Australian Government

Department of Health

Evaluation of Outreach Programs

Volume 2: Case studies

Revision history

Version	Date	Modification
0.1	11 February 2022	Initial draft.
0.2	29 July 2022	Draft report.
0.3	25 August 2022	Incorporates feedback received from fundholders
0.4	15 September 2022	Incorporates additional feedback received from fundholders.

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Glossary

ACCHO	Aboriginal Community Controlled Health Organisation
AMSANT	Aboriginal Medical Services Alliance Northern Territory
BRAMS	Broome Regional Aboriginal Medical Service
CAAC	Central Australian Aboriginal Congress
EESS	Eye and Ear Surgical Support Program
ENT	Ear, Nose and Throat
HEBHBL	Healthy Ears – Better Hearing, Better Listening (program)
Host providers	Health organisations that host visiting outreach service providers in target communities
HoA	Heart of Australia
HPA	Health Policy Analysis
IRSAD	Index of Relative Socio-Economic Advantage and Disadvantage
KAMS	Kimberley Aboriginal Medical Service
LOV	Lions Outback Vision
MM	Modified Monash
MBS	Medicare Benefits Schedule
MOICDP	Medical Indigenous Chronic Disease Program
NACCHO	The National Aboriginal Community Controlled Health Organisation
NDIS	National Disability Insurance Scheme
NSW RDN	New South Wales Rural Doctors Network
NT Health	Northern Territory Department of Health
NT PHN	Northern Territory Primary Health Network
PHN	Primary Health Network
PREMs	Patient-reported experience measures
PROMs	Patient-reported outcome measures
RFDS	Royal Flying Doctors Service
RHOF	Rural Health Outreach Fund
RHOF PM	Rural Health Outreach Fund Pain Management
RHT	Rural Health Tasmania
RHW	Rural Health West

SAHMRI	South Australian Health and Medical Research Institute
SEIFA	Socio-Economic Indexes for Areas
SE NSW	South East NSW
SNSW LHD	Southern NSW Local Health District
TAC	Tasmanian Aboriginal Centre
TAZREACH	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

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Introduction

The Australian Government Department of Health (the Department) engaged Health Policy Analysis (HPA) to evaluate the following outreach programs:

- Medical Outreach Indigenous Chronic Disease Program (MOICDP)
- Rural Health Outreach Fund (RHOF), including special time-limited extension to pain management specific services (RHOF PM)
- Visiting Optometrists Scheme (VOS)
- Eye and Ear Surgical Support Program (EESS)
- Healthy Ears – Better Hearing, Better Listening (HEBHBL)
- Heart of Australia (HoA) in Queensland only.

The evaluation included 6 case studies across 5 jurisdictions.

The case study approach

Towards the end of 2021, the 9 jurisdictional fundholders across Australia were invited to nominate outreach services as potential case studies. The evaluators aimed to select case studies representing a range of outreach delivery models and services operating across Australia. This volume provides details of each of the case studies. Themes and other findings drawn from these contributed to the evaluation findings in Volume 1.

Table 1 provides key attributes of the case studies undertaken.

Table 1: Case study site and focus

Jurisdiction	Fundholder	Program coverage	Mode of consultation	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	Northern Territory PHN	MOICDP	Virtual	**Geographically-based,** covering the central Australia region of the Northern Territory.
Qld	CheckUP	HoA	Face-to-face	**Geographically-based,** covering the Heart of Australia program providing services in the town of Theodore.
		RHOF	Face-to-face	**Service-based,** True Relationships & Reproductive Health providing reproductive and sexual health services with rural and remote clinics in 14 locations across Queensland.
TAS	Department of Health Tasmania through TAZREACH	All programs except EESS	Face-to-face	**Geographically-based**, covering the North West region of Tasmania, including the West Coast.

Jurisdiction	Fundholder	Program coverage	Mode of consultation	Focus
	Rural Health Tasmania (RHT)	EESS	Face-to-face	**Service-based,** with RHT as provider and fundholder of 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.

The case studies aimed to capture a wide variety of stakeholder groups to reflect the diverse perspectives and challenges organisations are facing in the delivery of outreach services. The following stakeholder groups were interviewed from each jurisdiction in relation to each case study:

- host providers
- visiting outreach providers
- jurisdictional fundholders
- National Aboriginal Community Controlled Health Organisation (NACCHO) affiliates
- local hospital networks (LHNs)
- primary health networks (PHNs)
- Aboriginal Community Controlled Health Organisations (ACCHOs).

Patients and consumers were not interviewed due to time and resources available for the evaluation.

HPA worked with fundholders and other local stakeholders to plan the case studies and organise interviews. A list of stakeholders interviewed as part of each case study is provided in the introduction of each case study.

In addition to interviews, the case studies in this Volume were also informed by documents and materials provided by stakeholders, including:

- Information provided by local services, outreach providers and fundholders, for example, needs assessments, financial and activity reports.
- Relevant local, jurisdiction and national reports and reviews.
- Data provided by the fundholders.

Impact of COVID-19

COVID-19 outbreaks and travel restrictions meant that some cases studies needed to be conducted via videoconference. For example, the evaluation team originally planned to undertake an in-person visit to Western Australia in mid-February 2022 after the state borders were scheduled to open. However, the borders remained closed indefinitely when the team was out in the field, resulting in a virtual case study.

Another consideration related to COVID-19 was the capacity of visiting and local services to accommodate the evaluators during the pandemic. As a result, some fundholders had to delay the case study visits due to competing priorities. This resulted in HPA conducting a virtual case study in the Northern Territory to ensure the case study visit was completed within the evaluation timeframes.

Comparative outreach, health and population data

Table 2 provides information on the social and demographic information of the main town in each case study region, excluding the service-based case study on True Relationships & Reproductive Health. It is noted that this information does not reflect the full extent of service

and coverage of the population in each case study region. Further details are provided in each case study.

Table 2: Social and demographic features of the case study regions (main town)[1]

Case study region	Jurisdiction	Modified Monash (MM) category (Location)	SEIFA Index	Population	Proportion Aboriginal and Torres Strait Islander
Theodore	Qld	MM 5 (Theodore Medical)	997	450	7.5%
NSW South Coast	NSW	MM 3 and 4 (Nowra and Batemans Bay, respectively)	996	8,000	7.7%
North West Tasmania	TAS	MM 3 (Burnie)	915	19,000	6.9%
Central Australia	NT	MM 6 (Alice Springs) to MM 7	881[2]	39,317	36.8%[3]
Kimberley	WA	MM 6 (Broome Regional Aboriginal Medical Service)	955	16,000	28.2%

[1] Australian Department of Health. (2019). *Modified Monash Model (MMM) Suburb and Locality Classification*. https://www.health.gov.au/sites/default/files/documents/2019/12/modified-monash-model-mmm-suburb-and-locality-classification-home-care-subsidy-modified-monash-model-suburb-and-locality-classification-home-care-subsidy_0.pdf

[2] Informed Decisions. (2022b). *RDA Northern Territory: SEIFA by profile area*. Informed Decisions,. https://profile.id.com.au/rda-northern-territory/seifa-disadvantage-small-area

[3] Informed Decisions. (2022a). *RDA Northern Territory: Population and dwellings*. Informed Decisions,. https://profile.id.com.au/rda-northern-territory/population?BMID=310

2

Queensland: True Relationships and Reproductive Health

Box 1: Key observations

- True Women's Health Service (True) reports that it invests in local community engagement to better understand its service needs and tailor its outreach clinics accordingly. It considers its service a success and believes a key factor contributing to this is the trust it has built with local providers and the community by understanding their preferences and prioritising service reliability and dependability.
- 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.
- True has developed a service approach with Queensland Health that allows the centre to triage clients and place them directly on the public surgical waiting lists. True would like to expand its service offering via a truck, equipped as a mobile clinic, to travel to locations without health services.
- Due to its largely female clientele, True employs only female staff, including doctors, nurse practitioners and advanced practice nurses. All care staff are expected to consider participation in outreach as part of their overall role in service provision for the organisation. While MBS bulk billing is used to partly fund the services, employees are salaried to remove pressure of throughput for a sustainable income under fee-for-service.

Case study scope and focus

This case study focusses on the state-wide outreach women's health services in Queensland funded by CheckUP through the RHOF.

CheckUP hosted HPA on a one-day visit to Brisbane to discuss its role in administering the outreach programs and explore the key aspects of the women's health services provided by True Relationships and Reproductive Health (True) in rural and remote communities across Queensland. Table 3 lists the organisations and roles of officers interviewed during the visit.

Table 3: Officers interviewed by organisation and role

Organisation	Role
CheckUP	• Acting CEO • Senior Business Coordinator
True	• CEO • Business Manager

From 1 July 2015, the Rural Women's General Practitioner Service transitioned from the Royal Flying Doctors Service (RFDS) to CheckUP. The program is now funded from the RHOF, and its priority is women's health.

The RFDS program provided patients in designated rural areas with access to female doctors on a regular visiting basis. These doctors were available to provide a full range of GP services. By facilitating the travel of female GPs, the program aims to improve access to primary health

care services for women in rural and remote Australia who have little or no access to a female GP. There are numerous aspects of wellbeing that women prefer and are more comfortable discussing and managing with a female doctor, including issues relating to sexual health.

After the transition in 2015–16, in conjunction with Health Workforce Queensland, CheckUP assessed the distribution of GPs in rural and remote areas of Queensland. The assessment revealed that 28 locations did not have access to a resident female GP, with a handful of these locations without access to any GP.

The assessment identified locations receiving visiting women's health services, as well as other locations not eligible to receive outreach services. After further mapping of services by existing providers, CheckUP partnered with True to consider and map identified needs in 16 priority locations for future provision of outreach women's health services.

Stakeholders claim that the transition of the program from the RFDS has significantly expanded the service eligibility criteria for women.

True Relationships and Reproductive Health

True Relationships and Reproductive Health was established in 1972 and considers itself a 'profit-for-purpose' organisation. True's goal is to achieve substantial, positive social impact by improving reproductive and sexual health and promoting safe and respectful relationships. True aims to achieve this through the delivery of expert clinical services, education and counselling.

True has facilities in Brisbane, Cairns, Ipswich, Rockhampton and Toowoomba providing reproductive and sexual health services. In Cairns, True provides a counselling service that supports both children and adults when faced with sexual abuse. True also has teams of child and family educators delivering relationship and sexual education programs in schools, supporting students, teachers, parents and carers. True also provides a variety of professional development programs for clinicians.

The funding provided to True from the RHOF enables the organisation to extend its usual service offerings and provide outreach clinics in selected rural and remote locations.

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.

True designed and piloted outreach services in Agnes Waters in 2016 and in 2017 rolled out services to a further 13 locations – Augathella, Bowen, Clermont, Collinsville, Dysart, Hughenden, Julia Creek, Mitchel, Moura, Quilpie, Richmond, Thargomindah and Texas (Figure 1) – with services now expanded to 16 rural and remote locations.

True states that over 70% of the population in Queensland is now within a one-hour drive of a location True services.[4]

Figure 1: Location of outreach clinics, 2017

[4] True Relationships and Reproductive Health. (2019). *Pop-up Womens Health Service for Rural and Remote Communities*.

Source: Unpublished data provided by True.

Governance and needs assessment process

True reported that an assessment of current service availability in the communities it now services revealed that many women, previously needed to travel over 1,000 kms to see a clinician for an initial consult and for any subsequent treatment.

The services provided by True are often of a highly sensitive nature, including intimate examinations and trauma counselling. In small rural communities, the nature of personal relationships can act as a barrier for women (and sometimes men), seeking these types of services. True indicated that service gaps can exist even in communities with GP access. True suggested that, where appropriate services and service environments are not readily available, the rates of unintended pregnancy, mental ill health, and acute and chronic diseases can be elevated.

CheckUP reported it monitors women's health service needs across its regional coordination network through regular engagement with local communities. It also provides a system of online feedback, where health services and communities can propose services needed.

CheckUP's initial process of needs assessment included mapping community needs across Queensland and consulting with community stakeholders to understand the need and service barries for reproductive and sexual health services locally. The initial needs assessment identified 16 target communities.

With an aim of avoiding duplication and respecting existing referral pathways, True assigned senior staff to work with community stakeholders in designing health outreach services. True reported being very focused on engagement with the local communities, with stakeholders often approaching the organisation directly to discuss possible service provision for the future.

The process usually starts out with a conversation, followed by consideration of the data from the community. True reported this can then lead to discussions about what possible services

could look like and then subsequent conversations with CheckUP to see if funding may be possible.

True noted that sometimes funding can be moved around to accommodate new service requirements. However, the service needs of existing communities have remained relatively stable over the last 5 years, and this has limited the ability to expand services to additional communities.

True indicated it also works with the PHNs to identify community needs. For example, True reported that the Western Queensland PHN is currently advocating for True to provide outreach services in Far West Queensland and Mount Isa Hospital.

Local service coordination and integration

In establishing an outreach service in a new location, True reported that it carries out an orientation visit, which is supported with funding through the outreach programs. This occurs before the start of a new service and allows a small team from True to meet the staff of the local health facility from which they will operate. The orientation visit allows True to:

- Meet local Hospital and Health Service (HHS)[5] staff and start forming working/personal relationships.
- Inspect the HHS facilities to understand how to manage logistics effectively.
- Engage with the local community to begin promoting the new service.
- Plan future service visits with input from local stakeholders.

For established services, True reported that its ongoing planning for services in the communities starts 6 months in advance. The process includes confirming arrangements with the local health service through fliers and emails throughout the year. True has an administration officer that takes care of the bookings and makes sure the clinicians visiting the community are aware of the number of clients booked into the clinic and why they are presenting for care and support. The clients can ring the administration officer to book into a clinic.

True reported that while its administration records and clinical notes are generally kept separate from the local services, where the client consents, the outreach clinicians leave notes for the local health service. This helps to create continuum of care, enabling the local GP to follow up care and make referrals to other services as required.

When conducting outreach visits, it was indicated that the clinicians from True make a point of meeting with people in the town, the local pharmacists, doctors, and council so they are aware of who True staff are, when they are in their town and what services will be provided to their community. True considers this engagement creates trust and an environment where collaboration and dialogue can flourish. It also believes this helps identify service gaps and possible solutions.

Outreach provider recruitment and retention

True employs 40 to 50 clinicians, including medical officers, nurse practitioners and advanced reproductive and sexual health nurses. True's clinical staff are 100% female, to provide services to their 97% female clientele. Employed clinicians are contractually obliged to participate in the organisation's outreach services, with a fair load-sharing arrangement in place to ensure the outreach commitments are well distributed. In reality, clinicians that express interest in participating in outreach identify preferred locations and these inform rostering. It was reported that over 30% of the clinicians participate in True's outreach programs.

[5] Queensland LHNs.

True reported Queensland Health as its largest funding source, contributing to both staff and infrastructure costs. True's clinics bulk bill patients, with MBS covering the cost of supplying medical staff and contributing to the cost of the nurse practitioners. Other nursing staff without access to MBS rely on workforce support payments. True confirmed the organisation's clinical staff are salaried and not based on patient volumes, removing billing pressures. RHOF funding through CheckUP contributes directly to outreach costs of travel, meals, accommodation and incidentals.

True reported not having trouble attracting and recruiting staff. However, it is cognisant of maintaining competitive renumeration rates with commercial private practice. True reported that the limiting factor in expanding services to more communities is funding.

Training and upskilling of local service providers

No host organisation was available for consultation, therefore this and the following two sections were informed through consultation with True, the outreach service provider, and CheckUP (the RHOF fundholder).

With funding provided through CheckUP, True supports upskilling and education of local practitioners in reproductive and sexual health. This takes place in formal and informal settings. For example, True has run structured sexual health programs with clinicians, as well as more informal dinner or morning tea sessions with staff. True also offers scholarships to Aboriginal Health Services to promote upskilling and education of local health workers.

True indicated the capacity to train and upskill local staff is limited due to several factors, but primarily funding. It suggested that the way services are funded, clinicians rarely have enough time to deliver clinical services and training in a single visit. This is further complicated by the limited availability of local staff in busy health services to participate in training sessions.

Cultural competence of outreach providers

True reports that 100% of its staff working as outreach service providers have undertaken cultural competency training.

The proportion of True's patients that identify as Aboriginal and/or Torres Strait Islander is estimated to be less than 10%. There are 35 different Aboriginal Medical Services across the region, and their sheer number makes coverage by True challenging given existing service capacity. True reports having good relationships with the Aboriginal Medical Services it works with, and the organisation seeks to ensure referral pathways are strong and to avoid duplication of services.

True observes that Aboriginal and Torres Strait Islander clients prefer Aboriginal and Torres Strait Islander Australian workers and/or staff they already have a relationship with. Therefore, fly-in and fly-out type services aren't always well received. For example, True commented on one Indigenous Australian community that actively resisted its outreach services, with a view from the local health service that it would provide the required services itself. True indicated the issue was not about the level of cultural competency of its clinicians but a strong commitment to local service provision.

Service provision and utilisation

True provides reproductive and sexual health clinic-based outreach services that focus on:

- contraception, including intra uterine device insertions
- complex gynaecology, including hormonal issues like polycystic ovary syndrome
- pregnancy care, including pre-conception, antenatal and post-natal services
- sexual health, including testing and treatment of sexually transmitted infections

- menopause issues.

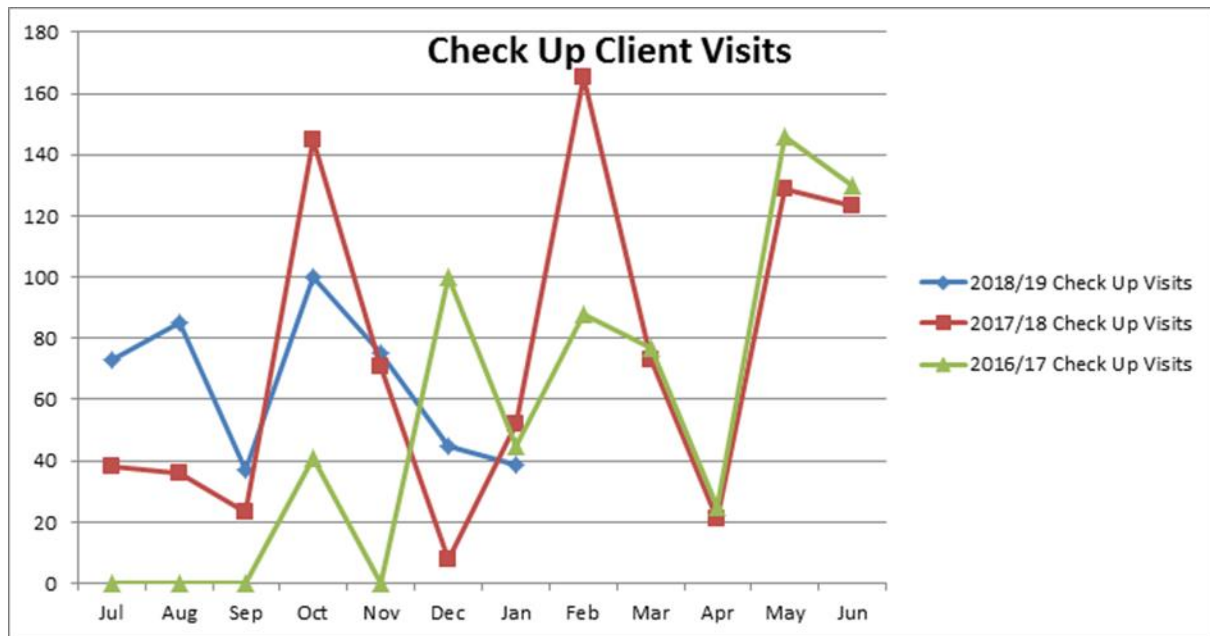
These service focus on prevention and detection and management of health conditions relevant to these areas of specialty, including cervical and sexually transmitted infection screening. The clinicians participating in the outreach clinics refer clients to other health professionals across a variety of disciplines, depending on each client's needs.

True indicated that many local communities are often not able to recruit and retain relevant specialist clinicians and that some regional hospitals are not equipped to cope with providing reproductive and sexual health services.

True stated that it relies on rooms at local health services to provide outreach services. It reported that remote locations often lack the infrastructure and clinic facilities to support more complex procedures, including calibration of equipment. Clinical consumables are often required to be shipped into the location.

Data provided by True from 2016–17 to 2018–19 has been used to assess the level of outreach services provided across the organisation since 2016 when the reproductive and sexual health services started (Figure 2). In 2016–2017, 652 clients attended the outreach clinics. This grew to 884 in 2018–19 and True reports steady growth since then given deepening of services in existing communities and expansion of services into new communities.[4]

Figure 2: True client visits by month 2016–17 to 2018–19



Source: Unpublished data provided by True.

During this period, True clinicians carried out over 2,000 visits to rural and remote communities, involving over 1,000 clients and providing over 3,700 services. The principal services provided were largely related to gynaecological and contraception issues (see Figure 3).[4]

Figure 3: True outreach services 2016–17 to 2018–19

Since October 2016		Principal service provided	
Visits	2,104	Contraception	14.45%
Clients	1,116	STI	0.71%
Services	3,726	Gynaecological	71.44%
Referrals (out)	2,098	Pregnancy	1.09%
Treatments	2,135	Other	12.02%
Diagnoses	2,101	Unknown	0.29%
Postcodes	49	Total	100%

Source: Unpublished data provided by True.

Telehealth and innovative models of care

Since establishing outreach services in 2016, True reported that it has sought to innovate its service offering by providing service dependability, telehealth, mobile clinics and referrals. These are described below.

Service dependability

A women's health service was previously provided by the RFDS. Although low uptake of the outreach services initially provided by True were observed, through subsequent building of community trust, True reported service demand has increased. True attributes its success to consistency of service provision. It indicated that communities have communicated the clear priority for dependable services and expressed frustration with the previous provider cancelling clinics. True indicated it listened to the communities and acted on changes requested.

Telehealth

True looked to establish a telehealth-based outreach service during the COVID-19 pandemic, in response to some communities requesting that outreach clinicians not visit their clinics during this time. MBS items for telehealth during the pandemic allowed True greater financial scope to develop a telehealth model. However, True noted that telehealth has remained limited due to preferences of clients in rural and remote communities to be seen face-to-face and the need for hands-on procedures. True indicated it has also faced challenges in training people via telehealth.

The organisation considers there is still scope for local capacity building. For example, a local provider who is presented with a complex case may setup a telehealth consult with a True clinician to assist them. True has been considering the employment of a sexual health counsellor to provide telehealth.

Mobile clinics

True is looking to expand its services to new locations such as Middlemount, Mount Morgan and Tieri and continuously tailor its existing services based on feedback from communities and CheckUP. The organisation is keen to explore the implementation of mobile clinics. This would involve the fitting out of a truck with 2 clinic rooms, allowing them to provide services in locations where infrastructure is insufficient. For example, they cited that in some remote locations, clinic rooms and sufficiently calibrated instruments are not readily available.

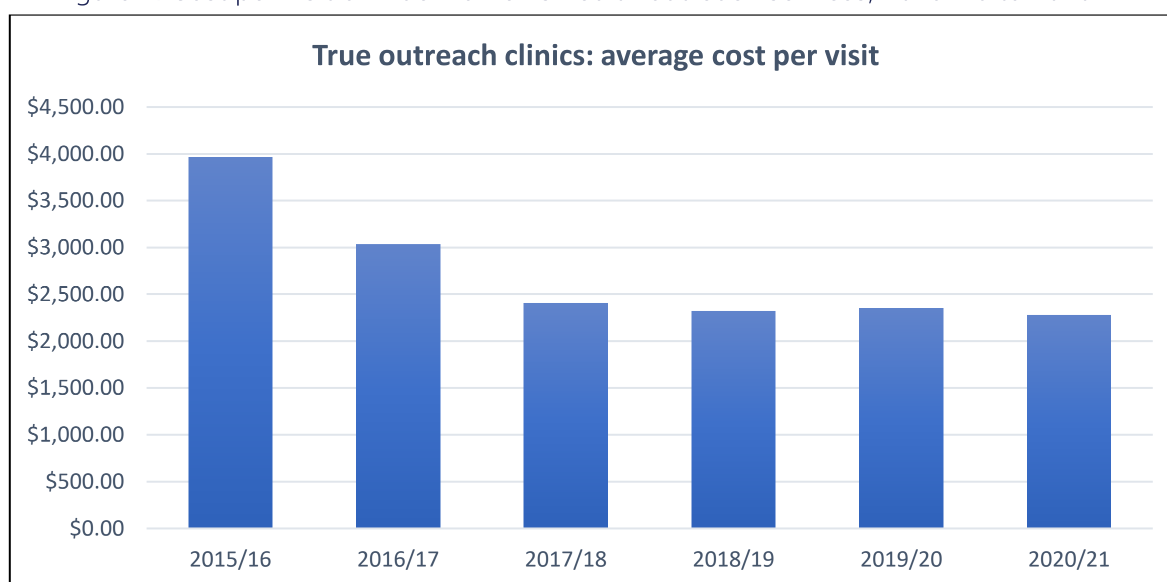
Referrals

True has been looking to integrate services and strengthen referral pathways. For example, patients attending its outreach clinics who are diagnosed with early stage cancer can be put directly on the surgical waitlist. The LHN has established arrangements whereby True is able to triage patients and allow direct access to the system level elective surgery waiting list, providing a more streamlined pathway of care. True indicated this pathway is more integrated and timelier than a client presenting to their local GP and seeking referral to a hospital. True continues to expand its triaging activities, including work in relation to complex contraception and heavy bleeding.

Costs

True reported that its model of supporting clinicians to work at the top of their scope of practice has enhanced access to high quality, multidisciplinary care for a larger number of communities at a lower cost to the health system. It asserts this is evident in the reduction in cost per visit since the women's health service transitioned to the RHOF under CheckUP (Figure 4).[4]

Figure 4: Cost per visit of True women's health outreach services, 2015–16 to 2020–21



Source: Unpublished data provided by True.

True reported increased costs due to the COVID-19 pandemic. The cost of flights and accommodation rose, with clinicians more frequently paid double time on Sunday to ensure clinic services proceed when flights were unavailable during the early parts of a working week. Plus, True reported that delays and re-routing resulted in more time away from service provision for clinicians, resulting in higher cost per service.

Barriers and enablers for delivering outreach services

True identified the rising costs of service provision, staff shortages experienced during the COVID-19 pandemic, disruptions due to weather events, and telecommunications infrastructure in remote communities as the main barriers to delivering outreach services. Key enablers were community trust brought about by service reliability and sustainability, careful building of staff culture and innovations in service delivery (e.g. mobile clinics). These point to the need for long term-term funding commitments.

As mentioned earlier, True attributed its success to building trusting relationships with local providers and communities. This was enabled by demonstrating it listens to each community

and tailoring services to their needs and preferences, as well as allaying fears of its staff and services being "here today, gone tomorrow". Service reliability, connections with local businesses and government, and education forums have built endorsement of and referrals to True's services.

Funding was the key factor identified for expanding services in existing locations and extending the services to other communities.

3

Queensland: Heart of Australia

Box 2: Key observations

- **There may be further opportunities for Heart of Australia (HoA) to partner and co-commission services with other organisations.** This includes increased communication and engagement with local, jurisdictional and national stakeholders to mitigate the risk of potential service duplication and explore opportunities to build local capacity or co-commission outreach services.
- Theodore Medical distinguished between specialist services that are less likely to be provided locally and primary care services that could more feasibly be provided locally. While providing outreach services is a valuable way to increase community access to certain health services, the clinic emphasised that stakeholders should look to **prioritise local solutions. Examples provided** included **increasing access to rural and remote education and training opportunities and supporting the local health workforce to deliver care to communities in their area.**
- Theodore Medical regards HOA's services as accessible and providing specialty care that the general practice is unable to offer to the community.
- Theodore Medical values outreach services 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.
- Costs of service were not available to assess value for money; therefore, this information would be helpful to understand

Case study scope and focus

The HoA case study was place-based and focused on the organisation's service delivery in the community of Theodore. HoA works closely with the local general practice, Theodore Medical Centre, to coordinate and deliver its specialist services in the community. HoA invited members of the HPA team to spend the day with its staff in Theodore as staff delivered services, including cardiology consults and echocardiograms, via its mobile medical truck, the HEART 4.

Table 4 lists the individuals interviewed for the case study by organisation and role.

Table 4: Interviewees by organisation and role

Organisation	Role
CheckUP	• Acting CEO • Senior Business Coordinator
Heart of Australia	• CEO and Cardiologist • Head of Operations and Business Development • Executive Assistant • Medical student – NextGen cohort • Allied health student – NextGen cohort
Theodore Medical Centre	• 3 general practitioners, including the practice owner • Operations and Finance Manager • Medical intern

Organisation	Role
	• Health Assistant

Heart of Australia

HoA provides specialist medical services via its multipurpose "clinics-on-wheels". HoA's trucks are equipped with diagnostic and treatment infrastructure that allows its multidisciplinary teams to see, diagnose and treat patients on site. Its current fleet consists of 5 trucks. The fifth truck, the HEART 5, started operations in January 2022. HEART 5 has additional features and equipment to the other trucks, including an audiology machine and the capacity for CT scans. HoA trucks currently provide specialist services to 32 rural and remote communities in Queensland spanning across 3 travel routes. HoA operates on a hybrid fly-in, fly-out model in which clinical and operational staff fly to meet the HoA trucks at various locations and travel on the trucks providing care to communities along its service routes. The HoA trucks only require electricity to operate; therefore, the community locations in which HoA trucks visit on their routes vary. Figure 5 shows the service's travel routes and the communities the trucks visit across Queensland.[6]

Figure 5: HoA service routes

While HoA's focus is cardiology, it has expanded its 3 initial service offerings to 21 specialty services. It contracts with health professionals across various specialties, including endocrinology, gynaecology, neurology and allied health. HoA has also trialled other outreach services, including psychology sessions and smoking cessation classes. HoA's website provides the following list of services:[7]

- cardiology consultations
- endocrinology consultations
- general medicine consultations
- gastroenterology consultations
- gynaecology consultations and procedures
- neurology consultations
- geriatric consultations
- stress echocardiograms
- exercise stress testing
- echocardiograms
- electrocardiograms
- Holter monitoring
- ambulatory blood pressure monitoring
- sleep apnoea testing
- phlebotomy
- CPAP trials
- sleep & respiratory specialist consultations.

[6] Hospital and Healthcare. (2021). *Trucking health services to remote Queensland.* https://www.hospitalhealth.com.au/content/aged-allied-health/article/trucking-health-services-to-remote-queensland-1461283461
[7] Heart of Australia. (2019c). Services. https://www.heartofaustralia.com/services/

HoA receives funding from various sources across the public and private sector. It has several corporate partners, such as Arrow, Bayer and Philips, and has received funding from the Australian and Queensland governments to assist in fitting out its trucks and other aspects of service delivery.[8]

HoA expanded its reach from 5 towns in 2014 to 32 towns in 2021. It is hoping to expand its service nationally to provide "a road-based RFDS". The service is also beginning to focus on specific populations. For example, it is working with the mining industry to address the increased incidence of coal workers' pneumoconiosis, commonly known as "black lung" disease. The HEART 5 truck is equipped with an x-ray machine and a high-resolution CT scanner for early detection of black lung disease amongst miners throughout Queensland and Western Australia.

Community overview

Theodore is one of the outreach locations HoA teams visit monthly. Other outreach services visiting Theodore since 2017–18 include optometry, dietetics, occupational therapy and speech pathology.[9]

Theodore is a small town with an MM5 classification, which means it is considered a non-remote location. Approximately 500 people live in Theodore and an additional 1,000 live on the outskirts. Major industries of employment include agriculture and mining, with the Cracow Gold Mine and the Dawson Coal Mine located nearby.

The HoA team works closely with the local general practice, Theodore Medical Centre. The Medical Centre refers patients to HoA and organises patient follow ups during HoA's visits. Six staff members from Theodore Medical Centre were interviewed for this case study.

Theodore Medical Centre is a family-owned practice operating since 1981. Over the years, the town and the practice have encountered many challenges and changes, including Tropical Cyclone Tasha in 2010, which flooded the town and destroyed the practice. Following the cyclone, the owners collocated the Medical Centre with Theodore Hospital. The Hospital is a multipurpose health service with 9 acute and 4 aged care beds. Theodore Medical Centre is connected to the Hospital by a small wing that staff move between to work together.

Theodore Medical Centre has 6 consulting rooms, 2 procedure rooms, and one nursing room. It is staffed by 18 permanent clinical and managerial positions. Table 5 lists Theodore Medical staff by profession.[10]

Table 5: Theodore Medical staff by role

Staff type	Total number of staff
GP	5
Nurse	4
Managerial and administrative staff	4
Aboriginal Health Worker	2
Health improvements	2
Coal Board Medicals	1
Total	18

In addition to its permanent staff, Theodore Medical Centre has become a hub for medical and allied health students with many interns, residents and students completing various stages of their training at the practice. The owners have operated a multidisciplinary model and thus

[8] Heart of Australia. (2019b). Partnerships. https://www.heartofaustralia.com/partnerships-2/
[9] Heart of Australia. (2021b). *Personal email communication - Heart of Australia Responses*.
[10] Theodore Medical. (n.d.). *The Theodore Medical Team*. Retrieved 4 April 2022 from https://theodoremedical.com.au/staff/

have prioritised expanding the range of disciplines amongst its permanent and visiting staff. Diagnostic services offered by the practice include x-ray, pathology and spirometry.

Theodore Medical Centre’s history with Heart of Australia

Figure 6: HEART 1 truck[11]

Before the arrangement with HoA, Theodore Medical Centre staff described referring patients to a cardiologist as a difficult, multi-step process. The process involved the GP triaging the patient and sending them to a radiologist. The radiologist would then refer the patient to a cardiologist in Rockhampton or Toowoomba. Long wait times due to availability of specialists and limited access to public transport posed further access barries that disproportionately affected certain community members, such as the elderly. To fill a need in the local community, particularly due to the older population of Theodore and hence the greater likelihood of heart issues, Theodore Medical entered an arrangement with HoA to refer its cardiology patients.

Theodore Medical Centre staff described the HoA service as “sophisticated” and “unique” in that it allows patients to have access to equipment and specialist services that the practice would not be able to have access to or provide otherwise, such as echocardiograms and electrocardiograms.

Needs assessment

HoA is not required to submit a needs assessment as part of its agreement with the Australian Government. HoA reported undertaking a needs assessment for its own purposes to ensure its services are fit-for-purpose and driven by community needs. Representatives of HoA described this as a ‘boots-on-the-ground’ process that is guided by regular informal conversations with key stakeholders, including community members and leaders, GPs and other local health providers about community health needs and priorities.

HoA receives requests from communities for its services as well as reaching out to communities itself. In all instances the organisation aims not to compete with services delivered by local health providers.

[11] Heart of Australia. (2021a). *Heart of Australia's Trucks*. https://hoachi.com.au/about/hoa-trucks/

HoA considers the following in relation to new service locations:[12]

- Level of remoteness. HoA targets more remote locations due to the more limited access to specialist health services.
- Proximity to existing routes. It is easier for the service to expand its existing routes to new locations due to vast distances and limited number of trucks.
- Feasibility of travel for clinicians. Routes must be accessible for clinicians and health professionals to meet trucks.
- Aboriginal & Torres Strait Islander population. HoA seeks to service towns with high numbers of Aboriginal and Torres Strait Islander people given the higher needs of this population.
- Funding continuity. To avoid the premature withdrawal of services and the disruption this causes, HoA will only expand to new locations when it can secure a minimum of 3 years of funding.
- Community engagement and support. Support for service delivery from local stakeholders, including local providers and community leaders.
- Consultation with federal, state and local governments. HoA consults with federal, local and state health departments to determine areas of need.
- Existing services and avoiding duplication. HoA seeks to avoid duplication of services and disruption to established referral pathways.

HoA training and upskilling

HoA established the NextGen Medics Program that allows medical and allied health students to accompany HoA teams on their service routes in 3 separate blocks over the course of a semester totalling 12 days. Students accrue 5 days of clinical hours for the 3 blocks. Representatives of HoA reported that creating a sustainable workforce in rural and remote areas is a core focus. Through the NextGen Medics Program, the organisation hopes to expand the health workforce in rural and remote areas across Australia.

HPA observed students on NextGen placement when conducting the case study visit in Theodore. The NextGen Medics students were positive about their experiences and appreciated the hands on learning they received. NextGen students were able to observe Theodore Medical staff on their rounds at the adjoining Theodore Hospital. Theodore Medical Centre staff described the NextGen program as incredibly beneficial, especially for allied health students who may have less access to training opportunities in rural and remote areas.

HoA also delivers a sonographer training program, and regularly hosts education sessions for local GPs and practice staff on its visits. HPA had the opportunity to observe the GP education session in Theodore, which included a two-hour presentation on electrocardiograms. Attendees included members of the Theodore Medical staff and the NextGen cohort.[13]

A member of Theodore Medical Centre staff distinguished between specialist services that are less likely to be provided locally and primary care services that can more feasibly be provided locally. However, funding for outreach is often prioritised, and outreach clinicians are often paid more, which may compromise the establishment of local services. An example was given of 'local' physiotherapist who travels to provide services at the practice but is not compensated for their travel time. While providing outreach services is a valuable way to increase community access to certain health services, local solutions should be prioritised. This includes increasing access to rural and remote education and training opportunities and supporting the local health workforce.

[12] Heart of Australia. (2021c). *Submission - Heart of Australia Outreach*.
[13] Heart of Australia. (2019a). *NextGen Medics*. https://www.heartofaustralia.com/nextgen-medics/

Cultural competence of outreach providers

HoA did not identify specific processes for developing the cultural competencies of its outreach providers. Staff noted that Aboriginal and Torres Strait Islander people are a key target population for the service. They highlighted aspects of their service they have designed to provide a comfortable and safe environment for Aboriginal and Torres Strait Islander patients. Representatives of HoA reported that their trucks were designed with Aboriginal and Torres Strait Islander peoples in mind. The HEART4 has an outdoor seating area to ensure a safe outdoor space to wait before an appointment. In addition, when HoA teams visit Aboriginal and Torres Strait Islander communities, they often park the truck where community members gather, so the service is in a familiar and accessible area. The organisation noted the value that communities place on face-to-face engagement and reported that it works to connect and establish relationships with community elders to ensure its services aligns with the culture and customs of the individual communities it services.

Local service coordination and integration

The HoA service model relies on referrals from local practice. As such, HoA reports prioritising coordination with local providers, a proposition supported by Theodore Medical. The nature of HoA's service model – requiring 3 years of funding to be secured and visiting locations monthly – has the potential to build working relationship with local providers and patients.

Staff at the Theodore Medical Centre confirmed that HoA is the only supplier of cardiac services available "locally." They also reported that referrals to HoA are smooth; the Medical Centre sends the referral, and patients are contacted and booked with HoA mostly within 2 days.

While HoA reported strong relationships with community leaders and general practices in some communities, the organisation appears to have limited involvement with the PHNs and the local HHSs. This suggests an opportunity for further coordination and collaboration with stakeholders across the public and private sectors. This will help to ensure other players in the outreach space are not delivering similar types of services to the same geographical locations and would allow for the identification of potential opportunities for partnerships and the co-delivery of outreach services.

Service provision and utilisation

HoA provided service and utilisation data only for July to December 2020 (Table 6).[14]

Table 6: HoA services provided by geography and demography, July to December 2020

Modified Monash Category	Service days	Indigenous patients	Total patient volume
MM 1–3	0	0	0
MM 4	92	193	1,295
MM 5	26	31	654
MM 6	20	67	301
MM 7	63	117	903
Total	201	408	3153

Source: Data extracted from HoA service and patient activity report July–December 2020.

The data from 2020 indicates that HoA spent the most service days and provided care to the most patients in towns classified in MM 4 followed by communities in MM 7. Data on the number and type of services was also provided for this period. A total of 18 types of services were provided, including stress echocardiograms, ECGs, FibroScans and colposcopies. ECGs

[14] Heart of Australia. (2020b). *Heart of Australia - July 2020 to Dec 2020 patients and services.*

were the most frequently delivered service across all towns within HoA designated service routes (n=604), followed by transthoracic echocardiograms (n=515). The data also incorporated a breakdown of the number of new face-to-face (n=437) and telehealth cases (n=106) and review face-to-face (n=499) and telehealth cases (n=59) by town.[15]

HoA staff expressed interest in the continued expansion of service routes and offerings. Staff feel the organisation has the potential to provide additional mobile health services, such as respiratory care, and would be interested in exploring partnerships to co-commission services in other medical fields.

Cost of HoA services

HoA is predominantly a private billing service, for which patients pay a gap fee. Staff estimated that patients can pay up to "a couple hundred dollars" for a specialist consult. Patient fees are set based on the kilometres patients save travelling to a specialist. Under some circumstances, such as financial hardship, HoA reported that specialists may bulk bill a patient, but this is at the discretion of the provider. A staff member of Theodore Medical Centre commented that they occasionally ask HoA staff to bulk bill specific patients, but most patients pay the out-of-pocket fee. Some stakeholders were concerned that the cost of the service is prohibitive to individuals' low incomes and could potentially lead local communities to disengage with the service. Nevertheless, Theodore Medical reported that it has liaised with the community and stated that individuals are willing to pay for the availability of this specialist service close to home.

Specialists can opt for a sessional or daily rate in which they charge patients a gap fee and receive MBS funding for their services. HoA is reliant on MBS funding, private billing and funding from its public and private partners to pay its clinical staff and facilitate service delivery and operations. For example, Rex provides free flights to HoA specialists when they are flying to meet the trucks on service routes and Bridgestone donates tyres for the HoA trucks. The organisation stated that MBS billing alone would not make the service sustainable.

HoA estimated the cost to buy and fit out a single HoA truck to be approximately $1 million but did not provide a breakdown of its costs beyond the expenditure report provided to the Department of Health from July to December 2020. Reported recurrent costs and income for this period are provided in Table 7 and Table 8. These figures only provide a partial picture of costs to operate the service and do not include the contributions of private sponsors, MBS payments or out-of-pocket payments from patients.

Table 7: Reported expenditure from July to December 2020

Expense type	Amount ($)
Total general office expenses	108,906
Professional services	396,411
Total employment expenses	699,524
Support vehicle expenses	1,042
Total accommodation, travel & allowances	192,750
Total truck expenses	37,310
Total expenses	**$1,435,942**

Source: Data extracted from HoA Milestone Report July–December 2020.

Table 8: Reported income and excess from July to December 2020

Income source	Amount ($)
Private partners & sponsors	Not reported
Check UP Australia	67,089
Commonwealth Department of Health	2,000,000

[15] Heart of Australia. (2020a). *Expansion of Heart of Australia's Mobile Specialist Clinics Milestone Report 1st Jul 2020 – 31st Dec 2020.*

Excess for period	631,147
For operational shortfall per June 2020 report	330,147
Total income	2,067,089
Total excess to date	**300,999**

Source: Data extracted from HoA Milestone Report July–December 2020.

Telehealth

While face-to-face care is HoA's predominant mode of service delivery, the organisation has capacity to provide telehealth services to patients. Telstra is one of HoA's partners, and members of the team reported that staff can conduct telehealth consultations on the trucks. They can also store and send data and images using enhanced exchange protocols, allowing for activities such as remote cardiac monitoring in the event the trucks are in a geographical area where there is no connection. Despite the trucks' technological capabilities, staff noted that in many instances patients do not have the connectivity to access specialists via telehealth. In some instances, HoA specialists can conduct telehealth consults at local general practices on their service routes, but this is sometimes not possible due to the truck's location and proximity to the local general practice.

Impact on health outcomes

Stakeholders identified collecting data on patient outcomes as a challenge. This is due to a myriad of factors, including differing patient management systems across local and outreach providers.

While HoA did not comment on specific aspects of patient data it collects, the organisation reported that it provides the opportunity for patients to submit feedback about their experience with the service on its website. Theodore Medical staff commented that they have not had any negative patient feedback thus far and have received positive feedback from a patient about the ease and convenience of the service.

HoA staff thought that the data the organisation collects on patient outcomes may be of interest due to the populations and geographical areas that it services and commented on the possibility of partnering with a research organisation to analyse the data.

Barriers to delivering outreach services

HoA cited barriers around service coordination and logistics of health provider visits. For example, in some instances, it reported challenges getting health professionals to the trucks in a timely manner due to airport and travel delays.

HoA reported that it has tried to engage local, jurisdictional and national stakeholders across sectors with the goal of expanding its service offering and increasing access to specialist services in regional, rural and remote areas. They described building trust with these stakeholders as a slow process.

HoA is particularly interested in fostering coordinating amongst stakeholders. This includes sharing resources and information.

The potential for duplication of service delivery between HoA and other services is an area of concern for stakeholders, and there appear to be opportunities to strengthen communications with public and private sector providers.

4

New South Wales: South Coast Region

Box 3: Key observations

- NSW RDN operates a **decentralised governance model** that supports local and regional input, ownership and coordination of outreach services across regions of New South Wales.
- 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.
- Visiting providers need to understand 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.**
- 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 reported that they 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**.
- 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 felt flexibility could be enhanced by **allowing for greater relaxation of certain eligibility guidelines** for outreach funding across programs.
- **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.
- 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.**
- Outreach providers are working to monitor patient feedback and outcomes more effectively by enhancing their data collection processes. This includes **developing questionnaires to gather data on patient-reported outcome measures (PREMs) and patient-reported outcome measures (PROMs).**

Case study scope and focus

The New South Wales case study was place-based and focused on providers delivering outreach services in the South East region of New South Wales (SE NSW). While many of the service providers interviewed as part of the case study deliver outreach services across SE NSW and surrounding regions, NSW Rural Doctors Network (NSW RDN) invited HPA staff to visit and speak with organisations and outreach providers in Nowra and Batemans Bay, as these locations are serviced by several organisations to coordinate the delivery of outreach services and provide a thorough representation of the supports and mechanisms required to

deliver outreach services; therefore, there is a particular focus on how outreach services operate within these communities.

In addition to conducting face-to-face interviews with providers in these communities, HPA interviewed several other organisations virtually to further inform the case study. These included Hearing Australia, the Aboriginal Health and Medical Research Council (AH&MRC) of NSW and COORDINARE (the South Eastern NSW PHN). The organisations interviewed for this case study are shown in Table 9.

Table 9: Interviewees by organisation and type

Organisation	Type
Grand Pacific Health	Service provider
Grand Pacific Health Batemans Bay Hub	Service provider
Grand Pacific Health Nowra Hub	Service provider
Cullunghutti Aboriginal Child & Family Centre	Host provider
Visiting specialist	Outreach provider
Visiting specialist	Outreach provider
Visiting allied health professional	Outreach provider
Aboriginal Health and Medical Research Council (AH&MRC) of NSW	NACCHO affiliate
Hearing Australia	Advisory forum member
NSW Rural Doctors Network	Fundholder
COORDINARE PHN	PHN
South Eastern Local Health District	LHN

Community overview

As indicated above, the case study visit focussed on the perspectives and experiences of services and outreach providers in Nowra and Batemans Bay. Figure 7[16] illustrates the location of Nowra and Batemans Bay in relation to the entire SE NSW region.

[16] South Australia Tourist. (n.d.). *Map of New South Wales South East*. https://www.sydney-australia.biz/maps/nsw/south-east-nsw-map.php

Figure 7: Map of SE NSW

Batemans Bay is a coastal town in SE NSW, with a population of 1,530. Of these, 169 (11.1%) people identify as Aboriginal and/or Torres Strait Islander, compared with the New South Wales average of 2.9%.[17] The town is classified as MM 4: Medium rural towns, though it is a frequent holiday destination for tourists, with Eurobodalla Shire Council – which Batemans Bay falls within – seeing a total of 1,200,426 visitors in 2019–20.[18]

The local hospital is Batemans Bay Hospital, which is comprised of 31 beds and had 12,886 emergency department presentations in 2020–21.[19] Adjacent to Batemans Bay is the town Moruya, which also has its a hospital, with 55 beds.[20]

Nowra is a town located in the Shoalhaven region approximately an hour and a half drive north of Batemans Bay and 160km south of Sydney. The community has a total population of 20,039 people (SA2 level) and 1,959 (9.8%) people identify as Aboriginal and/or Torres Strait Islander. Nowra has an MM classification of 3 and borders the Shoalhaven River. The town is described

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[17] Australia Bureau of Statistics. (2016a). *Batemans Bay*. Retrieved 22 April 2022 from https://abs.gov.au/census/find-census-data/quickstats/2016/SSC10229

[18] Eurbodalla Shire Council. (2020). *Research and data*. https://www.esc.nsw.gov.au/community/for-businesses/eurobodalla-tourism/Research-and-data

[19] Australian Institute of Health and Welfare. (2022). *Hospital: Batemans Bay Hospital* Australian Institute of Health and Welfare,. https://www.aihw.gov.au/reports-data/myhospitals/hospital/h0135

[20] Southern NSW Local Health District. (2020a). *Batemans Bay - Eurobodalla Health Service,*. Retrieved 22 April 2022 from https://www.snswlhd.health.nsw.gov.au/our-facilities/batemans-bay-eurobodalla-health-service

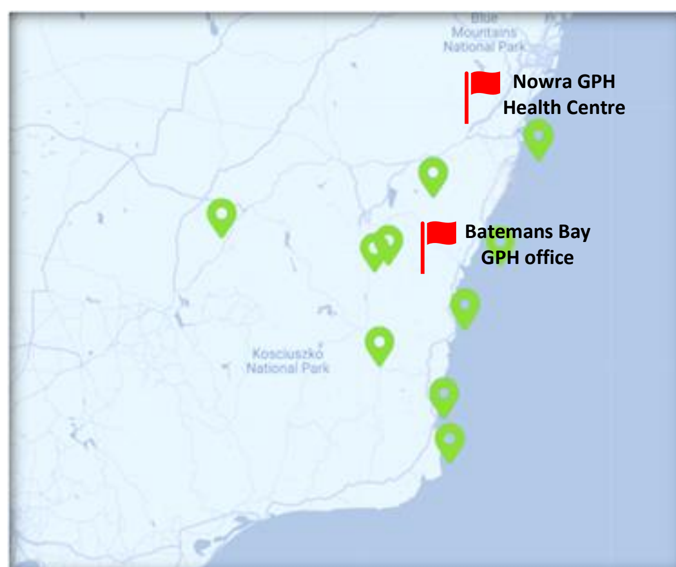
as the 'regional hub' of Shoalhaven. Compared with the national average of 6.9%, Nowra has an unemployment rate of 8.4%.[21]

Nowra has a 62-bed private hospital – Nowra Private Hospital – and a local public hospital – Shoalhaven District Memorial Hospital. Shoalhaven Hospital currently has 143 beds but is undergoing major redevelopment that is set to be completed in 2028 and will increase bed numbers and clinical capacity.[22] The South Coast Medical Service Aboriginal Corporation, an ACCHO that provides health services to Aboriginal and Torres Strait Islander communities across the Shoalhaven region, is also located in Nowra.[23]

Local stakeholders and outreach service delivery

There are several outreach providers that deliver outreach services to communities across SE NSW. This case study explored outreach service provision by select providers and how they operate in conjunction with each other and the broader outreach system in New South Wales. Descriptions of each of the organisations interviewed as part of the case study are provided below.

Figure 8: GPH Services across NSW



Grand Pacific Health (GPH) is a not-for-profit primary healthcare organisation that delivers a range of services, including outreach. Specifically, GPH delivers services as part of the RHOF, MOICDP and HEHBL programs across several locations and communities and has a clinic in Batemans Bay. In addition to Batemans Bay, GPH administers over 20 hubs in SE NSW, including 2 GP clinics in Shell Cove and Nowra, and 6 headspace centres. Representatives of the organisation reported that it employs a particular focus on Aboriginal and Torres Strait Islander health. GPH's services and programs include youth and adult mental health, support for housing and accommodation, health promotion, residential aged care facilities and chronic disease management. While the locations shown in Figure 8[24] may represent multiple GPH services in one area, the image highlights the distribution of their hubs and clinics across the South Coast and other areas of New South Wales, which span from Wollongong to Eden. The service also operates outreach clinics in several other locations including Goulburn, Bombala, Batemans Bay and Queanbeyan. While HPA had the opportunity to interview GPH staff virtually, the team visited and spoke with staff at its centre in Nowra and outreach clinic in Batemans Bay.[25]

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[21] Australia Bureau of Statistics. (2016b). *Nowra*. Retrieved 22 April 2022 from https://www.abs.gov.au/census/find-census-data/quickstats/2016/114011278

[22] Australia and New Zealand Infrastructure Pipeline. (2020). *Shoalhaven Hospital Redevelopment*. Retrieved 22 April 2022 from https://infrastructurepipeline.org/project/shoalhaven-hospital-redevelopment#:~:text=The%20NSW%20Government%20is%20planning,medical%20and%20aged%20care%20beds

[23] South Coast Medical Service Aboriginal Corporation. (2017). *About Us*. Retrieved 22 April 2022 from https://www.southcoastams.org.au/about-us/

[24] Grand Pacific Health. (2022b). *Find out services*. Retrieved 20 April 2022 from https://www.gph.org.au/find-our-services/

[25] Grand Pacific Health. (2022a). *About Us*. https://www.gph.org.au/about-us/about-us/

Cullunghutti Aboriginal Child & Family Centre is in Nowra and was established in 2014 as part of the Closing the Gap initiative. The centre reported that it provides holistic, wraparound services that focus on early childhood development, education, health and wellbeing. This includes comprehensive support and education for Aboriginal and Torres Strait Islander children and their families. Its health services include youth counselling, speech, occupational therapy and primary care services provided by paediatricians, nurses and Aboriginal health workers. The service has a strong partnership with GPH, and the organisation works with the centre to coordinate and provide outreach speech pathology, dietician and specialist services. While the centre receives funding from multiple sources, including the NSW Department of Communities and Justice, its outreach services are predominantly supported by Integrated Team Care (ITC) and MOICDP funding.[26]

Figure 9: Cullunghutti Aboriginal Child & Family Centre

Southern NSW LHD (SNSW LHD) covers an area of 44,547 square kilometres and provides services to approximately 200,000 residents across the region. The LHD's remit has 12 public hospitals, and the district provides a wide range of state services including mental health, oncology, dental and Aboriginal health services. Its service area spans from Crookwell and Goulburn in the Northern part of the district to Pembula and Eden in the south.[27] SNSW LHD receives outreach funding through the MOICDP to support the delivery of Aunty Jeans program, which provides community support to Aboriginal and Torres Strait Islander people with or at risk of chronic disease. Services as part of the Aunty Jeans program include health assessments, exercise sessions, nutrition support, health education and information, and are supported by various staff members including Aboriginal health workers, dieticians, endocrinologists, physiotherapists, occupational therapists and diabetes educators.[28]

Aboriginal Health and Medical Research Council (AH&MRC) of NSW is the NACCHO affiliate and peak body for its member ACCHOs and the Aboriginal and Torres Strait Islander communities in which it services. Beyond advocacy for its members, AH&MRC supports its members and Aboriginal health through various activities, including health promotion and planning, ethics and workforce capacity building.[29]

COORDINARE is the PHN for the SE NSW region. As a PHN, it is not a service delivery organisation but has a focus on commissioning and supporting primary health service delivery in the region. In relation to outreach, COORDINARE has worked with NSW RDN since being established and has been involved in NSW RDN's 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.

[26] Cullunghutti Aboriginal Child and Family Centre. (2022). *About Us*. http://www.cullunghutti.org.au/about/
[27] Southern NSW Local Health District. (2020b). *Our Services*. Retrieved 21 April 2022 from https://www.snswlhd.health.nsw.gov.au/our-services
[28] Southern NSW Local Health District. (2022). *Aunty Jeans Program*. Retrieved 21 April 2022 from https://www.snswlhd.health.nsw.gov.au/our-services/aboriginal-health-services/aunty-jeans-program
[29] Aboriginal Health & Medical Research Council of NSW. (2019). *Programs*. https://www.ahmrc.org.au/programs/

Hearing Australia is a national organisation that provides a range of ear health services across the country. In particular, the organisation runs the Hearing Assessment Program – Early Ears (HAPEE Program), which partners with communities to deliver free hearing assessments to Aboriginal and Torres Strait Islander children aged zero to 6 years.[30]

Governance and needs assessment process

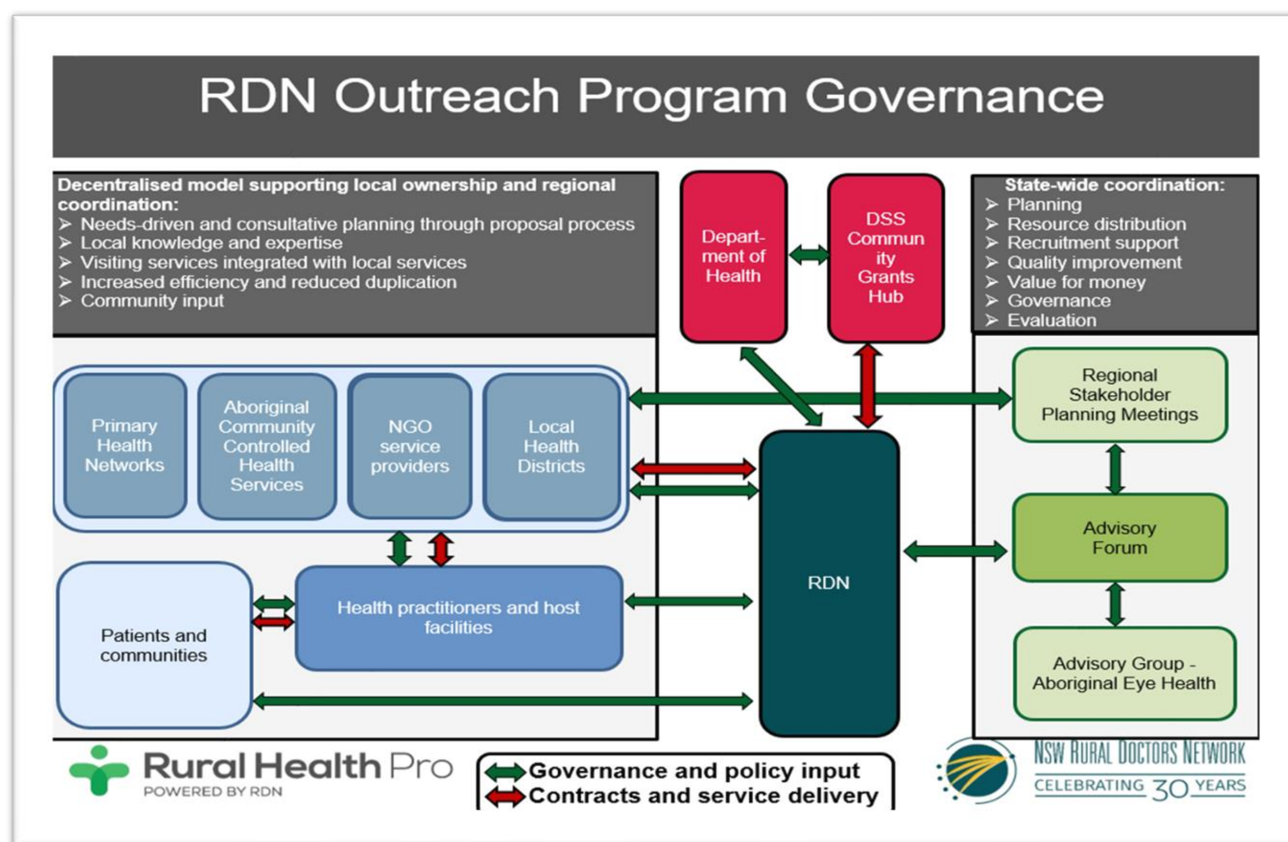
NSW RDN operates a decentralised governance model that supports local and regional input, ownership and coordination of outreach services across New South Wales (Figure 10).[31] It contracts with approximately 70 local partners who it believes have intimate knowledge of the communities they service. NSW RDN shares 7.5% of its 15% administration funding with these local partners acknowledging that these organisations control the service they run by holding the money, acquitting it, establishing budgets, etc. NSW RDN reflected that this has created an important dynamic, empowering local providers, who hire their clinicians directly, and better supports various functions, such as establishing practices to promote cultural safety.

In addition to liaising with and seeking input from key local, regional and jurisdictional stakeholders, including host facilities, ACCHOs, PHNs and Local Health Districts (LHDs),[32] NSW RDN stated it facilitates this model through its regional stakeholder planning meetings, advisory forum and Aboriginal Eye Health Advisory Group, which includes representation from many of these organisations. NSW RDN also contracts with ACCHOs, PHNs, NGOs and LHDs to deliver and coordinate services in conjunction with host facilities and visiting health practitioners.

Organisations largely reported positive experiences with NSW RDN and supported its outreach governance model. The organisation was described as helpful and responsive. Where challenges were reported, they were in relation to communication, and largely attributed to staff turnover within the organisation. For example, one stakeholder reported confusion regarding who its key organisational contact was. Stakeholders suggested more effective engagement and coordination of outreach services through information sharing and other strategies. For example, NSW RDN previously met regularly with other jurisdictional fundholders, but this had not occurred in recent times. NSW RDN felt these meetings were very useful for discussing innovations in outreach. At the jurisdictional level, some stakeholders described limited visibility of existing outreach programs. Stakeholders proposed various ideas to improve visibility, such as distributing a jurisdictional newsletter and developing a centralised information system stakeholders and service providers can access to gain a better understanding of outreach service provision at the local and regional level (that is, similar to the Northern Territory).

[30] Hearing Australia. (n.d.). *HAPEE Ears For Early Years*. Retrieved 21 April 2022 from https://www.hearing.com.au/Hearing-loss/HAPEE
[31] New South Wales Rural Doctors Network. (2020). *RDN Outreach Program Governance*.
[32] New South Wales LHNs.

Figure 10: NSW RDN outreach governance model



Source: NSW RDN.

Through its governance model, NSW RDN stated that it strives to enhance efficiencies, limit duplication of services and develop comprehensive, targeted needs assessments. The organisation described its needs assessment process as a bottom-up approach that focuses on knowledge and input from local communities. To effectively determine needs across communities, the organisation performs an annual needs assessment in which they consult with a wide range of stakeholders including local agencies, providers, ACCHOs, PHNs, LHDs and advisory forum members regarding potential areas of improvement and new and emerging needs. Stakeholder input, in addition to various quantitative sources (i.e. population data), is collated and analysed and helps to shape the organisation's annual outreach priorities. While NSW RDN still provides a list of unmet needs to the Department, organisational representatives stated that demand for health services often outstrips funding available which requires the organisation to use the information they have collected to determine which services are the highest priority.

While many providers, such as COORDINARE, Cullunghutti Aboriginal Child & Family Centre, and SNSW LHD, conduct their own needs assessments based on their organisational priorities and services, stakeholders described working with NSW RDN and gathering feedback from their workforce and communities to determine priority needs and inform NSW RDN's needs assessment process. For example, COORDINARE described sharing its PHN needs assessment with NSW RDN and participating in the organisation's needs assessment consultation reviews in the past.

NSW RDN has also encouraged providers to reach out to their local partners (i.e. local GPs, AMSs and LHDs) to facilitate strong partnerships and seek additional input into this process. For example, Cullunghutti Aboriginal Child & Family Centre described working predominantly with GPH and providing feedback to them regarding outreach service delivery. While there are always differing perspectives and political challenges to navigate, stakeholders feel the process

is comprehensive and considers existing service provision and a wide range of stakeholder perspectives.

Local service coordination and integration

NSW RDNs' local partners described their organisations as the middlemen that are responsible for coordinating outreach services and supporting visiting providers. They stated that they have strong relationships with local services on the ground and report directly to NSW RDN. They feel their organisations' role as a local partner is to ensure communication flows properly from the ground up. Much of this appears to be facilitated by engaging a wide range of stakeholders and seeking feedback from host services to ensure outreach services are running smoothly.

Stakeholders highlighted the complexity and high effort required to effectively coordinate outreach services. Interviewees commented that organisations across the jurisdiction have worked very hard to collaborate with each other to avoid service duplication. While NSW RDN allocates a portion of its administration funding to its local partners, interviewees stated that this funding does not support the coordination work their organisations do to plan and facilitate outreach which represents a large proportion of their work. This includes everything from organising patient transport, processing payments for visiting providers, providing IT support, following up with patients, performing health promotion activities and communicating with local services to ensure they are aware that providers are visiting. Stakeholders indicated that strong coordination at the local level is integral to the success of outreach service delivery. For example, one outreach provider stated that if GPH did not do this administrative and coordination work for them, they would not perform outreach. To enhance coordination and integration of service delivery, stakeholders advocated for additional funding to be directly allocated to host providers to support the coordination and administration of outreach programs.

Outreach providers also described the difficulties associated with following up patients after an outreach visit, such as barriers accessing patient records. While providers would like to have a face-to-face follow up visit with many patients shortly after an initial consultation, they reported this is often not possible due to the frequency and variation of outreach visits. Due to these challenges, providers stressed the importance of communicating and working with local GPs to ensure they follow them up and speak with them about their condition(s). While there is lots of work attached to this follow up, they acknowledged that it is necessary to promote continuity of care and facilitate better patient outcomes.

Outreach provider recruitment and retention

Provider recruitment and retention was a key topic of discussion amongst interviewees. Outreach providers in the region felt that the current level of renumeration under MBS may not sufficiently support providers or cover the opportunity cost of leaving their practice for a few days. For example, one provider stated that, compared with patients at their own practice, they often spend more time with patients they see on an outreach visit for a myriad of reasons, such as addressing cultural sensitivities and additional case complexity. While providers reported they receive strong administrative support from local services like GPH that facilitate their visits, many providers stated they are at the end of their careers and are not participating in outreach for financial reasons. They felt it would be difficult for younger providers to take time away from newer, less-established practices to participate in outreach given the travel, time away from family and the current level of renumeration.

Due to their current cohort of outreach providers, a key area of concern for stakeholders across the region is succession planning and maintaining high quality staff across local services. Stakeholders also highlighted the importance of community leaders, such as local permanent staff, who are invaluable to providing ongoing patient care and coordinating and facilitating

outreach services. Noting the risk that losing key outreach providers will have on future services in the region, interviewees advocated for establishing additional recruitment pathways and incentives for providers to participate in outreach.

Training and upskilling of local service providers

Due to the anecdotal reports of ongoing workforce shortages, training and upskilling the local workforce is a key priority for providers in the region. Stakeholders reported that local staff are invaluable to patient management and have a vital role in supporting outreach which includes telehealth and shared care arrangements. Interviewees described several approaches they have undertaken to facilitate this process. For example, one provider brings knowledge of new medications and shares this information with staff during his visits. The GPH clinic in Batemans Bay is working with the local TAFE to run a Certificate IV course in Aboriginal and/or Torres Strait Islander Primary Health Care.

While local providers are working to facilitate local training opportunities, the short-term nature of outreach funding has made it difficult to recruit local staff as they are only able to offer one-year contracts. In addition to establishing longer term funding contracts for outreach services, interviewees felt there should be more consideration of approaches to effectively measure and report on capacity building and training activities.

While the service delivery standards of the outreach programs highlight the importance of training and upskilling the local workforce, stakeholders felt there should be greater emphasis and more flexibility of funding to support organisations to facilitate training and upskilling of local staff. Stakeholders felt this should include the establishment of additional training and placement opportunities to encourage the younger workforce to work in rural and remote areas, such as implementing training pathways for local youth to undertake traineeships within their communities.

While developing the local workforce is often considered a long-term objective, interviewees cited examples that could facilitate and improve access to integral health services in the short term. For example, the NSW Spectacles Program provides free glasses and vision aids to qualifying recipients. Stakeholders indicated there are further opportunities for visiting optometrists to train local staff to order, receive and adjust spectacles for patients instead of having local services wait for visiting optometrists to return for their next visit. As one provider stated, "services only work if they are controlled by local services."

Cultural competence of outreach providers

Due to NSW RDN's decentralised governance, organisational representatives reported that its local partners develop cultural safety training and aid in monitoring this on the ground. Interviewees described working carefully with NSW RDN and local stakeholders to ensure the clinicians they recruit are culturally responsible. They stated that they frequently receive feedback from host provider staff on the cultural competency of their outreach providers. For example, GPH requires all outreach providers to complete online cultural safety training prior to commencing service delivery and has deliberately ended or given outreach providers a short-term contract in instances where they have found them to be culturally irresponsible. Cullunghutti Aboriginal Child & Family Centre reported that they have cultural immersion and awareness training. Before outreach providers start with their clients, they stated that visiting providers come into the centre and sit with cultural mentors for a few hours. To facilitate ongoing cultural learning, the centre reported they also have cultural supervision where clinicians can discuss various topics with cultural mentors.

In order establish trust and provide culturally safe care, stakeholders stressed that visiting providers need to understand local history and invest in ongoing relationship building with Aboriginal and Torres Strait Islander patients and community members. While stakeholders

reflected that empowering local providers to develop and implement cultural safety training has aided in facilitating culturally safe care in New South Wales, they hope to enhance their cultural competency training, so it better captures the diverse cultural history and customs of individual regions and communities. For example, GPH would like their training to be more tailored to local communities to more effectively capture this variation. The organisation is no longer funded to deliver cultural competency training and hopes for additional support to enhance its training in the future as every region is different and has a different cultural connection.

Stakeholders highlighted the importance of embedding culture into treatment and stressed that cultural competency is not simply a 'tick box exercise' and needs to be ongoing. Stakeholders cited examples of ongoing cultural competency training which includes supervision from cultural mentors, sitting with community elders and developing relationships through consultation. They also described monitoring and evaluation of culturally safe practices as critical. While stakeholders noted the challenges associated with directly measuring cultural safety, they felt seeking feedback from patients and family members on how they first engaged with a visiting provider or service is a key way to assess the cultural competency of visiting providers. Some stakeholders also suggested using attendance rates as a possible future metric for measuring cultural competency, with qualitative feedback gathered periodically to gain further insights as patients are less likely to see providers who they feel are not culturally appropriate.

Outreach funding

Stakeholders identified several areas where program funding could be improved to facilitate more seamless service delivery and help them to better achieve program objectives. While some of these points have been raised in other sections, they are presented comprehensively below as they were consistently highlighted by stakeholders as funding constraints that have hindered aspects of outreach service delivery.

Funding for coordination

Jurisdictional stakeholders continued to reiterate the importance of providing funding to host providers to support the coordination of outreach services. Stakeholders stressed that 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 feel they are not adequately compensated for this work. This includes satisfying data and reporting requirements across programs which they reported can be onerous and time consuming for staff.

To ensure coordination funding is allocated effectively, one stakeholder suggested providing needs-based funding that is not prescriptive (i.e. a certain amount of funding for coordination and clinical care). They felt this may enable host providers to use this funding more flexibly and allow it to titrate based on the needs of individual communities.

Program funding cycles

Stakeholders feel 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. For example, there were multiple reports that the 12-month contracts hinder planning and make it difficult to attract staff. Stakeholders reflected that communities are often reluctant to engage in partnerships that include short term contracts if they think their service may be cancelled next year.

Outreach visits appear to be regularly impacted and altered by unexpected events, such as adverse weather, workforce shortages and pandemics. Stakeholders stated that the short-term nature of outreach funding has contributed to program underspend as it is difficult to plan and

use underspend within a 6-month time frame. To combat this, NSW RDN over-allocates outreach funding on a contingency of 5 to 10% and has a reserve list of services that have gone through the organisation's proposal process but were not funded for various reasons, such as workforce availability. Due to these challenges, stakeholders advocated for a minimum of 3 to 5-year funding cycles to enhance planning processes, improve staff recruitment and support career pathways and allow for the establishment and ongoing development of sustainable local services.

Funding flexibility

There are examples where local services have been able to flexibly use outreach funding in conjunction with other funding streams to provide innovative, multidisciplinary services across a range of settings. Stakeholders described how they have used both MOICD and ITC program funding to enable their patients to see providers across multiples specialties in a single visit. HEBHBL funding has also allowed one provider to fund speech pathologists to work with local early childhood education centres. These providers can see kids in a day-to-day environment, do early intervention work and service many children who need ongoing assessment and support.

Stakeholders identified opportunities for improvement they felt would facilitate additional funding flexibility. These include further refinement of the program eligibility requirements in the service delivery standards (SDS) and reporting requirements. While it was stressed that steps must be taken to ensure the SDS are not narrowed for the purpose of consistency as this can disrupt service delivery, NSW RDN provided examples where the SDS could be amended to facilitate additional flexibility. For example, outreach programs with constraints around geography or patient age groups are often detrimental and disruptive because they exclude people who may need a service, but there are no other providers who can deliver the service as the patient is in an area of market failure. Another local partner has found it challenging to juggle 3 different contracts from New South Wales and navigate the program funding eligibility requirements. For example, their services try to link Aboriginal health workers to their clinics, but the fundholder requires evidence that the position is backfilled to be eligible for the funding. This has posed a large strain on providers to provide an Aboriginal health worker for one day per month, which they feel is not adequate. Stakeholders felt flexibility could be enhanced by allowing for greater relaxation of certain eligibility guidelines for outreach funding across programs.

RHOF funding

Stakeholders reported that there continues to be a very high demand for outreach services across New South Wales and they feel outreach funding must appropriately reflect and service this need. They cited the example of the RHOF and stated it has been fully subscribed and has not had an increase in program funding for several years; therefore, stakeholders have been unable to consider any proposals under the RHOF and expand service provision to communities in need. Due to the great demand for eligible services under the RHOF, they hope the Department will consider providing additional funding for this program.

Service provision and cost

A variety of providers visit the SE NSW region annually. This section provides information on outreach service provision, utilisation and costs across SE NSW region. For the purposes of the case study, Nowra and Batemans Bay are highlighted to shed light on the provision, utilisation and cost of outreach services within these individual communities. Table 10 illustrates the types of outreach services delivered to Nowra and Batemans Bay by supporting program in the 2020–21 financial year.

Table 10: Outreach service provision in Nowra and Batemans Bay by program for 2020–21

Community	Supporting program	Service
Batemans Bay	VOS	Optometry
	HEBHBL	Speech pathology
	RHOF	Midwifery Physician – geriatrics Vascular medicine Physician – Neurology Paediatrics – General Nursing – Clinical specialist
	MOICDP	Dietician/nutrition Exercise physiology Diabetes education Podiatry Occupational therapy Aboriginal health Nursing – RN, clinical specialist Midwifery Social work
Nowra	VOS	Optometry
	Follow-up Ear and Hearing Health Service (FEHHS)	ENT/ENT surgery Speech Pathology
	HEBHBL	Speech pathology
	RHOF PM	Registered nursing
	MOICDP	Dietician/nutrition Exercise physiology Podiatry GP Aboriginal health worker Nurse practitioner Midwifery Social work Psychology Nursing – clinical specialist, mental health Physiotherapy

Source: Information extracted from NSW RDN 2020–21 service activity report.

It was intended for an analysis of the number of visits and occasions of service against costs to be performed here using fundholder activity data; however, suitably reliable data could not be obtained (further explained in Volume 1). Reliable data would have facilitated an assessment on the costs per occasion of service and outreach visit.

NSW RDN undertakes cost benchmarking to review its cost of delivering outreach services annually. This includes discussing cost benchmarks of the reviewed outreach service relative to other similar services. During consultations, a staff member at NSW RDN reported this benchmarking has resulted in significant savings that have then been reinvested into outreach services in rural and First Nations communities. For example, a report by NSW RDN on the administration of the outreach programs reported a saving of 27% ($75) to the mean cost of RHOF medical specialist clinic hours over the period 2013–14 to 2016–17. The report cites that similar savings have been realised across all programs and medical specialist types.[33]

Telehealth and innovative models of care

Stakeholders described varying levels of success with telehealth in outreach. Similar to other jurisdictions, stakeholders noted its value in facilitating patient follow up and have found hybrid

[33] NSW Rural Doctor's Network. (2016). *RDN's Statewide Outreach Program Administration*. NSW Rural Doctor's Network.

models particularly effective. They commented that having an outreach visit every six months is often not satisfactory for patients; therefore, telehealth allows visiting providers to ensure patients are being followed up. They also indicated that telehealth is effective in facilitating training and shared care arrangements in which a specialist can conduct a telehealth consultation in conjunction with a local staff member, such as an Aboriginal health worker.

While telehealth can increase access to care and was particularly useful during the pandemic, stakeholders cautioned that there is a great deal of infrastructure and administrative capacity required to support this model of care, and it may be less applicable to certain specialties. Economies of scale exist with telehealth, and stakeholders observed that it is more cost effective in areas with more throughput. In addition, they commented that telehealth may not be preferrable for some patients and poses additional challenges for certain patient populations. For example, stakeholders cited the value Aboriginal and Torres Strait Islander communities place on face-to-face communication and that there is still some patient reluctance to receive care via telehealth. There are also questions around the management of adverse patient events and who is responsible for the patient in a telehealth arrangement.

Regarding other models of care, stakeholders discussed various national and local initiatives that focus on using online platforms and telemedicine to facilitate capacity building, patient screening and management. In partnership with SNSW LHD, St. Vincent's Hospital (SVHS) and the Agency for Clinical Innovation (ACI), COORDINARE has been undertaking the Southern NSW Pain Initiative. The program started in 2016 and seeks to address chronic pain and improve patient access to pain care. Representatives stated that the initiative takes a three-pronged, hybrid approach to meeting its objectives and includes specialist-led telehealth pain clinics, chronic pain management programs led by allied health professionals and in-person training and capacity building for local staff led by visiting SVHS staff. Using various assessment tools, providers are actively capturing patient outcomes as they progress through the program.[34] Another provider cited Tele-Derm, which allows rural and remote GPs to submit images via the online platform and receive dermatological advice and education on patient cases.

Despite the barriers associated with providing care via telehealth, stakeholders reflected that there is a great deal of innovation occurring in the region and they highlighted the ongoing role telemedicine will play in facilitating access to care in rural and remote regions.

Impact on health outcomes

Various stakeholders reported they are working to collect information on patient outcomes to assess the impact of the outreach programs more effectively. Some host services described collecting patient feedback via surveys and informal consultation. They reported that this often occurs opportunistically, and, in certain instances, the pandemic has negatively impacted providers' progress in this area. For example, one provider was trialling the administration of the personal wellbeing index but has not resumed collecting this information since the start of COVID-19.

Despite these barriers, stakeholders cited examples of local advances in the collection of patient reported experience measures (PREMS) and patient reported outcome measures (PROMs). In the past, SNSW LHD has had success collecting patient information via the Health Outcomes and Patient Experience (HOPE) platform, and they are now undertaking an initiative focussing on gathering PREMs and PROMs to track patient progress and identify potential gaps in service delivery. Their PREMs questionnaire concentrates on gathering patient

[34] COORDINARE, NSW Agency for Clinical Innovation, & Southern NSW Local Health District. (2019). *SNSW Chronic Pain Initiative: 2016-2019*. https://www.coordinare.org.au/assets/SNSW-Chronic-Pain-Initiative-Evaluation-v2.pdf

feedback on their experience with the Aunty Jeans program, and the team will administer the PROMIS-29 survey to track clinical outcomes.

While SNSW LHD is still in the process of implementing the surveys, the information will be collected via a digital system, and organisational representatives reported that patients will have the ability to complete the questionnaires via SMS, paper, email, or on an iPad in session with the support and assistance of an Aboriginal health worker. Results will be generated instantly and can be tracked over time. The LHD hopes to administer the questionnaires every 3 months to observe these trends over time. ACI is also working on a more culturally appropriate tool SNSW LHD hopes to use in the future.

SNSW LHD is enthusiastic about the developments it is undertaking to track patient experiences and outcomes but, due to the sensitive nature of the survey questions, it cited concerns about having enough staff to support patients during the administration of the surveys. The PROMIS-29 is a quality of life survey, and the questions have the potential to elicit strong responses from patients.

While measuring the impact of outreach programs through surveys can be an effective way to assess patient outcomes, one stakeholder noted that it can be hard to avoid bias in these types of questionnaires due to provider and patient fear of losing a service; therefore, there is a need for additional consultation with local services to alleviate these fears and for the expansion of data collection processes to facilitate better monitoring and evaluation of patient outcomes. Due to the sensitive nature of patient information, stakeholders also felt data sovereignty must be considered when establishing more robust measures and data collection processes for the monitoring and evaluation of patient outcomes.

Barriers to delivering outreach services

The top 3 barriers to delivering outreach services cited by regional stakeholders included:

Workforce shortages. There were reports of major workforce shortages, particularly in allied health and select specialties. Stakeholders cited high demand for occupational therapists, ENTs, pain management specialists and paediatricians. Stakeholders reported that they have an ageing cohort of outreach health professionals and have grave concerns about future service sustainability and have made succession planning a priority. Interviewees stated that these workforce shortages have made provider recruitment very challenging, especially since the National Disability Insurance Scheme (NDIS) is willing to pay health professionals more to deliver disability services. In addition to establishing additional training pathways and providing greater incentives for providers to participate in outreach, stakeholders reported a need for further alignment and resource sharing across sectors.

Limited resources (i.e. transport) and lack of funding for program coordination. Stakeholders reported that mainstream outreach is under resourced and oversubscribed. They stated that the region still faces great challenges with access, and that local providers require more resources and local capacity to support outreach service delivery. For example, stakeholders noted there is a great need for patient transport and additional funding to support program administration, coordination and data and reporting management.

Short term program funding cycles. Stakeholders reported that the short term nature of funding cycles have hindered their ability to recruit staff and contributed to program underspend. There is a desire amongst stakeholders for longer term funding cycles to facilitate sustainable service delivery.

5

Northern Territory: The Central Australia Region

Box 4: Key observations

- The Northern Territory Primary Health Network (NT PHN) is providing funding to Central Australian Aboriginal Congress (CAAC), which has a regional role in helping plan and coordinate local care and outreach services to surrounding communities. CAAC participates with other outreach providers in a regional planning group. Stakeholders asserted that this type of arrangement appears to provide ACCHOs 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.
- 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 must rely on same day fly-in, fly-out services which limits the ability for providers to establishing trusting relationships in the community.
- Many stakeholders expressed that MBS-based services do not always provide good care for Aboriginal and Torres Strait Islanders. They are driven by patient throughput and income imperatives rather than providing good care. There is a view that providers need 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.
- Spending time in community and building strong community relationships is important for outreach providers, particularly in more remote areas. Relationships of mutual respect 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.
- There is a view that 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.
- The RFDS appears to provide a highly valued outreach dental services to some remote communities, but stakeholders indicated that access to dental care remains a service gap in many areas with the need for strengthened outreach services.
- Telehealth and shared care models appear to play a vital role in overcoming geographic boundaries to provide better access to care and First Nations communities in Central Australia, however, stakeholders indicated that 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).

Case study scope and focus

Two fundholders manage the Outreach Programs in the Northern Territory, NT Health and Northern Territory Primary Health Network (NT PHN). The focus of this case study is MOICDP, administered by NT PHN, and the Central Australian Aboriginal Congress (CAAC). The interaction between NT PHN and NT Health will also be considered.

Due to COVID-19, interviews to inform this case study were conducted via video conference, save for an in person visit the RFDS base in Adelaide. The organisations that contributed to this case study are shown in Table 11.

Table 11: Interviewees by organisation and role

Organisation	Type
Individual podiatrist	Outreach provider
Aboriginal Medical Services Alliance Northern Territory[35]	NACCHO affiliate
Pintupi Homelands Health Service Aboriginal Corporation	ACCHO
Central Australian Aboriginal Congress	ACCHO
NT PHN	PHN and fundholder
NT Health	Jurisdictional health authority and fundholder
The Royal Flying Doctors Service (RFDS)	Outreach provider
South Australian Health and Medical Research Institute (SAHMRI)	Tele-podiatrist
Ali Curung Primary Health Centre	Host clinic

Central Australia region

The Central Australia Region covers an area of 551,218 square kilometres and has a population of 39,317 people. Alice Springs at the heart of the region has a population of 26,390 people and an MM classification of 6.[36] The remainder of the region is MM 7 classified with vast distances separating communities.[37]

Surrounding Alice Springs are numerous small remote communities, such as Amoonguna (population 281), Ntaria and Wallace Rockhole (population 711), Santa Teresa (population 682), Utju (population 229) and Mutitjulu (population 380). Also within the region are numerous remote communities, such as Ampilatwatja (population 490), Kintore (population 482) and Urapuntja (population between 600 and 1,000). Figure 11 shows a map of the communities in the context of the entire territory.[38]

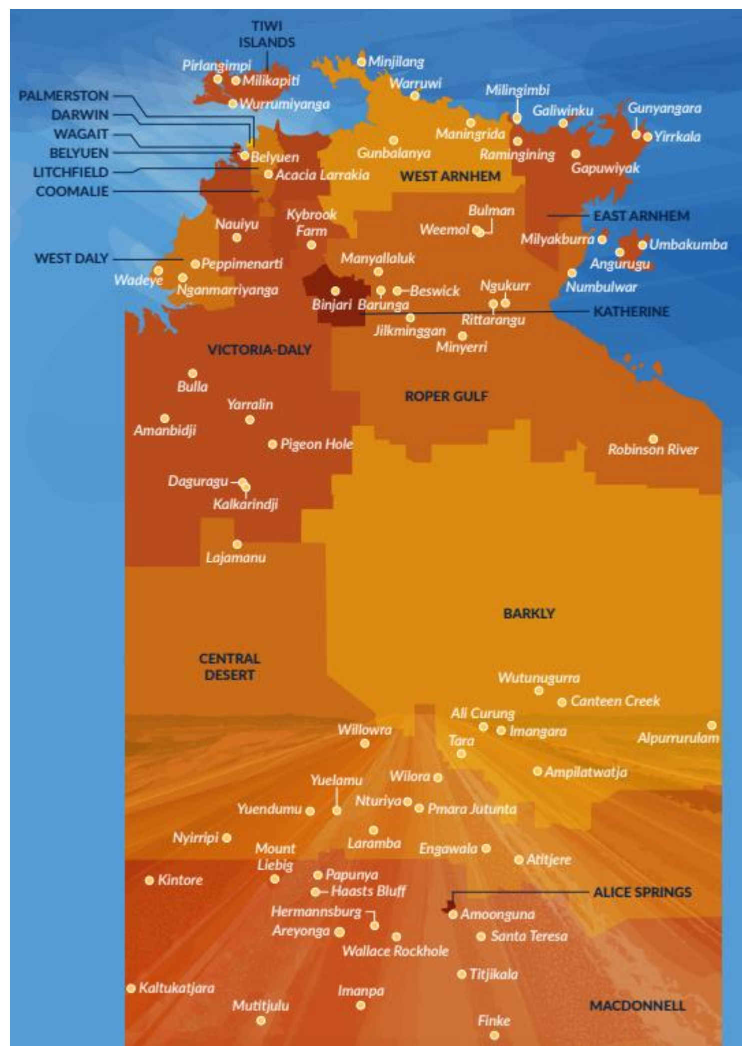
Central Australia region scores 881 on the Index of Relative Socio-Economic Advantage and Disadvantage (IRSD), placing it in the 8th percentile of disadvantage across Australia. This

[35] Aboriginal Medical Services Alliance Northern Territory. (2017). *Process Evaluation of the NT Medical Outreach – Indigenous Chronic Disease Program (MOICD).* https://www.ntphn.org.au/files/20170815%20-%20MOICD%20eval%20august%202017%20%20(003).pdf
[36] Northern Territory Primary Health Network. (2021). *Central Australia*. Northern Territory Primary Health Network. Retrieved 7 April 2022 from https://www.ntphn.org.au/living-and-working-in-the-nt/central-australia/
[37] Department of Health. (2019). *Modified Monash Model MMM Suburb and Locality Classification*. https://www.health.gov.au/sites/default/files/documents/2019/12/modified-monash-model-mmm-suburb-and-locality-classification-home-care-subsidy-modified-monash-model-suburb-and-locality-classification-home-care-subsidy_0.pdf
[38] Northern Territory Government. (2017). *73 Communities at a Glance*. Northern Territory Government. https://bushtel.nt.gov.au/api/Files/Passport?fromPage=PROFILE_DETAIL_PAGE ibid.

compares to the Darwin ISRD score of 1,038 (the 69th percentile) and Alice Springs ISRD score 1,007 (49th percentile).[39]

The Central Australia Health Service is serviced by 2 hospitals; Alice Springs and Tennant Creek in the Barkly region. Alice Springs Hospital handles up to 65,000 admissions annually, with approximately 84% of all patients identifying as First Nations people. Tenant Creek Hospital, a 20 bed facility, handles over 12,500 admissions annually, with over 95% of patients identifying as First Nations people.[40]

Figure 11: Map of communities in the NT



Morbidity and premature mortality rates in the Northern Territory, including Central Australia, are highest in Australia for a range of diseases, including cancer, diabetes, kidney disease, cardiovascular disease, respiratory disease and suicide.[41] They are further exacerbated by high levels of socio-economic disadvantage.

It was intended for a summary of outreach visits and occasions of service by MM to be provided here; however, data could not be obtained.

[39] Informed Decisions. (n.d.). *RDA Northern Territory*. Informed Decisions. Retrieved 7 April 2022 from https://profile.id.com.au/rda-northern-territory/seifa-disadvantage-small-area
[40] Northern Territory Government. (2020). Central Australia Medical Officer Positions. https://health.nt.gov.au/careers/medical-officers/cahs-jobs
[41] Northern Territory Primary Health Network. (2018). *MOICD Program: Service Delivery Needs*.

Local stakeholders and outreach service delivery

There are several stakeholders involved in the delivery of outreach services to communities across Central Australia. An overview of the stakeholders pertaining to this case study is provided below.

NT Health is the jurisdictional health authority for the Northern Territory, and also holds funds for Outreach Programs, including the VOS, Health Ears, RHOF programs. The focus of this case study is the NT PHN run MOIDCP, however outreach programs administered by NT Health reach into 28 communities within the Central Australian region.

Northern Territory Primary Health Network (NT PHN). As well as being the MOICDP fundholder for the Northern Territory, NT PHN is also the sole Primary Health Network and rural workforce agency in the jurisdiction. NT PHN commissions podiatry and diabetes services from CAAC under the MOIDCP. Other services commissioned under the MOICDP during 2020–21 include exercise physiology, endocrinology, ophthalmology, physiotherapy and dietician services.

Aboriginal Medical Services Alliance Northern Territory (AMSANT), is a NACCHO affiliate and is the peak body for ACCHOs in the Northern Territory. Its priority is promoting Aboriginal community controlled primary health care. AMSANT's members include CAAC, among other ACCHOs. AMSANT provides advocacy to, and for, its members, as well as corporate services, continuous quality improvement, workforce leadership, digital health services, social and emotional wellbeing support, health research, and the development of public health and policy initiatives.[42]

Central Australian Aboriginal Congress (CAAC), is the largest ACCHO in the Northern Territory. It operates under a hub-and-spoke model, with central operations from its Alice Spring office coordinating with ACCHOs operating in Amoonguna, Ntaria and Wallace Rockhole, Santa Teresa, Utju and Mutitjulu. In addition to its health service division, CAAC is also comprised of child, youth and family service, human resources, public health and business services divisions.

In 2020–21, 14,772 First Nations people accessed CAAC's clinical services across its affiliated ACCHO network. A breakdown of CAAC's episodes of care by service for 2020–21 is in Figure 12.[43]

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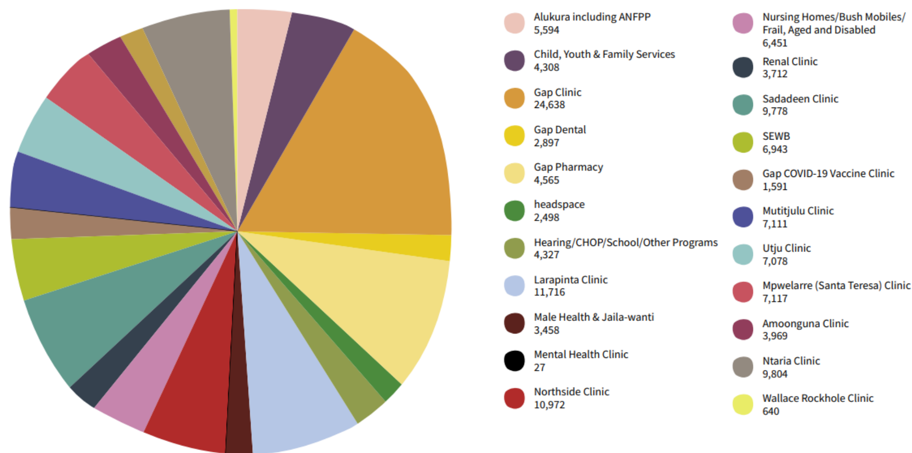
[42] Aboriginal Medical Services Alliance Northern Territory. (n.d.). *About Us*. Retrieved 3 May 2022 from https://www.amsant.org.au/about-us-new/

[43] Central Australian Aboriginal Congress. (2021). *2020-2021 Central Australian Aboriginal Congress Annual Report*. https://www.caac.org.au/uploads/pdfs/2020-2021-Annual-Report_web.pdf

Figure 12: CAAC 2020-21 episodes of care by service



There are several other clinics in Central Australia, including ACCHOs not affiliated with CAAC. A number of these service more remote Aboriginal and Torres Strait Islander communities, such as Ampilatwatja, Pintupi and Urapuntja. There are a further 28 non-ACCHO clinics in the region.

The Royal Flying Doctors Service (RFDS) is a not-for-profit organisation that operates numerous clinical services across Australia. South Australia and the Northern Territory make up the RFDS's Central Operations unit, servicing approximately 100 clients daily. RFDS provides a range of different service including aeromedical evacuation, visiting GP and community health nurse clinics, telehealth, mental and oral health clinics, and child immunisation programs.[44] RFDS relies on its own fundraising and donations, as well as being a contracted service provider under a range of different federal, state and territory, funded initiatives including these outreach programs being evaluated.

Pintupi Homelands Health Service Aboriginal Corporation is an ACCHO providing culturally sensitive healthcare to the Pintupi people. Located in Kintore (MM7), Pintupi services a community of 482.[45]

South Australian Health and Medical Research Institute (SAHMRI) is a not-for-profit organisation focusing on health and medical research. Based in Adelaide, it has funding for a diabetes foot complication prevention program being operated throughout South Australia, Western Australia, Northern Territory and Far North Queensland. The program assesses the burden of diabetes with a focus on foot complications among Aboriginal and Torres Strait Islanders, defining best practice, improving clinical care and developing the workforce to deliver these improvements. Part of the program involves a telehealth initiative, allowing patients suffering diabetic foot complications to remain in their communities with local supports, while receiving specialist care from a multidisciplinary team based at the Royal Adelaide Hospital. Telehealth is used to triage patients and monitor wounds, and where clinically appropriate clinicians can request to see patients in person. While not directly funded via the outreach programs, SAHMRI partners with organisations such as CAAC that integrate the service into its outreach models.

Needs assessment process

[44] Royal Flying Doctor Service. (n.d.). *What We Do in Central*. Retrieved 3 May 2022 from https://www.flyingdoctor.org.au/sant/
[45] Northern Territory Government. (2022). *Kintore - Major*. https://bushtel.nt.gov.au/profile/72

NT PHN reported that it takes a co-design approach to its services. NT PHN looks for opportunities to combine various funding streams and employ local health professionals to meet the needs across communities in a hub-and-spoke type service model.

To assess community needs in Central Australia, it uses a systematic process built upon 3 guiding principles; engagement, data and governance.[46]

As a rural workforce agency, NT PHN collaborates with 5 regional bodies (working groups) to administer the MOICDP. Regional working groups have representation from NT Health, CAAC, other ACCHOs, other NGOs, and local stakeholders. Regional working groups aim to meet quarterly to review the performance of the MOICDP against the service plan. Stakeholders felt that these groups were able to effectively identify emerging community needs in a more a bottom-up approach.

NT PHN attempts to align health needs assessment with workforce supply, sharing the plans with NT Health to help avoid service duplication.

Synergies between NT PHN and NT Health

Stakeholders from NT PHN and NT Health noted that needs assessments, program design and delivery processes have been more collaborative over the past few years. Both parties acknowledged that opportunities for improved collaboration still exist. For example, stakeholders recounted an outreach service visit to Tennant Creek. The flight, shared by providers contracted by NT PHN and NT Health included three physiotherapists contracted through the MOICDP, RHOF, and the NDIS. Further coordination may have been able to use one professional to save costs, but to also make better use of the limited local clinic space and equipment available at the host provider.

Aside from this example, stakeholders agreed that collaboration between NT PHN and NT Health had reduced significant amounts of service duplication. NT PHN and NT Health use a common online visiting medical services calendar to schedule all visiting services across the Northern Territory. Sharing information in this way helped both organisations identify opportunities to share travel and other costs at a glance.

Local service coordination and integration

Scheduling

Clinics across Central Australia reported significant understaffing. Therefore, according to staff, even the task of scheduling suitable times for an outreach visit places a significant burden on local resources, let alone arranging referrals.

Many clinics in the region operate on a walk-in basis, without an appointments. Trying to fill appointments or even alerting consumers to the visiting services can be difficult. Notices in local shops or council buildings are strategies often employed but are also often missed by patrons.

Clinical assistance

Visiting service providers noted that local staff are not always available to assist in service provision. In other instances, service providers can be met with a fully scheduled day, nurses on hand to assist, drivers available to collect patients and other opportunities to provide care to other patients or education to local providers.

[46] Northern Territory Primary Health Network. (2018). *MOICD Program: Service Delivery Needs*.

NT PHN coordination

Stakeholders reported NT PHN routinely organises a car, accommodation and full schedule for their visits. NT PHN has an online portal that allows providers to flag their requirements for an upcoming trip, as well as record data and suggested improvements following the visit.

Shared care

The visiting clinicians suggested there were limited opportunities for shared care arrangements, due to a lack of local clinicians to share patients. Clinicians suggested this may be addressed by improvements to telehealth. However, there remain more fundamental roadblocks to recording and sharing patient information, including a lack of access to local patient administration systems in many instances to record patient notes.

Cultural competence of outreach providers

Local cultural competency training

CAAC employs a detailed cultural orientation process for both its local staff and visiting providers across all clinics. The process includes mandatory cultural workshops run by cultural liaison officers. The half-day cultural workshops are held once per week. The workshops are community-specific to ensure providers understand the specific local cultural sensitives. Some workshops even include cultural liaison officers driving visiting clinicians to local art centres and significant sites to learn more about the history and culture of community.

Cultural liaison officers and Malpas

CACC also uses cultural liaison officers, and 'Malpas' (standing for 'helper' in the local language). Cultural liaison officers and Malpas all speak the local language and will often accompany clients when seeing visiting clinicians. CACC also stations Malpas in the community, strengthening ties and directing people to services.

Generic cultural competency

Other visiting providers have described being provided with limited materials in preparation for cultural competency by fundholders. Those same stakeholders were also critical of the adequacy of structured generic cultural competency education, indicating there is no substitute for experiencing the cultural context of individual communities in the field.

Clinical stakeholders suggested clients often need more than just the clinical service they attend for. There are many social, cultural and spiritual issues affecting their health and visiting clinicians aware of those issues and/ or active within the community has helped them surface and address these issues. Visiting clinicians have also found spending time meeting people in the community, or their own environment, can open up conversations on health, leading to more referrals.

Culturally safe service models

Aside from workshops, cultural liaisons and Malpas, CACC believes best practice for culturally safe care is to provide the care within the client's home environment. There are limitations to this model, most immediately being the availability of transportable, specialist equipment. CACC reports limited availability of medical equipment at local clinics; therefore, to see the in-home service model expand it would require significant capital investment.

Accountability

Some stakeholders suggest that providers needed to be more accountable for culturally safe practices. The RFDS monitored and followed up on patients that failed to attend clinics. Follow up seeks feedback on the reasons for non-attendance, using the information in quality improvement processes that include meeting community needs and cultural competency. If done correctly, it will not only enhance services but improve the overall viability of the service by limiting wasted resource due to non-attendance.

Outreach funding

Medicare benefits schedule

According to several stakeholders, MBS fee-for-service is not suitable in the regions where outreach services are being delivered. The rules of the programs do not allow the MBS to top-up provider remuneration/ session fees, and so, according to the stakeholders, rural health workforce support funding is required.

Many visiting providers noted that the patient volumes or throughput are not adequate for MBS rebates as they may be in more densely populated areas. Viability is further affected by clinician travel time to and from clinics. According to one visiting podiatrist, it can take 3 to 4 hours to holistically manage a single client, including locating the client, potentially transporting them to a clinic, and performing an assessment on the social determinants of health in addition to treating their primary condition.

Aboriginal liaison officers, care coordinators and/ or and Aboriginal health workers are often called upon to pick up patients, take them to the clinic, then drive them back. Many clients rely on this level of service; however, it is not renumerated under the MBS model.

Coordination

According to one stakeholder, higher level consideration should be given to coordination of the various outreach programs when awarding fundholders tenders. The result of the recent VOS program tender in the NT saw VOS administration transferred to a new fundholder. Stakeholders have suggested that this moves away from a single fund holder across all NT outreach programs will make it more difficult to coordinate services

Additionally, a selective tender process was employed to find the next fundholder. This led some stakeholder lamenting the fact that capable entities in the NT were excluded from the process.

Flexibility in funding rules

CAAC noted that as a subcontractor, it faces significant limitations on what it can deliver under service contracts. Specifically, the annual planning process make rescheduling cancelled visits difficult. Over the past few years, COVID-19 and significant weather events have led the to the cancellation of many scheduled clinics. At the end of the year unspent funds are returned to fundholders and, in turn, the Department of Health. Seeking approval to alter service plans or redeploy funds has been described by stakeholders as an involved process that usually results in no changes being possible, unspent outreach funding, and unmet community needs.

Infrastructure and support

Stakeholders routinely suggested that targeted capital investment may improve efficiencies locally, increasing the number of patients reached. Equipment shortages, and out of date medications are some of the common issues outreach providers describe in host clinics. Local accommodation is also limited in many areas meaning outreach visits are limited to single

days, That, or significant travel is required the beginning and end of each day to reach the next town.

Need for funded dental care

The RFDS noted the long-term contentiousness of funding oral health services in Australia with both state and federal governments suggesting the other should be responsible. Poor oral health can contribute directly and indirectly to serious health conditions, including cardiovascular disease and septicaemia.

The Pintupi Homelands Health Service in Kintore reported that the RFDS dental clinic is the most highly valued and eagerly awaited visiting services within the community. The RFDS indicated that its focus on dental care was strengthened after the release of its publication *Filling the Gap: Disparities in Oral Health Access and Outcomes in Remote and Rural Australia*. [47] The report underlined the impact of poor oral health on chronic disease and identified the priority need for more services in rural and remote locations. Many stakeholders noted that dental funding was a significant health gap in communities serviced by the outreach programs.

Service provision and utilisation

Attendance rates varied significantly across Central Australian host clinics. High non-attendances rates in some communities were combated in many instances by patient transport being provided by clinics. Non-attendance is also addressed in some clinics by staff prioritising the collection of active phone numbers for clients, as it provides an avenue for some clinical consultation if a patient fails to attend in person.

Clinicians also suggested that making themselves known and available to the community, provided opportunities for opportunistic referrals Visiting clinicians being visible in the community can work effectively in smaller communities, however, may prove difficult in larger communities to build the requisite amount of community trust. In either case, visibility, rapport and trust building were flagged by stakeholders as essential in boosting referrals and curbing non-attendance. As a bridge, when outreach services and host providers are well integrated, outreach service providers can leverage the trust and community standing built by host providers. Additionally, employing local aboriginal health workers and liaison officers can create a cultural bridge to improve accessibility for Aboriginal and Torres Strait Islander clients.

The consequences of not getting service integration right are highlighted by stakeholders noting the high acuity of patients presenting only in emergency situations.

Telehealth and innovative models of care

Stakeholders provided mixed views regarding the use of telehealth in Central Australia. While it can provide access to services that would otherwise be impossible, stakeholders suggest it can lead to complacency and further intrench health inequalities. Part of this is attributable to access to suitable technology and infrastructure (internet speeds and necessary hardware) to support telehealth, coupled with issues cultural issues for Aboriginal and Torres Strait Islander clients

The type of services available via telehealth can also be limited, especially in regions where patient tend to present with higher levels of acuity. However, there are innovations that are expanding the type of services possible. SAHMRI has a diabetes foot complication prevention program where specialist care is provided by a multidisciplinary team based at the Royal Adelaide Hospital. SAHMRI's program uses telehealth to triage patients, monitor wounds, and facilitate patient to specialist consultations. The SAHMRI program is designed to be as flexible

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[47] Bishop, L. M., & Laverty, M. J. (2015). *Filling the gap: Disparities in oral health access and outcomes between metropolitan and remote and rural Australia.*

using a range of communication platforms including, telephone, store-and-forward video calls, and multimedia text messages. Through the SAHMRI project, local clinicians have been able to provide foot procedures, such as debridement, supervised by a specialist via a video.

One stakeholder commented that one of the primary barriers for the client is knowing where care can be accessed. They suggested a single, well-known telehealth entry point could improve awareness and overall uptake of health services generally.

Workforce

Staff at the NT PHN spoke of a program in development in Darwin called 'The National Aboriginal and Torres Strait Islander Health Academy', developed to help address workforce gaps into the future. Administered by Indigenous Allied Health Australia and AMSANT, the community-led program leads to a Certificate III in Allied Health Assistance to school students during years 11 and 12. Other aspects of the program target foundational health literacy for students' year 7 onwards.

The NT PHN would like to expand the program through Central Australia in future years to engage local students, exposing them to the variety of different health careers and pathways. A staff member from CAAC also described a need for government funding of an allied health assistance program.

6

Tasmania: The North West Region

Box 5: Key observations

- Stakeholders stressed that Tasmania as a state suffers from **health workforce shortages** (including medical specialist and allied health professionals) that further limit availability of outreach providers locally. Stakeholders emphasised the importance of clinical networks and collaborative arrangements with service providers in other jurisdictions on the mainland as they are an important source of outreach clinicians for the North West.
- Stakeholders noted that the health needs for Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander communities in the North West **do not always align well with the priority areas identified for the outreach programs.** A substantial proportion of the RHOF is allocated to local needs (including Huntington's Disease and dual disability). Stakeholders consider there is a relatively low need for eye services for Aboriginal and Torres Strait Islander communities resulting in the allocation of 40% VOS funding being untenable.
- The Tasmanian Department of Health (TAZREACH) has recently transitioned from the procurement function to the service planning function of the Tasmanian Department of Health, reporting that they provide greater emphasis on **integration of outreach service planning** with overall needs, service and workforce planning processes of the Department. TAZREACH stated that they collaborate strongly with the PHN and HR+ (the rural health workforce agency in Tasmania) but duplication still appears evident.
- Fund holding for eye and ear services is held by a variety of organisations, with TAZREACH holding funding for VOS, eye coordination and Healthy Ears, while the non-ACCHO organisation, RHT 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 Aboriginal and Torres Strait Islander communities.
- HR+ 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 in Northern Tasmania and local communities in the North West region 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.
- Dental services are relatively well served in Tasmania. Through philanthropic and Department of Health 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 some stakeholders consider the need for dental care in the North West Region remains a priority.

Case study scope and focus

This case study takes in the communities on the on the North, North West and West Coast of Tasmania, including King Island off the North West coast. TAZREACH hosted HPA on a two-day visit to the region as part of the fundholder's annual review of outreach services. The

annual review process entails the TAZREACH team visiting outreach and host provider agencies to review existing services, alongside needs and service plans. In addition to the fundholder, HPA had the opportunity to interview a range of service providers and discuss potential issues with the outreach programs (see Table 12).

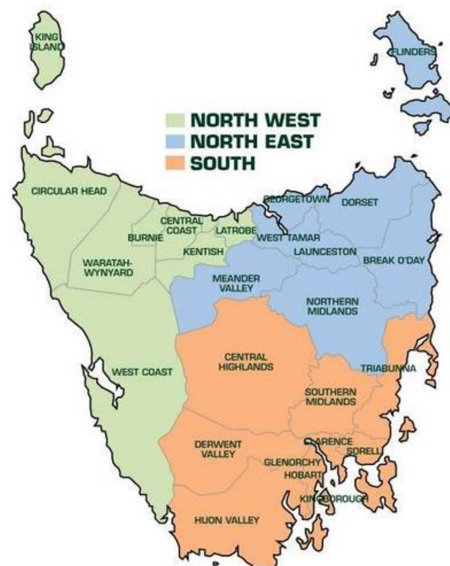
Table 12: Interviewees by organisation, location and role

Organisation	Location	Role
TAZREACH	Launceston	• Statewide Manager, Primary and Community Service Development and Planning
TAC	Launceston	• Regional coordinator
HR+	Launceston	• Primary Health Workforce Manager
Opal Pain Management Program	Burnie	• Exercise physiologist • Psychologist
North West Regional Hospital	Burnie	• Paediatric Nurse Practitioner • Paediatrician
No 34 Aboriginal Health Service RHT	Ulverstone	• Program coordinator • Clinical services lead

North West Tasmania

The North West Tasmania Region is one of 3 in Tasmania (Figure 13). The region is bounded by Bass Strait in the north, south and west, taking 9 local government areas: Burnie City, Central Coast, Circular Head, Devonport City, Kentish, King Island, Latrobe, Waratah–Wynyard, and West Coast.[48]

Figure 13: Regional map of Tasmania



Approximately 20% of Tasmania's 540,000 population reside in located in the North West region, remaining relatively steady over the previous decade. More than 75% of the Region's population is concentrated in the towns and cities along the coastal strip between Wynyard and Latrobe, with the 2 major centres being Devonport (25,000 people) and Burnie (20,000 people). Smaller townships are located at Latrobe (12,000 people), Ulverstone (6,500 people), Wynyard (6,000 people), Smithton (4,000 people), Penguin (4,000 people), Waratah (3,500

[48] .idcommunity. (2021). Community Profile: North West Tasmania. https://profile.id.com.au/tasmania/about?WebID=410

people), Port Sorell (2,000 people), Queenstown (2,000 people), Sheffield (1,500 people), Railton (1,000 people), Rosebery (1,000 people), Strahan (700 people) and Stanley (500 people). On King Island, which is off the north coast and in the Bass Strait, there are around 1,500 people. The main industries in the region are advanced manufacturing, mining and mineral processing, agriculture, forestry and tourism. The unemployment rate is generally higher than the national average; it was 6.8% compared with 5.8% nationally in 2016. Aboriginal and Torres Strait Islanders made up 8.5% (4,000 people) of the total population on the west coast in 2016, compared with 4.6% for Tasmania as a whole.

There are public hospital services provided throughout the region, with the North West Regional Hospital in Burnie, Mersey Community Hospital in Latrobe, West Coast District Hospital in Queenstown and district hospitals in Smithton and on King Island. The North West Private Hospital is in Burnie. GP clinics exist in most towns including Burnie, Devonport, Sheffield, Latrobe, Currie (on King Island), Queenstown, Roseberry, Smithtown, Strahan, Zeehan, Ulverstone, Penguin, Port Sorell, Wynyard, Sheffield and Somerset.

The North West Tasmania Region includes 9 local government areas. While distances and travel time between towns and the local GP are consistently short (apart from Zeehan where a GP service is not available locally) in these areas, this is not the case for the regional hospital in Burnie where distances and travel times vary considerably (see Table 13).

Table 13: Local government areas: population and main town distance and travel time from to health services[49]

Local Government Area	LGA	Local GP		Regional Hospital – Burnie	
Main Town	population	Distance	Time	Distance	Time
Burnie City – Burnie	19,700	0.5 kms	5 mins	8.4 kms	14 mins
Central Coast – Ulverstone	22,200	2.2 kms	5 mins	62.6 kms	50 mins
Circular Head – Smithton	8,200	4.4 kms	10 mins	166.4 kms	2 hrs 5 mins
Devonport City – Devonport	25,700	3.4 kms	10 mins	99.8 kms	1 hr 20 mins
Kentish – Sheffield	6,400	2.6 kms	10 mins	139.4 kms	2 hrs
King Island – Currie	1,600	1.6 kms	5 mins	–	1 hr 10 mins (by air)
Latrobe – Latrobe	12,000	4.2 kms	5 mins	118.6 kms	1 hr 30 mins
Waratah–Wynyard – Wynyard	13,900	7.2 kms	15 mins	34 kms	35 mins
West Coast – Zeehan	4,100	–	–	276 kms	3 hrs 40 mins

Source: Unpublished data provided by TAZREACH.

For example, it takes over 3 and half hours to drive from the small town of Zeehan and just over 2 hours from Smithton to the regional hospital in Burnie. Whereas it takes just over half an hour from Wynyard and a little under an hour from Ulverstone. For comparison, the case study undertaken in Queensland focussed on outreach services provided by HoA to the small town of Theodore. This town was just over 2 hours away from the regional hospital in Rockhampton.

Local stakeholders and outreach service delivery

The communities in the North West region of Tasmania 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 (RHT) and the RFDS.

Administered though the TAZREACH office, the Department of Health in Tasmania is the fundholder for several of the outreach programs being evaluated, including the RHOF, MOICDP, VOS and HEBHBL. Comparison of the funding allocation for Tasmania with that of the North West region (Table 14) shows significant variation in the distribution of funding across programs. For example, with 20% of Tasmania's population, the NW region received

[49] TAZREACH. (2022). *Planned outreach visits by location, specialty and health priority, 2021–22.*

52% of the RHOF funding (including funding for pain management) in 2020–21 and 8% of the VOS funding.

Table 14: Tasmania and North West Region Funding by program, 2020–21[49]

Program	Funding allocation		%
	Tasmania	North West Region	
RHOF	$1.40m p.a.	$0.72m p.a.	52%
MOICDP	$1.20m p.a.	$0.19m p.a.	16%
VOS	$0.35m p.a.	$0.03m p.a.	8%
HEBHBL	$0.03m p.a.	$0.01m p.a.	30%

Note: The regional funding data excludes funding for services on King Island and RHOF includes pain management.
Source: Unpublished data provided by TAZREACH

The outreach services planned in the North West Region for 2021–22 are summarised at Table 15.

Table 15: Planned visits by location, specialty and health priority, 2021–22[49]

Location	Specialties	Health priority	Visits per annum
Burnie	Neurology, dermatology, exercise physiology, physiotherapy, personal training	Chronic Disease Management	166
	Psychology, exercise physiology	Pain Management	40
	Psychiatry – dual disability	Mental Health	6
	Paediatrician, paediatric nurse practitioner	Paediatric Health	18
	Service coordination (MOICDP)	Service Coordination	4
	Speech pathology.	Disability Support	12
Devonport	Neuropsychiatry, Neurology and Neuropsychology – Huntington's, Psychiatry – Geriatric, Forensic and General	Mental Health	36
	Psychology, exercise physiology	Pain Management	40
	Geriatrics	Geriatric Health	7
	Orthoptist	Eye Health	13
King Island	Rheumatology	Chronic Disease Management	4
	Optometry, ophthalmology	Eye Health	9
	Midwifery, obstetrics & gynaecology	Maternity Health	22
	Psychiatry, counselling	Mental Health	28
	Paediatrician and paediatric nurse practitioner – general and asthma	Paediatric Health	20
Queenstown	Cardiology, podiatry, rheumatology	Chronic Disease Management	18

Location	Specialties	Health priority	Visits per annum
	Paediatrician and paediatric nurse practitioner – general and asthma	Paediatric Health	24
	Optometry	Eye Health	15
Rosebery	Optometry	Eye Health	12
Smithton	Cancer education, dermatology, dietician, exercise physiology, podiatry	Chronic Disease Management	38
	Optometry	Eye Health	24
	Midwifery, obstetrics & gynaecology	Maternity Health	22
	Service Coordination (Indigenous Eye Health)	Eye Health	4
	Speech Pathology	Disability Support	12
	Service Coordination (MOICDP)	Service Coordination	4
	Paediatrician and paediatric nurse practitioner – general and asthma	Paediatric Health	24
	Psychology – general and child & adolescent, Psychiatry – general, Perinatal mental health	Mental Health	101
Strahan	Psychiatry – general	Mental Health	10
	Optometry	Eye Health	12
Ulverstone	Footcare nurse	Chronic Disease Management	3
	Optometry	Eye Health	4
Wynyard	Rheumatology	Chronic Disease Management	10
Zeehan	Optometry	Eye Health	6
North West	Psychiatry – Dual Disability (child and adolescent)	Mental Health	4
West Coast *(Queenstown & Rosebery)*	Midwifery , obstetrics & gynaecology	Maternity Health	22
Statewide	Service Coordination (Indigenous Eye Health)	Eye Health	4
Total			**798**

Source: Unpublished data provided by TAZREACH

Organisations visited during the case study

HPA conducted site visits and face-to-face interviews with key organisations including TAZREACH, the Tasmanian Aboriginal Centre (TAC), HR+, Opal Pain Management Program,

North West Regional Hospital and the No 34 Aboriginal Health Services at RHT. HPA subsequently interviewed Primary Health Tasmania (PHT) via videoconference.

TAZREACH

Fundholder and program administrator for several of the outreach programs being evaluated including the RHOF, MOICDP, VOS, HEBHBL. It is also the administrator a variety of other like programs, including:

- **the Bass Strait Island Agreement** which aims to strengthen primary health and emergency services in the Bass Strait islands.
- **Aboriginal and Torres Strait Islander Eye Health** which aims to improve access to eye care services for Aboriginal and Torres Strait Islander people through improved coordination of services and improved linkages between Aboriginal organisations and the range of services available.
- **Access to Health Services (A2HS)** project aims to improve access to health services in regional, rural, and remote North and North West Tasmania by investing in and exploring place-focussed and place-based approaches as a way building regional community capability for collaboration on design and delivery of coordinated and integrated health services.

Located in Launceston, TAZREACH team is comprised of 4 to 5 staff, including the manager and program coordinator. TAZREACH was organisationally located within the purchasing and performance functions of the Department of Health until recently. It is now part of the overall service planning function of the Department.

Rural Health Tasmania (RHT)

Fundholder for the EESS and host provider for the MOICDP and VOS.

RHT provides a broad range of services to rural communities, including Circular Head, Waratah, Wynyard, West Coast, King Island, Ulverstone, Devonport, Burnie and Kentish.

RHT operates No 34 Aboriginal Health Service in Ulverstone, dedicated to working with Aboriginal people to improve their health and wellbeing. It provides a range of services to support children and families and hosts outreach providers funded by TAZREACH including podiatry (MOICDP) and optometry (VOS). No. 34 also coordinates the Eye and Ear Surgical Support Services program for Tasmania. RHT is not an ACCHO and not recognised by either TAC or the TAHRG.

No 34 Aboriginal Health Service provides services funded under the IAHP, including hearing services, emotional wellbeing and support, alcohol and drug counselling, new directions for mothers and babies (including immunisation, breast feeding support) and eye health. It also receives funding from PHT for integrated team care and dental services through RFDS.

RHT is not an ACCHO and as such does not receive the funding support for infrastructure that ACCHO services receive, including maintenance funds and payments to build ramps for wheelchair access. RHT does not participate in meetings of the TAHRG and as a result is not privy to related funding opportunities and involved in the Aboriginal health services network.

HPA visited No 34 Aboriginal Health Service in Ulverstone and spoke with the program coordinator and clinical services lead.

Tasmanian Aboriginal Centre (TAC)

TAC is a member of the TAZREACH Advisory Forum and a host provider.

TAC is the NACCHO affiliate organisation for Tasmania. It was established by the community to advocate for the rights of Aboriginal people in Tasmania. It 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. Its health service provides health clinics, aged care services, pregnancy support, cardiopulmonary rehabilitation, nutrition, tobacco control, counselling and a range of health promotional activities. The organisation has facilities in Hobart, Launceston and Burnie. In 2016–17 TAC provided about 34,000 episodes of health care, with 18,000 from Hobart, 9,000 from Launceston and 7,000 from Burnie.

HPA visited the Launceston facility of TAC and spoke with the regional coordinator.

HR+

HR+ is a member of the TAZREACH Advisory Forum.

It is the rural workforce agency in Tasmania, one of 7 jurisdictional rural workforce agencies funded by the Australian Government nationally. HR+ coordinates rural healthcare recruitment, but also supports local practices through professional development courses and scholarships for health professionals and practice staff.

HR+ delivers the *Health Workforce Scholarship Program* in Tasmania, a national program aimed at professionals providing primary health care. HR+ also engages with medical, nursing and allied health students in Tasmania and on the mainland to help strengthen the future primary health workforce in Tasmania.

Opal Pain Management Program

The NW Persistent Pain Program is otherwise known as the Opal Pain Management Program and funded under the RHOF to provide outreach services.

It is a free multidisciplinary group program run by Simon West (Exercise Physiologist) & Bernadette Smith (Psychologist) in Burnie. Both have specialist training in chronic pain having competed their Master of Science in Medicine, Pain Management, at the University of Sydney.

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. Patients travel to the sessions from local communities. The program is financially supported by TAZREACH, including the former pain management funding under the RHOF.

NW Regional Hospital

North West Regional Hospital is a 160-bed facility servicing North West Tasmania and King Island. The hospital was built in 1994 and was originally owned privately by Burnie Hospital Limited and leased to the Tasmanian Government. The Tasmanian Government entered an agreement to buy the hospital in 2010, to invest in and expand the facility. The hospital now offers services in medical, surgical and allied health specialities through inpatient and outpatient departments, as well as catering for the emergency resuscitation, surgery and intensive care of most trauma patients and other medical conditions.

The hospital also provides midwifery, obstetrics and gynaecology and paediatric (general and asthma) under the RHOF and MOICDP across the North West region.

Primary Health Tasmania

Primary Health Tasmania is the only primary health network in Tas. It is a non-government, not-for-profit organisation working to connect care and keep Tasmanians well and out of hospital. Like other PHNS, Primary Health Tasmania, works with communities and providers to develop needs assessments, identify health priorities and commission services on behalf of the Australian Government.

Primary Health Tasmania commissions a variety of services, including outreach services. A main area of focus is chronic disease management, with funding provided to ACCHOs and other organisations across Flinders Island up to the North West region to provide services in

this area, including local government, Diabetes Tasmania, RFDS, aged care providers and RHT. Mental health and drug and alcohol for youth are also key areas for commissioning service provision and outreach services, including headspace and short-term outreach response services. PHT also commissions outreach services in aged care and primary care, including outreach to homeless communities in the south and GP Assist which supports rural and remote GPs.

Governance and needs assessment process

The fundholder has important responsibilities in relation to administering the outreach programs, including overall governance and funding and needs assessment and service planning functions. The following section outlines the key observations in these areas from the case study.

Governance and collaboration

The Tasmanian Department of Health is the fundholder for the RHOF, MOICDP, VOS and HEBHBL outreach programs. The Department of Health was the fundholder of the EESS until June 2020, with the RHT assuming fundholder responsibilities in 2021–22.

Stakeholders reported program funding arrangements, including and in addition to the outreach programs, that creates particular issues in coordination across the North West region:

- **Ear and eye health programs** have multiple funds holders, including TAZREACH for the VOS, coordination of Aboriginal and Torres Strait Islander eye health and HEBHBL; TAC holds the funding for coordination of Aboriginal and Torres Strait Islander ear health (not in scope of the evaluation) and RHT holds the funding to support of Aboriginal and Torres Strait Islander access to ear and eye surgery. Furthermore, the Hearing Assessment Program – Early Ears for Aboriginal and Torres Strait Islander communities – is again administered by a separate entity, Hearing Australia.
- **Aboriginal and Torres Strait Islander health services.** RHT is not an ACCHO but provides an Aboriginal health service in the region and holds the funding to support of Aboriginal and Torres Strait access to ear and eye surgery. RHT is not a member of the Tasmanian Aboriginal Health Reference Group that represents ACCHOs in Tasmania. Stakeholders reported that the lack of integration into the ACCHO network of services has an impact on RHT's ability to smoothly coordinate access to care for their patient population and receive ongoing support that ACCHOs receive to help service their Aboriginal and Torres Strait Islander communities.

Stakeholders reported TAZREACH and RHT have a collaborative mutually supportive relationship in administering the outreach funds. However, there are concerns over the transparency of decision making by the Commonwealth, with stakeholders indicating that local consultation and clarification of the rationale for moving to multiple fundholders for the administration of the programs could have been strengthened.

HR+ has close and collaborative arrangements with TAZREACH, and while HR+ could feasibly fill the role of fundholder the jurisdiction, the organisation stated it was comfortable with the current arrangements and even suggested they should remain as is for stability of programs and relationships.

Funding

A broadly held stakeholder view was that the individual programs, and their focus on specific body parts, stovepipes the outreach funding, and in Tasmania's case of multiple fundholders, can lead service distortions and stifles innovation in care. PHT believes there is a need for greater responsiveness to local and regional planning, with an ability to pursue more

sustainable solutions and more flexible workforce models. For example, stakeholder identify that Tasmania's priority health needs lie in the areas of mental health and drug and alcohol abuse rather that eye or ear health.

As Tasmania has private optometrists in most towns, TAZREACH reported that access to optometry services is relatively robust across the North West region. It indicated that it struggles to meet the 40% Indigenous Australian provision of funding under the VOS, indicating there could be justification for a proportion of VOS funding be applied to meet other health priorities for the Indigenous community, should such funding flexibility exist in the future.

With optometrists available locally, TAZREACH has looked at alternate ways in which VOS funding can be utilised with the goal of improving sight. TAZREACH have made multiple approaches to the Tasmanian Spectacles Assistance Scheme with the intent to use otherwise unspent VOS funding to bolster the provision of subsidised spectacles. To date, TAZREACH is yet to receive actionable advice. TAZREACH believes that engagement on this course of action has the potential for VOS to more flexibly deliver on a broad goal of improved vision for the North West region.

Further, RHOF pain management funding may have had detrimental impact on pain management services in the region. Stakeholders suggested short-term funding affected stability and placed unrealistic timelines on providers. Fluctuations in funding meant relationships with long serving valued providers were adversely affected by ramping up and down of services. The fluctuations also eroded trust in the services by GPs and patients. Local consultation and an upfront understanding of the proposed funding may have helped smoothed or avoided the unintended consequences.

To meet local needs, TAZREACH reports it allocates a sizeable proportion of funding outside of the RHOF identified priority areas. Specifically, Tasmania and especially the North West region, has a large incidence of Huntington's disease. The RHOF has supported Huntington's services in the region since 2009 with the recruitment of a neurologist visiting the Devonport region. Since then, the service has been expanded to include a multidisciplinary team, with neuropsychiatrist and neuropsychologist, servicing both the Devonport and Launceston regions. The team works closely with local Huntington's case managers, servicing clients, their families, and supporting local clinicians. Stakeholders note without the RHOF funded Huntington's service, patient treatment would require regular travel to Melbourne.

The examples above show that some flexibility is available, individual outreach programs, their associated rules, and multiple fundholders, create rigidity that can prevent the fullest realisation of benefits for the region. With the program funding TAZREACH controls, it attempts to provide ACCHOs with maximal flexibility in their use locally within the rules of the individual programs. This does result in a complex and time-consuming Commonwealth acquittal process for TAZREACH.

Needs assessment and service planning

TAZREACH undertakes an annual review of health service needs and workforce availability in developing its outreach service plans. Each year, TAZREACH visits each of the providers in the North West region to discuss how well the outreach services are meeting local needs and what changes to the service mix need to be considered, informing annual service plans. HPA was able to observe planning discussions as part of these processes and engage with key outreach and host providers as part of the evaluation.

There is a view that planning processes are currently not well coordinated, with duplication and separate consideration of local intelligence and data sources by the PHT (health status), Department of Health (service data) and HR+ (workforce planning). Stakeholders reported that duplication and inefficiency are genuine issues, and they were concerned that each Department of Health bucket of funding requires a separate needs assessment and service

plan. The funding is provided to multiple organisations – and were described by one stakeholder as having a 'scatter gun effect.'

Stakeholders were concerned that the current situation does not promote joined up thinking and drives fragmentation. For example, the stakeholders indicated that the PHN creates community profiles and while TAZREACH reviews these profiles, it generates its own separate assessment. It was reported that the consumer health forum is also funded to undertake separate local needs assessments. These are all conducted in relative isolation and reported to the Department of Health separately. Stakeholders considered there was scope to create one regional process in the future.

Stakeholders expressed support for more intelligent use of the range of data held by the various organisations. They claimed this could better identify local needs and ensure resources are more effectively allocated to where they are most needed. The stakeholders clarified that each organisation currently provides the Commonwealth Department of Health with a partial view of the community needs, rather than bringing this intelligence together to provide a 'single version of the truth' at the regional level. They indicated this would help plan place-based solutions that cut across sectors and organisational programs.

TAC indicated that they should have a greater voice in what services are needed and who should have access to these services. The priority for them is to ensure funding goes where it is most needed but indicated this can be undermined when political processes intervene, and external decisions are made.

The organisational location of the TAZREACH office has recently shifted within the Department of Health, moving from a more operational focussed function within the procurement and performance portfolio to a more strategic function within the health services planning portfolio. TAZREACH suggested this now provides greater opportunity for outreach service planning to be integrated with the overall strategic health service and workforce planning of the Department for rural and remote areas in Tasmania. For example, the consideration of outreach services is being integrated into the current work on clinical delineation of health services.

Workforce

HR+ reported working with local leadership to build local workforce solutions across sectors and break down the silos of service governance and funding that often exists and create place-based solutions. They indicated that proactive councils and leadership within local government are starting to generate momentum for creative solutions, which brings expertise and resources together to attract and retain staff. For example, the development of a local store into an allied health practice facility enabled the necessary infrastructure to attract professional staff to one community.

Stakeholders reflected the sentiment that the North West region, like much of Tasmania, struggles to provide a basic primary health care system, given workforce shortages on the island. Some stakeholders asserted that new workforce models are required that do not rely on a GP in each town. They suggested that all too often programs are based on historic and outdated service models. Further, in many ways, outreach services should be considered a last resort and that the building of a local primary care workforce should be pursued as a priority. It was a broadly supported view of stakeholders that the fly-in and fly-out workforce is not optimal, lacking connection with the community, generating issues regarding continuity of care and creating downstream economic implications for the community.

Through HR+, work is underway in George Town to explore a place based model. The initiative is called HEAART (Health, Employment, Ability, Ageing, Rural Training). The aims are to improve training pathways and job opportunities for locals in primary care, aged care and NDIS and improve recruitment opportunities for employers in these sectors and thereby improve

access to care. It was described as a collaborative initiative that offers local communities the ability to co-design a solution to increase service access, build employment outcomes and the local economy (www.heaart.com.au). There are plans to build on the approach in George Town and expand to Deloraine, Campbell Town and the East Coast.

HR+ considers a longer term view to planning is required. A 10-year funding and service planning process is required to ensure stability over time and maintain investment in capacity building. They felt this will build trust and enable the investments locally to build capacity, only using outreach as a last resort. The aim is to access regional underspends in Outreach, NDIS and MBS to fund local capacity in more flexible ways.

Outreach provider recruitment and retention

Tasmania is relatively small and the relationship between agencies and providers appears close and well established. TAREACH recruits outreach providers through local clinical networks and well established clinical forums and relationships with public and provider facilities.

A consistent message conveyed to HPA during the case study is the persistent health workforce shortages across Tasmania, particularly medical specialities such as ear, nose and throat (ENT), ophthalmology, and allied health professionals. This impacts on the ability of local communities to attract a primary care workforce and for TAZREACH and other relevant agencies (including PHT, NDIS, Aged Care) from recruiting outreach providers from within Tasmania.

TAZREACH reported that it is increasingly required to rely on private sector providers, given the lack of public sector medical and allied health workforce outside of Hobart. This generates a significant cost variation for TAZREACH when contracting for outreach services. For example, TAZREACH reports that they reply on private ophthalmology and optometry services outside of Hobart.

Over the past 6 to 9 months RHT has been exploring what it can and cannot do with the EESS program funding. It has talked with other jurisdictions and stakeholders in Tasmania. Access to ENT is limited and payment of fees to private providers is often prohibitive. Around twenty referrals have been made to date and RHT is case managing each one. The key issues lie in the shortage of specialist services/surgical services. RHT is building relationships and evolving in its capacity to support patients in accessing surgical care for eye and ear needs.

On multiple occasions during visits to providers, HPA heard of the difficulties accessing the services of health professionals such as audiologists, psychologist and occupational therapists and the need to seek access to these services from providers on the mainland. For example, TAC indicated it recently needed to access audiology services from Victoria and psychiatry services from Queensland and that the cost to their service of psychology consults can be in the vicinity of $300 hour.

There was an instance during the visit to Tasmania where one agency reported that they accessed service from the mainland and TAZREACH indicated that they had the capacity to access these services from within Tasmania. Further coordination of workforce requirements across agencies (including disability, aged care and health care) could be indicated. This along with more strategic partnering with mainland jurisdictions in the provision of outreach services could potentially be explored further to strengthen capacity in the future.

Training and upskilling

TAC indicated that upskilling of the local workforce can be challenging, given a low appetite expressed by the local Aboriginal and Torres Strait Islander workforce for training and expanding scope of practice. There seemed to be a general preference for local services to rely more on outreach services provided through TAZREACH, RFDS and PHT.

The NW Regional Hospital provides midwifery, obstetrics and gynaecology, and paediatric (general and asthma) outreach services to communities across the North West region. The outreach providers explained that the aim is to create a model of shared care, where the outreach assessment and resulting ongoing care plan is largely implemented by local staff. However, it was reported that lack of staff capacity and turnover limit the ability to provide effective upskilling and capacity building and this results in more existing patients being reviewed during outreach visits.

Cultural competence of outreach providers

TAC provides cultural competency training for organisations and individual health professionals providing outreach care in Tasmania, including the North West region. Two staff working from the Hobart office provide face-to-face training across the state. While local Aboriginal health services may exchange information and help reinforce the need for cultural sensitivity when outreach providers visit, there was a view that many of the services would not have the capacity to provide a sufficient level of cultural competency training in-house.

Host services did not highlight any broad ranging concerns regarding the cultural competency capability of outreach providers, noting they have a close relationship with TAZREACH and where concerns may exist regarding a provider in the local Aboriginal and Torres Strait Islander Australian community, they can usually raise and resolve issues in a responsive and timely manner. An example was provided during interviews where TAZREACH quickly found an alternate provider in response to community concerns with an existing provider in Launceston.

Local service coordination and integration

Outreach providers interviewed during the site visits confirmed that GPs are the usual source of referral to outreach clinics and that local clinic staff usually coordinate and book patients into the clinics. They 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, needing to coordinate the patients for the visits and gather clinical tests and screening results ready for the 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.

HPA did not hear of reports from host providers that coordination of outreach providers at their clinics generated undue burden and distracted staff from other work priorities. For example, TAC did not express any significant concerns over host service coordination of outreach services.

Stakeholders stressed that the way the Commonwealth provides separate funding for building local service provision and for outreach services does not promote coordination across outreach programs or integration of outreach programs into local services.

There is a view that the Department needs to give greater policy visibility to support of out-of-hospital services and create an approach that is more planned. Stakeholders underlined the importance of creating consistent building blocks, with the overall aim of generating better service access. They indicated there is a need for greater coherency across programs. PHT indicated they have a set of foundational programs that help scaffold and wrap around services, for example, digital health. PHT noted that many Commonwealth programs preclude such infrastructure.

Service provision and utilisation

TAC indicated that access to some workforce groups is a challenge given the low availability across Tasmania. It was noted that while occupational therapy services were needed by the Aboriginal and Torres Strait Islander Australian community in and around Launceston,

TAZREACH had not been able to secure access to the services of a clinician for the TAC centre. Health professionals to provide drug and alcohol services was also identified as an area of priority need and not being currently provided due to persistent workforce shortages.

TAC expressed concern that, given there is a limited bucket of outreach funding and workforce shortages persist, greater care needs to be taken to ensure eligibility of patients and that eligible patients have priority access to the services available. Stakeholders consider that the existence of multiple fundholders in Tasmania creates the potential for distortions in access to care, particularly in relation to the role of RHT and its role as fundholder for the Ear and Eye Surgical Support program.

Stakeholders reported that, in some instances, the awareness of outreach services is low for both patients and providers and this is contributing to possible underutilisation of available services. In responding to perceived low GP knowledge of outreach services, TAZREACH developed a range of marketing posters to advertise all TAZREACH funded outreach services that includes information on the type of service, provider name and frequencies. These were printed and distributed to all service hosts, rural hospitals, community health centres, child and family centres, and other local health facilities in rural and remote areas where services were delivered, in addition to nearby locations.

In some instances, in the face of outreach service availability, stakeholders reported access is not fully utilised. For example, Coastal Physiotherapy receives outreach funding under the MOICDP to provide Aboriginal and Torres Strait Islander Australians regular access to physiotherapy services. However, uptake of these services by the Aboriginal and Torres Strait Islander community is reported as not strong, with the patient community not well coordinated for access to the services. The service is guided by the demands of the community, with greater preference to access to hydrotherapy and exercise classes.

TAC reported that it remains the view of many in the local Aboriginal and Torres Strait Islander Australian communities they serve that hospital and mainstream services are inconvenient and do not promote participation by the Aboriginal and Torres Strait Islander Australian community. But even promoting access to some of the outreach services provided through TAC remains a challenge. For example, while beneficial in terms of prevention and management of chronic health conditions, TAC finds it hard to get the community to embrace the use of existing physiotherapy services provided through TAZREACH outreach funding.

One stakeholder described dental services as a 'hot potato' in Tasmania. While the RFDS is funded through a philanthropic source to provide dental clinics in Tasmania, more generally, the funding of dental care is highly political and more often than not Commonwealth funding programs preclude using it for dental care, even though it is a reported priority across communities in North West Tasmania.

Unlike some other regions across Australia, stakeholders interviewed during the case study did not raise access to dental care as a pressing issue in rural and remote communities. They reported that dental services were relatively well served in the North West region, given current service arrangements with the RFDS. They outlined that the RFDS provides a dental outreach program that assists by providing education, preventative and dental treatments for children and eligible adults in rural and remote areas of Tasmania. For example, the RFDS Tasmania works with the Circular Head Aboriginal Corp (CHAC) in Smithton to treat local Tasmanian Aboriginals and community members in a culturally aware environment by addressing their unmet dental needs.

Costs

Funding and provision of outreach services in North West Tasmania were estimated using the biannual consolidated data provided by TAZREACH to the Department of Health for 2019-20.

Table 16 provides an indication of the relative share of the total outreach program funding for Tasmania that is allocated to service provision in the North West region. The population in the region represents about 20% of the total population in Tasmania, whereas the expenditure on outreach in the region represents about 50% of total expenditure. The MOICDP accounts for just over 30% of the state's expenditure on the program, whereas the RHOF accounts for 60% of the state's expenditure of the program.

Table 16: Outreach program funding for North West region and Tasmania by program, 2019-20

Program	TAS Expenditure	NW Expenditure	NW %
HEBHBL	$28,697	$12,316	43%
MOICDP	$969,236	$296,803	31%
RHOF	$1,199,799	$714,260	60%
VOS	$232,888	$104,135	45%
RHOF PM	$77,138	$77,138	100%
Total	**$2,507,758**	**$1,204,652**	48%

Source: Tasmanian Department of Health Biannual Data Report for MOICDP, HEBHBL, RHOF and VOS, July 2019 to June 2020.

Table 17 summarises the activity, expenditure and unit costs for the HEBHBL, MOICDP, RHOF, RHOF PM and VOS provided in North West Tasmania for 2019-20. The following is noted:

- Average patient unit cost across the programs is estimated at $180.
- Patient unit costs range from $167-$316
- MOICDP and RHOF together account for 84% of total patient activity
- Proportion of ATSI patients under the RHOF is 6% and the VOS is 16%
- Proportion of ATSI patients for Indigenous Australian focussed programs exceed 80%
- Patient unit costs for HEBHBL are over 70% higher than the MOICDP.

The national unit cost was estimated for the four programs over the years 2017-18 to 2020-21 at $107, noting this calculation excluded Tasmania, due to insufficient data being available across the time period. The observed difference in unit costs of North West Tasmania and the rest of Australia may in part be reflective of underlying differences in costs pressures face by jurisdictions.

Table 17: Outreach program services provided in North West Tasmania by program activity, expenditure and unit cost, 2019-20

Program	Expenditure	Visits	Cost/Visit	Patients	Cost/Patient	ATSI Patients	ATSI %
HEBHBL	$12,316	33	$373	39	$316	39	100%
MOICDP	$296,803	236	$1,260	1,766	$168	1,422	81%
RHOF	$714,260	362	$1,973	3,885	$184	279	7%
VOS	$104,135	59	$1,765	552	$189	86	16%
RHOF PM	$77,138	58	$1,330	463	$167	14	3%
Total	**$1,204,652**	748	**$1,610**	**6,705**	**$180**	**1,840**	**27%**

Source: Tasmanian Department of Health Biannual Data Report for MOICDP, HEBHBL, RHOF and VOS, July 2019 to June 2020.

TAZREACH reported that it is increasingly required to rely on private sector providers, given the lack of public sector medical and allied health workforce outside of Hobart. TAZREACH stated this is generating a significant cost impost in contracting for outreach services. For example, as mentioned earlier, TAZREACH reports that they rely on private ophthalmology and optometry services outside of Hobart. They also noted that recruiting private clinicians is becoming

increasingly difficult, claiming that this is due to the prescriptive nature of the service delivery standards. They indicated that the standards require hourly rates for travel or backfilling to be equivalent to public rates, which they claim equates to a half or third of what clinicians receive in private practice.

RHT became the fundholder for the EESS program in 2021-22. In preparation for service delivering in 2022, RHT had been exploring what it can and cannot do to be effective in facilitating eye and eye surgery for Aboriginal and Torres Strait Islander Australians under the EESS program. RHT indicated they had consulted widely, including other jurisdictions and a range of stakeholders in Tasmania. RHT reported that access to ENT surgeons and ophthalmologists are limited and payment of fees to private providers is often prohibitive.

TAC reported that the cost of services by private clinicians creates barriers to provision, citing that the cost of psychology services ranges from $190 to $290 an hour.

Telehealth and innovative models of care

There was a view expressed that the current funding arrangements stifle outreach service innovation. For example, stakeholders would like to explore hub and spoke models where a local allied health Assistant could be supported by a regional physiotherapist who in turn is supported by specialist services at a regional service if care is more complex. This could also involve technology including point of care testing and telehealth. One stakeholder indicated that there are too many buckets of money and the rules around the funding are so tight that such innovations cannot be easily pursued.

Fundholders would be supportive of processes where regional and local initiatives to improve access could be generated and considered by the Department on a case by case basis and not tied to specific program funding rules.

TAZREACH highlighted the need for greater sharing and learning across jurisdictions, noting there is currently no formal national network across the outreach fundholders, including a community of practice or forum that brings fundholders together to share experiences or make reflections on what each jurisdiction is doing to solve issues.

It was noted by stakeholders that the Department does not share data or provide jurisdictional comparison to help the fundholders learn from each other. TAZREACH valued previous annual meetings but noted these have not been in place for some time. They consider this to be an important issue for Tasmania, given the workforce shortages, relative size and isolation of the jurisdiction. TAZREACH noted that it is a complex system and that it would be good to have a forum to learn from each other and work together to resolve the common issues at hand, including innovations in models of care and variation in fundholder practices.

TAC emphasized their aim is to create a one stop-shop for services to the Aboriginal and Torres Strait Islander Australians it serves at their centre in Launceston. It works hard to encourage families to access their services and build trust in the people providing care and support. Examples were given where support is scaffolded around the client and their family, including taking care of the children while the mother received counselling.

Telehealth is an important aspect of a shared care model and requires technical and clinical expertise locally, included dedicated appointments with patients at the clinics. The local staff can implement, refer and action aspects of the care plan in conjunction with the paediatrician and nurse practitioner. Further support of local staff through outreach funding support would help could enhance capacity for shared care arrangements in the North West region.

TAC reported that telehealth facilities exist in most Aboriginal medical services and local clinics, but the Aboriginal and Torres Strait Islander population still prefers face-to-face care.

Impact on health outcomes

Stakeholders, including outreach providers and host providers, consistently underlined the value of the outreach programs and the value they represent for the people that receive them. However, some stakeholders interviewed during the case study lamented that measurement of the health outcomes from services is generally not undertaken routinely across providers, notwithstanding acknowledgement that persistent issues exist in relation to attribution of the services to any outcomes observed.

During the case study, it was noted that the Opal Pain Management Program in Burnie seeks to routinely measure and compare the health outcomes of their services. The program providers collect a standard set of information from patients to guide treatment, measure outcomes and allow comparison with peer services.

The Opal service collects outcomes data to assess how well its performing in relation to pain management across Tasmania, including pain severity, pain interference, depression, anxiety, stress, pain catastrophising and pain self-efficacy. The data collected indicate the program is effective in improving patient reported outcomes and that the outcomes are commensurate to those reported by other services in Tasmania.

A key outcome relates to the use of opioids, with Opal achieving nationally commensurate reductions in the use of opioids post treatment, with over 50% ceasing opioids (see Table 18).

Table 18: Opal Pain Management Program Outcomes

Service	Average mg morphine equivalent on referral	Average mg morphine equivalent post treatment	% Ceased opioid – post treatment
OPAL	55 mg	30 mg	51.43%
All Services (Australia wide)	49 mg	25.6 mg	NA

Source: Unpublished Opal Pain Management data collection.

Barriers to delivering outreach services

HPA asked stakeholders about the main barriers and enablers to providing access to rural and remote communities in North West Tasmania and where are their opportunities for improvement.

Promotion of alternative workforce models

Stakeholders surfaced issues related to the overall health workforce shortages in Tasmania, including medical specialities such as ENT surgeons and psychiatrists, GPs and allied health staff such as occupational therapists and psychologists. Stakeholders are looking to alternative workforce models, attracting clinicians from mainland states and resorting to the private sector to help supplement local workforce gaps.

Coupled with overall workforce shortage issues, there was an impression that outreach is not part of the DNA of health services with significant workforce capacity within North West Tasmania. One stakeholder indicated that it requires individual champions with an organisation to mobilise outreach services and involve local clinicians rather it be part of the mission or values on an organisation, whether it be a regional hospital or group primary care practice. Greater promotion and facilitation of clinicians to participate in outreach services as part of their overall clinical roles could be further explored.

Greater program coherency and flexibility

Stakeholders frequently referenced the need for regional hub and spoke models and greater collaboration across aged care, disability services and health care to establish viable access to services through local place based solutions but lamented at the structural issues holding back innovation and progress on these fronts.

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. Stakeholders noted the outreach programs do not sufficiently align with and reflect key national policy directions, including the National Health Reform Agreement on Closing the Gap and primary health care reforms. These policies promote joint planning and funding, paying for value and outcomes, enhanced health data and building the capacity of ACCHOs.

Increased program flexibility to allow greater scope for reflection of jurisdictional priorities and models of service are considered crucial factors for improvement in the future. Accountability that increases the focus on measuring and paying for value and outcomes rather than activity could underpin increased program flexibility.

Building more active policy dialogue

Stakeholders expressed concern over the level of accountability and transparency of the Commonwealth in the administration of outreach policy and programs. They call for an active approach from the Commonwealth, where the policy and funding arms of the Department of Health are more directly involved with all fundholders.

TAZREACH suggested that interaction between the local officers from the Australian Department of Health and the Department of Social Services Grants Hub could be strengthened, along with greater engagement of Grants Hub staff (as observers) at the Advisory Forum meetings. There is a view, the role of the Grants Hub provides an additional layer of bureaucracy that tends to hinder dialogue and agile policy decision making.

Stakeholders are concerned that the Commonwealth's role in bringing together and supporting jurisdictional fundholders has dropped away over the years and would like to see elements of a relational approach reinstated, with quality feedback, data, decision making, and future directions shared openly and transparently with fundholders.

Funding to meet unmet demand

There is a view that outreach program funding is not meeting the growing demand for services and is not sufficient to cover the increased costs associated with maintaining the current levels of outreach service delivery. TAZREACH reported that minimal increases to funding of 1-2% do not cover increases in budget items (i.e. flights, hire cars, hourly rates etc).

TAZREACH is concerned that without additional investment the funding will need to be spread across less services to reflect increases in actual costs. They indicate that while long-term outreach providers are generally understanding of the situation, queries regarding increased costs have been increasing.

7

Western Australia: The Kimberley Region

Box 6: Key observations

Regional level

- **There is a call for greater autonomy in decision making at the regional level.** Western Australia has a strong regional governance framework but requires greater devolvement of decision making and flexibility in funding to enable outreach services to respond to local needs.
- Stakeholders cited the need to support local workforce capacity and development, particularly in relation to the **coordination of outreach services.**
- **There was a view that better communication and sharing of information** is required between stakeholders to avoid duplication of services and to better identify areas of community need.
- Interviewees indicated that telehealth is increasingly being used to provide services where physical access is difficult, however, stakeholders noted that the **inequities associated with telehealth** (unequal access to technology, IT illiteracy, poor internet connection) should be addressed.
- There were reports that certain outreach services, such as ear services, **are being duplicated** due to funding from multiple sources and that better planning and coordination could improve the effectiveness of outreach service delivery
- Stakeholders highlighted that 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 **Aboriginal and Torres Strait Islander social determinants of health.**

LOV

- LOV is viewed as being less encumbered than the Department of Health with a greater social mission than private organisations which has made it **more agile and innovative in its approach** to eye health in the region. This, plus the long term commitment from LOV staff working in the region with communities to improve eye health, are noted as key organisational success factors.
- **There was a view that mobile services, shared care telehealth arrangements and a flexible scope of practice** have enabled improved access to eye health services.
- **By bringing funding together** from a range of sources including outreach programs, state and organisationally sourced funding, the organisation reflected that 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
- 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.

Case study scope and focus

The case study is place-based and focusses on outreach service delivery in the Kimberley region of Western Australia. With vast distances and arid landscapes often negotiated when travelling from one community to another, the state faces geographical challenges providing access to health care.

Due to these challenges and the reported need for health services across the region, providers in the Kimberley have developed and fostered service models to help overcome these barriers. The case study will highlight one of these services, the Lions Outback Vision North West Hub, otherwise known as the 'Kimberley Hub,' located in Broome which delivers eye health care and outreach services to the Kimberley and Pilbara regions via a hub-and-spoke model.

The name and type of the organisations interviewed as part of this virtual case study are shown in Table 19.

Table 19: Interviewees by organisation and role

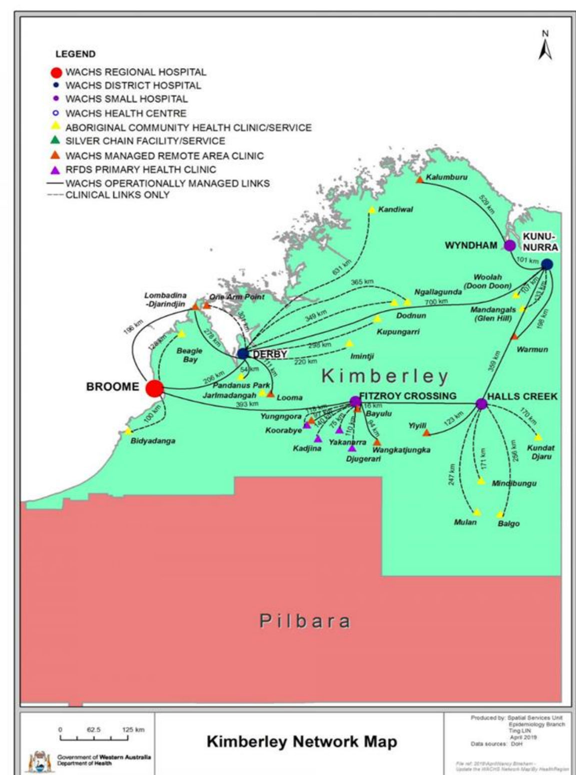
Organisation	Type
Lions Outback Vision	Provider
Aboriginal Health Council of Western Australia (AHCWA)	NACCHO affiliate
Broome Regional Aboriginal Medical Service	ACCHO
Rural Health West	Fundholder
WA Primary Health Alliance (WAPHA)	PHN
WA Country Health Service Kimberley	LHN

Kimberley region

At 3 times the size of the United Kingdom, the Kimberley is 424,517 square kilometres and is comprised of the major centres of Broome (population 16,961), Derby (population 8,345), Wyndham (population 7,494), and Halls Creek (population 9,592), as well as over 100 First Nations communities.[50] Forty five percent of the population is Aboriginal and Torres Strait Islander out of a total population in the Kimberley of 34,365 as of the 2016 Census in Australia – significantly higher than the proportion of Aboriginal and Torres Strait Islander people in the whole of Western Australia (3.6%). People under 20 make up 42% of all Indigenous people in the Kimberley.[51]

Using the IRSAD calculated from the 2016 Census in Australia, significant disadvantage can be seen in the Kimberley, with 32% (11,000 people) of the region scoring in the lowest 10% of IRSAD scores in Australia In particular, Halls Creek scores the lowest at 718 at a benchmark of 1,000 which is the level a region is not considered to be at a relative disadvantage. The Highest IRSAD score in the Kimberley is Broome

Figure 14: Map of the Kimberley



[50] WA Country Health Service. (2021a). *Kimberley Regional Profile*. WA Country Health Service. Retrieved 16 March from https://www.wacountry.health.wa.gov.au/Our-services/Kimberley/Kimberley-regional-profile
[51] Australian Bureau of Statistics. (2016). *Kimberley: 2016 Census All Persons QuickStats*. Retrieved 16 March 2022 from https://www.abs.gov.au/census/find-census-data/quickstats/2016/51001

(979).[52] The unemployment rate for the Kimberley region is 8.7% compared with 5.8% nationally at the time of the 2016 Census.[51]

Public hospitals are spread sparsely throughout the region, including 2 major hospitals, Broome Health Campus and Kununurra Primary Health Centre, as well smaller regional hospitals, including Derby Regional Hospital, Fitzroy Crossing Hospital, Halls Creek Hospital and Wynham District Hospital.

ACCHOs are also located throughout the region, including in Broome, Ord Valley, Derby, Yura Yungi, Beagle Bay, Bidyadanga and Nirrumbuk. These ACCHOs are supported by the centralised Kimberley Aboriginal Medical Service (KAMS), which also provides its own clinical services. There are also ACCHOs in Ngnowar and Nindilingarri.

Local stakeholders and outreach service delivery

There several key services providing care in the Kimberley. Information on each of the local providers interviewed as part of the case study is provided below.

Lions Outback Vision (LOV) is an organisation that provides eye health services across the Pilbara, Kimberley, Goldfields, Midwest and Great Southern regions.[53] For more information on LOV service provision, refer to Regional innovation – Lions Outback Vision.

KAMS is a regional ACCHO that represents 7 members across the Kimberley. The organisation was established in 1986 and provides collective advocacy and support to its members along with multiple other services, including research, health promotion, IT support, training and education. KAMS 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.[54]

Broome Regional Aboriginal Medical Service (BRAMS) is an ACCHO that administers care in the Broome area, providing approximately 40,000 occasions of service annually. BRAMS is a member of the Kimberley Aboriginal Medical Service network.[55]

The Aboriginal Health Council of WA (AHCWA) is the NACCHO affiliate in Western Australia and is the peak representative for ACCHOs in the jurisdiction, supporting 23 ACCHOs, including BRAMS. AHCWA reported that it governs using a bottom-up approach to leadership, with its leadership being appointed by the community, empowering the community to service the interests of its members. It stated that it has relationships with Rural Health West (RHW) and assists in coordination of outreach services.[56]

WA Primary Health Alliance (WAPHA) oversees the operations of the 3 PHNs in Western Australia and funds the Integrated Chronic Disease Care Program in Broome in conjunction with Boab Health, which is a not-for-profit charity that provides multidisciplinary primary health care services. WAPHA also commissions outreach services to numerous communities, of which the frequency of visits is dependent on the need for services. Some of their Integrated Team

[52] WA Country Health Service. (2018). *Kimberley Health Profile: Planning and Evaluation Unit November 2018*. https://www.wacountry.health.wa.gov.au/~/media/WACHS/Documents/About-us/Publications/Health-profiles-and-service-plans/Kimberley_Health_Profile_2018.pdf
[53] Lions Outback Vision. (2017a). *About Us*. https://www.outbackvision.com.au/about-us/
[54] Kimberley Aboriginal Medical Services. (2022). *About Us*. Retrieved 19 April 2022 from https://kams.org.au/about-us/
[55] Broome Regional Aboriginal Medical Service. (n.d.). *About Us*. https://www.brams.org.au/about-us/#governance
[56] Aboriginal Health Council of WA. (2019). *About Us*. https://www.ahcwa.org.au/about

Care (ITC) funding supports outreach services, and the PHN also funds low to moderate psychological outreach services across the Kimberley.

WA Country Health Service is the local health service covering the whole of Western Australia. The WA Country Health Service network provides services across 7regions including the Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and the Great Southern Region. The service has 6 regional health campuses and 15 district health campuses that support hospitals, inpatient and community-based mental health services, residential aged care facilities, population health services, health centres and nursing posts across these areas.[57]

WA Country Health Service Kimberley is part of the WA Country Health Service network and, in conjunction with the group of Aboriginal Medical Services in the region, was described as the 'default primary care service.' While they noted the great need and demand for outreach services, key areas of organisational focus include developing the local workforce and establishing additional health services, such as a regional hospital, to support the management of patients locally and provide their patient demographic with timely access to acute and emergent care.[57]

Governance and needs assessment process

In addition to the Rural Health Outreach Services Advisory Forum, RHW has established 8 regional working groups across the state in a reported effort to better govern the outreach programs and capture variation across communities. The regional working groups are chaired by RHW and include representation from WAPHA, WA Country Health Service, the Commonwealth Department of Health and the Regional Aboriginal Health Planning Fora. The regional working group meetings allow RHW to discuss service provision across each region and determine who is best placed to fund and support specific services.

RHW's stated that its annual review of services informs its needs assessment process. They described the review as multi-faceted and that it incorporates the views of service providers, local communities, the regional working groups and Aboriginal organisations and planning fora across the regions. RHW also collects its own snapshots of health priorities based on the data the organisation collects and populations across the regions, which vary in relation to need, geography and demographic composition.

RHW indicated that it faces challenges supporting new services each financial year. Funding a new service requires RHW to re-engage the regional working group to determine if funding the new service should be at the cost of an existing service. In some instances, these services can be delivered through reserve funding.

When receiving new contracts, RHW will typically hold a funding round in which providers can apply for funding. This provides opportunities for both new and existing service providers to deliver outreach services. One area of improvement that RHW identified is the need for better tracking of services through the alignment of outreach data sources.

When discussing the governance and needs assessment processes, regional stakeholders felt that there is a lack of transparency and community voice in central decision making and highlighted the need for additional opportunities for community input in determining regional needs and the overall planning and governance of outreach services. For example, one stakeholder cited the high level of variation in demography and need across geographies and stated that existing outreach services do not always align with local need. In light of this, there was support for further establishment of these regional governance models to facilitate information sharing and coordination to allow for additional community input into the needs

[57] WA Country Health Service. (2021b). *Overview*. https://www.wacountry.health.wa.gov.au/About-us/Overview

assessment process and more effective planning for outreach services. While stakeholders understand the need for accountability, they advocated for additional local autonomy in determining need and developing systems that are co-designed in close consultation with communities and Aboriginal and Torres Strait Islander representatives. In addition, they support additional transparency and information sharing between stakeholders as it would enable stakeholders to be more responsive to local communities and providing supports where necessary.

Local service coordination and integration

Coordination of outreach services was frequently cited as a barrier to outreach service delivery and a key area of improvement. Stakeholders described coordination as poor and cited various issues with the coordination of certain outreach services, including those focusing on eye and ear health.

One stakeholder described coordinating outreach (including satisfying the program reporting requirements, seeking funding from RHW for various activities, including travel and telehealth, and organising food, accommodation and transport for a few days of outreach) as incredibly complex and resource intensive. They stated that it often takes their organisation longer to undertake reporting activities than actual service delivery. Despite this, the organisation continues to participate and seek funding for outreach because it allows patients to receive care in their communities. They also rely on the strong partnerships they have with other regional organisations to deliver additional services to communities that may not be covered by outreach or to assist in the management of patients in between visits.

Stakeholders cited concerns about duplication of outreach services and limited communication and coordination amongst local and jurisdictional stakeholders. It was reported that limited local workforce and differing reporting software across sectors has contributed to these coordination issues. For example, pain management was cited by one stakeholder as a service that is needed in Broome, however, due to limited support and capacity to support the coordination of outreach services on the ground, they felt it is difficult to provide any meaningful care, prepare patients and arrange for them to be seen when minimal notice is provided (sometimes within one week) that a clinician will be visiting.

It was reported that some outreach services also do not interact cohesively together, and it can become burdensome when attempting to coordinate these services locally. For example, stakeholders commented on the multiple other players and programs in the outreach space delivering the same or similar services including the Ear Bus, HEBHBL, EESS and Hearing Assessment Program Early Ears. Stakeholders reported that this has made it incredibly confusing for local services and communities as patients are unsure of what provider they saw, and providers are referring patients on to a myriad of different providers. One stakeholder reflected that an ENT can get 4 referrals for the same patient, and they are often not following up and communicating back to the local service hindering continuity of care.

To improve coordination, one stakeholder suggested scheduling more frequent advisory forum meetings and planning days to enhance the visibility of outreach services and increase collaboration and understanding of what is happening on the ground. Others emphasised streamlining processes, the importance of planning at the local and regional level and supporting the development of the local workforce, such as coordinators, nurses and Aboriginal health workers, to facilitate and support both local and outreach service delivery.

The sentiment around visiting clinicians is that it is difficult to integrate outreach service delivery and replicate health services provided by a local provider, who may have a strong connection to the community; therefore, stakeholders highlighted the importance of prioritising local solutions. One stakeholder raised an issue surrounding incoming tenders for the provision of services. They reflected that local service providers may be highly capable of delivering services, however, they may not possess the administrative acumen to bid on tender, or bid on

a tender competitively, so contracts are often awarded to out-of-area providers, despite local services being able to deliver them more efficiently. This highlights the importance of developing local workforce capacity and supporting local providers to deliver care throughout the region to foster stronger continuity of care and better patient outcomes.

Stakeholders highlighted another example in which they have encountered challenges coordinating services in the ear and eye health space and aligning service provision with actual community need. For example, one stakeholder reported that a visiting optometrist is currently funded to visit their service once a month. Noting the importance of this vital outreach service, the stakeholder cited challenges coordinating and providing simple optometry services that do require an optometrist. The visiting optometrist may be able to provide the prescriptions required for a consumer to obtain glasses, however, stakeholders reported that coordinating this process with the State Glasses Program has been difficult and arranging a fitting for the glasses often requires integrated team care, GP management plans, referrals, and travel to Kimberley eye care for the fitting. Stakeholders consistently reinforced the need for prioritising the development of the local workforce, particularly allied health and Aboriginal health workers, to perform clinical tasks, assist visiting clinicians and coordinate care. In particular, one stakeholder has been receiving feedback that the coordination of ear health services in schools could be improved, with parents often not aware that visits are taking place.

Ultimately, stakeholders value fostering the strong partnerships and relationships cultivated amongst providers in the region. They hope to facilitate further communication amongst local stakeholders and support stronger coordination of outreach services through additional input and visibility of outreach service delivery and the development of the local workforce.

Training and upskilling

Local stakeholders highlighted the importance of supporting and upskilling the local workforce not only to facilitate local service delivery but also to promote strong community leadership. This is a key priority for many providers and services in the area. There was a sentiment that in addition to service provision, outreach programs should focus on local capacity building as stakeholders stressed there is no substitute for local place-based care. This view is also shared by RHW, which believes that the long-term sustainability of providing services in rural and remote areas should be built through greater workforce capacity across local communities (although, they noted that outreach still has its place in service delivery). Due to the vast nature of the region, stakeholders noted the importance of having a full time local workforce to facilitate sustainable models of care, train local staff and operate hub-and-spoke models in which resident services can take responsibility for the patient and associated tasks, such as documentation and engagement with referrers to facilitate continuity of care and improve patient outcomes.

It was noted that training pathways in rural and remote communities are still limited compared to metropolitan areas in Western Australia, and there is a strong desire to establish and continue to expand existing training pathways in the region. Stakeholders cited organisations that have and are in the process of establishing additional training opportunities in the Kimberley. For example, KAMS stated that it provides a great deal of training and support for Aboriginal health workers, and it was reported that Notre Dame University is exploring the idea of establishing an educational pathway for Aboriginal health workers to become nurses.

Outreach funding

RHW reported that there is strong demand for outreach services, and the organisation has no trouble allocating outreach funding. When preparing an activity work plan, they have a reserve services list, and the board overcommits its outreach budget to combat challenges with underspend across programs. This list is frequently reviewed to see if RHW has the capacity to deliver services on the reserve list. Underspend has been a challenge due to the short term

nature of program funding contracts, delays in obtaining approval from the Department of Health and the capacity for service providers to plan and engage in their services. It was described as a 'balancing act' between managing spend within the allocated time frames and acknowledging providers plan on the calendar year while they are on the financial year.

Local stakeholders have varying views of outreach funding, the way it is administered and approaches to enhance these processes. One stakeholder highlighted that there does not appear to be equal distribution of funding amongst local providers and the funding process has not been transparent which has been a problem for some providers who have not been successful in contracting with the fundholder. To improve the transparency of the funding process and help those providers who may be missing out on funding to one or a few of the larger providers in the outreach space, they advocated for more collaborative arrangements in the funding of services to facilitate better coordination of services across agencies.

While outreach services play a role in servicing the needs of the community, stakeholders reiterated the challenges associated with managing outreach programs that are funded by numerous sources and felt some outreach services may not always be the most suitable option. For example, NT Health and RHW previously provided funding for a visiting psychiatrist, however, one stakeholder reflected that they feel the stock of psychiatrists in Broome is adequate to provide mental health services locally. After identifying that coordination of mental health care was required rather than visiting psychiatry services, a mental health liaison nurse was instead funded. As such, interviewees felt that regional stakeholders would be best placed to determine community need and how outreach funding is used. They also advocated for additional flexibility and fewer rules around how these funding streams are used noting the extreme variation in need across communities. For example, stakeholders cited gaps in dental services, and one supported using outreach funding to reduce the large ENT surgical waiting lists.

Stakeholders noted the vital nature of outreach funding in supporting organisations to deliver health services to rural and remote communities. They highlighted the great complexity associated with the funding and deliver outreach services and that there is no 'fix all' solution. They stressed the is importance of providing funding that is flexible, sustainable and predictable and there is a desire to determine how much money is actually spent on outreach regardless of whether a patient attended a visit or not as it still costs providers and organisations time and money to deliver outreach services. Stakeholders advocated for increased efficiency and streamlining of processes and to 'keep the money flowing' because outreach is here to stay.

Telehealth

It was reported that COVID-19 has accelerated the use of telehealth, and there appears to be strong support for telehealth to enhance the delivery of outreach services, improve patient management in between outreach visits and facilitate local workforce development and shared care arrangements.

After performing service mapping at the beginning of the pandemic, WAPHA observed 90% of services incorporated telehealth into their service delivery, which was primarily used for mental health services, Aboriginal health services and chronic disease care. While acknowledging the diverse health needs across geographies and populations and varying alignment with the provision of telehealth services, stakeholders highlighted examples in which telehealth has been useful in increasing access to services in certain areas along the patient pathway. For example, BRAMS uses telehealth in its interactions with the Royal Perth Hospital, reviewing patient lists every 6 weeks. Stakeholders reported that the feedback received from patients is that telehealth is good for reducing the travel burden for seeking care.

Organisations, such as BRAMS and KAMS, noted that they have also been able to find ways to harness telehealth to assist its consumers and support innovative practices. For example,

doctors at BRAMS have been able to sit in on telehealth appointments at the organisation to assist with translation and further explain what the specialist is communicating. Specifically, the use of cameras for diagnosis has been valuable for patient care in ENT. Another service that has shown promise in other clinics is performing chest and heart screening where a nurse is able to listen to chest and heart sounds and relay this information back to a remote doctor. KAMS stated that it now has the capacity to perform eye consultations via telehealth using ophthalmoscopes. Ultimately, BRAMS and KAMS would like to expand its telehealth services into the future. KAMS noted that while they have telehealth infrastructure in place their biggest issues include clinician uptake and having the local workforce capacity to support the delivery of telehealth on the consumer end.

One stakeholder felt that telehealth assists in rebalancing power back to the community, empowering them to make decisions about their health. They cited the example of having an Aboriginal health worker facilitate a telehealth session which they felt may help an Aboriginal and Torres Strait Islander patient feel more comfortable in sharing information with a clinician. They commented that this also increases accountability as an Aboriginal health worker can supervise the telehealth session to ensure providers are delivering culturally sensitive care.

Stakeholders did highlight certain limitations and considerations in relation to telehealth. Considerations included its applicability and use across certain specialties. For example, while stakeholders felt telehealth may be very useful for certain health areas, such as chronic disease management and mental health, they surmised it may be less applicable to other specialties, such as podiatry. Others cited its potential for abuse and highlighted an example of GPs getting paid to provide blood results via telehealth whereas this has historically been done over the phone for free. Despite positive developments in the provision of telehealth, one stakeholder has also experienced challenges in delivering telehealth services and felt patient experience and education should be explored further. For example, they commented that many patients that they service find negotiating the technology difficult, and low levels of communications infrastructure, such as high-speed internet, sometimes make connecting to an online call difficult. They felt this can result in decreased equity of access to health services particularly as telehealth services expand.

With the benefits and limitations of telehealth considered, stakeholders noted that telehealth is not a substitute for face-to-face services but is an effective supplement to increase access to care. With this in mind, many stakeholders held the view that telehealth should be supported further to harness new and emerging technologies, empower local communities, and improve communication channels across organisations to facilitate information sharing and more effective coordination of care.

Impact on health outcomes

Stakeholders noted the importance and difficulties associated with measuring the value and benefits of outreach programs. Value could be measuring in a myriad of ways, such as service volume and PREMs. For example, one interviewee suggested measuring the value of outreach programs in increasing access to local care by collecting data on the number of surgeries performed close to a patients' home postcode.

As with other jurisdictions, stakeholders reported that the outreach programs are designed around specific body parts and visiting providers are assessed on how many patients they can get through the door. Stakeholders indicated that this quantity based, siloed approach encourages visiting clinicians to be too body part focused, and often overlook the important Indigenous social determinants of health. They reflected that it is important to ask the patient what is important to them, rather than just what is wrong with them. This may uncover deep issues that may be contributing to the person's overall health, such as family, poor living conditions, overcrowded housing or feelings of cultural isolation.

In regard to collecting patient feedback and measuring the quality of service delivery, stakeholders expressed that it is important to ask patients about their experience with a service, if it worked for them, what their journey was like and how a service can improve. While PREMS and other surveys can be useful in collecting this information, stakeholders indicated that these approaches can often be tiring for communities as there is consent fatigue. One organisation described mixing up their methods to collect this information including collecting input through yarning circles and looking at a service's impact on patient flows. While some of these approaches may be harder to translate into outputs, there is a view that these methods are is more cultural appropriate and can allow organisations to capture information on the quality of a service in a different way.

Stakeholders hoped to achieve a more robust system of accountability of outcomes for providers and highlighted potentially innovative ideas to measure the value of outreach services.

Barriers and enablers to delivering outreach services

Key barriers to delivering outreach services in the Kimberley include:

Local workforce capacity and coordination of outreach services – Stakeholders cited ongoing challenges with the coordination of outreach services due to limited workforce capacity and lack of funding to support this coordination.

Transparency and perceived lack of community involvement in decision making processes – There is a strong desire to increase the transparency of governance processes and increase community input into central decision making as it pertains to the design, planning and delivery of outreach services.

Communication and Information sharing across stakeholders – There are limited opportunities to share information across providers and organisations in the region. This has led to concerns of service duplication across outreach providers and calls for further communication across local and jurisdictional stakeholders through a variety of mechanisms including telehealth and centralised IT systems, regional co-design and funding models, to improve coordination and enhance the delivery of outreach services.

Despite these challenges, stakeholders reported many strong, long-standing relationships across the Kimberley and a shared passion amongst local providers and organisations to increase access to vital health services throughout the region. One stakeholder reflected that many of the local providers have trained and grown up together, and these individuals have subsequently gone on to train and establish multidisciplinary teams in the Kimberley. They felt this has fostered a strong intercollegiate network and a desire for further collaboration and communication across the region.

Regional innovation – Lions Outback Vision

Stakeholders described LOV as an organisation that has established and fostered strong relationships with local and regional stakeholders across the Kimberley. The LOV Northwest Eye Hub is located in the Kimberley and delivers outreach services across the Kimberley and Pilbara regions. This section will provide a background on the service and discuss what stakeholders believe are the key factors that have made LOV successful in mitigating many of the observed challenges associated with delivering outreach services across the region.

LOV service provision

Dr Angus Turner, an ophthalmologist at the Lions Eye Institute, founded Lions Outback Vision (LOV) in 2010 after obtaining initial funding from Lions Eye Institute and the University of

Western Australia. LOV currently administers several outreach services and is provided regular funding through various sources, including the federal and state government. Dr Turner noted that this funding has allowed him to deliver outreach services full time. Using a team of ophthalmologists, registrars, medical officers, optometrists, eye health coordinators and Aboriginal health workers, LOV operates 5 main streams of services:[58]

- **VOS**, which funds visiting optometrists to service 30 locations across the Kimberley, Pilbara and mid-west regions each year over the course of approximately 80 outreach visits and improves eye care coordination in identified areas of need.
- **Outreach clinics**, which is a visiting ophthalmology service funded by both RHW and WA Country Health Service. It involves ophthalmologists visiting regional hospitals in Kalgoorlie, Esperance, Katanning, Albany, Derby, Kununurra, Karratha, South Hedland, Port Hedland, Roebourne, Broome, Fitzroy Crossing and Halls Creek. Visiting ophthalmologists perform clinical assessments, screening, procedures and follow-ups.
- **Diabetic retinopathy** screening as a key part of diabetes care.
- **The Northwest Eye Hub Kimberley**, which opened in April 2021 and operates under a hub-and-spoke model to provide ophthalmology, optometry, retinal surgery, on-call emergency and Western Australia-wide on-call telehealth services to the Kimberley and Pilbara regions, as well as on-site diabetes education.
- **The Vision Van**, which is a mobile van, similar to HoA, that provides specialist eye services to 19 regional and remote communities bi-yearly, with the ability to diagnose and treat most major eye conditions. Using the EESS funding, Dr. Turner and his staff perform monthly visits to locations for procedures such as eye injections.

LOV's current sources of funding that facilitate the provision of the above services are highlighted in Table 20.[59]

Table 20: LOV funding sources

Funding source level	Funding source
Australian Government	• Medicare rebates • VOS • RHOF • EESS
State level	• WA Country Health Services • Rural Health West • Clinical/ Surgical infrastructure and consumables • Patient Accommodation and Transport Scheme

Other	• Non-Government Organisations, e.g.
	  ◦ Lions Eye Institute (LEI)
	  ◦ The Fred Hollows Foundation (FHF)
	  ◦ Eye Surgeons Foundation
	  ◦ Lotterywest
	• Private Foundations, e.g.
	  ◦ McCusker Charitable Foundation
	  ◦ Newman's Own Foundation Fund
	  ◦ Indigenous and Remote Eye Service (IRIS)
	• Corporate Sponsorship, e.g. Devil Creek Joint Venture
	• The University of Western Australia
	• Industry, e.g. Allergan, Device Technologies, Telstra
	• Patient out-of-pocket income

[58] Lions Outback Vision. (2017c). *Outreach Services*. Lions Outback Vision. https://www.outbackvision.com.au/outreach/
[59] Lions Outback Vision. (2017b). *Line of Sight - Evaluating the Impact of the Lions Outback Vision Program*. https://www.outbackvision.com.au/wp-content/uploads/2019/05/1712020_line-of-sight-report.pdf

Since founding LOV, Dr Turner's focus has been on service innovation and sustainability of service delivery to increase access to eye health services to prevent eye conditions that often lead to blindness or vision loss. As of early 2022, outreach services are offered in Western Australia's Pilbara, Kimberley, Goldfields, Midwest and Great Southern regions, with a particular emphasis on increasing access to Aboriginal and Torres Strait Islander peoples. LOV has also partnered with numerous supporters and donors, which facilitates the ongoing delivery of its services.

Vision Van

The Vision Van is funded by Lotterywest, which has been matched by WA Health and the Australian Government Department of Health. As of early 2022, the service incurs approximately $400,000 in operating costs annually, and has operated at a slight loss over the last 5 years, although, this does not consider the cost savings to the health system that are generated by the service. Dr Turner anticipates that the operating loss is not likely to continue long-term. As such, the WA Government has committed to another 5 years of funding.

The Van is equipped to treat cataracts, trachoma, glaucoma and diabetic retinopathy, amongst other ophthalmology services. Working from his base in Broome, Dr Turner also offers diagnostic services via telehealth using his staff in the Vision Van to operate the diagnostic equipment.

The Vision Van performs several loops across different parts of Western Australia. Due to the vast distance between Broome and its closest towns within the service circuits, Broome is instead serviced by Lions Outback Vision on a fly-in-fly-out model. Figure 15 shows the locations and communities the Vision Van includes as part of its service delivery.[60]

Figure 15: Map of circuits completed by the Vision Van

LOV recently evaluated its mobile ophthalmology service provision in 2017.[61] By implementing the social return on investment method using retrospective program data (such as account statements, funding agreements, billing and clinical records, and independent analyses of literature), the evaluation was able to determine the cost per patient for the provision of

[60] Lions Outback Vision. (2017d). *Vision Van*. https://www.outbackvision.com.au/vision-van/
[61] Lions Outback Vision. (2017b). *Line of Sight - Evaluating the Impact of the Lions Outback Vision Program*. https://www.outbackvision.com.au/wp-content/uploads/2019/05/1712020_line-of-sight-report.pdf

general optometry services (Pilbara region), ophthalmology via outreach clinics, ophthalmology via the Vision Van, ophthalmology via telehealth, and the cost of a transfer to Perth. The costs per patient found in the evaluation are seen in Table 21.

Table 21: Average cost per patient from the 2017 evaluation

Service	Average cost per patient ($)
Optometry (Pilbara region)	171
Ophthalmology – outreach clinic	444
Ophthalmology – Vision Van	320
Ophthalmology – telehealth	213
Transportation to Perth	1,589

Stakeholders commented on the use of mobile services, such as the Vision Van. Mobile services were cited as an innovative model of care that may have a place in outreach, particularly in rural and remote areas with small local clinics and limited infrastructure to support them in service delivery. However, stakeholders did note that this model does come with limitations and challenges. Many of the roads leading to rural and remote communities are treacherous and not suitable for a van transporting sensitive medical equipment. In addition, there may be a shortage of credentialed personnel who can drive the vans, as well as road travel limiting the number of sites that are able to be visited within a given period of time.

Funding LOV outreach services

Stakeholders described various challenges navigating and coordinating the various outreach funding streams. This includes constraints on the flexibility of outreach funding. To mitigate these challenges, LOV has applied for and brought together funding from multiple outreach programs including the RHOF, EEESS, MOICDP and VOS, to facilitate the delivery of its outreach services and establish a predictable and sustainable source of funding. For example, EESS funding has enabled Dr. Turner and LOV staff to perform monthly visits to locations for eye injections which would not be feasible or cost effective without this funding stream as the organisation feels Medicare does not sufficiently cover outreach costs, such as travel and accommodation. LOV is committed to bulk billing its patients to promote equitable access to his services in rural and remote communities and has also been able to use outreach program reserve funds to plan and conduct additional outreach visits.

Funding from these outreach programs, in addition to other sources including state and organisationally sourced funding, has also allowed LOV to establish and build a local team of salaried staff who work full-time performing outreach which has aided in the delivery of LOV's hub and spoke outreach model. In addition, the organisation reported that consolidating these multiple funding streams has enabled better coordination of service delivery and aided in avoiding service duplication. Through this approach, the NW Eye Health Hub indicated that it 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.

Telehealth at LOV

Telehealth has been vital in facilitating LOV's model of care and the organisation reported it is often prioritized over other services. In addition to support training and upskilling of the local workforce, LOV stated that the organisation has been able to streamline the referral process, speak with patients and facilitate their management locally. For example, the organisation noted that in order to turn up for a day of one or 2 surgeries and not have as many clinic days, it relies heavily on the optometry workforce. They described VOS optometry as the 'linchpin' of triage, and the only patients that Dr. Turner and other ophthalmologists see during their outreach visits require surgery. All the consultations prior to the surgery are done via telehealth in conjunction with the optometrist. An optometrist will see a patient and contact the doctor

who will consent to the surgery over videoconference. The ophthalmologist will then put a patient straight on the waiting list and meet them when they turn up to perform surgery on an outreach visit. The organisation reported that performing 'short and sharp' visits in particular areas has allowed the team to travel on the Vision Van or visit other small towns for longer periods of time and do primary care with optometrists as well.

LOV indicated that the organisation also supports local capacity building and the expansion of telehealth across the region by establishing shared care arrangements with local providers. Specifically, LOV offers assistance to local health providers looking to expand their telemedicine services to support local eye health and ophthalmology service delivery. This includes providing education to local providers and staff, which includes visual acuity testing and retinal screening, to help increase their scope of practice. The organisation also discussed the capacity and ability to capture pictures of patients' eyes via a smartphone or camera which they noted can still provide quality images. The organisation is investigating additional ways to use everyday equipment to support telehealth and increase access to eye care.

Interviewees were very supportive of the service and commended LOV on its use of telehealth. One provider described LOV as "the gold standard of minimising appointments and maximising efficiencies."

Organisational relationships and key success factors

Stakeholders discussed Dr. Turner's long-term work experience in the region establishing and cultivating strong relationships with communities and local providers. Stakeholders reported that LOV has established a level of trust by being respectful, listening to communities and asking what the organisation can do for them. They also considered LOV's services, including the Vision Van, visible and well regarded. There was a view that LOV has also facilitated stronger relationships and engagement between optometrists and ophthalmologists. While one stakeholder feared that other providers may be prone to 'working the system' if this type of model was rolled out in other areas, they described LOV as a trusted and credible service.

Interviewees described LOV as less encumbered than the Department of Health and feel the organisation has a greater social mission than private organisations making it more agile and innovative in its approach to eye health in the region. Stakeholders reiterated the long-term commitment from LOV staff working with communities to improve eye health and described it as a key success factor. They reported that the establishment of a regional eye health service with employees who can service needs locally and provide outreach to smaller, more remote communities across the region has advantages in terms of responsiveness, continuity of service and cost effectiveness. They indicated that this model has also given the service greater ability to foster local partnerships and additional capacity to deal with the disease burden in the region.

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