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Appendix 2

This appendix was part of the submitted manuscript and has been peer reviewed. It is posted as supplied by the authors.

Appendix to: Bailie J, Schierhout GH, Kelaher MA, et al. Follow-up of Indigenous-specific health assessments — a socioecological analysis. *Med J Aust* 2014; 200: 653-657. doi: 10.5694/mja13.00256.

Appendix 2

Social-ecological framework depicting themes relevant to follow-up of health assessments, with expanded list of exemplar quotes

Themes	**Sub-themes (where relevant), exemplar quotes and relevant program data**
Patient level	
Patient demand and information	*The next question is do Aboriginal people want to be followed up? Some only want to see doctors when they are sick. There is a hierarchy of needs of what people want in their household.* (Indigenous Health Project Officer, Medicare Local) *It's also important to explain to and educate patients about why the doctor wants them to have so many visits.* (Indigenous Health Project Officer, Medicare Local)
Access issues	Transient population: *Main issues are transiency of site Aboriginal population making follow-up difficult.* (AHS, group discussion) *Challenges contacting patients include highly transient population.* (AHS, group discussion)
	Difficult to contact patients: *patients often don't have mobile phones or if they do have mobile phones it is often shared between people, limited literacy, incorrect addresses or old addresses and no mail delivery.'* (AHS, group discussion)
	Transport: *Transport also causes the barriers for mainstream clients to uptake the extra services such as allied health compared to the access available (one stop shop) at AHSs.* (Division of General Practice, group discussion)
	Cost: *They have to pay first and then claim that gap … many patients can't afford the upfront payment.* (AHS, group discussion)
Interpersonal	
Culturally appropriate care	*A lot of allied health people don't understand the needs of the Aboriginal community from a cultural awareness perspective.* (AHS and Medicare Local, group discussion) *Trying to balance to make sure the patients are attending their appointments without being 'heavy handed' in a more culturally sensitive way.* (GP, AHS) *Patients are not very active. They are not very keen to come and get the health assessments done. Need to force them.* (Practice Manager, General Practice)
Perceptions of non-adherence and clinical inertia	*We do a lot of referrals but we don't get many people turning up for their appointments for them. Therefore it's not billed and therefore it doesn't register as a service … a failure to the system that is not coming through. When we are seeing and talking to people and spending that time one-on-one they are very enthused … it's a bit of a sales situation where the GP is suggesting referrals to allied health or practice staff for aspects of their care. They are keen … but then don't follow through.* (GP, General Practice) *I would like a Medicare Item number showing failure to attend, even if there was not money attached to it. Because we get kicks in the guts all the time. There is not recognition of the fact that we have done all the right things but they haven't bloody well turned up. I do not use a nurse for this follow-up item number as I contract them in for items such as health assessments and team care arrangements and its not worth my while to use this item number - not on a contract basis due to risk of no shows.* (GP, General Practice)

	The main factors that have discouraged general practices to get involved in Closing the Gap are preconceived ideas of what Aboriginal patients are like, for example multiple and too complex medical conditions. Non compliance with medical directions and drug regimens. (Indigenous Health Project Officer, Medicare Local) *Not much issues but when patients agree to a follow-up they never turn up. Patients get reminder frequently.* (GP, General Practice)
Awareness and external support	*The main problem is that a lot of patients do not turn up for the follow-up appointments, we rescheduled many times and that's really frustrating. To overcome the problem we involve the IHPO and the OW a lot.* (Practice Manager, General Practice) *The practice nurse items numbers are not readily understood or information not available to the nurses in remote area clinical setting so they go unclaimed.* (GP, AHS) *We have been successful in educating the GPs about the Aboriginal specific MBS item numbers but the allied health providers are not willing to take it on. I've had patients ring me up saying the provider has billed them even though they have been referred under a team care arrangement [or follow-up item number], even though they've got the appropriate form – it's been my biggest struggle. To get around it I refer to the providers that have the machine to swipe the Medicare card so they don't actually bill the patient at all.*(Care Coordinator, Division of General Practice)
Health Service	
Workforce shortage	*Workforce shortage of GPs in [site name] a limited number of GPs. There is a difficulty in getting into GPs. Challenge for nurses to find time to undertake chronic care as opposed to doing acute care. What do I do if I have limited time - immunisation or health assessment? I am constantly trying to)juggle acute and chronic care.* (Nurse, General Practice) *There is a private allied health shortage. (AHS and Medicare Local, group discussion)*
Organisational culture and commitment	<u>Focus on health assessments</u>: *Follow-up, we are not doing many. It is hard to get the nurse and AHW to bill. The focus has been on health assessments.* (AHS, group discussion) *Health checks happen but nothing much happens after that. That's where it ends.* (GP, AHS) *The target based incentive has just started – the practice manager spoke to the team last week that we have to reach the targe[number of health assessments]. Within the month, if you reach target you get incentive and if go over the target you get double the amount of the incentive. Trying to get as many as possible within the month.* (GP, AHS)
	<u>Small numbers of Indigenous patients</u>: *'In General Practice Aboriginal patients often only make up a small proportion of patients and so they would be less inclined to get head around Aboriginal specific item numbers when can just charge regular item numbers at no loss of funding to them.'* (Medicare Local, group discussion) *'Follow-up, we are not doing many. It is hard to get the nurse and AHW to bill. The focus has been on health assessments.'* (GP, AHS)
	<u>Acute care focus</u>: *There is a practice nurse but she is focused on acute care, if there was more nursing staff more things like health assessments and care plans could get done.* (Practice Nurse, AHS)
	<u>GP-centric model of care</u>: *We have different doctors that are happy to sign off on that item number. We have six doctors at the moment but we have three now that won't do it. This is what you claim for this patient, the nurse writes what they are to claim but still they don't do it.* (AHS, group discussion) *High uptake is because practice nurse drives it in practice. Focus is on practice nurses. We have an increasing number of practice nurse in practices.* (Division of General Practice, group discussion)

System capability to support follow-up	Lack of established systems: *The health checks are done fairly spontaneously and opportunistically. It's not that it rushed but it is not a stand-alone thing, often linked with when the patients presented with another problem. There is less interest from people on the day it is done and it's harder to make people to come back. The people did not come to do the health checks in the first place any way on the day.* (GP, AHS) *There has been a gradual exposure to more Aboriginal clients as patients start to self identify. Practices not knowing their clients were Aboriginal until the clients started to identify as a result of being asked about Aboriginal status.* (Indigenous Health Project Officer, Medicare Local)
	Leadership and management: *It's because the practice nurses are so busy they don't have the time to claim the item numbers. If there is a good practice manager they can keep an eye of what happens. The practice manager is in a position to follow-up with the practices nurses to claim the item numbers after the patients are out of the treatment room on each occasion. From [my] experience, the nurses are the clinical people so they do not think about the business side of the item numbers.* (Indigenous Health Project Officer, Medicare Local) *It is driven by a couple of GPs. There was a GP interested in health assessments and then they left. Clinic manager started recently and she is very focused on these.* (GP, AHS)
	Clinical information capability: *The administrative system at the practice needs to be set up properly that would impact the recalls, reviews, and claiming.* (GP, General Practice) *Have to have a good IT system and all staff be required to use.* (AHS, group discussion)
Delivery system design	High staff turn over and high use of locum staff: *Challenge implementing follow-ups, even for abnormal pathology, with high turn over of GPs as another GP has to pick up the patient.* (GP, General Practice)
	Bill for standard consultation: *Low claiming of practice nurse and allied health numbers is possibly because the item numbers are used that are for general population. Same for allied health … why use an Aboriginal specific one … there is no incentive for them to … they are not paid any extra and so just use mainstream item number. Why create confusion with item numbers?* (Program Manager, DGP) *Many allied health providers have been a source of frustration as … generally in the region [they] are not aware of and are resistant to the special MBS item numbers for follow-up care for Aboriginal patients, and even when informed of them by Aboriginal clients say 'well I don't know about that and I don't bulk-bill so here's the bill - pay up'. This approach then has a very negative effect on the patient and their willingness to seek further allied health services.* (Care Coordinator, Division of General Practice) *Were claiming under standard EPC items not the ones that are Aboriginal specific for some time. It is just that we were very comfortable with the others from a care plan.* (Nurse, AHS)
	Alternative service providers: *We tend to utilise our own in-house allied health if we can and other public system allied health.* (AHS, group discussion) *We use Government funded allied health from hospitals and community health so can't claim their follow-up items.* (AHS, group discussion)
Cost and transparency about cost	*We are promoting when you get your health check you are entitled to these allied health items but they have us over a barrel as they charge a huge gap. Practices identifying that they are doing health checks but nowhere to refer that will bulk bill. The practice is saying what was the value was in this then?*(Division of General Practice, group discussion) *I refer a lot for physio under a health check. They still charge a gap payment and they charge upfront even if I do a referral.* (GP, AHS)
Community	
Social and economic	*The Outreach Worker gets a list of patients that need to be recalled or followed up and goes and finds the person. The (people in the) community often have no fixed address, no phone or changing numbers or no credit so outreach worker has to track that person down; go and find that*

disadvantage	*person and get them.* (Practice Manager, AHS)
Limited evidence of work to promote community awareness	The focus of the work has been in the promotion of community awareness of health assessments rather than on importance of follow-up. *We are raffling bikes as an incentive to motivate people to have a health check* (Indigenous Health Project Officer, Medicare Local) *Also used the incentives for people to have a health check – provided with t-shirts for health checks, currently also providing vouchers for food.* (GP, AHS)
Policy	
Funding commitment for preventive care	Commonwealth Government has committed funds to preventive health care and follow-up Medicare rebate items.
Funding commitment for positions and programs	Commonwealth Government has funded programs or work such as Healthy for Life and the Indigenous Chronic Disease Package that have a focus on increasing uptake of health assessments and to a lesser extent on follow-up.
Focus on promotion of the health assessments	Commonwealth Government has focused funding primarily on promotion of health assessments. *Often the focus from Medicare and the Department (Department of Health and Ageing) is on sign up [for health assessments] not the ongoing requirement for follow-up.* (AHS and Medicare Local, group discussions)
Eligibility of Aboriginal Health Workers to bill	*There are a limited number of Aboriginal Health Workers with Cert IV, therefore, although national registration has commence … there are not yet enough accredited workers that can use the Medicare items.* (AHS, group discussion)

Note: Aboriginal Health Service (AHS)