A common vision: processes supporting regional eye care collaboration

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Introduction

Eye care is but one of the many specialist health care services provided within Aboriginal Community Controlled Health Services (ACCHS) and remote community health centres. Achieving positive eye care outcomes for these visiting services requires pro-active collaboration and two-way learning. Gaining and maintaining this stakeholder engagement can be challenging, but is a fundamental aspect of health system strengthening.¹

Aim

To support eye care improvements in the Katherine region of the Northern Territory, two non-government organisations (NGOs) have been working together over four years to strengthen links and facilitate regional collaboration. This paper outlines processes that were constructive and describes some of the positive impacts.

Methods

Upon feedback from the ACCHS, and observation of coordination challenges, key stakeholders in the Katherine Region articulated the need for intentional work to support collaboration for eye care. Eye care was one of the many specialist services provided within the primary health care setting and primarily delivered by visiting service providers.

A collaborative regional approach utilising participatory processes was undertaken to guide this process, involving three ACCHS, two NGOs (The Fred Hollows Foundation and Brien Holden Vision Institute), two government hospitals and a research centre (Vision CRC).

In a context where time and resources were limited, there were many challenges. These included a lack of communication between visiting Ophthalmology services, the hospitals and Aboriginal Organisations, limited support for the coordination of eye care services in the region and unacceptably long waiting lists for Ophthalmology. An analysis of the data revealed only a small number of communities were receiving visiting Ophthalmology services, the actual level of services were inadequate for the projected needs for the size of the population, efficiency was an issue indicated by high ‘did-not-attend’ rates and increasing combined waiting lists, due to limited Ophthalmology visits. When this information was fed back to the service providers—they all agreed that there was a strong need to support collaboration for eye care across the region. Most importantly, it was a process that the local stakeholders decided to participate in, rather than something that was being “imposed”, such as external NGOs coming in and “telling” how to make improvements.

With this strong commitment to collaboration, building a better understanding involved collecting a range of information to help understand where things were currently at across the region. This included undertaking regional eye care service mapping, collecting eye care service delivery data, gauging the ‘performance’ of the eye care system—according to stakeholders and patient and community perspectives on eye care and identifying the workforce availability and gaps. All this
information provided a comprehensive “current picture” on how the regional eye care system was performing.

In response to these findings, stakeholders collaborated to improve processes for eye care in the region. This was developed following structured conversation which invited individual perspectives then considered these in light of the broader stakeholder perspective. Helpful processes included an Eye Care Systems Assessment, focus-group guided enquiry, a polling process called ‘dotocracy’, and critical reflection. Importantly, these structured approaches happened on an existing platform of collaboration and trust between the stakeholders. This culminated in a regional, collectively owned eye care work plan, which articulated the “common vision”, prioritised activities, set targets, and listed responsibilities. Guided by this regional work plan, stakeholders worked together to improve regional eye care services. Activities included: increasing services towards population-based targets; addressing gaps in the local and regional eye health coordination workforce; continuous quality improvement (both service and system level); training in eye care checks and referral pathways for primary health care staff.

Results

The impact of this collaborative work over a few year period was noted: “impact” was gauged by comparing key outcome measures before and after the collaborative process of change. This included: clinical file audit data; regional eye care mapping data; regional eye care ‘systems assessment’ information.

Impact was noted in several areas:

- rates and frequency of optometry examinations increased
- percentage of people who had never had an optometry exam decreased
- rates of eye and vision assessments as part of routine primary health care assessments increased
- rates of annual dilated retinal examinations for people with diabetes increased
- frequency of referral and completion of referral pathways to ophthalmology increased
- available optometry and ophthalmology services provided to the region came closer to meeting the calculated population-based needs
- primary health care staff self-rated confidence performing routine eye and vision assessments improved
- mean performance “score” for the regional eye care system increased, most notably in the aspect of organisation of the regional eye care delivery system

Anecdotal observations were that relationships between stakeholders developed, communication improved and links between eye care and the ACCHS were strengthened over the course of the process of change.
Discussion

Improved coordination, integration and strategic alignment of projects was achieved using participatory methods. Taking a strengths-based approach, the various challenges for eye care (e.g. competing health priorities, accessing data, waiting lists, patient access barriers) were viewed as opportunities for improvement that were achievable by working together.

Some of the learnings from this project that are valued and are applicable to other projects include:

- Improved coordination, integration and strategic alignment of projects was achieved by using participatory methods and techniques.
- Taking a strengths-based approach was vital. Looking at the many challenges for eye care—for example the competing health priorities, access to data, waiting lists, patient access barriers etc—were viewed as opportunities for improvement that were achievable by working together.
- Collective responsibility led to collective action and a shared work plan articulated the ‘common vision’, it prioritised activities, set targets, and listed the responsibilities.
- Importantly, existing trust and collaboration among stakeholders underpinned the entire approach. It is vital that NGOs or other external stakeholders who intend to support improvements within Aboriginal communities do so on a basis of established and proven trust, and demonstrate a commitment to continue working there in the longer term. Current guidelines on the provision of sustainable eye care for Aboriginal and Torres Strait Islander Australians highlight the importance of commitment, continuity of relationship and a partnership approach to services. Whether participatory approaches are appropriate and how they are used in the cultural context should be determined by the people involved in the program. Traditional evaluation methods can be used in combination to inform the results. Participatory approaches can contribute to making the ‘measuring’ meaningful for everyone involved, and they are recognised as an effective and appropriate way of working with Aboriginal health services to support better health outcomes. It was important to consider that all evaluation activities that involve remote Aboriginal communities should be embedded within a community control model. Programs in remote Aboriginal communities need to consider specifics of local cultural, socio-economic and other health related traits, including the local and broader environments and systems, and community health-related structures, groups and services.

Relevance and conclusion

Celebrating achievements, embracing challenges and engaging widely were important aspects to this positive process of change for eye care across a region. The approach and tools are potentially helpful to apply in other regions, not only for eye care but for other specialty areas that must integrate with primary and tertiary care to achieve outcomes.

References


Presenter

Shaun Tatipata is an Aboriginal and Torres Strait Islander man with family connections in Cape York, Torres Strait and South Australia. Shaun has worked in Aboriginal and Torres Strait Islander health for over 16 years and is currently the Assistant Manager, Programs at The Fred Hollows Foundation’s Indigenous Australia Program (IAP). Shaun trained as an Aboriginal health worker in 2001 and since graduating he has gained experience delivering primary health care services and implementing outreach programs in both the Aboriginal community controlled health sector and with the Northern Territory Government. Shaun’s interests include strengthening service coordination through improved leadership and governance; and advancing the Aboriginal and Torres Strait Islander health practitioner profession.