). The service operates on a hybrid fly-in-fly-out model in which visiting providers fly to meet the trucks at predetermined locations. The trucks then transport providers to rural and remote communities along their planned travel routes. Box 6 outlines the services provided by HoA.

Box 6: Services provided by HoA[30]

- Cardiology consultations
- Stress echocardiograms
- Exercise stress testing
- Echocardiograms
- Electrocardiograms
- Holter monitoring
- Ambulatory blood pressure monitoring
- Sleep apnoea testing
- Phlebotomy
- CPAP trials
- Sleep Specialist consultations
- Endocrinology consultations
- General Medicine consultations
- Gastroenterology consultations
- Neurology consultations
- Gynaecologist/Obstetrician consultations
- Geriatrician consultation
- Respiratory function testing

[30] Heart of Australia. (2019). Services. https://www.heartofaustralia.com/services/

Other related programs

The programs below are out of the scope of the evaluation; however, they have existing and historical relevance to the outreach programs covered in this evaluation. This section highlights these programs and their linkages to the outreach programs.

Medical Specialist Outreach Assistance Program

As mentioned earlier, MSOAP was consolidated with other outreach programs to form the RHOF on 1 July 2013. It was initially established in 2000 to improve access to medical specialist outreach services for people in rural and remote communities in Australia. Its objectives were to:[31]

- Increase visiting specialist services in areas of identified need.
- Support medical specialists to provide outreach medical services in rural and remote areas.
- Facilitate visiting specialist and local health professional communication about ongoing patient care.
- Increase and maintain the skills of regional, rural and remote health professionals in accordance with local need.

The original MSOAP was subject to several expansions from 2000, including the Indigenous Chronic Disease expansion (2009–10), and Maternity Services and Ophthalmology expansions (2011–12).[32] In addition to allocating MSOAP funds to jurisdictional fundholders, the program also had funding arrangements in place with other organisations to target specific areas of need, including paediatric surgery services to communities in New South Wales and Victoria, as well as a separate arrangement for paediatric care in the Kimberley region, a Tele-Derm service in partnership with ACRRM, diabetes prevention and management services for communities in and around Alice Springs, and multidisciplinary care services for the Anangu Pitjantjatjara Yankunytjatjara lands. MSOAP and its expansions, were then consolidated to form the RHOF.

Deadly Ears

Deadly Ears is a state-funded program operates in 11 regions across rural and remote Queensland and aims to prevent and reduce the burden of ear disease and hearing loss in Indigenous children and young people aged under 18. The program is made up of 4 teams, including a primary health team, allied health team, ENT outreach team and administration teams. The primary health team provides training and support to local providers, while the allied health team provides audiology, speech pathology and occupational therapy services to assist in the management of hearing loss and other impacts of middle ear disease. The ENT team provides outreach clinics and surgery through ENT specialists for Indigenous children with otitis media or conductive hearing loss.

The functions of the Program include:

- Training and professional development of the health workforce, including healthcare educators.
- Delivery of frontline health services and capacity building of local providers across the 11 jurisdictions in Queensland.
- Co-ordination of policy and practice changes.

[31] https://www.ruralhealthwest.com.au/docs/outreach-in-the-outback-docs/msoap---specialist-services.pdf?sfvrsn=0
[32] Health Policy Analysis. (2012). *Evaluation of the Medical Specialist Outreach Assistance Program and the Visiting Optometrists Scheme*. https://doi.org/10.13140/RG.2.2.24315.75045

- Performing research activities into the treatment, impact and management of middle ear disease for children.

Since the end of 2019, clinics have been provided twice per year across each of the 11 partner locations. Children are seen at the outreach clinics by both an ENT specialist and audiologist. Where possible, those requiring surgical interventions are offered the surgery during the same visit. According to the Australian Institute of Health and Welfare, during the period from 2007 to 2019, 5,938 children and young people received 17,557 ENT clinic services, and 1,250 children and young people received 1,854 ENT surgery services. Between 2008 and 2019, 11,826 audiology services were provided to 4,502 children and young people.[33]

The service has resulted in marked improvements to ear health in Indigenous children and young people from 2015 to 2019. During this period, 3 out of 5 Indigenous children experienced improvements in their hearing over time. The proportion of those with conductive hearing loss who participated in 2 or more services reduced from 64% to 35% in children and young participants. In children aged zero to 4, the proportion with conductive hearing loss reduced from 65% to 38% from beginning to end of program service delivery. For those who attended 2 or more audiology sessions, the proportion of those with hearing within normal limits increased from 23% to 55% at the end of all sessions.

Coordination of Indigenous Eye Health Project (CIEH)

The CIEH focuses on continuity of care across all eye health services for Indigenous people. Like the outreach programs, CIEH is also funded by the Department of Health and aims to increase access to eye health services. CIEH aims to deliver all aspects of eye health services to Indigenous patients, including referral, initial consultations, treatment, integration and ongoing management in the community with the objective of achieving greater continuity of care across the system.[34]

The outreach program fundholders are also funded for the CIEH. Some fundholders refer to the CIEH using a different name. For example, NSW RDN refers to the CIEH as Aboriginal Eye Health Coordination. According to Vision 2020 Australia, the CIEH has achieved the following to milestones to date: [34 (p.13)]

- Increased patient attendance through enhanced coordination between VOS services and local Aboriginal health services.
- Improved triaging and clinical pathways for recall and referral, which have included use of telehealth and expanding culturally sensitive support for patients.
- Developed a training program for GPs, Aboriginal health workers and nurses working in ACCHOs to embed use of retinal cameras and other project outcomes.
- Developed a deeper understanding of service needs, gaps and barriers.
- Supported improved program administration and information sharing across funded programs such as EESS, RHOF, MOICDP and VOS.

Follow-up Ear and Hearing Health Service

The Follow-up Ear and Hearing Health Service is designed to ensure Aboriginal and Torres Strait Islander children who have received a hearing assessment under the Hearing Assessment Program – Early Ears have access to any necessary follow-up services. The Program is funded under the IAHP and is subject to the IAHP delivery standards. The Follow-up

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[33] Welfare, A. I. o. H. a. (2021). *Queensland's Deadly Ears Program: Indigenous children receiving services for ear disease and hearing loss 2007–2019*. https://apo.org.au/sites/default/files/resource-files/2021-02/apo-nid311135.pdf

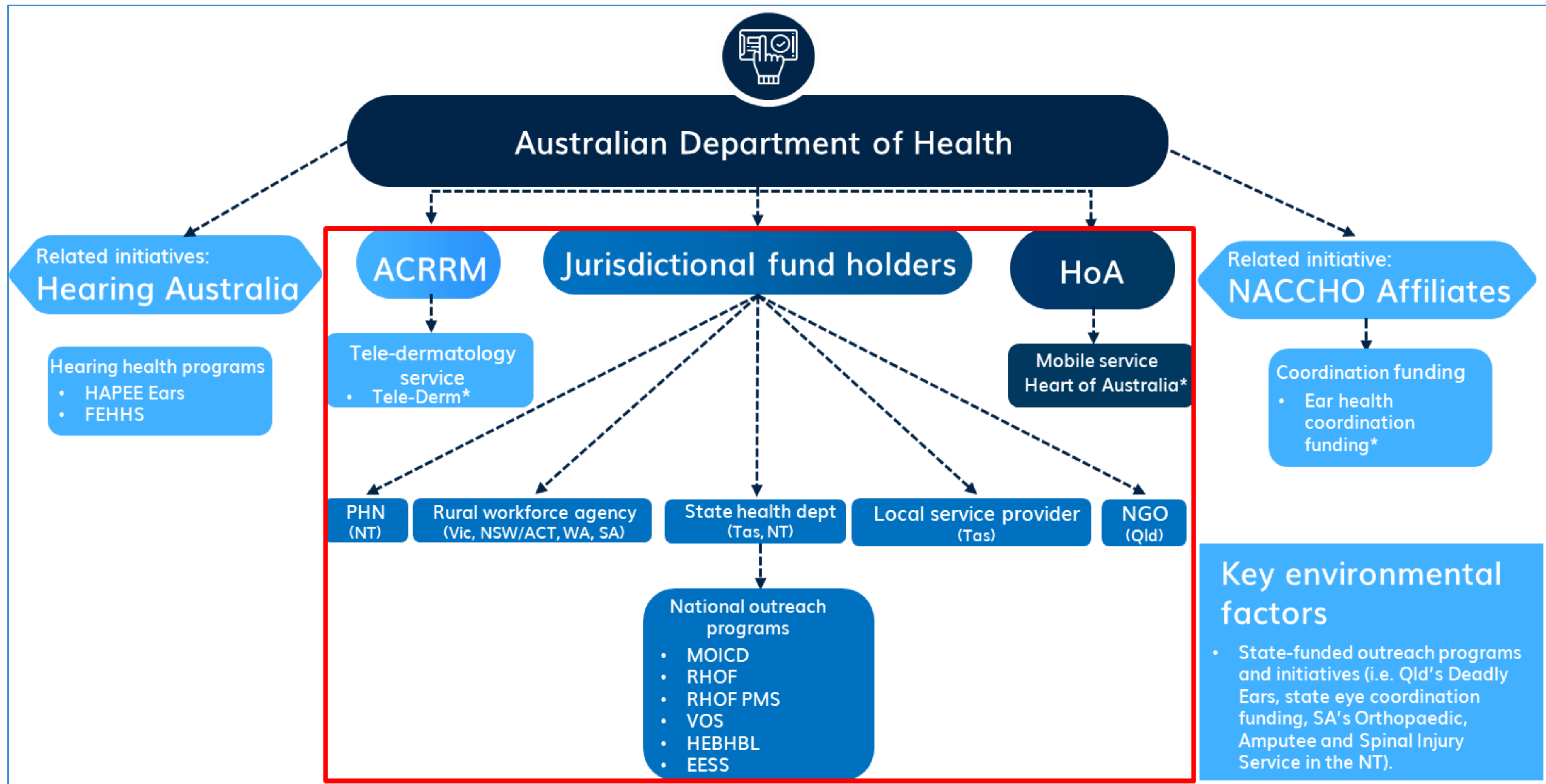
[34] Vision 2020. (2019). *Strong eyes, strong communities: A five year plan for Aboriginal and Torres Strait Islander eye health and vision 2019-2024*. https://www.vision2020australia.org.au/wp-content/uploads/2019/03/Strong-Eyes-Strong-Communities-A-five-year-plan-for-Aboriginal-and-Torres-Strait-Islander-eye-health-and-vision-2019-2024.pdf

Ear and Hearing Health Service is designed to ensure Aboriginal and Torres Strait Islander children who have received a hearing assessment under the Hearing Assessment Program – Early Ears have access to any necessary follow-up services. Similar to the Hearing Assessment Program – Early Ears, the program is managed by Hearing Australia. The program is funded under the IAHP and is subject to the IAHP delivery standards.[35]

The field of outreach is a rich space with many stakeholders and programs operating concurrently. Figure 6 provides a visual overview of the stakeholders that manage the national outreach programs described above.

[35] NSW Rural Doctors Network. (2022b). *Outreach Programs*. NSW Rural Doctors Network,. https://www.nswrdn.com.au/site/outreach-programs#:~:text=updated%20December%202021)-,Follow%2Dup%20Ear%20and%20Hearing%20Health%20Service%20(FEHHS),the%20required%20follow%2Dup%20services.

Figure 6: Overview of national outreach programs and related initiatives funded by the Australian Department of Health



Notes: Deadly Ears is not included in the diagram as it is a state-funded program. In Western Australia, New South Wales/Australian Capital Territory and Victoria, ear health coordination funding is managed by the NACCHO affilate in conjunction with the jurisdictional Fundholder. Tele-Derm is funded under the RHOF. In addition to the Australian Department of Health, HoA receives funding from multiple public and private sources.

Service delivery standards

As mentioned earlier, the outreach programs in the scope of this evaluation operate under guidelines outlined in the service delivery standards developed by the Department (excluding HoA).[10,11] The majority of the outreach programs are subject to the same service delivery standards, which include the VOS, HEBHBL, MOICDP and the EESS. The RHOF is subject to separate service delivery standards. Table 13 compares the items within the service delivery standards between the RHOF and the remaining outreach programs (excluding HoA).

Table 13: Service delivery standards between programs

SDS Domain	RHOF[11]	Remaining Outreach Programs[10]
Role of advisory forum	• Advise the appropriate types of services to be delivered. • Advise whether the proposals should be considered for funding for one, 2, 3 or 4 years. • Consider whether the service delivery plan contains the appropriate mix of team members/health professionals to deliver services that address identified needs. • Advise on the suitability of services being proposed under the RHOF. • Identify linkages (when appropriate) with the planning mechanisms of other programs to explore possibilities for integrated program implementation. • Review the needs assessment and identification of proposed locations and priority locations completed by the fundholder, including whether the proposed priority locations have the capacity and infrastructure to support the proposed service. • Determine gaps in services.	• Provide feedback on the needs assessment process and whether it has adequately consulted with key stakeholders in the jurisdiction. • Provide advice on the annual Needs Assessment and health service planning models proposed by the fundholder. • Identify linkages with the planning mechanisms of other programs within the jurisdiction to explore possibilities for integrated program implementation, including a focus on linkages with tertiary services. • Advise whether the proposed priority locations identified by the fundholder have the capacity and infrastructure to support the proposed service. • Advise if service proposals deliver value with public money in line with the Commonwealth Grants Rules and Guidelines 2017.
Role of fundholder	• Develop and implement a 4-year strategic service plan. • Accurate collection, collation and appropriate analysis of data, and provision of this data to the Department. • Monitoring, management and fulfilment of all reporting obligations. • Development and application of strategies to recruit and retain health professionals. • Administration of payments to participating health professionals in accordance with services provided • Verification of service delivery following receipt of invoices. • Communication with members of the medical community and the public to inform them about the RHOF. • Development and implementation of strategies to market and educate the public and the healthcare sector about the RHOF. • Working with locally based service providers including PHNs and local health services to ensure details of outreach visits are known, access to	• Deliver the activities and meet the terms and conditions outlined in their Standard Grant Agreements for each Outreach Program and the Outreach Program service delivery standards. • Commit to shared decision-making with Aboriginal and Torres Strait Islander people and delivery of culturally safe services that respond to the needs of Aboriginal and Torres Strait Islander people. • Undertake a detailed needs assessment or undertake service planning in line with current and relevant needs assessments. • Engage with local communities to ensure coordination of services. • Manage the recruitment and retention of outreach Health Professionals. • Maintain an internal administrative unit. • Maintain records and data to inform reporting deliverables.

SDS Domain	RHOF[11]	Remaining Outreach Programs[10]
	services is maximised and barriers to care (e.g. procedures/surgery) are identified and addressed. • Encouraging health professionals to provide culturally appropriate services. • Providing assistance with upskilling sessions to health professionals as required. • Planning and supporting effective coordination of service delivery at the community level. • Undertaking other activities necessary for the proper operation of the RHOF.	
Eligible activities and services	• Individual outreach, cluster, hub-and-spoke, telehealth (see below) • Specialist medical services, allied health services, midwife and nursing services, combinations of eligible services (i.e. multidisciplinary teams), outreach GP services (including support for female GPs to provide outreach services to broaden the health service choices available to rural women), and administration and coordination of these services • Administrative Support for Visiting health professionals • Travel costs, accommodation and meals/incidentals • Equipment lease • Facility fees (suggested maximum of $200 to $400 per day, depending on seasonal variations) • Cultural training and familiarisation • Absence from practice allowance for non-salaried private health professionals accompanying registrars. • Workforce support payment in MM 6–7 mostly Aboriginal and Torres Strait Islander communities. • Backfilling and locum support. • Upskilling • Professional support • Telehealth costs such as venue and equipment hire but not capital costs.	• Individual outreach, cluster, hub-and-spoke, telehealth. • Multidisciplinary team approach is the recommended service model. • Coordination and administration of services • Travel costs, accommodation and meals/incidentals for visiting health professionals • Equipment lease • Host facility fees • Upskilling / training associated with the outreach visit • Cultural awareness training for non-salaried private providers • Orientation to communities • Professional support associated with outreach services • Program administration costs for fundholders (in 2020–21 the maximum allowable administration costs will be 15% of the annual funding allocation • Marketing and activities to raise public awareness of outreach services • Hospital services limited to surgical support services provided under the EESS program only.
Service planning and needs assessment processes	• Fundholders will be responsible for completing a needs assessment for their jurisdiction(s) early in each calendar year to determine the level of community need for services for the following financial year. In developing the needs assessment, the fundholder will consult broadly with health organisations, including PHNs, Jurisdictional Health Departments and relevant Aboriginal and Torres Strait Islander health organisations in their jurisdiction to ensure the data accurately reflects need. • The needs assessment information will be provided to the State or NT Advisory Forum for consideration in line with the priorities of the RHOF. • Following consideration by the Advisory Forum, the needs assessment will be provided to the Department for approval.	• Each fundholder must undertake an annual needs assessment or health service planning to identify the priority health needs and priority locations within their jurisdiction. In undertaking the Needs Assessment, fundholders must consult broadly and ensure the views and expertise of Aboriginal and Torres Strait Islander people, communities and organisations are an integral part of the process. • Shared decision-making structures already exist and many of these have been developed by Aboriginal and Torres Strait Islander people. Fundholders should use existing mechanisms and build new partnerships to inform needs assessment. • The following groups must be consulted as part of the Needs Assessment / health service planning:

SDS Domain	RHOF[11]	Remaining Outreach Programs[10]
		– Aboriginal and Torres Strait Islander Peak Organisations – Aboriginal Community Controlled Health Services – Aboriginal Medical Services – PHNs – hospitals and mainstream health services – community-based services. • Fundholders must also: – Create a mechanism where health services and communities can propose required services – Promote the availability of outreach services broadly within their jurisdiction; and – Make publicly available the outcomes of the Needs Assessment.
Service proposals	• Any interested party can submit a service proposal application to the appropriate fundholder for consideration. Once service applications are received, they will be assessed by the state or territory advisory forum, where it exists to determine if the proposal meets eligibility criteria prior to being considered by the Department for approval. • For a service to be eligible for funding it must be for a location in MM 3–7 that has been identified by the fundholder as needing the proposed service and be provided on an outreach basis by an eligible health professional.	• Any interested health professional can submit a proposal for the delivery of outreach health services in areas of need identified by the fundholder. • In areas where workforce availability is limited, fundholders should seek workforce from outside their jurisdiction. • Fundholders are responsible for promoting outreach programs, seeking proposals, and informing applicants of the outcome of their proposal. • Service proposals should: – be in line with the aim and objectives of the relevant Outreach Program – addresses high community need for the service – complement existing service levels or addresses a shortfall or gap within the community – take account of local workforce and infrastructure that will support the service – links with other State, Territory or Australian Government health programs – offer bulk billing – demonstrate cultural appropriateness – demonstrate value for money when compared with other potential similar services
Administrative and reporting requirements	• Activity work plans at end of each financial year (endorsed by advisory forum) • Performance reports every 6 months, including statistical service data, financial information, de-identified service data and financial information about activity • Annual unaudited financial reports • Audited acquittal report after completion of activity during the activity period • Final report.	• Activity work plans for period endorsed by advisory fora (revised and updated by 31 May each year during activity period) • Performance reports every 6 months, including statistical service data, financial information, de-identified service data and financial information about activity. • Financial acquittal report for each financial year and part of a financial year • Final report.

Monitoring performance of outreach services

Fundholders' processes for performance monitoring include regularly reviewing visiting services' patient volume, visit cancellations and their overall ability and capacity to deliver services. One fundholder described developing a process in which local communities are required to state their priority need for outreach services, provide an evidence base for this need and outline how a service will operate within their communities. To facilitate this process, they have developed a proposal template that all services receiving outreach services are required to complete. While this is a laborious process, the fundholder feels it facilitates a bottom-up approach to determining need and the proposal template acts as a dynamic resource that allows the fundholder to regularly monitor progress and identify potential service issues. While there appeared to be no formal feedback mechanism for local communities across jurisdictions, the fundholders described capturing this information anecdotally through their host services, visiting providers, etc.

5

Literature scan

A literature scan was conducted to explore outreach service models operating in both the Australian and international context, the scope of outreach service offerings and relevant methods of evaluation to inform the evaluation methods.

Key messages and their relevance to the evaluation

The literature revealed that Australia is clearly a pioneer in rural and remote outreach with much of the literature identified focussing on the Australian context. The key messages derived from the literature scan are outlined in Box 7. A discussion on the relevance of these messages as they relate to the evaluation follows.

Box 7: Key messages from the literature

- Collaboration with Indigenous populations in the design, delivery and evaluation of outreach program was cited as a key gap in service delivery. Collaboration in program design and delivery is critical to program success as Indigenous populations have different perceptions of health and wellbeing.
- Flexibility and transparency of program funding will aid in meeting the diverse needs of populations residing in rural and remote communities across Australia and decreasing uncertainty around outreach funding arrangements.
- Outreach services should be carefully co-ordinated and integrated with host providers, local and regional health organisations to ensure continuity of care for patients.
- Education by outreach providers to local staff equips local services to provide better care through knowledge sharing and increased confidence to manage specialist conditions. This may also reduce waiting times for specialist services and increase community engagement. Interactive involvement between outreach and host practitioners has also shown to be effective.
- Coordination is a key component to the success delivery of outreach programs.
- Telehealth may act as a complimentary service to face-to-face appointments, but may not be suitable as a complete substitute, depending on the type of service. More research in this area and the potential for cost-savings is required.
- Key specialisations may be able to take better advantage of telehealth. Mental health and speech therapy appointments may be better suited for full replacement of face-to-face appointments, while screening services for diabetic retinopathy and ENT conditions may reduce specialist waiting times and increase access through store-and-forward services.
- Using telehealth for pre-treatment appointments and post-treatment follow-ups may reduce travel burden on outreach providers and also increase patient participation and outcomes.
- While telehealth may have a positive effect on patient access and outcomes, community engagement may be lost and the underlying social determinants of disease may be overlooked, which, again, highlights the importance of local coordination in facilitating telehealth services.

Collaboration with Aboriginal and Torres Strait Islander people in the design, delivery and evaluation of outreach programs was cited as a key gap in service delivery in the literature. Collaboration in program design and delivery is critical to program success as Indigenous populations have different experiences and needs relating to health and wellbeing. In addition, lack of engagement and trust in health interventions negatively impacts the success of

outreach interventions. As such, the evaluation team understood the critical importance of engaging with the Aboriginal and Torres Strait Islander sector throughout the evaluation. The stakeholder engagement plan was developed to ensure Indigenous stakeholders were suitably consulted and involved throughout the life cycle of the evaluation. The plan follows the Department's Stakeholder Engagement Framework and includes 4 of the 5 identified principles of effective engagement: inform, consult, involve and collaborate. Empower was not included as this method of engagement is frequently used in participatory action research, which was not the approach employed for this evaluation. Aboriginal services such as NACCHO, NACCHO affiliates and ACCHOs were engaged using all 4 engagement approaches, and involved in interviews, case studies and workshops. NACCHO's level of interest and influence in the project was rated as 'high' and its contribution to the evaluation was invaluable in achieving further engagement from other stakeholders in the Aboriginal and Torres Strait Islander sector.

Many studies concluded that greater flexibility and discretion in the use of funds, including more transparent funding and contractual arrangements, would assist in the delivery of outreach services. Rural and remote communities have diverse needs, and it would be advantageous to have the ability to direct resources into areas of need when they are identified by providers and the local community. The evaluation sought to assess program funding arrangements through the review and analysis of key documents, such as needs assessments, activity reports, data reports and financial reports. The evaluation also relied upon surveys, interviews, workshops and case studies with stakeholders to gather information on key funding issues and has developed recommendations to help address challenges and issues raised in relation to the flexibility of outreach funding.

The literature also identified coordinating a myriad of different outreach providers and services that target a broad range of health priorities as a key challenge which was consistent with our findings. Effective coordination was cited as essential to maintaining continuity of care when it is shared between visiting and local providers. As such, the evaluation investigated coordination between providers across different outreach programs and looked at areas of potential service duplication. Due to the challenges in relation to the coordination and integration of outreach services, the evaluation provides recommendations on ways to support local coordination and achieve maximum efficiency across programs.

The literature on telemedicine appears to fall short on making definitive workforce planning decisions relating to the inclusion of telehealth in outreach models. It is clear that outreach models incorporating telemedicine are emerging—particularly since the arrival of COVID–19 in Australia; therefore, the role of telehealth is strongly considered in the evaluation. While many studies in the literature review highlight the value of telehealth, particularly in relation to generating cost savings and increasing health access for vulnerable populations, the literature also discusses the shortcomings of this technology. In most instances, the literature indicated that telehealth is not a complete substitute for face-to-face care.

This sentiment was echoed by stakeholders who recognised the value and potential of telehealth in increasing patient access to care, facilitating patient management and follow up and fostering training and local capacity building, but highlighted that it cannot replace face-to-face care. Despite the potential limitations of telehealth, stakeholders cited clear examples of how service providers are using telehealth in conjunction with face-to-face care to drive innovation and efficiency in outreach. For example, telehealth is an integral part of the Lions Eye Vision's (LOV) outreach service model as it allows the organisation to increase access to care, streamline its outreach visits and support training and shared care arrangements. More information on the LOV and its service model can be found in Chapter 3, Volume 2 of the report.

While the literature highlights that it is difficult to directly assess the benefits of telemedicine due to the infancy of the technology and the diverse methods and approaches in which it is delivered, certain specialities may derive additional benefits from the inclusion of telemedicine approaches. In particular, mental health consultations have shown to be effective when performed virtually. In some instances, studies evaluating the effectiveness of telemedicine

approaches in the delivery of outreach services saw benefits in the delivery of hybrid-type models that incorporate elements of face-to-face and telehealth service delivery at certain points in the care pathway. For example, health screening and pre and post-surgical follow up were highlighted as potential areas where the inclusion of telemedicine could generate additional cost savings and improve the detection of certain conditions. Various studies noted that strong service co-ordination and high levels of engagement with local health workers and organisations are required to successfully operate these models.

Much of the literature commented on the limited number of studies that evaluate the effectiveness of outreach services for populations living in rural and remote settings and that more research is needed to assess the appropriateness of outreach models employed across different health settings and populations. This includes the establishment of more standardised evaluation and monitoring approaches and data collection processes to effectively assess and attribute health outcomes to specific outreach interventions.

For more information on our approach and the findings derived from the national and international literature by study type, refer to Appendix 1A: Literature scan.

6

Evaluation findings

This section discusses the key evaluation findings according to the evaluation questions and sub-questions (see Table 3, p. 16).

1. How well are each of the outreach programs being delivered?

This evaluation question seeks to assess how well the outreach programs are being administered by the fundholders and how well outreach services are being delivered by outreach providers, in conjunction with host providers, to people living in rural and remote communities.

This requires consideration of issues related to the:

- Governance and funding arrangements for the programs, including the role of the Advisory forum in service planning and the performance monitoring and reporting arrangements in providing robust accountability.
- Systems and processes taken by fundholders to assess the needs for outreach services across local communities in their jurisdiction and plan service responses in conjunction with other agencies to meet the priority gaps and avoid duplication.
- Role of fundholders in securing the services of outreach providers and ensuring there is sufficient awareness and support for the programs to enable priority services to be provided to identified communities in a reliable and respectful manner.
- The way outreach services are delivered in local communities, including how outreach providers and host providers work together to coordinate outreach visits and integrate outreach services into local care processes to ensure service continuity.
- Role of outreach providers in ensuring the services they provide are culturally safe and valued within the community and in providing education and training of host service staff to build local workforce capacity for shared care and promote care continuity.

The following sections of this chapter identify stakeholder views on the key issues and associated recommendations for improvement.

Governance and funding arrangements

Strong program governance is integral to achieving the intended objectives across the outreach programs. This question seeks to answer how well the outreach programs are being managed and delivered under the existing arrangements.

Stakeholder views

Existing governance structures.

Stakeholders were broadly supportive of the overall structure of the governance arrangements. This includes the role of the Department as the funder and the configuration of the fundholders

across each jurisdiction, the role of the advisory forum in overseeing the needs assessment and service planning and the reporting requirements for outreach providers and fundholders to ensure adequate accountability. However, several issues emerged from the consultations that are discussed below. They relate to:

- efforts to ensure coordination and integration of programs
- responsiveness of arrangements to regional and local needs
- the role of the advisory forum in overseeing the process of engagement
- processes for sharing and learning and performance feedback.

Coordination and integration of programs

Stakeholders consistently noted the large array of programs that exist to support local workforce capacity building and to ensure adequate access to key primary care and acute services for people living in rural and remote communities. Some stakeholders described the situation as 'overwhelming' and 'chaotic' with the way funding is provided to organisations to administer, characterised as 'scattergun'.

The programs under evaluation represent only a proportion of the total programs and service arrangements being applied by the Commonwealth, state and territory and local governments, to address the challenge of securing access to care for small rural communities. Stakeholders working in this context indicate they understand the situation and challenges it creates for coordinated and integrated care. They reported a variety of ways in which they work across organisations at the jurisdictional, regional and local levels to bring coherency to what they do and avoid duplication and gaps in services. Many, if not all stakeholders, indicated this is complex and time consuming.

Fundholders in each jurisdiction described the nature of their organisation and the scope of programs they administer, along with the other key organisations they deal with who also hold funds for outreach and other programs. In New South Wales, Victoria, Western Australia and South Australia, the fundholder is the jurisdictional rural health workforce agency. These agencies are largely responsible for implementing strategies for recruiting and retaining health professions for work in rural and remote areas and receive significant funding from government to do this.

In the Northern Territory and Tasmania, program funding lies with multiple agencies, with the jurisdictional department of health the fundholder for most of the programs. In Tasmania, a small regional Indigenous Australian service provider organisation holds the funding for the EESS. In the Northern Territory, the PHN holds the funding for the MOICDP. TAZREACH in Tasmania reports having close and collaborative relationship with the fundholder for the EESS and the rural health workforce agency in the state. The NT PHN has a dual role, being both the PHN and the rural workforce agency for Northern Territory and reports that it effectively collaborates with the NT Health.

Queensland differs from the other jurisdictions given a single fundholder administers all the programs, but it is neither a rural health workforce agency nor a jurisdictional department of health. Instead, the fundholder is an NGO that reports working with partner organisations and health providers to deliver programs and services to high need communities, including rural and remote communities. The organisation stated that it has an established service footprint in 190 communities across Queensland.

In consultation with stakeholders including peak bodies, PHNs, rural workforce agencies, jurisdictional departments of health and outreach and host providers, there was no clear message about a preference for a single fundholder model in a jurisdiction or any strong reservations about one or any of the existing fundholders. In most instances the stakeholders were appreciative and supportive of the role each fundholder plays, including their collaboration and coordination with other fundholders. The main reservation noted from a few stakeholders was in relation to the rationale used for selecting the fundholders, indicating the

need for greater transparency and more consultation with existing fundholders in the jurisdiction.

Stakeholders consistently pointed to the time and effort invested in creating trusted relationships between key organisations and the value of building partnerships between staff across services. There was almost universal agreement that there is a degree of duplication in the roles of organisations and that further coordination and integration of needs assessment, service planning and service delivery processes are warranted. However, fundholders and other key stakeholders asserted that stability in these relationships is important given any structural changes would require disruption to existing arrangements and it is unlikely the benefits would outweigh the costs. Although not explicitly mentioned, it would appear that adaptive processes are successfully bridging the challenges of a complex system.

HoA is a regional program in Queensland and directly funded by the Department, rather than a jurisdictional fundholder. Stakeholders consider that this anomaly contributes to HoA not being so well integrated into the needs assessment, service planning and outreach provision in Queensland as other providers. While HoA stated it consults directly with local services and communities in assessing need and coordination of their services, it did indicate that there was scope for the engagement with Queensland Health, the PHNs and the outreach program fundholder in Queensland to be strengthened. While stakeholders in Theodore where HPA carried out a case study expressed strong support for HoA, clinical stakeholders in other parts of Queensland expressed reservations about HoA providing services in areas where service capacity already exists and without robust integration with the local clinical network and ongoing planning for the region.

Responsiveness to regional and local needs

Early in the evaluation, it became apparent that the workforce and service capacity on the one hand and the health needs and service preferences of the community on the other hand varies across jurisdictions, regions and local communities. No one community is the same, with the differences accentuated in smaller and more remote communities. This was borne out through the case studies where, for example, the context of the small town of Theodore in Queensland is starkly different to that of Kintore in the Northern Territory. Although the population of both towns are in the vicinity of 500 people, the remoteness, health and social needs and the availability of health services of each community are starkly different.

This difference requires an adaptive response from those planning and providing outreach services. For example, stakeholders in Theodore talked about the availability of physiotherapists from neighbouring towns that could be available to support the services in their town. We spoke with representatives of HoA and learnt of the mobile cardiac and respiratory specialist services that are available to be provided in the community. In contrast, in talking with the stakeholders in Kintore we heard of the need to fly outreach staff to the town, given the time by road would be over 5 hours and staff accommodation was not available. The Royal Flying Doctor Service (RFDS) provided an overview of the process of engagement with Aboriginal and Torres Strait Islander communities and the value of time spent in the community building relations in the provision of dental care.

These observations aligned with stakeholders' calls for the governance structures across jurisdictions to capture the variation across communities, noting the 'one size fits all approach' to needs assessment and service planning is not appropriate. Many stakeholders called for further engagement of local communities, with support for a stronger voice in the governance of the programs, particularly for Aboriginal and Torres Strait Islander people. To achieve their intended objectives, stakeholders stressed that the outreach programs need to engage and listen more intently to communities as they have the intimate knowledge and understanding of local health needs and priorities.

The fundholders, in conjunction with jurisdictional stakeholders, reported that they have implemented a range of governance structures to better capture the voice of communities in decision-making processes. For example:

- Stakeholders in Western Australia emphasised the vast geography of the state and indicated that the challenges in one area are completely different to challenges in other areas. They reported having regional working groups that identify and confirm local community need for services. Stakeholders indicated these groups have strong ties with communities, with representation from key local service providers. They endorse local service plans at a regional level, and we were advised that without this endorsement, the fundholder's advisory forum would not approve the overall service plan. There was a call from regional stakeholders for even greater devolution of decision-making to these regional groups including budgets and service planning implementation.

  Stakeholders in the Kimberley region cited the ability for organisations in eye health to collaborate and co-fund services as a key enabler for their region. Stakeholders acknowledged that organisations have strengths and weaknesses and that this type of regional model allows them to come together and utilise the strengths of each organisation and support local communities more effectively. Stakeholders stated that by working together they have maximised the effectiveness of the outreach funding across programs and believe there should be additional emphasis on this type of regional approach in the future.

- Stakeholders in Northern Territory outlined a regional service model, with emphasis on establishing local service capacity through nurse-led services in small remote Indigenous Australian communities, with Aboriginal health practitioners working alongside the nurses and non-clinical staff to liaise with the community. This team provides the core primary health care with medical services and specialised allied health services provided through clinicians living and working in regional hubs like Alice Springs.

  The NT PHN talked about the creation of mechanisms to start regional discussions, where agencies are coming together and making decisions as a group. Stakeholders indicated they have been able to find common ground and save costs and create locally responsive models. They indicated that these opportunities don't just rely on MOICDP funding but rather rely on how they coordinate all funding streams.

  Given the scale of service provision in regional hubs there is the capacity for regional organisations to hire staff full time and engage them in providing outreach services. For example, with MOICDP funding, NT PHN commissions an ACCHO in Alice Springs to coordinate podiatry and diabetes education services to neighbouring ACCHOs in the region.

- New South Wales reported that it has pioneered a decentralised model, pushing much of the fundholder resources out to regional services. The fundholder reports having contracts with 60 or 70 local partners who know the lay of the land – they hold funding, acquit for it, make budgets for local providers and monitor and control the service they run. The fundholder believes an important power dynamic is created when the local agency is the employer – it empowers the local providers when they are hiring clinicians directly. It feels this decentralised model works for them and also has the benefits of helping with cultural safety through use of local knowledge and staff.

  The fundholder couples this regional devolvement of decision making with close monitoring of key performance parameters, including host and outreach provider experiences and the average unit cost of services across its locations and providers. This benchmarking adds discipline to the services and asks questions about variations, not in an accusatory way but more about asking why variances exist.

Australia's Primary Health Care 10 Year Plan 2022–2032 sets out a blueprint for changes to the funding and provision of primary healthcare for the future.[8] One of the main streams of action under the plan is termed 'integrated care, locally delivered'. This stream is about delivering

regionally and locally integrated health service models through joint planning and collaborative commissioning at regional and state-wide levels.

The plan states that actions in this stream are designed to support local solutions, use joint planning and collaborative commissioning approaches to drive value-based care and address gaps in service delivery, and build on best-practice models and community-driven solutions.

Consultation with national stakeholders mandated to formulate and inform rural and remote health service strategies, revealed a convergence of strategic intent centred around regional governance and service provision.

One stakeholder referred to the tendering out of regional governance with a capacity to lead and commission services. This could be a PHN in one location and an ACCHO in another location, depending on leadership and capacity to deliver by the various agencies. The stakeholder asserted that capacity varies across Australia and accordingly the type of organisation needs to vary too.

The regional governance bodies would be able to access pooled state, MBS, PBS and outreach funding and then set about to work with local communities in a model of co-creation to identify needs and address them in innovative and locally sustainable ways. The stakeholder reflected that while the standards of care or outcomes should be universal, the way in which services are provided on the ground could vary and be informed by local ways of solving solutions.

These regional governance bodies would focus on building robust models of multidisciplinary primary health care, incorporating generalist workforce models and with outreach services commissioned when local service provision is not feasible. The stakeholder saw outreach as inevitable for some specialist services.

Broadly, stakeholders underlined the need for the voice of the communities to be stronger in the governance of outreach programs. Stakeholders in New South Wales reflected on the governance of ACCHOs, indicating power flows from the bottom up, with members appointed from the community. Then members appoint the CEO, who is also a community representative. If the CEO does not carry the needs and wants of the community then they are held accountable.

Another national stakeholder advocated for a regional model of care called a RACCHO, which is linked to idea of an ACCHO but would be for non-Indigenous communities. They suggested these models could be a way to start thinking about delivering outreach services in the future. The aim being to bring funding together to establish regional organisations that hire staff and provide multidisciplinary services to rural communities, including related NDIS and aged care services. They are proposing to have about 30 of these RACCHOs nationally.

This aligns with the view of NACCHO, that outreach funding should be provided directly to Aboriginal community controlled sector, including through the NACCHO affiliates and their member organisations. NACCHO reflected that this is part of the Closing the Gap National Agreement, which is about strengthening the ACCHO sector by transferring funding from existing agencies. This sentiment was also reflected by NACCHO affiliates.

Governance role of the advisory forum

All jurisdictions reported having an advisory forum and that this forum plays a role in overseeing the needs assessment and service planning decisions across all programs, including those dedicated to eye and ear services and those concerned with more general outreach support. However, from the information provided during the evaluation there appears to be noticeable variation in frequency of meetings, composition of membership and actual role of forum.

Several advisory forum members noted the value of the forum for the jurisdiction and reflected that it has served as a vehicle to facilitate information sharing and allowed them to gain a stronger understanding of issues and challenges across programs. However, other

stakeholders reported instances where they felt the advisory forum did not widely disseminate information to stakeholders and communities who are not represented around the table.

For example, one Aboriginal and Torres Strait Islander stakeholder and jurisdictional advisory forum member stated that their organisation is bound by a non-disclosure agreement which has limited their ability to share information with ACCHOs and the wider Aboriginal and Torres Strait Islander sector. They reflected:

> *"…the existing service delivery standards mandate an advisory fora but not how transparent, open and engaged they are with people on the ground…this is probably the critical area where there needs to be improvements."* [NACCHO affiliate, stakeholder interview]

Most stakeholders reported that forum meetings are conducted once needs assessment processes and service plans are completed and agreed that the role of the forum is largely to review the outcomes and give the service plans a final stamp of approval. However, one fundholder drew to our attention that it invites forum members to actively contribute to the needs assessment process and to discuss and challenge the findings.

Stakeholders reflected that the function of the advisory fora is helpful in providing oversight, but there may be a need for greater attention and accountability on the process that leads up to this point. For example, in one jurisdiction it was reported that the outcomes and actions from annual service planning meetings with host services are documented and provide the evidence for the reported findings in the needs assessment.

One stakeholder indicated that the advisory forum is not expected to be across all the detail, but instead it relies on regional groups to undertake local analysis and have local conversations and then bring this back to the forum. The main issue is to have a model that ensures a rigorous consultative process has taken place. This is where stakeholders, such as NACCHO, call for greater national consistency, including in the documentation and dissemination of these processes.

In one jurisdiction, a stakeholder commented that the advisory forum had previously been very operational (for example, making decisions on funding for specialties in different areas) but that the function had changed so it now looks more at the process (for example, consulting with right people, good input from community, there was evidence that a service was needed) rather than making direct decisions. This is essential to manage agency risk, particularly to avoid the fundholder acting against the interests of the community.

In consulting with national stakeholders and peak workforce groups, interest was expressed in a clearer process for being involved in the needs assessment and planning processes of the fundholders and the subsequent decision-making process of the advisory forum. For example, stakeholders in eye health indicated they understood that it is not practical that all stakeholders be consulted individually, but it would be appreciated if the process was more transparent and identified when and how stakeholders could have input into the process to ensure a more planned approach.

To facilitate a bottom-up and representative approach to governance, many stakeholders feel there must be greater involvement and voice for the Aboriginal and Torres Strait Islander sector on the advisory fora. For example, one NACCHO affiliate stated that while they are represented on their jurisdictional advisory forum, they have only been allowed one representative from their organisation and no local ACCHO representatives had been invited to sit on their jurisdictional advisory forum.

NACCHO is calling for the development of a national framework to allow for a more consistent approach to advisory forum governance, amidst other key issues. It specifically points to the greater Indigenous Australian membership of the advisory forum, including a chair that is endorsed by the NACCHO affiliate in the jurisdiction.

It is reported that the advisory forum in South Australia is co-chaired by the fundholder and the NACCHO affiliate, with one stakeholder observing that "together they work through issues, and this has created a partnership of trust. It's taken time but there is now a solid relationship".

The fund holder reported that it has moved past consultation to localised partnerships and locally led service planning, where annually the CEO of ACCHOs, their business and clinic managers and other members of their team are involved. However, there remain concerns regarding ties with the communities, with a jurisdictional stakeholder claiming that while the level of consultation at the CEO level appears strong "this does not filter up and down through the system into real engagement and collaboration in working out what is needed".

Performance feedback and sharing and learning

All fundholders reported that they had routine administrative information systems that capture activity and financial information on the programs, including data from contracted service providers and outreach health professionals. These information systems support the fundholders in administering the programs and provide the basis for meeting the reporting requirements of the Department.

HPA sought access to national extracts of the data collected by the Department but was informed that it would be more appropriate to request data directly from the fundholders and then aggregate nationally. However, in seeking to establish a common data collection from across the fundholders for the evaluation, we noted significant variation in the scope and definition of data items collected by fundholders at the overall service level, visit, clinic and patient level. Variability in data collection across jurisdictions was previously noted in the HEBHBL program by Siggins Miller in 2017.[36] The report found that quality and completeness of activity data varied considerably for the program.

In addition, we noted a paucity of data were either collected by the Department or made available to HPA by the fundholders that allowed insights into service activity, workforce participation and related costs at the visit level across communities and regions nationally. However, there was evidence of data being used within one jurisdiction for this purpose. The fundholder indicated it regularly looks at average costs per visit hour across its locations and providers. They reported this benchmarking of costs adds discipline to the services and helps understand key cost drivers for specific communities. The fundholder stressed that the data is not used in an accusatory manner but is provided to ask why the variances exist and, where appropriate, explore avenues for improvement.

Some of the fundholders have established routine surveys of outreach and host providers to gain insights into their experiences in providing and receiving outreach services, with one to 2 fundholders establishing patient experiences surveys and other activities (for example, Yarning Circles) to capture insights into patient access to outreach services. It was noted that a nationally consistent tool or approach to capture key consumer facing indicators is not currently in place.

Stakeholders consistently stressed the need to build capacity to measure and report on the outcomes of outreach services, rather than simply focus on compliance with activity and budget compliance. For example, NACCHO representatives stated that a couple of fundholders currently report experiences of patients, outreach providers and host providers in the field back to NACCHO. The suggested a national approach to this type of experience reporting would be highly valuable to improving quality of care.

NACCHO called for the outreach providers to be more accountable through a more robust reporting mechanism, including a greater focus on delivery outcomes, rather than outputs, reporting on upskilling activities and reporting on outreach provider performance by host services, including their cultural competence, service integration and care continuity. These

[36] Siggins Miller. (2017). *Ear and Hearing Examination Final Report.*

comments were supported by a jurisdictional representative of the Department of Social Services Community Grants Hub.

One stakeholder was concerned that the data provided to the Department does not identify how many patients receive services, but rather focusses on occasions of service. They indicated, for example, that the Department cannot identify from this data how many new and how many existing patients may have received outreach services in a given period. They considered the data are largely limited to measuring inputs and that this contributes to the programs being too transactional, rather than allowing fundholders greater flexibility in program administration and focussing accountability more on final outputs.

Opportunities for information sharing

Stakeholders across all levels of governance identified the need for greater information sharing and learning within and across programs and jurisdictions. There was broad agreement across a wide range of stakeholders that the transparency of the programs is insufficient, and that data and information on program processes, performance and decisions are not regularly available in a timely manner. In particular, fundholders expressed an interest in a greater capacity for sharing and learning across the system, to consider how other fundholders are meeting similar challenges and to explore the potential to translate promising innovations. One stakeholder described the level of learning and sharing from the data provided to the Department as "non-existent".

The fundholders that are rural health workforce agencies reported that regular forums exist for them to hear and share experiences on a range of issues, including outreach. However, for the remaining fundholders such opportunities are not currently facilitated. NACCHO indicated it is keen to convene a national forum where ideas can be exchanged between the fundholders. It had planned to do this before COVID-19 and indicated it will look to do this in the future, noting a similar forum exists for the eye programs already.

Fundholders reflected that the data and reports to the department create a significant burden on resources but were understanding of the need for robust accountability for program funding. They did however, express concerns over the lack of transparency over program decision making and feedback from the department on performance. Some fundholders recalled the Department being more active and directly involved with them in performance feedback, including national forums where all fundholders had the chance to discuss key issues regarding the programs.

Monitoring fundholder performance is an integral part of program governance. Stakeholders note providing data and reports to the Department, however, report rarely receiving any feedback. Fundholders would welcome greater levels of feedback and direction from the Department as a means of continuous quality improvement and shaping future directions.

Fundholders expressed a clear desire for the Department to be more actively involved in discussing program issues and feeding back data and information on program performance, including appropriate opportunities for comparative analysis across jurisdictions, regions and communities. Grant management has always been separated from policy. Despite this, some stakeholders expressed a view that the Department of Social Services Community Grants Hub has created another layer of administration and contributed to delays in communication with the department on key program issues and approval of variations to service arrangements.

Stakeholders cited that providing additional opportunities for information sharing could:

- Spark discussion on innovative models of care in outreach.
- Allow stakeholders to gain a better understanding of the activities other organisations are undertaking in the Aboriginal and Torres Strait Islander and rural and remote health sectors.
- Support the alignment of objectives and foster the establishment of data sharing arrangements.

- Provide further opportunities for stakeholders to discuss issues and raise potential solutions.
- Facilitate additional opportunities to provide feedback on program management processes.

It was noted that the Funding Arrangement Managers have recently initiated a forum for sharing experiences in the administration of outreach programs. Additionally, stakeholders commented on the role that the Department had played in the past of bringing fundholders together to share experiences. There were fundholders who noted informal information sharing arrangements, NACCHO expressed specific interest in a national fundholder conversation to open dialogue and promote more consistent approaches to service planning and outreach implementation.

Evaluation findings

Coordination and integration of programs

There are a variety of fundholder arrangements that exist for outreach programs. An overview of these arrangements was provided in Chapter 4 (p. 30). In New South Wales, Victoria, Western Australia and South Australia, the jurisdictional rural health workforce agency administers the outreach programs, providing an opportunity for local workforce solutions to be integrated with outreach services. Other jurisdictions have different arrangements, as follows:

- Queensland: A separate not-for-profit that helps build rural and remote health programs administers the outreach programs. While this model requires effort to integrate with Queensland Health and the rural health agency, it was noted a PHN and a Queensland HHS are on the advisory forum.

- Tasmania: There are 2 fundholders. TAZREACH is the fundholder for 4 of the 5 programs, with RHT, a local community service provider in the Northwest, the fundholder for the EESS. Having the fundholder within the Tasmanian Department of Health allows for greater integration of service planning and state-based outreach services but not such close integration with the rural health workforce agency HR+ or Primary Health Tasmania, but both these organisations are on the jurisdictional advisory forum and the case study indicates a strong and trusting relationships between these organisations.

- Northern Territory: There are also 2 fundholders. The NT Health holds the funding for the RHOF and the ear and eye programs whereas the NT PHN holds the funding for the MOICDP. NT Health does not currently administer the EESS. NT PHN is both the PHN and the rural health workforce agency allowing for greater integration of primary healthcare commissioning, outreach and local workforce support.

Table 14 provides a comprehensive list of the role of the fundholders across jurisdictions.

Table 14: Fundholder role by jurisdiction

Jurisdiction	Fundholder	Role
NSW	NSW RDN	Rural workforce agency
Vic	RWAV	Rural workforce agency
Qld	CheckUP	Not-for-profit, not Health Workforce Qld
SA	RDWA	Rural workforce agency
WA	RHW	Rural Workforce agency
Tas	Tasmanian Department of Health – TAZREACH	State DoH, not HR+
Tas	RHT	Local service provider
NT	NT PHN	PHN/Rural workforce agency
NT	NT Health	Jurisdictional department of health

The time and effort devoted to establishing and fostering relationships and the importance of maintaining stability was consistently noted by stakeholders in consultations.

As noted above, the Department funds HoA directly. HoA is not subject to the same reporting requirements as the fundholders and is not required to submit a needs assessment to the Department. The service did state that it performs a robust needs assessment by consulting with communities directly to help determine local health needs, plan their service routes and avoid service duplication. While it is not a requirement, HoA did not report consulting with the fundholder in Queensland or other relevant jurisdictional stakeholders that commission and/or deliver outreach services in Queensland to inform this process. Due to this, HoA's services appear to sit outside of existing outreach services administered by CheckUP, the PHN and other related programs supported by Queensland Health. Both HoA and other stakeholders indicated there was capacity for increased engagement with Queensland Health, the PHNs and the fundholder in Queensland. In light of this, the Department should review administration of the funding for outreach services provided by HoA to see if there are opportunities to further integrate their services with existing outreach service provision to increase collaboration and enhance ongoing regional planning.

Stakeholders frequently raised the issue of integration. This points to wider system issues regarding Commonwealth and state roles and responsibilities in health and the role of health workforce agencies, LHNs and PHNs. Reforms to disability and the aged care sector, given shared workforce groups and multipurpose services in rural areas increases complexity. This evaluation considered just a few of the many programs and strategies aimed at improving rural and remote access to care, and changes to the governance arrangements to promote better integration may require broader reform than possible here.

To promote further integration, the Department could work to integrate outreach as an enduring and responsive mechanism to improving service access in underserved areas. To facilitate this process, the Department could consult with officers from relevant portfolio areas to ensure greater visibility on health outreach programs is achieved through future strategy development under the key policy initiatives, such as the Stronger Rural Health Strategy and the Closing the Gap Agreement.

Responsiveness to regional and local needs

The need to better engage and listen to local leadership to plan, deliver and govern outreach services was consistently raised by stakeholders. Multiple jurisdictions described working towards employing regional approaches to better adapt to community needs. There is support for further integrating the outreach programs into regional governance models to increase transparency, enhance local engagement and input, better reflect variation in needs and priorities across communities and facilitate stronger collaboration and information sharing. There is potential for further exploration of these types of governance models. While this approach may not be suitable in certain areas, regional governance models, as opposed to program or initiative specific models, may allow for better integration of all programs and initiatives focussed on local service planning and workforce development to ensure a more coherent and dynamic response.

Governance role of the advisory forum

Given the reported value of the jurisdictional advisory forums in providing oversight into needs assessment and service planning decisions, the fundholders should maintain a single advisory forum that oversees these functions across the outreach programs.

Existing fundholder arrangements could lead to potential duplication of needs assessment and service planning processes. To mitigate the potential for duplication, facilitate further alignment of health priorities and increase collaboration across organisations, consideration should be given to the following activities:

- In jurisdictions where 2 fundholders exist, encourage the fundholders to establish a shared advisory forum and coordinate needs assessment and service planning processes.
- Extend advisory forum arrangements to other jurisdictional organisations (for example, PHNs), where appropriate.
- Require fundholders to invite the NACCHO affiliate organisations (or their nominee) to co-chair the advisory forum.

There are other jurisdictional organisations that may be conducting needs assessments and service planning concurrently. The scope of their needs assessments and service planning may diverge from the outreach programs depending on the priorities and objectives of these organisations. Despite this, there may be overlap and potential opportunities for further alignment of these processes. Other jurisdictional organisations may also provide valuable input into the outreach needs assessment and service planning processes; therefore, advisory forum arrangements could be extended to other jurisdictional organisations.

The outreach programs seek to target and increase access to health services for Aboriginal and Torres Strait Islander people. In line with Closing the Gap priorities, stakeholders stressed that greater voice of Indigenous Australians in the advisory fora is warranted. To ensure greater representation of the Aboriginal and Torres Strait Islander sector, the NACCHO affiliates should co-chair the advisory fora with the jurisdictional fundholders.

Facilitating further transparency and consistency in governance

It is clear there are a wide range of stakeholders that want to provide input into governance processes and see the advisory fora as one vehicle in which they can provide input. At present, stakeholders are unsure of the timing and nature of the input they can have. Requiring the fundholders to provide the Department and NACCHO with their planned needs assessment and service planning process each period, including how and when they will engage with local communities and other key stakeholders, may also increase stakeholder engagement and collaboration with the Aboriginal and Torres Strait Islander sector. Furthermore, fundholders should make the process and outcomes of the needs assessment and service planning processes publicly available. Information on the needs assessment and service planning process should be made available to the public while the fundholders are undertaking this process. This will ensure stakeholders understand when and how they may provide feedback. The outcomes of these processes should be made publicly available each period in the 6 months following Departmental approval of the needs assessments and service plans. It should include details of the communities to receive services and the service providers and the local communities and other key stakeholders that provided input into the process. This could facilitate further transparency and provide additional opportunities for feedback.

Currently, there are inconsistencies in the service plan approval process. For example, the advisory fora currently sign off on the MOICDP service plan, but the Department signs off on the RHOF service plan. There is an opportunity to increase efficiencies across programs by aligning the work plan approval process for the RHOF. This alignment may also provide the transparency in process stakeholders want.

Performance monitoring and feedback

At present, the variability in data collection processes across jurisdictions, along with the specific data captured, makes assessing fundholder or program performance challenging. The Funding Arrangement Managers noted that their role should involve a value for money assessment in contract review, but a lack of hard data means this process is significantly diminished.

Variability in data collection across jurisdictions was noted in the HEBHBL program by Siggins Miller in 2017 and was similarly raised as an issue by stakeholders during consultation for this evaluation.[24] As encountered when collecting customised fundholder data for this evaluation across all programs, Siggins Miller found that quality and completeness of activity data varied considerably for the HEBHBL program. Feedback received by Siggins Miller suggested the

reporting process without clearly defined key performance indicators was also a considerable burden on fundholders. To enhance performance monitoring and facilitate cross-jurisdictional comparisons, there is a need to review existing fundholder data information and reporting and design and establish a new standardised single national minimum data set. Creating a single national minimum dataset that encompasses all programs will help:

- reduce data burden on fundholders
- improve performance monitoring and feedback
- enable consolidation of the data at the jurisdictional and national levels.

The varied nature of outreach target populations, diseases, and services means that patient outcomes across different outreach programs may not be comparable. Despite this, there is potential in using a nationally consistent approach to PREMs to monitor fundholder and service provider performance. As part of the new standardised national minimum data set, the Department should also look to establish and collect a small suite of key consumer facing key performance indicators (including outreach provider continuity, patient experiences, clinic utilisation, visit duration and unit costs) with data elements specified in the Australian institute of Health and Welfare metadata store to improve consistency and facilitate cross-jurisdictional comparisons.

To improve transparency and allow this data to improve the planning and delivery outreach services, the Department could establish data sharing arrangements that would allow access to patient experience data for key stakeholders, such as fundholders, NACCHO and their affiliates.

Opportunities for information sharing

Stakeholders consulted showed great interest in the diffusion of innovative models of care and practices, while others were interested in how other fundholders were overcoming specific challenges in local communities. Providing additional opportunities for stakeholders across jurisdictions to share and learn from each other could service as a vehicle for continued ongoing collaboration.

Box 8: Recommendations for outreach program governance

Program specific:

1. The Department to review the governance and funding arrangements for HoA with a view to strengthen the overall coordination and integration of regional and local outreach service planning and delivery across Queensland.
2. Remove variation in the annual service plan approval process and establish a consistent approach across all programs by enabling the advisory forum in each jurisdiction to approve annual service plans for the RHOF.

All programs:

3. Existing fundholders should be retained across all jurisdictions, while supporting the establishment or continued support of regional governance models that enable decisions regarding service planning, funding and delivery to be progressively devolved. This will build the capacity for regionally-responsive models that provide outreach to surrounding local communities.
4. Encourage fundholders to maintain a single advisory forum that oversees the needs and service planning functions for all outreach programs. Where multiple outreach fundholders exist in a jurisdiction, the fundholders could be encouraged to establish a shared Advisory Forum and coordinate needs assessment and service planning processes to avoid duplication and streamline reporting to the Department. These arrangements could be extended to include other organisations involved in improving access to health services (for example, PHNs), where appropriate.
5. To strengthen the role of the Aboriginal and Torres Strait Islander health sector in the governance of outreach programs, require fundholders to invite the National Aboriginal Community Controlled Health Organisation affiliate organisations (or their nominee) to co-chair the advisory forum.
6. Require fundholders to provide the Department and the National Aboriginal Community Controlled Health Organisation with their planned needs assessment and service planning processes for each

period, including how and when they will engage with local communities and other key stakeholders and to what extent the process will be coordinated with other fundholders to avoid duplication and streamline reporting to the Department.

7. Fundholders to make the following publicly available:
    - The planned needs assessment and service planning process before for each planning period, including the nature and timing of opportunities for local communities and other key stakeholders to provide input into the process and key contacts for feedback.
    - The outcomes of the needs assessment and the service plan before the commencement of each the service period, including details of the services and communities to receive the services.
8. The Department to review existing fundholder data information and reporting and design and establish a new standardised single national minimum data set, along with a streamlined data collection and reporting process, that:
    - covers all programs
    - reduces data burden on fundholders.
    - provides a sound basis for performance monitoring and feedback
    - enables consolidation of the data at the jurisdiction and national levels.
9. As part of the new standardised national minimum data set, the Department to establish and collect a small suite of key consumer facing key performance indicators (including outreach provider continuity, patient experiences, clinic utilisation, visit duration and unit costs) with data elements specified in the Australian institute of Health and Welfare metadata store to improve consistency and facilitate cross-jurisdictional comparisons.
10. To improve transparency and establish more robust data sharing arrangements that align with the National Agreement on Closing the Gap, the Department to provide key stakeholders groups, such as the National Aboriginal Community Controlled Health Organisation, its affiliates and the fundholders with regular and timely access to the national minimum dataset for the outreach programs.
11. The Department to engage with fundholders, and NACCHO and its affiliates, directly and more actively in creating opportunities for it to share and learn from each other and provide information and feedback on their performance and the future directions for the programs, including annual plenary planning forums, online communities of practice, regular performance feedback and national events to 'showcase' service innovations.

Box 9: Broader system observations about program governance

1. To strengthen consideration of health outreach as an enduring and responsive mechanism to improving service access in rural and remote communities, the Department could consult with officers from relevant portfolio areas to ensure further integration of the health outreach programs is achieved through future strategy development under the Stronger Rural Health Strategy and the National Agreement on Closing the Gap.

Funding

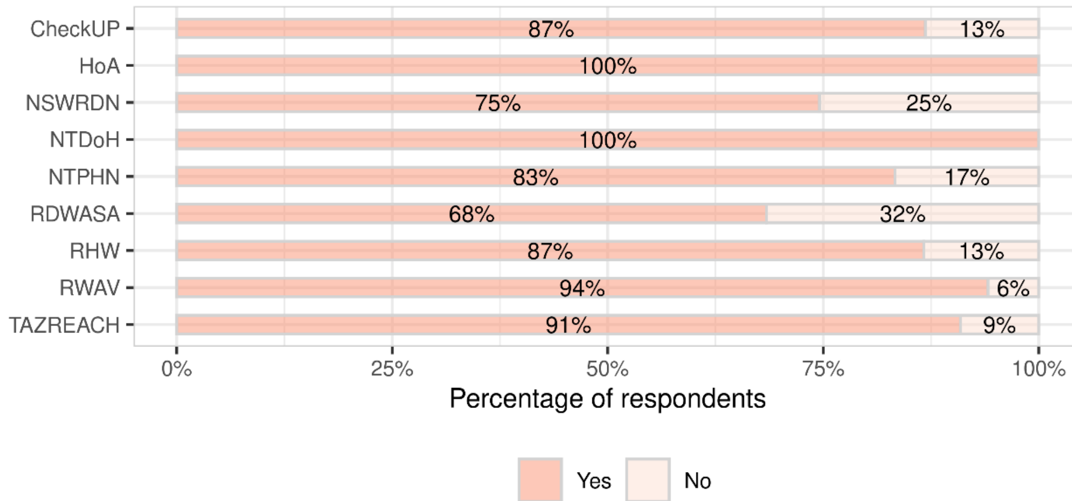
Stakeholder views

Stakeholders indicated they universally value the contribution that outreach services make to providing access to health care in rural and remote communities, but they equally expressed agreement that the funding available is insufficient and does not meet demand.

Fundholders reported being constrained in what services they can support, and the advisory forums highlighted the difficult choices they face in prioritising available resources across communities, services and providers. Some stakeholders expressed concern that priority needs may not be being fairly met. While each fundholder manages the prioritisation of resources differently, many report having created 'reserve lists' of providers in case resources become available throughout the year, due to unforeseen underspends.

The survey of outreach providers demonstrate that most providers indicate they are available and willing to provide more services should funding be available (see Figure 7).

Figure 7: Impact of funding on outreach provider service provision



Source: HPA Outreach provider survey, question 10.

One stakeholder suggested investment by governments in outreach should be funded in a way to accommodate predicted growth long-term.

Amidst this familiar context for the health system, fundholders and other stakeholders identified a number of specific program funding issues, which will be discussed in the following sections, including:

- Basis for allocating funding across fundholders
- Application of indexation of funding across programs
- Flexibility within and across programs in the use of the funding
- Stability and dependability of funding to support program sustainability

Basis for allocating funding across fundholders

The way in which the Department allocates funding to the fundholders is a key area of consideration by stakeholders. However, stakeholders indicate that the precise method by which the Department currently establishes the jurisdictional allocation of funds under each of the programs is not clearly understood. This comment was supported by several stakeholder groups, including a jurisdictional representative of the Department of Social Services Community Grants Hub.

Broadly, the RHOF and VOS are allocated on the basis of the relative size of the total population in each jurisdiction, with an additional weighting by MM category applied to the RHOF. Whereas the MOICDP and HEBHBL are allocated according to the estimated Indigenous Australian population in each jurisdiction. The EESS is allocated on the basis of needs assessment bid by each jurisdiction, which is not necessarily aligned with population size, disease prevalence or surgical waiting lists. The Department indicated that the method of allocation for the programs has changed over time (for example, when shifting classifications for areas of remoteness from ARIA to MM categories) and that various historical funding commitments to specific jurisdictions are also built into the allocations.

A preliminary analysis of the program funding allocation to jurisdictions for 2019–20 revealed significant variations from the relative population shared across jurisdictions and programs, with allocations to larger states, such as New South Wales and Victoria, consistently under their population share and notable inconsistent variations within other states, including Queensland (for example, MOICDP) and Tasmania (for example, HEBHBL). These observations

give further indications that a range factors are considered in addition to population size in configuring the programs allocations.

Regardless of this analysis, fundholders suggest that a population-based funding allocation approach may not accurately reflect the relative community need in each jurisdiction. A few fundholders reported that the current approach does not take account of the differences in geography and service arrangements in each state and territory. One stakeholder indicated there is limited opportunity to reflect areas of service need within the given budget allocations, so that a jurisdiction can receive more funding to address gaps or unmet need. Specific service gaps may dominate in certain communities or specific populations groups, whereas in others outreach services may duplicate existing services.

Some stakeholders also suggested that remoteness weightings used for certain programs, such as the RHOF PM, may need re-examination. One fundholder suggested that the current weightings for very rural and remote areas are too generous, and therefore skew funding distributions.

Similar to the governance processes, stakeholders feel there is minimal engagement and transparency regarding how the funding allocations are determined and distributed across jurisdictions. For example, Aboriginal and Torres Strait Islander organisations stressed that the Department needs to share the funding allocations and consult with the Aboriginal and Torres Strait Islander sector prior to distributing outreach funding. There is a view that this would aid in stopping the duplication of services, ensure there is local input in determining community and regional service needs and facilitate self-determination of Aboriginal and Torres Strait Islander people.

As mentioned earlier in this report, NACCHO calls for direct funding of ACCHOs rather than giving the funding to third parties in the first instance. They assert this aligns with the priority reforms in Closing the Gap. Some stakeholders expressed reservations over universal support of direct funding of ACCHOs, pointing to the need to demonstrate robust governance and strong leadership capacity as prerequisites. There are also considerations regarding the relative importance of a fundholder having strong ties with community vis a vis strong ties with the outreach workforce and broader provider community.

Fund holders identify the burden of data and reporting requirements, with one fund holder suggesting that this be a key factor for consideration in direct funding ACCHOs. The fund holder outlined that their sub contracts with ACCHOs for service provision provide significant support to assist with the administration, finance and reporting associated with provision of outreach services.

Application of indexation of funding across programs

Most fundholders suggested outreach program funding had not kept pace with service costs, pointing to rising costs related to COVID–19 in recent years. They also identified longer term trends in higher travel and accommodations costs and the higher rates of remuneration required of private providers, in comparison to public sector providers, given their expected commercial returns.

Stakeholders acknowledged that current indexation of the programs is inadequate and inconsistently applied, with fundholders identifying the RHOF as a program that has received no real funding increases in recent years despite significant reported increases in prices and demand.

Flexibility within and across programs in the use of the funding

Stakeholders universally pointed to greater flexibility in the use of the program funds as a key factor in driving the ability to improve the effectiveness and efficiency of outreach services provision.

They impressed on the evaluation team that each community is different. They asserted that funding needs to be flexibly applied to effectively scaffold around the existing workforce and local services in each community. How this is achieved can vary markedly from community to community. They underlined that it is vital that the funding enables and facilitates broad access to outreach care for the local community without undue restriction on the nature of the service or the provider.

One stakeholder asserted that the guidelines for outreach programs are too prescriptive, and funding is organised to sit apart from the rest of the health system – despite governance requirements that attempt to link system partners. They considered that increased program flexibility is required to allow greater scope for reflection of jurisdictional priorities and models of service. They felt that increased program flexibility could be underpinned by accountability that increases the focus on measuring and paying for value and outcomes rather than program inputs and activity.

Stakeholders talked about the ability for outreach funding to be flexibly applied to place-based solutions generated through consultation with local communities, and how the 'stovepipe' style of funding that focusses on specific population groups or conditions can create obstacles to delivering priority needs that lay outside the scope of the funding.

One fundholder indicated that they do not run the "outreach programs" but instead they empower and train locals to provide the services on the ground. Their "approach" is not a program-by-program one, they look to consolidate the programs and speak broadly of service requirements when working with host organisations. This sentiment was expressed by other fundholders, for example, one stakeholder described how outreach program funding is 'intermingled with other sources' to meet the community needs.

Fundholders referred to "running programs together", with one fundholder confirming that they try to provide funding to regional organisations without strings attached so they are freed up to coordinate the outreach services that are needed locally. They talked about their job as the fundholder was to ensure the funds were being used in line with program rules and manage the acquittal of funds with the department. Outreach providers and host providers consulted through the surveys and interviewed during the case studies confirmed they were largely unaware of the different funding programs, focussing more on simply providing care and meeting service targets. Interestingly, a number of longer-term outreach providers consistently referred to their work being supported by MSOAP and were not aware of the subsequent evaluation of outreach programs or any changes to program rules.

While there were mixed views expressed by stakeholders on the merits of having funding dedicated to body parts, there was broad agreement that outreach funding should support pathways of care and should enable the integration of services and support team based care. For example, one fundholder suggested funding should encourage ophthalmologists and optometrists working under the VOS to be able to better coordinate referrals and continuity of care. Another stakeholder, a peak eye health organisation, indicated that subsidised spectacle incentive schemes are positive financially for patients, but that they had received feedback from members that these schemes could be better coordinated with VOS and RHOF to improve service delivery. There was also the view that the VOS should support other workforce groups that have shared competencies with optometrists.

Fundholders confirmed that they were usually able to get permission from the Department to fund specific activities or providers that may not fit within program guidelines or budgets. However, they communicated frustration with the time and energy it took to negotiate the systems to gain approval, with some indicating the process could take up to 6 months and spill into next year's reporting period. Representatives from the Department of Social Services Grants Hub confirmed that identifying which practitioners or activities are eligible under each of the programs is particularly time consuming and interpretation of the service delivery standards at the state level has on occasion led to inconsistencies. For example, one stakeholder reported that chiropractic services were considered eligible for outreach funding in

one state, whereas in another state specific approval through Department of Social Services Funding Agreement Managers was required.

Stakeholders noted that differing age, condition and location (MM categories) eligibility criteria across programs make administering multiple programs difficult and can frustrate integration of services across programs. Some stakeholders went further and asserted that program eligibility should not be limited by age and MM location. One fundholder highlighted the need for ear health services amongst Aboriginal and Torres Strait Islander patients over the age of 21, noting the current rules under HEBHBL arbitrarily prevent anyone over 21 from accessing services. It was suggested that age restrictions may have good intentions but, in areas of market failure, they can reinforce inequality.

Some stakeholders also felt that the service delivery standards are too prescriptive and created further arbitrary barriers to service delivery. For example, stakeholders across several jurisdictions stressed the priority need for dental care in underserved areas and were unsure why this health priority is not supported by the outreach programs, particularly the MOICDP and RHOF. One stakeholder described dental services as a 'hot potato', where the funding of dental care is highly political and more often than not Commonwealth funding programs explicitly preclude dental care, even though it is a reported broadly as a priority across communities.

Concerns were not only directed at flexibility over recurrent funding of services, but also over the access to infrastructure to support outreach services. Clinical stakeholders discussed the need for well calibrated equipment to be in place to enable a clinic to be effective. They also cited the need for accommodation to allow outreach providers to stay overnight in remote communities and the need for digital infrastructure to support telehealth and shared care. Stakeholders reported that the restrictions on the availability of infrastructure funding and the use of program funds to support infrastructure was holding back innovation and access to outreach services in some instances.

One PHN stakeholder indicated they have established a set of foundational programs that help scaffold and wrap around their services, for example, digital health. They noted that many Commonwealth programs preclude funding of such infrastructure. Some stakeholders pointed to the opportunities for cost-effective service provision by investing in capital infrastructure. For example, one remote community leader indicated the value they place in outreach providers spending time in their community, meeting with elders and sharing in barbeques. However, due to a shortage of accommodation this is not possible and most professionals need to fly in and out on the same day. It was pointed out that the cost of the charter flights to this community were expensive and they would be interested to understand if over time the ability to have longer stays in the community could be more effective and more efficient.

Many stakeholders advocated for either a relaxation or complete removal of eligibility criteria from the programs, suggesting that specific and locally identified community needs may be better served by scope to provide services for a broad range of conditions and with greater funding flexibility. Some stakeholders did reflect on the merits of funding according to body parts, indicating that restricting eligibility to the care of eyes or ears does provide helpful guidance on where and what services should be targeted, particularly in the absence of robust needs assessment and planning processes. There was a view expressed that in the absence of reliable governance processes, there is a risk that funds could be allocated to the more vocal and persuasive advocates, rather than evidenced based health priorities.

Stability and dependability of funding to support program sustainability

Stakeholders consulted during the case studies and more broadly in other jurisdictions talked about their primary objective of building the capacity of the local workforce to provide robust primary health care to local communities. We heard about the aspirations in Northern Territory to supplement nurse-led clinics in small remote communities with medical and allied health services from regional centres, of place based planning initiatives in Tasmania where

intersectoral collaboration is building community models to support local primary care providers and of the efforts to scaffold around GPs in rural locations with outreach services.

In all instances, the stakeholders saw an enduring need for outreach to support local services, whether to supplement the primary health care workforce or to provide access to priority medical specialist care. One stakeholder suggested that "some communities will never be able to have their own specialists (for example, dermatologist). Outreach is very important in these areas; it can be the only way to reach these communities and should be considered an essential part of our health infrastructure". Similarly, a stakeholder from another jurisdiction indicated that outreach services are absolutely critical and should be at the forefront of policy and level pegging with maintaining services and trying to solve the problem of rural workforce. Outreach should be the equivalent of workforce in all discussions. It is the second platform.

In this context, many stakeholders called for greater policy awareness and longer term funding security. They impressed on the evaluation team the importance of funding dependability and stability to ensure confidence in making investments in services, to attract and retain outreach and host provider staff and to gain the trust in communities in the services. They considered outreach to be part of the DNA of the system and as such funding agreements should support this reality.

We heard on multiple occasions how shorter term funding can be counterproductive, with the following examples illustrative of the situation:

- **RHOF pain management funding**: Most stakeholders acknowledged that there are pressing issues to be addressed in analgesic stewardship and effective chronic pain management across rural and remote communities in Australia. But they consistently expressed concerns over the way in which the funding support for pain management was recently administered through the RHOF. Some local health practitioners talked about the rushed process of trying to establish services and recruit patients, while others talked about the time and investment required in setting up effective services.

  They emphasized that communities and providers require sustainable programs and services. Fundholders reflected that providing a service and then having to take it away, due to short term funding commitments, is disruptive to health services, disheartening for providers and above all erodes trust in the community. One fundholder indicated that the pain management program fell over in their jurisdiction as the model that was set out by the funding simply didn't fit with their service provision arrangements.

  Stakeholders at a pain management clinic in Tasmania indicated the pain management program did not provide stable funding and involved unrealistic timelines for place based projects such as theirs. The fundholder reported that long standing arrangements with valued providers had been adversely affected, given the requirement to flex up and back in line with the funding. They asserted this eroded trust in the services by GPs and patients.

  One fundholder reported that they had previously received funding for pain management from the Department and progress was made, but the pain management aspect of the funding ceased after 18 months. They indicated that, instead of scaling back, they integrated the opioids program into the RHOF. However, the resources now available for this specific service are stretched and without specific funding.

- **Attraction and retention of staff.** Stakeholders reported difficulty in recruiting both visiting providers and local staff due to uncertainty around the funding contracts. With prospective staff preferring certainty, short term contracts can further exacerbate health workforce shortages many regions are facing. Among host organisations, they reported a need to offer salaried positions to hold onto staff. Fundholders indicated they needed assurance of funding across multiple years, with fixed review periods that are timed well in advance of contract end dates to provide providers with more certainty.

Stakeholders in one jurisdiction discussed how a regional services model brought more stable state-sourced funding together with outreach program funding and other funding sources to establish a few key full time permanent clinical positions to provide eye outreach services. But generally, the provider community who relied on service contracts expressed some hesitation in relation to the uncertainty year-on-year, particularly when decisions regarding ongoing employment were sometimes based on funding decisions made very close to the beginning of the next funding cycle.

- **Alternative use of resources to avoid underspending:** Despite reported unmet demand for outreach services, all fundholders reported grappling with an underspend across programs each year. This was one of the most frequently cited challenges noted in the narrative reports provided to the department and by funds managers at the Department of Social Services Grants Hub. Fundholders indicated that the service plans required specification of service, community and frequency to justify the annual budget, but invariably actual service provision varied from planned due to unexpected events, such as severe weather, provider availability, cultural observance and, more recently, the impact of COVID-19. This invariably contributes to underspend.

  The narrative reports provided details on a myriad of unexpected events over recent years that have resulted in the cancellation or delay of outreach visits. Fundholders have tried to reduce unspent funds each year by overbudgeting and creating reserve patient lists. While this has made some difference in underspend for fundholders, underspend to some degree remains as a result of the annual funding cycles. Fundholders often look for alternative uses of the unspent funding but note that rigidity in program rules and long approval times make alternative use of the funding time consuming which causes delays. Sometimes, fundholders choose to return unspent funds to the Department, even though need within serviced communities remain. However, where approval is granted for alternative use of the funding, it is usually for a short period and similar to the experiences with the recent pain management funding requires to ramping up and down of services and community expectations. One fundholder indicated that they actively work against these short term service fluctuations, particularly in smaller and more remote communities where changes in services are more acutely noticed and trust eroded. One stakeholder cited examples of where communities have pushed back on offers by the fundholder for short term extensions of existing services.

As identified a number of times in this report, stakeholders indicate the programs are too transactional with a focus on short term outputs rather than global outputs, outcomes or value. One fundholder suggested that underspends are a symptom of the problem of focussing on outputs, with the fee for service approach limiting the ability to influence full year results. Greater flexibility in how services are defined would enable tailored solutions for communities that could involve greater support of local services to host outreach services.

Due to the challenges associated with the existing outreach funding contracts, stakeholders advocated for multi-year funding agreements, with some saying up to 10 years to mitigate the challenges mentioned above and allow stakeholders to prioritise local workforce development and better establish sustainable service delivery within rural and remote communities.

Evaluation findings

Basis for allocating funding across fundholders

Given stakeholder reflections regarding the funding allocations for the outreach programs, there is merit in reviewing the current approaches to allocating funding to jurisdictions for the programs and exploring alternative methods. Consideration should be given to methods that are responsive to both changes in demographics and the capacity of local service provision. For example, variations in MBS utilisation across rural and remote areas in each jurisdiction could provide a signal of local service capacity and align with the Workforce Incentives Program and other initiatives aimed at building the local workforce.

The aim of many of the outreach programs is to increase health access for Aboriginal and Torres Strait Islander people. Engaging with NACCHO and NACCHO affiliates prior to finalising funding allocations for Aboriginal and Torres Strait Islander Australians under the MOICDP, VOS, HEBHBL, EESS outreach programs will work to increase transparency, reduce potential duplication of services and increase collaboration between the Department and the Aboriginal and Torres Strait Islander health sector.

As noted above, many stakeholders consulted in the Aboriginal and Torres Strait Islander health sector also expressed the desire for ACCHOs to receive outreach program funding targeting Aboriginal and Torres Strait Islander people directly. There are some reservations about the national capacity of the affiliates to manage this effectively. The fundholders should work with the National Aboriginal Community Controlled Health Organisation affiliates to identify further opportunities to progressively devolve outreach program funding for MOICDP, VOS, HEBHBL, EESS to regional Aboriginal Community Controlled Health Organisations, where robust governance and service capacity are in place.

Significant time and effort by the fundholders, Funding Arrangement Managers and the Department could be saved if the rules were relaxed, and funding could be more broadly applied to providing primary health and medical speciality services according to priorities regionally. As described in the governance section above, many stakeholders supported the idea of 'regional governance models' to support flexibility and address regional needs and priorities. Given current policy directions and developments in some jurisdictions already, recommendation 3 also suggests consideration be given to explore regional allocations (based on regional needs and service plans) that are subsequently based on local community needs. In the long term, fundholders could pilot devolving funding allocations to regional agencies to support regional service plans and the provision of services that are responsive to local community needs.

Application of indexation of funding across programs

Many stakeholders consulted are of the view that outreach program funding has not kept up with the cost of service delivery. While the Department indicated they do index the outreach program funding, reviewing the current indexation rate may be warranted given the reported rise in the cost of service delivery across jurisdictions. This could include consideration of existing approaches, such as indexing the funding to align with the MBS indexation rate. MBS items were indexed at 1.6% from 1 July 2022.

Flexibility within and across programs in the use of the funding

Consideration of further integration of the outreach programs may work to promote additional flexibility. For example, eye health services, such as ophthalmology, are eligible under the RHOF and MOICDP, and there may be opportunities to consolidate VOS funding under these programs to better support overall eye health priorities. This approach could also help with the persistent issue of underspend across the outreach programs.

Stakeholders universally called for additional funding flexibility across programs to better respond to changing and emerging needs. Existing processes to gain approval to fund specific activities and providers were described as time consuming and resource intensive. To promote additional funding flexibility across programs, the Department should consider the following:

- Review the range of planned service arrangements that require fundholders to seek approval from the Department (including alternative services arrangements where an underspend is anticipated) with a view to allowing greater fundholder decision making capacity and strengthening reliance on fundholder accountability to ensure cost-effective and appropriate service provision is realised.

It was observed from stakeholder interviews that varying eligibility across programs has created additional complexities and hindered flexibility. There are opportunities to harmonise the service delivery standards and remove variation of eligibility across programs which includes the same level of coverage of:

- MM categories
- Age of patients
- Range of medical, allied health and nursing providers
- Broad range of health conditions that are reflective of local priorities

As indicated above, stakeholders did report advantages of funding services according to body parts as it has provided them with guidance on specific services that should be targeted. Due to these reflections, there is merit in enabling further funding flexibility while maintaining some form of guidance around specific health priorities. A happy medium may be achieved by retaining specific programs for Indigenous Australian eye and ear health whilst ensuring the service delivery standards for HEBHBL, VOS and EESS are harmonised with those for the RHOF and MOICDP. This will help to ensure the same scope and coverage of patient groups and outreach providers and facilitate further integration of services supported under other programs.

The Department should also look to extend the scope and coverage of the service delivery standards of the RHOF and MOICDP to explicitly include dental health and confirm coverage of eye and ear health services to clarify the scope for integration with services funded under other relevant outreach programs.

Stability and dependability of funding to support program sustainability

Stakeholders consistently reiterated the vital nature of the outreach programs in increasing access to health services in underserved areas. Stakeholders stressed that outreach is part of the system DNA and should be funded accordingly to promote sustainable local service delivery through longer-term funding contracts. The Department may look to consider revising the funding arrangements to better support more predictable and reliable funding, with indications that longer term funding stability of 5 to 10 years would be broadly supported.

Box 10: Recommendations for program funding

Program specific:

12. To improve transparency and support the objectives in the Closing the Gap Agreement, the Department to consult with the National Aboriginal Community Controlled Health Organisation and its affiliates prior to finalising funding allocations for Aboriginal and Torres Strait Islander Australians under the MOICDP, VOS, HEBHBL, EESS outreach programs.
13. Fundholders to work with the NACCHO affiliates to identify further opportunities to progressively devolve outreach program funding for MOICDP, VOS, HEBHBL, EESS to regional Aboriginal Community Controlled Health Organisations, where robust governance and service capacity are in place.
14. The Department to explore ways to further integrate the VOS with funding support under the RHOF and the MOICDP for ophthalmologists and other eye health providers to enable more flexible use of eye health funding and better support local community eye health priorities, including review of existing enabling legislation for the Visiting Optometrists Scheme.
15. Establish harmonised service delivery standards for the RHOF and the MOICDP to enable more flexible use of funding and better support local community health priorities. The service delivery standards should remove any inconsistencies by providing for the same level of coverage of the:
    - MM categories
    - Age of patients
    - Range of medical, allied health and nursing providers
    - Range of health conditions that can be addressed in meeting local priorities.
16. Extend the scope and coverage of the service delivery standards of the RHOF and the MOICDP to explicitly include dental health and to confirm coverage of eye and ear health services to clarify the scope for integration with services funded under other relevant outreach programs.
17. Ensure the service delivery standards for HEBHBL program, the provision under the VOS and EESS program are harmonised with those for the RHOF and the MOICDP to ensure consistent coverage of patient age groups and MM categories. While noting the variation in program objectives,

alignment of age and location of patients may facilitate integration of services in supporting the broader eye and health needs of individuals in local communities.

All programs:

18. Review the current approaches to allocating funding to jurisdictions for the programs and explore alternative methods, including those that are responsive to both changes in demographics and the capacity of local service provision. For example, variations in Medicare Benefits Schedule utilisation across rural and remote areas in each jurisdiction could provide a signal of local service capacity and align with the Workforce Incentives Program and other initiatives aimed at building the local workforce.
19. Review the current indexation of outreach programs with a view to applying a consistent approach across all programs with consideration given to existing approaches (for example MBS indexation, or the way the Independent Hospital Pricing Authority determines the hospital efficient price).
20. Review the range of planned service arrangements that require fundholders to seek approval from the Department (including alternative services arrangements where an underspend is anticipated) with a view to allow greater fundholder decision making capacity while strengthening reliance on fundholder accountability to ensure appropriated service provision and value for money.

Box 11: Broader system observations about program funding

2. Department could explore feasibility of revising funding arrangements to better support the sustainability of outreach providers and services by establishing processes for more predictable and reliable funding, with indications that longer term funding stability of 5 to 10 years would be broadly supported.

Needs assessment and service planning process

Amidst the principal functions of the fundholders are the capacity to undertake effective:

1. **Needs assessment** – understand the health and service needs and identify the key service gaps across the communities in the jurisdiction,
2. **Service planning** – decide on the priorities for service provision that are possible with the available budget and then identify service organisations and outreach providers to deliver the services

The effective assessment of service needs requires the fundholder to establish robust ties with local services and communities, collaborate and coordinate with other fundholders and service planning and commissioning agencies and have access to the ability to analysis demographic, epidemiological and service utilisation data.

The effective planning of services requires the fundholder to be decide on the priorities for service provision and then marry them with available services providers. This requires the fundholders to establish strong ties with health service providers, particularly in regional and metropolitan areas. It also requires the balance of priorities to ensure equity in service access.

Stakeholder views

As discussed earlier in the report, the advisory forum plays a key governance role in bring the voice of the communities to the table and ensuring service planning aligns with the priority needs of communities and that resources are allocated equitably in addressing these needs. NACCHO has underlined the need for greater transparency on the decision-making processes of the outreach programs to ensure the funding allocated by fundholders is 'going to places and communities most in need.' They acknowledge that the programs are critical but assert they are not transparent enough, making it difficult to understand how they are managed and how funds are allocated. Recognising the role of the advisory forum, NACCHO is calling for Indigenous Australian membership, including a chair that is endorsed by the NACCHO affiliate in the jurisdiction. They are seeking a more consistent approach across jurisdictions to needs

assessment, which includes a minimum set of principles and a mandate for input from a broad range of stakeholders in undertaking needs assessments processes.

Existing fundholders reported strong ties to the provider community and appear to have varying levels of ties and engagement to the local communities. Stakeholders acknowledged the practicalities of engaging with each small local community to assess and respond to the individual workforce and service needs is challenging. In some jurisdictions regional planning groups have been established which foster inter-agency collaboration and have strong ties to local communities. These groups then feedback regional plans to the fundholder for consideration along with the other regions.

Some fundholders noted there were opportunities to improve their needs assessment process, describing their current arrangements as 'static.' and not always agile in responding to the changing circumstances in communities. A few cited challenges effectively responding to changing needs given existing funding commitments and budget constraints. To mitigate this issue, some stakeholders described developing and implementing strategies. For example, fundholders discuss emerging community needs internally as they arise and then establish responses on a reserve service list. While fundholders consider this to be an ongoing challenge, they acknowledged their needs assessments must be flexible and be able to adapt to potential changes.

Fundholders recounted that there is room for improvement in access to and alignment of existing data sources held by various organisations, including local hospital networks, PHNs and health workforce agencies. This includes aligning needs assessments and service planning functions to avoid duplication and "creating multiple versions of the truth". It was acknowledged that existing duplication was underpinned by the requirement of the Department for separate assessments and plans for many programs. One stakeholder described how they spend much of their time in very similar discussions across various forums and meetings to plan for services to be provided in her region. They jokingly suggested that the agencies should get together and have one consolidated meeting in the future.

Whilst these organisations may have different overarching priorities, stakeholders reported that better alignment of data sources and planning processes across agencies may help improve need assessment and service planning. TAZREACH reported that the organisation is looking to use the data sources of the Department, the PHN, the health workforce agency and the fundholders more intelligently to create a regional service plan and workforce plan, with outreach service plans incorporated. They relayed that there is risk of significant duplication with the PHN, workforce agency HR+ and TAZREACH all preparing separate needs assessments under their agreements with the Australian Department of Health and Aged Care when one regional master plan may be a better and more coherent solution.

As identified earlier in the report, stakeholders feel there should be additional opportunities for communities and other key stakeholders to provide input into the needs assessment and planning process. Community stakeholders advocated for a more transparent, bottom-up approach that allows for additional input and engagement, particularly Indigenous Australian communities. Some local stakeholders feel it is not appropriate for individuals in metropolitan areas to decide what they need and how it will be provided, reinforcing the notion of 'outreach being done to them, not with them'. Other stakeholders, including peak workforce bodies and specific condition interest groups expressed more interest in knowing how and when they could have input during the planning cycles.

While community stakeholders appreciate and understand the need for systems of governance and accountability, there were calls for more autonomy or, at the very least, shared decision-making in this process as communities should decide what their needs are and what services should be supported. This includes allowing communities to drive outreach services by engaging them from the beginning and providing opportunities for involvement in the design, planning, implementation and evaluation phase of outreach programs.

One fundholder described ACCHOs as the 'gold standard' of facilitating a bottom-up approach as power flows from the bottom up. The Boards of ACCHOs are made up of local community members and so solutions endorsed by the Board have local ownership and accountability. While this is much more challenging to implement at a jurisdictional level, it perhaps points to the importance of regional governance models that work to undertake needs assessments and service planning collaboratively.

Western Australia's regional model offers a good example of this approach. RHW has established 8 regional working groups across the state to better determine need and capture the variation across the regions. While there is a push from some jurisdictional stakeholders for even greater regional autonomy, the fundholder in Western Australia can get feedback on its needs assessment and service plans from the individual regions in an attempt to better reflect the diversity across regions and individual communities. NSW RDN also reported relying on regional groups to gather local insights and bring this back to the jurisdictional advisory forum to help inform their needs assessment process.

In Queensland, Regional Outreach Planning and Coordination Engagement is led by four Regional Coordinators and supported by the State based CheckUP Outreach team to consult broadly and ensure the views and expertise of Aboriginal and Torres Strait Islander people, communities and organisations are an integral part of the process.

CheckUP reported that stakeholder engagement is constant and an iterative process in which engagement occurs from identifying needs, planning through to post outreach service implementation, monitoring and evaluation of the services.

In taking this consultative approach, CheckUP stated that those on the ground are actively engaged in the process of developing tailored health solutions for their local community.

The organisation reported that the purpose of their regional engagement is to:

- Manage and support the coordination and delivery of outreach services in the region.
- Confirm delivery of planned services.
- Identify areas of unmet need.
- Monitor appropriateness and quality of services delivered.
- Monitor and identify service duplication issues.
- Support coordination, integration with other program/services.
- Lead and support the development of regional service delivery plans.

Stakeholders expressed a preference for the service plans that are provided to the Department to be more flexible, less microscopic and pre-determined. Stakeholders feel service planning should be an ongoing process and not based on specific locations that visiting services must visit or hitting specific service targets prior to the end of the financial year. The need to adjust services to respond to external factors like extreme weather events, availability of transport, local community cultural events and coordination of outreach providers across programs is inevitable. Stakeholders report that it takes significant time and effort in progressing the formal process of rescheduling, adapting plans and requesting permission for variations in the delivery of services within specified contract periods. However, there was a view from a representative of the Department of Social Services Grants Hub that variation in funding does not necessarily require fundholders to obtain permission from the Department. Clarification on these processes may eliminate any apparent confusion. Another stakeholder observed that the administration of the programs is too transactional with a focus on planned inputs rather than allowing greater fundholder discretion and focussing more on global outputs and value.

Some stakeholders also expressed concern that existing planning processes are constrained by existing service provision. It's not clear that existing service planning processes in some jurisdictions adequately reassesses community needs and coordinate with rural workforce agencies to consider local workforce capacity building during the planning cycle. Some

stakeholders indicated that community needs can change, local workforce solutions can be found, and existing long standing outreach service arrangements may no longer be a priority. They suggested it may even be blocking a local workforce building opportunity. Fundholders told us they hold reserve service lists, but they did not indicate how often they divest from existing outreach services in order to reinvest in building services in other locations based on relative need.

Evaluation findings

Stakeholders consulted reported misalignment and potential duplication of process across agencies involved in needs assessment and service planning which indicates the need for greater coordination. One approach that may help to address these issues is to support the establishment of regional approaches and the development of regional master plans that seek to integrate outreach into broader regional health priorities.

Stakeholders consistently noted the importance of providing culturally safe care and building local capacity through the outreach programs as a means to create more sustainable access to high quality care in underserved areas. While providing culturally safe care and building local capacity are emphasised as priorities in the service delivery standards, stakeholders in the surveys and interviews expressed the need to better monitor, plan and support activities that aim to bolster the cultural competency of visiting providers and build local capacity. To ensure more purposeful planning is undertaken to support these priority areas, there should be a greater focus on these activities. This could be supported by incorporating specific plans guided by consultation with communities and budget allocations under the overall service plans. This would allow fundholders and service providers to better plan, monitor and fund cultural safety training to and local capacity building activities undertaken on outreach visits across communities.

Box 12: Recommendations for needs assessment and service planning

All programs:

21. Encourage fundholders to extend existing collaborative arrangements with other fundholders to foster regional approaches to conducting needs assessment and service planning and establishing a shared 'regional master plan' that incorporates outreach, regional and local services.
22. Establish a greater focus on planning, monitoring and funding time spent by outreach providers in undertaking community engagement and relationship building and host provider teaching and training. These activities could be supported by incorporating specific plans guided by consultation with communities and budget allocations under the overall service plans.

Provider recruitment and retention

In the previous section of this report, we identified that effective planning of services requires the fundholder to decide on the priorities for service provision and then marry them with available services providers. This requires the fundholders to establish strong ties with health service providers, particularly in regional and metropolitan areas.

Provider recruitment and retention is a key objective for fundholders, whether they achieve this through direct engagement of outreach providers or through a service provider organisation (for example, a major teaching hospital that coordinates the outreach providers).

Outreach provider participation

The number of professional groupings of outreach providers participating in each of the programs does not appear to be routinely collected and reported by the Department. However, it was noted by a representative of the Department of Social Services Grants Hub that the data reporting template requests fundholders to provide the health provider type and associated health category, but this information is not always provided.

Routine program data held by the fundholders was requested by HPA and provided by many of the fundholders during the evaluation but did not allow for direct identification of the workforce group of the outreach providers or the particular specialisation of the professionals involved in the service provision. In many instances, the fundholders did not provide this data, with some explicitly confirming this data was not readily available. Some fundholders explained that their agreements with service provider organisations did not require the specification of the professionals involved in providing the programs, with the service organisation directly managing the outreach providers. However, HPA was able to derive the broad categories of professional groups indirectly from other data variables, including the relevant service descriptors.

Table 15 presents estimates generated from the consolidated data from the fundholders for each program for the financial years 2017–18 to 2020–21. The data presents the annual **number of visits** per professional category by program. The following is noted:

- The number of visits in 2019–20 was generally lower than that for 2017–18 across the workforce groups within programs. While this may be expected, given the likely impact of the COVID pandemic, the pattern was not consistent. For example, the level of visits steadily grew over the 4-year period under the MOICDP. Further, activity levels in 2020-21 were generally higher than the previous 3 years, even though it could have been expected that COVID would continue to dampen activity.
- Both the MOICDP and RHOF provide for broad access to care but reveal quite different workforce profiles, with nearly 60% the workforce being medical specialists under the RHOF compared with just under 25% for MOICDP. The greater reliance on allied health workforce groups under the MOICDP may be indicative of the nature of care required for chronic disease management.
- Over 98% of the VOS visits are provided by allied health professionals, confirming that optometrists are the principal workforce group supported under program.

Table 15: Visits by program and the profession indicated in the service description

Program	Profession	2017-18	2018-19	2019-20	2020-21	% all years
HEBHBL	11 Medical specialist	1,072	926	727	1,152	21.1%
	13 Medical general practitioner	148	148	48	27	2.0%
	21 Nurse/Midwife	448	474	393	422	9.4%
	31 Allied health	2,647	2,577	2,217	2,522	54.1%
	41 Aboriginal health worker/practitioner	286	271	210	222	5.4%
	52 Care/service coordinator	401	398	389	151	7.3%
	55 Health education/health promotion	16	17	0	0	0.2%
	99 Other	0	0	20	0	0.1%
		24	24	24	0	0.4%
MOICDP	11 Medical specialist	5,685	5,523	5,732	6,645	23.6%
	12 Medical specialist registrar	164	151	138	125	0.6%
	13 Medical general practitioner	1,874	1,946	2,204	2,306	8.3%
	21 Nurse/Midwife	2,446	2,622	2,653	2,953	10.7%
	31 Allied health	9,689	9,752	9,836	10,584	39.9%
	32 Allied health assistant	24	32	126	85	0.3%
	41 Aboriginal health worker/practitioner	1,185	1,268	1,493	1,618	5.6%
	51 Mental health professional	410	483	337	468	1.7%
	52 Care/service coordinator	102	112	152	99	0.5%
	53 Administration	13	0	0	0	0.0%
	54 Technician/Scientist	335	284	217	277	1.1%
	55 Health education/health promotion	1,855	1,844	1,988	1,993	7.7%
	99 Other	16	15	62	2	0.1%
RHOF	11 Medical specialist	12,930	11,892	11,525	13,997	57.6%
	12 Medical specialist registrar	769	712	547	1,209	3.7%
	13 Medical general practitioner	2,625	2,299	2,334	2,482	11.1%
	14 Medical general practitioner registrar	8	8	8	5	0.0%
	21 Nurse/Midwife	2,079	1,906	1,736	2,341	9.2%
	31 Allied health	2,658	2,500	2,599	3,185	12.5%
	32 Allied health assistant	181	182	212	66	0.7%
	41 Aboriginal health worker/practitioner	230	222	154	164	0.9%
	51 Mental health professional	150	145	146	238	0.8%
	52 Care/service coordinator	91	77	83	7	0.3%
	53 Administration	8	8	13	17	0.1%
	54 Technician/Scientist	398	412	376	429	1.8%
	55 Health education/health promotion	210	157	208	256	1.0%
	99 Other	56	65	52	59	0.3%
VOS	21 Nurse/Midwife	8	2	13	3	0.1%
	31 Allied health	4,999	5,019	4,213	5,070	98.0%
	32 Allied health assistant	96	85	55	68	1.5%
	41 Aboriginal health worker/practitioner	0	3	2	1	0.0%
	99 Other	0	0	0	50	0.3%

Note: Adjusted for missing data. Excludes Tasmania due to insufficient data. Excludes EESS.

Table 16 presents the consolidated data from the fundholders for each program for the financial years 2017–18 to 2020–21. The data presents the annual **number of patients or occasions** per professional category by program.

The overall pattern of patient activity is consistent with the number of visits, with a dampening of activity in 20219-20 followed by higher levels of activity in 2020-21.

Table 16: Patients/OOS by program and the profession indicated in the service description

Program	Profession	2017-18	2018-19	2019-20	2020-21	% all years
HEBHBL	11 Medical specialist	7,112	6,106	4,517	6,227	13.7%
	13 Medical general practitioner	1,950	2,192	1,636	1,043	3.9%
	21 Nurse/Midwife	6,230	5,753	5,460	6,830	13.9%
	31 Allied health	24,378	24,067	19,305	19,239	49.8%
	41 Aboriginal health worker/practitioner	8,201	6,692	4,338	4,454	13.6%
	52 Care/service coordinator	2,128	1,822	1,606	1,953	4.3%
	55 Health education/health promotion	171	190	0	0	0.2%
	99 Other	0	0	155	0	0.1%
		312	312	312	0	0.5%
MOICDP	11 Medical specialist	26,573	25,619	28,912	31,201	11.6%
	12 Medical specialist registrar	1,684	2,102	2,477	1,878	0.8%
	13 Medical general practitioner	25,362	28,642	32,102	31,774	12.2%
	21 Nurse/Midwife	41,584	41,070	43,715	46,290	17.9%
	31 Allied health	88,261	88,745	78,882	85,465	35.3%
	32 Allied health assistant	392	461	1,320	1,174	0.3%
	41 Aboriginal health worker/practitioner	28,397	28,995	29,737	32,460	12.4%
	51 Mental health professional	2,996	3,292	3,270	3,681	1.4%
	52 Care/service coordinator	2,391	2,462	2,663	2,523	1.0%
	53 Administration	165	0	0	0	0.0%
	54 Technician/Scientist	1,811	1,764	1,748	2,043	0.8%
	55 Health education/health promotion	15,502	13,933	15,023	15,138	6.2%
	99 Other	453	328	396	53	0.1%
RHOF	11 Medical specialist	120,661	115,528	117,200	129,154	58.8%
	12 Medical specialist registrar	6,351	5,905	5,096	9,262	3.2%
	13 Medical general practitioner	28,421	23,197	20,244	19,115	11.1%
	14 Medical general practitioner registrar	14	14	3	9	0.0%
	21 Nurse/Midwife	20,566	18,675	16,444	20,410	9.3%
	31 Allied health	19,405	18,273	21,073	24,066	10.1%
	32 Allied health assistant	3,479	3,212	3,725	2,503	1.6%
	41 Aboriginal health worker/practitioner	2,566	2,560	1,150	1,754	1.0%
	51 Mental health professional	1,353	1,312	1,675	2,690	0.9%
	52 Care/service coordinator	1,871	1,800	1,927	199	0.7%
	53 Administration	190	184	296	452	0.1%
	54 Technician/Scientist	3,743	3,802	3,166	3,524	1.7%
	55 Health education/health promotion	2,362	1,777	2,518	2,863	1.2%
	99 Other	701	840	784	754	0.4%
VOS	21 Nurse/Midwife	134	42	109	155	0.2%
	31 Allied health	44,365	43,046	34,809	42,094	89.9%
	32 Allied health assistant	5,572	5,062	3,246	3,701	9.6%
	41 Aboriginal health worker/practitioner	0	196	71	22	0.2%
	99 Other	0	0	0	184	0.1%

Note: Adjusted for missing data. Excludes Tasmania due to insufficient data. Excludes EESS.

However, it is interesting to observe that the level of services (OOS) provided by Aboriginal health workers is proportionally higher than the level of visits under the HEBHBL and MOICDP and conversely the level of medical specialist services (OOS) is lower. Whereas for the RHOF the level of services (OOS) provided by medical specialists is similar to the level of visits by medical specialists. This is likely to reflect the greater role Aboriginal health workers play in providing care to Indigenous Australians under the Indigenous specific programs.

Stakeholder views

Most fundholders reported having access to a sufficient number and range of outreach providers, with many of the providers having been involved in outreach care for many years and tended to have started providing outreach later in their careers. However, most fundholders were concerned about succession planning and were unsure what will happen

when the current cohort retire. Stakeholders observed that some senior clinicians were exposing their students and registrars to outreach care, but existing funding support did not necessarily encourage the proliferation of student involvement.

Pockets of shortages were reported by some fundholders, most notably in mental health, including psychiatry, psychology and drug and alcohol workers. Shortages were also cited in other specialist medical areas, particularly those related to eyes and ears, such as ENT and ophthalmology. Fundholders reported that workforce mobility and availability is currently particularly low and that this has been exacerbated by COVID-19. Western Australia indicated that many remote communities rely on workforce from eastern states which has also impacted workforce availability. Tasmania reported that they needed to look to mainland states for outreach providers, given ongoing general shortages of key workforce groups in Tasmania. Northern Territory underlined the high level of turnover of staff in rural and remote communities and the challenges this created for sustaining outreach services.

Awareness of Programs

While outreach providers and other stakeholders are aware there are outreach programs that support the provision of services in rural and remote communities, there appears to be limited awareness of individual programs or funding streams and their specific objectives. This may be due to the volume of existing programs and changing policy directions. For example, some stakeholders had visibility or experience working with individual outreach programs due to their roles or had knowledge of outreach programs that are no longer in operation, such as MSOAP.

In Tasmania, TAZREACH ran a local awareness campaign for the GP clinics in the North West region to raise the visibility of outreach programs amongst the provider community and inform what could be provided in their communities. RANZCO expressed concerns about existing workforce shortages in outreach and reported that it is likely that their members may not know how to get involved in outreach, indicating the need to improve visibility of existing recruitment pathways.

Recruitment of providers

Most fundholders reported relying on their network from being a workforce agency or a government health department to reach out to known specialists to recruit into those outreach positions. They reported using expressions of interest, direct contact with people and advertising on their website. They reported working very closely with organisations to recruit, especially during the current workforce shortages generated by the COVID-19 pandemic. Some clinicians indicated that to participate in outreach required them to actively advocate within their organisations rather than outreach being actively promoted by their regional hospital as part of its service mandate. This contrasted with the context for clinical staff at the sexual health NGO True in Queensland where the organisation reported that participation in outreach services is a specified expectation in their employee contracts.

The majority of outreach providers responding to our survey began participating in outreach through the following channels:

- Employer, including outreach as a condition of their employment.
- Recruited by local, regional or national health organisation (that is, local practice, AMS, ACCHO, Division of General Practice, RFDS).
- Word of mouth or colleague referral.
- Direct approach by fundholder.
- Their own initiative.

Stakeholders also referred to market pressures, citing the increasing competition for health workforce from NDIS. Stakeholders in New South Wales reported that it is difficult to attract specialists and other health professionals to given NDIS are able to offer greater levels of remuneration. Similar sentiments were expressed by stakeholders in Victoria who also noted the levels of remuneration of clinician in private practice impacting on availability of outreach providers who were willing to bulk bill.

Attracting new providers

Fundholders reported that the financial incentives are currently not strong enough to attract new outreach providers into the program and strategies need to be developed to address this situation. Fundholders suggest further exploration of hub-and-spoke models, telehealth-based shared care, student placements and mentoring, use of allied health assistants and involvement of early career professionals to create regional capacity for an outreach workforce and establish alternative workforce models.

Only 2% of the outreach providers responding to our survey indicated that they are an undergraduate student or postgraduate trainee. Several fundholders reported working to introduce more students and trainees to outreach and cited positive developments in this area:

- NSW RDN reported that it recently provided outreach placements to 35 students as part of the MOICDP, comprising 7 medical students and 8 allied health students from metropolitan universities in New South Wales and Canberra. Outreach mentors were provided to students across a range of specialisations, including pharmacy, rheumatology, podiatry, cardiology, podiatry, diabetes education, obstetrics, speech pathology, dermatology, psychogeriatrics, general practice, midwifery, palliative care, psychiatry, and nursing.

  A survey of the students after their placements confirmed that, on average, they considered they were highly likely to work in a rural setting in the future. The students also reported a greater awareness of and sensitivity to Aboriginal and Torres Strait Islander people when providing services.[37]

- CheckUP in Queensland reported it recently worked to establish collaborative solutions with other stakeholders to address significant workforce shortages, including collaboration with local workforce agencies. It reported it is considering funding an Allied Health Student Outreach pilot in the future.[38]

Stakeholders expressed a desire to offer more support to these types of initiatives and to support funding for visiting providers to take trainees on their visits to observe and assist with administration of outreach services.

Financial incentives

Overwhelmingly, stakeholders pointed to the need to reform the way outreach providers are currently remunerated, strongly asserting that MBS is not fit-for-purpose when it comes to the provision outreach services in rural and remote communities.

Stakeholders consistently outlined a combination of factors that distinguish the viable use of the MBS in metropolitan areas from that in rural and remote areas:

- The need to remove financial barriers to access care was identified, given the relative health need and socioeconomic status of many people in rural and remote communities. Where MBS is applicable, fundholders require providers to bulk bill and where MBS is not applicable (for example, most allied health services) the fundholders rely on workforce support payments made from the program funding, given the low level of private health insurance cover in these populations.

- Some people in many of the smaller communities do not have access to MBS and consequently are not able to access financial support unless the services are subsidised through workforce support payments under the outreach programs.

- MBS is a fee-for-service arrangement that relies on caseloads to ensure a provider receives sufficient remuneration during a visit to a community. In some smaller

[37] NSW Rural Doctor's Network. (2021). *Medical Outreach Indigenous Chronic Disease Program (MOICDP) January to June 2021*

[38] CheckUP. (2021). *RHOF Six-Monthly Outreach Narrative Supplement*

communities the patient load is not sufficient to enable remuneration that is comparable to a clinician's usual place of practice. On other occasions unforeseen events (severe weather, community cultural commitments) result in planned caseloads being significantly reduced.

The stakeholders pointed out that the service delivery standards do not allow the use of outreach funds to pay outreach provider salaries without approval from the Department. They also state that if MBS is used then workforce support payments cannot be made to supplement the outreach providers remuneration. This they argue creates a level of complexity to arranging sufficient coverage of salaries and places undue pressure on outreach funds through the sustained use of workforce support sessional payments in lieu of MBS.

A fundholder consulted during the evaluation outlined that the purpose of the workforce support payments is to allow the initiation of services, with the view that MBS will support the workforce component once mature. But the insufficiency of MBS (particularly allied health) and lack of private health insurance means that these services remain dependent on other funding to remain, which limits the ability for the existing outreach funding to be allocated to other services. Stakeholders gave clear indications that the inability to supplement MBS bulk billed payments with workforce support payments limits the capacity to provide providers with sufficient remuneration and erodes the base funding of the programs.

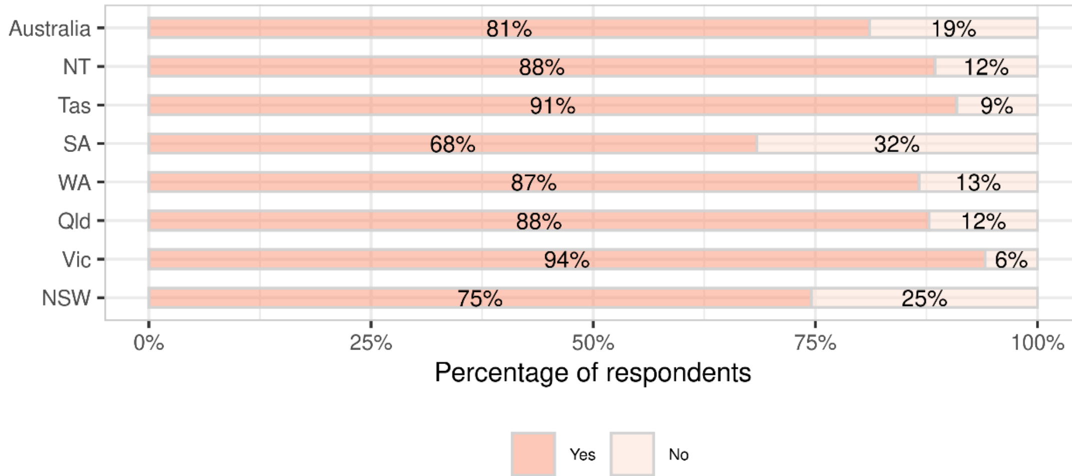
One fundholder indicated it supports all outreach providers by making workforce support payments from the program funds, due to the limited MBS items and eligible consults for allied health professionals and the difficulty for outreach providers to determine if a patient is being managed under a chronic disease management plan. The fundholder suggested that a top-up workforce support payment to supplement MBS items would be helpful.

Stakeholders reported an increasing need to access private providers, whether these be optometrists in private practice or psychiatrists, ophthalmologists and ENT in private hospitals. Fundholders noted that the remuneration expected by private providers exceeded funding availability and MBS was not sufficient, requiring supplementary funding. All too often getting clearance from the Australian Department of Health for such arrangements is time consuming and complex.

Specialists working in the public hospital system generally have local arrangements for rights of practice and, therefore, can bill for private patients. The NT indicated that doctors working in the public hospital system do not have rights of private practice. This was a main barrier reported by Northern Territory in relation to administering the pain management and EESS programs.

The outreach programs are designed to support and incentivise outreach providers to deliver outreach services. Figure 8 illustrates that over 80% of outreach providers responding to our survey across jurisdictions and programs would be willing to devote more time to delivering outreach services if funding was available to provide them with additional remuneration. In addition to personal commitments and retirement, respondents reported that the key factor that would contribute to their decision to discontinue providing outreach services is funding. This observation underlines that supply of outreach providers is available, but that issues of funding may be one of the main rate limiting factors.

Figure 8: Impact of funding on outreach provider service provision



Source: Outreach provider survey, question 10.

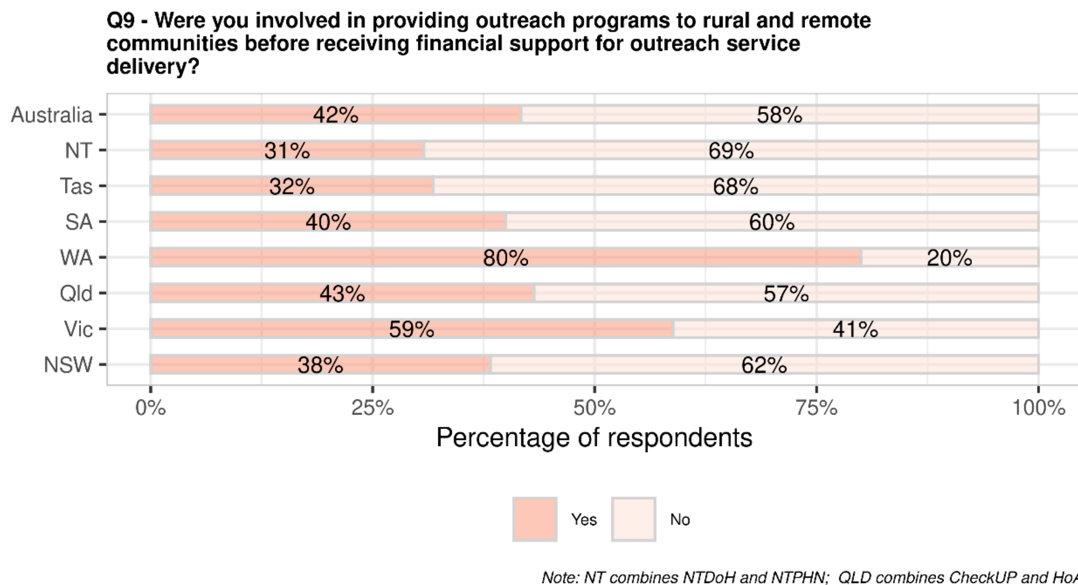
Contrary to other fundholders, one fundholder indicated that it has a large network of existing providers that could be available to accommodate future growth. They reported that recruitment and retention of the workforce has been relatively stable, with only a few exceptions. They reported that retention rates were also are good. They indicated that the RHOF is basically about providing medical speciality services and confirmed that all participating specialists bulk bill under MBS. They indicated this is not a not a problem for the clinicians, it's the default arrangement that doctors bulk bill. Allied health is different, this is where a support payments are required.

Provider retention

Fundholders indicated that existing outreach providers tend to have been providing services for quite some years, that some are in the latter years of their careers and indicate they have a commitment to giving back to the community. Others saw outreach as a vocation. From the medical and allied health providers we consulted directly, it was evident they had a longer term commitment to outreach services. Host services underlined the importance of care continuity, building relationships and trust in the community and ensuring sound take up of services, particularly in Indigenous Australian communities. Amidst high staff turnover in rural and remote communities in the Northern Territory, small communities like Kintore are trying ways to retain medical staff. They rotate a team of staff giving half of them one month off to allow them to return home or spend time in other locations before returning to work the next month. The service reported positive results from this arrangement.

Figure 9 indicates the number of service providers that participated in outreach prior to receiving financial support from the outreach programs. While the majority of outreach provider respondents across Australia were not involved in outreach prior to receiving financial support from the outreach programs, it is noteworthy that more than 30% of respondents across all jurisdictions were involved in providing outreach prior to receiving financial support from outreach programs.

Figure 9: Outreach provider involvement in outreach prior to funding support



Source: Outreach provider survey, question 9.

Evaluation findings

Provider recruitment

Reflections from stakeholder interviews and surveys indicate that the promotion of providing outreach services to clinical communities does not appear to be extensive, with many fundholders relying on informal clinical networks and well established relationships with services to source workforce gaps and replacement clinicians for outreach. Due the limited existing visibility of the outreach programs and the myriad of ways in which health professionals have been recruited to participate in outreach, there may be opportunities to enhance awareness of the outreach programs. To expand provider recruitment pathways and enhance the visibility of outreach services, the Department could consider the undertaking the following actions:

- Consult with universities and health agencies responsibilities for medical, nursing and allied health student clinical placement programs to explore scope to further integrate students into outreach services, including arrangements to financially support students.
- Encourage fundholders to engage with public and private health service agencies to identify and explore the potential to expand strategies to promote a workplace culture whereby participation in outreach is actively supported by the agency.

Financial incentives

Due to the challenges raised by stakeholders in relation to the viability of MBS in supporting outreach providers, the Department should look to review MBS and existing workforce support payment arrangements and their ability to adequately support the delivery of outreach services. This may include opening outreach service provision opportunities to the market through open expressions of interest and consideration of other options, such as allowing fundholders to compensate outreach providers with blended payments that are negotiated with public and private providers.

Beyond MBS and workforce support payments for outreach service delivery, there are provisions for backfilling, time away from practice, etc. to compensate providers and additional funding support for transport, accommodation and food. Despite this support, there seems to be a lack of clear guidance and transparency about how these arrangements work and how they interact with each other. Greater clarity is required with specific guidance for each workforce group.

Box 13: Recommendations for outreach provider recruitment and retention

23. Simplify and harmonise guidance in the service delivery standards across all programs on the remuneration arrangements available for each workforce group and how they interact with funding support for transport, accommodation and food, including clarification of appropriate use of the Medicare Benefits Schedule and Workforce Support Payments to provide coverage of time:
    - travelling while away from usual practice
    - providing direct patient care
    - building local workforce capacity
    - engaging with local communities.
24. Review the Medical Benefits Schedule and existing workforce support payment arrangements to create a simpler, more consistent and sustainable way to reimburse outreach providers. This may include exploring the feasibility of moving to blended payments.

Box 14: Broader system observations about outreach provider recruitment and retention

3. The Department could consult with universities and health agencies responsibilities for medical, nursing and allied health student clinical placement programs to explore scope to further integrate students into outreach services, including arrangements to financially support students.
4. The Department to encourage fundholders to engage with public and private health service agencies to identify and explore the potential to expand strategies to promote a workplace culture whereby participation in outreach is actively supported by the agency.

Local service coordination and collaboration

The fundholders have a responsibility to plan and provide effective coordination of outreach services at the local level. This requires clear and effective communication between the fundholders and outreach and host providers to schedule visits, book patients and ensure the necessary supports are in place for both the host provider and the outreach provider to together to provide coordinated and effective outreach clinics.

Stakeholder views

In consultations and the host and outreach provider surveys, stakeholders consistently reiterated the important role that staff working at host provider organisations play in enabling coordinated and effective outreach clinics. For example, outreach providers responding to the survey confirmed that engaged and dedicated local staff is the most important enabler for delivering successful outreach services. This message was reinforced time again during the course of the evaluation by a broad range of stakeholders.

Stakeholders reported that local staff are central to the coordination of outreach provider' visits, facilitating communication with the fundholder, visiting clinicians and the community. Host providers across jurisdictions reported that the local staff establish strong relationships with patients and are trusted supports for their communities.

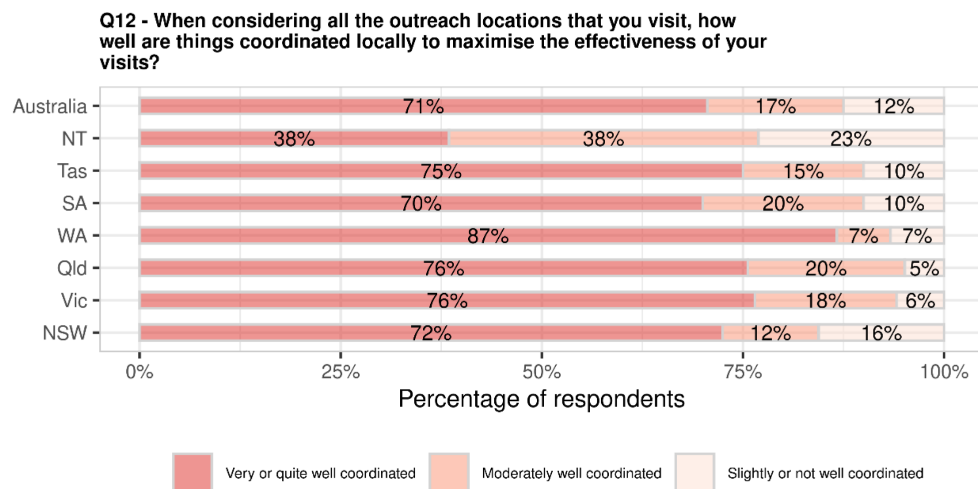
Outreach providers reported that support from both staff at their home practice and staff at the local host provider are important in helping them organise their outreach visits. Over 40% of outreach providers responding to our survey confirmed that host providers supported them in their outreach work.

Outreach providers interviewed during the case studies underlined that the local contact point in each local clinic is pivotal to the success of the service, whether that be a nurse, Aboriginal health worker or a GP. The input they provide is both administrative and clinical. Visiting providers and host services described how local staff support outreach visits by performing various tasks, including coordinating patient lists, gathering clinical tests and preparing screening results for visiting clinicians to review. It was noted, that where an effective

coordination point does not exist at a local clinic, then efficient and effective outreach service provision becomes less viable.

Figure 10 indicates that most outreach providers responding to our survey thought that local coordination was well coordinated, with over 70% of respondents rating the support either quite well or very well coordinated. There were indications of variation across jurisdictions with providers in the Northern Territory (38%) lower and in Western Australia higher (87%) when compared with the national average.

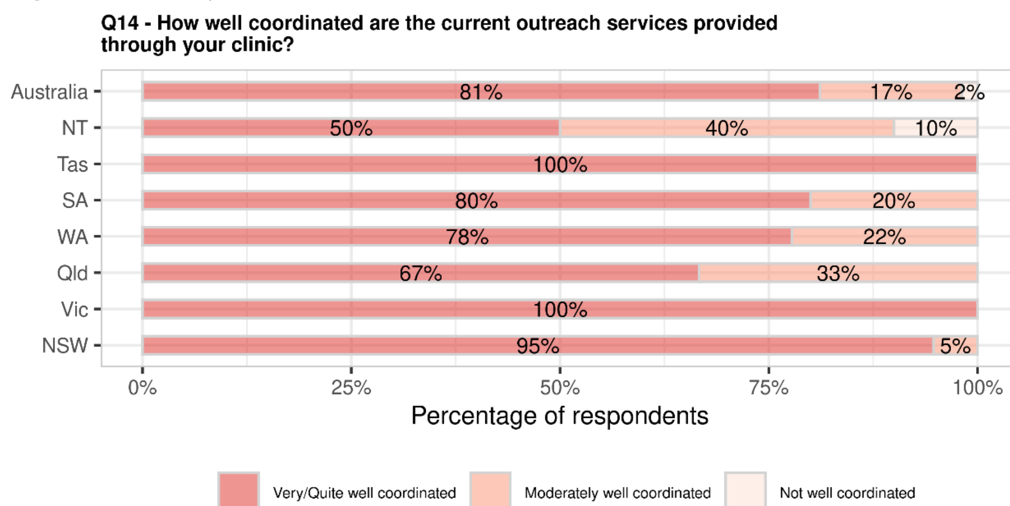
Figure 10: Outreach providers' views on the local coordination of outreach services



Source: Outreach provider survey, question 12.

Local host providers were also asked to assess how well they thought outreach services provided through their clinic were coordinated, with most providers confirming that they thought the services were well coordinated. Figure 11 shows that a greater proportion of host providers thought that the outreach services were well coordinated than outreach providers, with over 80% of the respondents to the host provider survey rating the support either quite well or very well coordinated. Again, there were indications of variation across jurisdictions. Although low response rates indicated caution in in interpretation of the data, the lower rating recorded in the Northern Territory (50%) is consistent with outreach provider views.

Figure 11: Host providers' views on the local coordination of outreach services



Source: Host provider survey, question 14.

Both outreach providers and host services emphasised that coordinating outreach visits across programs and service providers requires a great deal of time and effort. Key coordination activities cited by visiting and host providers included:

- Booking in, reminding and confirming appointments with patients.
- Organising accommodation for providers; transporting patients.
- Setting up telehealth consults and sitting with the patients during these consults.
- Ensuring clinical preparation is complete prior to outreach consults, including collation of test results, patient workup and calibration and set up of equipment.
- Undertaking health promotion activities and raising awareness of outreach services in the community.
- Engaging in ongoing communication with visiting providers.
- Updating patient administration systems and facilitating referral pathways.

Stakeholders reported that the role of host facilities in coordinating outreach clinics is carried out in addition to the day-to-day clinical care carried out through their services. They point out that in smaller and more remote communities the burden of responsibility for coordinating outreach services is amplified given they often have limited staff available and receive proportionally more services.

Stakeholders across jurisdictions stressed that funding support to all host providers needs to adequately reflect the staff and other resources required locally to support outreach providers, with many asserted that funding is currently insufficient. Stakeholders report that in many of these communities an ACCHO is responsible for coordinating outreach. While limited funding is available to support local staff through existing provisions under the RHOF and their organisations receive annual financial support as an ACCHO, resources are inadequate to support the level of coordination required to be effective and safe.

The Department currently allows for 15% of program funding to be allocated by the fundholder to administration of the programs. To better support the coordination of outreach services locally, one fundholder described allocating a portion of their administration funding to local services. This fundholder reported that it distributes 50% (7.5% of total program funding) of its administration allocation with their local host services. The fundholder indicated that the current provision for administration under the programs is inadequate and that it should possibly be increased from 15% to 20%. But stressed that the extra 5% should not compromise direct clinical services.

Regardless of sufficient financial resources to support local staff capacity, ongoing challenges with the recruitment and retention of local staff was also an issue that stakeholders consider has contributed to poorer coordination of outreach services. For example, in the Northern Territory stakeholders reported over 100% turnover in a year in local clinical staff across services in rural and remote communities. They indicated this erodes the ability to maintain continuity of care processes, provider relationships and coordination of services, including outreach services.

NACCHO has called for broader capacity building of host providers to build sustainability and ensure outreach services run efficiently, including requirements that would support outreach clinic coordination. For example, NACCHO advocates for the provision of:

- Support to NACCHO affiliates and host providers to enable them to train outreach providers to embed their care in local health systems, including training in the use of the patient administration systems
- Financial support of host providers to promote outreach services, enabling more meaningful engagement of local staff to promote the value of outreach services and attendance at clinics

Both visiting and host provider survey respondents also indicated that inadequate access to core public infrastructure has been a barrier to the effective coordination of outreach and was

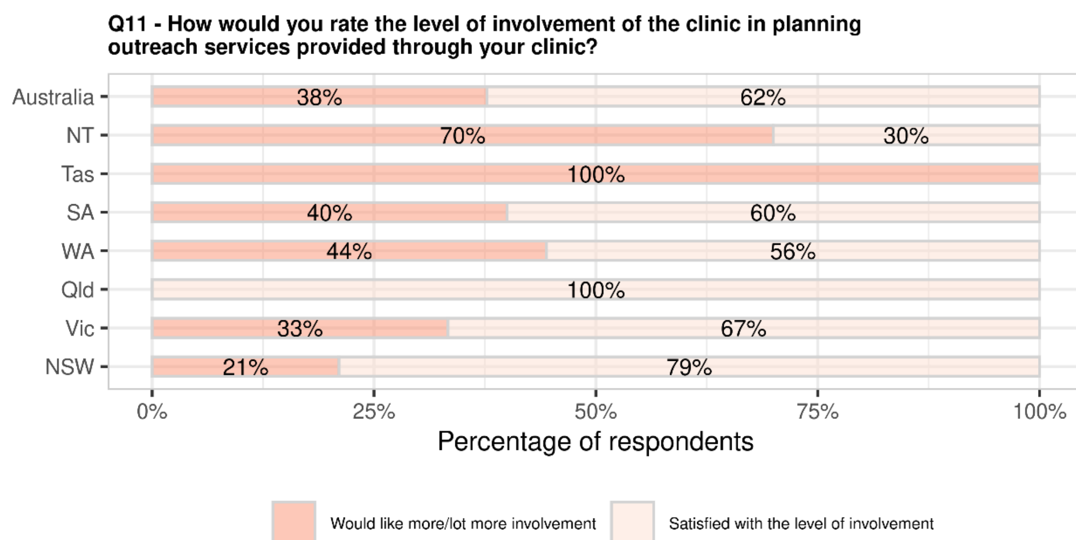
identified by host providers as a barrier to coordinating efficient and effective outreach services. For example:

- Some host providers emphasized the benefits of outreach providers spending time in the community as it helps to create relationships of trust and build a safe context for care. But many smaller communities indicated they simply don't have the infrastructure to accommodate clinicians overnight, requiring them to use expensive charter services to fly them in and out of their communities on the same day.
- Other stakeholders cited that lack of infrastructure has hindered the coordination of outreach services through poor local internet connections and WIFI reliability and limited access to transport and clinical equipment, including the expertise for calibration of the equipment.

Further discussion of upskilling and local capacity building will be taken up in following sections. However, some stakeholders pointed to opportunities for additional training and upskilling of local staff as a way to further strengthen the clinical and administrative coordination of outreach visits.

Stakeholders consistently called for a greater voice for local services and communities in the processes of the fundholders and their advisory forum to ensure effective input into needs assessment and service planning. Some host providers also expressed a desire to be more involved in the day to day planning of outreach services. While the majority of host providers that responded to the survey indicated they are satisfied with their level of involvement in planning the outreach services through their clinics, nearly 40% of respondents indicated they would like more involvement (see Figure 12). However, variation across jurisdictions may be evident, with lower levels satisfaction indicated in the Northern Territory and Tasmania and higher levels of satisfaction in New South Wales and Queensland.

Figure 12: Host provider rating of level of involvement in planning of outreach services



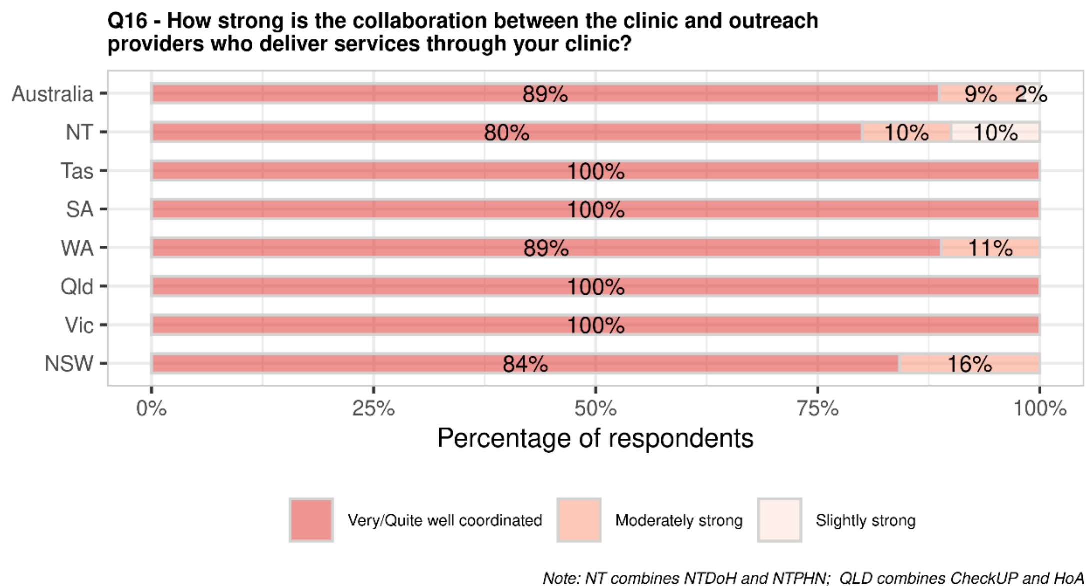
Source: Host provider survey, question 11.

Stakeholders confirmed that strong collaboration between host and outreach providers underpins effective coordination of outreach visits and the provision of care. Beyond assisting with clinical and administrative tasks, stakeholders highlighted that local staff enable more effective outreach visits as they can share their knowledge of local cultural priorities and events which may impact provider's visits. They can also liaise with patients, community leaders and elders, other host provider staff and local service providers to facilitate trust and raise

awareness of outreach services. Host providers suggested that staffing and administrative support enhances collaboration between their clinics and visiting providers.

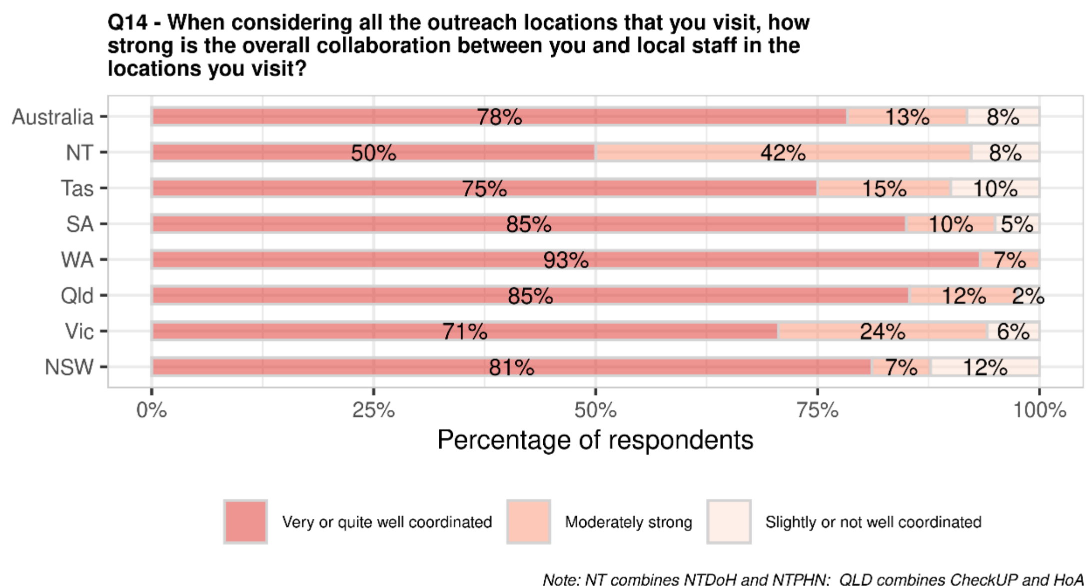
Most host and outreach providers who responded to the surveys rated the collaboration between both parties as strong, with approximately 89% of host providers and 78% of visiting providers rating collaboration as quite or very strong (see Figure 13 and Figure 14). However, in broader consultation with stakeholders during the evaluation, both parties identified opportunities for improvement in overall collaboration.

Figure 13: Host providers' assessment of collaboration with host providers



Source: Host provider survey, question 16.

Figure 14: Outreach providers' assessment of collaboration with host providers



Source: Outreach provider survey, question 14.

Some stakeholders expressed a desire for 'outreach to be provided with them, not to them.' In a few instances, when talking with host provider staff, there were indications that while they were aware that outreach providers came to their clinic, they were not sure when, why and how often they came. While host providers expressed a clear need and desire for outreach

services, there were instances where staff appeared disconnected from outreach providers currently working in their clinic.

NACCHO has called for orientation visits for new services and outreach service providers, with a commitment to work in such a way that their practice is embedded in the systems of the host provider and that visits are planned to avoid overloading the host service.

Some host provider survey respondents cited poor communication with visiting providers as a barrier to the effective planning and coordination of the outreach services at their clinics. When asked about what makes hosting outreach services more challenging, host providers most frequently identified the availability and reliability of visiting providers in their top 2 issues, including issues with visiting providers cancelling or changing outreach visits on short notice.

When asked about approaches to improve communication with outreach providers in planning and coordination services, host providers suggested a range of practical measures, including:

- Giving host providers clear and detailed information about visiting providers and consulting with them prior to establishing schedule of visits.
- Allowing host providers additional time to plan for visits by providing them with the anticipated visit dates further in advance.
- Promptly alerting host providers of any potential visit changes or shifts in mode of care delivery by outreach providers
- Conducting regular virtual and/or face to face meetings with visiting services.

In an effort to improve communications and better coordinate outreach services across the Northern Territory, NT Health established a systemwide online portal that is supported by a database that presents all funded outreach services, including information on the communities, dates and nature of outreach clinics planned. Both host and outreach providers can access this information and through contact with the outreach providers can facilitate better coordinated visits. This is particularly important in the Northern Territory, given each of the programs is coordinated by a different clinical directorate in NT Health and the MOICDP is separately administered by the NT PHN. A broad range of stakeholders referred to the usefulness of this portal during our conversations.

Host providers indicated they would also value additional engagement of outreach providers with communities and local clinical staff through joint planning sessions with the community board and attendance at annual clinic meetings.

Similar to host providers, many of the outreach providers responding to the survey identified a need to increase the overall level of communication between local staff and visiting providers through regular face to face meetings, contact by phone or email. Further understanding as to what prevents this from being realised could be explored further in the future.

Outreach providers also expressed the importance of engaging and collaborating with members of the local community, suggesting improved awareness of outreach services may help address some of the challenges associated with their coordination. They suggested increasing engagement of community leaders and elders, creating promotional campaigns, and fostering a better understanding of local community needs and goals to ensure outreach service delivery aligns with local priorities. These suggestions align with the views of other stakeholders, including representatives of the Australian Medical Association who indicated support for additional opportunities for clinicians to engage with local communities in the co-design of services.

Evaluation findings

Local service coordination

The importance of local coordination to facilitate the effective delivery of outreach services was consistently noted in the surveys, stakeholder interviews, narrative reviews and program reports. This appeared particularly important in small communities where the staffing base is

thin and the role of outreach is amplified. There will always be a need for staff on the ground to manage outreach services, particularly if telehealth and face-to-face visits are carried out.

As described above, the Department currently allocates 15% of program funding to the fundholders for administration of the programs. While some fundholders reported allocating a portion of this funding to local services to assist in the coordination of outreach services, these approaches did not appear to be consistent across jurisdictions. To support the coordination of outreach services, the Department should consider extending the provision of funding for administration of the programs from 15% to 20%, with the requirement that 10% of the funding to be provided to extend financial support to host providers. In addition to coordinating and participating in face-to-face outreach visits, host providers could use this funding to support telehealth shared care arrangements, upskill and educate their staff and enable community-led orientation and cultural awareness training.

While this increases the proportion of funding allocated to program administration and reduces the funding available for service delivery, it aims to reduce service efficiencies in the long run through better coordination at the local level and further support local health services. A review of this level of administration could be undertaken in the future in light of any efficiencies achieve (refer to recommendation 35**Error! Reference source not found.**).

Collaboration between visiting providers, host providers and communities

In an effort to strengthen collaboration and communication between visiting and host services, service frameworks for each host site should be developed to help guide host and visiting service arrangements. These service frameworks could be tailored to each host site but address issues including information on the number and nature of local staff involved in outreach, preferred methods of communication and clinical governance arrangements (see Table 17).

Table 17: Key issues to be included in service framework

Domain	Description
Health service	• Specify outreach providers involved in delivering and host providers involved in receiving the outreach services
Staff and workforce planning	• Number and nature of staff involved in delivering and receiving the outreach services • Supervision/oversight of roles • Workforce planning for ensuring a sufficient staff base for sustainable rosters
Skills and scope of practice	• Qualifications and experience of all staff involved in delivering and receiving the outreach service • Plan for ongoing professional development for all staff involved in delivering and receiving the outreach service
Clinical infrastructure	• Required clinical equipment and facilities for outreach services
Outreach clinic	• Number, nature and frequency of outreach visits, transport system, and clinic location • Roles and responsibilities of staff delivering and receiving the outreach clinic • Any variation to the outreach visits on the basis of changing conditions (for example, telehealth)
Referral protocol	• Referral protocols for ongoing treatment at rural sites, with support by outreach services
Communication between providers	• When, how, and to whom initial and subsequent referrals are sent and documented between providers • Process for documenting treatment changes and emergency or adverse events • Process for availability of pharmacy drug chart, treatment and discharge summary, pathology and radiology tests • Process for accessing and documenting outcomes of multidisciplinary meetings
Real-time professional support	• Systems for real-time professional support for rural sites managing complex cases • Protocol for contacting outreach provider during business hours and after hours for this purpose
Emergency care arrangements	• Documented risk management protocols and emergency care practices, including ongoing medical oversight for outreach clinics and rural sites
Clinical governance and quality	• A clinical governance committee overseeing the outreach clinic, with a role in the management of adverse events and quality improvement activities based on benchmarking indicators decided in advance.

To enhance the visibility of outreach services across programs and jurisdictions, the fundholders should also work to develop an online database that allows public access to information on the outreach services planned across jurisdictions. These online databases could include information on visit dates, clinic type and location. These databases would help to facilitate the coordination of outreach services and serve as a promotion tool.

Box 15: Recommendations to support coordination and collaboration

All programs

25. Extend the provision of funding for administration of the programs from 15% to 20%, with the requirement that 10% of the funding to be provided to extend financial support to host providers to coordinate and participate in face-to-face outreach visits, telehealth shared care arrangements, upskilling and education of their staff and enable community-led orientation and cultural awareness training.
26. Specify the requirement in the service delivery standards that a framework be applied to help guide the development of agreed local host and outreach provider arrangements in each community, including the number and nature of local staff involved, clinical equipment and facilities required, clinical referral protocols for ongoing treatment, risk management protocols and clinical governance arrangements.
27. Fundholders to establish online portals with information about all outreach services planned across jurisdictions, including interactive maps that highlight service location, clinic type, visit dates and contact details of host and outreach providers. There may be opportunities for these portals to evolve and enable consumers and referring health professionals to book appointments at the clinics and receive reminders in the future.

Cultural competency of outreach providers

Cultural competency is a key strategy for reducing inequalities in healthcare access and improving the quality and effectiveness of care for Indigenous people. It is more than cultural awareness, it is a set of behaviours, attitudes, and policies that come together to enable a system, agency, or professionals to work effectively in cross-cultural situations.[39]

The service delivery standards for the outreach programs require all providers who deliver outreach services to Aboriginal and Torres Strait Islander patients to confirm they have completed the appropriate cultural competency training. It is the responsibility of the fundholder to arrange this training and ensure outreach providers have completed it before taking up service.

The fundholders must also work with the NACCHO affiliate in their jurisdiction to determine the appropriate cultural training and, if deemed necessary, establish partnerships, training plans and/or agreements with Aboriginal and Torres Strait Islander organisations to facilitate the delivery of this training.[10]

The RHOF service delivery standards specify the importance of cultural training and indicated that program funding may be used to support activities associated with the cultural training.[13]

[39] Bainbridge, R. M., A. C. Tsey, K (2015). *Closing the Gap Clearinghouse Issues Paper 13: Cultural cometency in the delivery of health services for Indigenous people*. https://nacchocommunique.com/2015/07/31/naccho-cultural-competency-download-report-delivery-of-health-services-for-indigenous-people/

Stakeholder views

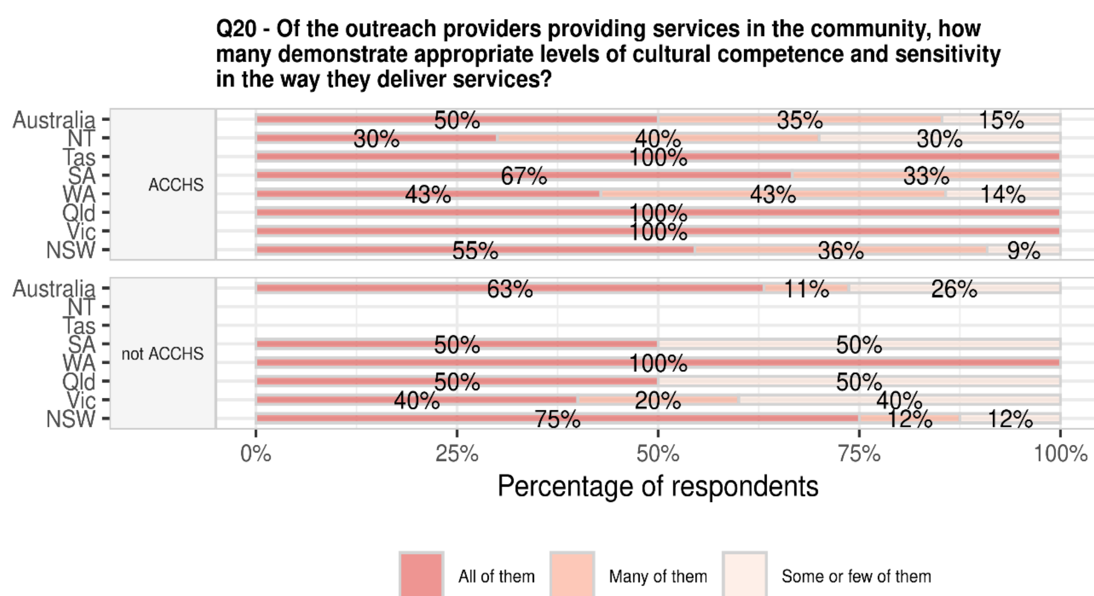
Existing cultural competency training

Fundholders described working with various Aboriginal and Torres Strait islander organisations to develop their cultural competency training. Respondents from the outreach provider surveys described receiving cultural competency training from a range of sources, including online training from fundholders, employers, universities and national workforce agencies and face-to-face training with community leaders and involving workshops. For example, stakeholders reported that the NACCHO affiliate in Tasmania provides cultural competency training for all organisations and individual health professionals providing outreach care in the state, with 2 staff working from the Hobart office providing a face-to-face training program.

While most respondents referred to 'one-off' training associated with orientation, a few respondents reported they received regular cultural supervision, participated in regular workshops or completed annual cultural competency courses. Some respondents reported that they have never received any cultural competency training.

We asked host providers if they could tell how many of the outreach providers visiting their clinics demonstrate appropriate levels of cultural competence. Figure 15 presents the survey responses by ACCHOs and non-ACCHOs and indicates that 85% of ACCHO host providers and 74% of non-ACCHO host providers feel most if not all outreach providers display appropriate cultural competence. There are indications of variation across jurisdictions which implies there may be opportunities to improve the cultural competency of visiting providers.

Figure 15: Host providers thoughts on the level of cultural competency of outreach providers



footnote: NT combines NTDoH and NTPHN; QLD combines CheckUP and HoA

Source: Host provider survey, question 20. Note: There were no non-ACCHO survey responses in the Northern Territory and Tasmania.

We also asked host providers to describe how cultural safety was displayed by outreach providers. Responses included:

- Engaging in active listening with clients.
- Respecting patients, culture and community elders.
- Working with local staff and including them in clinical decision-making.
- Understanding how to interact with patients in a culturally appropriate way, given English is likely a second language for many Indigenous patients.

Local services and Aboriginal and Torres Strait Islander organisations consulted advocated for strengthening the requirements around cultural competency training. They feel many outreach providers only perform what is required, which can be a single general online course prior to commencing outreach visits. They see this as inadequate in preparing them for the specific nature of the communities in which they work. NACCHO and other stakeholders call for orientation visits to communities before new outreach providers start providing care. Some stakeholders suggested that cultural competency training should be site-specific with induction given by local elders, with tours of local sites that are of cultural and historical significance. Others called for outreach providers to spend more time in community, engaging with community members and developing relations.

Stakeholders from Aboriginal and Torres Strait Islander groups indicated that they value service providers spending time with them and engaging with them outside of the clinical context. During the case study in the Northern Territory, we spoke with representatives from the small remote community of Kintore. As discussed in the Governance and funding arrangements, they reflected on the experience in their community of the dental outreach services provided by the RFDS. They reported it is the 'most valued and eagerly awaited outreach service' in the community. Not just because dental care is a priority, but because of the way they engage. They talked about the RFDS clinicians coming into the community and asking if their services are culturally safe, does the community want them to keep coming out and are the services meeting their needs?

They indicated the clinicians meet with community elders, took lunch break outside in the community and spent time at the local store. They joined the board of the health service during their annual meeting and enjoyed a barbeque with community elders. A health service representative told us the community remembers people, and these little things make a difference. It builds respect and trust. In a separate consultation with a podiatrist providing outreach services in central Australia we heard how he had learnt to step out of his clinic, walk the local streets, meet people and sit down with community members to understand their needs. He indicated that this helps source referral of patients from neighbours and build awareness of his clinic services.

The representatives of Kintore also talked about how the RFDS listens to the community. For example, they indicated the RFDS comes and stays in the community for 2 weeks at a time to provide clinics. They told us that the RFDS does not use the small container provided for them. They said clients didn't like it as they could not bring family members. RFDS now bring all their equipment on the plane and use a consulting room so that patients are in safe space with their family. The stakeholders indicated this sort of responsive model is what feeds into the support for the RFDS.

In talking with representatives from the RFDS, they impressed upon us their intent to work in partnership with communities and improve the way in which they deliver services and respond in culturally sensitive and safe ways. They reported they are exploring the measurement of cultural competency of providers by monitoring the 'did not attend' rates for its services. Not only to underpin the financial viability of its services but to more importantly enable clinicians to improve the relevance and cultural safety of their care. A staff member from RFDS indicated they use the data actively, following up on why community members do not attend clinics and look to adjust their service offering to better meet community needs and preferences.

NACCHO calls for greater fundholder accountability for cultural competence of its outreach providers, including regular reporting to the department on the cultural safety of the outreach providers working in local communities. Some jurisdictions regularly survey host providers, and this provides an opportunity for local staff to reflect on the cultural safety of outreach providers visiting their clinics. A few fundholders are now exploring ways of more systematically capturing patient experiences through surveys and other activities, such as yarning circles.

These initiatives may also provide opportunities for insights into provider cultural competency and safe practices. However, some stakeholders were somewhat sceptical about fundholders administering the surveys, suggested that consumers are reticent to provide negative feedback in case they lose the service altogether, while others indicated that surveys are not well accepted and adopted in some patient populations.

According to Aboriginal and Torres Strait Islander stakeholders, cultural safety training and ongoing education should be developed by, or in collaboration with, local and jurisdictional organisations and communities, such as the jurisdictional ACCHO peak bodies, to effectively capture the diverse cultures of individual communities and regions, and many stakeholders suggested that cultural competency training should be site-specific with inductions given by local elders, and tours of local sites that are of cultural and historical significance.

Evaluation findings

When discussing cultural competency, it is important to make the distinction between broad cultural awareness and competency training versus specific community engagement and understanding. The former does not substitute for the latter. Universally, Aboriginal and Torres Strait Islander representatives asserted that online cultural safety courses are not enough to bring clinicians up to speed on the nuances of the culture of the specific community they are working in, and that single-day in-person sessions in town are often not practical and community-centred. These reflections highlight the need for outreach providers and local communities to establish and foster stronger relationships.

As per recommendation 22, establishing greater focus on planning, monitoring and funding time spent by outreach providers in undertaking community engagement and relationship building aims to support outreach providers and local communities in building more trusted relationships and facilitating collaboration in the provision of culturally safe. These activities could be supported by incorporating specific plans guided by consultation with communities and budget allocations under the overall service plans.

At present, there is great pressure on MBS and seeing the maximum number of patients within an outreach visit, particularly given outreach services fly-in and fly-out on the same day in many instances. This leaves little room for providers to spend time within communities, establish and develop relationships and orient themselves to the community culture. When asked how cultural awareness and safety training could be enhanced, outreach provider survey respondents most frequently expressed a desire for more regular education opportunities and additional support for local staff and community members to provide community-specific provide cultural safety and awareness training. The significance Aboriginal and Torres Strait Islander communities place on relationships and cultural knowledge, underlines the importance of allowing providers to spend time within community and supporting locals to provide guidance and information to outreach clinicians that will help them be most effective in their communities.

To enhance systems of accountability and ensure outreach providers are delivering culturally safe care, systems should be put in place to ensure patients and individuals involved in patient care can speak freely and provide feedback on the cultural competency of visiting providers. This type of feedback is sometimes provided informally in conversations with the fundholder, where a host provider reports that a certain provider is not being accepted by the community. In instances where this was reported during the evaluation, it was apparent the fundholder would simply look to replace the clinician. Without systematic reflections of the experiences of host providers and patients, it will be hard to assess and improve care. One option is to fund NACCHO to oversee the administration of national host provider and patient experiences surveys to assess care as they are more independent to the fundholders who currently administer the surveys. The collection of patient experiences may also be facilitated through other appropriate activities, such as focus groups, yarning circles. The key findings of the host provider could be provided to the fundholders and the Department after each planning cycle to promote sharing and learning and facilitate continuous improvement.

Box 16: Recommendations to support cultural competency

All programs

28. The Department to commission the development of, and the National Aboriginal Community Controlled Health Organisation to oversee the administration of, national host provider and patient experiences surveys (and/or other culturally appropriate activities) after each planning cycle. The National Aboriginal Community Controlled Health Organisation to report back on the key findings to the fundholders and the Department before the next planning cycle.

Local capacity building

Most stakeholders acknowledged that a principal objective of government interventions aimed at improving access to healthcare in rural and remote communities focuses on building the capacity of the local and regional health workforce. The clinical care standards for the outreach programs acknowledge there is a role for outreach providers in providing educational and upskilling activities to local health professionals, but they fall short of making it a requirement.

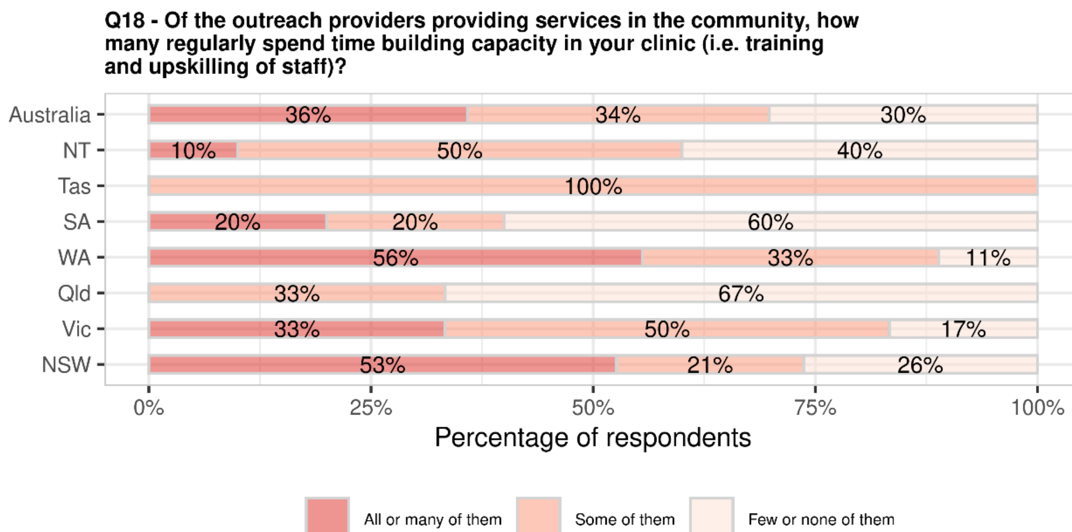
Stakeholder views

NACCHO expressed the central importance of building local workforce capacity in ACCHOs, calling for greater capacity building of host providers to strengthen sustainability and ensure outreach services run efficiently. Representatives of NACCHO think that making upskilling mandatory for every outreach provider visit is required and that this activity should be better recorded and reported by the fundholder to the Department.

Capacity building by outreach providers

Figure 16 presents the responses to our survey of host providers when asked how many outreach providers regularly spend time building capacity in their clinics. Just over a third of the host providers indicated that most outreach providers regularly spend time training and upskilling their staff. With another third of the respondents indicating some of the providers participate in local capacity building. There are also indications of variations across jurisdictions.

Figure 16: Host provider responses on number of visiting providers who participate in capacity building



Source: Host provider survey, question 18.

Table 18 highlights the categories of local staff that outreach providers reported they regularly upskill during their visits to local clinics, noting that upskilling aligns to the staff categories generally available in rural clinics including Aboriginal health workers, nurses and general practitioners. Just over 20% of outreach providers indicated that they do not regularly contribute to the upskilling of local staff on their outreach visits. Despite this, almost all providers (95.1% of survey respondents) report that they consider upskilling to be important

Table 18: Outreach providers upskilling local staff

Q16: Which of these categories of local staff do you regularly contribute to upskilling at the service locations you visit?	
Aboriginal Health Worker	107 (36.3%)
GPs	105 (35.6%)
Nursing staff	96 (32.5%)
Allied health staff	73 (24.7%)
Other medical officers	49 (16.6%)
Other health service staff	44 (14.9)

Source: Outreach provider survey, question 16.

Host providers identified establishing additional opportunities for local training and capacity building as one of the top things that would enhance the delivery of outreach services provided through their clinics. When asked to provide specific examples of capacity building at their clinic, host providers reported:

1. Regular education sessions and events conducted at clinic sites relating to a particular visit or specialty.
2. Mentoring, placement and supervision opportunities for a range of staff, including junior doctors and registrars.
3. Visiting professionals providing advice to staff on equipment.
4. Visiting services upskilling Aboriginal health workers to perform hearing assessments.
5. Visiting services establishing shared care arrangements with local staff.
6. Case conferencing arrangements between visiting and host providers.

Stakeholders confirmed that many of the health conditions prevalent in rural and remote communities are chronic in nature and require ongoing care and support to help them manage their conditions and maintain the patient in the community. Stakeholders indicated that outreach providers tend to focus on providing specialised screening, assessment, diagnosis and care planning for patients, rather than administer treatments. They considered that implementation of the care plan and ongoing care is often left to the host providers to manage. Stakeholders indicated this situation highlights the need for local capacity building and establishing effective shared care arrangements with outreach providers.

Stakeholders indicated that by building local capacity and providing more regular advice and support, outreach providers can play a role in building local access to care and improving quality. However, they considered this all too often an after-thought when providers are visiting communities, with priority given to treating patients and little time devoted to planning and delivering on identified local staff needs for development.

Of the outreach providers that responded to our survey, close to 90% of them indicated that given adequate resources and support they would like to devote more time to building local capacity in the locations they visit. These responses indicate outreach providers may face time constraints when visiting communities and there maybe scope to expand the provision of education and training of local staff in the future.

Other opportunities for capacity building

NACCHO wants outreach providers to transfer skills to local providers and host services, indicating that outreach providers need to be able to do more than provide direct care - they need to build capacity of local workforce. They think this could complement ACCHO efforts to

encourage health practitioners to obtain certification IV qualifications where they can acquire additional skills and pick up some aspects of what allied health professionals do.

Stakeholders provided examples of initiatives that explore or have established new training pathways to upskill the local workforce in rural and remote areas, including:

- Providing opportunities for staff in rural and remote areas to obtain their health practitioner certification IV.
- Establishing opportunities to better utilise and train local staff to become allied health assistants through the certification III and IV coordinated by the National Aboriginal and Torres Strait Islander Health Academy.
- Creating placements for students and trainees to participate in outreach programs and gain exposure rural and remote health care. For example, HoA reported that they have set up a specific program to develop the next generation of rural health professionals through their NextGen Medics program.

In consulting with stakeholders during the case studies, it was clear that a variety of opportunities exist for local staff to be involved in education and training, whether to establish new qualifications or enhance their skills and knowledge within their existing qualifications. For example, the fundholder in South Australia reported that it, like other rural health workforce agencies, administers a Health Workforce Scholarship Program.[40] Grants up to $10,000 per year for up to 2 years are available to increase clinical skills and scope of practice through training or study for primary health care professionals working in rural or remote South Australia. Activities supported by the Health Workforce Scholarship Program include post-graduate studies such as a postgraduate certificate, postgraduate diploma, Masters or PhD, conferences, seminars, workshops, webinars, and short courses.

However, stakeholders pointed to issues that can limit the ability to take up these offers or do not ultimately build local workforce capacity, given many of the training opportunities required staff to leave the community to participate. This can be difficult for staff working in small remote communities who have family and cultural commitments. Staff working in these communities indicated to us that it is also difficult to attend training and further education due the lack of staff to backfill them while they are away. One nurse in a remote community in the Northern Territory told us that she would welcome an opportunity to upskill and become a Nurse Practitioner but simply couldn't see where she would find the time given the needs of patients and the community. In another instance, a CEO of a local health service told us that these training opportunities can present as a 'double edged sword', giving staff experiences out of their community and enabling them acquisition of additional skills can result in some staff not coming back to the service. Stakeholders emphasised the need for training to be provided within their communities, given these constraints.

Some stakeholders cautioned about the potential reliance on outreach, and its possible flow on effects for local capacity building. For example, one outreach provider stated that outreach professionals are often paid far more than local clinicians to deliver the same services and can be overlooked when stakeholders are looking to fill a service gap. As cited in the Responsiveness to regional and local needs section, host providers reflected on a physiotherapist from a neighbouring community that could have been employed to provide care locally. Instead, they were relying on a periodic visiting service which they considered was 'less cost effective' to provide but was more readily able to be funded.

Evaluation findings

Outreach is implemented to fix market failure and all other avenues, including potential local solutions should be investigated first. Outreach services should be implemented with a plan to

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[40] See: https://www.hwsp.com.au/.

make themselves redundant over a predetermined timeframe though lifting local skills. This is not something achieved in recycling service plans year on year, funding cycle on funding cycle. Recycling plans and not adapting to changing local needs at best creates duplication, at worst creates reliance and widens the gap.

To support local capacity building, recommendation 25 above suggests extending a portion of financial support from the provision of funding allocated for administration of the programs directly to host providers to support various activities, including the upskilling and education of their staff.

Recommendation 22 suggests providing greater emphasis on host provider teaching and training under the outreach programs. This may include incorporating specific service plans guided by consultation with communities and budget allocations under the overall service plans. The aim is to better plan, monitor and fund time for outreach providers to teach and train local host provider staff.

It is recognised that it is not appropriate or feasible for outreach providers to cater to all the training and upskilling needs of local staff especially given the primary objective of the outreach programs which is to address gaps in health services. In light of this, the outreach programs could better align with existing local training pathways and initiatives that seek to bolster and develop the rural and remote health workforce instead of being '*disconnected*' as one stakeholder described them. For example, the Department could encourage host services to further explore new workforce models and existing training pathways offered by local organisations and workforce bodies, such as the Certificate III in Allied Health Assistance. These staff members could then act as a 'local anchor' and aid in the facilitation and coordination of outreach services.

In the long term, greater emphasis and support for local capacity building will allow health services in underserved communities to become more self-sufficient and require less support from outreach services; therefore, fundholders should work collaboratively with rural health workforce agencies, local host providers and other relevant agencies to plan and support local workforce capacity and actively plan for the withdrawal of outreach services.

Box 17: Recommendations for local capacity building

All programs

29. Require fundholders to work collaboratively with rural health workforce agencies, local host providers and other relevant agencies to actively plan for the withdrawal of outreach services in response to opportunities to build local workforce capacity, thereby actively working to reduce the risk of unnecessary ongoing reliance on the provision of services by outreach providers.

Box 18: Broader system observations about local capacity building

5. The Department could encourage host services to further explore new workforce models and training pathways, such as the Certificate III in Allied Health Assistance, which seek to bolster and develop local capacity to better support the outreach programs.

2. How effective are each of the outreach programs in achieving their intended outcomes?

The primary purpose of the outreach programs is to provide increased access to specialist and other health services in areas of market failure. As such, the programs focus on the provision of services in regional, rural and remote areas in Australia where it is difficult to attract and retain clinicians to work. The programs also aim to increase health service access to the Aboriginal and Torres Strat Islander population. This section will discuss the role of the outreach programs in increasing access to health services, contributing to improved health outcomes, and the impact of telehealth in these areas.

Access

Service provision and utilisation

Based on sample of data provided by the fundholders, HPA estimated the total activity provided under the outreach programs. Table 19 demonstrates the magnitude and distribution of outreach visits across the different areas of rurality and remoteness, as represented by MM categories.

Table 19: Total visits by program and MM category of the location visited, 2017-18 to 2020-21

Program	MMM	2017-18	2018-19	2019-20	2020-21	Percent across all years
HEBHBL	MMM 1 & 2	1,013	1,015	753	759	19.3%
	MMM 3 & 4	639	622	505	526	12.5%
	MMM 5	1,080	968	813	888	20.5%
	MMM 6	402	358	426	588	9.7%
	MMM 7	1,874	1,840	1,500	1,735	38.0%
MOICDP	MMM 1 & 2	4,164	4,295	4,111	4,638	17.2%
	MMM 3 & 4	3,499	3,712	3,748	3,655	14.6%
	MMM 5	6,162	6,337	6,953	7,436	26.9%
	MMM 6	1,607	1,637	1,563	1,740	6.6%
	MMM 7	8,364	8,051	8,561	9,682	34.7%
RHOF	MMM 1 & 2	929	863	851	1,367	4.6%
	MMM 3 & 4	4,461	4,593	4,124	4,321	20.0%
	MMM 5	6,086	5,711	5,623	6,437	27.3%
	MMM 6	2,827	2,601	2,644	3,200	12.9%
	MMM 7	8,090	6,817	6,751	9,130	35.2%
VOS	MMM 1 & 2	416	385	396	478	8.5%
	MMM 3 & 4	265	309	299	262	5.8%
	MMM 5	1,333	1,347	1,110	1,315	25.9%
	MMM 6	691	642	571	690	13.2%
	MMM 7	2,398	2,426	1,908	2,447	46.6%

Source: Unpublished outreach program data provided by fund holders. Note: Adjusted for missing data and excludes Tasmania and EESS

Table 20 demonstrates the magnitude and distribution of patient activity (expressed as occasions of service or OOS) across the different areas of rurality and remoteness, as represented by MM categories.

Table 20: Total patients (OOS) by program and MM category of the location visited

Program	MMM	2017-18	2018-19	2019-20	2020-21	Percentage (Across all years)
HEBHBL	MMM 1 & 2	12,805	12,269	8,878	8,877	24.6%
	MMM 3 & 4	6,894	6,499	3,858	4,079	12.2%
	MMM 5	10,488	10,063	7,093	7,946	20.4%
	MMM 6	4,099	3,845	4,883	6,499	11.1%
	MMM 7	16,066	14,328	12,487	12,345	31.7%
MOICDP	MMM 1 & 2	52,491	53,134	48,136	52,794	21.4%
	MMM 3 & 4	38,991	40,384	41,565	39,659	16.6%
	MMM 5	79,828	78,049	80,881	86,887	33.7%
	MMM 6	13,188	13,792	11,563	11,437	5.2%
	MMM 7	51,073	52,054	58,079	62,881	23.2%
RHOF	MMM 1 & 2	6,542	6,087	6,438	7,679	3.3%
	MMM 3 & 4	56,726	56,686	56,682	59,629	28.0%
	MMM 5	66,510	63,192	66,466	70,263	32.5%
	MMM 6	24,938	23,263	23,857	27,605	12.1%
	MMM 7	56,967	47,851	41,858	51,579	24.2%
VOS	MMM 1 & 2	7,215	6,810	5,616	7,069	14.6%
	MMM 3 & 4	2,125	2,440	1,819	1,902	4.5%
	MMM 5	14,752	14,048	10,462	12,195	28.1%
	MMM 6	7,735	7,088	6,972	8,448	16.5%
	MMM 7	18,244	17,960	13,366	16,542	36.2%

Source: Unpublished outreach program data provided by fund holders. Note: Adjusted for missing data and excludes Tasmania and EESS.

The RHOF service standards require that outreach providers target service provision in MM 3 – 7, which explains the low proportion of services provided in MM 1 – 2 relative to other programs.

The spread of total annual visits across the MM categories programs varies but is generally higher in very remote communities located in the MM 7 category. The instances where a lower proportion of patient activity (OOS) is provider in the MM 7 than other categories is likely to be reflective of the relatively smaller population sizes in these locations and the consequently the smaller scale of services provided in these locations.

Table 21 presents the estimated average total number of patients (OOS) receiving outreach services over the 4-year period from 2017-18 to 2020-21 and the rate per 1,000 population. This data confirms that across the jurisdictions and programs, the population rate of outreach services is higher in MM 7 than other MM categories – except in Victoria where MM 7 communities do not exist and in the Northern Territory where the population is concentrated in regional centres and very small remote communities.

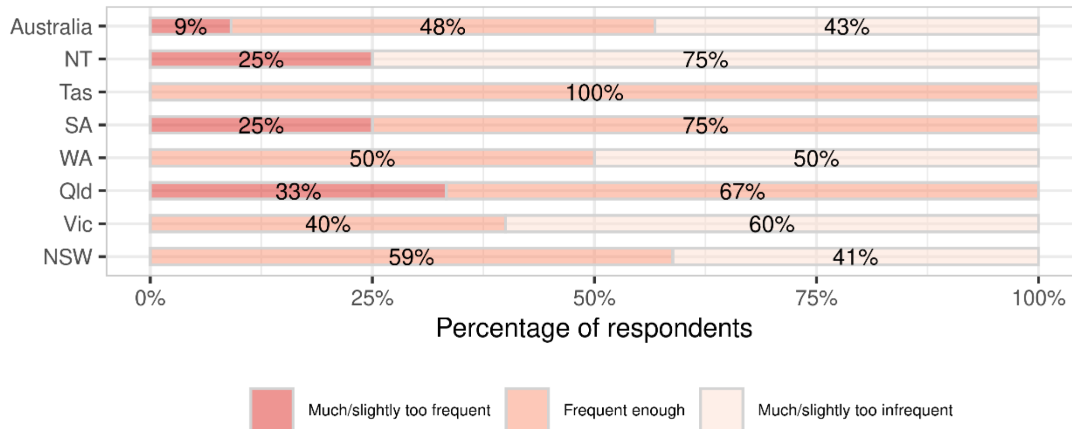
Table 21: Patients (OOS) per 1,000 population by program, state and MM category of the location visited, mean for 2017-18 to 2020-21.

Program	State	Patients/OOS per 1,000 (Mean of 4 years)					Patients/OOS total (Mean of 4 years)				
		MMM 1 & 2	MMM 3 & 4	MMM 5	MMM 6	MMM 7	MMM 1 & 2	MMM 3 & 4	MMM 5	MMM 6	MMM 7
HEBHBL	NSW	0	2	9	24	40	785	2,195	5,524	804	261
	Vic	0	2	1			256	1,109	361		
	Qld	2	4	6	26	37	9,031	1,484	2,021	1,930	2,604
	WA	0	1	3	21	136	438	250	336	1,940	9,332
	SA		2	1	3	51		313	242	121	1,175
	NT	1		118	1	8	198		428	39	441
	Total	1	2	5	16	58	10,707	5,350	8,913	4,833	13,812
MOICDP	NSW	3	29	116	61	872	15,947	33,984	68,189	2,089	5,636
	Vic	0	4	4			990	2,472	1,508		
	Qld	8	8	15	77	450	30,808	2,646	5,297	5,671	31,918
	WA	1	2	3	30	141	1,943	316	428	2,741	9,624
	SA		4	11	17	175		830	1,766	710	3,996
	NT	14		1,178	26	85	1,970		4,272	1,284	4,918
	Total	3	16	46	41	238	51,658	40,248	81,459	12,495	56,092
RHOF	NSW	0	21	42	72	84	935	24,715	24,672	2,450	543
	Vic	0	31	39	15		26	18,087	16,013	65	
	Qld	1	21	34	158	351	3,711	7,098	12,438	11,563	24,898
	WA	0	41	13	66	160	10	7,000	1,692	5,973	10,965
	SA		3	45	53	197		634	7,327	2,200	4,509
	NT	13		1,240	52	146	1,793		4,498	2,568	8,482
	Total	0	23	38	81	209	6,475	57,534	66,640	24,819	49,396
RHOF-PM	NSW		0	0				10	13		
	Qld	0	0	0	0		237	104	18	35	
	WA		0		1	2		28		62	168
	SA			1		0			204		6
	Total	0	0	0	0	1	237	142	235	97	174
VOS	NSW	0	1	7	42	186	1,748	1,154	4,408	1,431	1,200
	Vic	0	1	3	40		285	570	1,108	176	
	Qld	1	1	8	52	63	3,181	184	2,744	3,840	4,504
	WA	0		6	14	74	28		840	1,292	5,066
	SA		1	10	7	97		175	1,569	284	2,216
	NT	10		614	11	61	1,455		2,226	537	3,550
	Total	0	1	7	25	70	6,697	2,083	12,896	7,561	16,538

Source: Unpublished outreach program data provided by fund holders. Note: Adjusted for missing data and excludes Tasmania and EESS

Host provider survey respondents reported chronic disease, eye health, mental health and ear health as the predominant services delivered through outreach. They also commented on the frequency, regularity and reliability of the outreach services provided to their clinics. As indicated in Figure 17, most clinics feel outreach services were delivered frequently enough or much/slightly too infrequently.

Figure 17: Host provider views on the frequency, reliability and regularity of outreach services



Source: Host provider survey, question 24.

When asked for further comment on the frequency, regularity and reliability of outreach services, host provider survey respondents mentioned how staffing issues and the pandemic have had a negative impact. In some instances, respondents stated the pandemic has resulted in outreach service delivery transitioning to telehealth to appropriately service patients in rural and remote areas.

Multidisciplinary care

Multidisciplinary care is seen as an important way to support the individual changing needs of each consumer. Multidisciplinary teams can provide more comprehensive care and ensure patients' needs are treated holistically. Due to these advantages, the service delivery standards for the outreach programs state that, where possible, a multidisciplinary team care approach is recommended to facilitate efficiencies.[10]

Table 15 and Table 16 demonstrate that both the MOICDP and RHOF enable the provision of care from a broad range of health professionals, including:

- medical specialists and registrars
- general practitioners and registrars
- nurses and midwives
- allied health professions and assistants
- Aboriginal health workers and practitioners
- mental health professionals
- health education and health promotion officers
- care and service coordinators
- technical and scientific officers
- administration staff.

Understandably, the VOS is largely provided by allied health professionals, given the program is essentially delivering optometry services. Although there is also limited nursing and allied health assistant involvement in the VOS, the program rules require coordination and integration with other programs to enable broader consideration of eye health and promote multidisciplinary care, including ophthalmologists and other eye health professionals.

From consultation and review of the fundholder narrative reports, stakeholders reported they worked on integrating multidisciplinary care to improve care. For example, NSW RDN highlighted how it addresses parental childcare commitments, that prevent clients from seeking treatment, by using a social worker to connect with multiple agencies such as

Centrelink, Medicare and the National Settlement Service (if the client is originally not from Australia).

Program impact on access

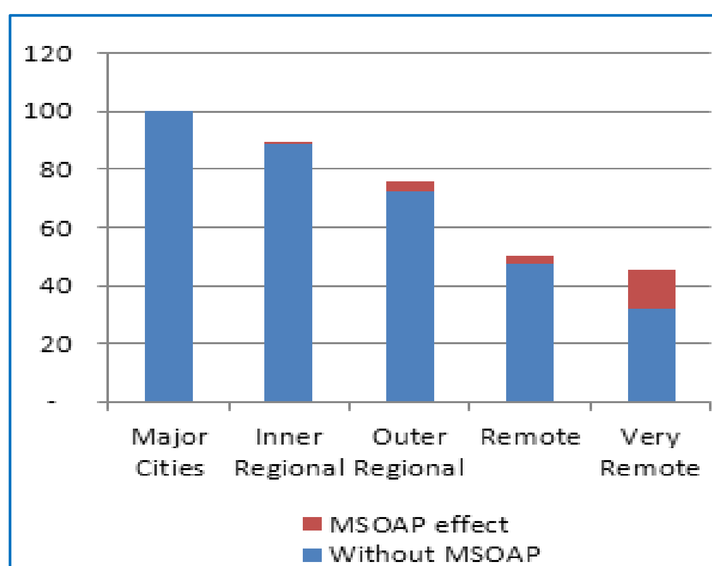
Table 22 provides an overview of the total number of occasions of services provided under the HEBHBL, MPOICDP, RHOF and VOS for each year between 2017-18 and 2020-21, including the number of services provided to Indigenous Australians. The HEBHBL and MOICDP are Indigenous specific programs and over 85% of services are reported as being provided to Aboriginal and Torres Strait Islanders. The RHOF and VOS apply to both Aboriginal and Torres Strait Islander and Non Aboriginal and Torres Strait Islanders with nearly 60% of the VOS services and just over 25% of services under the RHOF provided to Aboriginal and Torres Strait Islanders.

Table 22: Estimates of total and ATSI patients (OOS) by program for 2017-18 to 2020-21

Program	Activity measure	2017-18	2018-19	2019-20	2020-21
HEBHBL	Patients/OOS total	50,482	47,134	37,329	39,746
	Patients/OOS ATSI	45,219	42,649	33,540	34,733
	Percent ATSI	89.6%	90.5%	89.8%	87.4%
MOICDP	Patients/OOS total	235,571	237,413	240,245	253,680
	Patients/OOS ATSI	206,692	204,407	203,894	217,270
	Percent ATSI	87.7%	86.1%	84.9%	85.6%
RHOF	Patients/OOS total	211,683	197,079	195,301	216,755
	Patients/OOS ATSI	55,946	53,450	44,945	58,199
	Percent ATSI	26.4%	27.1%	23.0%	26.9%
VOS	Patients/OOS total	50,071	48,346	38,235	46,156
	Patients/OOS ATSI	29,080	27,787	21,544	26,831
	Percent ATSI	58.1%	57.5%	56.3%	58.1%

In 2012 when HPA evaluated the MSOAP and VOS, the summary of services and analysis of access revealed that both MSOAP and VOS improved access to specialist services in rural and remote Australia during the period of observation. In comparing the underlying use of specialist services relevant to the MSOAP, the evaluation found that the use of specialist services increased by 4.2% in remote and 28.7% in very remote areas (see Figure 18).

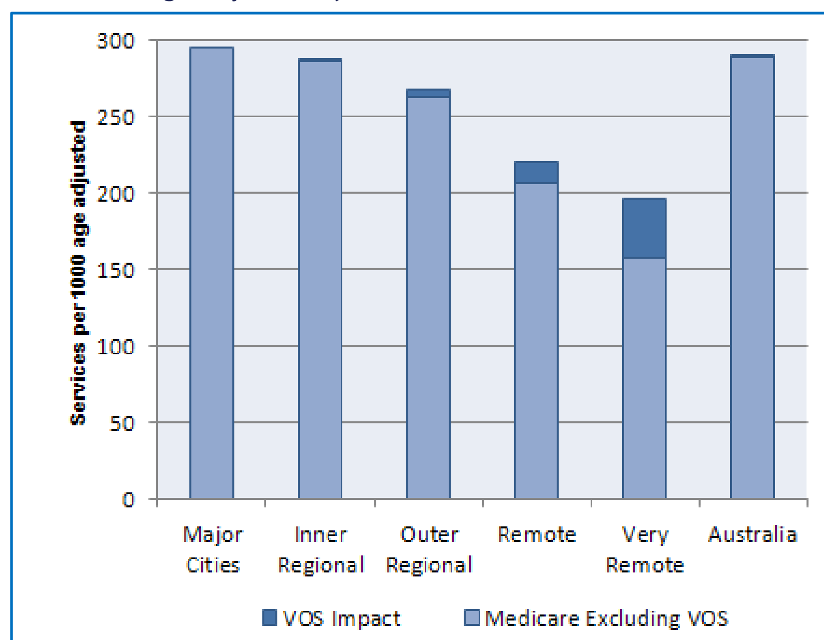
Figure 18: Estimated relative impact of MSOAP Core on access to specialist services assuming a proportion of MSOAP services are not billed to Medicare, 2009–10



Source: HPA analysis on the estimated impact of MSOAP core on access to specialist services 2009–10, HPA's 2012 Evaluation of the MSOAP and the VOS.

A comparison of the underlying use of optometry services if VOS was not available, the evaluation found that the use of optometry services increased overall, with the most seen in remote and very remote areas (6.2% and 20.3% respectively) (see Figure 19).[32]

Figure 19: VOS supported services and estimated total optometry services per 1,000 population age adjusted by remoteness areas, 2010–11



Source: HPA analysis on the estimated impact of VOS on access to optometry services 2010–11, HPA's 2012 Evaluation of the MSOAP and the VOS, p. 143.

HPA carried out similar analyses of MBS and fundholder outreach data to demonstrate the contribution of outreach services to overall access to care across MM categories for 2020–21, and to consider whether any discernible change in impact could be detected between the two periods for the programs, particularly the MSOAP, RHOF and VOS.

Impact on total service utilisation in each MM category

As evident from Table 15 and Table 16 there is a range of health professional groups providing services to local communities under each of the outreach programs, with a noticeably different profile of professional groups in each program. For example, almost 60% of the professionals providing RHOF services are medical specialists, whereas for the MOICDP less than 25% of the services are provided by medical specialists.

HPA undertook an analysis of the impact of the RHOF, MOIDCP, HEBHBL and VOS on the underlying use of services by separately considering the following workforce groupings:

- Allied health
- GP
- Nursing and Aboriginal Health Workers
- Medical Specialists

The professional groups included in each workforce grouping are detailed at Appendix 1K.

The MBS service utilisation data was aligned with the scope of health professionals evident within each workforce grouping across the outreach programs. The total MBS utilisation for 2020-21 for each workforce grouping was brought together with the total OOS data from each of the outreach programs to estimate total access to services by MM category.

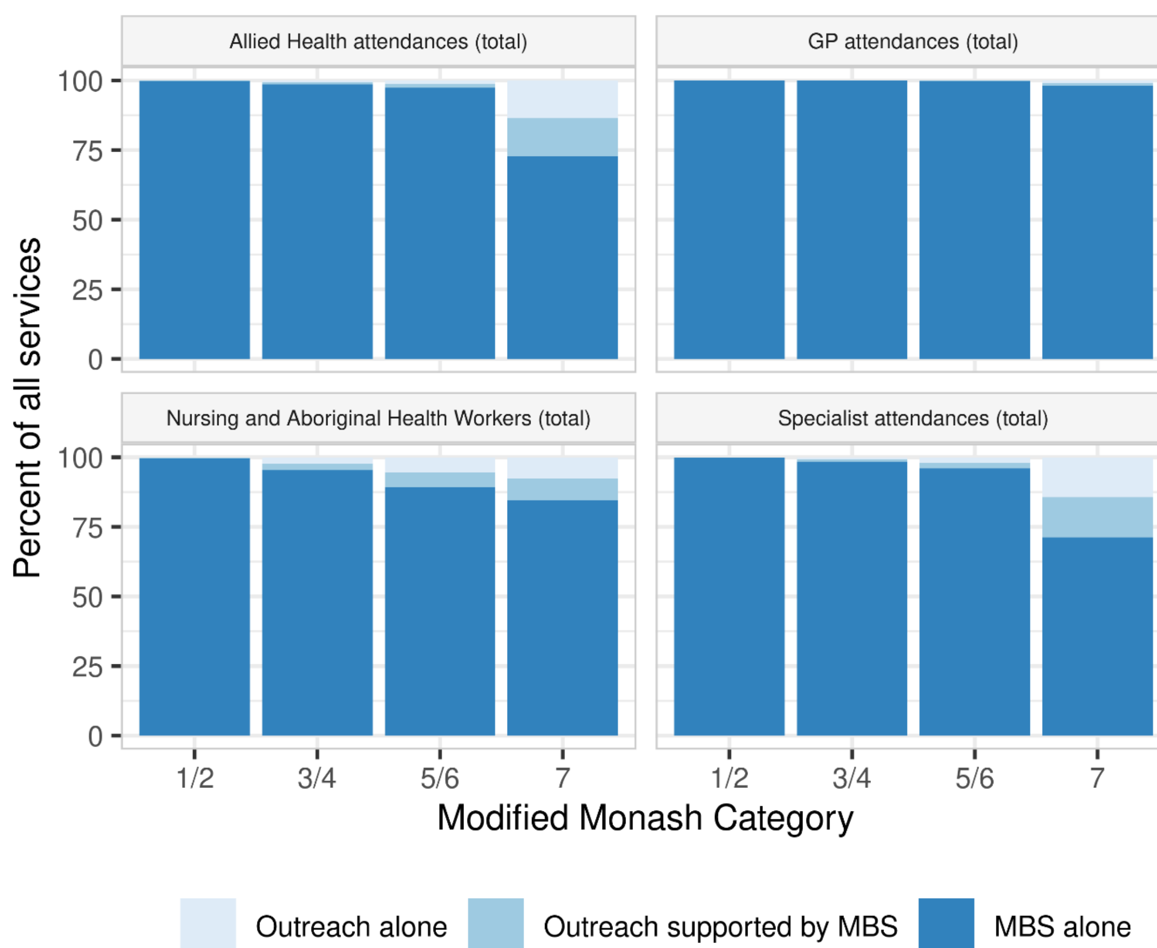
To avoid double counting, the MBS data was adjusted to reflect the assumption that 50% of the outreach services generated MBS payments. A reliable national estimate of MBS billing

rates by professional grouping and program was note feasible for the evaluation and further sensitivity analysis could be undertaken to assess the impact of variations in the assumed 50% MBS billing rate.

Figure 20 provides an indication of the combined impact of the HEBHBL, VOS, RHOF and MOICDP on service access within each MM category by workforce grouping for the period 2017-18 to 2020-21, including the impact of the estimated 50% of outreach services supported by MBS.

Together, it is estimated that the outreach programs contribute over 25% of allied health (27.3%) and medical speciality services (28.7%) and over 15% of nursing and Aboriginal health worker services (15.4%) across small remote community in Australia that are categorised as MM 7. Just less than 2% of GP services (1.8%) are provided by outreach in these communities.

Figure 20: Estimated impact of HEBHBL, VOS, RHOF and MOICDP on underlying service utilisation in each Modified Monash category by workforce grouping, 2017-18 to 2020-21.



Source: Unpublished outreach program data and MBS data publicly available through the AIHW.

The relative contribution of each outreach program to total underlining services provided by Allied Health professionals, GPs, Nurses and Aboriginal Health Workers and Medical Specialists in each MM category is illustrated at

Figure *21*.

It is noted that the contribution of each program varies across MM category and workforce group. For example:

- MOICDP and the RHOF has noticeable impact across all workforce groups.
- RHOF has a relatively larger impact on specialist medical services, contributing 18.3% of total underlying utilisation in MMM 7, compared with MOICDP at 8.2%.
- Conversely, MOICDP is the largest contributor to allied health services, accounting for 11% of services compared with 3.5% from the RHOF.
- VOS's impact is predominantly on allied health, given it focus on optometry services, contributing just under 10% of total allied health services.
- Service contributions across MMM 1-7 are evident for MOICDP, with 0.3% of nursing and Aboriginal health worker services and 0.2% of allied health services in MMM 1-2
- HEBHBL is a smaller program focussed on hearing services, but unlike VOS it provides outreach services across all workforce groupings.

Figure 21: Estimated impact of outreach programs on underlying service utilisation in each Modified Monash category by workforce grouping, 2017-18 to 2020-21.

Source: Unpublished outreach program data and MBS data publicly available through the AIHW. Note outreach program data reflects the assumption that 50% of outreach activity is MBS billed.

Impact on population access to services in each MM category

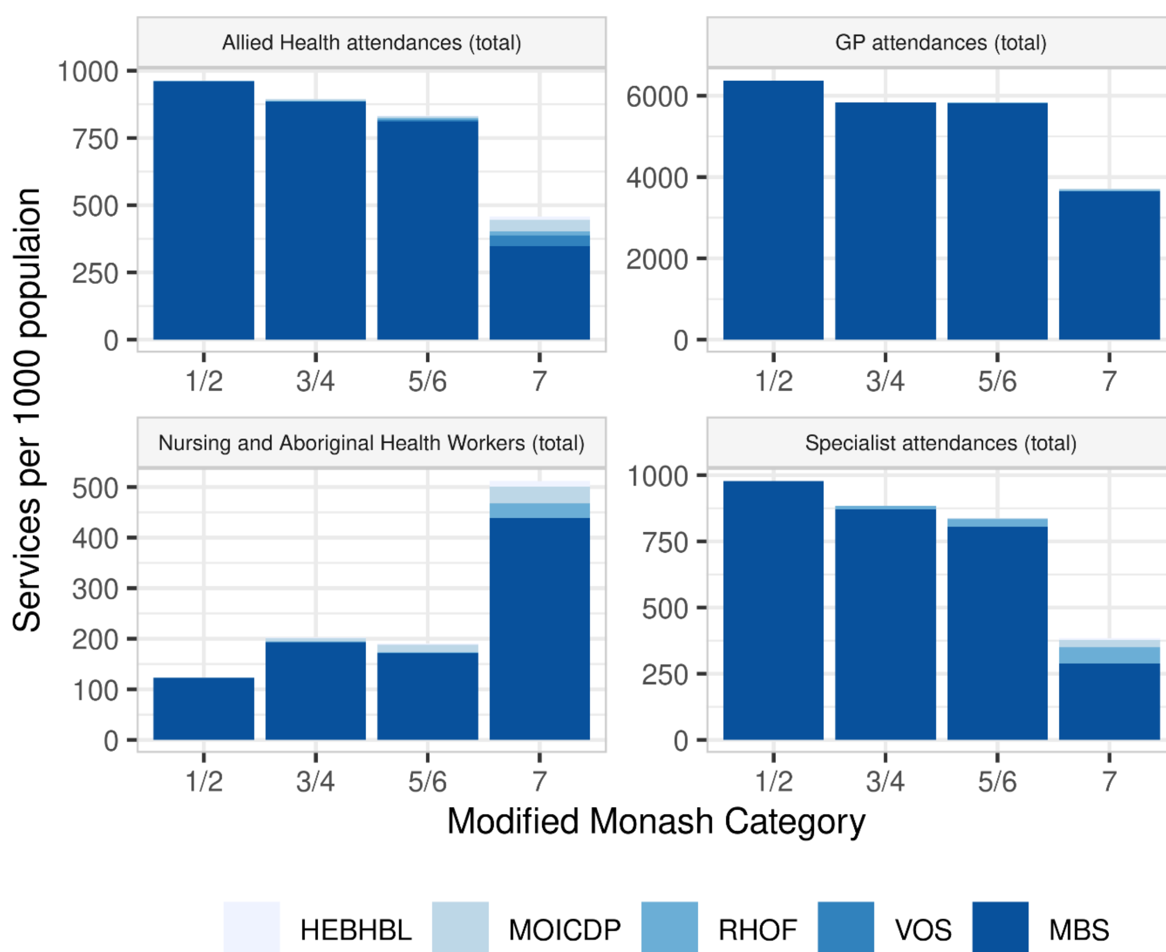
The previous section established that the outreach programs mainly focus service provision in MMM 7. For example, the contribution of MOICDP to total allied services in MMM7 is tenfold that of MM 5 and 6. The programs have a larger proportional impact on specialist medical (28.7%) and allied health services (27.3%) than nursing and Aboriginal health worker services (15.4%) and GP services (1.8%).

Figure 22 presents the underlying population service utilisation rate for each workforce grouping and MM category for the period 20217-18 to 2020-21, reflecting differences in both the total service utilisation based on MBS only and services provided through each of the outreach programs and the relative size of the population in each MM category. The following key issues are noted:

1. Patterns of population access to allied health and medical specialist services are broadly similar in magnitude (300-400 OOS per 1,000 population in MMM 7) and distribution (rate of access in MMM1-2 is between 2-3 fold that of MMM7). However, it should be noted that MBS coverage of allied health services is variable and generally more limited than medical specialist services.

2. In contrast, access to GP and nursing and Aboriginal health worker services vary markedly, with access to GP services around 10-fold that of allied health and medical specialist services in MMM 7. Access to nursing and Aboriginal health worker services varies from the other workforce groupings, with disproportionately higher access in more remote communities. The level of service utilisation in MMM 7 is commensurate to allied health and medical specialist services.

Figure 22: Estimated impact of outreach programs on underlying relative service utilisation in each Modified Monash category by workforce grouping, 2017-18 to 2020-21.



Source: Unpublished outreach program data and MBS data publicly available through the AIHW. Note outreach program data reflects the assumption that 50% of outreach activity is MBS billed.

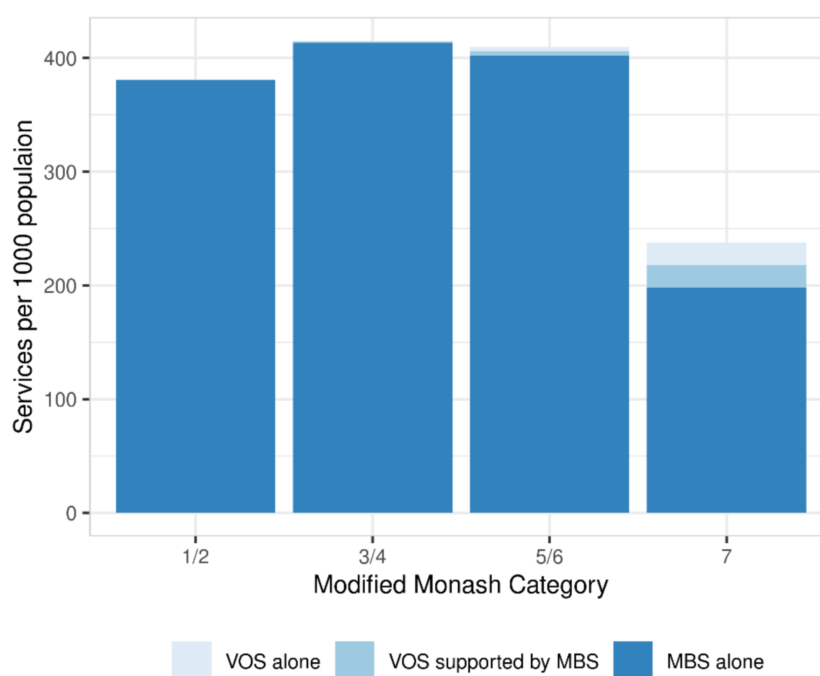
This dynamics behind the relative access to nursing and Aboriginal health worker services is likely to be multifactorial, reflecting the impact of:

- Variable access MBS for nurses and Aboriginal health workers services across MM categories, with greater access afforded to rural and remote communities.
- Greater scope for nurses in small remote communities to provide a range of primary care services, including nurse practitioners and other advanced practice nurses.
- Relative availability of Aboriginal health workers and nurses to provided primary care in rural and remote communities compared with allied health and medical workforce groups.

The outreach programs have contributed to improving the relative access to health care in rural and remote communities, particularly for allied health and medical specialist services. For example, we estimate the programs have reduced the difference in services access between MMM 1-2 and MMM 7 by 16.4% for allied health and 13.1% for medical specialists over the four years 2017-18 and 2020-21.

Given the specific nature of the VOS, an estimation of the direct impact of the program on underlying optometry service utilisation was also undertaken. Figure 23 outlines the estimated impact of the VOS on underlying relative optometry service utilisation in each MM category within the evaluation timeframe.

Figure 23: Estimated impact of VOS on underlying relative optometry service utilisation in each Modified Monash category, 2017-18 to 2020-21.



Source: Unpublished outreach program data and MBS data publicly available through the AIHW. Note outreach program data reflects the assumption that 50% of outreach activity is MBS billed.

In MMM 7 VOS accounted for 16.7% of total access to optometry services compared with less than 2% across the other MM categories. Over the four years 2017-18 to 2020-21, we estimate the VOS reduced the variation in access between MMM 1-2 and MMM 7 by 21.7%.

This analysis confirms that the outreach programs target services provision in rural and remote areas where population access to allied health, GP and specialist medical services is lower than other areas. It also provides evidence that the objectives of the programs, in improving

population access and reducing the gap between geographical regions and population groups, are being met.

Table 22 confirms that over 85% of the services provided under the HEBHBL and MOICDP are provided to Aboriginal and Torres Strait Islanders. While the RHOF and VOS apply to both Aboriginal and Torres Strait Islander and Non Aboriginal and Torres Strait Islanders, nearly 60% of the VOS services and just over 25% of services under the RHOF are provided to Aboriginal and Torres Strait Islanders.

Stakeholders frequently stressed the importance of outreach services in increasing access to health services in underserved communities. Only 1% of outreach providers surveyed reported that the outreach programs have not been effective in increasing access to health services for target populations. Stakeholders in the national workforce bodies survey reflected:

> *"Outreach programs are an incredibly important mechanism to begin to close the gap on medical service availability for rural and remote communities."* [National workforce body, survey]

> *"Outreach services are vital in a complete suite of options for regional communities."* [National workforce body, survey]

All host provider survey respondents assessed outreach services as important (97% very important; 3% quite important) and identified providing additional funding to support and expand outreach service delivery as one of the key things that would enhance outreach services provided through their clinics. This sentiment was echoed throughout stakeholder interviews and in the fundholder narrative reports.

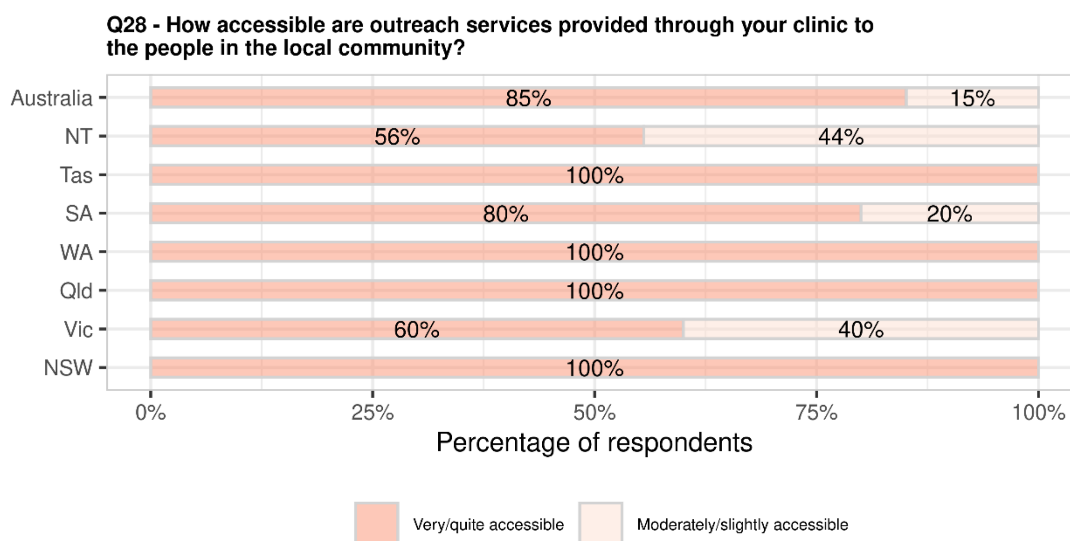
Fundholders provided many examples where the outreach programs have provided access to services that otherwise may have not been provided. For example, NSW RDN reported it commenced a new paediatric rheumatology service in Wagga Wagga in 2021 through the RHOF. A rheumatology service gap for children in region was noted for several years. As of mid-2021, the service has currently been scheduled to visit in-person 3 times each year, with an additional 3 telehealth visits.

RHW spoke of a new audiology and ENT service it established in 2021 in the Pilbara region of Western Australia with support from the HEBHBL program. Despite RHW previously visiting the area for 5 years preceding the establishment of the new program, this was the first-time audiology and ENT services have been provided. RHW reported patients are now able to receive these services locally through school and clinic visits, as opposed to transporting patients vast distances. The service has performed upskilling for local staff in video otoscopy and tympanometry, health promotion activities, as well as ear examinations and treatment. RHW reported that the establishment of the service has enabled the organisation to see more patients as it is no longer required to transport patients to another centre. It is looking to continue the program in the future.

Many stakeholders asserted during interviews that the core outreach system works well, despite opportunities for improvements. Along with additional funding to support the expansion of outreach visits, visiting providers feel the outreach programs would be more effective if there was more administrative support; better promotion of upcoming visits to improve community awareness of services and increase patient attendance rates; increased access to basic infrastructure (that is, reliable internet, equipment, patient transport, more consulting rooms) and enhanced communication between visiting and local providers.

Approximately 87% of host providers surveyed identified unmet health needs in their communities. These included mental health services (psychology, psychiatry and social work); dental care, paediatric care and physiotherapy. As discussed above, stakeholders consulted across various jurisdictions also identified gaps in dental services.

Figure 24: Host providers’ views on the accessibility of outreach services



Note: NT combines NTDoH and NTPHN; QLD combines CheckUP and HoA

Source: Host provider survey, question 28.

Figure 24 highlights host providers’ views on the overall accessibility of outreach services. Survey respondents most frequently identified travel and transport as the biggest barriers to community access. Stakeholders in interviews reflected that some patients may still be required to travel vast distances to access outreach services and may not have a reliable means of transport.

Other respondents identified patient engagement and general awareness of services as key barriers to access. They commented that some patients may not be aware of outreach services provided in their communities or have limited understanding of the importance of seeking care or attending appointments. For example, one outreach provider to remote communities in the Northern Territory described visiting towns of between 90 and 700 people. Often, community members would not know he was in town. In smaller communities, the provider was able to drive around the area to find patients, but this would not be possible in larger communities, so it is important that efforts are made to alert people to when health professionals will be in town, otherwise people would miss out on care.

Impact of COVID-19

During consultations, many stakeholders cited a marked decline in face-to-face services after the onset of COVID–19. Service cancellations were largely caused by the inability to visit communities because of lockdowns and travel restrictions which impacted visiting providers’ ability to travel. The decline in face-to-face services due to COVID-19 was also frequently noted by fundholders in their narrative reports in which they described substantial underspend due to visiting provider cancellations in the latter part of 2019 to 2021. The service utilisation data received from 2017–18 to 2020–21 within the fundholder datasets also demonstrated a decline in face-to-face services during 2020 and 2021, and, according to consultations with stakeholders, this has brought about increased use of alternative service delivery methods in outreach, such a telehealth.

For example, RDWA reported that COVID-19 had a significant impact on its ability to service a remote Aboriginal Country in SA for diabetes eye complications through the VOS. In response, RDWA provided support for a telehealth service to the community, involving training of an ophthalmic nurse employed by the local ACCHOs to assist in providing optometry care via telehealth. To establish the service, RDWA worked closely with the local ACCHOs to help co-design the service. The model resulted in 30 occasions of service within a 4-week period, most

of which were for patients with diabetes. RDWA reported similar situations where telehealth was incorporated to overcome COVID-19 restrictions in rural communities through other outreach programs.[41]

Table 23 shows how many annual visits outreach provider survey respondents estimated to have made prior to the start of COVID–19. A total of 51.6% of outreach provider respondents reported making one to 29 visits annually (noting that 22.6% of respondents did not indicate how many visits they made). Several providers (64%) reported using telehealth more than they did before the start of COVID-19. This was most likely due to travel restrictions associated with the pandemic. However, 36% of providers responded that they had not increased their use of telehealth since the start of the pandemic. For example, 53% of visiting providers in Western Australia responded that they have not increased their use of telehealth since COVID-19. This could be due to the variation in travel restrictions across jurisdictions.

Table 23: Total reported number of outreach visits conducted by providers annually

Question	Number of annual visits	Response
Q5_1 Before the start of restrictions related to the COVID–19 pandemic, on average, approximately how many annual visits did you make to discrete towns/communities to provide outreach services?	0	6 (2.4%)
	0 to 9	37 (14.9%)
	10 to 19	56 (22.6%)
	20 to 29	35 (14.1%)
	30 to 90	47 (19.0%)
	90+	11 (4.4%)
	Other	55 (22.2%)
	Unknown	1 (0.4%)

Source: Outreach provider survey, question 5.

Evaluation findings

The data reveals that the spread of total annual visits across the MM categories programs varies is generally higher in very remote communities (MM 7). The lower proportion of patient activity (OOS) in MM 7 is likely to be reflective of the relatively smaller population sizes in these locations. This illustrates that the outreach programs are providing access to health services in priority rural and remote areas.

A key aim of many of the outreach programs is to increase health access to Aboriginal and Torres Strait Islander peoples. The HEBHBL and MOICDP are Indigenous specific programs and the data reveals that over 85% of services are reported as being provided to Aboriginal and Torres Strait Islanders. The RHOF and VOS apply to both Aboriginal and Torres Strait Islander and Non Aboriginal and Torres Strait Islanders with nearly 60% of the VOS services and just over 25% of services under the RHOF provided to Aboriginal and Torres Strait Islanders.

As discussed above, the original aim was to replicate the analysis of MBS and fundholder outreach data to demonstrate the contribution of outreach services to overall access to care across MM categories for 2020–21, and to consider whether any discernible change could be detected between the 2 periods for the programs. However, access to the MBS data was not available at the time of preparing this report.

As per recommendation 27, the fundholders should establish online portals with comprehensive information on visiting services. These portals should be made readily available to the public and health service providers to promote visibility and increase overall awareness of outreach services.

[41] Rural Doctors Workforce Agency. (2020). *VOS Six-Monthly Outreach Narrative Report*

Health outcomes

Stakeholder views

Data collection processes and measures vary by fundholder, and stakeholders feel there are many opportunities to improve data reporting in outreach. Stakeholders frequently discussed the importance of measuring patient outcomes in outreach instead of focussing on metrics associated with service activity, such as patient volume and occasions of service. One fundholders stated that the data provided to the Department as part of routine activity reporting does not identify how many patients receive services. Instead, reporting focusses on occasions of service. As a result, it is not known how many new patients, existing patients are seen in a given period. The data are focussed on inputs and do not look at outputs, far less outcomes. The fundholder stated that the level of learning and sharing from the data is very limited and they consider the programs too transactional and advocated for additional focus on final outputs rather than reporting on inputs.

There is also no formal comparison or benchmarking of key performance indicators across programs or jurisdictions. Stakeholders feel a broader focus on health outcomes is required. This includes establishing nationally-consistent monitoring and evaluation frameworks that incorporate measures that focus on key specific and high-level program priorities, such as collaboration, cultural safety and local capacity building.

Stakeholders acknowledged the difficulties associated with effectively capturing and tracking health outcomes in outreach. Many feel establishing mechanisms for gathering patient feedback (that is, PREMS and, where possible, PROMS) would create a baseline for collecting health outcomes. Some fundholders and host services described making strides in this area. For example, RHW is working to establish a new patient information portal where they hope to capture patient feedback. Some host services have created and distributed their own patient surveys to gather information on PREMS and PROMs, and others described employing a range of approaches to navigate survey and consent fatigue, such as collecting feedback through Yarning Circles and reviewing patient flows. Another clinic in Tasmania (see Volume 2) collects a standard set of PROMs from all patients to assess the performance of clinicians against pain management benchmarks across Tasmania. One PROM used by the clinic is the quantity of opioid use post-treatment. Over 50% of consumers reported ceasing opioid use at the time the data were collected.

The Southern NSW LHD also highlighted its efforts in incorporating PREMs and PROMS into its outreach services. It is implementing a PROMs questionnaire through a Patient-Reported Outcomes Measurement Information System (PROMIS®). These tools are designed to be generalised and not specific to any disease.[42] The tool used by the LHD covers questions under a range of patient reported outcome categories, including physical function, anxiety, depression, fatigue, sleep disturbance, ability to participate in social roles and activities, and pain intensity. According to representatives from the LHD, patients can access the questionnaire via a link received through mobile phone text message, email, or in-person in a clinic on an electronic tablet or paper where a staff member can assist with interpretation and translation.

According to the LHD, the advantages of digital systems, such as PROMIS®, are that results can be tracked in real-time, as well as over a longer time series. While use of the tool is in its infancy at the LHD, it plans to re-administer the questionnaire every 3 months and will have a clearer understanding of how PROMs for its clients are changing over time. The LHD did caution there are certain limitations associated with the administration of PROMs tools. For instance, the LHD reported there is reluctance to use the tool in Aboriginal and Torres Strait Islander-led clinics due to cultural safety issues. A client may also be asked mental health-related questions which can open up old traumatic experiences that may lead to further mental ill-health, especially for clients who may live alone or be isolated from other community

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[42] University of Nebraska Medical Center. (n.d.). *PROMIS 29 profile v2.0*. University of Nebraska Medical Center. https://www.unmc.edu/centric/_documents/PROMIS29info.pdf

members. In these cases, it is important to provide adequate support and rigorous follow-up to ensure the well-being of clients both during and following the administration of these tools. As such, representatives of the LHD stressed that clinicians, support staff and Aboriginal health workers must have strong relationships with their community and clients. The program administered by the LHD is designed around community relationships, as opposed to systems, so the LHD feels the program is. currently working However, they feel that appropriate support needs to be funded and more work is needed to develop culturally safe tools.

CheckUP has trialed two standardized, validated PROMS in remote Aboriginal and Torres Strait Islander communities, measuring changes in sight or hearing specific aspects of quality-of-life following eye and ear surgery via Eye and Ear Surgical Support (EESS) funding. By utilising dedicated evaluation staff to collect and analyse patient feedback, CheckUP reported that it can ensure adverse patient outcomes are followed up with clinical interventions in a timely manner.

CheckUP has also co-designed a Patient Reported Experience Measures (PREM) survey with patients, health professionals, academics, and other stakeholders, with the purpose of capturing and evaluating critical aspects of the patient experience – from leaving home or community through to undergoing surgery. The EESS journey focuses strongly on patients feeling culturally safe and CheckUP's PREM measures seek to assess degree to which this is achieved through the domains of communication, decision-making, respect, access to family support and addressing practical barriers of travel and accommodation.

Stakeholders stressed that the social determinants of health (that is, housing, education, economic challenges) must also be considered when developing monitoring and evaluation measures. Many stakeholders in the Aboriginal and Torres Strait Islander sector stressed the importance of asking what is important to the patient rather than what is wrong with the patient.

Promoting high quality care and ensuring clinical safety

Promoting high quality care and ensuring clinical safety are key areas that must be considered when working to achieve positive patient outcomes. The transient nature of services and visiting health professionals presents unique challenges in establishing robust processes to effectively plan and monitor and control quality of care and clinical safety in outreach. While the 83% of visiting providers rated the overall processes to promote quality care and clinical safety as strong (moderately strong 24%; quite strong 34%; very strong 25%), they provided opportunities for improvement. Respondents most frequently expressed the desire for:

- mechanisms to capture feedback from patients and providers
- routine audits of care process and clinical outcomes
- improved documentation of clinical risks and incidents.

In line with visiting providers, the majority of host providers rated the processes implemented to promote patient safety and clinical quality as strong (39% very strong; 37% quite strong; 20% moderately strong) indicating they are comfortable with existing processes. Despite these responses, host providers provided potential opportunities for improvement in line with visiting providers' suggestions. Respondents advocated for increasing the frequency and mechanisms in which patient feedback is collected, providing additional opportunities for training and education, ensuring patient follow up is completed in a timely manner (that is, referrals, letters providing to specialists and visiting providers, etc.) and conducting ongoing quality improvement activities, such as reviews and audits of clinical policies and procedures, to facilitate continuous improvement.

In line with the survey feedback, there were calls to develop more robust systems of accountability for visiting services. One stakeholder relayed that thinking needs to progress beyond *'any health professional in a rural community will do.'* In addition, stakeholders advocated for further consideration of clinical governance arrangements in outreach. This includes establishing clinical governance frameworks and processes that determine which

party (that is, fundholder, visiting service, host provider) is responsible for a patient and how to effectively manage adverse patient events.

Evaluation findings

There is no national collection of health outcomes data in outreach. Because the outreach programs provide care for a range of conditions with different severities, it is often difficult to measure the effect of the programs on health outcomes.

Recommendation 8 advocates for the Department to design and establish a standardised single national minimum data set that covers all programs to streamline the data collection and reporting process. Recommendation 9 suggests that the Department also look to establish and collect a small suite of key consumer facing key performance indicators (including outreach provider continuity, patient experiences, clinic utilisation, visit duration and unit costs) with data elements specified in the AIHW metadata store. In addition to facilitating performance monitoring, these actions will serve as a basis for collecting patient experiences and, where possible, health outcomes.

The Australian Commission on Safety and Quality in Health Care (the Commission) has developed PREMs with hospitals and health services and is working with the NT Health to develop experience measures Aboriginal and Torres Strait Islander patients. The Department should consult with the Commission and explore whether these tools may be suitable for use to capture Aboriginal and Torres Strait Islander patient experiences in outreach. The development and implementation of these measures in outreach should also be done in collaboration with a broad range of stakeholders from Aboriginal and Torres Strait Islander organisations across jurisdictions, to ensure they comprehensively reflect the objectives and priorities of the outreach programs across target populations. To gather feedback from other relevant stakeholders and host services, the Department should also explore opportunities to pilot the tool during development.

Box 19: Recommendations for improving health outcomes

All programs

30. The Department to consult with the Australian Commission on Safety and Quality in Health Care on their progress in developing culturally safe PREMs suitable for use with Aboriginal and Torres Strait Islander patients, including exploration of opportunities for outreach services to pilot the tool during development.

Telehealth and innovation in outreach programs

Data analysis: Telehealth in outreach

The original aim was to undertake an analysis of MBS and fundholder outreach data to assess the contribution of telehealth to overall outreach services during the four years from 2017-18 to 2020-21, including any discernible impact on telehealth use during the COVID pandemic. However, access to complete and reliable fundholder data and the required MBS data to support this was not available at the time of preparing this report.

Stakeholder views

Due to the high cost and time associated with travelling and providing care to rural and remote communities, there is particular interest in maximising the capabilities and capacity of telehealth in outreach. The aim is to expand service provision and increase access to vital health services in rural and remote communities. For example, True Relationships and Reproductive Health Service in Queensland has been considering the employment of a sexual health counsellor to provide telehealth. Also, a staff member from the Central Australian Aboriginal Congress in the Northern Territory stated they wish for telehealth to take on a larger role in service delivery in the future; however, measures such as defined shared care models are first required to ensure clinical and cultural safety for the client. Many other local clinics

and NACCHO affiliates also asserted that telehealth services should expand in the future, provided the correct safety measures and protocols are established.

Figure 25 outlines outreach provider survey respondents' reported use of telehealth to support the delivery of outreach services.

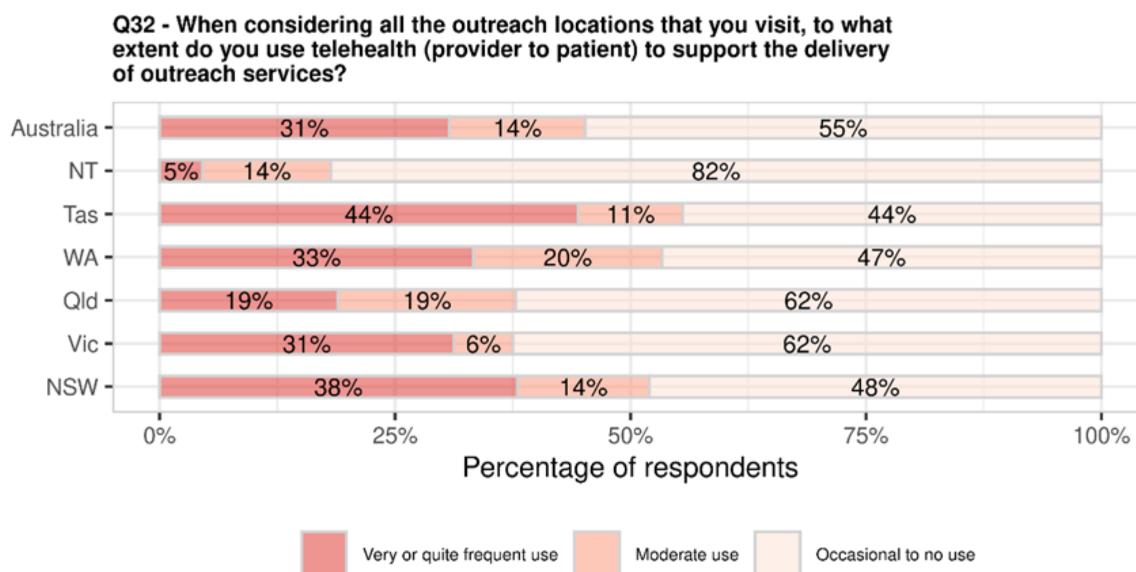
The survey results indicate there is largely moderate (14%) or occasional to no use (55%) of telehealth in outreach but there is a bit of variation across jurisdictions.

Jurisdictional stakeholders consulted reported varying levels of receptiveness and use of telehealth in outreach. Some jurisdictions have appeared to embrace and integrate telehealth into their outreach models of care more than others which is apparent through the feedback and information garnered through the surveys and interviews.

On the one hand, one fund holder expressed the view that telehealth does not fit the definition of an outreach service under the programs. While some of their providers use telehealth for follow up between outreach visits, this activity is not funded through the outreach programs. They expressed a firm view that rural communities deserve access face to face outreach services and that telehealth as a stand-alone service is a poor substitute for many of the services provided through their programs.

On the other hand, various fundholders discussed how host clinics and outreach providers are making great strides in integrating telehealth into their outreach models. For example, despite several stakeholders across the evaluation speaking of difficulties in incorporating telehealth into podiatry, an ACCHOs in the Northern Territory have been able to provide tele podiatry services through partnership with a telehealth project by the South Australian Health and Medical Research Institute. The project allows clients in Queensland, the Northern Territory and South Australia to stay in their communities while receiving specialist multidisciplinary care for diabetes-related foot complications. The service has provided care for foot complications to people in rural areas that otherwise would not be able to access foot care until the outreach provider arrives. Several other stakeholders provided examples of expanding telehealth services to improve access and adapt to environmental changes.

Figure 25: Use of telehealth amongst outreach providers



Source: Outreach provider survey, question 32.

Stakeholders noted key areas where they feel telehealth has a place and great potential for expansion in outreach.

- **Patient follow-up and management**. While stakeholders stressed telehealth is not a substitute for face-to-face care, there was great support for employing hybrid models that utilise telehealth at certain points along the care pathway as means to facilitate ongoing patient management and follow up. Due to the cost and resource constraints, the regularity and frequency of outreach visits often vary, and there may be limited opportunities for visiting providers to support ongoing patient management in rural and remote communities; therefore, telehealth is a resource both host and visiting providers can use to increase patient access to care beyond face-to-face outreach visits. One fundholder reported exploring this model which they described as 'assisted consultation through telehealth.' The idea is that a new patient can see a specialist face-to-face for the initial consult. Subsequent care planning and follow-up is then undertaken by local staff in conjunction with the specialist via telehealth consultations.

- **Shared care arrangements**. Stakeholders feel telehealth offers great potential for host and visiting providers to establish shared care arrangements. In addition to fostering multidisciplinary team care arrangements and improving continuity of care, telehealth can increase communication and promote skills transfer between visiting and local staff. Stakeholders described how telehealth can provide further opportunities for local staff to educate visiting providers on community priorities and facilitate relationship building in between outreach visits. One stakeholder reflected that shared care arrangements also have the potential to empower community members and allow for additional checks and balances in patient care. They cited the example of having an Aboriginal health worker sit in on a telehealth consult between a patient and visiting provider to facilitate culturally safe care.

- **Local capacity building**. The widespread acceptance of online webinars, and videoconferencing since the pandemic has the potential to create further opportunities for visiting providers to upskill local staff.

While stakeholders across programs and jurisdictions acknowledged the ongoing potential of telehealth in increasing access to health services in rural and remote communities, many cited important considerations and potential limitations of this technology in outreach.

- **Use across health professions**. There was a sentiment that telehealth may be more effective in some professions than others. For example, stakeholders highlighted the potential for use in less 'equipment-heavy' professions, such as mental health, dermatology and paediatrics, but cited there may be additional challenges delivering care in other professions, such as cardiology, ear health and ophthalmology, via telehealth.

- **Patient and provider acceptance**. Some stakeholders cited challenges with patients and providers embracing telehealth. For example, some providers and services reported that Aboriginal and Torres Strait Islander people have not been as accepting of telehealth and would rather see visiting providers face-to-face.

- **Patient inequity**. Stakeholders cautioned that in some instances telehealth may increase health inequities. For example, some patients may not have access to reliable internet connection and/or the technology required to participate in telehealth consultations. They may also have a limited understanding of how to use this technology.

- **Cost effectiveness of telehealth**. While stakeholders noted the potential for telehealth to generating cost savings in outreach, telehealth may be less cost-effective than anticipated due to the administrative burden associated with providing telehealth. As of January 2022, the Department has removed a 50% loading for some rural psychiatric services, leading to some providers having to charge patients a gap fee. Further, from

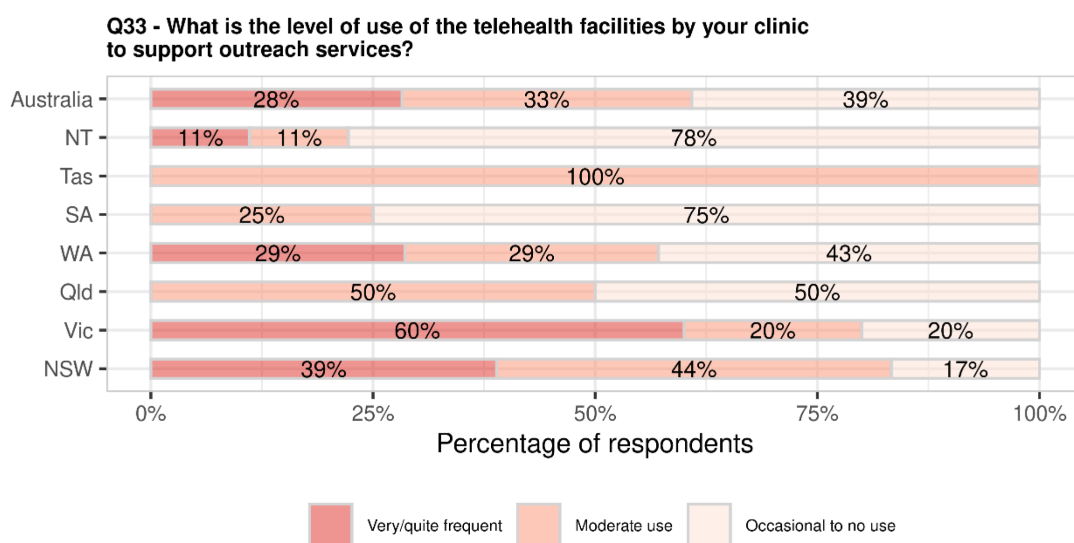
30 June 2022, Level C consultations (20 minute consultations) will no longer be available by telehealth consultation.

- **Start-up costs**. As highlighted in the literature, establishing the infrastructure to provide telehealth is not an insignificant cost. If telehealth utilisation was to underpin outreach expansion, support for start-up costs may be required. This is especially the case where throughput is low and therefore return on investment stretched out over a long period.

Local capacity to provide telehealth

Figure 26 highlights host provider clinics' reported use of telehealth to support outreach services. Table 24 outlines the level of use of telehealth by ACCHO vs. non-ACCHO host provider respondents. While most respondents indicated a moderate level of use, the results highlight the variation of use across host services.

Figure 26: Host providers' reported level of telehealth use



Source: Host provider survey, question 33.

Table 24: Host providers' reported level of telehealth use by non-ACCHO and ACCHO

Question response	ACCHO	Non-ACCHO
Very/quite frequent	7 (23.3%)	6 (37.5%)
Moderate use	9 (30.0%)	6 (37.5%)
Occasional to no use	14 (46.7%)	4 (25.0%)
Total respondents	30 (100%)	16 (100%)

Source: Host provider survey, question 33.

Host provider survey respondents reflected on the ways in which telehealth is currently used by their clinics to support the delivery of outreach services. In line with reflections from stakeholder consultations, this included using telehealth as a means to facilitate patient follow-up and management and supplement face-to-face care. For example, host providers mentioned that a range of specialists (that is, psychologists, paediatricians, endocrinologists and hepatologists and allied health professionals (that is, dieticians, chronic disease nurse) conduct outreach consultations via telehealth. Others described how visiting services have been able to use telehealth to conduct multidisciplinary case conferences and foster shared care arrangements.

When asked about the overall accessibility of telehealth to support the delivery of outreach services provided through their clinics, 84% of host providers rated telehealth as moderately to

very accessible (moderately accessible 24%; quite accessible 22%; very accessible 38%) with a remaining 13% and 2% of respondents rating it as slightly or not accessible. The most frequently reported barriers to providing effective telehealth services to support outreach were:

- Limited access to infrastructure (that is, equipment/technology, internet connection, clinic space).
- Community/patient ability and willingness to engage and participate in telehealth consultations (that is, patients may not want to participate in telehealth consultations or have access to technology or internet).
- Limited local staff to support the delivery of telehealth.

These barriers were reiterated by visiting providers who responded to the survey. They indicated that increasing access to reliable internet, IT equipment (that is, online booking systems), staff support and training at the local level would enable telehealth to be used more effectively in their role as outreach providers.

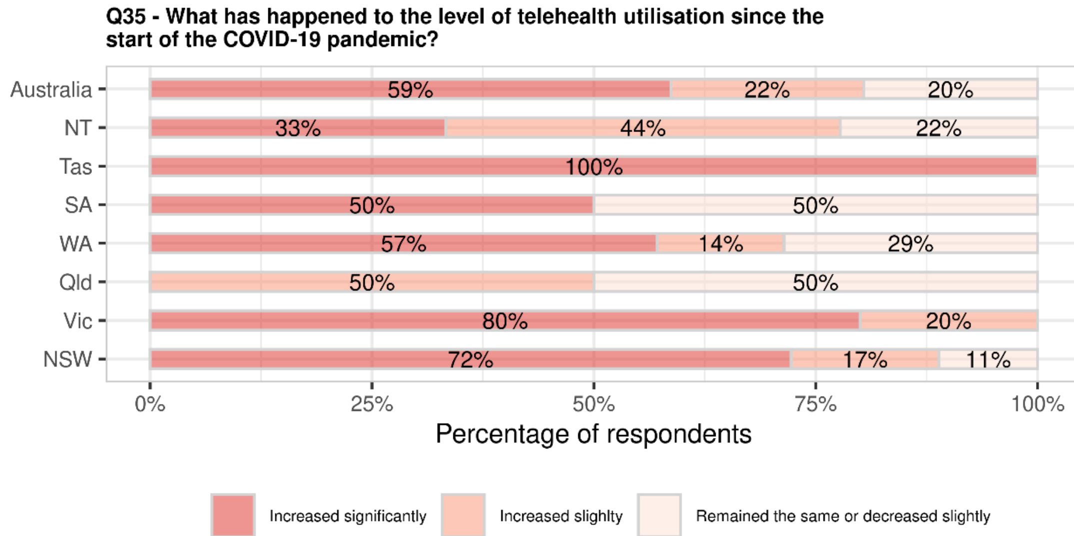
There was a general sentiment amongst stakeholders that telehealth consultations are most effective when delivered in the local clinic or the consumer's home with the assistance and support of a local staff member (that is, Aboriginal health worker, nurse, medical or allied health assistant). Stakeholders discussed the importance of local staff members in facilitating and managing telehealth consultations at the user end. Due to their knowledge of patients and their local communities, they are a vital asset to this process and are integral in supporting the planning and coordination of telehealth consultations. Stakeholders at all levels of governance cited challenges with local services in outreach locations having sufficient capacity to support the delivery of telehealth. As cited above, this includes limited access to staff and basic infrastructure, such as reliable internet and IT equipment.

Due to these challenges, stakeholders cited the need for additional funding to enhance local infrastructure, such as internet connection and IT equipment, and more flexibility to support capacity building and facilitate training for local staff to enhance the delivery of telehealth in outreach. Beyond training and education for local staff, educating patients on the benefits of telehealth would also enable more effective use of telehealth in the delivery of outreach services.

Existing utilisation trends

As stated above, the COVID–19 pandemic has brought forth increased use of telehealth in outreach across health settings. Since the onset of the pandemic, most visiting and host providers survey respondents indicated that their clinics' use of telehealth has increased due to limited travel options and ongoing travel restrictions and that this mode of care delivery has enabled many clinics to continue servicing their communities during this period (see Figure 27). For example, 64% of visiting provider survey respondents indicated they are using telehealth in outreach more than they did prior to the start of the pandemic. This sentiment was echoed by other jurisdictional stakeholders who reported communities have begun to embrace telehealth a bit more since the start of the pandemic.

Figure 27: Host providers' use of telehealth in outreach since the start of the pandemic



Source: Host provider survey, question 35.

Some host providers stated their clinics have increased their capacity to provide telehealth throughout this period and have had ongoing success with this model in outreach. For example, one host provider reported in the survey that its clinic has started using Healthdirect Australia to conduct telehealth consultations and this technology is now available in all of its consulting rooms. A First Nations service in Tasmania also reported that telehealth facilities exist in most AMS and local clinics in Tasmania though some First Nations clients are still reluctant to use the technology.

Despite a rise in the use of telehealth during the pandemic, some clinics reported largely reverting back to face-to-face care since travel restrictions have eased. Others reported their clinics still have limited to no use of telehealth as face-to-face care is their preferred method of service delivery. For example, a local clinic in New South Wales stated its clients, who are mostly First Nations peoples, prefer face-to-face interactions with clinicians and often struggle using technology that facilitates telehealth. Clients will often turn up to the clinic in-person without notice and the clinic will often hold barbeques with several clients to discuss health issues more informally which often yields richer insights, particularly identifying issues surrounding the social determinants of health. These models are not possible through telehealth for the clinic.

Other host providers who responded to the surveys commented on the untapped potential of telehealth and indicated this technology is not being used to its full potential in their clinics and are actively looking to increase their capacity to deliver telehealth for the benefit of the communities they service.

Evaluation findings

Since the onset of COVID-19, visiting services have increased their use of telehealth in outreach service delivery. Despite its reported limitations, stakeholders noted the ongoing potential of this technology in increasing access to health services and supporting local capacity building. Recommendation 31 seeks to extend support to host services to bolster local capacity to deliver telehealth services in outreach and support the expansion of shared care arrangements to facilitate local capacity building.

Further consideration should also be given to formally supporting shared care arrangements and the education and training of local staff via telehealth. The development of a national program of shared care arrangements may help to further support and expand the use of telehealth, increase access to care and facilitate local capacity building. The Department

should also look to assess existing and potential future MBS telehealth items to support the expansion of telehealth enabled shared care arrangements for medical and non-medical outreach providers.

Through the interviews and surveys, host services consistently identified challenges effectively supporting telehealth outreach services locally due to limited access to basic infrastructure. The Department could look to building an evidence base for innovations by commissioning assessments that assess their value for money. It could also support providers through a new national funding pool to establish the capital infrastructure for new models of care may reduce these barriers and better support host services to expand their use of telehealth in efficient and innovative ways.

Box 20: Recommendations for telehealth

All programs

31. Building on the momentum achieved through the COVID-19 pandemic, develop and monitor the implementation of a national program of shared care arrangements including local support for use of telehealth to broaden access and reliability of services, upskill the local workforce and support cost-effective continuity of care.
32. The Department to review existing and anticipated future Medicare Benefits Schedule items for telehealth to assess the viability to support the expansion of telehealth enabled shared care arrangements for both medical and non-medical outreach providers.

Box 21: Broader system observations about telehealth

6. The Department to consider the feasibility of commissioning the assessment of service models to build an evidence base for innovations that represent value for money, with a view to provide support for the capital infrastructure required for such innovations through the establishment of an open and contestable national funding pool.

Other models of care

Store-and-forward telemedicine

Store-and-forward technology promotes access to medical and specialist advice by allowing providers to submit and share images, x-rays and other patient information virtually to health professionals and specialists for further evaluation and advice to aid in the diagnosis, treatment and management of patient conditions. For example, there is support for 'store and forward' style telehealth which is showcased in the Tele-Derm model. (For more information on Tele-Derm, refer to Box 22).

While there are patient safety and privacy issues to consider in this model of care, stakeholders noted the potential to broaden and expand store-and-forward models into other areas, such as ophthalmology, to promote local capacity building and increase access to specialist advice in rural and remote areas.

Box 22: Tele-Derm

Tele-Derm is a free online resource for doctors practicing in rural and remote areas (MM 3–7). As indicated in Chapter 4, this initiative is funded under the RHOF. The platform provides virtual opportunities for rural and remote providers to connect via discussion forums and contains thousands of dermatological case studies they can access for educational and training purposes. In addition, the platform providers access to additional opportunities for learning an allows rural and remote providers to seek and receive advice from dermatologists and surgeons to help aid in the diagnoses, treatment

and management of dermatological conditions.[43] The service operates as a 'store-and-forward' model where rural and remote providers can store and forward an image via the platform and receive advice from a consulting dermatologist within 48 hours. It is estimated that the service provides support and education to approximately 3500 doctors in rural and remote Australia. It is estimated that the service provides support and education to approximately 3500 doctors in rural and remote Australia.[44]

The ACRRM undertook an evaluation of Tele-Derm in 2020. The organisation reported that 101 GPs consulted Tele-Derm for advice and guidance on 284 cases from January to June 2020. As part of the review, ACRRM distributed a survey. Of GPs that responded to the survey, most users were registrars seeking assistance on either the diagnosis or management of dermatological conditions. Noting there were 5 survey respondents. 80% of users who responded to the survey regarded the education and advice provided on the Tele-Derm platform as helpful or very helpful.[45]

The ACRRM has partnered with a variety of organisations, such as PHNs, local health organisations, to support the network and educate clinicians and patients on the benefits of digital health. When asked about their use and awareness of Tele-Derm, 88% of host provider survey respondents indicated they have had limited to no use of Tele-Derm. This may be due to visibility of the service, and there may be additional opportunities to promote Tele-Derm and align it with existing digital health initiatives. Similar to other stakeholders, ACCRM reported that interoperability and local infrastructure are still major barriers to the effective delivery of telehealth. Also, one visiting dermatologist contracted by another fundholder highlighted that, through their relationships with GPs during outreach visits, they will often informally receive images from GPs in host clinics via text message and provide an informal consult at no charge. The dermatologist stated this has been common practice for many years – similar to the informal consult practice seen in hospitals between senior and junior doctors – and they are happy to provide these consults.

The ACRRM trialled the Tele-Derm model in ophthalmology but did not have sufficient funding and resources to hire full-time ophthalmologists to support the service. In addition to upskilling local providers, the ACRRM noted benefits of the model and its potential to increase access to specialist services and reduce patient wait times. To facilitate these aims, they advocated for the expansion of the service into other areas of health like ophthalmology and mental health.

Mobile services

There are a range of other models and services employed in outreach to increase access to care in rural and remote communities across Australia. There has been a great of interest and an emergence of mobile services, such as HoA, in outreach. Table 25 provides an overview of some of the outreach mobile services in operation by health profession and jurisdiction.

[43] Australian College of Rural & Remote Medicine. (2022). *Apply for free limited access to Tele-Derm*. https://www.acrrm.org.au/forms/subscribers/rhof-tele-derm
[44]Australian College of Rural & Remote Medicine. (2020a). *Rural Health Outreach Fund extention supports ACCRM Tele-Derm delivery*. Retrieved 6 June 2022 from https://www.acrrm.org.au/about-us/news-events/media-releases/2020/09/22/rural-health-outreach-fund-extension-supports-acrrm-tele-derm-delivery
[45] Australian College of Rural & Remote Medicine. (2020b). *Tele-Derm Evaluation 2020*.

Table 25: Mobile health clinics operating nationally

Service	State	Organisation	Source of funding	Description
Broken Hill mobile health clinic	NSW	Maari Ma Health Aboriginal Corporation	Australian Government	A mobile clinic operated by the Maari Ma Health Aboriginal Corporation with $200,000 funding from the Australian Government.[46]
BreastScreen Australia	National	BreastScreen Australia	Australia Government State and territory governments	A mobile breast cancer mammogram screening service that aims to detect breast cancer early before it has a chance to spread in women aged between 50 and 74, improving chances of survival when cancer is detected.[47]
Mobile Dental Clinic	ACT	ACT Government	ACT Government	Provides 3 mobile clinics and offers preventative and restorative dental services for vulnerable community members, particularly children aged 10. Also serves residential aged care facilities.[48]
Budja Mobile Clinic	Vic	Halls Gap's Budja Medical clinic	MOICDP	Services Aboriginal and Torres Strait Islander people in Ararat Rural City and Northern Grampians Shire, including Ararat, Stawell, St Arnaud and other small towns. The clinic offers hearing and optometry services, and general health checks and health promotion and education.[49]
Indigenous Diabetes Eye And Screening Van	NSW	LookOut Project	RHOF	Provides ophthalmology and eye care using telehealth. Delivers services to Aboriginal and Torres Strait Islander people and people in remote communities.[50]
	Vic		Corporate sponsors[1]	
	Qld			

[46] Australian Mobile Health Clinics Association. (2017). *Australian and State Government Policy Support for Mobile Health Care*. Australian Mobile Health Clinics Association,. http://www.mobilehealthclinics.com.au/support-for-mobile-healthcare/

[47] Department of Health. (2021a). *About the BreastScreen Australia Program*. Department of Health,. https://www.health.gov.au/initiatives-and-programs/breastscreen-australia-program/about-the-breastscreen-australia-program

[48] ACT Government. (2019). *Better dental care for school students hits the road*. ACT Government,. https://www.cmtedd.act.gov.au/open_government/inform/act_government_media_releases/meegan-fitzharris-mla-media-releases/2019/better-dental-care-for-school-students-hits-the-road

[49] Budja Budja Aboriginal Co-operative. (2021). *Mobile Clinic Van – Great Outcomes and Strong Support from Community and Deakin University*. Budja Budja Aboriginal Co-operative,. https://budjabudjacoop.org.au/new-mobile-clinical-health-van-april-2019/

[50] IDEAS Van. (2022). *About Us*. IDEAS Van,. https://www.ideasvan.org/about-us

Service	State	Organisation	Source of funding	Description
The Vision Van	WA	Lions Outback Vision	Australian Government Corporate and philanthropic partners WA DoH	A mobile eye clinic comprised of 3 consulting rooms with specialist equipment. Offers ophthalmology services for cataracts, trachoma, glaucoma, and diabetic retinopathy. Operates in numerous regional, rural and remote locations in Western Australia.[51]
Moorditj Djena – Strong Feet	WA	Moorditj Djena	WA Government	Provides podiatry assessments, treatment and education using a range of staff, including Aboriginal health workers, a diabetes educator and dietician in Perth.[52]
The Purple Truck	SA WA NT	Purple House	Medicines Australia Papunya Tula Artists Fresenius	A mobile dialysis unit operated in conjunction with 18 remote clinics. Organisation is owned by Aboriginal and Torres Strait Islander people. The mobile truck includes 2 dialysis chairs and travels to remote Aboriginal and Torres Strait Islander communities.[53]
Earbus	WA	Earbus Foundation	Australian Government Corporate partners	Offers ear screening, surveillance and treatment through a range of different staff, including GPs, audiologists and ENTs. Operates 4 buses throughout regional, rural with a focus on young Aboriginal and Torres Strait Islander people.[54]
Chevron Pilbara Ear Health Program	WA	Telethon Speech & Hearing	Chevron Australia	Visits schools that register to participate in the program. Offers free ear health checks and a hearing screening, assists children and their families arrange appointments for hearing tests and nurse practitioner consultations and appointments with ENT specialist across Dampier, Karratha, Onslow, Pannawonica Roebourne and Wickham.[55]

[51] Lions Outback Vision. (2017). *Vision Van*. https://www.outbackvision.com.au/vision-van/
[52] Government of WA. (2022). *Moorditj Djena – Strong Feet*. Government of WA,. https://emhs.health.wa.gov.au/Hospitals-and-Services/Aboriginal-Health/Moorditj-Djena
[53] Purple House. (n.d.). *The Purple Truck*. Purple House. https://www.purplehouse.org.au/communities/the-purple-truck
[54] Earbus Foundation of Western Australia. (n.d.). *Earbus Program*. Earbus Foundation of Western Australia,. https://www.earbus.org.au/earbus-program
[55] Chevron Australia. (2022). *building on a sound legacy with telethon speech and hearing*. Chevron Australia,. https://australia.chevron.com/news/2021/building-on-a-sound-legacy-with-tsh

Service	State	Organisation	Source of funding	Description
Mobile Dental Care	Tas	RFDS	Australian Government Royal Flying Doctor Service	Provides a free mobile care service through several dental staff travelling to rural and remote locations weekly. Includes a mobile van that provides a dental clinic to schools.[56]
Moreton Group Medical Services mobile clinic	Tas	Moreton Group Medical Services	Australian Government Primary Health Tas	Provides a mobile clinic setup similar to permanent GP clinics.[57]

[1]*Note: The Indigenous Diabetes Eye And Screening Van project was funded through underspend from the MOICDP instead of corporate sponsors in Victoria.*

[56] Royal Flying Doctor Service. (n.d.). *The RFDS in Tas*. Royal Flying Doctor Service,. https://www.flyingdoctor.org.au/tas/what-we-do/dental-care/#:~:text=The%20Royal%20Flying%20Doctor%20Service,associated%20with%20poor%20oral%20health.
[57] Moreton Group Solutions. (2018). *Doctors - Medical Services*. Moreton Group Solutions,. https://moretongroup.com/ms/

Stakeholder views

Stakeholders discussed the advantages and disadvantages of mobile services. Some clinics cited challenges finding local accommodation for visiting providers. Some host services also reported that their clinics have limited consulting room space and lack the necessary equipment required for visiting professionals to deliver outreach services within their communities. Mobile services can act as an effective means of transportation and are often equipped with the appropriate equipment so visiting providers can deliver services in rural and remote communities that may lack the necessary infrastructure otherwise. Mobile services may also have the potential to transport large teams of visiting providers which can facilitate multidisciplinary care and increase rural and remote access to a range of health services.

While mobile services offer various benefits, stakeholders cautioned this model of care may not be suitable for certain locations. For example, mobile services may not be as effective in widely dispersed areas with poor road conditions. Some stakeholders also questioned the cost-effectiveness of mobile services due to the potentially high implementation costs associated with building and fitting out mobile vans with expensive medical equipment.

Other sources of innovation

Stakeholders cited the potential to explore other innovative practices, such as performing simple procedures via telehealth with the assistance of local staff and conducting point-of-care testing using cameras and other technology.

When discussing innovative models of care, stakeholders mentioned various points for consideration. For example, one stakeholder noted that the success of certain innovations may vary by location (that is, mobile services) and generating long-term sustainable change often requires significant investment, and short-term innovation grants will likely not achieve these ends. In addition, it is important to establish systems that enable comprehensive performance monitoring and evaluation to adequately assess the cost-effectiveness of new and emerging models of care and their impact on access.

Evaluation findings

Beyond face-to-face service delivery, there are a myriad of service delivery models, stakeholders are exploring and implementing to build local capacity and facilitate patient access to care (that is, Tele-Derm). Certain alternative models may be more cost-effective and fit-for-purpose in certain areas. To compare existing approaches with alternative services models and better harness potential innovations, the Department should look to commission assessments of alternative service models that services are exploring in outreach to assess their value-for-money and potential in increasing access to underserved communities. For example, there may be opportunities to review the costs associated with HoA's service model.

Many innovative models of care may be facilitated by new and emerging technology and equipment; therefore, it is important to support and provide additional funding flexibility to allow services to continue to develop and expand their capacity to trial and implement innovative models of care in outreach to increase access to health services (refer to recommendation 34).

Box 23: Recommendations to enhance innovation in outreach

Program-specific

33. The Department to commission a review of the cost of providing HoA mobile services to assess value for money and consider the sustainability of the services in light of planned local and regional service developments and alternative outreach services. The evaluation should include consideration of both total capital and recurrent costs.

All programs

34. Commission assessments of alternative service models that services are exploring in outreach to assess their value-for-money and potential in increasing access to underserved communities.

3. How efficient and cost-effective are each of the outreach programs?

Efficiency of outreach programs

Stakeholder views

As indicated in previous sections, stakeholders consulted highlighted concerns with current arrangements that may be impacting the efficiency of the outreach programs.

Variation in program eligibility and administration arrangements

Variation in eligibility, operational arrangements and accountability persist across outreach programs. Stakeholders consistently expressed concern over the complexity of program arrangements for specifying eligible services, remunerating providers and gaining approval for revision of service plans. For example, in its biannual narrative reports, one fundholder highlighted the need for added flexibility around the use of workforce payments to supplement lost income for clinicians who were not supported by MBS. Another fundholder in its biannual narrative reporting wrote that a key challenge in delivering services was inflexibility around the use of funding that resulted in the decommissioning of services (for example, private drivers or chartered flights were no longer funded at the time of the report).

Limited performance feedback and opportunities for sharing and learning

Stakeholders are looking for a more direct and active role from the Department, both in terms of day-to-day advice, and performance feedback. In addition, national outreach activity and outcome data are not standardised. Data that are collected are not made routinely available to fundholders. Stakeholders suggested a role for the Department in facilitating knowledge sharing across fundholders and providers to improve operational efficiencies and program outcomes.

Limited opportunities to foster relationships and invest in communities

Host services consulted during the evaluation spoke of the need to for outreach providers to spend time in their communities to establish relationships and develop understanding of culture and activities. They also identified the need for local staff to be trained and upskilled while remaining in community.

In the survey and consultations, host providers reported that lack of basic infrastructure has impacted communities' ability to adequately support outreach service delivery. They pointed to the need for capital infrastructure to assist with accommodation, equipment and technology to assist with outreach services. For example, many stakeholders cited that inadequate stock of medical equipment, including medication, can result in inefficiencies in performing outreach. For example, the fundholder in South Australia reported inefficiencies with the EESS in 2021 due to the unavailability of appropriate equipment at the host site which meant the ophthalmologist could not perform the scheduled procedures during their visit. To address this, RDWA collaborated with visiting ophthalmologists on the selection and purchase of an ophthalmic laser and several lenses that can be used to perform procedures across several sites in South Australia. As a result, patient travel time for these procedures has been reduced and resulted in greater efficiencies for the EESS. Stakeholders in the Northern Territory also described equipment and medication shortages across the jurisdiction

Limited assessment of cost-effectiveness and exploration of alternative models to harness innovations.

Stakeholders noted various alternative service delivery models they are exploring in outreach. They indicated that these models have the potential to increase access to target populations and may be suitable for exploration in other areas across Australia. Stakeholders cited the following examples:

- COVID–19 has amplified the potential for telehealth and shared care arrangements to be a cost-effective supplement for face-to-face outreach services and help extend and deepen access to care for remote communities.

- Mobile clinics are spawning across a variety of service modalities, including HoA in northern Queensland and the North West Eye Hub Bus in Western Australia, both of which featured in our case studies. These clinics have the potential to be cost-effective in providing local access to specialist medical care, by spreading capital costs and creating efficiencies across multiple communities.
- Regional hub-and-spoke models like the North West Eye Hub in Broome and Central Australian Aboriginal Congress in Alice Springs reported working to build self-sufficient regional models where capacity and scale exists to attract and employ staff in the region to provide local needs and service needs of surrounding communities through outreach services.

Evaluation findings

Variation in program eligibility and administration arrangements

There is scope for greater efficiency through additional flexibility and harmonisation of outreach program rules. HPA did not assess the adequacy of the funding allocated for administration or the variations in administration structures and costs of the fundholders during this evaluation but did note several factors that may place upward pressure on administration costs:

- An assumption that administration costs are variable and increase proportionate to the level of outreach funding could be challenged, particularly where existing program administration infrastructure is in place for the fundholder. There may be opportunities to lever off existing infrastructure and explore block funding support for fundholders administering multiple programs in the future.

- Funding for outreach programs is not routinely consolidated within one fundholder and this requires a degree of duplication in administration infrastructure and processes and perhaps misses opportunities for economies of scale in the administration of outreach programs. For example, in some jurisdictions outreach programs are administered separately by multiple organisations including PHNs, LHNs, rural workforce agencies and other non-government organisations

While there is merit in keeping stability in the existing governance arrangements for the outreach services, it may come at a cost in additional administration burden to bring about joined up services and has the potential to duplicate administration infrastructure and processes. Longer term, the establishment of single regional body that coordinates service planning and access, including outreach services provided by state and territory and national government agencies, would offer up opportunities for further administrative efficiencies. Such a structure is currently being promoted through various current national strategies and plans.

Although recommendation 25 suggests raising the proportion of funding allocated to program administration, this should be reviewed in 3 to 5 years considering the implementation of recommendations that point towards improved efficiency.

Limited performance feedback and opportunities for sharing and learning

Reflections from fundholders reveal they would like more feedback from the Department and additional opportunities to share and learn from each other. As per recommendation 8, considerations should be made for the Department to more actively engage with the fundholders in providing feedback and increasing sharing and learning across programs and jurisdictions.

Due to the inconsistencies in data collection processes across programs and jurisdictions, it is challenging to effectively monitor and assess fundholder and program performance. A review

and recasting of national reporting by fundholders has the potential to reduce data burden and improve efficiency and effectiveness of the data for service improvements. Recommendations 1 and 9 aim to achieve this by enhancing performance monitoring and feedback across programs and jurisdictions.

Investment in communities

There are a range of investments in communities that come at a cost but may generate efficiencies in outreach services that could be assessed and explored further. These are as follows:

- Outreach providers could be encouraged to spend more time in communities by reducing the preponderance on MBS billing and direct patient care targets. Instead, there should be additional emphasis on allowing new outreach providers to spend non-billable time in the community to establish relationships, share information and build trust. This could be directly supported and facilitated by community leaders. The flow on benefits of this invest could be visible in greater demand for services and lower rates of 'did not attend' at outreach clinics.
- Spending time in the community could also allow more capacity building of local staff and formalise the role of outreach providers in education and training to meet identified needs of local health professionals and support staff. This training could be extended to the use of telehealth facilities. The flow-on benefits could be visible in strengthened capacity for shared care, where the care planning by outreach providers is implemented and monitored in partnership with more empowered local care staff and supported through telehealth capacity (refer to recommendation 22).
- It is challenging to fully generate efficiencies from spending time in the community without related investment in infrastructure. The Department could look to explore investment in infrastructure which might include the provision of accommodation to allow outreach providers to remain overnight and enjoy a barbeque with locals and provide training to staff, the provision of reliable digital infrastructure to allow telehealth and a suite of other digital tools to enable remote care processes and the availability of static and mobile equipment to allow outreach providers to provide care effectively (broader system observation 6).

  As discussed above, some host services reflected that visiting providers are only able to undertake one-day visits as there is limited to no local accommodation available. In the long term, it may be more efficient and cost-effective to invest in accommodation to enable outreach providers to undertake longer visits. The Department should look to commission a study on the long term recurrent costs of transport for one day visits versus the provision of capital infrastructure that provides accommodation and support for longer stays by outreach providers, particularly in smaller and very remote communities.

Innovations in provision

Stakeholders discussed a range of alternative service models that could be further assessed to harness and diffuse innovative models in outreach. While it is recognised that existing arrangements allow fundholders to roll over unspent funds that may result from efficiencies generated from service innovations and invest them back into service expansion there may be opportunities to further incentivise efficiencies in outreach. The Department could look to assess possible ways to further encourage fundholders to explore potentially cost-effective service innovations.

Box 24: Recommendations for outreach program efficiency

All programs

35. Review the funding provision for program administration in 3 to 5 years in light of the impact of implementing recommended efficiency measures, particularly where there are existing systems

and the fundholder administers multiple programs. Rather than a percentage, consider the feasibility of capping the amount of funding allocated for administration.

Box 25: Broader system observations for outreach program efficiency

7. The Department could commission a study on the long term recurrent costs of transport for one day visits versus the provision of capital infrastructure that provides accommodation and support for longer stays by outreach providers, particularly in smaller and very remote communities.
8. The Department may seek to investigate possible ways to further encourage fundholders to explore potentially cost-effective service innovations, recognising that existing arrangements allow fundholders to roll over unspent funds that may result from efficiencies generated from service innovations and invest them back into service expansion.

Cost-effectiveness of outreach programs

The Commonwealth government provided $89.1m in funding support for the 6 outreach programs in 2020–21, excluding any related MBS expenditure (see Table 26). This funding covers the costs of administering the programs, the costs of making outreach providers available to support and provide care in local communities and contribution to the costs borne by host providers.

Table 26: Program funding 2017-18 to 2020–21

Program	2017-18	2018-19	2019-20	2020-21
HEBHBL	$7,255,027	$7,350,000	$7,350,000	$7,350,000
MOICDP	$33,750,000	$32,710,000	$36,350,000	$36,967,950
RHOF	$27,404,300	$26,980,245	$27,363,586	$27,814,559
RHOF PM	$0	$0	$2,030,000	$2,062,000
VOS	$6,552,831	$6,916,379	$7,006,292	$8,709,241
EESS	$2,801,000	$2,000,000	$1,660,000	$2,244,000
Heart of Australia	$0	$0	$4,000,000	$4,000,000
Total	$77,763,158	$75,956,624	$85,759,877	$89,147,750

Source: Unpublished data provided by the Department of Health.

Access to nationally reconciled activity and expenditure data was not available from the Department at the time of commencing the evaluation. Consequently, data and information to try and create a national picture was requested from the fund holders.

The activity and funding data subsequently received by the evaluation team was limited in terms of coverage, completeness and quality, generating the following key implications:

- Data presented in this report are based on a sample of national data, requiring estimation of parameters to compensate for data gaps and create national estimates of national activity and unit costs.
- Reconciliation between total program funding, fundholder expenditure data collected during the evaluation and income and expenditure data provided in the audited financial returns is incomplete.
- Inability to undertake full analyses of all programs at national and subnational levels, due to insufficient data coverage and quality, particularly for HoA, EESS and RHOF Pain Management program data.

- Exclusion of Tasmania from sub-national data modelling and analysis due to insufficient data.

Table 27 presents data on program income (funding by the Department) and expenditure reported in the annual audited financial statements for the HEBHBL, MOICDP, RHOF and VOS, noting that program over/under spending occurs each year. Although a full reconciliation was not achieved, the income data in Table 27 is broadly consistent with the funding data presented in Table 26.

Within the overall program expenditures, the amount spent on service delivery was identified and compared with the estimated service delivery expenditure generated from the fund holder data received during the evaluation. Differences between these two data sets are noted across programs and years, ranging from over 20% for HEBHBL to less than 5% for RHOF.

The estimated service delivery expenditure and activity data generated from the fund holder data returns allowed HPA to consider national estimates of unit costs and other variables and these are presented in this report.

Table 27: Comparison of income and expenditure in audited statements and estimated expenditure based on data requested from fund holders,2017-18 to 2020-21

Program	Name	Source	2017-18	2018-19	2019-20	2020-21
HEBHBL	Income	Audited statement	7,647	7,417	7,877	8,214
	Expenditure	Audited statement	7,156	7,063	6,293	6,809
	Program administration	Audited statement	957	1,070	1,007	881
	Service delivery	Audited statement	6,184	6,818	5,191	5,908
	Service delivery estimated	Activity reports estimated	5,281	4,984	4,216	4,605
	Percent differences	Calculated	14.6%	26.9%	18.8%	22.1%
MOICDP	Income	Audited statement	33,686	34,972	37,347	38,415
	Expenditure	Audited statement	30,890	32,623	33,126	35,978
	Program administration	Audited statement	4,614	4,906	5,251	5,474
	Service delivery	Audited statement	26,049	27,253	27,577	29,212
	Service delivery estimated	Activity reports estimated	24,236	24,592	25,433	27,324
	Percent differences	Calculated	7.0%	9.8%	7.8%	6.5%
RHOF	Income	Audited statement	27,007	26,374	26,622	27,641
	Expenditure	Audited statement	26,450	25,876	24,109	25,285
	Program administration	Audited statement	3,666	3,687	3,581	3,923
	Service delivery	Audited statement	22,735	21,987	20,414	23,941
	Service delivery estimated	Activity reports estimated	22,645	20,782	20,116	24,152
	Percent differences	Calculated	0.4%	5.5%	1.5%	-0.9%
VOS	Income	Audited statement	6,618	6,810	6,958	8,982
	Expenditure	Audited statement	6,301	6,339	5,956	7,330
	Program administration	Audited statement	781	952	956	1,191
	Service delivery	Audited statement	5,530	5,386	4,622	5,719
	Service delivery estimated	Activity reports estimated	5,124	5,126	4,344	5,239
	Percent differences	Calculated	7.3%	4.8%	6.0%	8.4%

Source: Unpublished outreach program data and audited financial statements

It is estimated that the mean service delivery expenditure provided under the MOICDP, HEBHBL, VOS and RHOF over the four years from 2017-18 to 2020-21 was $57.1m and this supported an estimated 56,000 visits by outreach providers to local communities across rural and remote areas of Australia, and an estimated 536,000 occasions of service to local patients.

Average cost of care

The average expenditure per visit across the MOICDP, HEBHBL, VOS and RHOF over the four years from 2017-18 to 2020-21 is estimated at $1,013 and the average expenditure per OOS is estimated at $106. Noting this expenditure is in addition to any MBS billing that may have occurred in relation to these services.

Analysis of the average unit costs over the four years from 2017-18 to 2020-21 reveals variations across the:

- programs,
- jurisdictions and
- geographical areas, as measured by MM categories.

Table 28 presents the estimated cost per occasion of service across programs, jurisdictions and MM category. It is noted that the data indicates that while there are inconsistent variations across programs and jurisdictions, generally the unit costs are higher for services provided to MM category 7 than to other geographical areas.

Table 28: Mean cost per patients/OOS by program, jurisdiction and MM category for 2017-18 to 2020-21

Program	State	Cost per patient/OOS mean $ (Mean of 4 years)				
		MMM 1 & 2	MMM 3 & 4	MMM 5	MMM 6	MMM 7
HEBHBL	NSW	102	125	99	76	255
	Vic	156	87	90		
	Qld	76	88	63	98	136
	WA	117	168	200	89	109
	SA		203	364	311	210
	NT	162		255	56	351
	Total	83	113	109	95	134
MOICDP	NSW	78	81	66	110	92
	Vic	210	203	223		
	Qld	70	82	77	100	105
	WA	135	123	198	176	251
	SA		241	211	170	226
	NT	233		251	190	361
	Total	84	92	83	131	160
RHOF	NSW	55	76	79	111	132
	Vic	63	65	68	219	
	Qld	138	93	83	97	123
	WA	516	89	131	124	195
	SA		58	131	162	167
	NT	285		155	118	198
	Total	167	76	89	113	156
RHOF-PM	NSW		326	980		
	Qld	272	72	167	55	
	WA		333		244	121
	SA			133		433
	Total	272	142	182	175	131
VOS	NSW	60	105	71	94	116
	Vic	118	217	145	134	
	Qld	39	88	67	54	166
	WA	204		144	126	142
	SA		151	161	230	137
	NT	104		113	103	117
	Total	63	138	99	86	140

Source: Unpublished outreach program data provided by fundholders.

The average cost per occasion of service may be impacted upon by a number of factors, including changes in input costs, the nature of the services provided within each program and the location of the services. Further analysis of unit costs, after taking account of such variables can provide insights into other key cost drivers of outreach services and may provide opportunities for improved productivity and efficiency in program administration.

For example, variations in the cost of an outreach visit can reflect variations in the costs of the logistics to enable providers to be available in the community to provide outreach services, including flight costs and administration overhead. Whereas the cost per occasion of service can reflect additional factors including volume of direct patient care during a visit, local service capacity and the model of service delivery.

Preliminary analysis of the available data by HPA indicates that the scale of services (as measured by OOS) provided during a visit maybe a statistically significant cost factor. HPA observed that the more patients seen during a visit, the lower the overall visit costs. This may

reflect the impact of spreading fixed and semi fixed costs of visits (for example, administration and travel costs).

It is noted that the unit costs account for the costs of direct patient care, but do not consider costs to government through generation of MBS billing or the provision by outreach providers of education and training of local staff or the building of community relations and cultural understanding during their visits to rural and remote communities. Further insights may be possible through more effective recording and monitoring of these activities and their costs in the future.

Dispersion of costs of care

Consideration of the average costs can provide insights into variations in unit costs across programs, jurisdictions and geographical areas. However, an understanding of the dispersion of unit costs can enable additional insights.

Preliminary analyses were undertaken to explore the dispersion of the cost per occasion of service by program, jurisdiction and MM category, including identification of the:

- Maximum and minimum (excluding outliers)
- 1st and 3rd quartile (interquartile range)
- Mean and median

Some fundholders reported working to better assess and monitor unit costs of outreach service delivery. As cited in the Performance feedback and sharing and learning section, one fundholder has implemented routinely monitors unit costs across its regional and local services to improve sharing and learning, identify opportunities for improvement and help drive operational efficiency.

Table 29 and Figure 28 present the dispersion of program costs by jurisdiction while Table 30 and Figure 29 considers the dispersion of program costs by MM category. Together these illustrate that:

1. Variability exists in both the unit costs and the dispersion of unit costs by program and jurisdiction, with indications that the dispersion of unit costs in larger states (Queensland, New South Wales and Victoria) is narrower than that for smaller states and territories (Western Australia, South Australia and the Northern Territory).

2. Variability exists in both the unit costs and the dispersion of unit costs by program and geographical locations, with markedly wider dispersion of unit costs in more evident in remote areas, including MMM 7.

The underlying cost drivers for variations in unit costs is multifactorial and the data presented here provides some insights into possible factors for further analysis.

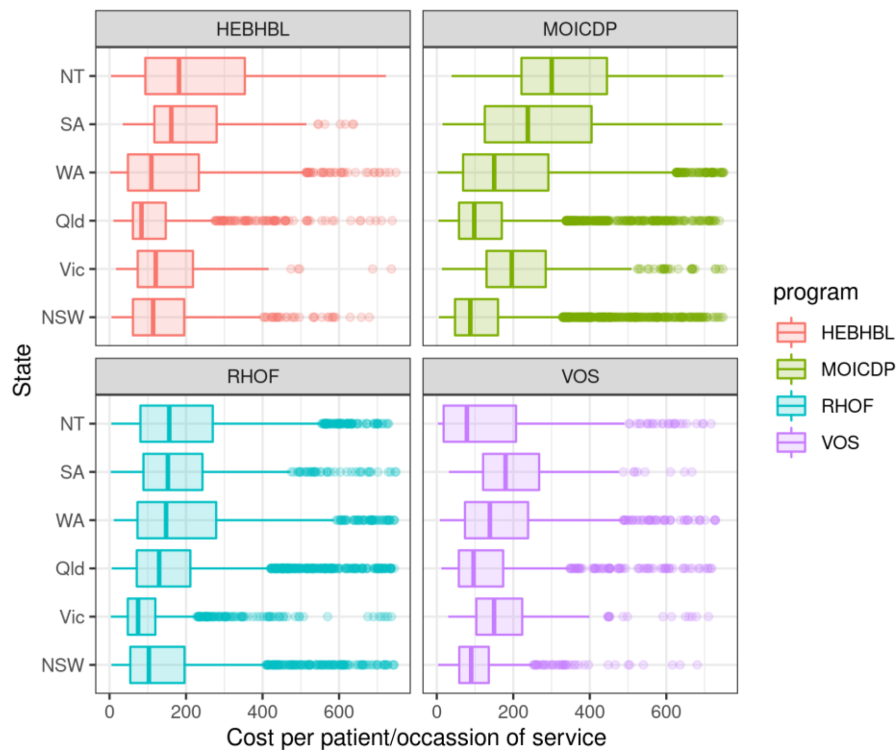
Some fundholders reported working to better assess and monitor unit costs of outreach service delivery. As cited in the Performance feedback and sharing and learning section, one fundholder has implemented routinely monitors unit costs across its regional and local services to improve sharing and learning, identify opportunities for improvement and help drive operational efficiency.

Table 29: Dispersion of cost per OOS by program and jurisdiction, 2017-18 to 2020-21

Program	Jurisdiction	OOS	Mean $	Min	Q1 $	Median $	Q3 $	Max
HEBHBL	NSW	38,208	107	5	48	84	137	270
	Vic	6,896	98	17	59	64	115	199
	Qld	68,276	87	10	51	71	104	184
	WA	49,183	107	1	23	65	126	280
	SA	7,354	153	35	76	124	196	376
	NT	4,384	272	4	94	182	276	549
	Total	174,691	105	1	45	74	123	240
MOICDP	NSW	502,903	73	6	28	48	88	178
	Vic	19,661	207	13	111	173	268	504
	Qld	305,358	86	4	40	66	103	198
	WA	60,206	216	2	53	104	241	523
	SA	29,160	200	15	85	130	255	510
	NT	49,579	283	39	159	230	340	612
	Total	966,910	103	2	35	64	118	242
RHOF	NSW	213,287	79	5	29	52	85	169
	Vic	134,684	67	3	37	56	79	142
	Qld	240,408	107	6	41	83	143	296
	WA	103,572	145	11	48	84	172	358
	SA	59,509	143	3	62	103	178	352
	NT	69,358	176	5	67	127	220	450
	Total	820,818	107	3	40	71	130	265
VOS	NSW	39,724	81	3	42	69	108	207
	Vic	8,386	161	30	102	134	183	304
	Qld	57,814	87	12	36	59	99	194
	WA	28,909	139	8	55	114	175	355
	SA	16,939	151	32	82	121	192	357
	NT	31,036	113	3	14	89	181	432
	Total	182,808	108	3	42	82	140	287

Source: Unpublished outreach program data provided by fundholders.

Figure 28: Dispersion of cost per OOS by program and jurisdiction, 2017-18 to 2020-21



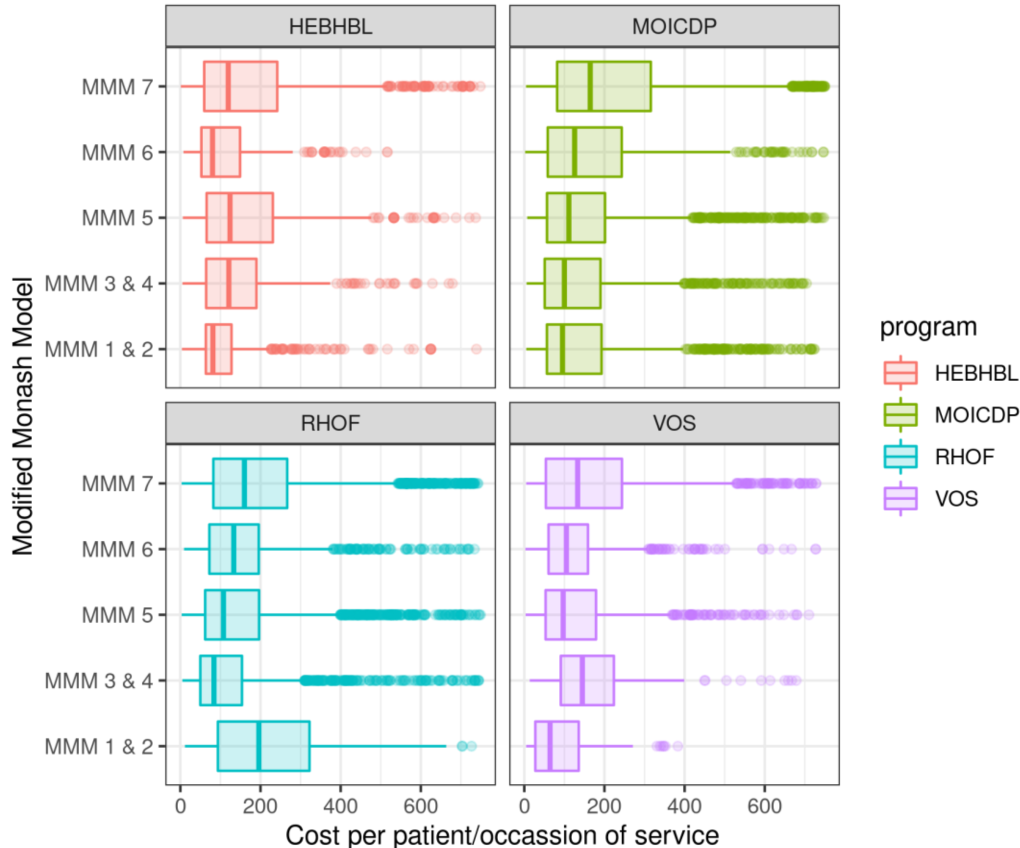
Source: Unpublished outreach program data provided by fundholder.

Table 30: Dispersion of cost per OOS by program and MM category, 2017-18 to 2020-21

Program	MMM	OOS	Mean $	Min	Q1 $	Median $	Q3 $	Max
HEBHBL	MMM 1 & 2	42,829	83	4	58	72	90	138
	MMM 3 & 4	21,330	107	5	56	74	147	284
	MMM 5	35,590	105	6	39	69	129	264
	MMM 6	19,326	92	8	40	70	120	240
	MMM 7	55,226	126	1	33	80	146	316
	Total	174,691	105	1	45	74	123	240
MOICDP	MMM 1 & 2	206,555	83	5	35	56	91	175
	MMM 3 & 4	160,599	91	6	29	63	115	244
	MMM 5	325,645	83	7	30	51	101	208
	MMM 6	49,980	131	2	41	90	150	314
	MMM 7	224,088	155	4	56	92	170	341
	Total	966,910	103	2	35	64	118	242
RHOF	MMM 1 & 2	26,746	150	11	61	88	209	431
	MMM 3 & 4	229,723	76	5	34	58	84	159
	MMM 5	266,431	90	3	37	62	106	210
	MMM 6	99,663	113	9	45	87	155	320
	MMM 7	198,255	155	3	58	107	185	376
	Total	820,818	107	3	40	71	130	265
VOS	MMM 1 & 2	26,710	63	5	23	34	87	183
	MMM 3 & 4	8,286	137	14	66	115	164	311
	MMM 5	51,457	99	3	47	71	126	244
	MMM 6	30,243	86	3	41	65	112	218
	MMM 7	66,112	139	5	67	112	175	337
	Total	182,808	108	3	42	82	140	287

Source: Unpublished outreach program data provided by fundholders.

Figure 29: Dispersion of cost per OOS by program and MM Category, 2017-18 to 2020-21



Source: Unpublished outreach program data provided by fundholders

Key cost drivers

As mentioned earlier in this report, access to nationally reconciled activity and expenditure data was not available to the evaluation team and this limited the ability to undertake related analysis of the key cost drivers for the outreach programs. This section of the report relies on information contained in the audited financial statements provided by the fundholders and stakeholder perspectives provided throughout consultations during the evaluation.

Administrative costs

Administrative reporting was described by stakeholders as a key cost driver. As discussed in previous sections, a maximum of 15% of funding available for each program is able to be allocated specifically for administration of the program [10,13]

Table 31 demonstrates that fundholders consistently report expenditure on administration that aligns with the maximum provision of 15% specified in the service deliver standards.

Stakeholders reported it is costly and time consuming for fundholders, visiting providers and host services to undertake administration of the programs due to the complexity of the programs, the burdens of compliance and the reporting processes. This they assert creates an opportunity cost, which impacts on access to outreach services.

Table 31: Total expenditure and expenditure breakdown by program for 2017-18 to 2020-21

Program	Line item	2017-18 $'000	2018-19 $'000	2019-20 $'000	2020-21 $'000	Mean %
HEBHBL	Total Expenditure	7,180	7,086	6,322	6,833	100%
	Program administration	**957**	**1,070**	**1,007**	**881**	**14%**
	Service delivery	6,208	6,841	5,219	5,932	88%
	Other	15	24	95	20	1%
MOICDP	Total Expenditure	31,841	33,618	34,189	37,158	100%
	Program administration	**4,643**	**4,936**	**5,352**	**5,595**	**15%**
	Service delivery	26,970	28,218	28,540	30,272	83%
	Other	27	189	98	191	0%
RHOF	Total Expenditure	28,232	27,637	25,846	26,637	100%
	Program administration	**3,955**	**3,969**	**3,865**	**4,040**	**15%**
	Service delivery	24,215	23,444	21,843	25,175	87%
	Other	52	224	139	182	1%
VOS	Total Expenditure	6,602	6,647	6,235	7,617	100%
	Program administration	**828**	**993**	**1,002**	**1,232**	**15%**
	Service delivery	5,784	5,654	4,854	5,965	82%
	Other	2	0	0	0	0%

Source: Unpublished audited financial statements.

Service delivery costs

Fundholders reported that travel and securing the services of private providers are key operational cost drivers in outreach. Jurisdictions, such as the Northern Territory where distances are much greater between communities, reported higher travel costs. For example, according to the 2019–20 first biannual narrative report for NT Health, travel costs consumed nearly one third of its budget allocation. This continued into 2020–21 where the fundholder exceeded its biannual travel budget by $38,000. Other jurisdictions, such as Tasmania, also reported high travel costs in cases where a site is only accessible via helicopter or private charter plane. Fundholders also reported higher travel costs since COVID-19 due to cancellations of commercial services.

Following the onset of COVID-19, stakeholders reported that travel costs have increased significantly for visiting providers. Limited travel routes and frequent cancellations have added significantly to these difficulties. This is particularly apparent for travel to very remote communities. Chartered flights are used to overcome the difficulties in travel routes and

cancellations, however at a considerable cost. Fundholders report that they are scheduling longer trips and visiting multiple communities to get the most out of travel expenses.

As noted in previous sections, stakeholders reported exploring a range of alternative service models. These models included telehealth and shared care arrangements to supplement face-to-face care; mobile services that provide economic access to expensive technologies, point-of-care testing that allow diagnosis and monitoring in the field and regional models where outreach services can be more responsive and integrated into regional workforce models.

Evaluation findings

In comparing outreach services with the costs of establishing local primary care capacity, the relative costs of various workforce models are required. The Department should look to establish unit costing methods using the routine national outreach data collection to facilitate sharing and learning across fundholders and service provider organisations and allow greater understanding of the key cost drivers facing fundholders for particular services, regions and communities.

Within the domain of outreach services, stakeholders noted the broad range of alternative service delivery models they are exploring to establish more effective and efficient ways of providing care. It was not within the scope of this evaluation to undertake a full economic assessment of various approaches to outreach services and their cost-effectiveness with alternative ways to provide access to services for rural and remote patients. However, from the data available to HPA, it is noted that the average expenditure per occasion of service supported under these four programs is estimated to have been $106, with the unit costs varying across the programs, jurisdictions and geographical areas of remoteness (as measured by MM categories).

The literature on the relative costs of face-to-face to telehealth outreach is equivocal, with some studies not considering the full costs and benefits of the options to all parties, including patients, providers and funders. Each of these innovations are worthy of closer evaluation – not only in the locations in which they currently exist, but in the potential for diffusion across other locations and contexts, recognising they may not be universally applicable (refer to recommendation 34).

Box 26: Recommendations for cost-effectiveness

All programs

36. The Department to establish unit costing methods using the routine national outreach data collection to facilitate sharing and learning across fundholders and service provider organisations and allow greater understanding of the key cost drivers facing fundholders for particular services, regions and communities.

4. To what extent are the outreach activities coordinated across the outreach programs?

Program administration across programs

There are many recommendations posed that have multi-faceted aims which include fostering improved administration across programs for fundholders, host and service providers and ensuring more effective monitoring of overarching health priorities. This section seeks to bring together these recommendations and highlight further opportunities for more efficient and seamless integration of the outreach programs to enable pathways of care rather than create silos.

As per the standard grant agreements, the fundholders are required to collect and collate data on the outreach programs. In addition to program needs assessments, the fundholders are subject to provide a range of other deliverables to their jurisdictional funding arrangement managers. The fundholders must submit the following:

- Performance reports and financial acquittal reports biannually.
- Activity work plans annually.
- Annual reports and final reports to be submitted at predetermined intervals as specified in the program standard grant agreements. The final report should include a summative evaluation of the performance of the specific program, including benefits and outcomes of the activity. The deliverable should also include a description of challenges, mitigation strategies and lessons learned.

For more information on the fundholder documents, refer to the Fundholder documents section and Appendix 1E: Fundholder documents provided.

Stakeholder views

The Department has worked to streamline outreach reporting requirements in recent years by transitioning from requiring the fundholders to submit performance and financial acquittal reports quarterly to 6-monthly reporting. This change was welcomed by many stakeholders, but fundholders reported that administration across programs still requires significant time and resources.

The activity work plans now encompasses all the outreach programs in a single document (with the exception of the EESS). While the Funding Arrangement Managers feel certain details may be lost in the reporting templates, they see the benefits of this approach due to the emphasis on providing multidisciplinary team care across programs. Despite this consolidated approach, there were questions about how the outreach programs work together synergistically in practice. One funding arrangement manager described the outreach reports as 'repetitive' due to the linkages across programs and reviews them together to observe consistency.

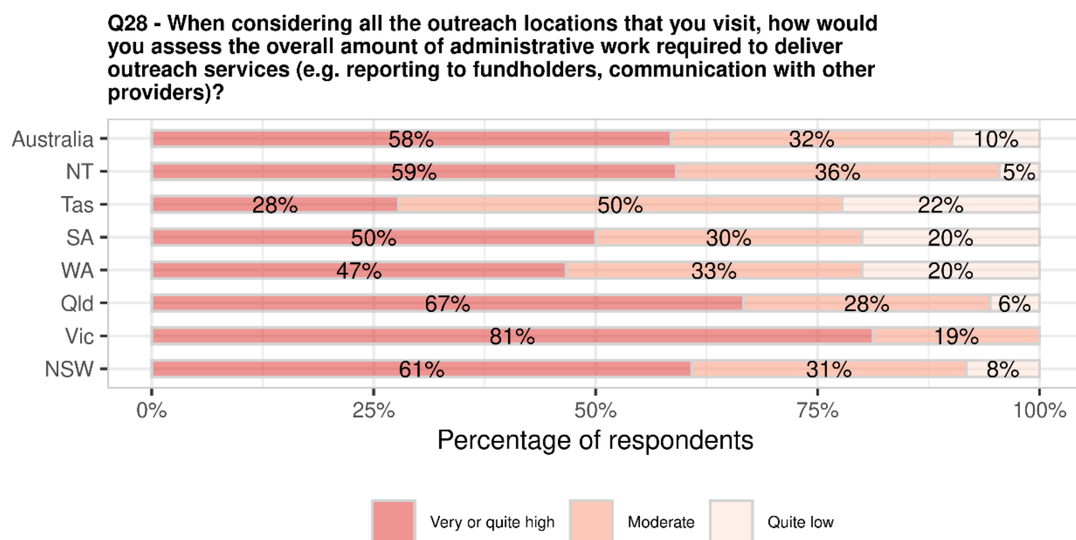
Reporting requirements for host services are determined by the fundholders and vary by jurisdiction, but feed into fundholder reporting to the Funding Arrangement Managers and, ultimately, the Department. While host services respect the need for administrative reporting to promote accountability and facilitate comprehensive data collection and performance monitoring processes, they hope to reduce administrative burden where possible and ensure it does not take away from service delivery.

One AMS described the current processes for accountability in the outreach programs as 'microscopic' with their service required to account for every moment of a visiting provider's time which includes counting the number of patients seen, hours of travel, meals, accommodation etc. This contrasts with the view of one fund holder that described the

requirement for providers to report their activity as more straightforward, indicating their online report takes providers about 5 minutes to complete and host services are not required to report activity, unless sub-contracted by them to provide outreach services.

Figure 30 highlights how outreach providers who responded to the survey viewed the level of administrative work required to deliver outreach services.

Figure 30: Visiting providers' thoughts on the level of administrative work required to deliver outreach



Source: Outreach provider survey, question 28.

Only 10% of survey respondents across Australia assessed the level of administration work required as 'low', with most respondents rating it as 'very or quite high.' These results indicate there is more effort required to deliver outreach services beyond actual service delivery and providers may be feeling the strain of the administrative work associated with delivering outreach.

As outreach provider administration appears to largely revolve around patient care and is tied to service integration and continuity of care, a more robust discussion about how to streamline administrative processes for outreach providers is included in the upcoming section.

Evaluation findings

As noted in the Fundholder routine administrative data and Performance monitoring and feedback sections, great variation was observed in the fundholder reporting across jurisdictions. This has created inconsistencies in data collection processes, which may negatively impact on the administration of the outreach programs. For example, the financial documents were reconciled against the aggregate costs and expenses listed in the fundholder activity reports. The analysis showed significant and widespread variation between the activity reports and financial documents. In some instances, the broader categories of program expenditure outlined in the financial reports (that is, program administration, service administration, other) also made it challenging to analyse how fundholders were spending program funding.

The establishment of a minimum data set with data elements specified as metadata will assist with inter-program administration and performance monitoring while supporting additional funding flexibility (recommendation 8).

Given the linkages across programs, the Department should allow fundholders to submit a single needs assessment and annual activity work plan that covers all the outreach programs. To further streamline reporting and reduce administrative burden, it may be permissible to allow fundholders to highlight key issues of specific programs in the performance reports that require attention. For example, fundholders could provide an overall performance report incorporating all programs to ensure they are meeting their service targets and go into more detail about any key issues or challenges through exception reporting (that is, issues report).

Reflections from host services consulted as part of the evaluation indicate there are further opportunities to streamline administrative reporting requirements across programs. Select host providers across jurisdictions have been collecting patient experiences and, in some instances, patient outcomes. Their approaches are varied and can be both resource and labour intensive. In line with recommendation 9, the establishment and collection of key consumer-facing indictors with data elements specified in the AIHW metadata store will allow for nationally consistent data collection of patient experiences across jurisdictions and programs. These indicators will provide fundholders and host services with guidance on what data to collect and ensure reporting across programs is not solely focussed on measures related to service activity. In regard to Aboriginal and Torres Strait Islander populations, implementing culturally safe PREMs and supporting NACCHO to gather the experiences of First Nation Australians and ACCHO host services will ensure this vital task is undertaken by an independent, representative body that can capture this data in robust and culturally appropriate ways. This action will remove the onus on individual fundholders and host services to assume the role of managing and collecting patient experiences (recommendation 30).

Box 27: Recommendations to improve administration across programs

All programs

37. Allow fundholders to provide a consolidated:

- needs assessment
- annual service plan
- narrative report.

These documents would cover all the outreach programs. The single narrative report should include an explanation of factors contributing to any significant activity and/or budget variances within specific programs and identify planned mitigation strategies to bring the programs back on track.

Service integration and continuity of care

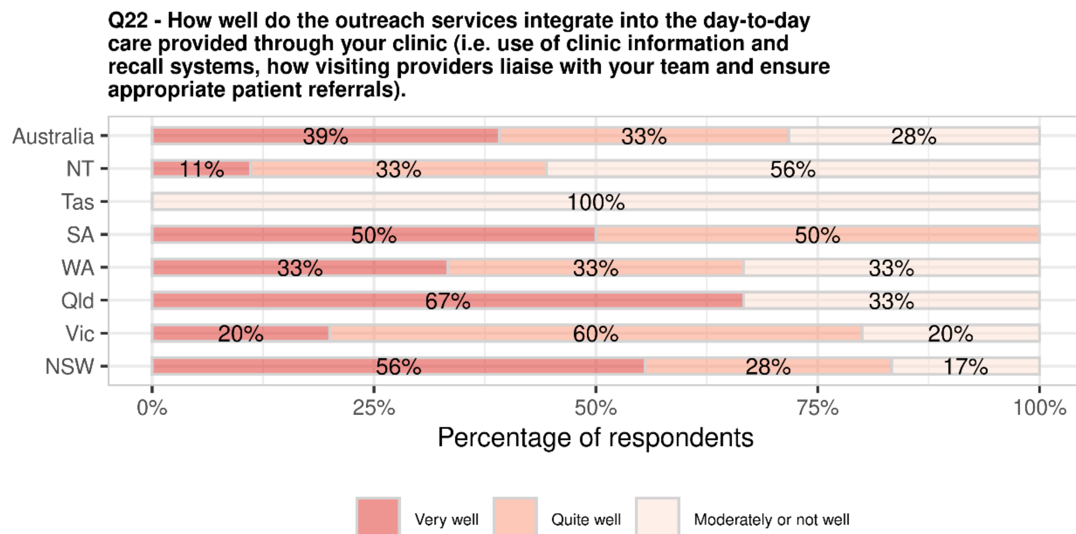
Since the outreach programs are designed to fill gaps in local service provision, there must be strong integration with existing local health services to support ongoing patient management and promote continuity of care. This section assesses how outreach services integrate with local service provision and potential opportunities for further integration of visiting services to enhance continuity of care.

Stakeholder views

Stakeholders consulted stressed the need to foster strong continuity of care in outreach. This includes ensuring patients have a resident provider who actually ‘owns the patient’ and is responsible for associated documentation, monitoring and engagement with referrers. They reported on key factors they feel enhance service integration which most frequently included strong communication and collaboration with local providers and established referral pathways.

Figure 31 outlines host provider survey respondents’ views on how well they feel outreach services integrate into the day-to-day care provided through their clinics.

Figure 31: Host provider views on how well outreach services integrate into day-to-day care



Source: Host provider survey, question 22.

Most survey respondents indicated that outreach services integrate 'very well' or 'quite well.' When asked to cite potential areas for improvement, host providers most frequently identified the following as factors that would improve the integration of outreach services into the day-to-day care of their clinics:

- An integrated software system for all visiting providers and/or increased use of clinic software.
- Better follow up and referral processes (that is, correct use of recall systems, comprehensive documentation, generating patient reports).
- Access to additional staff to facilitate administration and patient follow up.

Visiting providers echoed these sentiments. When asked to rate the overall quality of communication on clinical matters with patients' local GP/health service, outreach providers who responded to the survey largely reported strong communication with local providers before, during and after their visits, with 86% of respondents rating their communication as very to moderately strong (28% very strong; 34% quite strong; 24% moderately strong). Visiting providers most frequently reported communicating with local service/GP via letter or some form of written correspondence, such as a detailed report. Others stated that they communicate face-to-face or through host services' clinical software, phone or email. In line with the quality of communication between visiting and local providers, outreach providers largely rated the overall effectiveness of existing referral pathways as quite effective (38%) or moderately effective (20%).

Outreach providers commented on the myriad of clinical systems, and communication channels that exist between visiting and host services. They identified the need for centralised, integrated clinical systems that would allow them to access comprehensive patient medical records to improve documentation and referral processes. One visiting provider consulted recounted instances where they were unable to access patient records after their outreach visits, which hindered continuity of care. Visiting providers supported enabling digital record keeping to streamline administration and allow visiting and local providers to better share and monitor patient notes, referrals and outcomes.

It is acknowledged that while these issues are relevant to outreach programs, they are indicative of broader system issues and not unique to outreach. One fund holder observed that while outreach services can shed light on these issues and may be able to provide a catalyst

for integration and collaboration in local areas, they are not necessarily able to be fully addressed through these programs.

The establishment of referral pathways in outreach was cited as a key challenge in the surveys, stakeholder consultations and fundholder performance reports. In the survey, one national workforce body cited complex referral pathways as one of the top 3 barriers they feel limits the participation and effectiveness of the outreach programs. As reported in previous sections, there is currently no service directory that outlines existing outreach and local service provision across jurisdictions. The fundholder in Victoria described undertaking work in this area and has developed a service directory for their jurisdiction, but local services are not able to be included in the service directory. Many of the local services across regions are state-run health services and which inhibits the use and effectiveness of this directory.

All state and territory governments and the Department of Veterans Affairs have patient transport schemes that assist with travel and accommodation of rural and remote patients and their carers to access health care away from their communities. The services may be in a capital city or regional service centre. In some instances, patients may travel to access outreach services provided through a regional hub. For example, arrangements under the EESS can involve surgical teams from capital cities providing outreach at a regional base hospital to patients who have travelled from communities in the region. This creates a hybrid model whereby an outreach model integrated within a patient transport scheme. Host providers who responded to the survey largely reported limited to no interaction with patient assisted travel schemes provided within the community and that it is largely up to the clinic or patients to arrange transport. In some instances, they did indicate that clinics seek transport support from other community organisations, refer clients or patients are required to apply for transport support.

Evaluation findings

Given the importance of promoting continuity of care in outreach, consideration should be made to allocate funding to support telehealth consults with local staff between outreach visits. This would facilitate ongoing patient management by enabling visiting health providers to check in on local staff, ensure they are coping with patient management plans; offer advice and support and adjust patient care plans accordingly (refer to recommendation 32).

My Health Record is a tool that can act as a secure portal for host services and visiting providers to document and share information and serve a vehicle for enhanced communication. Requiring outreach providers to upload an event summary into My Health Record for every patient attendance and establishing arrangement for patients without records could help improve communication between visiting and local services at the primary, secondary and tertiary levels. It can also enable visiting providers to continue to have access to patient records following outreach visits which could further enhance continuity of care and patient follow up.

There appear to be further opportunities to integrate individual outreach programs, such as the EESS, into patient assisted travel schemes and align them with other jurisdictional programs, such as elective surgery waiting list programs. To facilitate access to eye and ear surgery for Aboriginal and Torres Strait Islander people under the EESS, there may be opportunities to harness and foster existing arrangements with public and private hospitals under associated initiatives. HPA suggests service and governance arrangements of the EESS be reviewed in 2 to 3 years, as there may be an opportunity to strengthen the integration of eye and ear outreach services with this program in the future.

Box 28: Recommendations to promote service integration and continuity of care

Program-specific:

38. The Department to work with state and territory departments to explore alternative arrangements for the Ear and Eye Surgical Support Services program that may better support access to elective

ear and eye surgery for Indigenous Australians in public and private hospitals, including options that build on existing national and regional systems and processes.

All programs:

39. To enhance communication across providers and patient access to care records, require outreach providers to upload an event summary onto My Health Record for every patient attendance at an outreach clinic, giving due consideration to arrangements for patients without My Health Record accounts.

7

Areas for improvement

This chapter groups the recommendations arising from the evaluation into key areas for improvement and stratifies them into initial and future-thinking actions.

The recommendations set forth below are actions that seek to alleviate reported and observed challenges within and across programs. The aim of the suggested actions is to reduce reported barriers and enhance the effectiveness and efficiency of the outreach programs in meeting their outlined policy objectives.

Building on a strong foundation

The evaluation focussed on identifying opportunities for improvement in the outreach programs.

It is important to acknowledge the existing value of the outreach programs to the many Australians living in rural and remote communities and the strong foundation they provide for improving access to health care for these communities. Along with government investment in building local workforce and service capacity and providing support for patient transport that facilitate regional service access, outreach provides an essential way of enabling patients to access services without travelling far from their local community.

The Commonwealth government provided $89.1m in funding support for the 6 outreach programs in 2020–21, excluding any related MBS expenditure (see Table 32).

Table 32*:* Program funding and activity 2017-18 to 2020–21

Program	2017-18	2018-19	2019-20	2020-21
MOICDP	$33,750,000	$32,710,000	$36,350,000	$36,967,950
Healthy Ears	$7,255,027	$7,350,000	$7,350,000	$7,350,000
VOS	$6,552,831	$6,916,379	$7,006,292	$8,709,241
RHOF	$27,404,300	$26,980,245	$27,363,586	$27,814,559
RHOF PM	$0	$0	$2,030,000	$2,062,000
EESS	$2,801,000	$2,000,000	$1,660,000	$2,244,000
Heart of Australia	$0	$0	$4,000,000	$4,000,000
Total	$77,763,158	$75,956,624	$85,759,877	$89,147,750

Source: Unpublished data provided by the Department of Health.

It is estimated that the mean service delivery expenditure provided under the MOICDP, HEBHBL, VOS and RHOF over the four years from 2017-18 to 2020-21 was $57.1m and this supported an estimated 56,000 visits by outreach providers to local communities across rural and remote areas of Australia, and an estimated 536,000 occasions of service to local patients.

Together, it is estimated that these four outreach programs contribute over 25% of allied health (27.3%) and medical speciality services (28.7%) and over 15% of nursing and Aboriginal health worker services (15.4%) across small remote community in Australia that are

categorised as MM 7. Just less than 2% of GP services (1.8%) are provided by outreach in these communities.

Figure 32 presents the underlying population service utilisation rate for each workforce grouping and MM category for the period 20217-18 to 2020-21. The figure demonstrates the extent to which outreach programs have contributed to improving the relative access to health care in rural and remote communities, particularly for allied health and medical specialist services. For example, we estimate the programs have reduced the difference in services access between MMM 1-2 and MMM 7 by 16.4% for allied health and 13.1% for medical specialists over the four years 2017-18 and 2020-21.

Figure 32: Estimated impact of outreach programs on underlying relative service utilisation in each Modified Monash category by workforce grouping, 2017-18 to 2020-21.

Source: Unpublished outreach program data and MBS data publicly available through the AIHW. Note outreach program data reflects the assumption that 50% of outreach activity is MBS billed.

This provides evidence that the objectives of the programs, in improving population access and reducing the gap between geographical regions and population groups, are being met.

Priorities for strengthening outreach

This evaluation aimed to place a subset of national programs within the context of health outreach programs more generally and the overall policy landscape for improving access to care in rural and remote communities. Although outreach will undoubtably remain an enduring

and necessary part of the fabric of the Australian healthcare system, the hope is that longer term policies and strategies will reduce the reliance on outreach services.

To achieve this, we believe there is a need for greater integration of outreach into overall rural health service policies and strategy. This better ensures outreach services meet gaps in services rather than perpetuate them, with the risk that in some instances funding for outreach services substitutes support for locally viable and potentially sustainable workforce solutions.

Many of the recommendations made in this report are more of a general nature, rather than specific to each of the programs. In undertaking the evaluation, we noted that most stakeholders, including fundholders, referred to outreach programs more generally rather than to individual programs. The issues they raised and the experiences they reflected tended to be more common across programs, emphasising general issues of funding, remuneration of providers, flexibility of funding and complexity of the system.

In terms of the evaluation of the outreach programs at hand, we consider the key areas for improvement are:

- Improving efficiency
  Outreach services aim to respond to the priority needs of local communities and be tailored to fill service gaps and integrate into the local services. Stakeholders consistently reported that the outreach programs were too complicated and prescriptive, offering little scope without a lengthy approval process to use the funds more flexibly within and across programs to meet health priorities.

- Build stronger community engagement
  Local communities value outreach services but often stressed that they have little involvement in service planning and configuration of the services. They are also concerned that once services are provided, many outreach providers do not spend sufficient time in the community building understanding and trust and assisting local staff in building capacity for shared care and developing priority skills and competencies. There were indications of robust engagement and partnership in the regional models reviewed during the evaluation.

- Further support local services
  Universally, stakeholders pointed to the importance of local service support as the pivotal factor for outreach service effectiveness. But local services reported being overstretched and not adequately resourced to provide adequate support for outreach services, including availability of staff to coordinate clinics and telehealth consults and capital infrastructure to accommodate providers and enable telehealth. Recognising this reflects a broader issue of resourcing local health services, there may still be scope to further support local capacity through outreach funding.

- Encourage further innovation
  There are a number of innovations in outreach services, including greater use of telehealth during COVID–19, regional ACCHO-led services, mobile clinics and integrated eye services, but these innovations tended to be isolated and rely on the efforts of champions rather than be encouraged more broadly through stronger program incentives. Such incentives could help promote broader system adoption of appropriate local innovations.

- Improve sharing and learning
  Effective communication between outreach and host providers is important and further facilitation and encouragement of stable and trusted partnership in this regard would be valuable. Fundholders broadly supported a more active role by the Department in creating opportunities for sharing and learning across the system and providing feedback to them on performance and future directions of the programs.

- Enhance transparency

NACCHO and other stakeholders support greater consistency in how fundholders carry out needs assessments and service planning. Nationally consistent and accessible data on program outputs is required. Fundholders would appreciate greater transparency over program funding and other program policy decisions. Stakeholders more broadly expressed the need for greater access to program information and more timely information.

- Strengthen governance and funding stability
  There was broad agreement that the 'shotgun' approach to fundholder arrangements was not optimal, but given the time and effort taken to establish productive relationships between agencies there is broad support across stakeholders for maintaining stability in the system. Fundholders and providers strongly support longer term funding assurances, to build trust in the system, enable attraction and retention of clinicians and ensure sustainability.

Action in these areas may facilitate patient-centred care and promote more responsive outreach services for local communities through simplification of program administration and more flexible use of funding. Greater attention to promoting system sharing and learning and the provision of incentives for further innovation will help deliver better value for money.

Box 29 lays out the priority areas for improvement and the associated recommendations that fall within these categories. The recommendations are stratified into initial and future-thinking recommendations. These timeframes illustrate the following goal posts:

- The initial actions are recommendations that may be considered and completed by the Department in the first instance as they may require less time and resources to achieve.
- The future-thinking actions will require more time and resources to achieve, which may include additional funding, program policy changes and further collaboration with national and jurisdictional stakeholders. These actions may require significant time and investment but will help shape the future of the outreach landscape and allow the programs to better achieve their intended objectives of strengthening local service provision and providing more equitable access to health services in underserved communities.

Several recommendations are proposed to foster further alignment and better meet the objectives outlined in the Closing the Gap. These are discussed in Chapter 8.

Whilst the scope of the recommendations has been confined to direct changes to the administration and funding of the outreach programs, the evaluation identified a range of broader system issues that are noted for further consideration. These issues point to more challenging changes to the structure and funding of the health system and are relevant to the outreach programs as well as other broader health policy considerations. These are outlined following the recommendations in Box 30.

Box 29: Priority areas for improvement, recommendations for action and broader system issues

Improving efficiency

Initial specific program actions:

Recommendation 2: Remove variation in the annual service plan approval process and establish a consistent approach across all programs by enabling the Advisory Forum in each jurisdiction to approve annual service plans for the RHOF.

Recommendation 15: Establish harmonised service delivery standards for the RHOF and the MOICDP to enable more flexible use of funding and better support local community health priorities. The service delivery standards should remove any inconsistencies by providing for the same level of coverage of the:

- MM categories
- Age of patients
- Range of medical, allied health and nursing providers
- Range of health conditions that can be addressed in meeting local priorities.

Recommendation 17: Ensure the service delivery standards for HEBHBL program, the provision under the VOS and EESS program are harmonised with those for the RHOF and the MOICDP to ensure consistent coverage of patient age groups and MM categories. While noting the variation in program objectives, alignment of age and location of patients may facilitate integration of services in supporting the broader eye and health needs of individuals in local communities.

Initial all program actions:

Recommendation 20: Review the range of planned service arrangements that require fundholders to seek approval from the Department (including alternative services arrangements where an underspend is anticipated) with a view to allow greater fundholder decision making capacity while strengthening reliance on fundholder accountability to ensure appropriated service provision and value for money.

Recommendation 23: Simplify and harmonise guidance in the service delivery standards across all programs on the remuneration arrangements available for each workforce group and how they interact with funding support for transport, accommodation and food, including clarification of appropriate use of the Medicare Benefits Schedule and Workforce Support Payments to provide coverage of time:

- travelling while away from usual practice
- providing direct patient care
- building local workforce capacity
- engaging with local communities.

Recommendation 37: Allow fundholders to provide a consolidated:

- needs assessment
- annual service plan
- narrative report.

These documents would cover all the outreach programs. The single narrative report should include an explanation of factors contributing to any significant activity and/or budget variances within specific programs and identify planned mitigation strategies to bring the programs back on track.

Future-thinking specific program actions:

Recommendation 14: The Department to explore ways to further integrate the VOS with funding support under the RHOF and the MOICDP for ophthalmologists and other eye health providers to enable more flexible use of eye health funding and better support local community eye health priorities, including review of existing enabling legislation for the VOS.

Future-thinking all program actions:

Recommendation 22: Establish a greater focus on planning, monitoring and funding time spent by outreach providers in undertaking community engagement and relationship building and host provider teaching and training. These activities could be supported by incorporating specific plans guided by consultation with communities and budget allocations under the overall service plans.

Recommendation 35: Review the funding provision for program administration in 3 to 5 years in light of the impact of implementing recommended efficiency measures, particularly where there are existing systems and the fundholder administers multiple programs. Rather than a percentage, consider the feasibility of capping the amount of funding allocated for administration.

Recommendation 39: To enhance communication across providers and patient access to care records, require outreach providers to upload an event summary onto My Health Record for every patient attendance at an outreach clinic, giving due consideration to arrangements for patients without My Health Record accounts.

Build stronger community engagement

Initial all program actions:

Recommendation 4: Encourage fundholders to maintain a single advisory forum that oversees the needs and service planning functions for all outreach programs. Where multiple outreach fundholders exist in a jurisdiction, the fundholders could be encouraged to establish a shared Advisory Forum and coordinate needs assessment and service planning processes to avoid duplication and streamline reporting to the Department. These arrangements could be extended to include other organisations involved in improving access to health services (for example, PHNs), where appropriate.

Recommendation 5: To strengthen the role of the Aboriginal and Torres Strait Islander health sector in the governance of outreach programs, require fundholders to invite the NACCHO affiliate organisations (or their nominee) to co-chair the advisory forum.

Recommendation 6: Require fundholders to provide the Department and the National Aboriginal Community Controlled Health Organisation with their planned needs assessment and service planning processes for each period, including how and when they will engage with local communities and other key stakeholders and to what extent the process will be coordinated with other fundholders to avoid duplication and streamline reporting to the Department.

Recommendation 7: Fundholders to make the following publicly available:

- The planned needs assessment and service planning process before for each planning period, including the nature and timing of opportunities for local communities and other key stakeholders to provide input into the process and key contacts for feedback.
- The outcomes of the needs assessment and the service plan before the commencement of each the service period, including details of the services and communities to receive the services.

Future-thinking specific program actions:

Recommendation 16: Extend the scope and coverage of the service delivery standards of the RHOF and the MOICDP to explicitly include dental health and to confirm coverage of eye and ear health services to clarify the scope for integration with services funded under other relevant outreach programs.

Recommendation 38: The Department to work with state and territory departments to explore alternative arrangements for the EESS that may better support access to elective ear and eye surgery for Indigenous Australians in public and private hospitals, including options that build on existing national and regional systems and processes.

Future-thinking all program actions:

Recommendation 13: Fundholders to work with the NACCHO affiliates to identify further opportunities to progressively devolve outreach program funding for MOICDP, VOS, HEBHBL, EESS to regional Aboriginal Community Controlled Health Organisations, where robust governance and service capacity are in place.

Recommendation 21: Encourage fundholders to extend existing collaborative arrangements with other fundholders to foster regional approaches to conducting needs assessment and service planning and establishing a shared 'regional master plan' that incorporates outreach, regional and local services.

Further support local services

Initial all program actions:

Recommendation 25: Extend the provision of funding for administration of the programs from 15% to 20%, with the requirement that 10% of the funding to be provided to extend financial support to host providers to coordinate and participate in face-to-face outreach visits, telehealth shared care arrangements, upskilling and education of their staff and enable community-led orientation and cultural awareness training.

Future-thinking all program actions:

Recommendation 29: Require fundholders to work collaboratively with rural health workforce agencies, local host providers and other relevant agencies to actively plan for the withdrawal of outreach services in response to opportunities to build local workforce capacity, thereby actively working to reduce the risk of unnecessary ongoing reliance on the provision of services by outreach providers.

Encourage further innovation

Initial all program actions:

Recommendation 31: Building on the momentum achieved through the COVID-19 pandemic, encourage and monitor the implementation of shared care arrangements including local support for use of telehealth to broaden access and reliability of services, upskill the local workforce and support continuity of care.

Future-thinking specific program actions

Recommendation 33: The Department to commission a review of the cost of providing HoA mobile services to assess value for money and consider the sustainability of the services in light of planned local and regional service developments and alternative outreach services. The evaluation should include consideration of both total capital and recurrent costs.

Future-thinking all program actions

Recommendation 32: The Department to review existing and anticipated future MBS items for telehealth to assess the viability to support the expansion of telehealth enabled shared care arrangements for both medical and non-medical outreach providers.

Recommendation 34: Commission assessments of alternative service models that services are exploring in outreach to assess their value-for-money and potential in increasing access to underserved communities.

Improve sharing and learning

Initial all program actions:

Recommendation 11: The Department to engage with fundholders and NACCHO and their affiliates directly and more actively in creating opportunities for them to share and learn from each other and provide information and feedback on their performance and the future directions for the programs, including annual plenary planning forums, online communities of practice, regular performance feedback and national events to 'showcase' service innovations.

Recommendation 26: Specify the requirement in the service delivery standards that a framework be applied to help guide the development of agreed local host and outreach provider arrangements in each community, including the number and nature of local staff involved, clinical equipment and facilities required, clinical referral protocols for ongoing treatment, risk management protocols and clinical governance arrangements.

Future-thinking all program actions

Recommendation 8: The Department to review existing fundholder data information and reporting and design and establish a new standardised single national minimum data set, along with a streamlined data collection and reporting process, that:

- covers all programs
- reduces data burden on fundholders.
- provides a sound basis for performance monitoring and feedback
- enables consolidation of the data at the jurisdiction and national levels

Recommendation 9: As part of the new standardised national minimum data set, the Department to establish and collect a small suite of key consumer facing key performance indicators (including outreach provider continuity, patient experiences, clinic utilisation, visit duration and unit costs) with data elements specified in the Australian institute of Health and Welfare metadata store to improve consistency and facilitate cross-jurisdictional comparisons.

Recommendation 30: The Department to consult with the Australian Commission on Safety and Quality in Health Care on their progress in developing culturally safe PREMs suitable for use with Aboriginal and Torres Strait Islander patients, including exploration of opportunities for outreach services to pilot the tool during development.

Recommendation 36: The Department to establish unit costing methods using the routine national outreach data collection to facilitate sharing and learning across fundholders and service provider organisations and allow greater understanding of the key cost drivers facing fundholders for particular services, regions and communities.

Enhance transparency

Initial specific program actions:

Recommendation 12: To improve transparency and support the objectives in the Closing the Gap Agreement, the Department to consult with the National Aboriginal Community Controlled Health Organisation and their affiliates prior to finalising funding allocations for Aboriginal and Torres Strait Islander Australians under the MOICDP, VOS, HEBHBL, EESS outreach programs.

Future-thinking all program actions

Recommendation 10: To improve transparency and establish more robust data sharing arrangements that align with the National Agreement on Closing the Gap, the Department to provide key stakeholders groups, such as NACCHO, their affiliates and the fundholders with regular and timely access to the national minimum dataset for the outreach programs.

Recommendation 27: Fundholders to establish online portals with information about all outreach services planned across jurisdictions, including interactive maps that highlight service location, clinic type, visit dates and contact details of host and outreach providers. There may be opportunities for these portals to evolve and enable consumers and referring health professionals to book appointments at the clinics and receive reminders in the future.

Recommendation 28: The Department to commission the development of, and the NACCHO to oversee the administration of, national host provider and patient experiences surveys (and/or other culturally appropriate activities) after each planning cycle. NACCHO to report back on the key findings to the fundholders and the Department before the next planning cycle.

Strengthen governance and funding stability

Initial specific program actions

Recommendation 1: The Department to review the governance and funding arrangements for HoA with a view to strengthen the overall coordination and integration of regional and local outreach service planning and delivery across Queensland.

Initial all program actions:

Recommendation 3: Existing fundholders should be retained across all jurisdictions, while supporting the establishment or continued support of regional governance models that enable decisions regarding service planning, funding and delivery to be progressively devolved. This will build the capacity for regionally models that are responsive to the outreach needs of surrounding local communities.

Recommendation 19: Review the current indexation of outreach programs with a view to applying a consistent approach across all programs with consideration given to existing approaches (for example MBS indexation, or the way the Independent Hospital Pricing Authority determines the hospital efficient price).

Future-thinking all program actions

Recommendation 18: Review the current approaches to allocating funding to jurisdictions for the programs and explore alternative methods, including those that are responsive to both changes in demographics and the capacity of local service provision. For example, variations in MBS utilisation across rural and remote areas in each jurisdiction could provide a signal of local service capacity and align with the Workforce Incentives Program and other initiatives aimed at building the local workforce.

Recommendation 24: Review the MBS and existing workforce support payment arrangements to create a simpler, more consistent and sustainable way to reimburse outreach providers. This may include exploring the feasibility of moving to blended payments.

Box 30: Broader system observations

Broader system observation 1: To strengthen consideration of health outreach as an enduring and responsive mechanism to improving service access in rural and remote communities, the Department could consult with officers from relevant portfolio areas to ensure further integration of the health outreach programs is achieved through future strategy development under the Stronger Rural Health Strategy and the National Agreement on Closing the Gap.

Broader system observation 2: Department could explore feasibility of revising funding arrangements to better support the sustainability of outreach providers and services by establishing processes for more predictable and reliable funding.

Broader system observation 3: The Department could consult with universities and health agencies responsibilities for medical, nursing and allied health student clinical placement programs to explore scope to further integrate students into outreach services, including arrangements to financially support students.

Broader system observation 4: The Department could encourage fundholders to engage with public and private health service agencies to identify and explore the potential to expand strategies to promote a workplace culture whereby participation in outreach is actively supported by the agency.

Broad system observation 5: The Department could encourage host services to further explore new workforce models and training pathways, such as the Certificate III in Allied Health Assistance, which seek to bolster and develop local capacity to better support the outreach programs.

Broader system observation 6: The Department to consider the feasibility of commissioning the assessment of service models to build an evidence base for innovations that represent value for money, with a view to provide support for the capital infrastructure required for such innovations through the establishment of an open and contestable national funding pool.

Broad system observation 7: The Department could commission a study on the long term recurrent costs of transport for one day visits versus the provision of capital infrastructure that provides accommodation and support for longer stays by outreach providers, particularly in smaller and very remote communities. This may contribute to broader economic consideration of the financing of capital infrastructure in rural and remote communities.

Broader system observation 8: The Department may seek to investigate possible ways to further encourage fundholders to explore potentially cost-effective service innovations, recognising that existing arrangements allow fundholders to roll over unspent funds that may result from efficiencies generated from service innovations and invest them back into service expansion.

8

Implications for Closing the Gap

Many of the outreach programs within scope of the review (MOICDP, HEBHBL, VOS, EESS) focus on increasing access to health services and improving the health outcomes of Aboriginal and Torres Strait Islander people.

A broad range of stakeholders stressed the importance of ensuring the evaluation makes recommendations about the priority reforms outlined in the Closing the Gap Agreement. The Closing the Gap Agreement is a national agreement that seeks to eliminate inequality and improve the health outcomes of Aboriginal and Torres Strait Islander people. It is driven by 4 priority reforms that seek to improve the health outcomes and life expectancy of Aboriginal and Torres Strait Islander people and enhance the way in which the government works with this population and communities. There are specific recommendations and system level observations that align with the priority reforms and associated tangible actions outlined in the National Agreement on Closing Gap (see Table 33). This section outlines these recommendations and observations and describes how they work to support the priority reforms in the agreement.[3,4]

Table 33: Closing the Gap priority reforms and associated evaluation recommendations and observations

Priority reforms	Associated evaluation recommendations and observations
Priority reform 1 – Formal partnerships and shared decision making	**Recommendation 11:** The Department to engage with fundholders and National Aboriginal Community Controlled Health Organisation and their affiliates directly and more actively in creating opportunities for them to share and learn from each other and provide information and feedback on their performance and the future directions for the programs, including annual plenary planning forums, online communities of practice, regular performance feedback and national events to 'showcase' service innovations. **Recommendation 6:** Require fundholders to provide the Department and the National Aboriginal Community Controlled Health Organisation with their planned needs assessment and service planning processes for each period, including how and when they will engage with local communities and other key stakeholders and to what extent the process will be coordinated with other fundholders to avoid duplication and streamline reporting to the Department. **Recommendation 5:** To strengthen the role of the Aboriginal and Torres Strait Islander health sector in the governance of outreach programs, require fundholders to invite the National Aboriginal Community Controlled Health Organisation affiliate organisations (or their nominee) to co-chair the advisory forum.

Priority reforms	Associated evaluation recommendations and observations
Priority reform 2 – Building the community-controlled sector	**Recommendation 3:** Existing fundholders should be retained across all jurisdictions, while supporting the establishment or continued support of regional governance models that enable decisions regarding service planning, funding and delivery to be progressively devolved. This will help build the capacity for regionally-responsive models that provide outreach to surrounding local communities. **Recommendation 13:** Fundholders to work with the National Aboriginal Community Controlled Health Organisation affiliates to identify further opportunities to progressively devolve outreach program funding for MOICDP, VOS, HEBHBL, EESS to regional Aboriginal Community Controlled Health Organisations, where robust governance and service capacity are in place. **Recommendation 25:** Extend the provision of funding for administration of the programs from 15% to 20%, with the requirement that 10% of the funding to be provided to extend financial support to host providers to coordinate and participate in face-to-face outreach visits, telehealth shared care arrangements, upskilling and education of their staff and enable community-led orientation and cultural awareness training.
	Broader system observation 1: To strengthen consideration of health outreach as an enduring and responsive mechanism to improving service access in rural and remote communities, the Department could consult with officers from relevant portfolio areas to ensure further integration of the health outreach programs is achieved through future strategy development under the Stronger Rural Health Strategy and the National Agreement on Closing the Gap. **Broader system observation 2:** Department could explore feasibility of revising funding arrangements to better support the sustainability of outreach providers and services by establishing processes for more predictable and reliable funding. **Broader system reform 7**: The Department could commission a study on the long term recurrent costs of transport for one day visits versus the provision of capital infrastructure that provides accommodation and support for longer stays by outreach providers, particularly in smaller and very remote communities. This may contribute to broader economic consideration of the financing of capital infrastructure in rural and remote communities.
Priority reform 3 – Transforming government organisations	**Recommendation 12:** To improve transparency and support the objectives in the Closing the Gap Agreement, the Department to consult with the National Aboriginal Community Controlled Health Organisation and their affiliates prior to finalising funding allocations for Aboriginal and Torres Strait Islander Australians under the MOICDP, VOS, HEBHBL, EESS outreach programs. **Recommendation 22:** Establish a greater focus on planning, monitoring and funding time spent by outreach providers in undertaking community engagement and relationship building and host provider teaching and training. These activities could be supported by incorporating specific plans guided by consultation with communities and budget allocations under the overall service plans. **Recommendation 28:** The Department to commission the development of, and the National Aboriginal Community Controlled Health Organisation to oversee the administration of, national host provider and patient experiences surveys (and/or other culturally

Priority reforms	Associated evaluation recommendations and observations
	appropriate activities) after each planning cycle. The National Aboriginal Community Controlled Health Organisation to report back on the key findings to the fundholders and the Department before the next planning cycle. **Recommendation 30:** The Department to consult with the Australian Commission on Safety and Quality in Health Care on their progress in developing culturally safe PREMs suitable for use with Aboriginal and Torres Strait Islander patients, including exploration of opportunities for outreach services to pilot the tool during development.
Priority reform 4 – Shared access to data and information at a regional level	**Recommendation 11:** The Department to engage with fundholders and National Aboriginal Community Controlled Health Organisation and their affiliates directly and more actively in creating opportunities for them to share and learn from each other and provide information and feedback on their performance and the future directions for the programs, including annual plenary planning forums, online communities of practice, regular performance feedback and national events to 'showcase' service innovations. **Recommendation 8**: The Department to review existing fundholder data information and reporting and design and establish a new standardised single national minimum data set, along with a streamlined data collection and reporting process, that: • covers all programs • reduces data burden on fundholders • provides a sound basis for performance monitoring and feedback • enables consolidation of the data at the jurisdiction and national levels. **Recommendation 9:** As part of the new standardised national minimum data set, the Department to establish and collect a small suite of key consumer facing KPIs (including outreach provider continuity, patient experiences, clinic utilisation, visit duration and unit costs) with data elements specified in the Australian institute of Health and Welfare metadata store to improve consistency and facilitate cross-jurisdictional comparisons. **Recommendation 28:** The Department to commission the development of, and the National Aboriginal Community Controlled Health Organisation to oversee the administration of, national host provider and patient experiences surveys (and/or other culturally appropriate activities) after each planning cycle. The National Aboriginal Community Controlled Health Organisation to report back on the key findings to the fundholders and the Department before the next planning cycle.

Note: There are recommendations that align with multiple priority reforms in the Closing the Gap Agreement. Recommendation 28 is noted in priority reforms 3 and 4.

Priority reform 1 – Formal partnerships and shared decision making

Priority reform 1 of the Closing the Gap Agreement focusses on increasing collaboration and communication between Aboriginal and Torres Strait Islander people and all levels of government. This includes establishing and fostering formal partnerships between Aboriginal

and Torres Strait Islander people and their chosen representatives in the Aboriginal and Torres Strait Islander sector to facilitate joint decision making. The aim of this reform is to enable self-determination and empower Aboriginal and Torres Strait Islander people to establish policy and reforms that effectively work to close the gap and address local and regional needs. The priority aims of this reform include establishing joint partnerships in 5 key areas, including justice, social and emotional wellbeing, housing, early childhood care and development and Aboriginal and Torres Strait Islander Languages.

One of the key objectives of the outreach programs is to increase Aboriginal and Torres Strait Islander peoples' access to health services. To achieve this end, there must be strong representation of the Aboriginal and Torres Strait Islander community and joint decision-making between the Department and the Aboriginal and Torres Strait Islander health sector. The recommendations outlined in Table 33 under priority reform 1 focus on strengthening the voice of the Aboriginal and Torres Strait Islander sector in key decision making processes as they relate to the outreach programs. Recommendations 8 and 11 seek to achieve the following aims:

- Support sharing and learning and further establish place-based partnerships between the NACCHO affiliates and the jurisdictional fundholders.
- Ensure there is greater representation of Aboriginal community-controlled organisations in the jurisdictional advisory fora.
- Facilitate joint-decision making as it relates to various governance processes, such as input into the needs assessment process, approval of outreach program service plans and review of service proposals.

Requiring the fundholders to provide both the Department and NACCHO with their needs assessment and service planning process for each reporting period aims to increase transparency of governance processes. This recommendation also works to ensure there is greater engagement with Aboriginal and Torres Strait Islander communities and key stakeholders in the planning and delivery of outreach services (recommendation 6).[58]

Priority reform 2 – Building the community-controlled sector

Priority reform 2 focusses on developing the Aboriginal and Torres Strait Islander community-controlled sector and associated organisations. This reform emphasises a commitment to establishing a sustainable, long term investment to support the ongoing development and expansion of workforce and infrastructural capacity of the community-controlled sector.

A key priority of the initial sector strengthening plans of the Closing the Gap Agreement is health and the Develop Sector Strengthening Plans specifically focus on developing capacity of the following 4 streams:[3]

- workforce
- capital infrastructure
- service provision
- governance.

There are key evaluation recommendations that specifically focus on building the capacity of these 4 streams.

[58] Closing the Gap. (n.d.). *Priority Reforms*. https://www.closingthegap.gov.au/national-agreement/priority-reforms

Recommendation 25 aims to better support and develop the local host provider workforce by extending financial support to these organisations to coordinate and participate in face-to-face outreach visits, shared care arrangements, training and education and community-led orientation and cultural awareness. Providing additional support for these activities aims to help the Aboriginal and Torres Strait Islander community-controlled workforce to better plan and integrate outreach into regular service provision and allow local staff to undertake additional training and education with the support of visiting professionals. Providing funding to support community-led orientation and cultural awareness will also facilitate stronger partnerships and improve the cultural awareness of visiting providers and services.

Host organisations frequently cited lack of capital infrastructure as a key barrier to hosting outreach services and overall local service delivery. There is a desire amongst host services to explore and harness innovations to increase access to local services and enhance local service delivery, but this often requires capital infrastructure, such as medical equipment, clinical space and software. The Department may look to building evidence for innovations that represent value for money. This may include looking to create a national funding pool for host providers to establish capital infrastructure for new models of care would also better support the Aboriginal and Torres Strait Islander community-controlled sector to explore and develop new, fit-for-purpose models of care across regions with the aim of strengthening the sector and expanding service provision (see broad system observation 7).

While outreach is only one component of health service delivery, it represents an integral part of the Australian health system and is vital to various populations. To promote sustainability and transparency and increase community engagement in outreach services, the Department could review and look to establish more predictable outreach funding. Much of this funding is specifically focussed on increasing health access to Aboriginal and Torres Strait Islander communities; therefore, long-term, multi-year funding contracts may provide ongoing reassurance that outreach services will continue to support community-controlled host services to develop and expand local health service provision (Broader system observation 2).

Recommendation 3 and 13 specifically focus on providing the Aboriginal and Torres Strait Islander community-controlled sector with additional control and influence over outreach funding and governance. Fundholders in some jurisdictions are providing funding to ACCHOs with a regional role to plan and coordinate local services and outreach services to surrounding communities. There were examples of this in the case studies in Western Australia and Northern Territory where KAMS coordinated outreach across the Kimberley including Broome and Congress coordinated across central Australia including Alice Springs. These funding arrangements allow greater latitude for a regional ACCHO to respond to local needs and establish a robust regional workforce to assist with outreach service provision. Recommendation 13 seeks to encourage further devolution of outreach funding for MOICDP, VOS, HEBHBL, EESS to mature regional ACCHOs equipped with stable governance to provide regional outreach service planning and provision.

It was observed that further integration of the outreach programs into the Stronger Rural Health Strategy and the Closing the Gap Agreement could allow the outreach programs to be less disconnected from existing initiatives and ensure outreach service provision aligns with the objectives of these key policies. This includes focussing on building capacity of the community-controlled sector (refer to broader system observation 1).

Priority reform 3 – Transforming government organisations

Priority reform 3 focusses on eliminating racism in government institutions and embedding culturally safe practices in these organisations to better support Aboriginal and Torres Strait Islander peoples and their cultures. A key aim of this reform is to improve the engagement of

Aboriginal and Torres Strait Islander people and increase transparency of government processes.

Recommendation 12 specifically focusses on improving the transparency of funding allocations. It advocates for the Department to consult with key representative organisations in the Aboriginal and Torres Strait Islander sector (that is, NACCHO and their affiliates) prior to allocating outreach program funding under the MOICDP, VOS, HEBHBL, EESS devoted to increasing health access to Aboriginal and Torres Strait Islander people. Appropriate consultation of these representative organisations prior to the distribution of this outreach funding will reduce duplication of services and seek to ensure the health priorities and needs of Aboriginal and Torres Strait Islander people are adequately aligned and addressed to better meet the program objectives.

Various stakeholders reflected that listening and fostering strong face-to-face relationships with Aboriginal and Torres Strait Islander communities is a core component of establishing trust and practicing culturally safe care. This includes spending time with community and attending community events. Recommendation 22 advocates for greater emphasis on planning, monitoring and funding time spent by outreach providers in undertaking community engagement and relationship building and host provider teaching and training. This could include incorporating specific plans and allocating a portion of funding for these activities which aims to help visiting providers establish stronger relationships with Aboriginal and Torres Strait Islander people and strengthen their understanding of community history, priorities and what is considered culturally safe care.

Monitoring and reporting of cultural safety and both patient and host provider experiences is central to improving and embedding culturally safe practices in outreach; therefore, culturally safe PREMs in outreach should be developed to achieve these aims. The Australian Commission on Safety and Quality in Health Care is working with NT Health to develop culturally safe PREMs. The Department should monitor the progress of this project and assess their potential for use in outreach. A core component of this will be ensuring proper engagement and consultation of the Aboriginal and Torres Strait Islander health sector; therefore, there should be opportunities for outreach services to pilot the tool prior to implementation (recommendation 30).

Stakeholders in the surveys and interviews called for increased monitoring of host provider and patient experiences. While several visiting services described implementing their own tools to capture patient experiences, there are currently no national tools in place to gather host provider and patient experiences. It is recommended that the Department commission the development of national host provider and patient surveys. To effectively capture host provider and patient experiences in an unbiased and representative way, it is recommended that NACCHO oversee the administration of the survey for community controlled host services and the patient experience survey (and/or other culturally appropriate activities) following each planning cycle and provide a report back to fundholders and the Department. This will work to enhance performance monitoring, increase accountability and foster information sharing across programs and jurisdictions (recommendation 28).

Priority reform 4 – Shared access to data and information at a regional level

Priority reform 4 focuses on increasing Aboriginal and Torres Strait Islander people's access to relevant data and information to enable self-determination and allow them to better determine priorities with the aim of closing the gap and improving the lives of Aboriginal and Torres Strait Islander people.

A key pillar of this reform is establishing partnerships and data sharing arrangements to enhance transparency and increase shared-decision making between government and the

Aboriginal and Torres Strait Islander health sector. As discussed in priority reform 1, recommendation 11 advocates for the Department to more actively engage with the jurisdictional fundholders and NACCHO and its affiliates in creating in opportunities for these stakeholders to share and learn from each other and provide feedback on their performance and future of the outreach programs. This recommendation serves many aims, including strengthening relationships between these groups and ensuring the identified needs and objectives of the outreach programs align with the priorities of the Aboriginal and Torres Strait Islander health sector.

To improve outreach reporting across jurisdictions and ensure more effective monitoring of outreach services, recommendations 8 and 9 support reviewing and establishing a national minimum data set, including key consumer facing indicators, with data elements specified in the AIHW metadata store to improve consistency; facilitate cross-jurisdictional comparisons and aid in the collection, management and use of outreach data. Recommendation 9 also supports sharing this minimum dataset with NACCHO and their affiliates to improve the transparency of data collection processes in outreach and increase Aboriginal and Torres Strait Islander peoples' access to this data.

As discussed in priority reform 3, recommendation 28 seeks to ensure the experiences of Aboriginal and Torres Strait Islander patients and community-controlled organisations are collected in a representative and culturally appropriate way. This could be achieved by having NACCHO oversee the gathering of community controlled host services and patient experiences through surveys and other culturally appropriate mechanisms (that is, yarning circles) and report back to the fundholder and the Department. This reform aims to foster stronger data sharing arrangements and information sharing between Aboriginal and Torres Strait Islander organisations, the Department and other key stakeholders, such as the jurisdictional fundholders. It also seeks to establish stronger Aboriginal and Torres Strait Islander ownership of their data and information.

Appendix 1A: Literature scan

The following section outlines our approach to conducting the literature scan and provides a summary of the findings in the domestic and international literature by study type. For more information on the key messages of the literature review, refer to the Key messages and their relevance to the evaluation section.

Approach

PubMed was the primary source for the literature extraction and included articles published from 2012 to 2021. A search strategy was developed that sought to identify literature that focuses on outreach services that are within scope of the evaluation. The search strategy is as follows:

> ("Outreach"[Title] AND ("specialist"[Title/Abstract] OR "eye"[Title/Abstract] OR "ear"[Title/Abstract] OR "chronic"[Title/Abstract] OR "maternity"[Title/Abstract] OR "mental health"[Title/Abstract] OR "paediatric"[Title/Abstract] OR "pediatric" [Title/Abstract] OR "disease*" [Title/abstract] OR "chronic pain"[Title/Abstract])) NOT ("Africa" OR "homelessness" [Title/Abstract] OR "housing" [Title] OR "education" [Title]) AND (2012:2021[pdat])

The terminology for outreach services varies across countries; therefore, the search strategy encompasses common language employed in domestic and international settings. For example, in some countries the term 'outreach' is frequently preceded by the word 'community.'

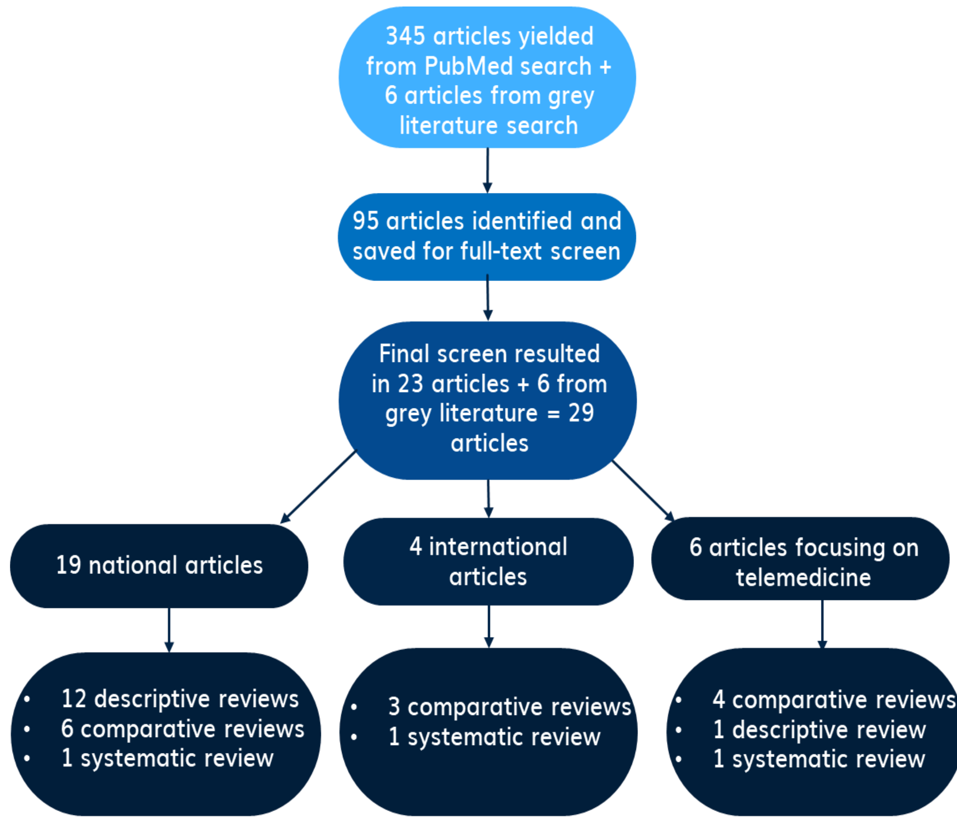
The search in PubMed yielded 345 articles. After an initial title and abstract review, 95 articles were identified and saved in Endnote for a full-text screen. The final screen resulted in **23 articles** included in the review. We excluded literature that did not specifically pertain to health outreach service delivery in regional, rural and remote settings in OECD member countries. For example, articles focusing on health promotion, global clinician training and humanitarian outreach were excluded for the purposes of this review.

To supplement the PubMed search and capture any other relevant articles and grey literature, a Google search was also undertaken along with a scan of the bibliographies of the systematic reviews included in the literature review. This yielded **6 additional articles** that were included in the review, **resulting in a total of 29 articles.** The literature consists of 13 descriptive studies, 13 comparative reviews and 3 systematic reviews. Articles within scope of the review largely focus on outreach services in the national context, with a total of 25 articles examining outreach services in the Australian setting and 4 articles examining outreach in an international setting which includes one systematic review that investigates various aspects of outreach service delivery in both domestic and international settings.

Due to the policy relevance and rapidly evolving use of telemedicine, articles from both the national and international that focus on telehealth are highlighted separately within the chapter. There is exploration of different models of telemedicine, potential impacts of technology on outreach service delivery and any potential implications and innovations that have occurred as a result of COVID–19.

Figure 33 provides a comprehensive breakdown of the articles and how they are categorised including the total number of national and international reviews, the type of study and those that focus on telemedicine across these contexts.

Figure 33: Literature scan search



Summary of findings by literature source

This section highlights specific articles and provides a high-level description of the findings in the literature. This summary is divided into articles focusing on outreach services in the national and international context and divided further into the findings observed from descriptive studies, comparative studies and systematic reviews. The observations centre around each of the key messages observed from the literature across these settings and are presented in totality in Box 7. The key findings focus on information revolving around the following topics:

- Local capacity building and upskilling
- Outreach funding and the sustainability of outreach programs
- Program coordination and continuity of care
- Telehealth and innovative models of care

National literature

A total of 19 of the 29 articles within scope of the review examine outreach services in the Australian context. Of the 19 national articles, there are a total of 12 descriptive studies, 6 comparative reviews and one systematic review. The key findings from the national literature are discussed below.

Descriptive studies

The descriptive studies largely consisted of cross-sectional and longitudinal studies which reviewed characteristics of Australian providers who participate in outreach, service delivery

patterns, the distribution and prevalence of outreach models across geographic settings and disease prevalence of certain conditions amongst Aboriginal and Torres Strait Islander people residing in rural and remote communities.

O'Sullivan et al. conducted a range of cross-sectional and longitudinal studies using Medicine in Australia: Balancing Employment and Life (MABEL) survey data over multiple years (2008 to 2014). The studies examine various aspects of health outreach service delivery, including supply and distribution of workforce, specialist participation, models and subsidies. For example, O'Sullivan et al.[59] reviewed the characteristics of Australian specialists who participate in the delivery of outreach services and the potential impacts of service provision and supply. Out of a sample of 4,596 doctors, 909 participants (19%) responded that they participate in outreach service delivery and 149 (16%) provide outreach to remote areas. Of these 909 specialists, 75% worked in urban areas. Specialists participating in general outreach service delivery were more likely to be male, have a rural or regional/remote residence and work in a private consulting room. The results of the survey indicate that more of an effort may be required to promote and raise awareness of opportunities to participate in outreach amongst the regional, rural and remote clinical and specialist workforce. This includes females and individuals from culturally and linguistically diverse backgrounds. Working to prioritise local solutions may increase sustainable access to health care and reduce the cost and barriers related to travelling to deliver outreach services.

Other studies investigated the use of subsidies to supplement outreaching service delivery and funding models in outreach. O'Sullivan et al.[60] examined the distribution of subsidies and their potential to increase the delivery of outreach services in remote areas. The study analysed a cohort of 575 specialists who reported providing outreach services. Respondents were predominantly male (73%), and the average age was 45. A total of 46% of respondents reported receiving subsidies for participating in outreach services. These subsidies were mostly from the RHOF (19%; 27% other funding sources). Receipt of any form of subsidies meant that specialists were more likely to travel longer distances (≥4 hours; twofold increase) and visit more remote areas (fourfold increase) compared to those who did not receive subsidies. Even though specialists who received subsidies from the RHOF reported travelling further distances and providing services to more remote areas, they delivered outreach services at a similar rate (40% at least monthly) compared to specialists that did not receive subsidies (47%).

Specialists who received subsidies from another source were significant less likely to deliver monthly service (27%) compared to specialists that received subsidies from the RHOF or those that did not receive any form of support. Specialists who received subsidies through the RHOF also reported participating in outreach service delivery for a longer period on average compared to those that received subsidies from other sources or did not receive them at all (mean length of outreach service delivery: 11 years vs. 8 years vs. 9 years, respectively) and were also more likely to continue delivering outreach services in the long-term (62% ≥5 years) compared to those that did not receive subsidies (61% ≥5) or those who received them from another source (51% ≥5). The findings suggest that further analysis on the structure and distribution of subsidies provided by the RHOF is warranted and that subsidies from a centralised program play an important role in encouraging and incentivising providers to participate and deliver outreach to communities in hard-to-reach geographic locations.

Foy and Tierney[61] performed a clinical audit of an outreach service located in New South Wales. The study analysed the service, which included visits from a consultant and trainee who

[59] O'Sullivan, B. G., Joyce, C. M., & McGrail, M. R. (2014, Sep 4). Rural outreach by specialist doctors in Australia: a national cross-sectional study of supply and distribution. *Hum Resour Health, 12*, 50. https://doi.org/10.1186/1478-4491-12-50

[60] O'Sullivan, B. G., McGrail, M. R., & Stoelwinder, J. U. (2017, Jul). Subsidies to target specialist outreach services into more remote locations: a national cross-sectional study. *Aust Health Rev, 41*(3), 344-350. https://doi.org/10.1071/ah16032

[61] Foy, A., & Tierney, A. (2014, Apr). Internal medicine in the bush: a clinical audit of a rural and remote outreach programme. *Intern Med J, 44*(4), 369-374. https://doi.org/10.1111/imj.12372

visited 2 towns 8 times per year from February 2006 to July 2013. The providers drove and delivered outreach services through 2 local primary care clinics across the 2 towns. In 2008, a fly-in, fly-out cardiology and diabetes outreach service was also established. While the service saw a low volume of patients initially in the first year (86 patients), acceptance and demand for the service grew over time (266 visits from July 2012 to June 2013). This showcases the importance of allowing ample time to implement outreach services, and the pivotal nature of fostering and supporting long-term, sustainable outreach services in order to improve patient access and continuity of care. Over the study period, the outreach service had 1070 presentations from 583 patients. The authors cited difficulties around the flexibility of funding and highlighted the importance of being able to provide comprehensive care to meet the needs of the overall community and patients who often present with a wide range of issues and comorbidities. The authors concluded that flexibility of funding and strong partnerships with local primary care services are integral to the success of rural outreach programs.

Turner et al.[62] performed a descriptive analysis of funding models and their effects on outreach eye services in Australia. The authors conducted semi-structured interviews with key stakeholders of the outreach services in 9 areas across Australia, as well as an analysis of clinical records. The primary measures used for the study were the availability of ophthalmologists, the costs of delivering the service, waiting times and rates of consultations and surgery. Surgical and clinic throughput times were shown to improve by a factor of 3.2 and 2.3 respectively in those practitioners who operated under a fee-for-service funding model. Observed waiting times decreased by 58%, in addition to a reduction in cost per attendance of almost 50%. In the semi-structured interviews, the authors found that many practitioners were of the view that base costs of providing an outreach service were not adequately covered. Some suggested the ability to bulk bill beyond a 100% rebate to account for loss of efficiencies in very remote locations. Another practitioner suggested incorporating a model for specialists that is similar to the Rural Retention Program for GPs.

The authors noted uncertainty arises from complex funding and sources, which also decreases transparency in funding arrangements. All 9 areas received funding from multiple sources, including state and federal governments, and non-government organisations. The study indicates that a fee-for-service model for outreach services may increase efficiencies, decrease waiting times, and increase clinical activity of specialist providers. However, the authors also mention that a market in fee-for-service specialists may result in smaller or less cost-effective communities being overlooked. This final point reiterates the challenges associated with a fee-for-service model in more rural and remotes due to the lack of patient volume; therefore, while this study indicates that a fee-for-service model may be beneficial in some ways, a hybrid model with a mix of funding sources may be required to supplement fee-for-service funding, but it is important to consider promoting further transparency and ways to reduce the complexity of outreach funding arrangements.

Comparative studies

The national comparative studies largely focussed on measuring the impact of various outreach interventions across a variety of rural and remote settings. In addition to increasing access to a range of health services, including chronic disease management and mental health services, some outreach programs focussed on building local capacity by establishing training arrangements between local and outreach providers. The findings across the studies substantiated the importance of skills transfer and training the local workforce to increase their scope of practice and provide them with the knowledge to better treat and provide ongoing management for a range of conditions. Strong coordination and collaboration between outreach services and local providers also appeared to be a major contributor to the success of these initiatives.

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[62] Turner, A. W., Mulholland, W., & Taylor, H. R. (2011, May-Jun). Funding models for outreach ophthalmology services. *Clin Exp Ophthalmol, 39*(4), 350-357. https://doi.org/10.1111/j.1442-9071.2010.02475.x

Hotu et al.[63] performed a quantitative evaluation of health outcomes for patients receiving diabetes outreach services in remote Aboriginal communities in Australia during a period of 12 months. The outreach services involved diabetic nurse educators visiting outreach clinics 3 to 4 time per year, while an endocrinologist visited twice per year. The service also used a priority coding system to first treat patients most at need. Diabetes education was provided to local practitioners, nurses and Aboriginal health workers. The authors found that patients maintained significantly better control of their blood glucose during the study period, in addition to lowering total cholesterol levels. Communication and co-ordination between local and outreach providers were pivotal to the successful delivery of the service which included education and upskilling of local staff.

Moffatt et al.[64] examined the effectiveness of outreach training of local GPs in endocrinology through qualitative semi-structured interviews. The study particularly focuses on the Physician in Practice Clinic in Toowoomba, Queensland where specialists and GPs perform joint consultations with the patient simultaneously. GP education via the joint consultations and supplementary lunch time forums are a focus of this program. All doctors interviewed in the study stated they had accrued immediate new patient-specific knowledge from the joint consultations, which was further reinforced through the lunch time forums. Rural and small practice GPs were found to report benefits the most. Longer term, GPs reported an increase in confidence managing diabetes and developing insulin plans, and an increase in generalised knowledge that can be applied with many patients. GPs also reported an improved relationship with specialists. The findings could result in decreased referrals to specialists due to better diabetes management by GPs, which could lead to decreased waiting times for endocrinologists.

Bridgman et al.[65] evaluated the impact of a Tasmanian mental health outreach service developed and implemented by the Pulse Youth Health Service and headspace Hobart. The service aimed to increase access to mental health services for young people living in rural and/or low socioeconomic areas. Measures included patient wait times, number of referrals and patient volume by postcode. These measures were assessed at baseline and after 2 years of service operations. The review found the outreach service increased access to mental health services amongst youths residing in disadvantaged, rural areas. The number of individuals from MM 5 locations with an Index of Relative Socio-economic Disadvantage (IRSD) rating of 1 or 2 accessing the service rose by 54%. The service, along with enhanced coordination between headspace Hobart and Pulse YHS which included streamlining of the patient assessment process, reduced patient wait times at headspace Hobart by at least 10 working days. The study illustrates the need for mental health services in vulnerable, rural communities and the importance of developing strong partnerships with existing local health services to streamline service delivery and increase access to health services in these areas.

Systematic review

Gotis-Graham et al.[66] assesses studies that evaluate the effectiveness of ear, nose and throat (ENT) outreach interventions for Aboriginal and Torres Strait Islander Australians. The studies evaluated ENT outreach services operating across various jurisdictions of Australia, including

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[63] Hotu, C., Rémond, M., Maguire, G., Ekinci, E., & Cohen, N. (2018, Dec). Impact of an integrated diabetes service involving specialist outreach and primary health care on risk factors for micro- and macrovascular diabetes complications in remote Indigenous communities in Australia. *Aust J Rural Health, 26*(6), 394-399. https://doi.org/10.1111/ajr.12426

[64] Moffatt, J., Hossain, D., & Hansford, G. (2012, Oct). Physician in practice clinic: educating GPs in endocrinology through specialist-outreach. *Rural Remote Health, 12*(4), 2265.

[65] Bridgman, H., Ashby, M., Sargent, C., Marsh, P., & Barnett, T. (2019). Implementing an outreach headspace mental health service to increase access for disadvantaged and rural youth in Southern Tasmania. *Australian Journal of Rural Health, 27*(5), 444-447. https://doi.org/https://doi.org/10.1111/ajr.12550

[66] Gotis-Graham, A., Macniven, R., Kong, K., & Gwynne, K. (2020, Nov 26). Effectiveness of ear, nose and throat outreach programmes for Aboriginal and Torres Strait Islander Australians: a systematic review. *BMJ open, 10*(11), e038273. https://doi.org/10.1136/bmjopen-2020-038273

the Northern Territory, Western Australia and Queensland. The studies included in the systematic review assess the effectiveness of some outreach services that are included in this evaluation and provide a foundation for our evaluation efforts. Table 34 categorises the studies included in the systematic review by intervention and provides additional information on setting, conditions, and study design.

Table 34: Characteristics of studies included in Gotis-Graham et al. (2020) review

#	Study	Intervention	Condition(s)	Jurisdiction/Setting	Study design
1	Australian Institute of Health and Welfare[67]	NT Outreach Hearing Health Programme	Range of ear and hearing conditions	NT; remote community	Cross-sectional pre-post study
2	Durham et al.[68]	Deadly Ears Program	Otitis media	Qld; range of geographic settings including community and education	Qualitative
3	Elliott et al.[69]	Mobile telemedicine-enabled screening and surveillance	Otitis media	Qld; range of geographic settings including community	Quantitative non-randomised
	Nguyen et al.[70]				Retrospective costing study
	Smith et al.[71]				Retrospective review of service activity
	Smith et al.[72]				
	Smith et al.[73]				
4	Fernee and Sockalingam[74]	ENT Outreach Project	Otitis media	Qld, Remote community	Retrospective case–

[67] Australian Institute of Health and Welfare. (2018). *Northern Territory Outreach Hearing Health Program: July 2012 to December 2017*. https://www.aihw.gov.au/reports/indigenous-australians/nt-hearing-program-2012-2017
[68] Durham, J., Schubert, L., Vaughan, L., & Willis, C. D. (2018). Using systems thinking and the Intervention Level Framework to analyse public health planning for complex problems: Otitis media in Aboriginal and Torres Strait Islander children. *PLoS One, 13*(3), e0194275. https://doi.org/10.1371/journal.pone.0194275
[69] Elliott, G., Smith, A. C., Bensink, M. E., Brown, C., Stewart, C., Perry, C., & Scuffham, P. (2010, Nov). The feasibility of a community-based mobile telehealth screening service for Aboriginal and Torres Strait Islander children in Australia. *Telemed J E Health, 16*(9), 950-956. https://doi.org/10.1089/tmj.2010.0045
[70] Nguyen, K. H., Smith, A. C., Armfield, N. R., Bensink, M., & Scuffham, P. A. (2020). Correction: Cost-effectiveness analysis of a mobile ear screening and surveillance service versus an outreach screening, surveillance and surgical service for indigenous children in Australia. *PLoS One, 15*(6), e0234021. https://doi.org/10.1371/journal.pone.0234021
[71] Smith, A. C., Brown, C., Bradford, N., Caffery, L. J., Perry, C., & Armfield, N. R. (2015, Dec). Monitoring ear health through a telemedicine-supported health screening service in Queensland. *J Telemed Telecare, 21*(8), 427-430. https://doi.org/10.1177/1357633x15605407
[72] Smith, A. C., Armfield, N. R., Wu, W. I., Brown, C. A., Mickan, B., & Perry, C. (2013, Oct). Changes in paediatric hospital ENT service utilisation following the implementation of a mobile, indigenous health screening service. Ibid., *19*(7), 397-400. https://doi.org/10.1177/1357633x13506526
[73] Smith, A. C., Armfield, N. R., Wu, W. I., Brown, C. A., & Perry, C. (2012, Dec). A mobile telemedicine-enabled ear screening service for Indigenous children in Queensland: activity and outcomes in the first three years. Ibid., *18*(8), 485-489. https://doi.org/10.1258/jtt.2012.gth114
[74] Fernee, B., & Sockalingam, R. (2002). Outcomes in ENT Surgery for Middle-Ear Disease in Aboriginal Populations Living in Remote Communities: A comparison between pre and post operative audiometric results. *Australian Otolaryngology, 5*(1).
, ibid.

#	Study	Intervention	Condition(s)	Jurisdiction/Setting	Study design
					control study
5	Gruen et al.[75]	Specialist Outreach Service	Various surgical specialties i.e. general surgery, ophthalmology, ENT	NT, Remote community	Observational
	Gruen et al.[76]				Mixed methods
6	Jacups et al.[77]	Eye and Ear Surgical Support	Otitis media	Qld, remote	Retrospective evaluation
	Jacups et al.[78]				Case series
7	Mak et al.[79]	ENT Outreach Programme	Otitis media	WA, remote community	Prospective case series
	Mak et al.[80]				Descriptive
8	Reeve et al.[81]	Electronic Health Programme	Otitis media	WA, remote community and education	Retrospective evaluation

The authors evaluated the potential risk of bias using the mixed methods assessment tool and found the quality of the research was variable with only 2 studies receiving a 'Yes' on each of the 5 categories in its associated study type.

The review also considered the level of capacity building and engagement undertaken with Aboriginal and Torres Strait Islander communities in relation to the design, delivery and evaluation of these programs. This included collaboration with various national and community Aboriginal health organisations, such as Aboriginal Community Controlled Health Organisations and found varying degrees of engagement and collaboration with Aboriginal and Torres Strait Islander communities. Only studies evaluating mobile telemedicine-enabled screening and surveillance stated that the initiative had community involvement in all phases of the project life cycle. There were 4 initiatives that partnered and collaborated with Aboriginal stakeholders at the program execution and/or evaluation phase (programs include EESS,

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[75] Gruen, R. L., Bailie, R. S., Wang, Z., Heard, S., & O'Rourke, I. C. (2006, Jul 8). Specialist outreach to isolated and disadvantaged communities: a population-based study. *Lancet, 368*(9530), 130-138. https://doi.org/10.1016/s0140-6736(06)68812-0

[76] Gruen, R. L., Bailie, R. S., d'Abbs, P. H., O'Rourke, I. C., O'Brien, M. M., & Verma, N. (2001, May 21). Improving access to specialist care for remote Aboriginal communities: evaluation of a specialist outreach service. *Med J Aust, 174*(10), 507-511. https://doi.org/10.5694/j.1326-5377.2001.tb143400.x

[77] Jacups, S. P., Kinchin, I., & McConnon, K. M. (2018, Dec). Ear, nose, and throat surgical access for remote living Indigenous children: What is the least costly model? *J Eval Clin Pract, 24*(6), 1330-1338. https://doi.org/10.1111/jep.13044

[78] Jacups, S., Newman, D., Dean, D., Richards, A., & McConnon, K. (2017, 07/01). An innovative approach to improve ear, nose and throat surgical access for remote living Cape York Indigenous children. *International Journal of Pediatric Otorhinolaryngology, 100*. https://doi.org/10.1016/j.ijporl.2017.07.011

[79] Mak, D., MacKendrick, A., Bulsara, M., Coates, H., Lannigan, F., Lehmann, D., Leidwinger, L., & Weeks, S. (2004, Dec). Outcomes of myringoplasty in Australian Aboriginal children and factors associated with success: a prospective case series. *Clin Otolaryngol Allied Sci, 29*(6), 606-611. https://doi.org/10.1111/j.1365-2273.2004.00896.x

[80] Mak, D., MacKendrick, A., Weeks, S., & Plant, A. J. (2000, Jan). Middle-ear disease in remote Aboriginal Australia: a field assessment of surgical outcomes. *J Laryngol Otol, 114*(1), 26-32. https://doi.org/10.1258/0022215001903843

[81] Reeve, C., Thomas, A., Mossenson, A., Reeve, D., & Davis, S. (2014, Jun). Evaluation of an ear health pathway in remote communities: improvements in ear health access. *Aust J Rural Health, 22*(3), 127-132. https://doi.org/10.1111/ajr.12098

Deadly Ears, ENT outreach programme, and Electronic Health Programme) and the remaining programs did not report engaging Aboriginal and Torres Strait Islander stakeholders at any stage of the initiative (3 programs).

Jacups et al.[78] evaluated the EESS which aims to increase access to ENT outreach surgical supports for Indigenous people in residing in rural areas. While stakeholders reported that funding through the EESS largely only pays for travel and accommodation, the authors reported that travel and surgery costs, including surgeon fees, hospital bed time and anaesthetics, were predominantly funded by CheckUP through the EESS. The study sample included 16 Indigenous children requiring surgery for the treatment of otitis media residing in the remote Cape York region. Post-operative management included the use of telehealth for patient review and follow up. In addition to evaluating cost-savings, patient characteristics, clinical presentation figures and outcomes post-op, the authors examined outreach service engagement and collaboration which they found was vital to successful delivery of the service. Partnerships were established between health providers, patient escorts and Indigenous Aboriginal Health Workers who facilitated patient travel and coordinated pre and post -op appointments.

All 16 children received surgery and the mean wait time for surgery was 1.2 years compared to >3 years. The review found the majority of study participants presented with bilateral otitis media with effusion, and the surgery resulted in successful clinical outcomes in 80% and successful hearing outcomes in 88% of study participants. Using telehealth for post-operative review generated a total estimated minimum cost-savings of $21,664 AUD for the 16 patients ($1,354 to $2,158 cost savings per patient). While this service may be applicable in certain areas that are facing barriers to access and high wait times that may jeopardise the long-term health of individuals, the authors noted that operating the service is resource intensive and requires a high level of coordination compared to routine service delivery.

Jacups et al.[77] subsequently conducted a retrospective costing study that evaluated the cost-effectiveness of 3 different ENT outreach service models for Aboriginal children with otitis media living in remote areas. The main outcome measure was the incremental cost difference between model 1, 2 and 3.

- **Model 1**: Surgery provided in public hospital in regional centre with a coordinator.
- **Model 2** (EESS service model evaluated in 2017): surgery provided to a group of patients over a short-time period through private regional hospital co-funded by partnership of health organisations and support from coordinator. Telehealth conducted for post-operative follow-up.
- **Model 3**: Surgery provided by remote hospital with support from earing and hearing health team which includes a nurse and clinician. Telehealth consultations conducted for pre and post appointments.

The study found that model 1 was the most expensive form of outreach service delivery, followed by models 2 and 3. Cost savings for model 3 were an estimated $3,626 to $5,067 per patient compared to model 1. While costs for model 2 generated savings of $2,178 to $2,711 per patient. In addition to generating the most cost-savings, model 3 was preferrable to patients as it resulted in the least travel time which could also reduce patient non-attendance.

While the review found that 6 of the 8 outreach programs generated positive outcomes for the ear and hearing health of Aboriginal and Torres Strait Islander people, there is limited transparency on the long term benefits of these services. Studies that assess the efficacy of ENT outreach interventions are largely dissimilar in evaluative methods, intervention setting and design; therefore, it is difficult to adequately measure and attribute outcomes to these programs. The authors commented that there is limited program coordination across programs and low involvement and collaboration with Aboriginal and Torres Strait Islander people which has resulted in irregular service delivery and monitoring. The authors advocated that these should be key areas of focus going forward.

International literature

While there were few articles in the international literature that met the eligibility criteria for the review, 3 comparative studies and one systematic review were included in the scan. Due to Australia's vast amount of rural and remote areas and wide dispersion of the population (28% of Australians live in a rural or remote area), stakeholders reported that the country is seen as being at the forefront of outreach service delivery which may be reflective of the small amount of relevant literature found in the international context. The wide definition of what is considered 'outreach' and the variation in demographics, political and health systems across countries also appeared to contribute to the number of articles yielded for the purpose of this review.[82]

Two of the 3 comparative reviews are narrative-based qualitative studies and the final comparative review is a retrospective evaluation for an outreach laparoscopic surgical service operating in the United Kingdom. The systematic review assesses the overall cost-effectiveness and benefits of outreach initiatives in international settings. A summary of the international literature is presented below.

Comparative studies

Peeraully et al.[83] performed a retrospective evaluation of an outreach laparoscopic service provided by 4 paediatric surgeons to a district hospital in the United Kingdom over an 11 year period. Over the course of the study, the surgeons performed 1,339 surgeries through the outreach paediatric survey program of which 128 patients received laparoscopy. The principal indicators for the procedure included impalpable unilateral or bilateral undescended testes (UDT) (62%) or insertion of a feeding gastrostomy (38%). The results showed that most cases were performed as day surgeries (96% UDT cases) with a median hospital stay of 2–3 and minimal complications from surgery across the patient sample. The authors concluded that elective laparoscopic procedures in children can be performed effectively as part of an outreach paediatric surgical service and can help to increase access to specialised surgical care by allowing patients to receive care closer to their communities.

Abdelhamid et al.[84] performed a qualitative study that investigated the potential cost effectiveness and clinical benefits of outreach rheumatology services in Norfolk, United Kingdom. Semi-structured interviews were performed with hospital-based doctors, GPs, nurses and rheumatology practitioners in 5 rheumatology practices that provided outreach clinics. The majority of participants viewed the outreach service as being valuable, citing a reduction in waiting time compared to a minimum of 3 weeks waiting time if the patient were to travel to the primary practice location. Many practitioners also viewed patient educational services positively. One GP stated that the outreach clinics provide better continuity of care as the same practitioner will often see a patient, as opposed to central secondary clinics where the patient must find their own transport and will likely see a practitioner who is unfamiliar with their history. Patients reported improved access to rheumatology services and greater convenience. It was not clear if the outreach clinics provided cost savings to providers, however, participants viewed the clinics as being cost effective for patients, particularly due to reduced costs associated with travel. The primary shortcomings of the outreach clinics were lack of additional on-site services (such as diagnostic imaging) and the inability to prescribe medication.

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[82] Australian Institute of Health and Welfare. (2020). Rural and remote health. https://www.aihw.gov.au/reports/australias-health/rural-and-remote-health
[83] Peeraully, R., Hill, R., Colliver, D., Williams, A., Motiwale, S., & Davies, B. (2017, May). Can laparoscopy be part of a paediatric surgery outreach service? *Ann R Coll Surg Engl, 99*(5), 355-357. https://doi.org/10.1308/rcsann.2017.0011
[84] Abdelhamid, A. S., Mooney, J., Walker, A. A., Barton, G., MacGregor, A. J., Scott, D. G., & Watts, R. A. (2012, May 20). An evaluation of rheumatology practitioner outreach clinics: a qualitative study. *BMC Health Serv Res, 12*, 119. https://doi.org/10.1186/1472-6963-12-119

The authors recommended that outreach services should integrate with specialist centres to better enhance care co-ordination. This supports the notion of supporting and facilitating specific outreach models of care, such as the hub-and-spoke model. While outreach services in rural and remote locations may not have access to certain services, the findings highlight the importance of offering health services at the local level and establishing strong partnerships with regional health hubs as it will help to improve access to care and promote continuity of care. Ultimately, the findings illustrate that there are clear global challenges associated with evaluating the cost effectiveness of outreach services and it is important to work to establish consistent and more robust data collection processes to better monitor and evaluate outreach services.

Systematic review

Angell et al.[85] undertook a systematic review of literature that evaluated the economic effectiveness of outreach health interventions in Indigenous populations across high-income nations. Studies within scope of the review included an examination of more traditional outreach interventions, such providing outreach services via local clinics, and more innovative approaches, such as telehealth services and retinal photography screening. Due to the global health disparities that exist between Indigenous and non-Indigenous populations, the authors sought to analyse and shed light on the economic effectiveness of interventions employed to increase access to health services and improve outcomes in Indigenous populations.

A total of 19 studies that included 27 different interventions met the inclusion criteria and were part of the final review. Out of the 19 studies, 7 focussed on the delivery of outreach services to Indigenous populations in rural and remote community settings in OECD countries. More information on these studies can be found in Table 35.

Table 35: Angell et al. studies evaluating outreach interventions in rural and remote settings

Study	Country	Geography	Health intervention	Evaluation type
Baker et al.[86]	Australia	Remote	Prescribing medication for Aboriginal adults with hypertension, diabetes	Cost analysis
Dyson et al.[87]	Australia	Rural and remote	Dental outreach services	Cost-effectiveness
Jin et al.[88]	Canada	Remote	Primary health outreach via mobile clinic	Cost analysis
Martin and Yidegiligne[89]	Canada	Remote	Primary health outreach and retinal photography screening	Cost analysis

[85] Angell, B. J., Muhunthan, J., Irving, M., Eades, S., & Jan, S. (2014). Global systematic review of the cost-effectiveness of indigenous health interventions. *PLoS One, 9*(11), e111249. https://doi.org/10.1371/journal.pone.0111249
[86] Baker, P. R., Hoy, W. E., & Thomas, R. E. (2005, Jan). Cost-effectiveness analysis of a kidney and cardiovascular disease treatment program in an Australian Aboriginal population. *Adv Chronic Kidney Dis, 12*(1), 22-31. https://doi.org/10.1053/j.ackd.2004.10.001
[87] Dyson, K., Kruger, E., & Tennant, M. (2012, Dec). Networked remote area dental services: a viable, sustainable approach to oral health care in challenging environments. *Aust J Rural Health, 20*(6), 334-338. https://doi.org/10.1111/j.1440-1584.2012.01318.x
[88] Jin, A. J., Martin, D., Maberley, D., Dawson, K. G., Seccombe, D. W., & Beattie, J. (2004). Evaluation of a mobile diabetes care telemedicine clinic serving Aboriginal communities in Northern British Columbia, Canada. *Int J Circumpolar Health, 63 Suppl 2*, 124-128. https://doi.org/10.3402/ijch.v63i0.17871
[89] Martin, J. D., & Yidegiligne, H. M. (1998). The cost-effectiveness of a retinal photography screening program for preventing diabetic retinopathy in the First Nations diabetic population in British Columbia, Canada. Ibid.*, 57 Suppl 1*, 379-382.

Study	Country	Geography	Health intervention	Evaluation type
McDermott and Segal[90]	Australia	Remote	Primary health and outreach specialist services	Cost analysis
Shore et al.[91]	USA	Remote	Mental health outreach services via telehealth for American Indian Veterans	Cost analysis
Modelling intervention studies				
Maberley et al.[92]	Canada	Remote	Primary health outreach and screening and retinopathy screening by specialists	Cost-utility analysis

The authors separated the articles into 4 evaluation types: cost analysis, cost-effectiveness analysis, cost-utility analysis and cost benefit analysis. They also stratified the 27 interventions into 2 different categories which included 'primary intervention studies' that evaluated economic effectiveness collected within the study and 'modelled intervention studies' which utilised information from other literature to simulate the impact of the intervention. The most common comparator was analysing the effect of the intervention against no intervention which was done by using a control group, analysing historical data or modelling different scenarios.

Most of the studies on outreach interventions were primary intervention studies. McDermott and Segal[90] performed a cost analysis to evaluate the economic impact of implementing an enhanced outreach diabetes service in a predominantly Indigenous community located in a remote area of Northern Australia. The intervention included visits from specialist outreach, training and upskilling of local health professionals and the implementation of patient recall systems, registries and patient care plans. The study took place over 6 years and compared costs prior to and after the implementation of the enhanced diabetes outreach service. Incremental costs associated with running the diabetes outreach service and patient travel expenses were considered in the study, and the authors analysed costs associated with hospitalisation (including hospitalisations related to 3 categories of diabetes-related conditions and complications) pre and post implementation. The authors analysed and compared costs using data from district financial reports and determined the cost of hospitalisations attributable to diabetes from hospital admission data using Diagnosis-Related Group costings. Without implementation of the service, the authors estimated an 5% annual increase in diabetes-related hospitalisations over the study period; therefore, they applied a discount rate of 5% per year due to potential cost savings and a reduction of future service costs. The net present value cost amounted to an estimated $600,000 over 6 years. Four years after implementation, the authors found that yearly costs savings were higher than the annual costs of operating the service. Due to the findings, the authors advocated for investing in health interventions that enhance and support diabetes care delivery and management in Indigenous communities with a high prevalence of diabetes.

Jin et al.[88] evaluated the cost effectiveness of a mobile diabetes outreach program delivered in rural Indigenous communities with a high prevalence of diabetes across Northern British Columbia. The intervention included yearly visits from a diabetes nurse educator, who also provided support via phone, and an ophthalmic technician who offered diabetes management services and a range of health checks, including screening for diabetic retinopathy, measurement of blood pressure, height and weight and foot examinations. The service was

[90] McDermott, R., & Segal, L. (2006). Cost Impact of Improved Primary Level Diabetes Care in Remote Australian Indigenous Communities. *Australian Journal of Primary Health, 12*(2), 124-130. https://doi.org/https://doi.org/10.1071/PY06031

[91] Shore, J., M.D., M.P.H. ,, Brooks, E., M.S. ,, Savin , D. M. D., Spero, D., Ph.D. ,, & Libby, A., Ph.D. ,. (2007). An Economic Evaluation of Telehealth Data Collection With Rural Populations. *Psychiatric Services, 58*(6), 830-835. https://doi.org/10.1176/ps.2007.58.6.830

[92] Maberley, D., Walker, H., Koushik, A., & Cruess, A. (2003, Jan 21). Screening for diabetic retinopathy in James Bay, Ontario: a cost-effectiveness analysis. *Cmaj, 168*(2), 160-164.

also supported remotely by an ophthalmologist and endocrinologist who offered clinic advice and supervision. The authors compared the costs of operating the mobile clinic to patients accessing alternative services. Within the first year of service operations, the team hosted 25 clinics across 22 sites and assessed 339 patients with diabetes. The mean cost per patient was $1,231 CA which was less costly ($1,437 CA) than transferring patients to the nearest city to receive care. The findings highlight the potential cost benefits of alternative outreach models and how technology can assist in delivering and increasing access to health services in rural and remote areas.

Shore et al.[91] evaluated and compared the costs of using videoconferencing to undertake psychiatric interviews versus in-person sessions with male American-Indian veterans in a rural community. The study was conducted in 2003 and 2005 and included 53 participants. Psychiatrists conducted one in-person and one videoconference session with each participant. The authors looked at costs in clinics with established telehealth services and those that had just begun offering telehealth services. In 2003, the review found that the cost of telehealth sessions in clinics in which these services were newly implemented was $6,000 higher and $1,700 higher in clinics with established telehealth services compared to face-to-face person consultations. Despite these findings, the costs associated with telehealth sessions was $8,000 less for clinics with new telehealth service offerings and $12,000 less for clinics with established services compared to in-person sessions in 2005. While the higher cost of service delivery amongst clinics with newly established telehealth services may be attributed to various factors, such as implementation costs and lower initial patient throughput, the study suggests that telehealth is increasingly becoming a more cost-effective option for health services as transmission costs decrease and new telehealth providers enter the market. The authors concluded that the ongoing expansion of telehealth services and the reduced costs associated with operating this model of care over time will make it an attractive alternative or supplement to face-to-face care while simultaneously increasing access to patients living in rural, remote and/or underserved communities.

While the systematic review included 11 interventions in the "modelled intervention studies category' only one of the studies, Maberley et al.[92] focuses specifically on outreach service delivery in a rural, community setting in James Bay, Ontario. The study evaluated the cost-effectiveness of retinopathy screening through visiting outreach retina specialists compared to utilising retinal photography through a digital camera able to capture 50° photos of the retina in a rural Canadian First Nation community with a high diabetes prevalence. The camera could be operated by technician and the quality of the images were able to be assessed concurrently. The authors used Monte Carlo modelling and had the programs to operate simultaneously over 5 years and assessed outcomes generated over 10 years. The authors considered total costs of operating the models and costs associated with visual outcomes, costs per sight-year saved and quality-adjusted life years in the analysis.

The findings yielded that the camera was the most cost-effective option compared to the specialist outreach model. Over a 10-year period, the interventions resulted in 67 versus 56 sight-years saved compared to no intervention, and the screening modalities incurred a cost of $3900 versus $9800 C$ per sight year with a cost-per-QALY ratio of $15,000 versus $37,000 C$. While the camera was the more cost-effective option and is a valuable tool for the screening of diabetic retinopathy, the authors noted the limitations of this technology as it is used for screening purposes and does not take the place of a full ocular assessment.

All 7 studies included in the Angell et al.[85] review that evaluate outreach interventions in rural and remote communities across OECD countries were found to be cost-effective or generate some form of cost savings. As highlighted above, many of these studies assessed the cost of outreach services compared to usual care. Despite these findings, questions remained around the sustainability of outreach models and the high-cost associated with delivering these services, particularly in very remote areas.

The authors also commented on the small number of studies that evaluate the economic effectiveness of health interventions for Indigenous populations. There are additional difficulties associated with evaluating the benefits of health interventions in Indigenous populations due to their differing perspectives of health compared to non-Indigenous populations. The economic approaches undertaken to evaluate these programs are 'Westernised' and new methodologies may need to be employed that properly assess and consider interventions from a local and cultural perspective.

Telehealth and innovative models of care

Six articles that focus on telemedicine were included for review which includes 4 comparative reviews, one descriptive review and one systematic review. Two of the articles were captured from the PubMed literature search. These focus on the cost effectiveness of substituting telehealth for face-to-face services and how telehealth is currently being used in an outreach context. The other 4 articles were found via the grey literature search.

O'Sullivan et al.[93] investigated how frequently video conferencing is used for specialist medical outreach consultations, the services that were deemed suitable, implementation barriers and the impact that video conferencing has on the provision of outreach services. The authors identified that only one in 5 specialists participate in rural outreach services in Australia, leaving room for improving participation numbers. Telehealth may be one avenue to achieve this. The authors sent a survey to specialist doctors in Victoria who were already receiving funding for travel associated with face-to-face outreach services, but not for telehealth consults. The authors found that 57% of specialists use telehealth to compliment face-to-face services, but telehealth consults were infrequent at 12 times per year. Telehealth was used in a wide range of specialisations, however, many specialists reported concerns over losing community engagement though increased telehealth appointments. Half of the specialists surveyed also reported no change to total travel time associated with providing outreach services, while 43% reported that telehealth consultations took more time than physical consultations. Those specialists that were not already using telehealth reported that it could be provided as a supplementary tool, especially for follow-up consultations, however, 78% reported that funding would be required for co-ordination of telehealth services. The authors found that bandwidth was mostly of medium quality and suitable for follow-up appointments and checking of results. The findings suggest that telehealth may act as a complimentary service to face-to-face appointments, but not a substitute, and support services are required to facilitate co-ordination. Larger studies are needed to better identify trends in telemedicine.

Caffery, Hobbs et al.[94] performed a comparative case study of outreach services delivered by CheckUP to analyse the cost savings of providing telehealth services as a substitute for face-to-face outreach services in Queensland. The authors created several cost models across 16 specialisations. Three of these reflected substitution rates of 25%, 50% and 75% for telehealth appointments in place of face-to-face appointments, while 7 reflected clinician remuneration and reimbursement. Savings were evident in 13 specialisations that used a blended face-to-face and telehealth service in at least one of the cost models created by the authors, primarily due to saved travel time. There was no consistency to these savings and savings were seen throughout the different substitution rates. No savings were seen in 3 of the specialisations in any cost model, with increased costs occurring when clinician remuneration and reimbursement exceeded the cost of saved travel. Cost savings increased as the rate of substitution for telehealth increase in the specialisations that experienced some level of cost savings, however, some cases resulted in increased costs of providing a blended service. The study again highlights the need for further investigation into the potential benefits of

[93] O'Sullivan, B., Rann, H., & McGrail, M. (2019, Mar). Outreach specialists' use of video consultations in rural Victoria: a cross-sectional survey. *Rural Remote Health, 19*(1), 4544. https://doi.org/10.22605/rrh4544
[94] Caffery, L. J., Hobbs, A., Hale-Robertson, K., & Smith, A. (2017). Telehealth substitution of rural outreach services: an economic analysis. http://www.ruralhealth.org.au/14nrhc/sites/default/files/Caffery%2C%20Liam_A2.pdf

telehealth. Cost savings can be seen in some cases where blended services have been provided. The authors suggest that an analysis at the local level of each jurisdiction is required on a case-by-case basis.

Galen Elliott et al.[95] investigated the potential for incorporating telehealth screening services for eye, throat and ear conditions into existing community services for Indigenous Australians. This involved a transportable clinic equipped with ear, throat and eye screening devices and telehealth facilities that visited rural Aboriginal schools in South Burnett, Queensland. The clinic was staffed by an experienced local Aboriginal health worker who performed hearing, throat and vision tests. A telehealth examination by a specialist was subsequently performed for those who failed the eye and ear assessments. Health information and diagnostic imaging was shared via a secure database. The trial resulted in a participation rate of 76%, with 41% and 15% of patients failing a minimum of one element of the screening tests, respectively. Diagnostic imaging was rated 'good' or above in 90% of assessments. The study and additional discussion within the publication suggests that telehealth assessments can be performed reasonably accurately. Furthermore, telehealth reduces travel burden on Aboriginal and Torres Strait Islander patients, increasing access to services in their specific community. The study conducted by the authors was able to match the annual number of ear disease screenings (n=440) within the trial period of 6 months. The clinic was also reported to have integrated efficiently with local health services, including referrals to outside services.

Caffery, Bradford, et al.[96] performed a systematic review of the outcomes of telehealth services provided to Aboriginal and Torres Strait Islander people. Although a systematic review, this article has been included in this section because of its focus on telehealth. The search yielded 14 articles that identified 11 unique telehealth services, which are detailed in Table 36. Key articles from the systematic review have also been discussed below.

Table 36: Characteristics of telehealth services targeting Indigenous Australians identified by Caffery, Bradford et al.[96]

Service	Studies	Location	Geography
Mental health	Alexander and Lattanzio (2009)[97]	SA	Rural and remote
	Buckley and Weisser (2012)[98]	NSW	Rural and remote
Ophthalmology and diabetic retinopathy	Barry et al. (2006)[99]	WA	Rural and remote
	Kanagasingam et al. (2015)[100]	Torres Strait Island, Qld, Goldfield, Great Southern, WA	N/A

[95] Elliott, G., Smith, A. C., Bensink, M. E., Brown, C., Stewart, C., Perry, C., & Scuffham, P. (2010). The feasibility of a community-based mobile telehealth screening service for Aboriginal and Torres Strait Islander children in Australia. *Telemedicine journal and e-health, 16*(9), 950-956. https://doi.org/10.1089/tmj.2010.0045
[96] Caffery, L. J., Bradford, N. K., Wickramasinghe, S. I., Hayman, N., & Smith, A. C. (2017). Outcomes of using telehealth for the provision of healthcare to Aboriginal and Torres Strait Islander people: a systematic review. *Australian and New Zealand journal of public health, 41*(1), 48-53. https://doi.org/10.1111/1753-6405.12600
[97] Alexander, J., & Lattanzio, A. (2009, Dec). Utility of telepsychiatry for Aboriginal Australians. *Aust N Z J Psychiatry, 43*(12), 1185. https://doi.org/10.3109/00048670903279911
[98] Cashin, A., Buckley, T., Donoghue, J., Heartfield, M., Bryce, J., Cox, D., Waters, D., Gosby, H., Kelly, J., & Dunn, S. V. (2015). Development of the Nurse Practitioner Standards for Practice Australia. *Policy, politics & nursing practice, 16*(1-2), 27-37. https://doi.org/10.1177/1527154415584233
[99] Barry, C. J., Constable, I. J., McAllister, I. L., & Kanagasingam, Y. (2006, Jun). Diabetic screening in Western Australia: a photographer's perspective. *J Vis Commun Med, 29*(2), 66-75. https://doi.org/10.1080/01405110600890459
[100] Kanagasingam, Y., Boyle, J., Vignarajan, J., Di, X., & Ming, Z. (2015, Aug). Establishing an indigenous tele-eye care service. *Annu Int Conf IEEE Eng Med Biol Soc, 2015*, 1608-1611. https://doi.org/10.1109/embc.2015.7318682

Palliative care	Hannig et al. (2011)[101]	Kimberley, WA	N/A
Chronic disease home monitoring	Integrated Living (2015)[102]	Toowoomba, Goodna, Coffs Harbour, Armidale	N/A
Oncology	Mooi et al. (2012)[103]	Far North Qld	N/A
	Sabesan et al. (2012)[104]	Far North Qld	N/A
Speech and language therapy	Muir et al. (2013)[105]	N/A	N/A
ENT screening	Reeve et al.[106] Smith AC et al. (2013)[107]	Fitzroy Valley, WA South Burnett, Qld	N/A N/A
Pre-anaesthetic care	Roberts et al. (2015)[108]	Katherine, NT	N/A
ENT outpatient care	Smith AC et al. (2013)[107]	South Burnett, Qld	N/A
ENT pre-surgery and post-surgery care	Smith AC et al. (2013) [107]	South Burnett, Qld	N/A

The different models of telehealth services used vary in the above articles. Video calls were used in public regional hospitals for simple consultations across several specialties, and for chemotherapy supervision and speech therapy. A store-and-forward service, within the community or in an Indigenous health service, was used as a screening tool for ear health, while telehealth monitoring was used to monitor chronic diseases in the home or in telehealth hubs, as well as pre-surgery and post-surgery follow up appointments.

Buckley and Weisser investigated the effects of video-based virtual mental health consultations from a central mental health service on the number of patients being transferred to the central mental health facility. Using logistic regression, the authors calculated a 30% reduction in transfers with respect to the number of transfers prior to the integration of a video function in virtual appointments. The study suggests that the use of telehealth can be an effective tool for mental health consultations and assist in keeping Indigenous patients in their community, reducing significant travel burdens for patients in rural remote locations. While revealing positive patient outcomes resulting from telehealth, the study limits comment on economic benefits to providers who deliver mental health services through telehealth. The mechanism of the decrease in patient transfers is also not understood.

Reeve et al.[106] performed a retrospective evaluation of outreach tele-ear health service for patients in Kimberley, Western Australia. Prior to the introduction of the Ear Health Program, patients experienced increased waiting times due to repeat appointments resulting from incomplete electronic documentation such as referral letters, diagnostic imagery and audiometry. Post-treatment follow-up was also poor, with only 40% of adults and 27% of

[101] Hannig, L., & Cunningham, K. (2011, Mar 13-16). *Clinical services via telehealth in the Kimberley.* Proceedings of the 11th National Rural Health Conference, Perth, AUST.
[102] Integrated Living. (2015). *Staying Strong Pilot Project Concise Report.*
[103] Mooi, J. K., Whop, L. J., Valery, P. C., & Sabesan, S. S. (2012, Oct). Teleoncology for indigenous patients: the responses of patients and health workers. *Aust J Rural Health, 20*(5), 265-269. https://doi.org/10.1111/j.1440-1584.2012.01302.x
[104] Sabesan, S., Larkins, S., Evans, R., Varma, S., Andrews, A., Beuttner, P., Brennan, S., & Young, M. (ibid.). Telemedicine for rural cancer care in North Queensland: bringing cancer care home. 259-264. https://doi.org/10.1111/j.1440-1584.2012.01299.x
[105] Muir, A., & James, K. (2013). *Using telehealth to overcome barriers to access communication therapy: A case study of a successful service delivery model for an Aboriginal man with chronic communication impairment following stroke.*
[106] Reeve, C., Thomas, A., Mossenson, A., Reeve, D., & Davis, S. (2014, Jun). Evaluation of an ear health pathway in remote communities: improvements in ear health access. *Aust J Rural Health, 22*(3), 127-132. https://doi.org/10.1111/ajr.12098
[107] Smith, A. C., Armfield, N. R., Wu, W. I., Brown, C. A., Mickan, B., & Perry, C. (2013, Oct). Changes in paediatric hospital ENT service utilisation following the implementation of a mobile, indigenous health screening service. *J Telemed Telecare, 19*(7), 397-400. https://doi.org/10.1177/1357633x13506526
[108] Roberts, S., Spain, B., Hicks, C., London, J., & Tay, S. (2015, Jun). Telemedicine in the Northern Territory: an assessment of patient perceptions in the preoperative anaesthetic clinic. *Aust J Rural Health, 23*(3), 136-141. https://doi.org/10.1111/ajr.12140

children documented to have received a follow-up consultation within 3 weeks. The study found that, with the introduction of the Ear Health Program, ENT screenings and referrals had increased for children during the study period from 148 to 710 and 35 to 67, respectively. Completeness of referral letters also improved significantly and waiting times for ear health services decreased. Post-treatment follow-up improved, with the number of patients receiving antibiotics also increasing. A decrease in waiting times for ENT reviews was also found. Of note, when the ear health nurse took an extended period of leave, referrals and telehealth appointments were noted to drop. Consequently, Indigenous project officers have since been trained to perform these functions. The study suggests better co-ordination of care and access to care can be achieved with the correct training of staff on telehealth care and management. Mitigation strategies, such as training of several staff, should be implemented to ensure continuity of care if key staff members are absent.

Smith et al.[109] continued their work reporting on the results of a mobile-ear screening service provided in South Burnett, Queensland , as examined earlier by Galen Elliott et al.[95] The study by Smith et al.[109] reported similar results, with a failure rate of 26% of all screening tests, and participation rate of 85%. Of note, the authors state that the program would have little impact on screening failure rates until socio-economic factors contributing to conditions such as otitis media have been addressed. Indigenous Health Workers who perform and coordinate the screening play a crucial role in the provision of this service, as does consultation with the local Indigenous communities to assist in shaping improvements to the model.

Wickramasinghe evaluated the usefulness of a tele-diabetes service managed by Princess Alexandra Hospital in Brisbane.[110] evaluated the usefulness of a tele-diabetes service managed by Princess Alexandra Hospital in Brisbane. The service delivered clinical outreach to Indigenous patients requiring diabetes management in regional areas of Queensland. The study focused on acceptance, satisfaction and comfort of using the telehealth service, as well as clinical outcomes using activity data from clinics and HbA1c levels of patients. A cost comparison between the telehealth mode and face-to-face services was also performed. The results of this are discussed further later. The specialists were of the opinion that decisions made in the clinical management of diabetes were similar to those made during in-person consultations, provided that an adequate consultation was first performed by the local health service prior, and there was active involvement from the local GP. This process proved challenging for the local health services, however, specialists performing telehealth consultations found the service useful. Patients also reported that clinical management specific to the individual was only achieved when telehealth consultations were performed in conjunction with local health providers. Patients were satisfied and comfortable with the experience using telehealth and were happy to use the service long-term, however, this was again contingent on active participation from local health services. In particular, cultural competency and Aboriginal representation was important to patients. Uptake of telehealth was higher in locations where face-to-face specialist services were not available. Only negligible improvements were seen in HbA1c levels (less than an average of 0.5 units) and these were seen in 66% of patients in one location (n=6) and 43% in another (n=5). Not including establishment costs for telehealth, a specialist telehealth consultation was calculated to cost $95 per consultation, compared to $513 per consultation for in-person specialist consultations as part of an outreach service. The study highlights the importance of local co-ordination and cultural competency in outreach telehealth services and that telehealth can be effective as a complimentary service, but further evidence is needed to determine if telehealth is suitable as a substitute, and more consideration should also be given to costs to the patient. Short-term patient outcomes attributed to telehealth are difficult to measure. The sample size in the study was small and although telehealth was found to be cheaper than visiting outreach,

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[109] Smith, A. C., Brown, C., Bradford, N., Caffery, L. J., Perry, C., & Armfield, N. R. (2015, Dec). Monitoring ear health through a telemedicine-supported health screening service in Queensland. *J Telemed Telecare, 21*(8), 427-430. https://doi.org/10.1177/1357633x15605407

[110] Wickramasinghe, S. (2019). An evaluation of a telehealth-based specialist consultation service for Indigenous people living with diabetes in Queensland.

in-person consultations may be cheaper when more consultations are performed in one visit. Including the establishment costs of telehealth would be useful to reconcile against the findings of Shore[91] which found higher costs were associated with newly established clinics, and costs savings as clinics became more established with more throughput.

Lower cost savings amongst clinics with newly established telehealth services can be attributed to fees associated with implementation, such as integrating a platform with existing software and training costs, the study suggests that telehealth is increasingly becoming a less costly option as transmission costs decrease and more telehealth providers enter the market. The authors concluded that the expansion of telehealth and reduced costs associated with operating telemedicine models may make it an attractive alternative to the delivery of in-person health services where feasible while simultaneously increasing access to rural, remote and/or underserved communities

Appendix 1B: Information provided to stakeholders

Information sheet – Evaluation of outreach programs

Health Policy Analysis has been contracted by the Department of Health to evaluate several of its outreach programs. These initiatives have a particular focus and impact on Aboriginal and Torres Strait Islander people and individuals residing in regional, rural and remote areas as they aim to improve access to health services and outcomes for these populations. The evaluation will assess multiple aspects of the outreach programs including implementation processes, data collection and monitoring, impacts, efficacy, governance, costs, barriers and enablers to implementation and ongoing operations and outcomes. The timeframe for the evaluation will be from 2017–18 and will encompass the following 6 programs:

- Medical Outreach – Indigenous Chronic Disease (MOICDP), which supports increased access to healthcare for Aboriginal and Torres Strait Islander people. The scope of this program includes all Indigenous people with chronic disease regardless of geographical location (Modified Monash Model (MM) categories 1–7).
- Healthy Ears (HEBHBL), which aims to increase access to ear and hearing services for Aboriginal and Torres Strait Islander children and youth in rural and remote areas (MM 2–7).
- Eye and Ear Surgery Support (EESS), which supports for access to eye and ear surgery for Aboriginal and Torres Strait Islander people in rural and remote areas (MM 3–7).
- Visiting Optometrist Scheme (VOS), which supports optometry services for people in regional, rural and remote areas (MM 2–7). The program has Indigenous (40%) and non-Indigenous (60%) components.
- Rural Health Outreach Fund (RHOF) aims to improve access to healthcare services for all residents in rural and remote communities (MM 3–7). The program has 4 areas of focus: mental health, eye health, chronic disease and paediatric health.
- Heart of Australia (HoA) which provides specialist medical services, including cardiology and respiratory medicine, to 25 regional, rural and remote communities in Queensland (MM 2–7), expanding to further 6 communities in 2021.

Of the above programs, the MOICDP, HEBHBL and EESS are funded through the Indigenous Australians' Health Programme (IAHP), and the Medicare Services Special Appropriation, Outcome 4.1 funds the VOS. HoA receives funding via Government grants and private sponsorship, while the RHOF is an independent fund.

Fundholder organisations have been appointed in each jurisdiction in Australia, except the Australian Capital Territory, to manage these programs. While these programs operate independently, there is a single fundholder model in place for all 6 programs across multiple jurisdictions, except for the Northern Territory, Tasmania and Queensland.

For more information on these outreach programs, please refer to the following program service delivery standards and websites listed in Table 37.

Table 37: Service delivery standards for the outreach programs

Program	Service delivery standards
Medical Outreach – Indigenous Chronic Disease Healthy Ears – Better Hearing, Better Listening Eye and Ear Surgery Support Visiting Optometrist Scheme	Outreach programs service delivery standards
Rural Health Outreach Fund	RHOF service delivery standards

Notes: The HEBHBL, VOS, EESS and MOICDP operate under the same service delivery standards. HoA does not operate under any set of service delivery standards.

Evaluation objectives and methodology

The purpose of the evaluation is to assess the efficiency, effectiveness and appropriateness of these programs. The intention is to evaluate the outcomes of these programs to inform future policy directions rather than to assess the performance of individual fundholders or service providers. The high-level questions that the evaluation seeks to address include:

1. How well are each of the outreach programs being delivered?
2. How effective are each of the outreach programs in achieving their intended outcomes?
3. How efficient and cost-effective are each of the outreach programs?
4. To what extent are outreach activities coordinated across the outreach programs?

The evaluation will be conducted in 4 stages and will run between now and September 2022. HPA will seek feedback from a variety of stakeholders and draw upon on a wide range of qualitative and quantitative sources. Key methods through which evidence will be gathered for the evaluation include:

- a review of program documentation and other relevant literature
- consultations with key stakeholders nationally and across jurisdictions
- the collection of written feedback and comments from key stakeholders
- a selection of case studies conducted across jurisdictions
- a survey of clinical service providers who have been supported through these outreach programs.
- analysis of program and other secondary data sources, including MBS, AIHW and local clinical and administrative datasets.

Appendix 1C: Stakeholders consulted

The evaluation team spoke with 69 stakeholder organisations across Australia to help inform the evaluation on the outreach programs. Table 38 outlines the stakeholder organisations by organisation type and associated method of consultation

Table 38: List of stakeholder organisations consulted

Stakeholder group	Organisation type	Method of consultation
WA jurisdictional stakeholders		
RHW	Fundholder	Interview
Aboriginal Health Council of WA	NACCHO affiliate	Interview
WA Primary Health Alliance, Country North	PHN	Interview
WA Primary Health Alliance, Kimberley	PHN	Interview
WA Country Health Service, Kimberley	State health department	Interview
Broome Regional Medical Service	Provider	Interview
Lions Outback Vision	Provider	Interview
Kimberley Aboriginal Medical Services	ACCHO/Host provider	Interview
WA funding arrangement manager	Funding Arrangement Manager	Interview
NSW jurisdictional stakeholders		
NSW RDN	Fundholder	Interview
Aboriginal Health and Medical Research Council of NSW	NACCHO affiliate	Interview
Coordinare PHN	PHN	Interview
Hearing Australia	Advisory forum member	Interview
UNSW	Advisory forum member	Interview
Grand Pacific Health	Host provider	Interview
Cullunghutti Child and Family Centre	Host provider	Interview
Southern NSW LHD	LHD	Interview
Individual provider	Visiting provider	Interview
Individual provider	Visiting provider	Interview
NSW funding arrangement manager	Funding Arrangement Manager	Interview
NT jurisdictional stakeholders		

NT Health	Fundholder/Territory health department	Interview
NT PHN	Fundholder/PHN	Interview
AMSANT	NACCHO affiliate	Interview
Central Australian Aboriginal Congress	ACCHO/Host provider	Interview
Central Australia Health Service	LHN/Advisory forum member	Interview
CEO Pintupi Homelands Health Service	ACCHO/Host provider	Interview
Ali Curing Health Centre	Aboriginal health service/Host provider	Interview
Royal Flying Doctor Service	Visiting provider	Interview
Individual outreach provider	Visiting provider	Interview
NT funding arrangement manager	Funding Arrangement Manager	Interview
Tas jurisdictional stakeholders		
TAZREACH	Fundholder	Interview
RHT	Fundholder	Interview
Tasmania Aboriginal Centre	NACCHO affiliate	Interview
HR+	Rural workforce agency	Interview
Opal Pain Management Program	Visiting provider	Interview
North West Regional Hospital	Regional hospital	Interview
Tas funding arrangement manager	Funding Arrangement Manager	Interview
Qld jurisdictional stakeholders		
CheckUP Australia	Fundholder	Interview
HoA	Fundholder	Interview
Qld Aboriginal and Islander Health Council	NACCHO affiliate	Interview
True Relationships and Reproductive Health	Health organisation	Interview
Theodore Medical Centre	Host provider	Interview
Cairns and Hinterland Hospital and Health Service	HHS	Interview
Cairns Hospital	Hospital	Interview
Qld funding arrangement manager	Funding Arrangement Manager	Interview
SA jurisdictional stakeholders		
RDWA SA	Fundholder	Interview

Aboriginal Health Council SA	NACCHO affiliate	Interview
SA Health	State health department	Interview
Country SA PHN	PHN	Interview
Individual outreach provider	Visiting provider	Interview
Optometry Vic/SA	Advisory forum member	Interview
SA funding arrangement manager	Funding Arrangement Manager	Interview
Vic jurisdictional stakeholders		
RWAV	Fundholder	Interview
VACCHO	NACCHO affiliate/advisory forum member	Interview
Blue Star Eyecare	Outreach provider	Interview
Njernda Aboriginal Corporation	ACCHO/Host provider	Interview
Optometry Vic/SA	Advisory forum member	Interview
Western Vic PHN	PHN	Interview
Vic funding arrangement manager	Funding Arrangement Manager	Interview
National bodies		
National Rural Health Commissioner		Interview
National Rural Health Alliance		Interview
Vision 2020[111]		Interview
RANZCO		Interview
Services for Rural and Remote Allied Health		Interview
Aboriginal services		
National Aboriginal Community Controlled Health Organisation		Interview
Aboriginal workforce groups		
Indigenous Allied Health Australia		Interview
Government policy makers		
Australian Government Department of Health – Directors and officers of Health Workforce Division		Group interview
Australian Government Department of Health – Directors and officers of Indigenous Health Division		Group interview
Australian Government Department of Health – First Assistant Secretary Indigenous Health Division		Group interview

[111] Vision 2020 also provided a written submission.

Other workforce groups	
Australian Medical Association	Survey
RACGP	Survey
Australian Nursing and Midwifery Federation	Survey
Australian Primary Health Care Nurses Association	Survey
Allied Health Professions Australia	Survey
Audiology Australia	Survey
Australian Society of Otolaryngology Head and Neck Surgery	Survey
Australian Society of Ophthalmologists	Survey
Optometry Australia	Survey
Rural Doctors Association of Australia	Survey
Rural Health Workforce Australia	Survey
Australian College of Rural and Remote Medicine	Survey
Australian Rural Health Education Network	Survey

Appendix 1D: Interview topic guides

This section provides examples of the interview topic guides by stakeholder group. These topics include examples of questions explored in interviews with stakeholders.

Interview topic guide – Fundholders

Evaluation question	Question
Introduction	• Introduction of researcher and describe the project and its purpose. • Remind the participant that participation is voluntary; that they do not have to take part, and that there will be no repercussions if they choose not to do so. • Describe what participation in the interview involves. • Remind the participant that they can withdraw from the interview at any time, and that they do not have to answer any further questions. • Outline confidentiality/anonymity provisions, that is, that the participant will not be named in any reporting of results to any parties, that any personal information gathered will not be disclosed to any other party. • Outline how the participant will be informed of the results of the research when it is finished. • Seek permission to audio record interview. • Check whether the participant has any questions. • Summarise the structure of the interview and confirm the scope of programs the fundholder is responsible for.
Ice breaker	How do the outreach programs being evaluated contribute to the overall strategic intent and operational effort of your organisation?
1. How well are each of the outreach programs being delivered?	
1.1. How well are the programs being governed?	
Funding	**What is your experience of the funding process by the Department?** Prompts • Level, relative share and duration of funding? • Requirements under the services standards and funding agreements? • Key challenges and suggested areas for improvement overall? Specific programs?
Advisory fora	**What are your reflections on how well your jurisdictional advisory forum is functioning?** Prompts • Representation of key stakeholders? • Role in needs assessment and service planning? • Key challenges and suggested areas for improvement overall? Specific programs?
Performance	**How do you manage performance of your service providers and the overall programs?** Prompts • Key performance metrics and data sources? • Alignment with Department performance reporting requirements?

Evaluation question	Question
	• Key challenges and suggested areas for improvement overall? Specific programs?
Engagement	**How do you interact with the Department and other bodies in administering the programs?** Prompts • DSS community grants hub and Department of health? • Other jurisdictional bodies – State and territory DoH, PHN, LHN, NACCHO affiliates? • Key challenges and suggested areas for improvement overall? Specific programs?
1.2. How well are community needs identified and addressed through service planning?	
Needs assessment	**Briefly describe your needs assessment process?** Prompts • What data sources do you rely on? • What role do providers and local communities play? • Key challenges and suggested areas for improvement overall? Specific programs?
Service planning	**Briefly describe your process for service planning?** Prompts • Identifications of areas of highest need? • Balancing priorities of need, service availability and resources? • Key challenges and suggested areas for improvement overall? Specific programs?
1.3. How well are outreach providers recruited and placed according to the service plan?	
Provider recruitment	**What are the main activities you undertake to recruit service providers?** Prompts • Promote awareness of programs? • Process for assessing and engaging providers? • Key challenges and suggested areas for improvement overall? Specific programs?
Provider retention	**How do you seek to retain service providers?** Prompts • Feedback mechanisms? • Successful means of support for providers? • Key challenges and suggested areas for improvement overall? Specific programs?
1.4. How well are the services operating within the local communities?	
Service coordination	**Describe how outreach services are coordinated within local communities?** Prompts • Support for local service coordination? • Coordination of services across outreach programs? • Key challenges and suggested areas for improvement overall? Specific programs?
Service integration	**How do you promote service integration and continuity of care?** Prompts

Evaluation question	Question
	• Relationship building between outreach and host providers? • Integration and sharing of patient records across host, outreach and other providers? • Key challenges and suggested areas for improvement overall? Specific programs?
Capacity building	**How do you build capacity of your outreach and host providers?** Prompts • Upskilling and capacity building of local providers • Cultural sensitivity and competency of outreach services providers • Key challenges and suggested areas for improvement overall? Specific programs?
2. How effective are each of the outreach programs in achieving their intended outcomes?	
2.1. How effective is each program in increasing access by the relevant service populations?	
Service arrangements	**Describe the predominant service arrangements in place across the outreach programs?** Prompts • Fit for purpose for each program (for example, hub-and-spoke, fly in and fly out, telehealth)? • Role of the public and private sectors? • Key challenges and suggested areas for improvement overall?
Models of care	**Describe the nature of the models of care provided in local communities?** Prompts • Degree to which they are multidisciplinary? • Balance between prevention, detection and management of conditions? • Key challenges and suggested areas for improvement overall?
Access to care	**What are the key enablers and barriers to accessing outreach services?** Prompts • Providers (remuneration, time, service infrastructure, cultural awareness) • Patient (out of pocket costs, trust, cultural safety, availability of services) • Key challenges and suggested areas for improvement overall?
2.2. How effective is each program in improving health outcomes for the relevant populations?	
Health outcomes	**What evidence is there that the programs are improving health outcomes?** Prompts • Clinical data and information available? • Patient reported experience and outcome measures? • Key challenges and suggested areas for improvement overall?
2.3. What impact is telehealth having on delivery of each of the programs?	
Local capacity	**What capacity exists to use telehealth to support outreach services across local health services?** Prompts • Local infrastructure and expertise • Cultural acceptance and trust of patients • Key challenges and suggested areas for improvement overall?
Current utilization	**In what ways is telehealth currently used to support outreach services?** Prompts

Evaluation question	Question
	• Use by outreach providers (initial assessment, follow up care)? • Impact of COVID–19 on the nature and extent of use of telehealth? • Key challenges and suggested areas for improvement overall?
Access to care	**What are the key enablers and barriers to accessing telehealth?** Prompts • Providers (remuneration, time, service infrastructure, cultural awareness) • Patient (out of pocket costs, trust, cultural safety, availability of services) • Key challenges and suggested areas for improvement overall?
3. How efficient and cost-effective are each of the outreach programs?	
3.1. What are the key cost drivers in managing the outreach programs?	
Cost drivers	**What are the biggest cost drivers you face in providing outreach services?** Prompts • Administration and service deliver costs drivers? • Areas amenable to improving productivity and efficiency? • Location specific challenges and suggested areas for improvement overall?
3.2. Are the outreach programs a cost-effective method of achieving desired outcomes?	
Alternative models	**Are there alternative models of care that could deliver better value for money?** Prompts • Different ways of providing outreach services (e.g. integrating telehealth)? • Alternatives to outreach (e.g. patient travel)? • Key barriers and enablers for models that can improve value for money?
4. To what extent are the outreach activities coordinated across the outreach programs?	
4.1. To what extent has program administration been coordinated across programs?	
Program coordination	**How do you coordinate across the outreach programs you administer and other programs?** Prompts • Relationship with other program fundholders (if multiple) • Coordination with other programs out of scope of this evaluation (e.g. Deadly Ears) • Key barriers and enablers for greater coordination of program administration?
4.2. To what extent have the programs provided integrated services and continuity of care?	
Continuity of care	**What arrangements are in place to promote service integration and care continuity?** Prompts • Coordination of care across programs (e.g. VOS, Healthy Ears and EESS) • Patient referral pathways and clinician documentation (e.g. My Health Record) • Key barriers and enablers for promoting greater continuity of care?

Interview topic guide – Advisory forum

Evaluation question	Question
Introduction	• Introduction of researcher and describe the project and its purpose. • Remind the participant that participation is voluntary; that they do not have to take part, and that there will be no repercussions if they choose not to do so. • Describe what participation in the interview involves. • Remind the participant that they can withdraw from the interview at any time, and that they do not have to answer any further questions.

Evaluation question	Question
	• Outline confidentiality/anonymity provisions, that is, that the participant will not be named in any reporting of results to any parties, that any personal information gathered will not be disclosed to any other party. • Outline how the participant will be informed of the results of the research when it is finished. • Seek permission to audio record interview. • Check whether the participant has any questions. • Summarise the structure of the interview and confirm the scope of programs in which the advisory forum has a role.
Ice breaker	What is your understanding of the role of the advisory forum in the administration of the outreach programs?
5. How well are each of the outreach programs being delivered?	
5.1. How well are the programs being governed?	
Role	**To what extent is the forum's role aligned with requirements of the service delivery standards?** • RHOF • MOICDP, HEBHBL, EESS, VOS • Key challenges and suggested areas for improvement overall? Specific programs?
Membership	**To what extent do the members provide expertise on existing health delivery arrangements?** Prompts • Regional, rural and remote health services? • Expertise in health services planning? • Key challenges and suggested areas for improvement overall? Specific programs?
Decision-making	**How does the forum carry out its role in the governance of the programs?** Prompts • How often does the forum meet? • What is the process of decision-making at meetings? • Key challenges and suggested areas for improvement overall? Specific programs?
Evaluation	**How do you manage performance of your service providers and the overall programs?** Prompts • Key performance metrics and data sources? • Alignment with Department performance reporting requirements? • Key challenges and suggested areas for improvement overall? Specific programs?
Advice	**How do you interact with the Department and other bodies in administering the programs?** Prompts • DSS community grants hub and Department of health? • Other jurisdictional bodies – State and territory DoH, PHN, LHN, NACCHO affiliates? • Key challenges and suggested areas for improvement overall? Specific programs?
5.2. How well are community needs identified and addressed through service planning?	

<table>
<tr><th>Evaluation question</th><th>Question</th></tr>
<tr><td>Needs assessment</td><td>Briefly describe the role of the forum in the needs assessment process?

Prompts

• Ensure consultation with key stakeholders?
• Advice on annual needs assessment?
• Identification of areas of highest priority?
• Key challenges and suggested areas for improvement overall? Specific programs?</td></tr>
<tr><td>Service planning</td><td>Briefly describe the role of the forum in service planning?

Prompts

• Advice on types of services and proposed health service planning models
• Identification of opportunities for program linkage and integration
• Advice on capacity of service locations to support service proposals
• Advice on value for money of service proposals
• Determination of service gaps
• Key challenges and suggested areas for improvement overall? Specific programs?</td></tr>
</table>

Appendix 1E: Fundholder documents provided

As part of the review, HPA requested the Department to provide relevant fundholder program documents. These included copies of fundholder needs assessments, 4-year service plans, along with routine reports they submit to the Department, including annual service plans, narrative reports and regular performance and finance reports from financial years 2017–18 to 2020–21. The Department requested that HPA reach out to the individual fundholders directly for these documents. During our initial communications with the fundholders in August and September 2021, HPA requested this information via email from the following fundholders (see Table 39).

Table 39: List of fundholders

Fundholder	Jurisdiction
NSW RDN	NSW/ACT
NT Health	NT
NT PHN	NT
CheckUP	Qld
HoA	Qld
RDWA SA	SA
TAZREACH	Tas
RHT	Tas
RWAV	Vic
RHW	WA

All the fundholders, excluding RHT and HoA, provided some of the reporting documents listed above from September 2021 to February 2022. RHT was only recently appointed as the fundholder in Tasmania for the EESS program; therefore, they did not begin service operations until 2022 and had yet to report on the EESS program. While HoA does report to the Department, they are a private organisation that receives funding from a mix of public and private sources; therefore, they are not subject to the same reporting requirements as the fundholders that manage the other outreach programs. The Department provided a milestone and service activity report on HoA for the July to December 2020 period.

Approximately 1,200 fundholder documents were provided. While there was some variation in the volume and type of fundholders, a description of the key reporting documents submitted by the fundholders across jurisdictions is provided below:

Biannual narrative reports:

A detailed 6-monthly update of each outreach program that lists a variety of information on program activity over the reporting period, such as operational status, service activity, program expenditure, unspent funds and associated upskilling activity. This information is compared to previous financial years and the documents includes visuals on program occasions of service and upskilling hours. There are also sections that report on key challenges and associated strategies applied to overcome these issues and good news stories.

Biannual data reports:

While the biannual data reports vary by program activity (that is, EESS reports surgeries performed within reporting period and MOICDP lists visits and occasions of service), more recent versions of the document provide a general executive summary of program activity and associated expenditure per reporting period. The outreach reporting template (lists reporting period, program, location, PHN region, MM classification, service number, health professional,

category, priority, provider name, actual period expenditure, number of occasions of service, number of Aboriginal and Torres Strait Islander occasions of service, upskilling provided, professional support provided, new service and comments) and data validation lists.

Most versions of the biannual data reports (that is, 2017–18, 2018–19) are consolidated into a single spreadsheet that show various aspects of service volume for each program during the reporting period by provider. While VOS, HEBHBL, MOICDP, and RHOF are reporting in a single sheet, the EESS is reported separately from the other programs.

Biannual financial reports:

Biannual reporting document that lays out the planned approved budget outlined in the activity work plan, all income sources (including Federal funding, rollover funding and any other sources), expenditure by category, total expenditure for the reported 6-month period and total unexpended funding remaining. Depending on the reporting period, the biannual report may include the balance as at 31 December and 30 June for the specific financial year and the total progressive balance.

Performance report assessment template:

This document provides information on performance over 6 month period and provides a table that lists the item agreed upon in the performance report, deliverable/milestone, comments on progress and status of project.

Activity work plan:

An annual high-level document that includes information on program objectives and aims and a table that lays out overarching program goals, objectives, strategies to achieve the goal, deliverables. The document also contains information on the outreach program needs-assessment methodology, data collection strategies, communication, monitoring strategies, services, administration, risk management strategies, linkages (details of how program will link with other organisations and health programs in the jurisdiction to deliver well-coordinated care), annual review and budget. The activity work plan has a table in the appendix that lays out tasks, outcomes, program deliverables, performance measures and a timeline for expected completion.

While there is slight variation in the activity work plan template from 2017–18 to 2021–22, they have a similar layout across the years for each program. In the 2021–22 activity work plan, all programs were consolidated into a single activity work plan which diverges from previous years where each program had their own activity work plan. This includes a newly standardised methodology that has been applied across programs.

2017–2020 Final Program Reports:

Provided by specific fundholders for select programs. Document details program context, performance, outputs, activity, linkages, challenges and opportunities for improvement, highlights and achievements, program outcomes for patients, practitioners, subcontractors and host facilities and concluding thoughts and alignment with program aims from 2017 to 2020.

Program grant agreements:

Follows the standard Departmental grant agreement template outlines program information and the standard funding agreement schedule. This includes requirements to be met as detailed in the activity work plan, funding and payment, reporting requirements, supplementary conditions

Table 40 provides a comprehensive list of the type of documents provided by individual fundholders.

Table 40: Document types provided by fundholders

Fundholder	Document type		Approx. # of documents
ACRRM	• Biannual narrative reports • RHOF ACRRM reports • RHOF ACRRM financial reports • ACRRM Tele-Derm Evaluation Report • Ophthalmology Assist Evaluation	• Performance Reports • Tele-Derm workplans • Terms of Reference • Standard Grant Agreement	21
CheckUP	• Biannual narrative reports • Biannual service activity reports • Biannual financial reports • Outreach activity work plan • Vital Health Outreach Services Review SW Qld • CheckUP Australia Costing Review • Standard Grant Agreement Healthy Ears 2018–2022 • Standard Grant Agreement EESS 2020–21 to 2023–24 • Standard Grant Agreement MOICDP 2020–21 to 2023–24	• Standard Funding Agreement VOS 2017–18 to 2019–20 • Standard Grant Agreement VOS 2020–21 to 2023–24 • Patient feedback survey • Patient feedback card • Performance report assessment template (MOICDP)	114
HoA	• HoA milestone report July-December 2020 • HoA patients and service activity data July-December 2020 • HoA submission on HPA evaluation		3
NSW RDN	• Standard Grant Agreement RHOF 2019–20 to 2020–21 • Activity report templates for HEBHBL, MOICDP, RHOF, EESS, FEHHS • Health service costs per clinic hour • VOS definitions for data collection • Outreach health practitioner survey results 2013–16 • Outreach patient survey results 2017–18 • Outreach visiting health practitioner survey results 2017–18	• Activity work plans • Annual service plans • Biannual narrative reports • Biannual service activity reports • Biannual financial reports • Needs assessments • 2017–2020 Final Program Reports	250
NT Health	• Activity work plans • Biannual narrative reports • Biannual service activity reports • Biannual financial reports • Steering Committee Agenda • Referral Working Group agenda and minutes • Activity highlights of ear health coordinators nationally • Working Group minutes • Working Group Terms of Reference	• Ear Health Terms of Reference • HAPEE, HHP and AMSANT Collaboration meeting agenda and minutes • Ear health planning workshop – draft work plan and workshop overview • Hearing Services Continuous Quality Improvement Framework 2020 • NT Health Strategic Plan 2018–2022 • Deadly Sounds Communicare and MBS Guide • Access and equity reports HEBHBL • AIHW NT Outreach Hearing Health Program reports	146

		• 2017–2020 Final Program Reports	
NT PHN	• Activity work plans • Biannual narrative reports • Biannual service activity reports • Biannual financial reports • East Arnhem Regional Data Profile	• Central Australia Regional Data Profile • OHS Resource Distribution Model Methodology • Outcome Report Template • MOICDP Evaluation • 2015–2017 Final Program Reports	45
RDWA SA	• Biannual narrative reports • Biannual service activity reports • Biannual financial reports	• 2017–2020 Final Program Reports • Annual service review and needs assessment 2021–2022	118
RHT	• None provided.		0
RHW	• Activity work plans • Biannual narrative reports • Biannual service activity reports • Biannual financial reports • Audited financial reports • Terms of Reference	• Advisory forums • Consultation opportunities • Ear and Hearing Digital Health Forum Program • Kimberley Terms of Reference – Regional Working Group • 2017–2020 Final Program Reports	283
RWAV	• Activity work plans • Service plans • Biannual narrative reports • Biannual service activity reports • Biannual financial reports	• 2017–2020 Final Program Reports • Details on advisory fora • outreach programs - Terms of Reference • RHOF Terms of Reference • Vic Advisory Forums' Membership 2021–2022	161
TAZREACH	• Activity work plans • Biannual narrative reports • Biannual service activity reports • Biannual financial reports • Private provider template • Public provider template • Public host provider template	• Private host provider template • Advisory forum minutes • TAZREACH communication strategy • Community Health and Hospitals Program Brief • Terms and conditions 2020–21 • State advisory forum terms of reference • 2017–2020 Final Program Reports	59

In conjunction with the data provided by the fundholders in the data specification, HPA used the fundholder service activity and financial reports in our quantitative analysis. Due to gaps in some of these program service activity and financial documents across years and programs, HPA asked the Department to provide the evaluation team with the remaining documents in June 2022. While the Department was able to provide some of these documents, others were unable to be provided (particularly program service activity and financial reports for the 2017–18 financial year as the Department transitioned to a newer electronic filing system). The HPA team then reach out to the individual Funding Arrangement Managers across the jurisdictions to request these documents. In total, there were 57 out of 704 biannual service activity and financial reports that the team did not receive. Table 41 highlights the documents HPA was not able to access and include in our analysis by fundholder, document type, program and financial year.

Table 41: Missing fundholder biannual activity and financial reports by program and financial year

Fundholder	Document	Program	Year(s) (17–18 to 20–21)
ACRRM	Financial reports	Tele-Derm	2020–21
CheckUP	Activity reports	RHOF PM	2019–20, Jan–Jun 2021
CheckUP	Activity reports	MOICDP	Jan–Jun 2019
CheckUP	Activity reports	VOS	Jan–June 2019
HoA	All	HoA	All years
NSW RDN	Activity reports	RHOF PM	2019–20
NT Health	Activity reports	RHOF PM	2019–20, 2020–21
NT Health	Activity reports	EESS	Jul–Dec 2019
NT Health	Activity reports	MOICDP	2017–18
NT Health	Financial reports	MOICDP	2017–18, 2018–19
NT PHN	Financial reports	MOICDP	Jan–Jun 2020, 2020–21
RDWA SA	Financial reports	EESS	2017–18
RDWA SA	Activity reports	RHOF PM	2019–20, 2020–21
RDWA SA	Financial reports	RHOF PM	2019–20, 2020–21
RWAV	Activity reports	RHOF PM	2019–20, 2020–21
TAZREACH	Activity reports	EESS	Dec–Jun 2017, Dec–Jun 2018
TAZREACH	Activity reports	RHOF	Jul–Dec 2020
TAZREACH	Activity reports	RHOF PM	Jul–Dec 2020
TAZREACH	Activity reports	VOS	Jul–Dec 2020
TAZREACH	Activity reports	HEBHBL	Jul–Dec 2020
TAZREACH	Financial reports	MOICDP	2017–18
TAZREACH	Financial reports	RHOF PM	2019–20, 2020–21

Appendix 1F: Review of fundholder documentation

Fundholders in all jurisdictions were asked to provide copies of their current service agreements with the Department, needs assessments and service plans along with routine finance and activity reports submitted to the Department across all programs for the 2017–18 to 2020–21 financial years. Documents ultimately supplied varied across the fundholders. A full list of document types provided by individual fundholders is provided above in Appendix 1E.

The overview revolves around key challenges discerned from the outreach program biannual narrative reports, final program reports and other program reviews and associated strategies implemented by the fundholders to help resolve these issues.

Challenges associated with outreach program service planning and delivery and examples of mitigation strategies implemented by the fundholders are described below.

- **COVID–19.** From 2019 to 2021, fundholders frequently identified COVID–19 as a key challenge impacting outreach service delivery across programs. In particular, the pandemic and associated restrictions reduced travel options and affected visiting providers' overall ability to visit outreach locations across the country which resulted in the cancellation of outreach visits across jurisdictions. Also, many rural and remote communities were concerned about virus transmission and certain prevention control measures were put in place which restricted the number of visitors allowed in certain communities and host sites.

  In an effort to mitigate the impact of COVID–19, many fundholders reported transitioning to telehealth to continue to provide outreach services to underserved communities. While this resulted in the national expansion of telehealth in outreach and further acceptance of this mode of care delivery, some fundholders reported challenges with this transition, predominantly due to the desire for face-to-face engagement with visiting services. Multiple fundholders also reported working closely with host sites to enable some face-to-face outreach visits to go ahead during this period with appropriate measures in place.

- **Unexpected events.** Over the 4 financial years, fundholders reported a myriad of unexpected events that impacted visiting services ability to travel and deliver outreach services and frequently resulted in visit cancellations, delays and patient non-attendance. Examples included weather events (that is, flooding, cyclones, bushfires), cultural priorities and events, community unrest and power outages.

  In many instances, fundholders reported planning outreach visits around the seasons and shifting plans in response to these unexpected events to ensure the continuation of outreach service delivery. For example, following the bushfires on Kangaroo Island in 2020, RDWA reported supporting RHOF providers to undertake longer visits to the Island and working with other jurisdictional stakeholders, including the Country South Australia PHN, to make alternative travel arrangements for visiting providers to maintain outreach service provision to Kangaroo Island during this period.

- **Workforce issues.** Fundholders reported a wide range of workforce issues that have limited outreach service delivery across programs over the evaluation period. Most frequently this included issues with staff turnover and recruitment of local host staff and visiting health professionals which resulted in workforce shortages and made it more difficult to effectively coordinate and deliver certain outreach services at select

locations. For example, TAZREACH, RDWA, CheckUP and RWAV reported workforce shortages and significant challenges recruiting mental health professionals under various programs, including MOICDP and RHOF.
Lack of local staff at host sites was a key challenge that impacted their capacity and ability to communicate with visiting services and effectively coordinate and support outreach service delivery. In its final program report for 2017 to 2020, the NT Health reported lack of local coordination support and clinic capacity as a key challenge to delivering VOS services at outreach locations.

To help resolve these issues, the fundholders employed several strategies. For example, TAZREACH cited issues with visiting provider workforce shortages which impacted its ability to deliver the MOICDP. Its mitigation strategies included working closely with its state rural workforce agency, HR+, to aid in recruitment efforts and receive timely updates about ongoing health needs and provider availability, putting out expressions of interest for visiting providers, and working with existing outreach providers to plan and book visits well in advance to ensure ample travel options for visit dates.

- **Challenges with infrastructural capacity.** Fundholders consistently highlighted issues with existing local infrastructure which impacted host services' ability to support the coordination and delivery of outreach services. This included, but was not limited to, lack of:

    - appropriate and interoperable program management software
    - clinic room space
    - accommodation for visiting providers
    - medical equipment
    - IT equipment to support telehealth
    - patient transport.

  For example, NSW RDN cited the lack of availability of specialised eye equipment as a key challenge to delivering optometry services under the VOS program in its 2019–20 biannual narrative report. The fundholders reported liaising with other regional stakeholders in an attempt to support resource sharing, co-commissioning initiatives that sought to enhance local capacity (that is, integrated transport initiatives) and exploring cost-effective approaches to improve local infrastructure.

- **Short term funding contracts and uncertainty of outreach program funding.** The short-term nature of the outreach funding contracts have caused challenges for jurisdictional stakeholders. For example, NSW RDN and RHW reported issues spending all allocated and approved rollover funding across specific programs (that is, RHOF, EESS). TAZREACH and RHW found the timeliness of rollover approvals and contract notifications negatively impacted their ability to effectively deliver outreach services within a given year. Ultimately, these issues have contributed to overall uncertainty of program funding for future contracts which has impacted jurisdictional stakeholders' ability to plan, increased provider uncertainty and reduced local engagement in outreach services.

  Efforts to mitigate challenges associated with short-term funding contracts, such as underspend, included:

    - Establishing reserve lists and allocating funding to these services when required.
    - Creating and regularly updating a priority register of services.
    - Fostering open communication with service providers to ensure the timely notification of visit cancellations and delays so fundholders could implement the appropriate contingency plan and/or risk responses.

Cost of service delivery. The cost of outreach service delivery appears to be rising, particularly due to unexpected events, such as COVID–19. In particular, fundholders most frequently reported the high cost of travel and provider reimbursement as a barrier to service delivery. For example, NT Health reported that travel costs consumed nearly a third of the VOS budget allocated in the 2019–20 financial year.

The fundholders in Queensland, Northern Territory, and Western Australia also highlighted challenges appropriately reimbursing providers under Medicare due various factors, including low patient volume, provider eligibility and the inability of this funding to appropriately address cost variation across geographic locations, and frequently relied on workforce support payments to compensate certain outreach providers. Despite this, some service providers in select geographic locations are not eligible for workforce support payments and there continued to be reports of increased demand for these payments; therefore, fundholders advocated for increased flexibility of this funding stream to support outreach service provision.

In an effort to reduce this barrier, fundholders undertook a range of activities, including exploring opportunities for flexibility in the service delivery standards to provide additional funding to support visiting providers, investigating alternative cost-effective models of service delivery and reviewing MBS funding and formulating policy recommendations for specific workforce groups (that is, CheckUP and South West Queensland PHN review of MBS funding for allied health services conducted in 2019–20).

- **Demand for services.** Fundholders reported high demand for certain outreach services across various regions. They frequently reported long waiting lists for specific services (that is, eye and ear surgery supported by the EESS program) and that the level of demand for outreach services exceeds existing program funding and resources.

  While the health needs and demand for certain services varied across jurisdictions, fundholders frequently cited high demand for specific services across programs, such as allied health and mental health services. For example, RDWA cited high demand for select outreach services, such as psychiatry and endocrinology, supported under the RHOF as a key challenge in their final program report for 2017 to 2020.

  In an effort to decrease the demand for certain outreach services, fundholders reported meeting regularly with service providers to discuss potential strategies, utilising unspent program funds to provide additional visits to reduce patient waiting lists, engaging in the upskilling of local staff and exploring alternative service delivery arrangements, such as telehealth.

- **Duplication of services and integration with local service provision.** In some instances, fundholders identified challenges with service duplication due to competing priorities across regions, organisations and sectors (that is, NDIS) and issues integrating outreach with local service provision. In New South Wales, the fundholder reported that significant investment into pain management services in some regions via the PHNs and other health organisations made duplication of services a key risk when attempting to planning and deliver RHOF PM services. There were also reported instances of confusion from community members regarding the wide range of outreach services and funding streams which appeared to exacerbate this issue.

  To mitigate challenges associated with duplication of services, the fundholders (that is, RHW) reported implementing several mitigation strategies, including scheduling regular meetings and working closely with regional stakeholders to identify and address identified service duplication issues and engaging in regular planning sessions with visiting services and host providers as a preventative measure to increase communication and reduce the potential for service duplication in the future. But

stakeholders indicate that effective communication and coordination requires significant time and resources to achieve.

Integration with local service provision and associated initiatives, such as access to state spectacle schemes (that is, New South Wales Spectacle Program and Tasmania's Spectacle Assistance Scheme) and the establishment of robust referral pathways was also reported as a challenge across programs. For example, navigating the complex surgical pathways and effectively communicating with metropolitan hospitals to coordinate eye and ears surgery under the EESS program was cited as a particular challenge by various stakeholders. Beyond establishing surgical pathways, fundholders attributed challenges establishing local referral pathways to a range of factors including local GP turnover and general workforce shortages in rural and remote communities. Several fundholders also reported challenges getting local specialists (that is, ophthalmologists) to agree to bulk-bill select patients (that is, Aboriginal and Torres Strait Islander patients) which increased barriers to access and limited referral options in some instances.

Fundholders described funding administrative support workers to facilitate service delivery where possible and working with local services, relevant organisations and hospitals to facilitate more effective engagement and communication to establish additional referral pathways and improve the integration of outreach services with local services and associated initiatives.

- **Coordination and communication issues.** There were frequent reports of coordination and communication issues between visiting and host services in select areas across jurisdictions. Associated workforce and infrastructure challenges appear to have exacerbated these challenges due to lack of local capacity to coordinate and support the delivery of outreach services.

  In an effort to improve coordination and communication, fundholders reported implementing strategies to improve engagement and collaboration between visiting and host services and ancillary organisations (that is, NT Health for VOS) which included implementing a coordination framework (RWAV for the EESS program), providing additional communication and distributing marketing materials to improve awareness of services across patients, referring organisations and other local health services; regular meetings between relevant stakeholders and establishing more regular follow-up communication between visiting and host services.

- **Service promotion and community awareness of outreach services.** Fundholders reported low uptake of services in some instances. Fundholders often attributed this to low community awareness of outreach services but also cited existing local services, difficulties engaging local organisations, challenges with coordination and lack of patient transport options as impacting patient volume. For example, the IDEAS van, which is a mobile Indigenous diabetes eyes and screening service in Victoria, was implemented in 2019–20. RWAV reported low patient numbers across the 5 sites as a key challenge.

  Fundholders reported employing several strategies to raise awareness of specific outreach services. For example, RWAV organised teleconferences with regional ACCHOs to improve visibility of the service, co-develop promotional materials and increase referral pathways. In addition to service promotion, a key component of these strategies focussed on engaging local services and developing stronger relationships with key stakeholders.

The issues and examples outlined above highlight many of the themes observed in the stakeholder interviews and surveys. There is a clear desire and emphasis across jurisdictions for the outreach programs to provide increased access to more holistic care and ongoing

patient management in conjunction with local services through the use of multidisciplinary teams. As indicated above, this aim and overall effective outreach service delivery requires close relationships with local services and communities, strong local capacity and flexible, long-term program funding to support sustainable service delivery.

Despite these reported challenges, fundholders highlighted many good news stories in the narrative reports about how the programs have increased access to vital health services and fostered relationships between visiting services and communities. Some examples of these good news stories are provided in Chapter 6.

Appendix 1G: Key observations from case studies

In consultation with the jurisdictional fundholders, HPA selected locations to conduct a series of case studies to inform the evaluation. A case study approach can provide deeper insights into the operation and impact of the outreach programs within chosen communities, complementing interviews conducted with national and jurisdictional stakeholders.

The aim was to select a mix of case studies that capture a range of challenges communities face and the outreach delivery models employed. These studies are not provided as examples of specific challenges or of best practice. Table 42 provides a case study overview including location and nature of the 6 case studies completed.

Table 42: Case study site and focus

Jurisdiction	Fundholder	Program coverage	Mode of consultation	Case study location and focus
NSW	NSW Rural Doctors Network	All programs	Face-to-face	**Geographically-based,** covering the SE NSW region, and, in particular, outreach service delivery in the communities of Nowra and Batemans Bay.
NT	NT PHN	MOICDP	Virtual	**Geographically-based,** covering the Central Australia region of Northern Territory.
Qld	CheckUP	HoA	Face-to-face	**Geographically-based,** covering the HoA program providing services in the town of Theodore.
		RHOF	Face-to-face	**Service-based:** True Relationships and Reproductive Health.
TAS	TAZREACH and Rural Health Tas (EESS)	All programs	Face-to-face	**Geographically-based**, covering the North West region of Tasmania and system-wide EESS.
WA	Rural Health West	All programs	Virtual	**Geographically-based,** covering the Kimberly region with the Lions Eye Vision Northwest Eye Hub highlighted as an example of regional innovation.

Common themes

Together these 6 case studies start to demonstrate the **varied approaches** to providing outreach services across different parts of Australia. Through these case studies, the evaluation was able to observe and gather feedback on a range of the services supported by the outreach programs. They show how fundholders and providers are working with local communities to meet their health service's needs, including the coordinated eye health services in Western Australia, state-wide sexual health services in Queensland and ACCHO-led regional services across remote community of central Australia in the Northern Territory. Amidst the diversity common themes and observations emerged with national significance.

Regional planning and service delivery

The case studies identify regional models that demonstrate promising signs of improved regional workforce sustainability and greater outreach service self-sufficiency. For example, the Kimberly in WA has established localised service planning and coordination and in the Central Australia region of the Northern Territory, the Aboriginal Congress ACCHO is now funded as a regional service provider organisation.

Innovations in service delivery

There is a strong sense of innovation in service provision with further exploration of telehealth to support shared care models (for example, Central Australia region in Northern Territory) investment in mobile clinics (for example, HoA) and consolidation of funding to create more integrated service responses (for example, North West Eye Hub).

Telehealth and shared care

COVID–19 has clearly created momentum for telehealth, but while stakeholders caution the substitution of face to face outreach services with telehealth, the case studies demonstrate there is significant scope to grow telehealth services in supporting shared care through remote learning for local staff, greater access to outreach provider advice and for direct patient care between visits.

MBS telehealth items are available to GPs, medical practitioners, specialists, consultant physicians, nurse practitioners, participating midwives, allied health providers and dental practitioners in the practice of oral and maxillofacial surgery.

The Government has indicated they intend to pause the proposed new prescribed pattern of service (a '30/20 rule') for telephone attendances provided by consultant physicians and GPs. It is now intended this rule will be paused and will be recommenced on 1 October 2022.

Responsive to local communities.

Providers across the case studies stressed the importance of listening to the local communities to understand their needs (for example, True Women's Health Service in Queensland), spending time with local elders and community leaders to build relationships (for example, RFDS Dental Outreach in Northern Territory) and working more closely with host providers in models of shared care (for example, Lions Eye Care in Western Australia).

Ability to respond to broad health service needs

Case study stakeholders value the resources for eye and ear health but consistently pointed us towards greater flexibility in funding and the ability to address the broader needs of the community, including dental care and specific needs within regions (for example, Huntington's Disease in NW Tasmania). The value of creating integrated care pathways was underlined through the approach taken to consolidating outreach funds (for example, North West Eye Hub).

Case study summaries

The following section of the report provides an overview, and highlights the key findings of, each case study, along with implications for the overall evaluation.

Queensland: True Women's Health Service

This case study focusses on True Relationships and Reproductive Health (True). True provide state-wide outreach women's health services in Queensland, funded by CheckUP through the RHOF.

True seeks to improve reproductive and sexual health and promote safe and respectful relationships through the delivery of expert clinical services, education and counselling. The organisation has clinics in Brisbane, Cairns, Ipswich, Rockhampton and Toowoomba and a local counselling service in Cairns that support both children and adults when faced with sexual abuse.

True designed and commenced providing pilot outreach services in Agnes Waters in 2016 and subsequently rolled out services to a further 13 locations in 2017, with services now expanded to 16 rural and remote locations. The organisation reported that over 70% of the population in Queensland are now within a one-hour drive of True's services.

True's outreach clinics provide reproductive and sexual health services by expert clinicians in regional, rural and remote communities across Queensland. This includes contraception advice, pregnancy planning, menopause advice, sexual health screening, cervical screening and breast examinations.

Key observations:

Actively listens to local communities

True reported that it invests in local community engagement to better understand its service needs and tailor its outreach clinics accordingly. They indicated that a key factor for the perceived success of its services is how it has built the trust of local providers and the community by seeking to understand their preferences and prioritising service reliability and dependability.

Capacity for service to expand

True reports there is significant scope to deepen services in existing local communities and stakeholders indicate the need to extend services to additional rural and remote communities. However, True reports that existing funding levels are not keeping up with rising costs and additional funding is required for the future.

Organisation has an eye on innovation

True report that it has an innovative approach to service integration that enables them to triage clients and place them directly on the surgical waiting list of Queensland Health. The organisation is looking to further innovate its services by establishing a truck that can be equipped to provide mobile clinics to locations without sufficient infrastructure.

Promotes and supports staff to provided outreach

True employs only female staff, including doctors, nurse practitioners and advanced practice nurses. This is important for promoting appropriate care for women, particularly in the context of cultural safety for Indigenous Australian women. As employees they are expected to consider participation in outreach services. While MBS bulk billing is used to partly fund the services, employees are provided with a salary, removing pressure for throughput from a fee for service remuneration. In many instances the planned and actual patient throughput at

small remote clinics do not provide sufficient bulk-billed MBS revenue to appropriate reimburse outreach providers.

Queensland: Heart of Australia (HoA)

This case study focusses on HoA's service delivery in the community of Theodore in North Queensland. HoA receives funding from various sources across the public and private sectors, including national and state governments. Funding from the Australian Government is provided directly by the Department rather than via the outreach programs administered by CheckUP.

HoA provides a mobile specialist medical service across 32 communities in North Queensland, including the small rural community of Theodore. Five trucks equipped with diagnostic and treatment infrastructure allow a multidisciplinary team to see, diagnose and treat clients on site, including cardiology, endocrinology, gastroenterology, gynaecology, neurology and respiratory specialist consultations.

Theodore has a population of around 500 people and is in a gold and coal mining region about 200 km inland from Rockhampton. The town has a medical centre and multipurpose health service with 9 acute beds and 4 aged care beds. HoA provides onsite mobile cardiology clinics in Theodore once a month.

Key observations:

Public-private sector communications

There appear to be barriers in communication and collaboration between stakeholders in the public and private sector. This has the potential to create mistrust, increase service duplication and disrupt continuity of care. There are further opportunities for service co-design, partnerships and co-commissioning, resource pooling and information sharing which would enhance the mission of increasing access to health services in regional, rural and remote areas.

Potential for service duplication

Theodore Medical has found value in HoA's outreach services because the program delivers accessible, specialty care that the general practice is unable to offer to the community. Due to the number of players in the outreach space and rural providers' broad scope of practice, there is the potential for duplication of services across regional, rural and remote communities. Communication and engagement with local, jurisdictional and national stakeholders is critical to mitigate the risk of service duplication and to explore potential opportunities to further support local capacity or co-commission outreach services.

Opportunities for building local workforce

There is a distinction between specialist services that could never be provided locally and primary care services that could feasibly be provided locally. While providing outreach services is a valuable way to increase community access to health services in certain instances, stakeholders should prioritise local solutions. This includes increasing access to rural and remote education and training opportunities and supporting the local health workforce to deliver care to communities in their area.

Upskilling valued by local services

Host provider reflections underlined the importance of outreach services at Theodore being 'facilitative,' 'educative' and 'additive.' This highlights the importance of knowledge and skills transfer between visiting outreach providers and the local health workforce, which includes education and capacity building, and delivering outreach services that complement existing local health services by providing care that is not readily available to communities.

Asses economic sustainability

While HoA appears to be effective at increasing access to specialist services in rural and remote areas, questions remain around the cost effectiveness and sustainability of the model; therefore, a full independent economic analysis is recommended to fully evaluate the cost effectiveness and sustainability of the service as not enough data around average costs per visit and activity costs has been provided.

New South Wales: South Coast Region

This case study focusses on outreach services provided in the south-east region or south coast region or New South Wales, particularly services provided out of Nowra and Batemans Bay including:

- Grand Pacific Health is a not-for-profit primary healthcare organisation that delivers a range of services across several locations and communities and has a clinic in Batemans Bay. The focusses on Aboriginal and Torres Strait Islander health, including programs on youth and adult mental health, support for housing and accommodation, health promotion, residential aged care facilities and chronic disease management.
- Cullunghutti Aboriginal Child and Family Centre is located in Nowra and provides holistic, wraparound services that focus on early childhood development, education, health and wellbeing. Their health services include youth counselling, speech, occupational therapy and primary care services provided by paediatricians, nurses and Aboriginal health workers.
- Southern NSW Local Health District has 12 public hospitals and provides a wide range of services from Crookwell and Goulburn in the north to Pembula and Eden in the south. It receives MOICDP funding to support the delivery of the Aunty Jeans program which provides community support to Aboriginal and Torres Strait Islander people, including health assessments, exercise sessions, nutrition support and health education and information.
- COORDINARE is the PHN for the SE NSW region and works with NSW RDN to ensure provision of primary healthcare services in the region, including through involvement in their advisory forum. The organisation manages the ITC program which supports Aboriginal and Torres Strait Islander people with chronic disease and works with NSW RDN to align ITC program activity and funding with the MOICDP.

Key observations:

Strong regional governance

NSW RDN operates a decentralised governance model that supports local and regional input, ownership and coordination of outreach services across the regions of New South Wales.

Focus on succession planning

Due to ongoing workforce shortages and an aging cohort of outreach health professionals, succession planning and establishing recruitment pathways for outreach providers and local staff is a key priority for stakeholders in the region.

Investing in cultural competency

Cultural competency is not simply a 'tick box exercise' and needs to be ongoing. Visiting providers need to have an understanding of local history and invest in ongoing relationship building with Aboriginal and Torres Strait Islander patients and community members. Stakeholders hope to enhance their cultural competency training, so it better captures the diverse cultural history and customs of individual regions and communities.

Funding to support host services

Planning outreach visits, following up with patients to ensure they attend their appointments and supporting outreach providers takes a great deal of time and effort, and host providers are not adequately compensated for this work. Jurisdictional stakeholders continued to reiterate

the importance of providing funding to host providers to support the coordination of outreach services.

Funding flexibility to pursue innovation

There are examples where local services have been able to flexibly utilise outreach funds in conjunction with other funding to facilitate innovative, multidisciplinary care. Stakeholders feel flexibility could be enhanced by allowing for greater relaxation of certain eligibility guidelines for outreach funding across programs.

Funding stability to underpin service sustainability

The short term program funding cycles have negatively impacted various aspects of service delivery including provider and staff recruitment and retention and overall sustainability of services.

Potential for telehealth to support shared care

Stakeholders described varying levels of success with telehealth in outreach. Similar to other jurisdictions, stakeholders noted its value in facilitating training, patient follow up and shared care arrangements.

Looking to measure patient reported experiences

Outreach providers are working to more effectively monitor patient feedback and outcomes by enhancing their data collection processes. This includes developing patient questionnaires to gather information on PREMs and PROMs.

Northern Territory: The Central Australia Region

This case study focuses on outreach service delivery in the Central Australia Region of the Northern Territory. While both the NT PHN and the NT Health manage outreach programs in the region, this case study is primarily concerned with the administration of the MOICDP by the PHN and the regional provision of outreach services by the Central Australian Aboriginal Congress (Congress) in Alice Springs.

Congress is the largest ACCHO in the Northern Territory. In addition to its health services, CAAC also provides child, youth and family service, human resources, public health and business services. It operates a hub-and-spoke model from Alice Springs with surrounding ACCHOs serving communities in Amoonguna, Ntaria and Wallace Rockhole, Santa Teresa, Utju and Mutitjulu.

Several independent ACCHOs not affiliated with Congress service more remote Indigenous communities, such as Ampilatwatja, Pintupi and Urapuntja. For example, Pintupi Homelands Health Service Aboriginal Corporation is an ACCHO servicing a small remote community of about 450 people. The community is about 500 west of Alice Springs

Twenty eight other primary healthcare clinics exist in the region that are not Aboriginal community controlled and are services through the NT Health.

Key observations:

Value in ACCHO led hub-and-spoke models

NT PHN is providing funding to Congress which has a regional role in helping plan and coordinate local care and outreach services to surrounding communities. Congress participates with other outreach providers in a regional planning group. This type of arrangement can provide Aboriginal and Torres Strait Islander community-controlled services with sufficient capacity to have more control and influence over outreach funding which in turn can allow greater latitude to respond to local needs and establish a robust regional workforce to assist with outreach service provision.

Inadequate infrastructure to support outreach

All stakeholders called out for more capital spending to support outreach in remote communities, with accommodation, medical equipment, digital technologies and transport the priorities. Communities without sufficient accommodation have to reply on same day fly and fly out services which limits the ability for providers to establishing trusting relationships in the community.

Good care not always possible with fee for service

MBS based services do not always provide good care for Indigenous Australians. They are driven by patient throughput and income imperatives rather than providing good care. There is a need for providers to get out of the clinics and move their care into the communities and into the patient's home – and fee-for-service simply does not work in this context.

Investing time in community is productive

Spending time in community and building strong community relationships is important for outreach providers, particularly in more remote areas. Relationships of respect mutual underpin good planning and coordination, cultural safety and the effective clinical delivery of services on the ground and should be seen as a priority for Central Australia. Greater connection with community helps build trust in providers and the services they provide and can work to improve the proportion of patients that do not attend appointments.

Community-based cultural competency training

Cultural competency training should move beyond structured one-time courses and put more focus on gaining experience in the field, meeting the locals, visiting important sites, meeting Elders and building connections with locals.

Gaps in dental care persist

The Royal Flying Doctor Service provides highly valued outreach dental services to some remote communities but access to dental care remains a service gap in many areas with the need for strengthened outreach services. Many chronic conditions experienced in the region stem from poor oral hygiene.

Further potential for telehealth shared care

Telehealth and shared care models play a vital role in overcoming geographic boundaries to provide better access to care and Aboriginal and Torres Strait Islander communities in Central Australia, however, the full potential of telehealth is yet to be realised due to gaps in technological literacy, cultural barriers, availability of necessary infrastructure (stable internet, videoconferencing facilities) and trained staff (nurses, Aboriginal health workers).

Tasmania: The North West Region

This case study focusses on outreach service delivery in the North West Region of the Tasmania. The communities in the region receive outreach services from a variety of government funded programs that are administered through multiple organisations including TAZREACH, Primary Health Tasmania, TAC, Rural Health Tasmania and the Royal Flying Doctor Service. Service providers include:

- Tasmanian Aboriginal Centre, an Aboriginal community controlled organisation that has facilities in Hobart, Launceston and Burnie and delivers a range of community programs including health, training, advocacy, palawa kani (Tasmanian Aboriginal language retrieval and promotion), land management and children and family programs.
- The NW Persistent Pain Program, otherwise known as the Opal Pain Management Program, provides a free multidisciplinary group pain management service in Burnie. The program involves an initial assessment followed by 6 half day pain education sessions and post program review. The program helps people understand their pain

and the role of self-management to improve quality of life and functionality in the presence of persistent pain.
- RHT provides a broad range of services to rural communities, including Circular Head, Waratah, Wynyard, West Coast, King Island, Ulverstone, Devonport, Burnie and Kentish.

As part of its service offering, it operates No 34 Aboriginal Health Service. This service is located in Ulverstone and is dedicated to working with Aboriginal people to improve their health and wellbeing. It provides a range of services to support children and families, hosts outreach podiatry and optometry services and coordinates the Eye and Ear Surgical Support Services program for Tasmania.

Key observations:

Persistent health workforce shortages

Tasmania as a state suffers from health workforce shortages (including medical specialist and allied health professionals) that further limit availability of outreach providers locally. This requires consideration of new workforce models. Clinical networks and collaborative arrangements with service providers in other jurisdictions on the mainland provide an important source of outreach clinicians for the North West.

Local needs not aligning with program priorities

The health needs for Indigenous and non-Indigenous communities in the North West do not always align well with the priority areas within the outreach programs, with a substantial proportion of the RHOF allocated to local needs (including Huntington's Disease and dual disability) and relatively low need for eyes services for Indigenous communities resulting in the allocation of 40% VOS funding being untenable.

Integration of outreach into regional service planning

TAZREACH within the Tasmanian Department of Health, has recently transitioned from the procurement function to the service planning function of the of the Tasmanian Department of Health, providing greater emphasis on integration of outreach service planning with overall needs, service and workforce planning processes of the Department. TAZREACH collaborates strongly with the PHN and HR+ (the rural health workforce agency in Tasmania) but duplication is still evident.

Multiple fundholders adds complexity

Fundholding for eye and ear services is held by a variety of organisations with TAZREACH holding funding for VOS, eye coordination and HEBHBL, while the non ACCHO organisation, Rural Health Tasmania holds the funding for eye and ear surgical support and the NACCHO affiliate Tasmanian Aboriginal Centre (TAC) holds the ear coordination funding. This adds a complexity to program coherency and impacts on local sensitivities around service networks and access for Indigenous communities.

Local solutions integrate workforce capacity building and outreach support.

HR+ role is focussed on building a primary care workforce across rural and remote communities and sees outreach as a way of helping address service gaps in the interim, Work is underway in George Town and other local communities in the North West to explore place-based models to build local workforce capacity. The integration of planning functions of TAZREACH and HR+ and other outreach providers is underpinning the dynamic relationship between local workforce capacity and the need for outreach support.

Gaps in dental care persist

Access to dental care in rural and remote communities appears to be a pressure point in mainland jurisdictions. Dental services are relatively well served in Tasmania. Through philanthropic and government funding support, RFDS Tasmania provides a dental outreach program that assists by providing education, preventative and dental treatments for children

and eligible adults in rural and remote areas, but the need for dental care still remains a priority.

Western Australia: The Kimberley Region

The case study focusses on outreach service delivery in the Kimberley region of Western Australia, with a particular emphasis on the Lions Outback Vision North West Hub located in Broome.

The hub delivers eye health care and outreach services to the Kimberley and Pilbara regions via a hub-and-spoke model. It provides ophthalmology, optometry, retinal surgery, on-call emergency and telehealth services to the Kimberley and Pilbara regions, as well as on-site diabetes education. The service also has a mobile clinic that provides specialist eye services to 19 regional and remote communities, with the ability to diagnose and treat most major eye conditions.

Kimberly Aboriginal Medical Service is a regional ACCHO that represents 7 members organisations across the Kimberley, providing collective advocacy and support to its members along with research, health promotion, IT support and training and education. The organisation also runs primary care clinics in several remote communities across the Kimberley including Beagle Bay, Mulan and Billiluna with a view of supporting these services to become fully fledged ACCHOs that operate on their own in the future.

Broome Regional Aboriginal Medical Service is a member of the Kimberley Aboriginal Medical Service network. It is located in Broome and administers care in the region, providing approximately 40,000 occasions of service annually.

Key observations:

Regional model underpinned by regional governance

There is a call for greater autonomy in decision making at the regional level. Western Australia has a strong regional governance framework but involves greater devolvement of decision-making and flexibility in funding to enable outreach services to respond to local needs.

Coordination and communication issues persist

There is a need to support local workforce capacity and development, particularly in relation to the coordination of outreach services. Better communication and sharing of information are required between stakeholders to avoid duplication of services and better identify areas of community need.

Many services, such as ear services, are being duplicated through funding from multiple sources. Services across agencies should be better planned. In some instances, outreach can be burdensome on a local service due to poor communication and coordination

Further strengthen access to telehealth

Telehealth is increasingly being used to provide services where physical access is difficult, however, inequities generated through unequal access to technology, levels of IT literacy and availability of stable internet connections should be addressed.

Telehealth sessions supervised by an Aboriginal Health worker can result in consumers being more forthcoming with information as the balance of power is shifted from a face-to-face interview with just a non-Indigenous clinician. These clinicians are also held more accountable for culturally competent and safe care.

More holistic approach to outreach

The focus of visiting providers should shift from treating ailments specific to the body part that is the focus of the funded program and instead address overarching Indigenous social determinants of health.

Leadership and governance contribute to Lions Outback Vision success

Lions Outback Vision is viewed as being less encumbered than the Western Australia department of health and having a greater social mission than a private organisation, enabling it to be more agile and innovative in its approach to eye health in the region. The long term commitment and leadership of staff working in the region with communities to improve eye health is also noted as a key organisational success factor.

Lions Outback Vision promotes innovation in regional service delivery

The establishment of a regional eye health service that operates via a hub-and-spoke model in which employees can service local needs and provide outreach services to smaller remote communities in the region is viewed as having advantages in terms of responsiveness, continuity of service and cost-effectiveness.

By bringing funding together from a range of sources including outreach programs, state and organisationally sourced funding, the NW Eye Health Hub has created a one stop shop that provides initial assessment, follow up, ongoing management and surgical support for people with eye health needs locally in Broome and surrounding remote communities

Mobile services, shared care telehealth arrangements and a flexible scope of practice for outreach professionals is enabling improved access to eye health services.

Appendix 1H: Analysis of program service delivery standards

Table 43 provides a list of eligible activities supported by the outreach programs.

Table 43: Definitions of eligible activities of Outreach Programs per service delivery standards

	Program				
Activity type	MOICDP	HEBHBL	EESS	VOS	RHOF[112]
Cultural training and orientation, and familiarisation	Cultural training and orientation: Orientation visits to each new location for each new health provider. Visits to include briefing on cultural protocols specific to community. Includes travel and travel time. The method of delivery is flexible and may take the form of a formal cultural awareness course provided by facilitators/presenters and/or self-learning cultural awareness education program. Non-salaried private Health Professionals providing outreach services may claim	Cultural training and orientation: Orientation visits to each new location for each new health provider. Visits to include briefing on cultural protocols specific to community. Includes travel and travel time. The method of delivery is flexible and may take the form of a formal cultural awareness course provided by facilitators/presenters and/or self-learning cultural awareness education program. Non-salaried private Health Professionals providing outreach services may claim	Cultural training and orientation: Orientation visits to each new location for each new health provider. Visits to include briefing on cultural protocols specific to community. Includes travel and travel time. The method of delivery is flexible and may take the form of a formal cultural awareness course provided by facilitators/presenters and/or self-learning cultural awareness education program. Non-salaried private Health Professionals providing outreach services may claim Travel Time Allowance for the time	Cultural training and orientation: Orientation visits to each new location for each new health provider. Visits to include briefing on cultural protocols specific to community. Includes travel and travel time. The method of delivery is flexible and may take the form of a formal cultural awareness course provided by facilitators/presenters and/or self-learning cultural awareness education program. Non-salaried private Health Professionals providing outreach services may claim	Cultural training and orientation: RHOF may provide funding for cultural training and familiarisation for health professionals who provide outreach services. The method of delivery is flexible and may take the form of a formal cultural awareness course provided by facilitators/presenters and/or self-learning cultural awareness education program. Non-salaried private health professionals providing outreach services under the RHOF may claim Absence from Practice Allowance for the time they attend cultural training and familiarisation.

[112] Australian Department of Health. (2020b). *Rural Health Outreach Fund: Service Delivery Standards.* https://www1.health.gov.au/internet/main/publishing.nsf/Content/651B62BEE7DE74CFCA257BF0001C95A3/$File/RHOF-Service-Delivery-Standards-From-1-July-2020.pdf

Activity type	Program MOICDP	HEBHBL	EESS	VOS	RHOF[112]
	Travel Time Allowance for the time they attend cultural training and orientation.	Travel Time Allowance for the time they attend cultural training and orientation.	they attend cultural training and orientation.	Travel Time Allowance for the time they attend cultural training and orientation.	
Travel, meals, accommodation for visiting professionals	Air: economy class flights, consideration of private aircraft (capped at cost of economy commercial flight if available).	Air: economy class flights, consideration of private aircraft (capped at cost of economy commercial flight if available).	Transport of patient and one carer from MM 3–7 locations into regional/metropolitan centres for eye or ear surgical treatment. Includes the cost of meals and accommodation for the patient and their carer. Fundholders should aim to transport multiple patients and carers at one time.	Air: economy class flights, consideration of private aircraft (capped at cost of economy commercial flight if available).	Private vehicles: RHOF will cover the cost of travel by the most efficient and cost effective means to and from the outreach service location. This may include commercial air, bus or train fares, charter flights, and/or expenses associated with the use of a private vehicle as per the national rates by the ATO. Flights will be costed at the economy class level. Other incidental costs such as fuel for hire cars, parking and taxi fares may also be covered in line with accepted ATO rates.
	Self-drive hire car: Fuel allowance per ATO determination, parking and taxi fees (cost recovery only).	Self-drive hire car: Fuel allowance per ATO determination, parking and taxi fees (cost recovery only).		Self-drive hire car: Fuel allowance per ATO determination, parking and taxi fees (cost recovery only).	If road travel is the most cost effective option, the visiting health professional may elect to travel to/from the outreach location by a self-drive hire car. Fuel allowances payable for a hire car are paid per the ATO determination. Parking and taxi fares can be paid (cost recovery basis only).
	Accommodation: Aligned with ATO determination. Consideration of higher rates on case-by-case basis for seasonal changes and	Accommodation: Aligned with ATO determination. Consideration of higher rates on case-by-case basis for seasonal changes and		Accommodation: Aligned with ATO determination. Consideration of higher rates on case-by-case basis for seasonal changes and	Accommodation: will be paid in accordance with the rates published by the ATO determination. Consideration of higher rates on case-by-case basis for seasonal changes and accommodation scarcity.

Activity type	MOICDP	HEBHBL	EESS	VOS	RHOF[112]
			Program		
	accommodation scarcity.	accommodation scarcity.		accommodation scarcity.	
	Meals: Aligned with ATO determination.	Meals: Aligned with ATO determination.		Meals: Aligned with ATO determination.	Aligned with ATO determination. The ATO determination for meals and incidentals for high cost centres will be used as the rates which may be paid under the RHOF.
	Incidentals: Aligned with ATO determination. Only payable for second and subsequent days of a visit. Breakfast on first day and dinner on last day are not payable.	Incidentals: Aligned with ATO determination. Only payable for second and subsequent days of a visit. Breakfast on first day and dinner on last day are not payable.		Incidentals: Aligned with ATO determination. Only payable for second and subsequent days of a visit. Breakfast on first day and dinner on last day are not payable.	Incidentals: Aligned with ATO determination. Only payable for second and subsequent days of a visit. Breakfast on first day and dinner on last day are not payable.
Absence from practice allowance/ travel time allowance	Travel time allowance: Payable to non-salaried private Health Professionals and accompanying registrars to compensate for loss of business opportunity due to the time spent travelling to and from a location where they are delivering an outreach service and/or upskilling. Hourly rate is consistent with the fee-for-service hourly rates paid by the relevant jurisdiction, area health	Travel time allowance: Payable to non-salaried private Health Professionals and accompanying registrars to compensate for loss of business opportunity due to the time spent travelling to and from a location where they are delivering an outreach service and/or upskilling. Hourly rate is consistent with the fee-for-service hourly rates paid by the relevant jurisdiction, area health service or local hospital.	Travel time allowance: Payable to non-salaried private Health Professionals and accompanying registrars to compensate for loss of business opportunity due to the time spent travelling to and from a location where they are delivering an outreach service and/or upskilling. Hourly rate is consistent with the fee-for-service hourly rates paid by the relevant jurisdiction, area health service or local hospital.	Travel time allowance: Payable to non-salaried private Health Professionals and accompanying registrars to compensate for loss of business opportunity due to the time spent travelling to and from a location where they are delivering an outreach service and/or upskilling. Hourly rate is consistent with the fee-for-service hourly rates paid by the relevant jurisdiction, area health	Absence from practice allowance: Payable to non-salaried private Health Professionals and accompanying registrars to compensate for loss of business opportunity due to the time spent travelling to and from a location where they are delivering an outreach service and/or upskilling. Hourly rate is consistent with the fee-for-service hourly rates paid by the relevant jurisdiction, area health service or local hospital.

Activity type	Program MOICDP	HEBHBL	EESS	VOS	RHOF[112]
	service or local hospital.			service or local hospital.	
Administrative support	Administrative costs associated with the delivery of outreach services, such as the organisation of appointments, processing of correspondence and follow up with patients. Up to the same consultation/treatment time undertaken by the health professional. Hourly rate is equivalent to the hourly administration rate in the jurisdiction at grade 2 or 3, depending on the complexity of the work. Does not include time visiting professionals upskill local professionals.	Administrative costs associated with the delivery of outreach services, such as the organisation of appointments, processing of correspondence and follow up with patients. Up to the same consultation/treatment time undertaken by the health professional. Hourly rate is equivalent to the hourly administration rate in the jurisdiction at grade 2 or 3, depending on the complexity of the work. Does not include time visiting professionals upskill local professionals.	Administrative costs associated with the delivery of outreach services, such as the organisation of appointments, processing of correspondence and follow up with patients. Up to the same consultation/treatment time undertaken by the health professional. Hourly rate is equivalent to the hourly administration rate in the jurisdiction at grade 2 or 3, depending on the complexity of the work. Does not include time visiting professionals upskill local professionals.	Administrative costs associated with the delivery of outreach services, such as the organisation of appointments, processing of correspondence and follow up with patients. Up to the same consultation/treatment time undertaken by the health professional. Hourly rate is equivalent to the hourly administration rate in the jurisdiction at grade 2 or 3, depending on the complexity of the work. Does not include time visiting professionals upskill local professionals.	Administrative costs associated with the delivery of outreach services, such as the organisation of appointments, processing of correspondence and follow up with patients. Up to the same consultation/treatment time undertaken by the health professional. Recommended rate payable for administrative support is equivalent to the hourly rate paid using the Department of Health pay scale at an APS 2 or 3, depending on the complexity of the work. Does not include time visiting professionals upskill local professionals.
Backfilling and locum support for health professionals	Backfilling salaried health professionals may be covered, but this may be void if also claiming MBS for the service. Optometrists may receive locum support for the principal practice up to 600 hours.	Backfilling salaried health professionals may be covered, but this may be void if also claiming MBS for the service. Optometrists may receive locum support for the principal practice up to 600 hours.	Backfilling salaried health professionals may be covered, but this may be void if also claiming MBS for the service. Optometrists may receive locum support for the principal practice up to 600 hours.	Backfilling salaried health professionals may be covered, but this may be void if also claiming MBS for the service. Optometrists may receive locum support for the principal practice up to 600 hours.	RHOF will cover the salary costs of backfilling salaried medical staff who provide approved outreach services, but this may be void if also claiming MBS for the service. RHOF will provide funding for a locum for private health professionals to cover their travel, accommodation and incidental costs.

Activity type	Program MOICDP	HEBHBL	EESS	VOS	RHOF[112]
Upskilling	Includes supporting the building of a sustainable workforce in regional, rural and remote locations and improves health outcomes in those communities. Includes theoretical or clinical activities to local medical and health professionals and other members of the public, such as carers. Formal upskilling should be developed with the local professionals and complement existing training activities. The claimable rate for non-salaried private health professionals is consistent with the FFS rates for the time required to present the agreed upskilling activity.	Includes supporting the building of a sustainable workforce in regional, rural and remote locations and improves health outcomes in those communities. Includes theoretical or clinical activities to local medical and health professionals and other members of the public, such as carers. Formal upskilling should be developed with the local professionals and complement existing training activities. The claimable rate for non-salaried private health professionals is consistent with the FFS rates for the time required to present the agreed upskilling activity.	Includes supporting the building of a sustainable workforce in regional, rural and remote locations and improves health outcomes in those communities. Includes theoretical or clinical activities to local medical and health professionals and other members of the public, such as carers. Formal upskilling should be developed with the local professionals and complement existing training activities. The claimable rate for non-salaried private health professionals is consistent with the FFS rates for the time required to present the agreed upskilling activity.	Includes supporting the building of a sustainable workforce in regional, rural and remote locations and improves health outcomes in those communities. Includes theoretical or clinical activities to local medical and health professionals and other members of the public, such as carers. Formal upskilling should be developed with the local professionals and complement existing training activities. The claimable rate for non-salaried private health professionals is consistent with the FFS rates for the time required to present the agreed upskilling activity.	Upskilling is not a requirement of health professionals providing outreach services, however, they may wish to provide educational and upskilling activities of either a theoretical or clinical nature, to local medical practitioners and health professionals aimed at developing or enhancing specific skills, sharing of knowledge; and/or enhancing on-going patient care. Upskilling activities should be developed with local medical and health professionals and take place at the location where an outreach service is being delivered and should aim to complement existing training arrangements within the area. Funding may be provided for supported procedural and non-procedural upskilling. The claimable rate for non-salaried private health professionals is consistent with the FFS rates for the time required to present the agreed upskilling activity.
Workforce support	Paid at a sessional rate as a last resort in MM 3–7 locations and paid in circumstances where access to MBS payments are not assured or patient attendance is uncertain. Requests	Paid at a sessional rate as a last resort in MM 3–7 locations and paid in circumstances where access to MBS payments are not assured or patient attendance is uncertain. Requests must be	Paid at a sessional rate as a last resort in MM 3–7 locations and paid in circumstances where access to MBS payments are not assured or patient attendance is uncertain. Requests must be submitted to the	Paid at a sessional rate as a last resort in MM 3–7 locations and paid in circumstances where access to MBS payments are not assured or patient attendance is uncertain. Requests	Paid under exceptional circumstances to private health professionals providing outreach in MM 6–7, primarily in Aboriginal and Torres Strait Islander communities. Paid where access to MBS payments are not assured or patient attendance is uncertain.

Activity type	Program				
	MOICDP	HEBHBL	EESS	VOS	RHOF[112]
	must be submitted to the Department for approval on a case-by-case basis. Precludes claiming an MBS payment for the same clinical session.	submitted to the Department for approval on a case-by-case basis. Precludes claiming an MBS payment for the same clinical session.	Department for approval on a case-by-case basis. Precludes claiming an MBS payment for the same clinical session.	must be submitted to the Department for approval on a case-by-case basis. Precludes claiming an MBS payment for the same clinical session.	Considered on a case-by-case basis.
Professional support	The informal support provided by the visiting health professionals to local medical and health professionals through, for example, lunchtime meetings and/or telephone/email support once the health professional has returned to their principal practice. Non-salaried private health professionals may claim an hourly rate for providing professional support consistent with the fee-for-service rates paid by the jurisdiction, area health service or local hospital.	The informal support provided by the visiting health professionals to local medical and health professionals through, for example, lunchtime meetings and/or telephone/email support once the health professional has returned to their principal practice. Non-salaried private health professionals may claim an hourly rate for providing professional support consistent with the fee-for-service rates paid by the jurisdiction, area health service or local hospital.	The informal support provided by the visiting health professionals to local medical and health professionals through, for example, lunchtime meetings and/or telephone/email support once the health professional has returned to their principal practice. Non-salaried private health professionals may claim an hourly rate for providing professional support consistent with the fee-for-service rates paid by the jurisdiction, area health service or local hospital.	The informal support provided by the visiting health professionals to local medical and health professionals through, for example, lunchtime meetings and/or telephone/email support once the health professional has returned to their principal practice. Non-salaried private health professionals may claim an hourly rate for providing professional support consistent with the fee-for-service rates paid by the jurisdiction, area health service or local hospital.	The informal support provided by the visiting health professionals to local medical and health professionals through, for example, lunchtime meetings and/or telephone/email support once the health professional has returned to their principal practice. Non-salaried private health professionals may claim an hourly rate for providing professional support consistent with the fee-for-service rates paid by the jurisdiction, area health service or local hospital. Not a requirement of the RHOF.
Equipment lease	Must first be approved by the Department. All lease quotes must include a budget for replacement parts and maintenance to ensure equipment meets	Must first be approved by the Department. All lease quotes must include a budget for replacement parts and maintenance to ensure equipment meets	Must first be approved by the Department. All lease quotes must include a budget for replacement parts and maintenance to ensure equipment meets required standards. The	Must first be approved by the Department. All lease quotes must include a budget for replacement parts and maintenance to ensure equipment meets	Must first be approved by the Department. All lease quotes must include a budget for replacement parts and maintenance to ensure equipment meets required standards. The period of the

Activity type	Program MOICDP	HEBHBL	EESS	VOS	RHOF[112]
	required standards. The period of the lease may not exceed the end date of the contract the fundholder has with the health professional.	required standards. The period of the lease may not exceed the end date of the contract the fundholder has with the health professional.	period of the lease may not exceed the end date of the contract the fundholder has with the health professional.	required standards. The period of the lease may not exceed the end date of the contract the fundholder has with the health professional.	lease may not exceed the end date of the contract the fundholder has with the health professional. RHOF may assist with the cost of transportation of equipment (on commercial transport) for use by the health professionals in delivering approved services.
Telemedicine and eHealth	The use of telemedicine services as a supplement to usual face-to-face consultations between patients and Health Professionals is supported through outreach programs. This includes the cost of venue and equipment hire associated with consultations using this medium. Other telehealth service costs will be considered by the Department on a case-by-case basis by special arrangement to guarantee service delivery in priority locations to Aboriginal and Torres Strait Islander people.	The use of telemedicine services as a supplement to usual face-to-face consultations between patients and Health Professionals is supported through outreach programs. This includes the cost of venue and equipment hire associated with consultations using this medium. Other telehealth service costs will be considered by the Department on a case-by-case basis by special arrangement to guarantee service delivery in priority locations to Aboriginal and Torres Strait Islander people.	The use of telemedicine services as a supplement to usual face-to-face consultations between patients and Health Professionals is supported through outreach programs. This includes the cost of venue and equipment hire associated with consultations using this medium. Other telehealth service costs will be considered by the Department on a case-by-case basis by special arrangement to guarantee service delivery in priority locations to Aboriginal and Torres Strait Islander people.	The use of telemedicine services as a supplement to usual face-to-face consultations between patients and Health Professionals is supported through outreach programs. This includes the cost of venue and equipment hire associated with consultations using this medium. Other telehealth service costs will be considered by the Department on a case-by-case basis by special arrangement to guarantee service delivery in priority locations to Aboriginal and Torres Strait Islander people.	RHOF supports the use of telemedicine services as a supplement to usual face-to-face consultations between patients and health professionals. Does not support the capital costs associated with the establishment of telemedicine services but may cover costs, such as hire of venue and equipment, associated with consultations using this medium. RHOF also supports the use of eHealth initiatives such as the My Health Record(MHR) and access to and use of Video conferencing for patient consultations and to supportcontinuity of care.

Activity type	Program MOICDP	HEBHBL	EESS	VOS	RHOF[112]
Host facility fees	Incurred in hiring appropriate venues or facilities to support either outreach service provision or upskilling activities will be paid as appropriate. Suggested maximum facility fee payable for any venue is $200 per day (GST exclusive), with consideration by the Department given on a case-by-case basis up to $400 for seasonal variations or availability.	Incurred in hiring appropriate venues or facilities to support either outreach service provision or upskilling activities will be paid as appropriate. Suggested maximum facility fee payable for any venue is $200 per day (GST exclusive), with consideration by the Department given on a case-by-case basis up to $400 for seasonal variations or availability.	Incurred in hiring appropriate venues or facilities to support either outreach service provision or upskilling activities will be paid as appropriate. Suggested maximum facility fee payable for any venue is $200 per day (GST exclusive), with consideration by the Department given on a case-by-case basis up to $400 for seasonal variations or availability.	Incurred in hiring appropriate venues or facilities to support either outreach service provision or upskilling activities will be paid as appropriate. Suggested maximum facility fee payable for any venue is $200 per day (GST exclusive), with consideration by the Department given on a case-by-case basis up to $400 for seasonal variations or availability.	Incurred in hiring appropriate venues or facilities to support either outreach service provision or upskilling activities will be paid as appropriate. Suggested maximum facility fee payable for any venue is $200 per day (GST exclusive), with consideration by the Department given on a case-by-case basis up to $400 for seasonal variations or availability.

Appendix 1I: Related reviews and evaluations

There are several related reviews that have been, and are currently, being conducted on outreach programs related to, and within scope, of the outreach programs in this evaluation. Table 44 provides information on these related reviews including program scope, geographic coverage and year.

Table 44: Previous reviews on outreach programs

Review	Year	Geographic coverage	Programs within scope
Meta-evaluation of Regional Health Strategy 2000–2004, Department of Health and Ageing[26]	2005	National	VOS
Outreach Eye Services in Australia by the University of Melbourne[113]	2009	National	Outreach eye services including VOS, MSOAP and Rural Retention Program (RPR).
Evaluation of the MSOAP and the VOS by HPA[32]	2012	National	MSOAP and VOS
Monitoring and Evaluation of the Indigenous Chronic Disease Package: Final Report Volume 1: Evaluation of the overall package and its individual measures by KPMG[114]	2014	National	MOICDP
Process Evaluation of the NT Medical Outreach – Indigenous Chronic Disease Program (MOICD) by AMSANT[115]	2017	NT	MOICDP
Indigenous Ear and Hearing Health initiatives by Siggins Miller[11624]	2017		Six programs in scope: • HEBHBL • Surgical support (subset of the EESS) • Provision and maintenance of equipment – specifically for ear and hearing assessment equipment • Training – specifically for ear and hearing assessment training • Ear Health Coordinators • Care for Kids' Ears

[113]Turner, A., Mulholland, W., & Taylor, H. (2009). *Outreach Eye Services in Australia*. https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0011/1984142/outreach_eye_services.pdf
[114] KPMG. (2014). *Monitoring and Evaluation of the Indigenous Chronic Disease Package: Final Report Volume 1: Evaluation of the overall package and its individual measures.*
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[116] Siggins Miller. (2017). *Ear and Hearing Examination Final Report.*

Review of the Rural Health Workforce Support Activity (RHWSA) by KPMG[117]	2020	National	RHWSA program
Evaluating the progress and effectiveness of regional implementation of The Roadmap to Close the Gap for Vision by ARTD Consultants[118]	2022	National	Review assesses progress in establishing regional approaches to addressing eye health needs for Aboriginal and Torres Strait Islander people since the development of the National Agreement on Closing the Gap in 2012.
Aboriginal and Torres Strait Islander Primary Health Care Systems Evaluation by Allen+Clarke[119]	Ongoing, 2018–2023	National	Assessing the effectiveness of primary care services funded under the Indigenous Australians' Health Programme. The following outreach programs are funded under the IAHP: • MOICDP • HEBHBL • EESS

Key themes and recommendations

While these reviews assess various outreach programs that seek to improve access to a range of different health services, many of the themes and recommendations presented are interconnected and there are clear synergies to the findings and recommendations put forth in this evaluation.

The following themes are highlighted:

- **Workforce development and capacity building**
  The need for strong workforce development and local capacity building was a theme across multiple evaluations. This included creating workforce strategies to bolster recruitment and retention of the local workforce, with a particular emphasis on building the Aboriginal health workforce and developing strong community leadership. To facilitate workforce development and local capacity building, evaluators offered several suggestions including:

  - Providing ACCHOs with funding to directly employ outreach staff.
  - Ensuring outreach professionals provide education and training during their visits by making it a requirement or offering support.
  - Offering additional ways to support the training of the local workforce through telehealth, 'e-huddles,' webinars and shared care arrangements.
  - Developing official, area-specific workforce plans or strategies to develop and train the new workforce to support the broader health workforce.
  - Introducing a funding pool that allows rural workforce agencies to propose funding for additional activities.

- **Coordination and integration of outreach services**
  Effective coordination and integration of outreach services into existing local health service delivery is imperative to support continuity of care. Several reviews have highlighted coordination issues and the need to develop infrastructure to support more seamless delivery of outreach services. This included establishing centralised systems, such as visiting calendars shared between all outreach services, creating a

[117] KPMG. (2020). *Review of the Rural Health Workforce Support Activity.*
[118] ARTD Consultants. (2021b). *Summary Report: Evaluating the progress and effectiveness of regional implementation of The Roadmap to Close the Gap for Vision.*
[119] Allen and Clarke. (2021). *Aboriginal and Torres Strait Islander Primary Health Care Systems Evaluation.* https://www.iahpyarnes.com/phc/introduction/

standardised system for referrals and implementing guidelines for patient handover. Also, stakeholders advocated for the allocation of funding to support local coordination of outreach services, including scheduling patient and specialist visits, sending patient reminders, supporting telehealth consultations, informing visiting specialists of specific cultural or community events that might impact patient attendance and organising patient transport.

Multiple reviews also cited challenges with strong integration of outreach services into existing local health systems and the facilitation of effective continuity of care to support patient management in between outreach visits. Some of the challenges associated with integration may be attributed to the variability and frequency of outreach services.[13]

To encourage stronger integration and continuity of care in outreach services, one review suggested offering incentives to ACCHOs and local health organisations to provide effective patient referrals, assessments and follow up and to better encourage the achievement of positive patient outcomes. Another called for a broader assessment of the existing national infrastructure and how resources are allocated to foster alignment across programs. For example, Siggins Miller[24] suggested combining the Australian Hearing's Specialists Program for Indigenous Australians with the HEBHBL or, to facilitate alignment, establishing a set of KPIs and coordinating scheduling and planning across these 2 programs.

- **Governance and information sharing across programs**
  Several recommendations were made across evaluations that emphasised the need for more communication, partnerships and information sharing across stakeholders, local communities and the general public. Increasing communication and providing more transparency around governance processes and operations of the outreach programs would help to facilitate stakeholder engagement around outreach services, raise public awareness, improve coordination, increase access to outreach services and decrease the potential for duplication of services across programs. Many reviews suggested increasing transparency by sharing information with the public regarding:

    - the availability of local health services and outreach services across communities.
    - the nature of service providers delivering outreach services.
    - dissemination processes between jurisdictional advisory fora, fora member organisations, agencies, providers and local communities.
    - the nature of the investment the Department is making towards the outreach programs, including the broader objectives of these programs.
    - how the Department is hoping to achieve these goals through this investment.
    - Outreach programs' contribution to achieving specific government initiatives, such as Closing the Gap.

  Evaluators also suggested providing more information on the role of stakeholders in the outreach space and establishing more formal collaborative agreements to facilitate planning, increase the involvement of local communities the planning and delivery of outreach services, enhance communication and complement the delivery of existing local health services.

  In its independent review of the progress and effectiveness of regional implementation of the Roadmap to Close the Gap for Vision launched by the Indigenous Eye Health Unit at the University of Melbourne in 2012, ARTD Consultants looked to assess implementation of regional activities across jurisdictions in the eye health space, key enablers and barriers and lessons for the future. The review revealed that 63 of 64 regions across Australia were categorised as 'active collaborations' and 99% of the 182 ACCHOs and AMSs are included in these 'roadmap regions.'

Key enablers to building effective regional implementation of the Roadmap to Close the Gap for Vision included strong representation from the Aboriginal and Torres Strait Islander sector in regional collaborative arrangements, establishing and fostering strong connections with local communities and associated health sectors to collaborate and work to establish solutions for specific regions, a funded coordinator for regional groups to facilitate associated activities and foster accountability and Close the Gap for Vision IEHU meetings and updates to support information sharing and learning across the eye heath sector.

Key barriers included constraints around funding and existing short-term funding arrangements which has impacted staff turnover and limited organisations' ability to devote staffing resources to facilitate regional arrangements and foster collaboration; competing priorities in the health sphere; and limited reporting on cultural safety across some regions.[22]

It is clear there is a great support and activity associated with regional working groups across Australia. These groups are working to implement the Roadmap to Close the Gap for Vision and the associated priority reforms. Stakeholders highlighted positive changes in the space in relation to awareness of eye health programs, resource-sharing and regional communication and collaboration, but noted the need to better understand potential data collection and monitoring issues in the Aboriginal and Torres Strait Islander eye health sector. The review identified 4 lessons to better incorporate regional approaches to meet the intended objectives of the Roadmap to Close the Gap for Vision:[3, 120 (p. iii)]

1. Strengthen Indigenous leadership and ownership
2. Sustain regional partnerships and networks
3. Enhance cultural competence of eye health workforce
4. Continue to build the evidence base.

- **Outreach funding and assessment of need**

The consensus across evaluations is that there is great complexity around funding arrangements for outreach programs and how funding is distributed across jurisdictions Therefore, there were calls for greater transparency regarding how need is assessed and funding is allocated. Recommendations included developing better mechanisms to determine levels of need and potential gaps in local health service provision, such as using population weights to determine the allocation of funding across programs and developing a formula that considers geographical constraints and the varying cost of service delivery across regional, rural and remote locations. Other reviews suggested providing administrative funding at the jurisdictional level for Aboriginal and Torres Strait Islander health organisations to assist in the consultation and engagement of Aboriginal and Torres Strait Islander communities and local health services to identify health needs and priorities of outreach programs across jurisdictions.

In addition to providing greater transparency around funding allocations across outreach programs, several reviews recommended that the Department establish longer term funding agreements with fundholders and allow for greater flexibility of funding to account for changes in circumstances, allow for services to better target areas of need and limit underspend across outreach programs.[14] Establishing longer term funding arrangements would allow fundholders to establish longer term contracts with service providers and improve the sustainability of outreach services. In its review of MSOAP and the VOS, Health Policy Analysis[32] recommended allowing fundholders to approve changes in service delivery offerings at outreach locations currently receiving services within a given financial year without approval from the Department. In

[120] ARTD Consultants. (2021a). *Summary Report: Evaluating the progress and effectiveness of regional implementation.*

addition, they indicated that the 3-year funding agreements and annual plans should include reserve services to mitigate the risk of underspend. In KPMG's review of the Rural Health Workforce Support Activity,[117] stakeholders cited a need for more flexibility in the funding arrangements so funds can easily be moved across different program streams in cases where emerging needs are identified. The review also found evidence of duplication across outreach programs targeting similar health priorities. As a result, it identified the need for stakeholders to establish better communication and advocated for further alignment of funding across the outreach programs as one way to help improve efficiencies.

- **Data collection and management**
  The need to develop a standardised, national approach to data collection across outreach programs was a recurrent theme across evaluations. Stakeholders described the importance of establishing a national outreach program dataset to assist with the planning, reporting and tracking of patient outcomes, which is currently limited in the outreach space. In its review of the Indigenous Ear and Hearing Health initiatives, Siggins Miller[24] advocated for the development of a national ear health data set and the establishment of national KPIs linked to Closing the Gap for Aboriginal and Torres Strait Islander ear health. As an approach to securely store and share patient data, they recommended health services collect and upload this data to My Health Record. In line with this recommendation, Health Policy Analysis' review of MSOAP and VOS[32] recommended establishing a secure, national database for the programs. This online portal would provide information on outreach service arrangements and any approved changes to service delivery, visits, patient volume and payments. It would also have the ability to capture associated provider comments. This could then be used by the fundholders and the Department for reporting purposes and to conduct further analysis. These recommendations indicate there is a clear need to establish a more seamless and consistent process to collect, store and manage data across programs and jurisdictions.

Appendix 1J: Data specifications

1. Fundholder outreach program data specification

Session dataset – where there can be multiple sessions over multiple days during a visit to one host service provider in one location

Visit-ID	Session-ID	Session-date	Session-service- category	Session-professional-category	Session-professional-type

Note: each session is allocated to one professional. This data will enable an appreciation of the range of professions participating in outreach services but not the total number of professionals.

Visit dataset – where there can be multiple visits to one host service provider in one location over the service period

Visit attributes						
Service-ID	Visit-ID	Visit-date-start	Visit-date-finish	Visit - location	Visit- facility	Visit -organisation (ACCHO Y/N)

Visit activity					
Visit - Occassions of Service -Attended-All	Visit - Occassions of Service -Attended-ATSI	Visit-Occasions of Service-Did not Attend-All	Visit-Upskilling -hours	Visit-Professional support -Y/N	Visit-multidisciplinary care-Y/N

Travel, meals and accomodation expenses			
Visit-actual-expenses-travel -flights($)	Visit-actual-expenses-travel -car($)	Visit-actual-expenses-meals and accomodation ($)	Visit-actual-expenses-travel, meals accomodation -other($)

Provider support payments								
Visit-actual-expenses-professional support ($)	Visit-actual-expenses-upskilling ($)	Visit-actual-expenses-backfill ($)	Visit-actual-expenses-workforce payment ($)	Visit-actual-expenses-absence from practice ($)	Visit-actual-expenses-locum support ($)	Visit-actual-expenses-telehealth - provider fee ($)	Visit-actual-expenses-provider-adminstration and coordination($)	Visit-actual-expenses-provider-other($)

1. Fundholder outreach program data specification (continued)

Host provider payments				
Visit-actual-expenses-facility fee-other ($)	Visit-actual-expenses-equipment lease ($)	Visit-actual-expenses-facility fee -telehealth ($)	Visit-actual-expenses-host-adminstration and coordination ($)	Visit-actual-expenses-host-adminstration and coordination($)

Service dataset where services specified in the annual service plan can involve a contract with service providers for multiple visits to one or more locations over the service period.

Service-period-end (date)	Service-period-start (date)	Outreach Program-ID	Service-ID	Service-name	Service provider - ID	Service provider-name	Initial-planned-visits (count)	Final-actual-visits (count)	Initial-budget-expense-total ($)	Final-actual-expense-total ($)

2. Fundholder EESS program data specification

Visit dataset – where a number of patients travel to a facility and undergo one or more procedures. The patients may be accompanied by one or more carers. Some of the providers may need to travel to the host facility to conduct the procedures.

Visit attributes							
Service-ID	Visit-ID	Visit-date-start	Visit-date-finish	Facility-name	Facility-location	Facility-type	Facility-sector

Visit activity				
Procedure-category-ear-count	Procedure-category-eye-count	Procedure-total-count	Patient(s)-total-count	Carer(s)-total-count

Travel, meals and accomodation expenses				
Visit-actual-expenses-travel - patients and carers ($)	Visit-actual-expenses-accomodation and meals - patients and carers ($)	Visit-actual-expenses-travel - providers ($)	Visit-actual-expenses-accomodation and meals - providers ($)	Visit-actual-expenses-travel,accomodation and meals -other($)

2. Fundholder EESS program data specification (continued)

Provider support payments								
Visit-actual-expenses-professional support ($)	Visit-actual-expenses-upskilling ($)	Visit-actual-expenses-backfill ($)	Visit-actual-expenses-workforce payment ($)	Visit-actual-expenses-absence from practice ($)	Visit-actual-expenses-locum support ($)	Visit-actual-expenses-telehealth - provider fee ($)	Visit-actual-expenses-provider-adminstration and coordination($)	Visit-actual-expenses-provider-other($)

Host provider payments				
Visit-actual-expenses-facility fee-other ($)	Visit-actual-expenses-equipment lease ($)	Visit-actual-expenses-facility fee -telehealth ($)	Visit-actual-expenses-host-adminstration and coordination ($)	Visit-actual-expenses-host-adminstration and coordination($)

Service dataset where patients and procedures specified in the annual service plan can involve a contract with service providers for multiple visits to one or more facilities over the service period.

Service period-start-date	Servicem period-end-date	Outreach Program-ID	Service-ID	Final-actual-patients (count)	Final-actual-carers (count)	Final-actual-procedures-eye (count)	Final-actual-procedures-ear (count)	Initial-budget-expense-total ($)	Final-actual-expense-total ($)

Appendix 1K: Workforce groups

1. Allied Health

MBS service type	Profession	Specialty
Allied Health attendances (total)	31 Allied health	311 Physiotherapist
		312 Exercise Physiologist
		313 Dietitian
		314 Speech pathologist
		315 Audiologist
		316 Occupational Therapy
		317 Podiatry
		318 Social Work
		319 Optometrist
		320 Orthoptist
		321 Orthoptist
		322 Orthotics
		323 Pharmacist
		324 Psychologist
		325 Counsellor
		327 Chiropractor
		399 Not specified

2. General Practitioners

MBS service type	Profession	Specialty
GP attendances (total)	13 Medical general practitioner	10 General practitioner
	14 Medical general practitioner registrar	10 General practitioner

3. Nursing and Aboriginal Health Workers

MBS service type	Profession	Specialty
Nursing and Aboriginal Health Workers (total)	21 Nurse/Midwife	211 Nurse practitioner
		212 Clinical nurse consultant
		213 Midwife
		214 Registered nurse
		215 Enrolled nurse
		219 Other nurse
	41 Aboriginal health worker/practitioner	

4. Medical Specialists

MBS service type	Profession	Specialty
Specialist attendances (total)	11 Medical specialist	11 Cardiology
		13 Dermatology
		14 Endocrinology
		15 Gastroenterology
		17 Haematology
		21 Neurology
		22 Nephrology
		22 Oncology
		24 Respiratory
		25 Rheumatology
		27 General medicine
		281 Paediatrics
		282 Geriatrics
		283 Hepatology
		283 Vascular medicine
		284 Sexual health
		285 Other physician genetics
		43 Colorectal surgery
		46 Neurosurgery
		48 ENT
		49 Orthopaedics
		50 Ophthalmology
		52 Urology
		54 General surgery
		54 Vascular surgery
		541 Paediatric surgery
		545 Anaesthetist
		73 Obstetrics and/or Gynaecology
		74 Neonatology
		83 Psychiatry
		84 Rehabilitation medicine
		85 Psychogeriatrics
		86 Palliative care
		861 Pain medicine
		99 Not specified

4. Medical Specialists (continued)

MBS service type	Profession	Specialty
	12 Medical specialist registrar	13 Dermatology
		14 Endocrinology
		22 Nephrology
		24 Respiratory
		27 General medicine
		281 Paediatrics
		48 ENT
		49 Orthopaedics
		50 Ophthalmology
		54 General surgery
		73 Obstetrics and/or Gynaecology
		83 Psychiatry
		861 Pain medicine
		99 Not specified

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