Examine Australian Government Indigenous Ear and Hearing Health Initiatives

Final Report

SON2647271-24

To the Australian Government Department of Health

June 2017
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Purpose of project and examination questions

The Australian Government is providing approximately $36 million from the Indigenous Australians’ Health Programme (IAHP) over the period 2013-14 to 2018-19 for six programs that commenced in 2013 and comprise the Indigenous Ear and Hearing Health Initiatives.

The funded programs and activities aim to:

- increase access to coordinated primary, secondary and where required tertiary health services;
- improve timeliness of diagnosis, management and treatment;
- support health workforce to have the necessary skills and boost qualifications;
- provide information to raise awareness of ear health; and
- reduce the number of Indigenous people suffering avoidable hearing loss.

The funded programs and activities are intended to support the IAHP’s targeting of health conditions of high prevalence in the Aboriginal and Torres Strait Islander population (in this case eye, ear and oral health); and align with key domains in the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023, especially Health Systems Effectiveness (programs that focus on chronic disease including ear health), Childhood Health and Development (e.g. ‘facilitating strong, resilient children who are able to negotiate the world’) and Adolescent and Youth Health (e.g. ‘successful engagement in education and work’).

The six Australian Government currently funded programs are summarised in Table 1.

1. Healthy Ears – Better Hearing, Better Listening (HEBHBL) program
2. Surgical Support
3. Provision and maintenance of equipment
4. Training
5. Ear Health Coordinators
6. Care for Kids’ Ears

In addition to these programs the Australian Government provides the Clinical Care Guidelines on the management of Otitis Media in Aboriginal and Torres Strait Islander populations.

Not every program operates in every State or Territory; and not every program under examination has been operating for the same length of time. During the course of this project, an additional 12 months’ funding (for 2017-18) was extended to the Healthy Ears, Better Hearing, Better Listening Program and the Surgical Support program was extended for a further three years (2017-18 to 2019-20).

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1 Department of Health, Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023, Australian Government, Canberra, 2015
### Table 1. Australian Government Indigenous Ear and Hearing Health Initiatives

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Program Investment</th>
<th>Program Objectives</th>
<th>Program Activity</th>
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</table>
| **1. Healthy Ears Better Hearing Better Listening Program (HEBHBL)** | $24 million is provided for the HEBHBL for the period 2013-14 to 2016-17. | The objectives of the HEBHBL are to increase:  
- access to multidisciplinary care in primary health care settings; and  
- the range of services offered by visiting health professionals to prevent, detect and manage ear disease more effectively. | Increase access to a range of health services for Indigenous children and youth (0-21 years) for the diagnosis, treatment and management of ear and hearing health. |
| **2. Surgical Support**                          |                     | To expedite access to ear surgery for Indigenous children who have been on lengthy surgery waiting lists. | The initiative is focussed on rural and remote locations. Support is provided for the travel and accommodation costs of both the health professional and the patient and their carer. |
| **3. Provision and maintenance of equipment**    | $3.4 million is provided for Ear and Hearing Assessment Equipment for the period 2013-14 to 2018-19. | The objective of the ear and hearing assessment equipment program is to supply and maintain ear assessment equipment at no cost to Australian Government funded Aboriginal Medical Services and other health services with a predominance of Aboriginal and or Torres Strait Islander clients. | Provision of equipment is conditional on health services having trained staff to use the equipment. Training on the use of equipment is available free of charge to health professionals prior to the delivery of equipment. This training is provided through the Ear and Hearing Health Assessment Training initiative outlined below at item 4. |
| **4. Training**                                  | $2.6 million is provided for Ear and Hearing Assessment Training for the period 2014-15 to 2018-19. | The aim is to train health professionals to be able to more readily recognise clinical symptoms and behaviours indicating ear health issues and initiate early intervention or ongoing surveillance. | Ear and Hearing Health Assessment Training is available free of charge to improve the skills base of health professionals with clinical responsibilities who have regular contact with Indigenous children in their community. |
| **5. Ear Health Coordinators**                   | $2.9 million is provided for EHC’s for the period 2013-14 to 2018-19. An Ear Health Coordinator is employed in the Aboriginal Community Controlled Health Organisations state/territory peak organisations in NSW, QLD, SA, Vic and WA. | The primary objective of the Coordinator position is to work with Aboriginal and Torres Strait Islander communities to build skills and knowledge to enhance early identification of ear conditions, commencement of treatments and facilitate best practice care. | Ear Health Coordinators support Aboriginal Community Controlled Health Organisations (ACCHO’s) to better detect and manage ear disease at the jurisdiction level and link to other relevant services to maximise treatment and health outcomes. |
| **6. Care for Kids’ Ears (CFKE)**                |                     |                                                                                     |                                                                                                                                                                                                                  |

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2 Funding approved for 2017-18.
3 Note: Funding for the HEBHBL program in Tasmania was agreed during the course of the project and will commence on 1 July 2017. Although Tasmania has been delivering eye surgical support, to transport patients and their carers for eye surgery, the Tasmanian fundholder, the Tasmanian Department of Health, has to date not wished to participate in HEBHBL or Ear Surgical Support Programs.
4 The surgical support initiative has been operating as a pilot. As of 1 July, 2017, it will be fully implemented with all jurisdictions included.
In February 2017, the Department of Health engaged Siggins Miller Consultants to undertake an examination of the progress and outcomes to date of the six funded programs. It is intended that this examination’s findings will enable an assessment of the effectiveness, efficiency and appropriateness of ear and hearing health activities nationally; and that the examination will:

- assess the extent to which objectives of the individual activities have been achieved;
- review equity of access to services;
- identify opportunities to improve implementation, linkages and coordination of Australian Government initiatives to enhance efficiency and effectiveness and improve the patient journey; and
- consider opportunities for additional Australian Government activity.

To achieve this, the Department suggested the following preliminary examination questions (Table 2), for application to both individual programs and to the Australian Government Indigenous Ear Health Initiatives as a suite of programs:

**Table 2.**

<table>
<thead>
<tr>
<th><strong>Key examination questions</strong></th>
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<tbody>
<tr>
<td><strong>To what extent are the initiatives achieving their objectives?</strong></td>
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<tr>
<td><strong>How do the initiatives contribute to improved Indigenous ear health and hearing outcomes?</strong></td>
</tr>
<tr>
<td><strong>How well are the programs and services operating, individually and as a suite?</strong></td>
</tr>
<tr>
<td><strong>How efficient and effective are the processes, structures and systems for the delivery and monitoring of the programs and services?</strong></td>
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<tr>
<td><strong>Equity of access:</strong></td>
</tr>
<tr>
<td>- How are service locations prioritised?</td>
</tr>
<tr>
<td>- Are patients prioritised if there is a waiting list? How does this occur?</td>
</tr>
<tr>
<td><strong>How well aligned, coordinated and linked are the programs and services with other ear health and hearing services, including those provided by state government and the non-government sector?</strong></td>
</tr>
<tr>
<td><strong>What are the challenges and enablers for the initiatives?</strong></td>
</tr>
<tr>
<td><strong>How could the programs and services be strengthened or improved?</strong></td>
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</tbody>
</table>

It should be emphasised that the purpose of this project is not to conduct an audit or to review the performance of organisations or individuals. Nor is the purpose to identify demand for services or measure prevalence or unmet need. Rather, the project’s purpose is to examine the systems and process of the programs and their effectiveness, and to obtain stakeholder advice about how the current Australian Government investments could be strengthened or improved.
<table>
<thead>
<tr>
<th>Glossary of terms</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACCHOs</td>
<td>Aboriginal Community Controlled Health Organisations</td>
</tr>
<tr>
<td>AHCSA</td>
<td>Aboriginal Health Council of South Australia</td>
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<tr>
<td>AHCWA</td>
<td>Aboriginal Health Council of Western Australia</td>
</tr>
<tr>
<td>AHW</td>
<td>Aboriginal Health Worker</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<tr>
<td>AMS</td>
<td>Aboriginal Medical Service</td>
</tr>
<tr>
<td>APY</td>
<td>Anangu Pitjantjatjara Yankunytjatjara</td>
</tr>
<tr>
<td>ASAP</td>
<td>Audiometry Screening and Assessment Program</td>
</tr>
<tr>
<td>CFKE</td>
<td>Care for Kids’ Ears</td>
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<tr>
<td>CPD</td>
<td>Continuous Professional Development</td>
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<tr>
<td>CtG</td>
<td>Closing the Gap</td>
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<tr>
<td>DE</td>
<td>Deadly Ears</td>
</tr>
<tr>
<td>DNA</td>
<td>Do Not Attend</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
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<tr>
<td>EACS</td>
<td>Enhanced Aboriginal Child Schedule</td>
</tr>
<tr>
<td>EESS</td>
<td>Eye and Ear Surgical Support</td>
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<tr>
<td>EHC</td>
<td>Ear Health Coordinator</td>
</tr>
<tr>
<td>EN</td>
<td>Enrolled Nurse</td>
</tr>
<tr>
<td>ENT</td>
<td>Ear, Nose, Throat</td>
</tr>
<tr>
<td>EOI</td>
<td>Expression of Interest</td>
</tr>
<tr>
<td>FaFT</td>
<td>Families as First Teachers</td>
</tr>
<tr>
<td>FAQs</td>
<td>Frequently Asked Questions</td>
</tr>
<tr>
<td>FASD</td>
<td>Fetal Alcohol Spectrum Disorders</td>
</tr>
<tr>
<td>FIFO / DIDO</td>
<td>Fly-in Fly-out / Drive-in drive-out</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HEBHBL</td>
<td>Healthy Ears - Better Hearing, Better Listening</td>
</tr>
<tr>
<td>HHS</td>
<td>Hospital and Health Services</td>
</tr>
<tr>
<td>IAHP</td>
<td>Indigenous Australians’ Health Programme</td>
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<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>LHD</td>
<td>Local Health District</td>
</tr>
<tr>
<td>MoU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>NACCHO</td>
<td>National Aboriginal Community Controlled Health Organisation</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organisation</td>
</tr>
<tr>
<td>NSW</td>
<td>New South Wales</td>
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<tr>
<td>NT</td>
<td>Northern Territory</td>
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<tr>
<td>OAE</td>
<td>Otoacoustic emission</td>
</tr>
<tr>
<td>OM</td>
<td>Otitis Media</td>
</tr>
<tr>
<td>PHN</td>
<td>Primary Health Network</td>
</tr>
<tr>
<td>QAIHC</td>
<td>Queensland Aboriginal and Islander Health Council</td>
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<tr>
<td>QI</td>
<td>Quality Improvement</td>
</tr>
<tr>
<td>QLD</td>
<td>Queensland</td>
</tr>
<tr>
<td>RACs</td>
<td>Royal Australasian College of Surgeons</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>--------------</td>
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<tr>
<td>RAICCHO</td>
<td>Regional Aboriginal and Islander Community Controlled Health Organisation (Qld only)</td>
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<tr>
<td>RDWA</td>
<td>Rural Doctors Workforce Agency</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>RTO</td>
<td>Registered Training Organisation</td>
</tr>
<tr>
<td>RVEEH</td>
<td>Royal Victorian Ear and Eye Hospital</td>
</tr>
<tr>
<td>SA</td>
<td>South Australia</td>
</tr>
<tr>
<td>SEQ</td>
<td>South East Queensland</td>
</tr>
<tr>
<td>TAS</td>
<td>Tasmania</td>
</tr>
<tr>
<td>VAHS</td>
<td>Victorian Aboriginal Health Service</td>
</tr>
<tr>
<td>VIC</td>
<td>Victoria</td>
</tr>
<tr>
<td>VMO</td>
<td>Visiting Medical Officer</td>
</tr>
<tr>
<td>WA</td>
<td>Western Australia</td>
</tr>
<tr>
<td>WACHS</td>
<td>Western Australia Country Health Services</td>
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</tbody>
</table>
Executive summary

Indigenous communities in parts of Australia have rates of chronic middle ear disease (Otitis Media, OM) that are classified by the World Health Organisation (WHO) as a massive public health problem needing urgent attention. The hearing impairment produced by OM affects ability to learn; and development of the disease to its chronic suppurative stage (CSOM) is linked to inadequate antibiotic treatment, frequent upper respiratory tract infections, nasal discharge, and poor living conditions with poor access to medical care. Poor housing, hygiene and nutrition are also associated with higher prevalence rates.

The Australian Government, through the IAHP, currently invests in six programs that aim to: increase access to coordinated primary, secondary and where required tertiary health services; improve timeliness of diagnosis, management and treatment; support health workforce to have the necessary skills and boost qualifications; provide information to raise awareness of ear health; and reduce the number of Indigenous people suffering avoidable hearing loss.

The Australian Government’s investment is conceptually sound in its elements (improving access to primary and secondary care; overcoming barriers to accessing surgery; providing training, equipment and support; providing resources for practitioners, teachers and families to support prevention).

The programs have different histories, different durations and not every program is available in every State. Except for an evaluation of the resources program Care for Kids’ Ears, the other programs – outreach (HEBHBL), surgical support, equipment provision, training and coordination roles in State ACCHOs – have not been independently examined for their effectiveness and efficiency.

This examination reviews the systems and processes of the six programs and their effectiveness, and obtains stakeholder advice about how the current Australian Government investments could be strengthened or improved. The project is not an audit or a performance review of organisations, nor is the purpose to identify demand for services or measure prevalence or unmet need. Indeed, a clear message from the findings is the ongoing lack of data and processes across the whole health system (Federal, State, NGO) to identify need and any progress towards addressing this.

Many stakeholders felt that a specific target and measure for ear health in the Closing the Gap program would coalesce disparate efforts across different providers of ear health services (e.g. Commonwealth/State/Territory) to achieve the necessary, systematic information collection. The 2017 Budget announcement of investment in a national opt-out My Health Record approach is an opportunity to build this data, using this existing infrastructure as it is further developed over the next two years.

There are, however, whole-of-health-system issues that are reducing the investment’s effectiveness. A fundamental obstacle is that ear health appears to be a lower priority than is warranted, especially considering the lifelong impact of hearing impairment on all other aspects of the health and wellbeing of individuals and on Closing the Gap at a population level.

The Indigenous ear health sector, although small and less prominent than other disease-specific areas of Indigenous health, is complex and varied. No two jurisdictions are the same and the approaches and levels of investment by State governments and NGOs vary considerably. In the NT, the investment has a longer history and the HEBHBL funds, for instance, are contributing to part of a Territory-wide program that is funded from two Federal sources. In other States (e.g. Qld, NSW and WA), there are State Health department activities co-existing with Federally funded programs.

A key finding of this research is that, among service providers and other stakeholders, there are low levels of awareness that the Commonwealth is investing in the six programs, and of how and why it is investing. There was considerable misunderstanding and misinformation, even among experienced service providers, all of which could be remedied by improved communications and more promotion of the government’s investment. This lack of awareness is compounded by high rates of staff turnover in the Indigenous health sector and in government.

The data from July 2014 to March 2017 show that the HEBHBL outreach program has been effective in increasing access to coordinated primary and secondary care, with an estimated 106,087 patients nationally accessing an ear health service in up to 406 locations.

The surgical support program (more recently introduced in response to long waiting times for Indigenous children and the challenges of distance and remoteness), has had mixed success in coordinating access to tertiary care (i.e. surgery), due to systemic barriers consistently identified in some States. These barriers, which include credentialing of ENT surgeons and some public hospitals failing to prioritise access for the most disadvantaged Indigenous children, have made it challenging for some implementing organisations to arrange surgeries. Nevertheless, since commencement in 2015-16 to 31 December 2016, the program has expedited surgery for 190 children who would otherwise be on long surgical waiting lists. Issues of poor coordination raised by stakeholders, when explored, often related to non-program factors like workforce credentialing or access to theatre time in public hospitals, or simply to not knowing who to contact (a communication issue).

In some States, where there is separate State funded or independent NGO activity in Indigenous ear health, communication and coordination arrangements are not always ideal. Even though HEBHBL links with existing established coordination and governance processes used for other Federal outreach programs at the State level, there are still reports of poor information sharing between providers. The governance process for HEBHBL consists of State/Territory Advisory Fora that also govern other Australian Government outreach programs such as the Medical Outreach - Indigenous Chronic Disease Program (MOICDP). The HEBHBL program is but one of several outreach programs governed by this structure, and is a ‘smaller player’. Stakeholder representation is broad, but representation of an organisation in the State Advisory Forum does not guarantee that the right people in that organisation then know about HEBHBL activity.

Between Federally funded programs, there are opportunities for better communication and collaboration leading to greater efficiencies, particularly with Australian Hearing. Creating these opportunities may involve change to legislation or regulations that govern Australian Hearing, but could help to better address workforce shortages, training support on site and reduce travel.

The logic of the equipment provision and training programs is that the training program will provide the skills for primary health care staff in communities to effectively use the equipment to screen for ear problems and refer children where appropriate. Both programs are free to health services with predominantly Indigenous clients. From 1 July 2016 to 31 December 2016 1,137 pieces of equipment was provided to 171 clinics nationally. Most survey respondents who have equipment in their services reported using it regularly. This, however, was a small survey sample and, on the contrary, interviewees reported unused equipment sitting in health services because of staff turnover and the loss of skills. Gaps in the processes and data capture were identified and these are addressed in the recommendations.

The training program is effectively meeting its KPIs, which are based on numbers of courses offered per year, their locations (outside metropolitan centres - 64% of courses) and the mix of health professionals attending them. In the first 18 months of the program (July 2015 - December 2016) a total of 1,137 pieces of equipment was provided to 171 clinics nationally. Most survey respondents who have equipment in their services reported using it regularly. This, however, was a small survey sample and, on the contrary, interviewees reported unused equipment sitting in health services because of staff turnover and the loss of skills. Gaps in the processes and data capture were identified and these are addressed in the recommendations.

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whether the training is reaching health services staff in the areas of most need. From stakeholder advice, the elements of a good Indigenous ear health training program are presented to guide any future program revisions (Table 4, p. 67).

The Care for Kids’ Ears resources are regarded positively by service providers who are aware of them (43% of survey respondents), but orders for the resources are slowing down, possibly reflecting lower awareness as staff members leave and little promotion of the resources. Useful advice on enhancing the resources and the website was provided by stakeholders. The resources are regarded by stakeholders as part of what should be an extensive, ongoing and persistent national public health and education campaign about the causes and outcomes of chronic ear disease.

Many stakeholders emphasised the importance of increasing and concerted effort in working with communities to ‘de-normalise’ ear disease and increase awareness of bacterial infection and how to prevent it. This could be coordinated across outreach programs, which are all working to improve the same environmental factors contributing to chronic disease.

There is increasing consensus that the focus of attention needs to shift to 0-4 year-olds, with the literature, service providers and planning advising that ‘school age’ may be too late. This will have implications for how staff are trained and the equipment they are trained to use.

The Australian Government’s OM Clinical Care Guidelines are influential and there is evidence of their increasing use by service providers. However, in attempting to implement the clinical care pathways outlined in the Guidelines, service providers and planners working in the outreach programs are facing systemic barriers to delivering timely care to children. There are longstanding structural barriers between Federal, State and even regional health authorities, that are impeding access to secondary and tertiary care and to essential data for effectively addressing the burden of ear disease in Indigenous communities.

The potential de-skilling of the primary health care workforce is a risk to this and other outreach programs. Where staff in Indigenous communities are managing multiple visiting teams treating multiple diseases, they risk becoming coordinators rather than health carers. More training and ongoing support in ear health care for health workers in Indigenous communities is essential. The opportunities of new ear health technology have the potential to change the way care is provided to Indigenous children. These will have repercussions for government investment in the near future.

The system-related issues are considerable and these are addressed in the recommendations.
**Recommendations**

**At the program level (Australian Government)**

<table>
<thead>
<tr>
<th>1</th>
<th>Let people know about the Australian Government’s investments in Indigenous children’s ear health – what it is doing, why it is doing it and how to find out more about it. This would involve more promotion and communication to Aboriginal and Torres Strait Islander communities, service providers, Aboriginal and Torres Strait Islander peak bodies, State governments and other potential stakeholders.</th>
</tr>
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<tbody>
<tr>
<td>2</td>
<td>Strengthen the HEBHBL service delivery standards, to require fundholders to inform all Indigenous communities in their jurisdiction about availability of ear health services. This will take time and repeated contacts, but will improve equity of access and needs-based prioritisation of service locations. Allow time and resources for this process as part of the annual activity planning cycle.</td>
</tr>
<tr>
<td>3</td>
<td>Require (rather than recommend) adherence to the National OM Clinical Care Guidelines as a condition of Commonwealth funding. This would apply to funding agreements with fundholders, and to fundholders’ subcontracts with service providers.</td>
</tr>
<tr>
<td>4</td>
<td>Support a communication campaign to service providers, healthcare and education organisations to promote the use of the updated National OM Clinical Care Guidelines, when finalised.</td>
</tr>
<tr>
<td>5</td>
<td>Focus on building and maintaining the capacity of primary health care in Aboriginal Community Controlled Health Organisations (ACCHOs) to provide effective assessment, referral and follow up. Consider providing incentives to ACCHOs to do so.</td>
</tr>
<tr>
<td>6</td>
<td>Focus on achieving early identification of ear disease in 0-4 year-olds, using agreed age points for testing in primary health services.</td>
</tr>
<tr>
<td>7</td>
<td>Increase use of telehealth/virtual care that is redesigned around convenience for patients, as well as best use of the specialist workforce - both audiologists and surgeons. This would align with other parts of Commonwealth health reform, like Health Care Homes, that seek to redesign models of care around patients.</td>
</tr>
<tr>
<td>8</td>
<td>Review the list of equipment available for supply to ensure it supports advances in technology and services for younger children.</td>
</tr>
<tr>
<td>9</td>
<td>Use the efficiencies from greater use of technology to reach more people, more often in local communities for screening, for diagnosis and for post-operative follow up.</td>
</tr>
<tr>
<td>10</td>
<td>Modify models of care to fit the 0-4 year-old focus of the HEBHBL program and, eventually, to utilise new technologies.</td>
</tr>
<tr>
<td>11</td>
<td>Use the similarities between the HEBHBL program and other Australian Government Indigenous health programs to produce efficiencies and clear messaging, especially where health promotion and prevention activities require the same work in the same locations (such as hygiene promotion, nutrition, smoking cessation, breast feeding promotion).</td>
</tr>
<tr>
<td>12</td>
<td>Review the structure, membership and procedures of the State Advisory Forums, as they relate to ear health. In particular, review how information is shared between agencies and providers; and</td>
</tr>
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6 *Recommendations for clinical care guidelines on the management of Otitis Media in Aboriginal and Torres Strait Islander populations*. The Guidelines are currently being updated, funded by the NH&MRC.
disseminated within Forum member organisations. This could include developing role descriptions and expectations of Forum chairs and representatives.

13 Explore the ways existing national infrastructure and resources can be better used for integrated service delivery, e.g. how the role of Australian Hearing audiologists might be expanded; or incorporating the Australian Hearing’s Specialist Program for Indigenous Australians (AHSPIA)\(^7\) into a single outreach program with HEBHBL, or at least aligning the KPIs, client age range (0-26), planning and schedules of the two Commonwealth programs.

14 Move to six monthly reporting in the HEBHBL program and review the essential data that is required, especially if agreed clinical data is to be recorded at primary health services in communities and accessible via My Health Record.

15 Increase the financial delegations of HEBHBL fundholders to vary their planned annual activities.

16 Review the purpose and roles of Ear Health Coordinator (EHC) positions that are located in ACCHO state/territory peak organisations. Clarify how these roles can better align with the fundholders’ State and Regional Coordinator roles in the HEBHBL program.

17 Maintain the current Care for Kids’ Ears Resources. Consider developing more resources for parents whose children require surgery (or promoting existing relevant state-based resources); and promoting all the State based resources on the CfKE website to develop a complete national repository of current resources. Freshly promote the availability of the resources and the website through existing stakeholders and through targeted media channels.

### At the health system level nationally (Commonwealth and State and Territory Governments)

18 Raise awareness across the health, education, housing, police and corrections systems of the burden of Indigenous ear health disease and the lifelong disadvantage for Indigenous people if it is untreated. Explore ways to achieve cross-sectoral action to address the social determinants of ear disease and to improve the health outcomes for Indigenous people living with or at risk of ear disease and hearing loss.

19 Prioritise the need to address Indigenous children’s ear health nationally. Create a specific Closing the Gap target and measure for Indigenous ear health that identifies key areas for action by all stakeholders.

20 Reflect this priority in Commonwealth and State partnership and contractual arrangements, especially for making surgical theatre time available and credentialing ENT surgeons working in outreach programs.

21 Treating surgeons should be encouraged to use the discretion provided in the Guidelines\(^8\) to follow the escalation principles in their respective state or territory and accelerate access to curative ear surgery.

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\(^7\) Currently funded by the Department of Human Services. The outreach program focuses on provision of services to people with permanent hearing loss (e.g. hearing aids, classroom amplification)

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<td><strong>22</strong></td>
<td>Clarify the respective roles and expectations of the Commonwealth and States/Territories in addressing the burden of Indigenous ear disease. Formulate cooperation between the levels of government in planning, collaborating or complementing service provision and sharing information.</td>
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<tr>
<td><strong>23</strong></td>
<td>Develop an agreed ear health data set that is relevant to all jurisdictions.</td>
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<td><strong>24</strong></td>
<td>Build data collection into the day to day operations of all services delivering Indigenous ear health programs, with a view to eventually incorporating these data into My Health Record. This will become a nationally accessible patient information and data collection system. This data collection could also be informed by the recently developed seven Primary healthcare indicators for otitis media (OM) in Aboriginal and Torres Strait Islander children or by other regional work, such as the Aboriginal Health Council of South Australia’s ‘ear health tabs’ in the existing Communicare system or the NT’s data collection formats.</td>
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<tr>
<td><strong>25</strong></td>
<td>Assess emerging technologies and the potential for greater use of technology in ear health – in a concerted way, nationally. This may involve collaboration with the Australian Digital Health Agency to invest in linking the uploaded ear health data from a proprietary cloud to My Health Record.</td>
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<tr>
<td><strong>26</strong></td>
<td>Use system level improvements, together with a national evaluation framework, to contribute to a National Strategy and Framework for Indigenous Ear Health.</td>
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**Workforce**

| **27** | In collaboration with NACCHO, explore better use of previously developed resources by that organisation, together with the currently funded shorter training programs, have the potential to be modified and used to support training that will reflect the elements of a good training model that were identified by stakeholders (see page 62). |
| **28** | In reviewing the Indigenous ear health curriculum, ensure that the skills and equipment training aligns with the focus of the program, e.g. 0-4 year olds; and upskills the workforce in telehealth and new ear health assessment devices. |
| **29** | Make it a requirement for all visiting service professionals to provide upskilling and supervision of the local health workforce at each visit. |
| **30** | Engage clinicians in brief training/updates to support the investment in new and existing eHealth technologies. |
| **31** | Use a teaching and learning shared care approach, supported by increased use of distance communication technology. This could involve, for example, the concept of the "e huddle" - that brings staff together to debrief or handover for staff who work remotely; and would contribute to continuous quality improvement and risk management. Fundholders could facilitate this, if the funding model allowed. |

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10 Sibthorpe et al. 2017. See Literature Review
Conclusions

Based on all the findings, the conclusion we draw is that the Australian Government’s investment has facilitated and improved access to multidisciplinary ear health care for Indigenous children and young people in 406 locations across Australia. Over the 2.75-year period studied, there have been an estimated 106,087 patients seen during outreach visits nationally. More recently, the investment has expedited the surgical treatment of 190 children. These are services that, in most cases, children would not have received at all, or would not have received as frequently or as quickly.

The scant evidence that we have of health outcomes (e.g. from the NT data) and of the waiting lists for children still needing attention suggests that, despite considerable Federal and State investment, the burden of disease is not declining significantly. The first step in addressing this, as suggested by stakeholders (and supported by the evidence we have collected), is extensive and prolonged public health education, supported by genuine cross-agency action to address the social determinants of ear disease.

The Australian Government’s OM Clinical Care Guidelines are influential and there is evidence of their increasing use by service providers. The Guidelines spell out a care pathway for Indigenous children with (or at risk of developing) ear disease. However, service providers and planners working in the outreach programs are facing systemic barriers to following this pathway and delivering timely care to children.

These barriers are reported to be the result of longstanding system issues, such as:

- separate clinical credentialing processes for private and public sector hospitals in the same towns
- the lack of appropriate item numbers in the MBS for Indigenous ear health
- failure to record Aboriginality in outpatient clinic records that in turn means planning for increasing access is difficult or impossible
- practices in the management of specialist outpatient clinics in State health services that disadvantage Aboriginal families who must travel from remote and very remote communities.

Barriers such as these are impeding access to secondary and tertiary care and to essential data for effectively addressing the burden of ear disease in Indigenous communities.

The potential de-skilling of the primary health care workforce is a risk to this and other outreach programs. Where staff in Indigenous communities are managing multiple visiting teams that are treating multiple diseases, they risk becoming coordinators rather than health carers. More training and ongoing support in ear health for health workers in Indigenous communities is essential. The opportunities that new ear health technologies provide have the potential to change the way care is delivered to Indigenous children. These technologies will need to be assessed for their appropriateness, feasibility, quality and safety, but they have the potential to increase access to timely care for more Indigenous children and young people.

Much of the success of the program relies on the commitment, goodwill and persistence of the health professionals who work in the programs and those who plan the logistics. Some interviewees described the Australian Government funded outreach programs as a ‘patch up’. In many ways, they are indeed a ‘patch up’ they are also addressing systemic problems in the short-medium term. They are patching up gaps where other outreach programs are not providing services, they are helping other services to get their specialist staff out into communities, they are paying to train the ear health workforce and to develop career pathways and to ensure the workforce has the equipment it needs, they are supporting Aboriginal health services to manage the competing demands on their time and resources.
We have made several recommendations about: how to improve the effectiveness and efficiency of the investment at the program level; how the health system level activity could enhance the program; and how the workforce’s capacity to support improved Indigenous ear health outcomes could be enhanced.
**Brief Methodology**

The Department identified the key examination questions it sought to answer. The research process applied these questions both to individual component programs/activities and to the program as a whole, where appropriate.

To comprehensively address the progress and outcomes to date of the six funded programs/activities (and of the program as a whole), a mixed-method approach was used, consisting of:

- Literature and document review;
- Mapping of services providing Indigenous ear and hearing health activities;
- Analysis of available service/activity data;
- Consultation with key stakeholders;
- Survey (online) of health professionals providing ear health services to Aboriginal and Torres Strait Islander children and youth in rural and remote areas;
- Visits to fundholders, service providers and key groups in relevant States and Territories; and
- Analysis and synthesis of issues and evidence from all the above sources.

**Literature and document review**

Originally intended as a rapid review of international peer-reviewed and grey literature, the literature review has remained a ‘living document’ throughout the project, with literature and data relating to any issues raised by stakeholders added to the review as required (e.g. the publication of new State strategies or the release of more recent data or other documents published during the time frame of the review).

The review sought to describe current prevalence of and issues relating to the ear and hearing health of Indigenous people - in particular, of Indigenous Australian children and youth in rural and remote areas. The review also sought to describe the current status of Indigenous ear health programs and research, and to describe recent literature on the impact of ear disease and hearing loss on Indigenous people if it goes untreated.

For each program/initiative, all relevant documents made available by the Department were reviewed. These were predominantly documents for the 2014-15 and 2015-16 financial years; and for the first two quarters of the 2016-17 financial year. The documents included:

- Standard contracts with fundholders (e.g. rural workforce agencies; ACCHO state/territory peak organisations) and service providers (e.g. Sonic Innovations and Benchmark);
- Activity reports, progress reports and acquittal reports of fundholders and service providers to the Department;
- Policy and procedural documents relevant to each program/initiative, and to the program as a whole;
- Other documents/reports provide by the Department.

**Mapping of services**

To the extent that the relevant information was available from the Department or from the fundholders and/or from the State/Territory departments, Siggins Miller mapped the Indigenous ear and hearing health services in each jurisdiction that are currently funded (either federally or by States/Territories or by the non-government sector). The purpose of the mapping was to identify the geographic spread and reach of ear and hearing health services for Indigenous communities; and any gaps, overlaps or duplication of services. Where possible, existing linkages between services were mapped. Qualitative data from the consultations contributed to this mapping.

**Analysis of available service/activity data**

Depending on the activity and the data available, Siggins Miller analysed service and activity data relating to each initiative, from July 2014 to December 2016.
Consultations

Three consultation approaches were used, as follows:

Key stakeholders - semi-structured interviews

Interviews were conducted for those stakeholders with a higher level of involvement with the initiatives (e.g. fundholders; service providers directly funded by the Department; policy makers and other Departmental officers (Commonwealth and State/Territory); and representatives of interest groups, alliances or networks, prominent senior clinicians, researchers and others influential in Indigenous ear health).

Face to face interviews – frontline health professionals and their representatives

We conducted site visits to each State/Territory where fundholders are providing health services, workforce support or equipment services in rural and remote locations (e.g. HEBHBL, Surgical Support and/or Ear Health Coordinator roles). Where possible, small group interview or focus groups were arranged with the assistance of the local fundholder.

For the personal stakeholder consultations (telephone and face to face; and for group consultations), the target of n=60 was exceeded. At the conclusion of consultations, n=65 stakeholders had been interviewed and n=16 participants had attended focus groups.

Online survey (health professionals and direct service providers)

An online survey was disseminated (via fundholders and peak bodies) to AMSs, ACCHOs, PHNs outside metropolitan areas and other organisations or health professionals providing ear and hearing health services to Indigenous children and youth.

The survey covered similar areas of questioning (based on the examination questions), but consisted of a mix of quantitative data collection (Likert scales, tick boxes) and qualitative data collection (free text for opinions, reasons, suggestions). Questions about Ear Health Coordinator program were not included, because these are in effect five individual positions and it was not appropriate as the subject of a survey.

The target of online survey respondents was n=70. The survey closed on 13 April 2017 and 148 people had started the survey, and 71 people completed it.

Contribution analysis

From the above data sources, non-program factors that may impact upon the Indigenous ear health initiatives were identified. This allowed Siggins Miller to reflect, in a measured way, on the contribution of both program and non-program (or contextual) factors to answers to the examination questions.

Triangulation of data

Data were collected and analysed from the different sources. Data from each source are reported by initiative/activity, but taken together (triangulated) to formulate overall conclusions and to cross-check the quality of the data from any single source.

Limitations of the data

The time frame for the project (February-May) allowed for a relatively short period to disseminate invitations to participate in the survey. The strategy to overcome this was to use the assistance of third parties (fundholders, peak bodies, interest groups etc.) to circulate invitations to their memberships or service providers, using their established contact lists. The jurisdictional representation of survey respondents, therefore, is skewed towards WA, SA and Qld. In some cases,

11 To be counted as ‘starting the survey’ a respondent would have clicked the link and read the opening page which explained the project and the survey. 45 people did not proceed from this first page.
a jurisdiction preferred to use focus groups with service providers, in another case the peak body had only recently surveyed their membership and felt it would be ‘overload’ to disseminate a survey for this purpose. In the case of some stakeholders, there was preference expressed for on-site visits by the researchers to rural and remote Aboriginal health services to speak with staff, which the project could not accommodate given timeframes and budget. Nevertheless, the survey achieved its target number of respondents; 18.5% of respondents identified as being of Aboriginal or Torres Strait Islander descent; and the spread of service provider roles reflected the Indigenous ear health workforce, except for the low number of speech pathologists responding.

Another limitation was the incompleteness of some clinical data in HEBHBL program reports and the different ways of recording data in the NT versus other jurisdictions. This means that the numbers of activities and patients reported do not necessarily reflect the full level of activity for HEBHBL; and cross-program measures for HEBHBL are not readily available. Siggins Miller did not have access to activity data from some separate state-based programs, or to the activities of NGOs. In some cases (especially WA, where both WACHS and several NGOs are operating) this restricted the capacity to meaningfully identify overlap or duplication. In such cases, the findings are heavily reliant on stakeholder feedback and the HEBHBL data only.
Current government investments in the ear health of Indigenous children and young people

The six Australian Government funded programs

For all the following programs, contract management is the responsibility of the relevant Commonwealth Department of Health, State Network Office. Policy direction and oversight are the responsibility of the Program, Services and Access Support Branch, Indigenous Health Division, Department of Health.

Healthy Ears - Better Hearing, Better Listening (HEBHBL)\(^\text{\tiny 12}\)

($24 million for the four-year period 2013-14 to 2016-17; all jurisdictions except Tasmania)

The primary goal of the HEBHBL program is to improve access to ear and hearing health services for Indigenous children and young people aged 0-21 years.

Using the model established for the Medical Outreach - Indigenous Chronic Disease Program (MOICDP), HEBHBL funding agreements are in place with established fundholders who then subcontract with service providers to deliver hearing services in Indigenous communities. With the exception of the NT\(^\text{\tiny 13}\), HEBHBL fundholders are rural workforce agencies or former general practice workforce agencies that are already delivering Australian Government Indigenous outreach programs in their jurisdiction.

Any interested party can submit a HEBHBL service proposal application to the fundholder, but fundholders are also expected to undertake needs assessments to identify the communities in most need, to prioritise locations and to ensure that HEBHBL services complement any existing services provided by jurisdictional governments or other providers.

Services are endorsed by a State/Territory-based Advisory Forum for needs assessment, planning, coordination, and planned annual activity. These fora also endorse the other Australian Government outreach programs, such as the Medical Outreach Indigenous Chronic Disease Program.

There are specified models of care which are funded under HEBHBL, but the preferred model of care is a multidisciplinary team-based approach where service provision is provided to communities by service providers travelling to these locations from a larger town; and adhering to The Clinical Care Guidelines on the Management of Otitis Media in Aboriginal and Torres Strait Islander Populations. Fundholders are required to ensure that health professionals visiting Indigenous communities have completed cultural awareness training.

HEBHBL does not pay for health professionals’ services. It coordinates their participation in service delivery and pays for: the cost of travel and accommodation, backfilling of salaried medical staff; an absence from practice allowance for non-salaried private health professionals. The provider is compensated for the service through using (preferably bulk billing) items under the Medical Benefits Schedule (MBS). In some exceptional circumstances, payments are available, through a workforce support payment in remote and very remote areas.

Surgical Support

($1.9 million across Queensland, South Australia, Victoria and Western Australia over 2 years – 2015-16, 2016-17)

The Surgical Support funding for ear health is a subset of the larger Eye and Ear Surgical Services Program (part of the Indigenous Australians Health Programme). The fundholders and specifications for surgical support are the same as for HEBHBL, except that the funding agreement requires fundholders to ensure appropriate levels of pre- and post-operative care and funding is provided to

\(^\text{\tiny 12}\) Source: HEBHBL Service Delivery Standards

\(^\text{\tiny 13}\) In the NT, the NT Department of Health is the fundholder. -
support the patient (and one carer) by arranging and paying costs associated with travel to and from
the surgery location; pre- and post-operative accommodation, meals and incidentals.

**Provision and maintenance of equipment**
(Nationally available: $1.4 million over 3 years 2016-17 to 2018-19.)

The equipment program supplies, maintains, calibrates (annually) and repairs hearing assessment
equipment provided at no cost to AMSs, ACCHOs and other services with predominantly Aboriginal
and Torres Strait Islander clients. Having staff completing a training course is a pre-requisite for a
health service to be eligible for the equipment program.

The program is managed by a single fundholder, Audmet Australia Pty Ltd, trading as Sonic
Innovations, which is based in Brisbane.

**Ear and Hearing Assessment Training**
(Nationally available: $2.6 million over 5 years 2014-15 to 2018-19)

The Ear and Hearing Assessment Training program’s objectives are to improve the skills base of
health professionals who have regular contact with Indigenous children in their community so that
they: use ear assessment equipment; are able to more readily recognise clinical symptoms and
behaviours indicating ear health issues; and initiate early intervention or ongoing surveillance.

To achieve this, Benchmarque has been contracted to deliver accredited training programs to health
professionals who work with Aboriginal and Torres Strait Islander patients to specialise and/or
increase their knowledge of ear and hearing health conditions. These courses are: *Otitis Media and
Aural Health Care* (1 day) and *Audiometry Screening and Assessment* (3 days). Training is to be
delivered in metropolitan, regional, rural or remote settings and tailored to suit the clinical needs of
participant profiles to maximise attendance and participation. Courses may be to a single clinical
profile or to a clinic with a mix of clinical workforce. All training is expected to be sympathetic to the
clinical setting and referral pathways of participants.

The Benchmarque program has been providing since July 2015. A training program was previously
provided by NACCHO. Examination of the NACCHO program is out of scope for this project.

**Ear Health Coordinators**
($2.1 million for the four-year period 2015-16 to 2018-19. in NSW, QLD, SA, Vic and WA).

This program funds the ACCHO state/territory peak organisations in the above States to engage an
Ear Health Coordinator (EHC). The EHC’s role is to:

- Undertake needs assessments to determine current ear health needs, gaps in ear health
  services and workforce skill sets across the jurisdiction;
- Address identified gaps in services to meet the needs of children living with ear disease,
  including referral pathways to care providers and secondary and tertiary ear health services
- Enhance ear health outcomes including prevention of ear disease through improved clinical
  and community practices;
- Plan and implement ear health services, activities, programmes with consideration given to
  existing resources, i.e. staffing, equipment etc. and available Commonwealth and state
  health programmes; and
- Access current information and resources to guide and enhance service delivery and patient
  care, i.e. OM Guidelines and Care for Kids’ Ears Resources.

**Care for Kid’s Ears - Resources**
($0.15 million is provided for these resources for the period 2016-17 to 2018-19)

The CfKE resources are intended to raise awareness about Indigenous ear and hearing health. They
are available on a website (audio and visual), can be downloaded or ordered in bulk in hard copy.

Originally the CfKE program involved both the provision of resources and a campaign of engaging Indigenous radio stations and other Indigenous media in ear health promotion and prevention activities. The CfKE program is now based solely around the website and is being managed by the staff in the Department’s Indigenous Health Division.

Clinical Care Guidelines

The Australian Government Department of Health’s Recommendations for clinical care guidelines on the management of Otitis Media in Aboriginal and Torres Strait Islander populations, (the National Guidelines) were first produced in 2001, revised in 2010 and are currently being updated. Intended users are health care professionals who work with Aboriginal and Torres Strait Islander populations (including Aboriginal Health Workers, Aboriginal ear health workers, primary care and specialist physicians, nurses, remote area nurses and nurse practitioners, audiologists, audiometrists, speech therapists, and child development specialists).

Other Australian Government Investments in Indigenous Ear Health

Australian Hearing

Australian Hearing Services was established by the Australian Government in 1947 to provide hearing services to children whose hearing was affected by a series of rubella epidemics and to assist veterans who suffered hearing damage during World War II. It is now a non-General Government Sector entity established under the Australian Hearing Services Act 1991 (Cth); and a corporate Commonwealth entity under the Public Governance, Performance and Accountability (PGPA) Act 2013. The entity is known as Australian Hearing (AH). It is located within the Human Services portfolio of the Australian Government and is governed by a board that is appointed by the Minister for Human Services. After recent consideration of the future ownership of Australian Hearing the Government has decided to retain full ownership and control of the entity.

AH is the largest provider of Government funded hearing services, with 145 permanent service centres and 426 visiting locations (e.g. in GP clinics, community health centres) across Australia, a staff of 1,284 (at a ratio of clinical:non-clinical of 1:1.6) in 2015-16.

Although governed by the Department of Human Services, AH is also contracted to provide services to the Department of Health’s Office of Hearing Services, through the Community Service Obligations (CSO) of the Australian Government Hearing Services Program. The CSO program delivers hearing services and devices to clients under 26 years of age or with complex hearing needs. The Office of Hearing Services provides funding and manages policy related to the provision of the CSO program delivered by Australian Hearing (the sole program provider). The Indigenous client base of AH under the CSO is: children and young adults from 0 to 26 years of age, Aboriginal and Torres Strait Islander adults aged over 50, pension recipients and Veterans.

Under the Australian Hearing Specialist Program for Indigenous Australians (AHSPIA), which is funded by the DHS, Australian Hearing provides Hearing Services in more than 200 Aboriginal and Torres Strait Islander communities across Australia each year to help overcome distance, culture and language barriers. The Indigenous clients seen by AH during outreach visits are those eligible for services under the CSO.

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Under the ‘voucher’ program administered by the Office of Hearing Services as part of the National Disability Insurance Scheme (NDIS)\textsuperscript{16}, AH is one of the service providers in a contestable market. AH’s client services are represented in Figure 1.

![Figure 1: Australian Hearing client services, including the DHS funded AHSPIA Outreach program](image)

The AHSPIA model is similar to the HEBHBL model, except that AH focuses on the tertiary end of treatment. Like HEBHBL, AH contracts with local Aboriginal Health Services and/or Hospitals, on the basis of a service agreement (typically of three years’ duration).

- Children are to be seen if there is a concern that their hearing loss is permanent and requires amplification. Adults eligible under the CSO are also eligible to be seen.
- The AH audiologist provides tertiary audiological support. This includes hearing assessment, fitting of devices if required, rehabilitation and report writing to the required source.
- Local services are expected to ensure that children with hearing concerns have their hearing screened prior to being seen by AH. Written approval from an ENT specialist, paediatrician or GP is required for all children before they are fitted with amplification devices.
- Australian Hearing also assists in community education, staff education on hearing loss and management.

**National Acoustics Laboratory**

National Acoustics Laboratories (NAL) is the research division of Australian Hearing. The NAL undertakes both engineering development (hearing assessment equipment, hearing devices etc.) and hearing loss management and rehabilitation research (including projects funded by other Australian Government Departments). For example, the Department of Prime Minister & Cabinet, under its Indigenous Advancement Strategy, is currently funding a pilot study on the hearing-related factors that support Indigenous children in their learning.\textsuperscript{17}

\textsuperscript{16} As part of the introduction of the National Disability Insurance Scheme (NDIS) on 1 July 2013, the Government agreed to transition existing Commonwealth programmes providing support to people with a disability to the NDIS. The Australian Government Hearing Services Program was included as one of these programmes, and will transition (in part) through an ongoing process to the NDIS by 2019-2020. http://hearingservices.gov.au/wps/portal/hso/site/about/whoarewe/history/

\textsuperscript{17} https://www.nal.gov.au/project/hearing-to-learn-learning-to-hear/
State and Territory Government investments

**Brief description of the NSW Indigenous ear health investments**

**Health promotion and prevention; surveillance (NSW Health)**

The revised 2011 NSW Guidelines discontinued ‘near universal screening of Aboriginal children 0-6 years’. The focus moved to a public health approach that ‘encompasses existing child health surveillance strategies and a greater focus on health promotion activities designed to address the major risk factors for otitis media, identified as:

- reducing maternal ante-natal smoking;
- increasing maternal post-natal breastfeeding;
- improving safe and healthy housing conditions;
- linking with existing child health surveillance programs; and
- improving awareness and education amongst the Aboriginal community and human services professionals.

This aspect is now managed by the Child and Family Health team of the Health & Social Policy Branch of the NSW Ministry of Health.

Currently there are 11 funded roles in NSW (not all are full-time); at least 4 are in ACCHOs (based on direct contracts with NSW Health which include ear health responsibilities); the rest are in LHDs (not under a separate contract, regarded as part of the LHD’s routine responsibilities) and funds are spent according to the LHD’s judgement about the needs of their communities.

The funding is about implementing the NSW program guidelines (i.e. focus on prevention and health promotion). Regarding the ‘existing child health surveillance programs’ it was explained that ‘The expectation is that, during the course of preventive work, if a child is identified with disease or at risk, they will be referred for further assessment and treatment via the usual channels.’

**HEALS Program (NSW Health)**

Hearing Ear health and Language Services (HEALS), a NSW Ministry of Health initiative, was implemented in 2013 and 2014, with $900K+ and has subsequently been refunded annually (for decreasing amounts – currently $230K). It operates over 5 ACCHOs in metro or outer-metro locations. There is little transportation involved in HEALS, as it works mostly out of John Hunter (Newcastle) and the 2 Children’s Hospitals in Westmead & PoW, Sydney). It provides ENTs and speech pathologists only (who are salaried employees of NSW Health).

The program is managed by the Sydney Children’s Hospital Network, which has MoUs with the 5 ACCHOs.

The HEALS program is currently being independently evaluated (this commenced March 2017) with a final report due in December 2017. This report will inform NSW government decisions about the continuation of the program. [Those closely involved in the HEALS program expressed an expectation that the program will be continued and possibly rolled out State-wide. Those in government did not foreshadow any anticipated outcome].

**Other**

The John Hunter Hospital has an MoU with Awakabal ACCHO to provide outpatient services in the community (using the salaried staff of the ENT team at the hospital).

**Brief description of the NT Indigenous ear health investments**

Ear health activities in the NT are based on an integrated program funded by both the Australian and NT governments. HEBHBL funding is contributing to pre-existing NT Australian Government ear health programs, which commenced in 2007. The history is briefly as follows:

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18 Sources: available documentation and stakeholder interviews

2009-2012: Closing the Gap Initiative – Commonwealth funding continued and follow-up services were expanded; a case management service delivery model was introduced through the roles of Child Hearing Health Coordinators (CHHCs). A preventative program was also introduced.

2012-2022: (ongoing agreement)

July 2012 to June 2015, the ear and hearing health services were replaced and expanded by the Commonwealth funded, National Partnership Agreement on Stronger Futures in the Northern Territory (SFNT).

Since July 2015, these services have been continued through a new national partnership on the Northern Territory Remote Aboriginal Investment (NTRAI) Hearing Health Program. The funding from the NTRAI (former SFNT) was mainly used to provide audiology and care coordination.

2012- present: further Commonwealth funding to the Hearing Health Program is provided through the HEBHBL program, which is largely used for secondary and tertiary services: providing specialist audiology and ENT, including surgery.

The integrated NT Program is known as the Hearing Health Program and consists of elements of funding from NTRAI, HEBHBL and the NT Government’s - Families as First Teachers Program (FaFT). The FaFT program is intended to provide a platform for Community Hearing Workers to promote positive behaviours and talk to parents about ear disease by giving them guidance for medication; encouraging mothers to go to clinics and making sure that their children’s ears are checked. The integrated Hearing Health Program services 72 remote communities.

Hearing Health Program functions and service delivery is performed by State employees. ENT specialists are based in Darwin (Royal Darwin Hospital) and do not travel to remote sites, but use teleotology to assess patients. Audiologists do travel to remote sites and conduct initial assessments and referrals for ENT treatment if required. The personnel seeing patients in community therefore consist of:

- Community Hearing Workers (residing in communities and funded under the FaFT program) working on public health programs- nutrition, hygiene; and education – handwashing, nose blowing, nutrition. (One stakeholder suggested it is a flaw that these workers have no clinical skills (e.g. to clean ears, administer ear drops).
- Clinical Nurse Specialists Hearing Health (formerly known as CHHCs) (working across communities at the identification/surveillance and primary health care levels
- Clinical Nurse Specialists (funded by HEBHBL) and/or visiting audiologists (funded by HEBHBL), working at the secondary care level.

The NT Government’s Healthy Under 5 Kids (HU5K) incorporates a series of age specific child health checks, which include growth assessment, hearing assessment, developmental

19 Only available in NTER Prescribed Areas
20 Only available in NTER Prescribed Areas
22 ‘The HEBHBL was used to support outreach audiology services for people aged 16–20 who are not eligible under the SFNT/NTRAI. As well, the HEBHBL funded additional audiology services to children aged 0–15. Although all Indigenous children and young people aged 0–21 in the Northern Territory are eligible to receive these services, the AIHW currently has data for people aged up to 20 only. In the Northern Territory, the Healthy Ears services have mainly been delivered by outreach service teams to children and young people in remote areas because there are insufficient local services to meet the high demand in these areas.’ (AIHW, 2017 p. 72).
24 Based on Hearing Strategy Unit, Integration and Innovation Slide 2.
25 ‘Outreach teams consisting of an audiologist and at least one other member of staff, such as a registered nurse, nurse audiometrist, Aboriginal health worker, or a community hearing worker’ (AIHW, 2017. p.4)
assessment and the childhood vaccination schedule of the NT Immunisation Program. The majority of the routine scheduled child health assessments are conducted by the nursing and Aboriginal and Torres Strait Islander Health Practitioner (ATSIHP) staff. Where a Medical Practitioner is involved, the assessment can be claimed as Medicare items. A nurse or ATSIHP can claim for a Medicare item when they provide follow up health assessment services for any Aboriginal and Torres Strait Islander clients.

The NT’s iHearing Project (2016) has developed a project plan, through stakeholder consultation. The aim of iHearing is to provide education personnel with up-to-date hearing health data and to support learning and amplification programs for individual students, classrooms and schools. There is a current four phase plan for implementation (from 1 April 2016 to 31 December 2017). The NT Department of Health has designed and is implementing the Hearing Health Information Management System (HHIMS) to enhance hearing health care to Indigenous children. The HHIMS software captures complex hearing health clinical data and shares information with other service providers. The iHearing Project Plan is accompanied by detailed requirements (for both technical functionality and usability) for implementing the HHIMS in early childhood and school facilities.

**Brief description of the Queensland Indigenous ear health investments**

**Queensland Department of Health: Deadly Ears**

The Deadly Ears (DE) program is a State initiative that delivers clinical services to the Torres Strait, Northern Peninsula Area (Bamaga), Hope Vale, Wujal, Palm Island, Mornington Island, Doomadgee, Normanton, Mt Isa, Woorabinda, and Cherbourg. It is managed and funded by Children’s HHS Qld. From 2005, Qld Health funded communities which self-identified via DE project officers and community consultations. MOUs were signed with 19 communities; 12 were visited, and the other communities not visited agreed to send patients to neighbouring sites. Access close to home was seen as critical.

Service providers in the DE program are salaried health professionals in the Children’s HHS Qld. A number of HEBHBL services are provided by DE (they are a HEBHBL sub-contractor in this context). HEBHBL is funding the travel for DE to reach its rural and remote outreach sites. DE has also run an on-site training program for health professionals in the locations it visits. The program is currently on hold, as the development of an online platform for the training is being finalised. The platform is due for launch in September 2017.

There are a range of resources for health professionals and parents produced by the DE program. The Queensland Hearing Loss Family Support Service links to the screening of newborns and is intended to help people whose children have hearing loss to navigate the system. The Indigenous Pathway Project is a web-based tool that is an extension of this service which is due to commence in August 2017 and will be targeting providers (staff).

Regional Aboriginal and Islander Community Controlled Health Organisations (RAICCHOs) have a prominent role in the Queensland planning and negotiation processes. Some RAICCHOs are also service providers and are subcontracted to HEBHBL to deliver ear health services.

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27 Item 715 (Indigenous children, all ages); Items 701, 703, 705 and 707 - Healthy Kids Check at least 3 – 5 years (includes non-Indigenous children)

28 MBS Item No 10987 – Health Check Follow up. Up to 10 services in a calendar year, after Item 715 has been claimed.

29 NT Department of Health (July, 2016). iHearing Project Plan. Provided by the NT DoH.

30 NT Department of Health (January, 2017). iHearing Functional Requirements Specification. Provided by the NT DoH.

Brief description of the South Australian Indigenous ear health investments

SA Health-funded activities in SA consist of the Universal Neonatal Hearing Screening Program (UNHS) service coordinated by the Women’s and Children’s Health Network in South Australia,32 the Women’s and Children’s Health Network Hearing Assessment Service (a team of five audiologists visiting twice per year) that, at the time of the inception of HEBHBL, did not visit the APY Lands, Coober Pedy, Roxby Downs or Ceduna. SA Health’s Watto Purrumna has invested in the Under Eight Child Health Screening Program33 for Aboriginal children in metropolitan areas, using a school-based screening model and home visits.34

SA Health has published the recent SA Ear Health Framework. This has been in development over a couple of years and was driven by the SA Aboriginal Ear Health Reference Group (SAAEHHRG) that consists of ‘all interested parties’ – about 14 representatives from government and NGOs. (SAAEHHRG is separate from the State Advisory Forum, although some people are on both groups). SAAEHHRG reportedly assists services in being complementary.35

All stakeholders emphasised that the SA Health infrastructure does not have a strong regional presence, therefore most of the workforce have to come from Adelaide. Remote access is available through the Country Health system, although stakeholders reported an emphasis on eye health activity rather than ear health.

In the public school system, SA’s Department of Education and Community Development (DECD) has service agreements with Aboriginal Health Services for hearing screening. These agreements were in Port Lincoln, Ceduna, Berri, Mount Gambier, Port Augusta and Leigh Creek at the time of HEBHBL commencement. In SA, each school has access to a Hearing Services Coordinator who can facilitate acoustic upgrades and teacher training.

Brief description of the Victorian Indigenous ear health investments

There were no reported additional Indigenous Ear Health programs funded by the Victorian DHHS. However, Victoria is the only State to have an eye and ear-specific hospital – the Royal Victorian Ear and Eye Hospital (RVEEH) – which was involved in a (Commonwealth funded) pilot program in 2012-13. This pilot included outreach services (audiological screening and diagnostic testing, ENT specialist consultations; management and treatment, including ongoing monitoring, medication or surgery).

The Outreach services were delivered in collaboration with Victorian Aboriginal Health Service (VAHS, inner-metro) and Worawa Aboriginal College (WAC, outer-metro). The multidisciplinary health professionals involved were salaried employees of the Vic DHHS, working out of the RVEEH ENT department. The pilot was an expansion of RVEEH’s approach to include screening of Aboriginal children into ‘business as usual’ for the hospital.36 The RVEEH continues to have a clinic at the VAHS in Fitzroy. This clinic commenced as part of the 2012-13 pilot and continues to be funded jointly by VAHS, the RHEEV and RACS37 and also receives HEBHBL funds.

There are reportedly no additional Victorian DHHS Guidelines, Strategies of Policies for Indigenous Ear Health.38 In 2006, the Victorian Department of Justice conducted an Investigation into hearing

32 Which has a mobile component that will travel to the nearest CaFHS sites for infants under 6 months.
34 Further details of the program were not located on the SA Health website. We were verbally advised that the program also offers home visits.
35 SAAEHHRG membership: Australian Hearing, DECD, Flinders University – Audiology Department, RDWA, Country Health SA, Public Health Partnerships Branch (SA Health), WCHN Children’s Audiology Service, Watto Purrumna (NALHN, SA Health), Aboriginal Health Services (SALHN, SA Health), Cora Barclay Centre, AHCSA.
36 The hospital to initially embedded hearing screening sessions for Aboriginal children living in the Ballarat & District area into a “business as usual” strategy under the hospital’s Aboriginal Health Plan (2011-2013).
37 Royal Australian College of Surgeons (based on stakeholder information, RACS also contributes)
38 Our internet search did not identify and current, publicly available Victoria-specific Indigenous Ear Health materials, document or research
impairment amongst Indigenous prisoners in the Victorian Correctional System. Its recommendations included: education of correctional staff; routine hearing screening of Indigenous prisoners and provision of counselling and hearing aids; data collection to monitor prevalence in the corrections system.

Brief description of the WA Indigenous ear health investments

Each of the seven WA Country Health Service (WACHS) regions has a Regional Resource Centre in a hub and spoke model - a bigger hospital with smaller hospitals dotted around it and then community centres. Most of the seven regions have (quarterly) visiting ENT specialists organised through the WACHS. WACHS also organise audiology visits by subcontracting private practitioners.

At the same time, WACHS acts as a service provider to HEBHBL in some locations. Based on 2015-16 full year data, HEBHBL funded WACHS for visiting specialists in three of these regions - Great Southern, Kimberley and Midwest.

WACHS visiting teams reportedly try to train a few people in the region at the same time as delivering services, although this depends on patient lists and attendance. The aim of WACHS ENT visits is to build skill and confidence for workers and to provide mentorship and support. If WACHS have an audiologist in the region, included in the contract is a requirement that that they deliver locally based training.

The WA Health Department reportedly funded an iPad or other device for Aboriginal Health Workers - to use on the ground for taking ear images, also using it as teaching tool; and for the use of telehealth and sending images to ENT specialists, audiologists for the referral pathway.

WA Health and WACHS provide the Enhanced Aboriginal Child Health Schedule (EACHS) – which includes ear health checks. The program is a modified version of the NT’s “Healthy Under 5 Kids” program, which was piloted in 2008, evaluated and then implemented State-wide. No referral is required.

In WA, there are also private organisations delivering services in remote communities. Of all the States, WA has the largest number of NGO ear health service providers, many of which have been operating for longer than HEBHBL.

There is currently a State-wide project underway (involving the AHCWA, funded by WA Health) to map all of the Aboriginal health services across the state, including ear health. One reported purpose is to identify closer (regional) points from which to follow up children who go back to the community - post-surgery.

There is a current project run by WA Primary Health Alliance (WAPHA) called Health Pathways, - which is developing and online resource that includes ear health. Based on a NZ model, it is intended for use by primary health clinicians (mostly GPs) to access both clinical guidelines and information on referral pathways (e.g. referral procedures for metro and regional hospitals). A number of clinical resources are accessible through the Health Pathway, including the National Clinical Care Guidelines.

During the course of the project, WA Health was on the verge of releasing its Child Ear Health Strategy directed at improving the ear and hearing health of children across Western Australia, particularly Aboriginal children. Some regions – Goldfields, Pilbara, Kimberley – have regional ear health plans that were developed in consultation with a range of providers and/or research bodies.

42 The alliance of the 3 PHNs in WA: Perth North, Perth South, Country WA.
43 We understand this has been delayed, awaiting the new Health Minister. A draft-for-consultation was available at the time of the study. http://www.ruralhealthwest.com.au/docs/default-source/marketing/publications/wa-ear-health-strategy-draft-for-consultation.pdf?sfvrsn=2
Whole of Program Findings

Program Factors

MAIN MESSAGES FOR THE WHOLE PROGRAM

There are low levels of awareness among service providers and other stakeholders that the Commonwealth is investing in the six programs, and of how and why they are investing.

Addressing this lack of awareness will also address many misunderstandings about the investment.

The Australian Government’s investment is conceptually sound in its elements (improving access to primary and secondary care; overcoming barriers to accessing surgery; providing training, equipment and support; providing resources for practitioners, teachers and families to support prevention).

There are, however, whole-of-health-system issues that are reducing the investment’s effectiveness (see non-program factors below).

The capacity building and support of primary health care staff in Indigenous communities is falling short, which links to capacity for effective early intervention and referral.

The health promotion and prevention work has had a low profile in the program as a whole, but is identified as a priority by stakeholders.

Not enough people know about the programs and understand their purpose; some people might know about one program, but not the others. There is a lot of misunderstanding and misinformation about the Australian Government’s investment. For the program as a whole, lack of communication and promotion seems to have reduced its overall effectiveness.

The HEBHBL program has provided access to ear health services that Indigenous communities did not have before. The number of communities visited, the number of health professionals going out and the number of children seen has increased steadily. It has supported other State-based or local initiatives, such as Deadly Ears and WACHS, thereby supporting the sustainability of those programs or enabling them to expand services elsewhere (e.g. by paying for and coordinating their travel). In that way, it is supplementing State based programs, which seemed to be largely unacknowledged in documents and consultations.

The Surgical Support program has enhanced the capacity of some HEBHBL fundholders to expedite surgery for Indigenous children in rural and remote areas. It has taken a while to establish but, in most locations, it is starting to work effectively.

The concept of the Equipment Program was initially effective, but with staff churn in health services and the passage of time, it will need a review of: what equipment in the field is being used; how the program keeps track of its use as well as its location; how to fit the type of equipment supplied to a focus on younger children; and how to align with models of care that are based around new technologies.

The Training program is attracting the right numbers of people in the right places, but is it training the right people? There was concern expressed about whether the courses were specific to Indigenous ear health and there was lack of clarity about costs of the program to Aboriginal Medical Services. (These latter concerns were expressed not necessarily by those attending the courses, but by others in the sector). There are low numbers of Aboriginal health professionals attending. This examination has suggested some possible explanations for this feedback, partly due to the website, but this needs to be explored further in consultation with the Aboriginal Community Controlled sector.

The Ear Health Coordinator position is only being implemented as expected in one State. There are new people in some roles, but in others the position has ‘morphed’ into something else. The concept
of just one position being able to achieve the same results, regardless of the size and demography of the State is questionable. This program also needs to be reviewed in consultation with the Aboriginal Community Controlled sector.

The CfKE resources are doing their intended job, except that awareness is falling as time passes and as new people join the sector. There are some areas where new resources have been suggested (e.g. about the surgical pathway), but these resources have been developed elsewhere, so the concept of the CfKE website being a repository for all good current resources is suggested.

The key gaps in effectiveness of the program overall are in:

- Understanding the importance of ear health
- The capacity building and ongoing support of primary health care staff in Indigenous communities, which is the linchpin in the success of the HEBHBL program
- The effectiveness of health promotion and prevention work hitherto, although we note that this Indigenous ear health initiative is not solely responsible for addressing health promotion in Indigenous communities.

**Non-Program Factors**

It was clear from the research that the Australian Government investment in these programs is hindered by a number of non-program factors.

These are reported to be the result of longstanding system level barriers such as:

- separate clinical credentialing processes for private and public sector hospitals in the same towns
- availability of appropriate item numbers in the MBS
- failure to record Aboriginality in outpatient clinic records that in turn means planning for increasing access is difficult or impossible
- practices in the management of patients who did not attend (DNAs) in specialist outpatient clinics in State health services that disadvantage Aboriginal families who must travel from remote and very remote communities (for example – policies that remove children from outpatient waiting lists after two DNAs).

These factors are impeding access to secondary and tertiary care and to essential data for effectively addressing the burden of ear disease in Indigenous communities.

Non-program factors impeding the effectiveness of the Australian Government’s Indigenous Ear Health Initiatives are summarised below.
MAIN MESSAGES ABOUT NON-PROGRAM FACTORS

Health system

- Indigenous ear health has varying prominence in State and National Aboriginal Health strategies, frameworks and plans. Yet ear disease has been consistently identified in the literature, since the 1970’s, as a key contributor to life-long disadvantage for Australian Indigenous people if untreated.

- The HEBHBL program needs to work in health promotion, primary health care and specialist service provision. The Surgical Support program needs to work with the tertiary health care system (hospitals). Therefore, both programs are crossing traditional State and Federal areas of responsibility in health care. This is reducing current program effectiveness because of systemic barriers in some States/Territories.

- Credentialing arrangements and the autonomy of hospitals in deciding priorities and allocating resources are proving to be a significant barrier to accessing theatre time for ear surgery on Indigenous children and young people in some locations.

- Separate, State-based ear health programs using State employees have the potential to act in competition for workforce with HEBHBL, especially in relation to their capacity to pay health professionals more attractive rates.

- The specific statutory role of Australian Hearing in Indigenous outreach is a barrier to more effective use of that organisation’s existing national resources, reach, infrastructure and workforce.

Aboriginal health services

- Aboriginal health services are ‘overwhelmed’ by the requirements of other, broader outreach programs. Ear health tends to have a lower priority in all aspects of the outreach process.

- The health workforce issues that disadvantage rural and remote communities are negatively impacting the quality and intended outcomes of the ear health outreach. High staff turnover, competing demands from multiple programs and lack of training in ear health has reduced the capacity of staff in many locations.

- In some locations, the Aboriginal health workforce has the potential to become de-skilled as an unintended consequence of the burden of administering multiple outreach programs and becoming ‘coordinators’ rather than practitioners.

Data

- The capacity to collect clinical data on the ear health of Indigenous children and of communities is a significant barrier to assessing the effectiveness of any programs in improving ear health outcomes.

- There are some data projects underway at the State level, but a national approach is feasible and would avoid duplication of effort.

- The use of multiple patient information systems in most jurisdictions is a significant barrier to effective data collection. However, most systems in use in ACCHOs would have the capacity to upload data to the national My Health Record.

- Staff turnover is affecting the program at all levels – from the staff shortages and churn in Aboriginal health services, through to the oversight of the program contracts in the Department of Health’s State Network.
RESPONDING TO STAKEHOLDER ADVICE

The most senior and experienced stakeholders (prominent in research and/or service delivery over a long period) were of the strong view that nationally, the joint investments of Australian governments should involve certain elements. Taking all this advice together, Table 3 summarises the elements of a good model for Indigenous children’s ear health, and indicates which recommendations reflect the implementation of the advice.

Table 3 How the recommendations respond to stakeholder advice

<table>
<thead>
<tr>
<th>Elements of good model</th>
<th>RECOMMENDATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The overarching approach</strong></td>
<td></td>
</tr>
<tr>
<td>Cross-sector awareness raising, collaboration and effort</td>
<td>18,19</td>
</tr>
<tr>
<td>between health, education, housing, police and corrections</td>
<td></td>
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<tr>
<td>to address the social determinants and impacts of poor ear</td>
<td></td>
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<tr>
<td>health.</td>
<td></td>
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<tr>
<td>Recognise that to plan for and fund fly in fly out services</td>
<td>2,4,5,27,28,29,30,31</td>
</tr>
<tr>
<td>is not the full solution to the burden of Indigenous ear</td>
<td></td>
</tr>
<tr>
<td>disease.</td>
<td></td>
</tr>
<tr>
<td>Invest in building the skills, capacity and confidence of</td>
<td>3,4,5,6,27,28,29</td>
</tr>
<tr>
<td>local health services.</td>
<td></td>
</tr>
<tr>
<td>Enable local approaches to meet local needs.</td>
<td>2</td>
</tr>
<tr>
<td>Invest time in establishing relationships with Indigenous</td>
<td>2</td>
</tr>
<tr>
<td>communities, so that the activity that follows is managed</td>
<td></td>
</tr>
<tr>
<td>and controlled by the communities.</td>
<td></td>
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<tr>
<td><strong>Health promotion, public education and prevention</strong></td>
<td></td>
</tr>
<tr>
<td>A persistent, intergenerational public health campaign that:</td>
<td>11,17</td>
</tr>
<tr>
<td>✔ aims to address the ‘normalisation’ of ear disease in</td>
<td></td>
</tr>
<tr>
<td>some Indigenous communities and tells families ‘it is not</td>
<td></td>
</tr>
<tr>
<td>OK’ for children or their families to tolerate the acute</td>
<td></td>
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<tr>
<td>symptoms of ear disease and chronic hearing impairment</td>
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<tr>
<td>✔ educates families about the contributing factors to ear</td>
<td></td>
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<tr>
<td>disease (bacterial infection and poor hygiene, exposure to</td>
<td></td>
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<tr>
<td>smoking, poor nutrition, not breast feeding), supports</td>
<td></td>
</tr>
<tr>
<td>them to change behaviour and reinforces this in perinatal</td>
<td></td>
</tr>
<tr>
<td>and antenatal care, in the hospital and in the community</td>
<td></td>
</tr>
<tr>
<td>✔ explains to families the consequences of not preventing</td>
<td></td>
</tr>
<tr>
<td>ear disease (speech and developmental delay, learning</td>
<td></td>
</tr>
<tr>
<td>difficulties, behavioural issues interpreted as ‘difficult’</td>
<td></td>
</tr>
<tr>
<td>or ‘anti-social’, poor school and employment outcomes)</td>
<td></td>
</tr>
<tr>
<td>✔ sustains effort from the school years on to build health</td>
<td></td>
</tr>
<tr>
<td>literacy and understanding of what causes middle ear</td>
<td></td>
</tr>
<tr>
<td>disease and how to prevent it</td>
<td></td>
</tr>
<tr>
<td>✔ develops local champions.</td>
<td></td>
</tr>
<tr>
<td>Further, the above campaign should extend beyond awareness</td>
<td>1,2</td>
</tr>
<tr>
<td>of the disease, to awareness of the services that are</td>
<td></td>
</tr>
<tr>
<td>currently available to communities, so that communities</td>
<td></td>
</tr>
<tr>
<td>can make informed choices about services provided to them</td>
<td></td>
</tr>
<tr>
<td>and locations are systematically prioritised on need</td>
<td></td>
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<tr>
<td>rather than awareness of service availability.</td>
<td></td>
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<tr>
<td><strong>National coordination</strong></td>
<td></td>
</tr>
<tr>
<td>National coordination of services, ear health resources,</td>
<td>3,11,12,13,21,23,24,25,26</td>
</tr>
<tr>
<td>training, equipment and data</td>
<td></td>
</tr>
<tr>
<td>Set measurable national goals</td>
<td>19</td>
</tr>
</tbody>
</table>
### Service delivery model

<table>
<thead>
<tr>
<th>Activity</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both the ACCHO and the LHD are engaged and committed to the process.</td>
<td>2,20</td>
</tr>
<tr>
<td>Focus on 0-4 year-olds, beginning in the first months of life, prior to vaccinations; with regular assessment of ears at regular time points</td>
<td>6,8,10,28,29</td>
</tr>
<tr>
<td>Build and maintain the capacity locally to take over otoscopy and typanometry.</td>
<td>4,5,8,27,28,29</td>
</tr>
<tr>
<td>The role of visiting audiologists is used for diagnostic testing to assess the degree of hearing loss, not simply for referral (which could be done by adequately skilled local staff).</td>
<td>3,4,5,8,27,28,29</td>
</tr>
<tr>
<td>User friendly technology to reduce expenditure on FIFO and allow development of trusting working relationships with specialists at a distance</td>
<td>7,30,31</td>
</tr>
<tr>
<td>Access to ear surgery for Indigenous children with OM is a priority in the funding agreements with local hospitals and a KPI.</td>
<td>20,21</td>
</tr>
<tr>
<td>ENT specialists working on outreach are credentialed by local hospitals so that their referrals are accepted and they have access to theatre time and facilities.</td>
<td>20,21</td>
</tr>
<tr>
<td>My Health Record becomes the platform used by all ear health service providers. National data set requirements and indicators are co-designed by Aboriginal Health Services, LHDs, service providers, researchers and other key stakeholders in consultation with the Digital Health Agency.</td>
<td>24,25</td>
</tr>
<tr>
<td>Co-design and ownership between aboriginal communities, aboriginal health services, service providers, researchers and State and Commonwealth governments of a national evaluation framework, which includes agreed intermediate and longer-term outcomes and include regular feedback loops to all stakeholders at all levels to allow for continuous improvement.</td>
<td>26</td>
</tr>
</tbody>
</table>

Source: advice of senior, experienced stakeholders who were consulted between February and May 2017.

### Findings by Program

This section presents findings gathered from data from interviews with stakeholders of all types, program documentation and reports and online survey. The findings are presented by programs and examination questions.

**Healthy Ears, Better Hearing, Better Listening (HEBBL)**

**In brief:**

A total of $24 million is provided for the HEBBL for the period 2013-14 to 2016-17. This program is implemented nationally through a single outreach fundholder in each state and territory, with the exception of Tasmania. The objectives of the HEBBL are to increase:

- access to multidisciplinary care in primary health care settings; and
- the range of services offered by visiting health professionals to prevent, detect and manage ear disease more effectively.

It also aims to increase access to a range of health services for Indigenous children and youth (0-21 years) for the diagnosis, treatment and management of ear and hearing health.
MAIN MESSAGES ABOUT HEBHBL

- The HEBHBL program has increased access to ear health services for Indigenous children and young people, although it is seen as operating less than optimally because of a range of factors (both program and non-program).
- HEBHBL activities have taken considerable time to set up and to operate effectively due to its establishment as a new program. However, relationships with Indigenous communities and LHDs and the local service delivery arrangements that have been developed are demonstrating increasing numbers of patients, locations and occasions of service.
- There is concern expressed that primary healthcare staff in local health services are becoming de-skilled (i.e. working as coordinators rather than practitioners).
- Simple telehealth models are increasing access to ENT specialists in some jurisdictions and improving cost-effectiveness, thereby freeing up funds for service provision in more locations, more frequently.
- There is some criticism that HEBHBL is mostly seeing school age children, and this is regarded as ‘too late’.
- There is strong agreement that there needs to be a shift in emphasis to 0-4 year-olds, but at the same time, existing services to minimize harm to older age groups need to be maintained.
- Many suggest that existing outreach services need to extend to people over 21 years, including people in the corrections system.
- The planning and coordination processes, e.g. through State Fora, look good on paper, but do not always work.
- Many of the ‘HEBHBL’ coordination problems raised by visiting clinicians were actually system problems related to credentialing, access to theatre time and knowing who to contact.

Answers to examination questions

1. To what extent is HEBHBL achieving its objectives?

The program has increased access to visiting professionals and access to multidisciplinary care in primary health settings. The visiting professionals are providing the multidisciplinary care during visits to primary health settings in communities. In many instances, this care would not have been delivered without the support of the HEBHBL program.

The data show that the HEBHBL outreach program has been effective in increasing access to coordinated primary and secondary care, with an estimated 106,087 patients nationally accessing ear health services in up to 406 locations.

The HEBHBL data demonstrates activity and outputs (locations, numbers of patients seen, number and types of health professionals visiting sites), all of which demonstrate that, without the HEBHBL funding, thousands of Indigenous children each year would not have been seen by ear health professionals.

In some models (e.g. the NT Hearing Health Program, Central Desert in WA) ENTs do not travel at all, but use teleotology (in the relatively ‘low-tech’ form of emailed images sent by primary health workers in the field to ENTs in urban centres). This reduces the time and cost of FIFO/DIDO and is felt to be a more efficient and timely way to increase access.

2. How does the HEBHBL program contribute to improved Indigenous ear health and hearing outcomes?

There was a consistent view from stakeholders that it was not possible to tell how HEBHBL contributes to improved ear health and hearing outcomes.
Interviewees saw HEBHBL as one of many factors that are intended to contribute to improved ear health outcomes, but for which attribution was not possible. The social determinants of ear health were frequently identified as key, non-program factors that were not measured and which impact on the effectiveness of any Indigenous health programs.

“I guess for me what’s missing (not reported on and outside the remit of the fundholder) – if you want to really have some idea as to whether we’re kicking goals, what we’re losing and needs to be improved - is some way of monitoring the outcomes through better data that is reported back to the DoH. You can’t always have direct attribution to this program; but data is a gap. We don’t have a hearing KPI to report on (in Closing the Gap).”

Others saw HEBHBL as a workforce program that should be measured and assessed on its workforce activities and outputs and not on health outcomes.

“HEBHBL should not be the source for health outcomes – it can describe access, but not outcomes. But the clinical data needs to be better and more consistently recorded by service providers (through other means) …with discrete KPIs.”

“It’s not really intended to be a program that will manifestly improve health outcomes – it’s meant to plug holes.”

Interviewees were asked: For instance, what data do you use to measure ear health outcomes that can be linked to the program’s activities?

(The following comments are relevant to jurisdictions other than the NT, where data collection procedures are different).

There was broad agreement that measures like number of locations, mix of workforce, number of visits, number of ‘services’\(^{44}\), number of patients seen were useful in assessing improvements in access to ear and hearing health assessment and treatment.

Measures like the age groups seen, if tracked, were felt to be useful in assessing whether activities are reaching the targeted age groups and would eventually be useful in identifying any improvements over time within and across communities.

However, other required HEBHBL data items were not felt to be useful in measuring outcomes because:

- data were not recorded for the whole community (only for children attending the outreach service on the day of visit, therefore not representative of the community)
- the same children may or may not be seen in subsequent visits (recording the number of ‘new patients’ had ceased)
- the categories of clinical presentation data were too broad and ill-defined
- the categories of clinical referral data were mostly ill-defined
- the quality of data reported by clinicians working without defined terminology and guidelines on use of the data categories was questionable; and
- one patient could be counted for several clinical presentations and several referral outcomes.

Interviewees were dubious about whether much of the HEBHBL data ‘tells you anything’; and others thought that the required data doesn’t capture everything the HEBHBL programs do, such as upskilling and professional support of local staff.

The HEBHBL data is unable to capture short-term outcome data, such as whether the clinical pathway is being followed:

“Follow up is also an issue and because of the lack of integrated data there is no surety that those who are screened actually make their way to appointments.”

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\(^{44}\) service = a discipline going to place; e.g. ENT specialist going to Ceduna
Please note: As mentioned above, after the commencement of this project, the Australian Government confirmed an additional 12 months’ funding (2017-18) for the programs whose funding period was drawing to a close. This included HEBHBL. The Department advises that the new funding agreements no longer require the collection of clinical-related data. The HEBHBL ear clinical data was implemented to try to understand what level of disease was being seen by health professionals at the outreach locations. Issues encountered by the Department with the data included:

- lack of compliance with reporting;
- inconsistent reporting, inability (due to privacy) to track individuals; and
- any course of consultation/further treatment that may have been identified and/or treated their condition or at a minimum enabled them to a clinical review or management program.

3. How well is the HEBHBL program operating?

Most respondents to this question felt that HEBHBL is operating well. The areas highlighted were: good collaboration, providing upskilling during visits; providing more services in more locations; culturally appropriate work with communities.

There were some doubts expressed about whether HEBHBL was increasing access in the most efficient way.

Criticisms of the HEBHBL program’s operations were linked to non-program factors (such as the limitations on the operations of Australian Hearing; the absence of systematic linkages to education and teachers; poorly coordinated programmatic funding for services by State and Commonwealth Departments; the dependence on the quality of local coordination; restrictions on age ranges for the services; variability between locations; and the burden on Aboriginal communities of too many programs and too much research.

“People in remote communities are just awash with people doing things for them and to them.”

The key dependencies of the HEBHBL program were seen as: the need for data in order to work effectively (and these data are lacking); the dependency of other programs on HEBHBL (e.g. supplementing Deadly Ears, for travel); the need to link with other programs, departments and agencies

“Ear health problems are connected to other issues so it stands to reason that to be effective these programs cannot operate in isolation from other programs. Making assessment of outcomes illustrates this issue because outcomes are determined by so many variables it is impossible to attribute outcome to one program alone other than to say it has had an impact on the number of people seen, assessed, referred and treated.”

4. How efficient and effective are the processes, structures and systems for the delivery and monitoring of HEBHBL?

The processes, structures and responsibilities are depicted in Figure 2 below.

The HEBHBL process (based on the Service Delivery Standards) consists of annual funding allocation → development of annual budget and Activity Plan of outreach services, locations and timing that is based on an assessment of need → approval of the annual Activity Plan by State Advisory Forum → subcontracting of service providers and plan implementation → quarterly reporting against the Activity Plan and budget (including financial and visit data) → end of year reporting that includes reflection on issues, barriers and enablers → then the cycle repeats.

There are variations between jurisdictions (e.g. not every fundholder has a regional structure for planning, coordination or needs assessment).
Taking all the data sources together (interviews, document review, program documents), dotted lines indicate areas where communication or information sharing is suboptimal.

The quality and completeness of data received from fundholders varies. Templates are provided by the Department for use in all jurisdictions. Most fundholders expressed concerns about both the templates (clarity of purpose, reliability and utility) and about the annual nature of the activity planning process (inadequate time to plan after confirmation of funding; inflexibility of planning) and the frequency of reporting (administrative burden).

There is evidence of local variations in delegations of authority to vary plans; and consequent inconsistency or inequity in fundholders’ capacity to respond to changes in need, accessibility of communities or availability of staff.

The subcontracting arrangements of the fundholders are not monitored and were outside the scope of this study.

An observation from the interview and site visit process is that, although the governance and planning structure of the State Advisory Fora is consistent across jurisdictions⁴⁵, some interviewees who are representatives of entities on those State Fora indicated they were unaware of how locations are prioritised. Others (e.g. members of organisations represented, State Department of Health staff, or some DoH grants officers) were also unaware. Stakeholders reported that the State Fora deal with between four and seven other outreach programs, of which ear health is one. This suggests that, although the Forum structure is representative of the key stakeholder groups on paper, its effectiveness as a planning and coordination body depends on the capacity of Forum members to disseminate and consult within their own organisations.

⁴⁵ The membership and role of the State Advisory Forum is described in the Service Delivery Standards.
Many service providers indicated that they did not know how locations were prioritised. Fundholders and others closely involved in the management of the programs (e.g. subcontractors) provided most of the information.

In theory, locations are prioritised based on identified need. This process can include – (1) a call for submissions from ACCHOs that identify need in their community and seek support from the program; and or (2) identified need through consultation with other agencies and from services mapping by the fundholder; (3) focusing activity based on geographic areas (e.g. in Qld and NSW avoiding duplication in locations serviced by other programs – Deadly Ears and HEALS). A combination of approaches was evident in most jurisdictions. In States with regional coordinators, these roles played a part in identifying local need.

In the NT, with centrally coordinated planning, the current model focuses on prioritising children with current infection and those with significant hearing loss. This information is based on (consenting) patient data collected by outreach service providers and entered into the NT’s single patient record system.

From this process, annual Activity Plans are developed and submitted to the State Forum for (1) discussion at committee level by other ear health organisations and services representatives, then (2) endorsement by the State Forum.

Several interviewees felt that the process of identifying locations for activity worked well, but it was limited by its annual cycle. The process of having pre-approved ‘reserve’ activities to cover the contingencies of remote travel worked well, with teleotology often being the substitute.

The exception was WA where differing views were received, with some interviewees reporting duplication of services, in spite of existing structures for collaborative planning. The examples given (of poor coordination) involved reported failure to share information, from NGOs in particular.

Several interviewees suggested that greater flexibility would improve the fundholders’ ability to respond to changes in need, or newly identified need in a timely way. For example, having greater discretion to re-allocate funds in a time period. Some thought that the method of calling for submissions or EOIs from ACCHOs was flawed. As one informant said, there is need in all Aboriginal communities, so relying on awareness and capacity or interest of an ACCHO in applying to the fundholder, rather than undertaking a full needs assessment, did not always mean that the locations prioritised had the greatest need.

Prioritising patients

Prioritisation occurs in 2 ways:

(1) Local health service staff prioritise children to be seen by visiting professionals and create patient lists for the next outreach visit. In theory, this occurs as a result of ear problems being identified during a screening process conducted by local health workers.

(2) Visiting health professionals may prioritise patients for ongoing monitoring and management locally and for follow up at the next outreach visit (e.g. by a ENT, audiologist or speech pathologist).

Some interviewees had the view that (1) is sometimes flawed because local services are short staffed, have competing demands and inadequate resources; and think of ear health as a smaller part of their work (in comparison with other larger outreach programs). The staff may be too busy, inadequately trained or inadequately supported to confidently screen children and refer them for assessment.

The NT prioritises those patients with the greatest need and these children can then be tracked for outreach services.
“We have identified this [prioritising patients prior to an outreach visit] as a potential weakness in the capacity of some services.”

“A lot can be done much, much better by primary health care – otoscopy and tympanometry can be done by primary health care. In remote communities, primary health care is overwhelmed by chronic diseases; ear health is put in the ‘too hard basket’ and they say ‘let’s get the [visiting] audiologist to do that.’”

6. How well aligned, coordinated and linked is HEBHBL with other ear health and hearing services, including those provided by state government and the non-government sector?

Alignment with State/Territory programs is relevant in WA, Qld & NSW. Coordination appears to be determined by geography. There is close planning and cooperation between programs in Qld, where the State-funded ‘Deadly Ears’ (DE) has specific geographic areas of operation. The role of HEBHBL, in this relationship, is to provide the transport and accommodation for State-funded DE health professionals to travel to remote areas in Qld.

In NSW, it was felt that communication and cooperation had improved after initial problems related to uncertainty of State program funding, but the mechanism for communication could be further improved and was currently ad hoc. However, alignment with the State-funded HEALS program (which operates only in urban communities) can only occur late in the financial year, after HEALS annual funding is confirmed.

In WA, where the WACHS offers quarterly ENT regional visits, some are funded under HEBHBL and coordination is managed through the regional health working groups46. A distinctive feature of WA is the longer established NGOs (e.g. EarBus Foundation, Telethon Kids Institute, Ear Science Institute Australia) which, in addition to being subcontracted to the HEBHBL program, continue to offer outreach services independently. The lack of information sharing between NGOs was reported as a barrier to alignment.

The State Advisory Forum approval process reportedly adequately coordinates ear health programs. However, in several States interviewees reported they had developed additional mechanisms (e.g. SAEHHRG in SA, a small ‘operational group’ in NSW). In some States, the size of health departments meant that the existence of the State Advisory Forum, despite nominal representation, did not guarantee that key staff in other policy and planning roles in a health department were aware of the existence or details of HEBHBL. Several officers in the DoH State Network reported not knowing how alignments and coordination with other programs were worked out, and felt it was outside their remit to know this.

The subcontracting process meant that many service providers in the field were unaware of what program was funding their visits, or funding may be combined from different programs. Indeed, some interviewees who were critical of the Commonwealth initiatives were working in programs that were funded by them, but unaware. While this may not impact on the effectiveness of the HEBHBL, it is a reflection of the common lack of awareness of the Commonwealth’s investment.

There was little specific evidence of linkage and alignment with other Commonwealth and State and Territory funded outreach programs or primary health programs. With the exception of the NT, where the NT Health Families as First Teachers (FaFT) program is part of the ear health model of care, there was little evidence or mention of linkage with programs like Mums and Bubs or other maternal and child health programs.

7. What are the challenges and enablers for HEBHBL?

The following challenges for HEBHBL were identified:

46 consisting of Rural Health West, WA Primary Health Alliance, WACHS, AMS, the WA Department of Health and those who have experience and knowledge in that local area
(Program factors)

- Lack of awareness of HEBHBL among service providers, and few financial incentives for health professionals to participate in outreach.
- Uncompetitive pay rates for service providers; unable to guarantee sufficient patients for bulk billing
- Developing a model that will work with a local community
- Establishing and supporting referral pathways at the local level
- Inability of outreach visiting staff to know whether the stipulated follow up care occurs after their visits, because of different record keeping systems at different sites. There is limited record-keeping of clinical follow-up, even though the HEBHBL program supports this type of clinical communication
- Several interviewees (fundholders and grant administrators) found the reporting requirements a considerable burden and questioned the quality and utility of some of the data collected
- The timing of annual funding was also problematic when, if funding is confirmed in, say, June, the first quarter (July-September) is largely spent on sub-contracting and setting up arrangements for the year. This is often too late to attract ENT specialists, whose annual calendar is likely to be full by mid-year.
- Allied health would prefer to be paid to attend ACCHOs in all locations due to high DNA rates and limited MBS billing opportunities
- Variations between regions call for specific models for specific regional areas.

(Non-program factors)

- An over-reliance on self-reporting of ear health problems and the normalisation of hearing loss in communities means that existing screening (including during Child Health Checks) can be inadequate
- Access to surgery, in particular theatre capacity, at some hospitals
- Competing demands and workloads in ACCHOs
- Declining capacity in ear health in some ACCHOs
- High staff turnover in ACCHOs
- Workforce shortages in ACCHOs and in the professions sought for visiting teams
- High DNA rates in general affect all service delivery and specialist and allied health commitment to the program.
- Low levels of awareness about the program and little information sharing between the Commonwealth and State Health Departments
- The social determinants of Indigenous health and the difficulties of achieving cross-agency action to address them (education, housing, corrections, health) are a challenge for HEBHBL.

The following enablers for HEBHBL were identified:

- Using established outreach providers with existing infrastructure, governance and relationships
- Willingness of the ACCHO and the community to participate
- Willingness of service providers to participate and bulk bill
- Willingness of LHDs to participate and to bulk bill
- The use of telehealth
- Shared patient records/information systems across services
- Flexibility to design local approaches
- Regional coordinators and regional planning
- Case management and care coordination
- Outreach funding
8. How could the HEBHBL program be strengthened or improved?

Interviewees made a number of suggestions, which are summarised below.

- Raise the profile, awareness and understanding of the HEBHBL program, its approach and purpose; and where it fits in relation to other ear health programs and activities. Many suggested this should be part of the development of a national strategy and approach.
- Improve cross-jurisdictional information sharing between program fundholders, grant managers, policy makers and State/Commonwealth health departments.
- Develop agreed, national data collection standards and mechanisms to share the data. HEBHBL reporting requirements modified to capture more ‘useful’ data. Data collection coordinated and overseen by regional coordinators working with ACCHOs.
- Encourage the use of the national clinical care guidelines (possibly linked to KPIs and payment).
- Use more telehealth and thereby expand the reach of services.
- Reconsider the logic of the current age restrictions (0-21), but within the program have a greater emphasis on 0-4 intervention.
- Acknowledge and allow for the time to conduct respectful consultations with Aboriginal communities to build understanding and trust about the HEBHBL program. Go repeatedly to communities, not just occasionally. ‘Be in there for the long haul.’
- Improve post-surgical follow up.
- Navigator or coordinator roles at different levels (1) at a State level to help the HEBHBL program navigate between the Commonwealth and State systems (referral pathways, access to surgical lists etc.); (2) at the regional level to coordinate service delivery, avoid duplication and coordinate systematic data collection; and (3) at the local level to help families navigate their individual journeys through the system.
- A national clearing house function to maximise availability of the specialist ENT workforce, regardless of State boundaries.
- Expansion of the service delivery standards to include a broader range of services, e.g. to support Indigenous children with Fetal Alcohol Spectrum Disorder (e.g. paediatric, developmental, psychological).
- Move from quarterly to half yearly reporting to reduce the administrative burden; and have program KPIs that are clearly defined so that data are consistent. Allow for larger delegations to fundholders to make variations on annual plans.
Surgical Support

In brief:
Approximately $1.9 million is provided for the Surgical Support program during 2015-16 and 2016-17. The funding has been provided to outreach fundholders in Queensland, South Australia, Victoria and Western Australia.

The program aims to expedite access to ear surgery for Indigenous children who have been on lengthy surgery waiting lists. The initiative is focussed on rural and remote locations. Support is provided for the travel and accommodation costs of both the health professional and the patient and their carer. Where possible, surgery is undertaken locally.

MAIN MESSAGES ABOUT SURGICAL SUPPORT

• The surgical support program has facilitated access for Indigenous children and young people to surgical procedures.

• Where it works well, key hospitals are engaged and committed to prioritising Indigenous children’s ear surgery, but in some jurisdictions there are significant systemic barriers to overcome.

• The surgical support activities have taken considerable time to set up and to operate effectively, but relationships with Indigenous communities and LHDs and local service delivery arrangements that have been developed are demonstrating increasing numbers of surgery events and reductions in surgical waiting lists.

• Unless systemic barriers to access to surgery are addressed, there is a risk that the efficiencies and increased access achieved from telehealth will further exacerbate waiting lists for ear surgery by generating more referrals.

• Many of the ‘program coordination’ problems raised by visiting clinicians were actually system problems related to credentialing and access to theatre time.

Answers to examination questions

1. To what extent is the Surgical Support program achieving its objectives?

Since its inception in the 2015-16 financial year, the Surgical Support program has assisted 190 Indigenous children from rural and remote areas to access in surgery, predominantly in WA.

Figure 3. Number of ear surgeries completed July 2015-December 2017.
Most stakeholders who are aware of the program were positive about its impact, feeling that it was addressing a need created by the burden of disease, long waiting lists for ear surgery and the barriers to Indigenous children from remote communities reaching hospitals.

In WA, the fundholder has worked closely with WACHS, which is responsible for a network of regional hospitals and regularly sends ENTs to regional centres. In addition to WACHS-employed ENT surgeons, a large number of surgeries were completed by non-WACHS outreach surgeons in (e.g. n=40 in Kalgoorlie), working in collaboration with local ACCHOs. WA stakeholders felt that the program is unique (because of its including of travel for a family member), works efficiently and has been successful in eliminating ‘bottlenecks’ in the system.

SA stakeholders have worked closely with the relevant public HHS to complete surgeries in Adelaide and Ceduna. Similarly, in Victoria the RVEEH has collaborated with the HEBHBL fundholder to provide theatre time and staff.

Implementing the program in Queensland, however, has exposed unforeseen systemic barriers (see below), which have caused delays in implementing the program. Consequently, the fundholder has developed work-arounds, such as purchasing time in private hospitals and bringing in private ENT surgeons to perform procedures.

There were also examples provided by interviewees in NSW and WA of regional hospitals refusing to accommodate ear surgery for Indigenous children identified in the outreach program in their hospital catchment areas.

Stakeholders frequently emphasised the amount of time and the resources it takes to get a child to surgery. In North Queensland, it is estimated to take 6 months to overcome the systemic issues. Even without barriers to hospital access, the process is complex and time consuming. Nevertheless, the majority of interviewees saw the program positively:

“The solution can only occur because of the funding from the surgical program.”

Others expressed concerns about the costs, efficiency and outcomes of the program, for example:

“I see massive inefficiencies in getting the children through that surgical pathway – diagnosis – preparation for operation – making sure the parents understand the process.”

The importance of the program providing education and support to families is seen as contributing its effectiveness and essential to reducing DNAs:

“The program doesn’t just provide an air or bus ticket, there is a navigator to support the process.”

2. How does the Surgical Support program contribute to improved Indigenous ear health and hearing outcomes?

The surgical support program has been funded since July 2015. There is little systematic data collection on the outcomes of ear health surgery on Indigenous children. Some fundholders have collected patient satisfaction survey data, but not consistently, and it is not a requirement of the funding agreement. Therefore, measures of the effectiveness of surgery delivered under this program in terms of alleviating their ear disease and improving hearing are not available.

Some interviewees suggested that the achievement of getting the children to surgery was a good outcome especially for myringoplasty (closure of perforation).

“From my point of view, kids waiting for Myringoplasty is a travesty. They should all be done because it is a curative procedure.”

“On the basis that because a greater number of Aboriginal children have had access to surgery than before, then ear health has improved for them. In terms of outcomes at this point there is no clearly defined outcome set.”
However, there was some doubt expressed about the outcomes of inserting tympanostomy tubes (“grommets”) in children from communities in tropical areas where there is a high risk of reinfection. These are clinical issues that are outside the scope of this project, but were raised by stakeholders in the context of questioning what sort of surgery should be funded under the program, given the risk of poor outcomes in some environmental circumstances, and the amount of effort and disruption for all involved in getting the child to surgery.

There is anecdotal evidence from interviews that post-surgery, children have shown increased attendance and attentiveness in schools, but data from schools is not systematically collected or linked to the program.

An indirect beneficial outcome of both HEBHBL and the surgical support program was reportedly raising awareness of the existence of the program(s) among ENTs and attracting more ENTs to become engaged; thereby leading to more clinical sessions and more access; and thereby improving health outcomes.

3. How well is the Surgical Support program operating?

Amongst interviewees, there were mixed views about how well the program is operating, and the program had been implemented with varying degrees of ease, depending on systemic issues. Most interviewees involved in coordinating the program spoke of the long set up time required, but felt that after the first year, the relationships and processes are established and the program is operating well. Most interviewees who are involved in the program indicated they have more surgeries organised for the new financial year and that the process is becoming smoother.

In Queensland, where the systemic issues were seen as most problematic, some stakeholders felt it was not working well simply for that reason and that the costs of getting around the barriers were too high.

Survey respondents in the field who had experience of the Surgical Support program (32%) were mostly positive about the process, rating it as easy or very easy (52%) as opposed to not easy or difficult (36%). The three most commonly reported difficulties were:

- Difficulty in coordinating services across various service providers and agencies (e.g., finding transport and specialist that is linked to a hospital that could provide operating time) (n = 5 responses)
- Funding criteria not covering a visit if the ENT decides not to operate (e.g., families are only reimbursed if when they have surgery when sometimes they require a consultation with the ENT first before deciding on the surgery) (n = 3 responses)
- Poor communication between services regarding the surgery schedule and patients’ progress in their treatment (n = 3 responses).

The same survey respondents indicated that, mostly the travel was well organised; but two respondents reported poor experiences when complex cases were sent to a metropolitan hospital a long way from home.

The six survey respondents who were involved in delivering the program more directly had differing experiences of whether patients received pre and post-operative care; and whether patients were treated at the surgery location closest to home.

4. How efficient and effective are the processes, structures and systems for the delivery and monitoring of the Surgical Support program?

This feedback also relates to NSW, to a lesser extent, but NSW did not receive surgical support funding during the project’s research period. The NSW HEBHBL program, however, does arrange for surgery in regional hospitals where the State-based HEALS program does not operate. The same long set-up time occurred, but the program reports indicate waiting lists are resolving.
The Surgical Support program that is examined in this project is a sub-set of the Eye and Ear Surgical Support Services (EESS). Stakeholders reported that eye surgery has typically been more prolific than ear surgery, for a range of factors. (This is covered in the literature and document review).

In the case of ear surgical support, the structures and processes in each jurisdiction vary, depending on the State’s structure and governance of HHSs. Where a State has either a network of regional HHS (e.g. WA with WACHS; or SA with the Women’s and Children’s Health Network) or one HHS that is committed to and prioritises Indigenous ear health (e.g. Victoria with RVEEH), the local arrangements developed by the fundholder are achieving the intended results.

In Queensland, the structure and processes have been difficult to establish because of: the absence of waiting lists in some regional hospitals; problems with accepting the referrals of ENTs who are not locally credentialed, thereby requiring travel for a second assessment by the local ENT who would perform the surgery. This required funding for two trips – one for the child to be re-assessed by the HHS outpatients in order to be officially placed on the surgical waiting list; and a second for surgery (at some indeterminate time).

There is no systematic monitoring of the program’s effectiveness in terms of measuring improved ear health and hearing post-surgery. Data collection consists of six-monthly reports based on EESS reporting template, although only one of these (number of surgeries per location) appears to be systematically available.

- Financial Report: Income and expenditure for the period, with line items for patient costs and carer costs (travel, meals, accommodation)
- Data Report: (Location/Type of health professional/ Number of procedures/ Total number of patients/Planned number of patients/Total carers travelling/Planned number of carers); patients receiving surgical intervention only.
- Data Report: procedures undertaken by location (number of ear procedures) – effectively a summary of the more detailed data report.

There is also an End of Year Statement (or Final Report) that, like the HEBHBL end of year report, is descriptive of services provided (and any barriers), contains a series of questions about administration activity, issues that have arisen, best practice examples and other information. In most cases, these were a line item in the HEBHBL reports.

Based on information from the consultations, it appears that many of the ‘Activity Administration’ questions would be difficult for the fundholder to answer, for example:

- ‘Have the services delivered reduced the number of patients waiting for services?’ assumes access to waiting lists in HHSs and ACCHO (which is not universal, and data which are not collected in other HEBHBL data)
- ‘Have the services delivered impacted on linked programmes?’ assumes access to information from other programs, when some stakeholders are reporting a lack of information sharing as a barrier.

5. Equity of access: How are service locations prioritised? Are surgical patients prioritised if there is a waiting list? How does this occur?

ENTs prioritise patients for surgical support. This prioritisation may occur as part of the HEBHBL program, or as part of another program (e.g. the WACHS regional ENT visits). It may occur in community during an outreach visit, or by telehealth with images relayed to the ENT in a metropolitan centre.

Consent forms from families or guardians are then required. This process further determines the surgical support list.
Surgical Support

Where access to hospital waiting lists is not possible, needs analysis is limited and therefore prioritisation relies on the effective operation of HEBHBL or similar programs, and information sharing.

“Identifying clients that require surgery can be a challenge and it is really through word of mouth and stakeholders engaged with the [HEBHBL] program.”

6. How well aligned, coordinated and linked is the Surgical Support program with other ear health and hearing services, including those provided by state government and the non-government sector?

The surgical support program is described by some as complementary to or an expansion of HEBHBL. Others suggest that, because the program is not well known, it is not aligned with other programs.

In Victoria, the program links key roles across education and health - Koori Educational Support Officers, the Hospital Aboriginal Liaison Officers and other AHWs working in the ACCHOs; as well as the existing program operated by the RVEEH and VAHS.

In WA and SA, the program links with the activities of the relevant HHS networks.

In Queensland, a key partner has been the IUIH, a RAICCHO, that has collaborated to facilitate access to theatre time in a private hospital at a discounted rate. The HEBHBL fundholder also coordinates with Deadly Ears, through the existing planning groups, to avoid duplication of surgical services provided in the Children’s Health Queensland Hospital and Health Service for the twelve communities with which Deadly Ears has MoUs. There are reported difficulties with aligning with existing hospital programs/schedules in other parts of Qld, especially North Qld.

Except for Qld and NSW, the participants report that the program is aligning and linking well with existing services.

There is criticism from some in the surgical profession about the inability of interstate ENTs to be deployed to surgical programs in other States. This was regarded as an inefficiency or poor alignment of the Commonwealth’s Surgical Support program with other services. However, the consultations indicate that State-based barriers, like credentialing, Hospital Board priorities and autonomy and the practice of some individual ENTs (re acceptance of referrals) are the limiting factors.

7. What are the challenges and enablers for the Surgical Support initiative?

Many of the issues related to the HEBHBL program were seen as relevant to the Surgical Support program.

The following challenges for the surgical support program were identified by stakeholders:

(Program factors)

- Coordination is required between the AMS (assessment), the ENT (diagnosis, surgical assessment, surgical procedure), and the AMS again (for post-surgery follow-up). Optimal use of ENTs when on sessional visits is a challenge that requires considerable organisation by the AMS.
- Preparation of the family for the surgical event; explanation of where they are going to; what to expect.
- Cultural and trust issues where the family is taking a child to someone that they have not met. Parental concerns about leaving other children on community while they travel.
- Very difficult for a co-ordinator role to have the clout to address some systemic issues. Coordinators in NGOs do not have real influence and access to the hospital information system to make the resource allocation.
- The greatest challenge is to attract more ENTs to the Program so that the services can be made available to a larger group of patients.
The restricted age group of the program excludes ear surgery support for adults who may not be comfortable travelling to Perth or regional hospitals for surgery.

Programs such as Ear and Eye Surgical Support are given no indication of the amount the fundholder will receive until they see the contract. This prevents developing more sustainable programs that can link in with other local programs and funding streams.

Short term funding means only small groups of children can be seen.

Health workers who accompany families, don’t go for long but it does leave a gap in the delivery of services

(Non-program factors)

- Theatre time is a ‘constant challenge’.
- Local patient transport services (PATS) are ‘not culturally friendly’. For complex cases needing to go a metropolitan hospital, the process was ‘woeful’.
- (North Qld specific): Access to hospitals; credentialing issues; no existing waiting lists; waiting lists that do not record Aboriginality; the ‘two strikes and you’re out’ policy for DNAs; needing to buy theatre time in the private sector; different pathways, needing more flexible rules for the hard to reach and those in most need.
- (North Qld specific) one HHS (Cairns) is responsible for other regions with no surgical facilities. So that one HHS is controlling another HHS (e.g. Cairns controls what happens in the Cape). Surgeons and doctors are completely separate and ‘do their own thing’.
- Poor compliance from parents in terms of attending appointments and being ready to travel.
- Parents’ fear and misunderstanding of surgery and its value.
- Additional barriers for the children who are in Out of Home Care.
- Difficulties or perceived difficulties of using teleotology for surgical assessment (mostly technical, attitudinal and coordination; the clinical use of teleotology was not an issue).
- The independence of hospital boards, e.g. “In Qld, the HHS are more autonomous from the Dept.”
- Hospitals wary of setting a precedence for some patients to be fast tracked through the health system to receive ear or eye surgery.
- Primary Health services that are ‘not equipped to ensure that the clinical pathway is intact’ (i.e. under-resourced, under-trained).
- If children go back into the same environment post-surgery and don’t have further care, they are at risk of further infection.

The following enablers for the Surgical Support program were identified by interviewees and survey respondents:

- Advocates or ‘champions’ for the program in different organisations and roles (e.g. hospitals, specialists). “Champions make it happen, rather than building the right systems.”
- Credentialing of private providers or interstate providers as VMOs in relevant HHSs.
- Telehealth is seen as a major potential enabler of the surgical support program, to both overcome workforce shortages and to overcome jurisdictional barriers to access to ENTs.
- Supporting patients and their carers along the surgery journey has increased the chance of a successful surgery, and allowed for adequate pre- and post-surgical care.
- Working with a small number of ACCHOs where there are existing relationships.
- Being able to offer surgery in regional hospitals (not too far from community): “We try to keep kids not too far from home, or going to a place where at least someone in the family is...
familiar with it. And we try to get people back safely – meaning that in their absence, welfare hasn’t come and taken the other kids away.”

- An uneventful return home from surgery for the child is seen as an enabler: “Having 12 families whose kids have successfully travelled for surgery and come back, means that 12 more families will think – they did it and nothing happened to them, so we might agree to doing it too.”

- Predictable, ongoing funding assists with the lengthy planning and coordination process.

- A dedicated coordinator for the program (either at regional or State level) who is a conduit for information and support.

- Strong partnerships with HHSs and ACCHOs.

- ENTs engaged and committed to the program.

- Hospitals willing to bulk bill patients from pre-consultations, surgery and post consultation.

- Establishing good clinical pathways between the assessment, surgery and follow-up and the injection of resources especially to the independent primary health services.

- Engagement and advocacy by key people in RACS is an enabler to help ENTs think beyond surgery as the only intervention.

- Funding for HEBHBL is a key enabler of the Surgical Support program.

8. How could the Surgical Support program be strengthened or improved?

Interviewees suggested the following ways to strengthen and improve the Surgical Support program:

- Longer term funding that acknowledges that the program is doing system diagnosis and system change to get the patient journey sorted out.

- Developing a policy or system level intervention between the Commonwealth and the State in light of Closing the Gap (CtG). Working it in as part of service agreements with HHSs; including CtG targets in HHS service agreements (and adding ears to the CtG indicators). HHS are not bound to CtG targets in their funding, that would be leverage if they were.

- Developing some way of redressing the low priority given to Indigenous ear health at a structural level. Whether this is through a series of financial incentives, hospitals revaluing waiting priority, or directed from the Commonwealth that these children should not be at the lowest priority. There should be a reweighting of priority of specific interventions for kids - so they don’t get held up in extremely long waiting list of hospitals.

- Creating a centralised coordinating agency that can look at all these policy issues and will have the clout to say to these organisations [hospitals] “well, you’re not fulfilling your remit by not providing this service;” and there needs to be consequences for the administrators involved if they don’t.

- Credentialing outreach ENTs as VMOs.

- Increased use of telehealth to overcome geographic and system barriers. A viable model - that can pay for telehealth.

- Surgical funding that is more flexible and would pay for surgeons’ time.

- Addressing clinical referrals and clinical protocol issues (need uniform guidelines).

- Including adults in the surgical support program

- Doing more surgery in the community. There are models used where day surgery can occur on site in local communities in cooperation with local services (e.g. the NZ model).

- OM is listed for surgery as Category 3, but should be listed as Category 2.

- More research is required to establish and track clinical effectiveness with different sub populations.
• Preserve the highly effective funding for carers and for supporting the children to get to the surgery.
• Simplify the process: It’s very hard and challenging to get the surgical support (e.g. paperwork & systems).
• Continue funding to support clients; provide care coordination/ case management
• Aboriginal and Torres Strait Islander children should be prioritised on pre-consultation and surgical lists;
• Outpatient clinics should be asking client’s if they identify as Aboriginal and Torres Strait Islander when booking initial pre-consultation if they are not already.
• Develop an integrated clinical pathway that ensures follow-up. The recruitment of more ENTs and the resourcing of the independent health services to properly manage the clinical pathway and follow-up as it affects their clients. This means ensuring that the surgeon performing the surgery is involved with team providing the follow up. (This can involve follow up from a distance).
Provision of Ear and Hearing Assessment Equipment

In brief:
A total of $1.4 million is provided for Ear and Hearing Assessment Equipment for the period 2016-17 to 2018-19.

The objective of the ear and hearing assessment equipment program is to supply and maintain ear assessment equipment at no cost to Australian Government funded Aboriginal Medical Services and other health services with a predominance of Aboriginal and or Torres Strait Islander clients.

Provision of equipment is conditional on health services having trained staff to use the equipment. Training on the use of equipment is available free of charge to health professionals prior to the delivery of equipment. This training is provided through the Ear and Hearing Health Assessment Training initiative outlined below.

MAIN MESSAGES ABOUT THE EQUIPMENT PROGRAM

• The equipment program had an initial impact, but is not achieving full effectiveness because of levels of awareness, workforce and training issues.

• Future expenditure on equipment needs to consider advances in technology that have occurred since the program’s introduction in 2010.

• These technological changes have the potential to affect models of care and improve timeliness and efficiency.

Answers to examination questions

1. To what extent is the Equipment program achieving its objectives?

Some interviewees commented on the initial impact of the equipment program in 2010, but 58.67% (n=41) of survey respondents indicated that they did not know about the program. Data from the consultations suggest that there are low levels of awareness about the equipment program; and this may be attributable to staff turnover in health services and/or lack of training. A representative response from stakeholders was:

“[People in services say] ‘that was a long time ago, the staff member who was trained has moved on. The equipment has been put into a cupboard. The new staff don’t know about it.’”

Interviewees reported a ‘surge’ in 2010, when everyone knew about it and got the equipment, but not hearing anything much since.

Survey respondents who had equipment indicated ‘more than three’ people in their health service have been trained to use it (n=10, 38%), and have used the ear health assessment equipment. However, more than 50% of respondents (n=16) indicated that there were not enough people in their health service who were trained to use the assessment equipment.

Most respondents reported that they were provided with equipment that they need, and that their health service used the equipment either on a weekly or daily basis. Those who reported not having the equipment further described what that they needed - otoscope, digital video otoscope, OAE machine and audiometers.

2. How does the Equipment program contribute to improved Indigenous ear health and hearing outcomes?

The logic behind the Equipment program is that, once trained, primary health staff in urban, rural and remote health services will be able to assess children’s ears and identify signs of middle ear disease, then refer them for further assessment and treatment. The program is intended to provide some of the essential infrastructure for the prevention, early intervention and timely referral to the care pathway.
Based on the available data, 41% of survey respondents who were aware of the equipment program said that their health service uses the equipment.

3. How well is the Equipment program operating?

Lack of awareness of the program was consistently reported and is supported by the online survey data (58% unaware). Therefore, promotion and dissemination of information about the program is falling short. The contract with the provider is silent about responsibility for the promotion and advertising of the availability of equipment. Most contact between the provider and the health services is with services that already have equipment. It is not clear who is responsible and what the mechanism is for informing and updating health services about the program’s existence.

Of the ‘aware’ survey respondents, 71% (n=20) said that the equipment provided worked well or was not broken. More than half of the respondents (n=29, 55.17%) agreed that the organisation of equipment repair was done quickly. Thirteen respondents (43%) said that they were provided with replacement equipment while theirs was being fixed.

Interview data suggests that the flaws in the operations of the equipment program are:

- Unused equipment (and no way of knowing that it is unused)
- Lack of training, low levels of confidence in using it
- Equipment which is not the most suitable for rural and remote services
- Equipment that is not suitable for testing younger children.

4. How efficient and effective are the processes, structures and systems for the delivery and monitoring of the Equipment program?

The Equipment program provider is contracted to supply and maintain, calibrate and repair ear health assessment equipment (and coordinate the process with services). The provider is required to submit:

- quarterly reports to the Qld State Network grants officer, using a specified template that documents these activities by location, maintains a register of equipment, and reports on the use of the allocated funds
- an annual report
- an annual plan (including systematic scheduling of calibrations repairs
- a final report at the end of the contract period.

In addition, the contractor maintains and distributes a Contractor Manual, for use by the health services, explaining the procedures for the program and simple care and maintenance of the equipment on site.

In terms of the contracting, reporting and internal processes of the program, the efficiency of the operations do not appear to be an issue. Stakeholders using the program were mostly satisfied. There is very little equipment unaccounted for (0.5%, n=6) and the provider reported very little equipment damage.

The provider appears to be dealing efficiently with the same cohort of services – the ‘aware users’.

What appears to be lacking in the systems and processes is:

- A mechanism to know who else is out in the field and might need the equipment
- A platform for promoting the program to potential users
- Clear responsibilities for promoting the program.

Further, there does not appear to be a mechanism for tracking or applying the stated pre-requisite of eligibility for equipment, that is: having completed training (see alignment and linkages below).

5. How well aligned, coordinated and linked is the Equipment program with other ear health and hearing services, including those provided by state government and the non-government sector?
The key alignment of the Equipment program is with the Training program. The stated pre-requisite of eligibility for equipment is: having completed the training program. From the documents and consultations, we have not been able to identify the mechanism for ensuring this policy is applied. Moreover, if there is unused equipment sitting in health services, and new staff employed in those services, the notion of a pre-requisite may not be feasible or practical.

There was some misinformation in the field about this pre-requisite. Some stakeholders said they weren’t aware that training was a requirement; others said that they thought the program had finished; and one stakeholder in a pivotal role thought that equipment was only available to sites where training takes place, and not to services that had attended training elsewhere.

The other key alignment of the equipment program is with the HEBHBL program. The equipment to be provided is intended to support primary health assessment and early intervention with the targeted population. Interviewees raised two pertinent issues:

1. Many are proposing that the model of care has a focus on 0-4 year-olds, where specific assessment equipment is appropriate
2. Many are proposing a greater emphasis on telehealth and the use of smaller, portable equipment that uploads to a database to be accessed by specialists.

Therefore, in future, re-alignment of the equipment provided would be required to effectively support any new models of care.

6. What are the challenges and enablers for the Equipment program?

The following challenges for the Equipment program were identified by stakeholders:

- Staff turnover in AMSs means that knowledge of equipment use and maintenance can be lost; and the remoteness of the services calls for more portable, simpler equipment.
- Getting the right information about what equipment is funded and what isn’t. It’s not listed anywhere.
- Often the equipment at the service is a bit older than the equipment they learn on at Benchmarking training (which is digital). The AHWs don’t feel confident using the equipment if it’s different.
- Lack of training and inappropriate deployment of equipment.
- Audiology and ENT teleotology are only screening tools - they don’t solve the problem. Adequate referral pathways need to be in place to make it effective.
- There’s a gap for under 2’s. There’s paediatric hearing equipment, but little kids need a sound proof environment and the right equipment.
- Any type of equipment needs to come with training.
- NT Health Department is only able to train people in the communities three or four times a year. Although they have a big focus on ear health assessment training, they do not have sufficient funds and resources to conduct training across the region at the desired frequency.

The following enablers for the Equipment program were identified by stakeholders:

- Awareness: “Everybody is now on board and they are aware and most of their equipment is calibrated, so they all know, which is really great to hear, so that’s feedback we are getting, and I think they’re quite happy”.
- Australian Hearing: “Locally, we used Australian Hearing to help with support for use of equipment. We had a local coordinator which made a big difference. A lot of work done by us to make sure the equipment is used properly.”

7. How could the Equipment program be strengthened or improved?
Interviewees and survey respondents suggested that the Equipment program could be strengthened by

- Letting people know about it - more communication about the program.
- Increase the use of newer technology such as phone attachments for otoscopy, audiometry; vision; diagnostic audiology and tympanometry. All data goes to a single source; or OAE oto-acoustic emissions (also attaches to a phone and you stick it in an ear and it sends results by phone) – these technologies have implications for models of care, workforce models, patient pathways and data collection. If it were used in primary health, you could get prevalence data.
- Consulting more with services about the type of equipment required.
- Consider whether more diagnostic equipment should be provided, in addition to the screening equipment.
- Explore teleaudiology - that could take away the remoteness issues. The technology is currently available and it depends on its uptake/rolling out - With the rollout of NBN and part of satellite services, the technology is there. It’s more about rolling it out.
- There are new technologies on the horizon - telehealth and more.
- Developing ways of quickly identifying who is likely to have hearing loss, such as classroom games of games on apps. There is early evidence that they can identify hearing loss faster than audiometry.
- Look very carefully at the success of the teleotoscopy in the NT to understand and then put into a structural program that can be effective. Then think seriously how that should be implemented across the country for people who do not have ready access to teleotology.
- Make the equipment available to everyone, not just to services that provide the training.
- Provide greater incentives to ACCHOs and other primary health care providers to undertake ear and hearing checks and people involved need to be better informed about what's available and how equipment provision is linked to training and other aspects of ear health service.
- “We need to devise a system that allows for technology to support the community need. The emerging technology is fantastic, and it should be investigated. If I could have images taken in the community available to me via My Health Record, (and able to be added to a database) that would be fantastic.”
Ear and Hearing Assessment Training

In brief:

A total of $2.6 million is provided for Ear and Hearing Assessment Training for the period 2014-15 to 2018-19.

The aim is to train health professionals to be able to more readily recognise clinical symptoms and behaviours indicating ear health issues and initiate early intervention or ongoing surveillance.

Ear and Hearing Health Assessment Training is available to improve the skills base of health professionals with clinical responsibilities who have regular contact with Indigenous children in their community.

MAIN MESSAGES ABOUT THE TRAINING PROGRAM

• The Training program is meeting its KPIs as per the funding agreement; 64% of courses were delivered outside metropolitan areas; and 65% of participants were located outside metropolitan areas.

• There is a low percentage of Aboriginal health professionals attending the courses.

• The provision of one-off training, without ongoing at-elbow support, capacity building and confidence building for health workers is regarded as insufficient to sustain quality ear health services.

• In two States, there are local training programs, funded by the Commonwealth and offered through local ACCHO state/territory peak organisations, to address the needs of staff in Aboriginal health services. In Queensland, the Deadly Ears program offers a training program, which is transitioning to online delivery.

Answers to examination questions

1. To what extent is the Training program achieving its objectives?

Benchmarque has been contracted to deliver accredited training programs to health professionals who work with Aboriginal and Torres Strait Islander patients to specialise and/or increase their knowledge of ear and hearing health conditions. These courses are: Otitis Media and Aural Health Care (1 day) and Audiometry Screening and Assessment (3 days). Training is to be delivered in metropolitan, regional, rural or remote settings and tailored to suit the clinical needs of participant profiles to maximise attendance and participation. Courses may be to a single clinical profile or to a clinic with a mix of clinical workforce. All training is expected to be sympathetic to the clinical setting and referral pathways of participants. The program forms part of the Indigenous Australians Health Programme.

The Benchmarque program has been providing training since July 2015. Course data show that in the financial year 2015-16, Benchmarque conducted 109 1-day courses (target=110); and 13 3-day courses (target=12) – therefore almost meeting and exceeding the respective targets for that year. In the first 18 months of the program (July 2015–December 2016) a total of 1839 people attended 156 courses.

In terms of course locations, 64% of courses were delivered outside metropolitan areas; and 65% of participants were located outside metropolitan areas.

These data indicate that, in terms of target numbers of courses and locations of courses the program is meeting its objectives relating to access.
In terms of achieving the overall objective of skill improvement, Benchmark’s course participant surveys show overall positive ratings (99%+ for participants in both courses.48 The two survey respondents who indicated that they had received training from Benchmark said that they are utilising the skills learned.

Of the 73 respondents to survey questions about training, 45.2% were unaware of any national training program. Ten respondents who said they had received training could identify the training provider. Four respondents reported Benchmark as the provider (only two had completed the training, the other two had applied), while five said they received training from NACCHO or ACCHO state/territory peak organisations. One identified Rural Health West as the training provider.

Five out of eight respondents (62.5%) reported that they used an Aboriginal Community Controlled Organisation for training staff about ear health. Two (25%) nominated Benchmark and one indicated ‘Other’, which was later described as the Aboriginal Health Council of South Australia, for training staff.

These data highlight the point that, in some States, the Commonwealth is also funding ear health training through its funding of the Ear Health Coordinator program. In SA, a purpose-built training program (unaccredited) is delivered on site to member health services of the AHCSA, as part of the role of the Ear Health Coordinator. Similarly, in WA, components of the accredited NACCHO program are taught on site by the AHCWA’s equivalent staff member. A key difference is that both these programs incorporated follow-up of course participants on site (usually @ 3 months), although logistics and funding sometimes restricted this.

There was a frequent misunderstanding about who is delivering the national training program, with some interviewees stating that the peak body NACCHO delivers it. Of the few interviewees who were aware of the Benchmark program, four spoke positively about it; although two of these expressed concerns that maintaining skills and confidence of staff when they return to the workplace is the biggest challenge, and that this is not addressed by the Benchmark program. Three interviewees were negative about the program. One reported having done the 3-day course, being assessed as competent, but not feeling competent or confident to apply the skills. Another thought that the courses were fee-paying and too expensive for AMSs; that the courses were regarded as culturally inappropriate; and that “in some cases people don’t even get shown a tympanometer.”49 Another said the Benchmark program did not address the diseases seen in remote communities. Two of the three negative responses were based on ‘what service providers had told them.’ We report the issues here to reflect the absence of information in the sector and the word-of-mouth information that was evident in the consultation process. [Note: except for the interviewee who had completed the training program, other advice from interviewees was based on third party information].

The absence of some elements of training was lamented by some stakeholders, who felt that the primary care workforce in Aboriginal health services is becoming de-skilled by outreach programs:

“in years gone by the Ear Health workers could do a clinical role – they were trained in otoscopy, cleaning ears, giving antibiotic drops etc.”

On paper, the current subsidised program does not redress this skills gap because, for example, the competency Perform Wax Removal AEHPWR003A is not included in either of the funded courses.

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48 Surveys are only available for the six months reported in Interim Report Ear and Hearing Health Project July - December 2016. These surveys were collected at the end of each delivered workshop. Benchmark also reportedly conducts post-course follow up surveys, but these data were not available at the time of writing.

49 This statement is correct in that tympanometry is only taught in the 3-day course. Benchmark advises that, in the 1 day course “students are taught the practical skills to conduct a comprehensive ear health assessment. The equipment we use includes a range of otoscopes (standard, pocket, digital and macroview) and we also use a range of tuning forks for application of the Weber and Rinne tests.”
This program has been added by Benchmarque since the program’s introduction. It is not one of the originally contracted programs, but is publicised on the Benchmarque website. It is available from Benchmarque in the form of a half day Bridging Course at the cost of $325.

Based on the evidence available, it can be shown that Benchmarque is offering the courses in the right types of locations; that more than 1839 people have completed the courses; and that the feedback from participants immediately after the course is positive.

From the available data, it is not possible to measure improvement in the ear health workforce’s skills base.

Interviewees reported gaps in the capacity of the primary health workforce in understanding what is involved in a hearing check and using the equipment. This included GPs. Interviewees reported that Medicare Item 715 (Child Health Check) performance doesn’t always adhere to the Commonwealth guidelines; and that supporting people to comply with properly checking children’s ears (e.g. training and equipment) is still required.

2. How do the initiatives contribute to improved Indigenous ear health and hearing outcomes?

There are insufficient data to determine the outcomes of this program in contributing to improved Indigenous ear health and hearing outcomes.

However, the intent of the program is to ultimately improve the skills base of health professionals who have regular contact with Indigenous children in their community so that they: use ear assessment equipment; are able to more readily recognise clinical symptoms and behaviours indicating ear health issues; and initiate early intervention or ongoing surveillance.

3. How well is the Training program operating?

The Benchmarque program became fully operational in mid-2015 initially as complementary to the formerly-funded NACCHO program which NACCHO was unable to continue (which was a 2-week program, predominantly offered in metropolitan areas), 50

The operation/administration of the Benchmarque program is arranging and conducting the specified ear health courses as required. The targets for course numbers were met in its first full year of operation; locations of courses were geographically diverse (in terms of remoteness classifications), attendance rates were good and participants reported high levels of satisfaction with their courses.

During the 18 months of operation, Benchmarque has deployed a workforce of twelve trainers to deliver the courses. However, to deliver the 3-day Audiometry course, Benchmarque is in partnership with a private audiometry practice, Central Coast Hearing. These courses are provided by a single trainer, which could potentially pose a risk; although there is no evidence from the documentation of cancellations or inability to offer the course due to staffing issues. Waiting lists for the 3-day course are reported to be due to popularity and the annual resources being fully allocated. 51

There are two levels of operation that appear to require further attention. These are:

Marketing and promotion of the courses

Most people who participated in this examination of the programs had very low levels of awareness of the Benchmarque program. There was also considerable confusion about whether the programs were fee-paying or subsidised, and whether the programs were specific to Indigenous ear health.

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50 Based on advice from the Department. Examination of the NACCHO program was not within the scope of this project.
51 Interim Report Ear and Hearing Health Project July - December 2016
Benchmarque produces flyers specifically for the *Otitis Media and Aural Health Care* (1 day) course in different locations. These carry images of Indigenous children or staff, provide brief information about the course and promote the forthcoming local course date and time and how to enrol. Benchmarque reports that it works closely with organisations and stakeholders to support the delivery of courses in local areas. This could include a Primary Health Network, a Rural Health Organisation, a local AMS or similar. Once the course is scheduled, Benchmarque supply a range of materials to promote the course and encourage registration. The flyers reportedly tend to be the entry point for students.

[It should be noted that, although the opening text in the flyers describes the course as: “a nationally accredited program [that] is fully funded by the federal Department of Health under the *Ear and Hearing Health Project,*” the flyer carries five logos – but not the Department of Health logo].

The marketing approach therefore, appears to rely on relationship building and collaboration with identified organisations. The spread of course locations shows that Queensland is consistently over-represented in the number of courses offered (43%) vis-à-vis other jurisdictions.

The other way for services to find out about the training is from internet searching. On the Benchmarque website, the Commonwealth funded courses have little prominence. For the visitor searching for these courses, the website can be confusing or requires persistence to locate which of four Benchmarque ear health programs are funded by the Indigenous Ear Health Initiative. The courses most easily located are fee-paying courses that are not Indigenous-specific. A Google search for Indigenous Ear Health training does not yield Benchmarque on the first page. It is possible that the website information may be contributing to the confusion among stakeholders about the programs (e.g. not free, not appropriate for Indigenous people).

**Mix of participants in courses**

The Training Program contract states that courses should be “tailored to suit the clinical needs of participant profiles to maximise attendance and participation. Courses may be to a single clinical profile or to a clinic with a mix of clinical workforce. All training is expected to be sympathetic to the clinical setting and referral pathways of participants.”

The data indicate that courses are predominantly attended by Registered or Enrolled Nurses (RN, EN), particularly in the 1 day *Otitis Media and Aural Health Care* course, where 59.3% were RNs or ENs and Aboriginal Health Workers or Aboriginal Health Practitioners represented 8.5% of participants.

The significant presence of nurses could be partly attributed to (1) provision of a specify entry point to nurses on the Benchmarque website (2) the absence of any specific information about CPD points for Aboriginal Health Practitioners in the course FAQs (whereas this information is promoted for nurses and GPs) and (3) all the access and perception issues previously raised about the web-based information as it is currently structured.

**4. How efficient and effective are the processes, structures and systems for the delivery and monitoring of the Training program?**

As stated above, the Benchmarque program has been efficient and effective in conducting courses outside the metropolitan areas for a range of health professionals to improve their skills in ear disease and hearing health. The target numbers of courses were largely achieved in the first full year of operation, and in the first 18 months, 1839 people attended 156 courses.

The distribution of courses has been skewed towards Queensland, although activity in other States is increasing. There is little evidence of a needs-based approach to identifying locations for training. Like the HEBHBL program in some cases, it relies on individual approaches or expressions of interest from services, which is an indication of awareness, but not necessarily of the greatest need.
However, needs-based identification of locations is not a requirement of the contract. The same barriers to accurately identifying need (inadequate data and too many local data sources) were identified as barriers to this process working effectively for the Training program.

There is a reported high demand from individual students and from Primary Health Networks for the 3-day Audiometry Screening and Assessment Program (ASAP), with waiting lists established. However, for privacy reasons, the researchers were unable to obtain data on which PHNs were seeking training. Such data would be useful in identifying: whether the (few) PHNs currently collaborating in programs like HEBHBL are requesting the training; whether it is different PHNs undertaking additional Indigenous Ear Heath activity; or whether the training is being delivered in PHNs that are not as heavily involved in Indigenous ear health and therefore should be lower priority.

There were concerns expressed in some interviews that the training does not prioritise staff in Aboriginal Health services, that the mixed groups in training sessions consist of clinicians from areas of low Aboriginal population, or who infrequently have contact with Aboriginal people (e.g. GP registrars on placement).

There is a relatively low proportion of Aboriginal health professionals attending the courses, compared to other clinicians. Although the program is not specifically targeted at Aboriginal and Torres Strait Islander staff, stakeholders have identified the capacity and confidence of Aboriginal Health Workers and Health Practitioners as crucial to the success of all the ear health programs. Some stakeholders (in interviews and the survey) suggested that the program is not culturally appropriate:

“The Otitis Media and Aural Health Care Program was very biased towards non-Aboriginals. I believe that seeing that Aboriginal Children have the worst ear health in the world, the teaching should be directed at this sector of the health community. I recommended Aboriginal Health Workers attend the course. I feel that there should be a specific course tailored to their cultural needs i.e. Written by Aboriginal and for Aboriginal. More pictorial content, simple language, less words.”
- Survey Respondent in WA

There is some evidence that the marketing approach and information on the website could be contributing factors to lack of awareness and understanding of the training program in the sector.

Based on the advice from several stakeholders, the program is lacking the crucial element of follow-up training and support to build competence and confidence. However, this is not a requirement of the contract.

The processes for monitoring the program are adequate for monitoring activity and financial management, but are inadequate for monitoring the outcomes of the program in terms of skill improvement, except for surveys immediately post-course. The sustained use of new skills, the reach of the program into the communities at most risk and the targeting of clinicians most likely to need the skills cannot be measured using the current monitoring processes.

5. How well aligned, coordinated and linked is the Training program with other ear health and hearing services, including those provided by state government and the non-government sector?

As mentioned above, the Commonwealth is currently funding three types of training programs: the two Benchmarque courses and two different programs in WA and SA, funded indirectly through the Ear Health Coordinator program.
The latter two state-based programs are a manifestation of the different ways that the Ear Health Coordinator funding has been applied in different States. From the consultations, there appeared to be no formal mechanisms for aligning these training activities or collaborating or linking, although some informal communication was reported. The key difference in the programs is that the State-based programs include follow-up site visits to those who have been trained, to provide further training and support.

The Qld Department of Health Deadly Ears program also has its own training program. Benchmarque reported discovering the Deadly Ears Program incidentally because of the training it was doing in Queensland and suggested that effectiveness of the Training Program could be enhanced with better collaboration and coordination. The Deadly Ears program representative has advised that 'up to 2017 the Deadly Ears Program provided some targeted training for people responsible for ear health checks, especially those doing the checks for 0 to 4 year olds (as part of their routine Child Health Check). In the Queensland context, this means that training was frequently provided to child health nurses and sometimes GPs. [Aboriginal] health workers needed to have Cert IV qualifications (to do the DE training). The trainers went to locations where there was significant evidence of demand for services [i.e. child health checks which did not include ears and hearing, high burden of middle ear disease] and generally where there was a significant number of people who required training. The Deadly Ears training course was aligned to the relevant VET ear hearing screening competencies[2]. It did not involve participants obtaining a formal competency because Deadly Ears is not a RTO. It was intended to enable people who had ear and hearing screening within their existing scope of practice to undertake this task. It did not coordinate formally with Benchmarque, but some requests were referred to Benchmarque if demand exceeded capacity or if Benchmarque was known to be delivering in key regions of Queensland. At the time of writing, training delivery of the Deadly Ears Program was on hold, pending the development of an online training module. They are hoping to make the training live in the first quarter of the new financial year (hopefully by September 2017).

In WA, WACHS provides the Enhanced Aboriginal Child Schedule (EACS) – which is prerequisite training for WACHS staff in the skills required for ear health checks. This does not appear to be coordinated with the Benchmarque training program. “If we have audiologist in the region, we included that in the contract that they deliver locally based training. There may be duplication of numbers.”

The Benchmarque training is consistent with and aligned to the National Guidelines. In terms of aligning with the equipment program, Benchmarque reports that the training utilises all forms of equipment that is available in the field (from the national equipment program). The training provider suggested, however, that the emergence of newer technologies could be incorporated into the training.

In general terms, Benchmarque felt it was not adequately aware of the other Commonwealth programs and often discovers aspects and elements of the Program that it could enhance and better connect to, but did not know about.

Some ACCHO state/territory peak organisations reported communicating and working with Benchmarque, informally, to advise or give feedback on the program content and advise about gaining access to Aboriginal Health Services to arrange training.

6. What are the challenges and enablers for the Training program?

The following challenges for the Training program were identified:

[2] Benchmarque’s Audiometry course teaches the new units of competency, in which ‘There have been significant changes to the elements and performance criteria. New evidence requirements for assessment, including volume and frequency requirements. Significant change to knowledge evidence.’ [Industry Skills Council (December 2016) HLTAUD001 Assess hearing. https://training.gov.au/TrainingComponentFiles/HLT/HLTAUD001_R1.pdf]
• Dissatisfaction within the sector about the introduction of a new program to replace the former NACCHO program. The length of the program (2 weeks) was seen by some as preferable for instilling competency and confidence and the shorter duration of the Benchmarque programs was seen as a barrier to effectiveness. [Note: the consensus however was that the optimal duration of training was less than 2 weeks, but with ongoing, on-site support post-training].
• Dissatisfaction with cultural appropriateness of a ‘mainstream’ program, as opposed to a program developed and delivered by Aboriginal people to Aboriginal people.
• Increasing the numbers of those trained which means making the training more accessible, especially in remote areas.
• Limited awareness and understanding of the training program content and purpose.
• Limited specific promotion to Aboriginal Health Workers and Aboriginal Health Practitioners.
• Limited specific information about CPD points for Aboriginal Health Practitioners.
• The lesser content for the funded Otitis Media and Aural Health Care course (2 competencies, when compared with 3 competencies in the fee-paying Course in Aural (Ear) Health) is a potential barrier to people working in AMSs learning skills for Performing Wax Removal, because the cost of the half day bridging course to gain this competency ($325) is not included in the subsidised program [identified from document review]. \textit{Please note} that this course was recently added by Benchmarque and was not part of the original contract.

The following enablers for the Training program were identified:

• Ensuring any training provided will lead to a recognised certificate.
• Ensuring that any training provided will include ongoing support and follow up.
• Prioritising people who see a lot of Indigenous patients, especially ACCHOs and AMSs
• Providing the opportunity for people to practise their new skills.
• Better connection and collaboration between services and organisations in the sector.
• Better promotion, explanation and publication of the Commonwealth’s investment.

7. How could the Training program be strengthened or improved?

When asked how the training could be made better, survey respondents and interviewees suggested:

• the training could be tailored to registered nurses or child health nurses
• there should be a specific course tailored to their cultural needs i.e. written by Aboriginal people and for Aboriginal people
• prioritising staff in AMSs and ACCHOs
• more and frequent training should be offered and delivered
• there is a need for upskilling every few years
• training materials could contain more pictorial content, simple language and less wording to suit participants’ learning style
• having a nationally recognised qualification that would attract workers to do it – something that would be seen to have value, be portable, lead to recognition
• the training should not just be about preventing, diagnosing and managing ear disease and hearing loss, but also about the behavioural and social impacts of that hearing loss and what that means for communication. This is relevant for teachers, corrections officers, parents and others outside the health sector.

Taken together, the information provided by all stakeholders in interviews and the survey suggested an ideal training model for Indigenous ear health outreach services.
Table 4. Elements of Good Training Model for Indigenous Ear Health Outreach Services

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<tr>
<th>ELEMENTS OF A GOOD TRAINING MODEL FOR INDIGENOUS EAR HEALTH OUTREACH SERVICES</th>
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<tr>
<td><strong>Training should:</strong></td>
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<tr>
<td>Be Indigenous specific and culturally appropriate</td>
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<tr>
<td>Be delivered as close as possible to where the people are working</td>
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<td>Be delivered in a series of short sessions over 1-2 days</td>
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<td>Use new technologies</td>
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<td>Be delivered face to face, but have web-based platforms available</td>
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<tr>
<td>Be regularly supported by at-elbow supervision and support at the workplace, including by visiting health professionals in outreach teams or by supervision at a distance</td>
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<tr>
<td>Eventually lead to recognition/certification and articulation within the VET sector and potentially to University.</td>
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Ear Health Coordinators

In brief:
A total of $2.1 million is provided for Ear Health Coordinators for the period 2015-16 to 2018-19.

An Ear Health Coordinator is employed in the Community Controlled Aboriginal Health Services peak organisations in NSW, QLD, SA, Vic and WA. Ear Health Coordinators work with health professionals in Aboriginal Community Controlled Health Organisations (ACCHO’s) to reduce the impact of ear disease in communities. By building skills and knowledge to identify ear conditions, earlier treatment and management can occur to maximise health outcomes.

MAIN MESSAGES ABOUT THE EAR HEALTH COORDINATOR PROGRAM

• The Ear Health Coordinator roles, located in five ACCHO state/territory peak organisations, have been interpreted or implemented differently and have varying foci.

• The effectiveness of the role can depend on the geographic size of the jurisdiction, as well as other State characteristics.

• Stakeholders generally felt that meeting all the expectations of the role was not feasible with the amount of funding provided.

• The application of the current roles varies between jurisdictions due to local history and context.

• The roles do make, or potentially could make, an important contribution, but need to be reviewed to clarify their purpose and expectations; and how they would work with other ‘coordinator’ roles, such as those in the HEBHBL fundholders.

• It may be feasible to redesign the EHC roles so that they have key responsibility for training and overseeing ACCHOs in data collection and in the use of equipment for screening and referral.

Answers to examination questions

1. To what extent is the Ear Health Coordinator program achieving its objectives?

Many of the interviewees were unaware of the EHC program and some confused the role with other coordination roles in their jurisdiction or region.

In two of the five States, the EHC has been in the role for less than a year. In both cases, the respondents felt it was too early to assess achievement of the EHC Program’s objectives.

In WA, the incumbent (whose role is described as Ear Health Project Officer/ Clinical Trainer) has been in the role for two years. In both Qld and SA, the EHCs have been in their roles for 5 years (since 2012). In each of these longer established roles, the interpretation and application of the role has been different.

In WA, AHCWA sees its role as upskilling and ensuring capacity in its member services, as well as active involvement in health promotion activities. AHCWA is a Registered Training Organisation (RTO) that delivers Ear Health Skill set training to Aboriginal Health Workers in their 21 member services. This training is delivered both in Perth and on site. Ear Health Skill set training\(^{53}\) provides three units of competency that can count towards a Cert IV qualification (screening children; screening adults; and ear health promotion/prevention and early detection). AHCWA is in the process of mapping and identifying needs (for ear health services, equipment and training) across its membership. There has been a Deed of Variation between AHCWA and the Commonwealth to address what the State Network felt was inadequate reporting of the EHC’s activities. Due to the

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content of reports submitted to date, it had been difficult to assess whether the program is achieving its objectives.

In Qld, the QAIHC role is interpreted at a higher level, with the EHC being involved in policy making, representation on committees, collaboration with other ear health programs (HEBHBL, Deadly Ears) etc. QAIHC interviewees saw a misalignment between the objectives of the EHC role and the organisation’s mission - QAIHC viewed themselves as a body that represents the members in terms of policy and strategic development at the national and state level. QAIHC are ‘the interface with the State and regional peak bodies (e.g., RAICCHOs) provide the operational support to ACCHOs. QAIHC suggested that “If we were to canvass our members, probably ¾ of them would say they have not heard from their ear health coordinator. We have some member services who need a lot of support, because they are at risk of not delivering on key services if they were not provided with support. It’s all about going to where’s the needs are.”

In SA, the AHCSA role appears to be the only established role that is working in full accordance with the role description in the funding agreement. A key role of the Ear Health Project Officer in SA is to deliver the (locally developed) training program to staff in ACCHOs, delivered on site. The training program is intended to equip staff to screen for ear disease and consists of aetiology, epidemiology; anatomy, technical skills, equipment use, tympanometry and audiometry. Training originally occurred over 2 days. All (ACCHO) staff who have client contact are supposed to do the course and the program has supporting materials (a flowchart and manual for ACCHO staff). In addition, the EHC audits ear health equipment in AHCSA member services, works on improvement in data collection by member services, participates in ear health working groups and liaises with RDWA (the HEBHBL fundholder) about the HEBHBL program.

Common feedback from other stakeholders included

- Uncertainty about the EHC role and responsibilities
- Comments about the complexity of the ACCHO structure in Qld
- Views that a standard role definition and the same amount of funding for States of different size, distribution of Indigenous communities, numbers of member services and consequent travel costs was not feasible
- Confusion about the number of coordinator roles in the ear health sector.

2. How does the Ear Health Coordinator program contribute to improved Indigenous ear health and hearing outcomes?

Several respondents thought that, theoretically, the EHC role contributes to improved ear health by: building capacity; identifying need and gaps in services and improving data collection. However, several respondents pointed to the same gaps in data (both patient data and service quality data) as mentioned in the HEBHBL and Surgical Support program feedback.

EHC roles in different States are also in different stages of development. For example, in NSW, the program is still in the mapping and needs analysis phase.

3. How well is the Ear Health Coordinator program operating?

In most jurisdictions, respondents felt that one funded position was insufficient to achieve the expectations of the EHC role. There was a view that some tasks – such as the development of indicators in each jurisdiction – were duplicative.

Except for the newly established roles, which are still in the set up and mapping phase, the longer established roles have developed different emphases or made choices about what to prioritise, not all of which are in the stated expectations of the funding agreement.
4. How efficient and effective are the processes, structures and systems for the delivery and monitoring of the Ear Health Coordinator program?

Under the current funding agreement (2016-19) ACCHO state/territory peak organisations are required to:

(1) Consult with ACCHO members and other health care services as appropriate, and develop an Ear Health Needs Assessment and Advisory Report that:

- Maps current ear health activity and programs available
- Identifies needs and gaps
- Maps current formal and informal referral pathways between ACCHOs and other primary and secondary ear health services, identifying where they need improvement;
- Assesses availability, quality and use of ear health equipment;
- Assesses training needs and training availability for ACCHOs;
- Develops strategies to address identified needs and gaps;
- Identifies effective networks and committees that will be useful in implementing the strategies.

(2) Based on (1) develop an annual *Ear Health Activity Plan and budget* to address needs and gaps (using a template provided by the Commonwealth).

(3) six monthly *Ear Health Performance Reports*, using a template provided.

(4) an *Ear Health Coordinator Final Report* at the conclusion of the funding period that includes outcomes of the strategies and activities, evaluation of the effectiveness of the project, key results, benchmarking and trend analysis over the life of the project; and recommendations for the future of the project and Indigenous Ear Health in the jurisdiction.

The reporting requirements (in terms of the templates and data collected) and the quality of the reports submitted about the EHC role have been criticised by two grant managers. The concerns expressed include “small description about the outcomes of the coordinator role within a big reporting template”, difficult to determine resource allocation, difficult to determine the effectiveness of activities and a lack of comparative data. In these two States, the fundholders have been required to revise and resubmit their reports or to modify their activities to better meet the contractual requirements.

Interviewees not directly involved in the program expressed a lack of clarity about the EHC role; and some fundholders have interpreted the emphasis of the role differently. This suggests a need for further efforts to clarify and define the role.

A common theme in the consultations was the ‘unrealistic’ expectations of the role, based on the funding provided; and the equal funding allocated to jurisdictions regardless of different contexts.

Another issue is the ‘reach’ of ACCHO state/territory peak organisations in their jurisdictions. The Table below shows the current numbers of member health services in each of the ACCHO state/territory peak organisations, and the current number of IAHP-funded Aboriginal Health Services in each jurisdiction.\(^{54}\) There is a caveat on these data, as there is not always an exact match of ACCHO members with IAHP funded organisations. (Not all Aboriginal health services are members of their state/territory ACCHO peak body; and not all Aboriginal health services receive IAHP funding). It is presented to give an indication of the reach and coverage that an ACCHO EHC may have within their jurisdiction, and an indication of comparative workloads.

\(^{54}\) Based on IAHP data re `organisation type` receiving IAHP funding.
### Table 5. ACCHO member health services versus current IAHP-funded Aboriginal health services

<table>
<thead>
<tr>
<th></th>
<th>WA</th>
<th>Qld</th>
<th>SA</th>
<th>NSW</th>
<th>Vic</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCHO members</td>
<td>22</td>
<td>21</td>
<td>25</td>
<td>11</td>
<td>52</td>
</tr>
<tr>
<td>IAHP funded orgs</td>
<td>55</td>
<td>10</td>
<td></td>
<td>41</td>
<td></td>
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<tr>
<td>ACCHO members</td>
<td>11</td>
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<td></td>
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<tr>
<td>IAHP funded orgs</td>
<td></td>
<td></td>
<td></td>
<td>23</td>
<td></td>
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</tbody>
</table>

These variations in membership size, together with the variations in remoteness classifications, distances and travel costs between jurisdictions, do support the argument that, for a flat rate of funding, different expectations would be warranted in different jurisdictions.

5. How well aligned, coordinated and linked is the Ear Health Coordinator program with other ear health and hearing services, including those provided by state government and the non-government sector?

Key points from the consultations were:

- EHC coordinators (or the fundholder) reported regular collaboration with ear health service providers (in a range of forums/committees/working groups).
- It is less clear whether and how the EHC program links with other Commonwealth programs (for instance there were differing degrees of familiarity and contact with the Benchmarque training program and the equipment program).
- There was close cooperation with the HEBHBL program in most jurisdictions.
- Because not all ACCHOs are members of the peak jurisdictional organisation for ACCHOs, not all Aboriginal health services are necessarily supported by the EHC in each State.

6. What are the challenges and enablers for the Ear Health Coordinator program?

The following challenges for the EHC program were identified by interviewees:

- Expectations of the role were too broad and unrealistic: “The activities need to be realistic – some of them you think ‘how could anybody achieve that?’ In some ways, you are setting yourself up to fail. But the objective of the program is good.”
- The cost of travel.
- Inadequacy of the funding to support all the required activities.
- Staff turnover in ACCHOs and the need for ongoing, continual training and support of staff.
- The lack of incentives for ACCHOs to prioritise ear health.
- The time required to get established in the role, make connections with services and maintain relationships.

The following enablers for the EHC program were identified by interviewees:

- Existing relationships between the ACCHO affiliate and key stakeholders.
- Telehealth and the cost savings and efficiencies it brings.
- Being funded early and having ongoing funding.
- SA’s collaboration with the NT in the APY Lands and ability to share travel etc.
- Working towards consistency in patient information across the member services will enable other outcomes.

7. How could the programs and services be strengthened or improved?

Interviewees suggested that the EHC program could be strengthened by:

- More funding to deliver the expectations of the role – more positions to achieve what the program stipulates.
• Staggering the activities and building the program up over time.
• Considering whether the EHC program should be sitting within the peak bodies or elsewhere.
• Focusing the role on providing training and upskilling primary healthcare providers.
• Avoiding duplication with roles in the HEBHBL fundholders that do similar work in the ear health area.
• Better promoting and explaining the position to the sector.
• Improve the reporting requirements.
• Establishing evaluation and monitoring of the program.
• Changing the roles to regional coordinators, to reduce travel costs and enable follow up on training.
• Give the roles more responsibility for health promotion and prevention – to make them more proactive than reactive.
• Give the roles responsibility for supporting ear health data.
• Re-consider the essential qualifications for the role and employ ear nurse specialists who can train local staff in operating otoscopes, audiogram assessment and basic ear health screening and treatment.
Resources and Promotional Materials

Care for Kids’ Ears Resources

In brief:

$0.15 million is provided for these resources for the period 2016-17 to 2018-19.

The CFKE resources raise awareness about Indigenous ear and hearing health by highlighting risk factors and promoting the importance of seeking and following treatment regimens to prevent hearing loss.

MAIN MESSAGES ABOUT CARE FOR KIDS’ EARS RESOURCES

- The resources provided by the Commonwealth are regarded as useful and culturally appropriate by the majority of service providers who have used them.
- The gap in resources is in relation to hygiene and a patient focussed patient pathway for ear health surgery.
- Discontinuation of the use Indigenous media outlets as part of a health promotion is regarded by some key stakeholders as a mistake, particularly because appropriate public health messages need to be ongoing and persistent in order to raise awareness and change behaviour.
- Other resources and health promotion approaches have been developed locally or in other programs and these could further enhance the resources available on the Commonwealth website.
- Some templated resources, available in digital format that can be adapted by local health services for their communities, would enhance the resources.

MAIN MESSAGE ABOUT OTITIS MEDIA CLINICAL CARE GUIDELINES

- The Otitis Media Clinical Care Guidelines are highly regarded by service providers and are the reference point for other State-based documents in describing the pathway for the clinical care of Indigenous children with middle ear disease.

Answers to examination questions

1. To what extent are the initiatives achieving their objectives?

The CfKE resources are intended to raise awareness about Indigenous ear and hearing health by highlighting risk factors and promoting the importance of seeking and following treatment regimens to prevent hearing loss.

More than half of survey respondents were not aware of the CfKE resources (n=39, 57%) while the rest were aware of them (n=30, 43%). Respondents who were aware mostly indicated that they knew about them through their workplace. Others said they found out about them through word of mouth or from an internet search. When asked about the usefulness of the CfKE resources, more than 80% of respondents rated ‘useful’ and ‘very useful’. Most were unaware of whether parents, early childhood educators and teachers used the CfKE resources.

Some respondents knew little about the resources, but were aware of the OM Clinical Care Guidelines (available from the resources website) and said that the Guidelines were used and useful.

The program’s ordering data show that a range of organisations have requested the materials, with the principal groups being: Health Services, Schools, General Practices, Early
Childhood Educators and Aboriginal Health Services (66%), suggesting that the resources are being accessed by the target groups.

Most stakeholders interviewed knew of the resources, although at varying levels of detail.

“We’ve heard they are good resources for early educators, teachers, health professionals, family who use them. And it’s useful that they can be requested in hard copy and electronically.”

Despite mostly positive feedback about the usefulness of the resources, ordering data suggest that the rate of ordering resources is declining.

2. How do the CfKE resources contribute to improved Indigenous ear health and hearing outcomes?

CfKE resources

Interview respondents suggested that the resources are useful for educating families and for reducing the fear of children prior to an ear examination. However, some respondents expressed dismay that the personal hygiene resources were no longer available, especially when the importance of hand washing has been identified in the literature as a key contributor to prevention.

“But the thing they used most (soap, tissues) is no longer available. That’s the sort of promotional material they’ll take out to the community.”

Generally, the resources were seen to have a two-pronged influence on improving health outcomes – improving consistency and supporting clinical practice; and supporting health promotion and health education.

The CfKE resources program had previously included funding of public awareness raising and education through local Aboriginal media outlets. This had been positively evaluated in 201355 and some interview respondents suggested that this campaign had been working effectively to reach communities and said they were disappointed by its cessation.

OM Clinical Care Guidelines

The national OM Clinical Care Guidelines56 were widely known by service providers and highly regarded. All the State-based clinical guidelines that were identified in the literature search (whether they are Indigenous specific or not), as well as recently released strategies or frameworks, refer clinicians to the Guidelines for the care of the ear health of Indigenous children. The proportion of orders for the Guidelines has increased over the time period examined.

Clinically related resources (the OM Clinical Care Guidelines, the plastic anatomical models of the ear) and the Early Childhood (Educator) Kits are the most frequently ordered resources. In the interviews, there were anecdotal examples given of providers being unaware of the Clinical Guidelines; and one jurisdictional representative thought they focused too much on treatment of children in remote areas and not enough on urban children and prevention. The Clinical Care Guidelines are currently being reviewed and will

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56 Recommendations for clinical care guidelines on the management of Otitis Media in Aboriginal and Torres Strait Islander populations
be available in an app format. The revised guidelines will have an increased focus on health promotion and prevention. 57

3. How well is the CfKE resources program operating?

Survey respondents suggested that, like the equipment, even if resources are already sitting in a health service, unless staff are aware and know how to use them, they will not be utilised. Others said that resources form one part of health promotion and, by themselves, cannot be expected to work effectively without a broader and ongoing education campaign about Indigenous ear health and hygiene.

4. How efficient and effective are the processes, structures and systems for the delivery and monitoring of the CfKE program?

The CfKE resources are provided on a relatively low budget, managed in-house by the Indigenous Health Division staff and with website support. The ordering system is operating as required to process requests and collect data.

5. How well aligned, coordinated and linked are the CfKE resources with other ear health and hearing services, including those provided by state government and the non-government sector?

The Clinical Care Guidelines are influential among clinicians and are linked to other State-based clinical guides, frameworks and strategies, where they exist. The training program in SA developed by AHCSA and delivered by the EHC demonstrably link to the guidelines; and the Benchmarque training program links to the guidelines.

About 50% of survey respondents reported using a range of other resources, produced in other organisations, or by State government or by individuals. Many of these resources appeared to be complementary to the CfKE materials.

Based on the ordering data for the resources showing the requests for materials from schools and pre-schools/child care, and the survey respondents reported usage by teachers and early childhood educators (45% ‘yes’) the CfKE resources are supporting education and health promotion beyond health services.

6. What are the challenges and enablers for the initiative?

Nil responses in the interviews or surveys.

7. How could the CfKE resources be strengthened or improved?

Interviewees suggested that the CfKE program could be strengthened by:

- Providing a template for services to develop localized material:
  
  “The CFKE resources aren’t seen as out of date, but services prefer to develop their own resources for the local context. They see the CFKE resources as ‘too national’. They have told us what they’d prefer is a template that they can adapt for their own use, so that community can engage more.”

[Note: such a template exists on the website, but some providers are clearly unaware of it].

- Promoting awareness:
  
  “It’s not being actively promoted but they are still good resources.”

57 The Menzies School of Medical Research proposed and was granted funding by the National Health and Medical Research Council to review the Guidelines. This review is currently underway, but the Department of Health has not been involved in the grant application process or the review.
“I don’t use it enough and that’s my fault - I don’t use it enough because it’s not in my face enough.”

- Providing more resources about surgery:

“It could be expanded to help demystify the process of interaction with the health services more, particularly if that person needs surgery.”

“We need more engaging resources for kids & families who are going to have surgery. Information about consent. Getting them to understand the process and the journey. For example, explaining what happens when you have grommets put in. How long they have to stay in town; where to stay; other useful information (for liaison officer & the GP). More information for teachers of kids who have had surgery (what to expect).”

- Producing the talking book in more languages:

“…one of the great resources is the talking book. This could continue to be improved to include different languages. Aboriginal people love to hear their own language and this is often used in schools as well as in health.”

- Using the website as a repository or ‘library’ so that it contains all the resources produced in different parts of the country.

- Involving Aboriginal media outlets.

- Making the hygiene resources available again.

“The point of the resources is to change behaviours, not just increase knowledge and awareness. This kind of health messaging is largely ineffective in my experience when it is not part of an intensive active program of parent/child/community education. As stand-alone resources, they don’t produce needed change.”